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ation (AMA) reports that twelve states face crises in their medical liability systems, with problem signs appearing in another thirty.[4] However, there does not appear to be a crisis in the remaining states, as growth in insurance premiums has been low.

The spike in premiums has created much tension within the physician community. Prospects for federal tort reform limiting payments from malpractice suits have been improved by support from President George W. Bush and a lobbying campaign by the AMA. The House of Representatives recently passed the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003 (H.R. 5), which would limit payments from malpractice claims. However, similar legislation has not passed in the Senate.

The crux of the debate focuses on the underlying causes of the most recent rise in premiums. Providers point to a rise in jury awards and rising costs of defending malpractice claims (rising severity). They also highlight the role that contingency fees paid to attorneys play in creating incentives for "frivolous" suits. Some consumer groups, however, believe that rising rates can be traced to lower returns on investments received by the medical malpractice carriers and a downturn in the economy. Such disagreements have led to a contentious debate over what, if any, changes should occur in medical malpractice liability law. This paper examines recent trends in the medical malpractice industry and estimates the impact that tort reforms could have on premiums.

## Trends In Key Medical Malpractice Premiums And Financial Ratios

The past four years have seen rising medical malpractice premiums, declining profits, and a reduction in the number of liability carriers offering insurance (Exhibit 1). According to data collected by the National Association of Insurance Commissioners (NAIC), total medical malpractice premiums earned (those retained by malpractice insurance carriers) increased by 23 percent in 2002.

These averages mask variation in the growth in premiums across states. Premium increases in several states, including Florida (more than a 50 percent premium increase for internists) and Ohio (more than a 60 percent premium increase for some internists), were substantial. However, other states such as California saw very small premium increases.

The most important drivers of recent rate increases are (1) severity (awards, settlements, and defense and administrative costs); frequency (claims per insured physician); and (3) changes in investment income. In combination, these factors largely determine expenses and, when compared with premiums earned and investment income, are an indication of overall profitability.

One widely used profit measure is the loss ratio (awards, settlements, and defense costs as a percentage of premium). Exhibit 2 presents data concerning the combined loss ratio, a broader measure that also includes dividends paid to policyholders and corporate income

**EXHIBIT 1**
**Trends In Medical Malpractice Premiums, As Percentage Change, 1998-2002**

| Year | Premiums earned (%) | OB-GYN premiums (%) | Internal medicine premiums (%) | General surgery premiums (%) |
|---|---|---|---|---|
| 1998 | 9.1 | 0.3 | -2.9 | 1.0 |
| 1999 | 3.9 | 2.1 | 5.1 | 1.1 |
| 2000 | 5.3 | 4.8 | 7.3 | 7.0 |
| 2001 | 14.1 | 10.3 | 9.9 | 12.0 |
| 2002 | 23.2 | 14.2 | 20.[illegible] | 21.9 |

**SOURCES:** Premiums earned: National Association of Insurance Commissioners data; and premium increases for physician specialties: tabulations from the Medical Liability Monitor, 8 October 2002.
**NOTE:** OB/GYN is obstetrician/gynecologist.

**EXHIBIT 2**
**Trends In Medical Malpractice Financial Ratios, 1995–2002**

| Year | Broad combined ratio[a] (%) | Loss ratio[b] (%) | Investment insurance ratio[c] (%) | Net income[c] (%) |
|---|---|---|---|---|
| 1995 | 126 | 95 | 49 | 23 |
| 1996 | 124 | 91 | 44 | 20 |
| 1997 | 124 | 91 | 45 | 21 |
| 1998 | 126 | 92 | 43 | 17 |
| 1999 | 122 | 91 | 34 | 12 |
| 2000 | 129 | 103 | 33 | 4 |
| 2001 | 141 | 113 | 31 | –10 |
| 2002 | 129 | 111 | 18 | –11 |

