

(Below are a pair of July 2003 postings by Professor O'Hara to a listserv for business law professors: ALSBTALK www.alsb.org The topics are medical malpractice insurance, the purported existence of a failure in the tort system, and the quality of the targeting of the "solution" of capping medical malpractice claims. Since the date of those postings, only minor editorial changes have been made [e.g., several typos corrected; two web links corrected].)

FIRST: July 19, 2003: Defense of Tort Reform (Poison the Well)

As one hears the repeated chorus of laments about the abuse of legal process via frivolous lawsuits one might be forgiven if drawn to the conclusion that frivolous lawsuits were not actionable. For surely, no laments of frivolous lawsuits would be proffered by any honest person who had a genuine cause of action to redress this wrong so egregiously foisted upon the lamenting soul.

But, alas, there are those who walk the face of the earth who are so blinded by their pursuit of riches that truth is not the only sound that parts their lips.

The interface of zealous advocacy with that peculiarly American region void of objective truth, political free speech, enables (and I use that term in the pejorative) insurance spin doctors.

Least ye be too judgmental, let us but take a moment to examine the contour of the profit maximization problem confronting an insurance company, and then ask yourself: "Would I tell the unvarnished truth?"

The insurance company, at a mean price, accepts the transfer of risk from multiple insureds. The predictability of that aggregated risk is believed to be greater than the individual risk. Additionally, the fixed costs of reserves to cover near term occurrences of those individual risks are believed to be lower than aggregated self insurance, especially when coupled with the compounding time value of money. Additionally, the transferred risk runs out into the increasingly murky future, where the superior acumen of the insurer is expected to be handsomely rewarded. But all is not sweetness and light, moral hazards and adverse selection are but a couple of the devils lying in wait to deny the insurance company its rightful profit for its noble deeds. As a consequence of this context, one should reasonable expect, and one should forgive, insurers if they are biased in their estimates of risk and fastidious in their contract interpretations of risk transferred to the insurer from the insured to the insurer. Without such vigilant bias and fastidiousness one would need to reasonably expect bankrupt insurers. Their corporate forms are populated by humans with hearts like yours and mine. If not tethered by their biases and fastidiousness, surely those humans would relent when confronted with the calamities their positions require them to witness. And, I believe one and all can agree that the only thing genuinely worse than a biased and fastidious insurer is a bankrupt insurer.

In calculating the mean price the insurer forecasts each of the individual losses in terms of both probability and dollar magnitude. Most difficult to accurately forecast are the risks that are both infrequent and have large dollar magnitude losses. These risks also are the losses that can seriously reduce an insurer's profitability or even bankrupt an insurer. These risks capture an insurer's attention. These risks drive up the average price of insurance, by a minuscule amount if the pool of aggregated insureds is huge. Such large dollar loses that capture the insurer's attention also should drive the insurer towards educating the insured on minimizing the risk.

The real question is when does fraud supplant vigilant bias and righteous fastidiousness?

Nearly all major insurers (especially after the rampant "privatization" of mutual companies) also dwell within the securities market. It is not good that the securities markets of

the USA are perverted. The dominate perversion of our era is shortsightedness. For example, many corporations only see, at best, the earnings of the next quarter; at worst, earnings this quarter. This is the antithesis of insurance (e.g., how many quarters remain on your life insurance policy?). Poorly trained managers are bewitched by the siren song of quarterly earnings, fail to reach harbor safely, and thus defeat the reasonable expectations of those who sought contractual association with the insurer.

It gets worse. Within the insurer, the arriving future is the dominion of the insurer's minor minions. These minor minions are charged with temporally narrow and administratively confined authorities as well as subjected to pressures calculated to generate value in this quarter. This is the primary source of bad faith by the insurer that triggers punitive damages, ala the All State case in the USA Supreme Court this year.

But what is the source of sub-libelous casting of aspersions related to frivolous lawsuits? In a word, it is sophistication.

Time is the stock and trade of insurers; major corporations also market time, but less so.

These giants of Wall Street are not fully under the sway of the sirens. They understand full well that board room decisions today will reach fruition 10's or 100's of months in the future. And, legal liability is a part of those time tethered decisions. The contours of future legal liability are uncertain, but they are subject to some control.

One form of risk management that seeks to control future legal liability is a lawful document retention plan. Hence, with no known law suit in sight, lawyers counsel clients to establish a well crafted and practiced document retention plan. There are many goals of a document retention plan. Avoiding storage costs is but one. Avoiding the proof of truths that create, rather than extinguish, legal liability, in a court of law is another.