SOURCES: Senate Committee on Health, Education, Labor, and Pensions hearing, 11 February 2003; and Tillinghast-Towers Perrin tabulations using the National Association of Insurance Commissioners filings of Physician Insurers Association of America (PIAA) companies for 2002.
[a] Awards, settlements, and defense costs plus dividends, administrative costs, and corporate income taxes as a percentage of premium.
[b] Awards, settlements, and defense costs as percentage of premium.
[c] As a percentage of premiums.

taxes, as well as investment income as a share of premium. Net income is the difference between the broad combined ratio and investment income.[5]

Several important trends appear in these data. First, the broad combined ratio, which measures claims payments, reserves for potential future awards settlements, and defense and administrative costs as a percentage of earned premiums, has risen since 1999. Thus, by 2002 every premium dollar collected resulted in $1.29 in total expenses, awards, and settlements. Historically, malpractice carriers have offset these underwriting losses with earnings from investment income. Starting in 1995, investments as a share of premiums decreased sharply, falling thirty percentage points by 2002. All combined, these trends reduced carriers' overall net after-tax income from 23 percent to –11 percent by 2002.

## What Accounts For The Deteriorating Financial Condition Of Malpractice Carriers?

Several factors likely account for medical malpractice carriers' deteriorating financial condition.[6] At issue is whether the most recent trends reflect the traditional underwriting cycle that will eventually regress to mean profits in the industry, or a permanent upward increase in average losses and premiums. Factors influencing these trends include the following.

■ **Traditional insurance cycle trends.** Although all lines of insurance have underwriting cycles, the medical malpractice market experiences wider swings in profitability. Malpractice claims face a long lag from the time an event occurs and a claim is filed to the actual payout date. Premiums established in a given year are designed to cover the claims and defense costs associated with claims filed during the same year. However, it may take several years before claims and premiums can be reconciled to a given year, which adds much uncertainty in setting premiums. Unpublished data from one large carrier revealed that nearly 70 percent of claims were paid within five years of being filed. However, nearly 12 percent took at least eight years to resolve.

Firms' policies for setting aside reserves also influence calendar-year profits.[7] Reserves are treated as an expense and, other things constant, reduce profits. During the early 1990s actual claims payments turned out to be lower than projected, and reserves set aside to pay future claims were too high.[8] Over time,

loss reserves were reduced (thus reducing expenses), resulting in rising profits (lower loss ratios) during the early 1990s. The combination of relatively high investment returns and overreserving in the early and mid-1990s resulted in rising profits that encouraged some firms to hold the line on rates. With declining profits and a projected rise in costs, medical malpractice companies have increased their reserves by drawing down surplus, resulting in lower profits (higher loss ratios).

■ **High investment returns.** The net investment yield for malpractice firms increased to nearly 8 percent by 1998 and has since declined to approximately 6 percent.[9] The growth in returns produced a high investment income ratio through 1998 but has decreased since then. Higher investment returns offset the need to raise premiums. A one-percentage-point increase in expected returns is associated with a reduction in premiums of two to four percentage points.[10]

■ **Rising severity.** Median malpractice awards (including both jury awards and settlements) per paid claim have doubled in real terms between 1990 and 2001.[11] The data indicate that severity has increased approximately 9 percent per year since 1990 (other estimates tracking the market are similar; see, for instance, data in National Practitioner Data Bank annual reports). Several factors may account for the rise in severity. (1) Rising economic costs (future medical expenses, lost wages) appear to be rising slightly faster than overall indemnity payments (the sum of noneconomic and economic awards).[12] (2) Severity of injury per paid claim is also rising. (3) The share of million-dollar awards is also rising. The rise in payments over time is particularly high among cases with grave permanent injury. The Physician Insurers Association of American (PIAA) reports that nearly 8 percent of all awards now exceed $1 million—double the share just five years ago.[13] Data from Illinois reveal that average indemnity of paid claims for an adult with grave permanent injuries has risen from $960,100 (during 1990–1994) to nearly $1.6 million (1995–1999).[14]

(4) Defense and administrative costs are also rising. Data from PIAA and several state insurance departments (such as Ohio and Illinois) show a sharp rise in defense and administrative costs per paid claim. Defense costs have greatly increased in the most severe cases (major and grave permanent injury).

■ **Rising costs of reinsurance.** The rise in claims severity flows through to the reinsurance market. Rising severity, coupled with the events of 11 September 2001, has led reinsurers to add to their reserves and increase reinsurance rates to medical malpractice companies.

■ **Reduced capacity.** The structure of the insurance market has changed dramatically in some of the states facing the sharpest rise in premiums (such as Nevada, West Virginia, Pennsylvania, and Ohio). Several years of underwriting losses led the St. Paul Companies, one of the largest national carriers, to increase its reserves by $600 million in 2001 alone. It was the largest carrier in several states that are now facing sharp increases in medical malpractice premiums.[15] For example, it was the second-largest insurer in Nevada by 1996, accounting for 32 percent of all written premiums.[16]

In addition to The St. Paul, several physician-owned companies—most notably, PHICO (in Pennsylvania) and PIE Mutual (in Ohio)—expanded their medical malpractice business outside their state of domicile. In virtually every case, these companies generated large operating losses outside their home states. By 1996 PHICO wrote medical malpractice policies in twenty states, while PIE Mutual entered about a dozen states. PIE Mutual had the largest market share—nearly a third of premiums written in West Virginia in 1996 alone. However, it was declared insolvent in 1998 and ceased operations. The Commonwealth of Pennsylvania declared PHICO insolvent in 2002. As a result, nearly a third of the physicians in West Virginia changed carriers. The St. Paul largely filled the void in West Virginia between 1996 and 2001. However, by 2001 it ceased writing new business, again placing West Virginia's physicians in a precarious position looking for new medical malpractice insurance coverage. The St. Paul announced in December 2001 that it would exit

the medical malpractice market altogether.[17] The company's exit left more than 36 percent of Nevada's physicians looking for new coverage. More than a third of Ohio's physicians have changed liability carriers over the past five years as well.[18]

These recent changes in market structure have strained the underwriting capacity of medical malpractice companies in several states. Nearly 15 percent of the entire medical malpractice book of business nationally (highly concentrated in several states) has switched, or attempted to switch, malpractice companies since 1998. The issue here concerns liability companies' ability to write the new business. The remaining companies are drawing down surplus and increasing reserves in anticipation of rising claims payments. At the same time, the entire St. Paul book of business is seeking new coverage. Thus, an emerging issue is how much new business the remaining carriers can underwrite. Regulators and rating agencies (such as A.M. Best) use metrics such as the premium-to-surplus (PS) ratio for guidance regarding underwriting capacity, with PS ratios less than 1 preferred. In some cases, the PS ratios have been rising sharply, raising concerns about the (short-run) capacity of the remaining carriers to absorb the new business.

■ **Rising frequency.** While the number of claims per physician rose sharply between 1956 and 1990 (from 1.5 claims per 100 covered physicians in 1956 to approximately 15 per 100 in 1990, as reported by The St. Paul), the trends appear relatively flat nationally over the past couple of years. In some states (such as Missouri) reported frequency has declined.[19] However, other states have reported a rise in frequency, particularly states with caps on noneconomic damages and no process for discouraging claims frequency (such as an affidavit or certificate of merit)—for instance, Louisiana reports approximately thirty-one claims per physician, double the national average.[20]

**"Certainly to the physicians facing 40–60 percent increases in their premiums, the recent spike in premiums is a crisis."**

## Is This A Crisis, Or Simply The Workings Of The Insurance Cycle?

Certainly to the physicians facing 40–60 percent increases in their premiums, the recent spike in premiums is a crisis. With respect to the broader functioning of the market, however, the jury is out. Rising claims costs may reflect a rise in underlying negligence. If true, the system may be functioning as designed, and the spike in premiums may provide stronger incentives for physicians to improve the quality of care provided (the deterrence function of medical liability law). On the other hand, we may be observing a permanent rise in claims payments and costs unrelated to trends in physician negligence. At issue is the extent to which the underlying factors generating higher premiums are following a traditional cyclical insurance pattern, or whether a structural change has occurred in severity and frequency.