If such advice had been heeded, then it should have prevented the titanic losses of the cigarette companies. For example, never should it have been possible for the plaintiffs to prove the truth in court. In court, plaintiffs never should have been able to prove that cigarette companies knew their product was addictive, knew their product materially elevated the risk of disease and death, knew they falsely portrayed their product otherwise, and knew they manipulated their product to maximize addiction. That was just bad risk management.

What is good risk management? The rampant claims of frivolous lawsuits is good risk management.

Do you believe a good lawyer begins voir dire no sooner than the moment the jury panel enters the box? Should an artful voir dire do no more than identify persons who are incapable of honest judgement? Or, might it seek to sway those that do make it to the petit jury? Was the pre-trial media circus of OJ crafted to leave untouched the minds of those who might become petit jurors? Do you believe GE's Jack Welch is a less talented public relations artisan than OJ's Johnny Cochran? Does the understanding that profit lies 10's or 100's of months in the future invite inaction? Does the champion artisan of public relations, Joseph Goebbels, who perfected The Big Lie, have nothing to teach the major minions of the major corporations and insurers? Are they not merely transferring that technology from politics to economics? For example, see <http://www.defencejournal.com/2000/jan/p-warfare.htm> . (*The archive of the www.defencejournal.com now requires registration.*)

Suffice it to say that insurers and other major corporations seek riches. Suffice it to say they retain the skill sets of sophisticated people, and compensate them well for perceived effectiveness.

If you doubt daily life can poison the well from which the petit jury is drawn, then, when you are in Nashville I invite you to talk with Kimberlianne Podlas about her research on those bogus television shows that are passed off as "reality" court TV. Who owns NBC? Or, yeah, its GE. Viacom owns CBS. Walt Disney owns ABC. News Corp. (i.e., Murdoch) owns FOX. AOL owns CNN. See, <http://www.newint.org/issue333/facts.htm> .

I will leave largely untouched the "loser pays" suggestion for "improving" the USA tort system. I will but note that the so-called victims of frivolous suits proffer the claim that they do not seek redress for the frivolous lawsuit wrongs they suffer because their would-be defendant could not make them whole. How odd that with the other fork of their tongue these same spokespersons identify those ne'er-do-well frivolous plaintiffs as able to afford to sue-and-lose when suit appears justified, and thus in no way are unjustly retarded from righting what wrongs these plaintiffs might suffer at the hands of their masters. How odd indeed.

Or, we might paraphrase the greatest media giant of direct marketing, and say: "Forgive them not for they know what they do.". That might be a tad harsh, but I would need to consult Dante for an accurate placement.

http://www.gpc.edu/~shale/mapping_files/lowhelm.html

Michael

SECOND: July 20, 2003: Let me see if I understand.

The health care industry has multiple actors of widely varying economic size, each actor occupying one or more levels in a multiple level industry, with each actor having varying degrees of economic dependence upon the health care industry, and with each actor sharing a multiplicity of interactions with other actors within the health care industry. At best, some actors share a market interaction that imitates competition. Most frequently, economically small actors confront economically large oligopolists. Additionally, the members of those oligopolies, both within individual oligopolies and across oligopolies, often conjoin within trade associations and/or lobbying consortia and generate market results that approximate lawful collusion, if not explicitly seek that outcome. Further, because the market interface between MDs and third party payers has effectively capped the maximum revenue of MDs, the market interface known as tort litigation between consumers and malpractice insurers is broken.

Did I capture the essence of the market failure afflicting medical malpractice insurance?

Please forgive me, but I am not persuaded by the second clause of the last sentence of that particular view of the essence. I would have found far more persuasive either [a] a call for the elimination of all third party payers, or [b] a call for a single third party payer. Does the category of market actor known as a third party payer exist because malpractice insurance exists? I think not. The linkage between previously and continuously exerted third party payer market power and malpractice premiums is tenuous from a policy perspective. For the individual MD feeling the squeeze from two (different?) oligopolies, the pinch is real. That real pinch on the MDs balance sheet does not translate into the tort system is broken.

(Although, I do see a connection between increases in medical malpractice triggered by the denial of medical care by third party payers and predicated upon third party payer financial

decisions. I also see a broken tort system in so far as patients harmed by such clandestine actions are legislatively stripped of standing to sue. But, somehow, I suspect that is not what is meant by insurers and major corporations when they say the tort system is broken. Accordingly, I will leave aside that break in the tort system and turn to what is meant when it is said that the tort system is broken.)

What then is the source of the impetus for MD exit and malpractice insurance increases? Let's explore those two separately, taking the MD exits first.