The 2000 "crisis" does differ in several key respects from earlier ones. The substantial disruption in market supply in several states—traced to a handful of multistate physician-backed firms and the experience of The St. Paul—are new and, it is hoped, transitory events. It appears that a substantial share of the multistate, physician-owned companies have refocused their effects on their state of domicile. With The St. Paul now out of the market, both trends should eventually bring some stability into states that have been adversely affected. Thus, these substantial disruptions may not signal long-term structural problems of competition or capacity.

Second, many physicians also feel squeezed by rising insurance premiums and declining Medicare reimbursement. Indeed, the rise in premiums has occurred just as Medicare payments to physicians decreased 5.4 percent in 2003.[21]

With respect to broader structural changes, data from PIAA (along with some selected state data) reveal a long-term rise in claims severity.

In Illinois, for example, million-dollar awards accounted for 4 percent of all claims and nearly 42 percent of all indemnity payments between 1985 and 1989. By 1995–1999, 12 percent of all claims exceeded a million dollars, accounting for 52 percent of all indemnity payments.[22] The PIAA data show a similar long-term trend. During 1990, 1.5 percent of all paid claims exceeded a million dollars. By 2001 the percentage had risen to 8 percent.[23]

## Policy Options For Addressing Medical Malpractice

The goals of the liability system are to provide financial incentives to deter substandard medical care and to compensate those injured by such care. There is some evidence that the current system performs poorly on both counts.[24] First, program administration—defense and underwriting costs—accounts for approximately 60 percent of total malpractice costs, and only 50 percent of total malpractice costs are returned to patients.[25] These costs are high even when compared with other tort-based systems, such as automobile litigation or airplane crashes, that determine fault and compensate victims.[26] Moreover, most patients that receive negligent care never receive any compensation. The Harvard Medical Practice Study found that only one malpractice claim was filed for every eight negligent medical injuries.[27] Second, deterring substandard medical care is a major rationale for using a tort-liability system for medical malpractice.[28] There is a considerable theoretical literature examining the potential of a tort-based system for optimally promoting safety.[29] Several empirical studies have also been conducted to evaluate whether the tort system deters medical errors. Overall, the literature is mixed.[30]

The recent spike in premiums has renewed state and national interest in limiting claims payments. Several states adopted such limits in response to the spike in premiums in the 1970s and 1980s. More recent interest has been expressed by President Bush, the AMA, and others, in the form of supporting federal legislation capping award payments and reducing "frivolous" claims.[31] Congressional Democrats have advanced their own approach, aimed at curbing an exemption from antitrust laws provided under the McCarran-Ferguson Act. A key issue in the debate is whether state tort reforms slowed the growth in premiums and improved malpractice insurance firms' profitability. To address this question, the final section examines the impact of existing state tort reforms on malpractice premiums and profits through 2001.[32]

## Impact Of Traditional Tort Reforms

Using new data from the NAIC, I examined trends in premiums earned and loss ratios, by state, for 1985–2001.[33] I estimated two versions of the premium model. The first entered total earned premiums as the dependent variable, with total nonfederal physicians as an explanatory variable. The second model entered earned premiums divided by nonfederal physicians as the dependent variable. The key explanatory variables used in the regression are the state tort reforms and other factors (outlined below) influencing claims payments, claims frequency, and insurer costs. I also examined the impact of competition on premiums and profitability over time.