Yes, indeed, MDs are exiting in noticeably elevated numbers. Yes, indeed, many exiting MDs point to a monetary motive. Sometimes the indicated monetary motive is said to be either primarily or fractionally influenced by malpractice insurance premiums. When the fixed cost of malpractice insurance exceeds \$10,000/month for an OB/GYN and \$30,000/month for an ER doc, then we should expect those who retain CPAs to exhibit decision making with some rational attributes.

Historically, is there an age at which earnings peak regardless of job title? Is that peak relatively stable regardless of income level? The answers are "Yes" and "Yes".

As a statistical group, MDs reach peak annual income earning potential at about age 52. This is one of the youngest peaks. Regardless of job title and regardless of annual compensation, statistically, all workers reach peak earnings between age 50 and 60. It does not matter if you are a carpenter, airline pilot, or a nanny: all jobs display a lifetime annual income curve similar to that of MDs. All jobs have an annual income peak, all jobs have that peak between age 50 and age 60. How the jobs differ primarily is in the height of the peak (e.g., \$25k versus \$250k), and less so in the pre-peak slope and post-peak slope. Market participation is a major factor in the peak's location and especially the steepness of the post-peak drop. Some market exits are voluntary (e.g., I now am rich enough.) and others are involuntary (e.g., My bursitis prevents hammering, so now I will be a Wal-Mart greeter.). Historically, MDs have the steepest post-peak drop.

Why the steepest? My guess is MDs can not hide from mortality as easily as the rest of us.

When I first shared data of the peak with my brother-in-law physician he was just ready to turn 52. Protestations were in abundance. One year later he had attended the funerals of four patients who had passed annual check-ups with flying colors less than 8 months prior to death. Mortality, especially the value of youthful retirement, was appraised anew.

The rate of voluntary exit of MDs is much greater than other jobs. Objective fiscal analysis, objective mastery analysis, and subjective emotional analysis drive MDs from the market. MDs are driven from the market by:

- [1] the requirements of continual, new, substantial investments of time and money needed to sustain acceptable skill levels;
- [2] the diminishing marginal value of income dollars because of accumulated wealth;
- [3] the medical profession's insistence on sustained mastery of an evolving skill set;
- [4] the MD's internalized commitment to the profession's insistence on sustained mastery of an evolving skill set;
- [5] a superior objective, and quite likely superior subjective, sense of mortality; and
- [6] shifting personal priorities away from profession and towards family (who were denied access to the MD during training).

I am sure there are more drivers, but these are just the few that are obvious.

The "MD" is an asset that continually is becoming obsolete. Both internal metrics of sufficient proficiency as well as peer group M&M conferences alert the MD of the onslaught of obsolescence. The newest and best technology is arriving daily. To avoid involuntary exit the MD must avoid obsolescence. That obsolescence only can be held at bay by additional and increasing new investments in human capital. The fear of harming a patient is great and grows with knowledge of one's limitations. Driven by an allegiance to the motto "First, do not harm.", many MDs conclude exit is morally required. That fear is quantifiable, to a degree, because the MD knows that the risk of indisputable malpractice increases with any deferred continuing education as does the risk of loss of a malpractice suit.

Of course, no MD ever would exit the market claiming escalating insurance premiums drove the MD from the market, when, instead, the prime variable was a combination of fear and reduced profitability from embedded investments. Of course, no MD ever would exit the market with a face saving statement. Of course, no MD would ever exit the market with a statement calculated to improve the financial condition of the remaining members of the tribe. Of course not. The tort system must be broken.

What then is causing an elevation of the number of MDs exiting the market. Surely it is not something as simple as the leading edge of the baby boom bumping up against the job which has the historically earliest peak in annual earning, primarily because of voluntary market exit. No, that could not be it. Nor could it be as simple as an industry engulfed in rapid technological change that requires continual new investment in aging human capital when that industry has internal and external metrics based on a commitment to outcome based analysis. It could not be that simple. Surely, the insurance industry and major corporations would not miss something that simple. It must be that the tort system is broken. Perhaps a bit of economic analysis will shed some light so that we all can clearly see that the tort system is broken.

Normal profit is the accounting profit necessary to attract to and to keep entrepreneurial ability. Normal profit is a subjective reaction to an objective dollar amount. More importantly, normal profit has both fixed cost and variable cost components. Critically, the fraction of normal profit that is fixed cost is susceptible to instantaneous subjective reappraisal. That is, in an instant the entrepreneur can recategorize a previously fixed cost of normal profit as a variable cost.

Rational actors use the Shut Down Rule to choose when to exit a market. A rational actor shuts down when total revenues are less than variable costs. As long as total revenues are greater than variable costs, even if total revenues are less than total costs, the rational actor minimize losses by staying in the market. Destructive Competition is the unfortunate condition of total costs persistently exceeding total revenues, but total revenues exceeding variable costs. In destructive competition the rational actor continually earns an economic loss, but can not rationally cease doing so: shutting down increases the losses.