■ **State tort reforms.** *Damage caps.* Damages in medical malpractice cases fall into three general categories: noneconomic damages (pain, suffering, anguish), economic damages (lost wages and medical care expenses), and punitive damages, if conduct is viewed as malicious or in reckless disregard of plaintiffs' rights (these are rarely awarded). Only five states cap both economic and noneconomic damages, so I combined states that cap noneconomic damages or both noneconomic and economic damages into a composite "award cap" measure (twenty-four states by 2001). The empirical analysis was designed to assess the impact that award caps and caps on punitive damages, or not allowing punitive damages, have on profits and premiums.

*Joint and several liability.* Joint and several liability is the ability to collect the entire award from any liable defendant, independent of the degree of fault. This allows the plaintiff to collect from the group, or any individual provider,

the entire amount of the award. Tort reforms have limited this so that the defendant is not liable for more than his or her degree of fault and is not jointly liable with any other person for damages attributed to them.

*Statutory caps on attorneys' fees.* Attorneys in malpractice cases are generally paid a percentage of the award received by the plaintiff. These reforms limit the contingency fees attorneys may receive, which reduce the financial incentives to file a claim.

*Collateral offset rule.* This rule states that a plaintiff could recover the full amount of the reward even if the plaintiff received money from other sources such as health insurance or worker's compensation. Some states have adopted mandatory and discretionary offsets that reduce the award by the amount the plaintiff will receive from other sources, while other states allow the information on collateral sources to be entered as evidence before an award amount is determined. I use two measures in the analysis—one indicating whether the state had a mandatory offset for collateral sources, and a second for states that permit an offset for collateral sources.

In addition to state tort reforms, the analysis included other factors found by previous research to influence premiums and profits.[34] These include factors affecting the frequency of claims, including attorneys per capita, percentage of population in an urban area, unemployment rate, and the number of welfare recipients per 100,000 population. Factors affecting the severity of awards, such as surgical procedures performed per 100,000 population and per capita income, were also included. Finally, I examined the impact of competition on premiums and profits using the Hirschman-Herfindahl Index (HHI).[35]

The final data set included all fifty states and the District of Columbia (cross-sectional) over seventeen years (time series). Using both random and fixed-effects models, I regressed the (log) loss ratio and earned premiums on state dummies indicating whether the state had adopted each reform, and if so in what year.[36] The key results are presented in Exhibit 3. The model was estimated using both fixed- and random-effects models.[37]

**Empirical results.** The empirical results indicate that the caps on awards adopted by several states were associated with lower loss ratios and lower premiums (Exhibit 3). However, other than states with discretionary offsets, other tort reforms were not associated with lower premiums or improved profits. Loss ratios in states capping awards were 11.7 percent lower than in states without caps.[38] In addition, loss ratios were 13.3 percent lower in states with discretionary collateral offsets. Loss ratios were 25 percent lower in states that adopted both reforms. The impact of states with mandatory offsets on loss ratios was not significantly different from zero.

Premiums in states with a cap on awards were 17.1 percent lower than in states without such caps. When using earned premium per physician as the dependent variable, the caps were associated with a 12 percent reduction in

**EXHIBIT 3**
**Impact Of State Medical Malpractice Tort Reforms On Loss Ratios And Premiums, Relative To No Tort Reforms**

| Performance measure | Awards caps | No punitive damage or punitive cap | Mandatory collateral offset rule | Discretionary collateral offset | Attorney fee caps |
|---|---|---|---|---|---|
| Loss ratio | −11.7% ($p = .06$) | NS | NS | −13.3% ($p \leq .10$) | NS |
| Total earned premium | −17.1% ($p < .05$) | NS | NS | NS | NS |
| Earned premium per physician | −12.7% ($p < .05$) | NS | NS | NS | NS |

**SOURCE:** Author's analysis (regression results available upon request).
**NOTES:** Statistical findings denote difference from zero. NS is not significantly different from zero.

premiums. The analysis found no association between the adoption of other state tort reforms on loss ratios, premiums, joint liability, caps on attorneys' fees, or collateral offsets.

The results also highlight the effect of competition on premiums and loss ratios. Competition varies in the industry across states as well as over time. The results indicate that a 10 percent increase in the index (less competitive) is associated with a 2 percent increase in premiums ($p < .05$). Several states have seen considerable changes (both increases and decreases) in market competition during the past two decades. Some states, such as West Virginia, have become less competitive since 1996, while competition in other states has increased. The regression results indicate that the 20 percent rise in the HHI in West Virginia between 1996 and 2001 was associated with a 4 percent increase in premiums. The HHI increased by 80 percent during this period in Minnesota (associated with a 16 percent increase in premiums) but declined by 40 percent in Idaho. So at least in some states, the rise in market concentration has contributed to higher medical malpractice premiums. The impact of market concentration on loss ratios was not statistically significant.

**"At least in some states, the rise in market concentration has contributed to higher medical malpractice premiums."**

## Conclusions

Physicians in several states are facing sharp increases in their medical liability premiums. As a result, some facilities have temporarily shut down; physicians in some states are reluctant to perform high-risk procedures; and early physician retirements appear to be on the rise.[39] These physicians, and their patients, are facing an important short-term crisis. A major part of the policy debate concerns the factors generating the large increases in premiums in some states. Rising severity is now a two-decade-old phenomenon in the industry. Several malpractice firms with substantial market shares in some of the hardest-hit states—Ohio, West Virginia, Pennsylvania, and Nevada—either left the market, became insolvent, or refocused their underwriting in their state of domicile. These trends caused substantial disruption in the medical malpractice marketplace in these states. Thus, a major part of the crisis in these states concerns both severity and the resulting impact on underwriting capacity among firms remaining in the market.

The analysis indicates that capping payments from malpractice carriers was associated with lower premiums.[40] Yet how should we interpret these results? At issue is whether we should adopt short-term, stopgap solutions to slow the growth in premiums, or use the recent experience to more fundamentally evaluate and perhaps reform the liability system. The recent spike in medical malpractice insurance premiums allows us an opportunity to reexamine whether the tort system is achieving its goals. If it isn't, what changes in the system would improve the dual goals of deterrence and compensation? The results suggest that capping awards may improve the profitability of malpractice carriers and reduce premiums. Whether this is socially desirable or improves the goals of deterrence and compensation remains an open question.[41]

Another key question is the extent to which the most recent premium spike simply reflects the insurance cycle and changes in market structure and competition. Alternatively, do the recent trends also reflect a structural and secular rise in the severity of awards that, absent reforms, will permanently change the traditional insurance premium cycle? In this case, physicians could face several more years of rising premiums. Although experience varies across states, the data do indicate a long-term increase in awards and settlements per paid claim. At issue are the factors that underlie these trends. Do they reflect increases in the incidence of negligent adverse events and substandard physician care? If so, simply capping awards will ultimately result in lower growth in premiums but will leave unchanged

the fundamental problem of rising substandard care.

Surprisingly, we know very little about trends in the rates of negligent adverse events over time. The two most cited studies, from California in the 1970s and New York in the 1980s, suggest that these rates have been constant. More recent studies from Colorado and Utah conducted in the 1990s produced similar results.[42] Clearly, more work in this area is required.

Stopgap reforms (caps on awards) of our current liability system would ultimately result in lower premiums (relative to their levels without the caps). On the other hand, it is also important to evaluate any such reforms in the context of their ability to further the dual policy objectives of deterrence and compensation.