Since shut down is triggered by the relationship between revenues and -variable- costs, and since insurance premiums are fixed costs, how then is it that insurance premiums prompt shut down? Oh yeah, the output is in units of a year as are the premiums. Rather than pay a new premium for the next year I exit the market. Thus, insurance premiums are a variable cost that feeds the shut down rule. If insurance premiums are to be -the- variable cost that triggers the exit of MDs, and if the tort system is broken, then surely the only variable costs that are increasing materially are the insurance premiums. But, alas, such is not the case. In addition to annual insurance premiums, MDs encounter an escalating variable cost structure to stave off obsolescence. But, wholly unlike escalating insurance premiums, escalating continuing

education and escalating technology investments do not prompt any MDs to exit the market. Nay. These other escalating variable costs do not cause MDs to exit the market because, as we know, the tort system is broken.

MDs have a substantial fixed cost investment in their career. However, these fixed costs are sunk costs and rational persons ignore these sunk/fixed costs. But MDs are human, and merely, on occasion, mimic rational beings. Humans derive significant subjective value from some sunk/fixed costs: for example, the social role of practicing physician. When MDs, just as with farmers, approach the margin of the Shut Down Rule, that subjective value of the sunk cost can either steel the backbone for adhering to the Shut Down Rule, or that subjective value of the sunk cost can instantaneously transform the fixed cost into a variable cost and trigger shut down.

(Personally, this, I think, is a major factor in triggering MD exit. Be it malpractice insurance premium increase or be it technology cost increase or be it continuing education credits expiring or be it lower capitations by third party payers, for each individual MD there is some straw that breaks the emotional back and triggers a cascade of reappraisals that are the true source of the decision to exit.)

I take as axiomatic that -any- increase in -any- input for -any- job title will push over the margin -some- members of that job title. MDs are no exception. I accept as true that in some States some insurers have raised insurance rates materially and thus a noticeable increase in MD exit either has occurred or should be expected as policies mature.

I reject the proffered allocation of a many, let alone most, MD exits to the cause of malpractice insurance premiums and in turn to the cause of a broken tort system. It does not follow that the only reason those exiting MDs left was/is the premium level. The insurance premium compels an objective process of appraisal but does not compel only those dollars nor only dollars fill the scales.

Nor does not follow that "tort reform" of the ilk proposed by insurers will reduce premiums. On three counts it does not follow. First and, to my eye, foremost, if the tort system is not broken in the manner proffered by the insurers (and I strongly suspect it is not broken), then the likelihood of their remedy generating a solution is a low likelihood. Second and third, even if the remedy either is tailored to an accurately identified problem or is, per chance, tailored to some other untargeted flaw in the tort system, that does not translate into reduced malpractice premiums and does not translate into recovery of the lost physicians.

Particularly in oligopolies, market prices move easily upward and are very sticky on downward movements. Particularly in professions it is far less costly to exit the market than to enter.

As promised above, let us now turn to why the malpractice insurance premiums have gone up.

I am sure that if we examine the data of insurance carriers that have raised their premiums, then, without exception, we will see a pattern of claims made escalating beyond those reasonably forecasted by the insurers. Also, we will see a pattern of claims paid also escalating beyond those reasonably forecasted by the insurers. Lastly, we will see a pattern of magnitude of the largest claims paid also escalating beyond those reasonable forecasted by the insurers. Otherwise, what, possibly, could be the explanation for malpractice insurance premiums climbing?

I am sure these are no more than the biased conjecture of some wild eyed and fool hardy liberal, but, could it be the repeal of Glass-Steagall? Or, could it be insurance managers have found it easier to reap profit from public relations induced alterations in the contours of legal

liability post-contractual commitment? Or, could it be, insurance managers focused on quarterly returns, and salivating at the sight of an expanding equities bubble, invested imprudently? Or, could it be, pure and simple, greed? No, of course, it could not be any of those, for as we all have been told repeatedly, the tort system is broken because of the death of personal responsibility at the hands of greedy trial attorneys.

Surely, the only feasible explanation is that insurers, wholly unlike trial lawyers, are driven by an eleemosynary interest in efficient markets. The learned opinion of insurers and major corporations is that the tort system is broken. Clearly, that opinion is beyond reproach. Their opinion is vouchsafed equal to their credibility established by their decades of selfless service of the common good.

If you will excuse me now, I need to visit an ER doc to obtain stitches for a long series of injuries to my cheek.

Michael