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## NOTES

1. See, for example, R. Bovbjerg, "Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card," *University of California, Davis, Law Review* 22, no. 2 (1989): 499–556.
2. As reported by *Medical Liability Monitor*, October 2003.
3. Tabulations from National Association of Insurance Commissioners, *Market Share Report—Medical Malpractice*, 1997–2001 (Kansas City: NAIC, various years).
4. American Medical Association, "AMA Analysis: A Dozen States in Medical Liability Crisis" (Chicago: AMA, 17 June 2002).
5. This broader combined loss ratio combined with the investment income ratio produces a measure of net income. This is a standard measure used by actuaries in medical malpractice firms to measure changes in calendar-year profitability.
6. See, for example, Jim Hurley, Tillinghast–Towers Perrin, testimony before the House Energy and Commerce Subcommittee on Health, "Harming Patient Access to Care: The Impact of Excessive Litigation," 17 July 2002. Much of the discussion in this section is based on my analysis of data from the NAIC. In addition, I benefited greatly from the analyses of Jim Hurley from his testimony and a recent study from the U.S. General Accounting Office, *Medical Malpractice Insurance, Multiple Factors Have Contributed to Increased Premium Rates*, Pub. no. GAO-03-702 (Washington: GAO, June 2003).
7. Actuaries use a variety of methods for establishing reserves for medical malpractice firms. Reserves are generally posted on a claim filed within ninety days of the date an expected loss is reported. Reserves depend on the number of claims filed, the firms' expectation of the percentage of claims that will result in a payment, expenses (defense costs), and the expected payout. Reserves are reported as part of the loss expenses incurred in each firm's statement of income. If reserves turn out too high (that is, expected payouts were lower than actual payouts), a credit on the income statement is taken in a later year. Therefore, expenses on an income statement reflect both actual benefit and loss payments during a year (for events that occurred in a prior year) and reserves for claims filed this year expected to result in a future payment. They also show up on the balance sheet as a liability.
8. Hurley, "Harming Patient Access to Care."
9. A.M. Best, *Aggregates and Averages*, 1997–2002 editions (Oldham, N.J.: A.M. Best, various years).
10. The precise impact will depend on the length of time it takes to resolve a claim. Some states with fast-track laws resolve claims faster than other states. The shorter the tail, the less impact a one-percentage-point change in investment returns will have on premiums.
11. Median jury awards plus median settlements per paid (awards plus settlements) claim, derived from the Physician Insurers Association of America (PIAA) data-sharing project. See L. Bartholomew, "Using PIAA Data: A Valuable Resource" (Washington: PIAA, 17 May 2002).
12. Missouri Department of Insurance, *Medical Malpractice Insurance in Missouri* (Jefferson City: Missouri Department of Insurance, February 2003). These data also indicate a rise in severity of injury per paid claim.
13. Bartholomew, "Using PIAA Data."
14. Illinois Department of Insurance, *Medical Malpractice Claims Study* (Springfield: Casualty Actuarial Section, 2001).
15. The St. Paul Companies, "The St. Paul Announces Fourth-Quarter Actions to Improve Profitability and Business Positioning," Press Release, 12 December 2001.

16. Market share data are from NAIC, *Market Share Reports*, 1994–2001.
17. Tabulations by author from NAIC, *Market Share Report by Line of Business—Medical Malpractice, 1995–2001* (Kansas City: NAIC, 2003).
18. Ibid.
19. However, the number of liability companies with closed claims still flowing through the system that report claims has likely declined here as well. For instance, the 2001 totals do not include claims from PHICO. So it is not clear whether the reports of falling claims frequency are real or simply an artifact of exiting companies' failure to report closed claims to the state.
20. See, for example, LAMMICO, "The Letter" (no date provided), www.lammico.com/letter/article.asp?letter_article_id=294&letter_id=35 (23 July 2003).
21. The scheduled 4.5 percent additional cut was recently replaced by a 1.5 percent increase in payments in 2004. See H.R. 1, *The Medicare Prescription Drug Improvement Act of 2003*.
22. Illinois Department of Insurance, *Medical Malpractice Claims Study*.
23. Bartholomew, "Using PIAA Data."
24. P.C. Weiler et al., *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (Cambridge, Mass.: Harvard University Press, 1993).
25. J.S. Kakalik and N. Pace, *Costs and Compensation Paid in Tort Litigation* (Santa Monica, Calif.: RAND, 1986).
26. Weiler et al., *A Measure of Malpractice*, 77–109.
27. Ibid., 70.
28. W.B. Schwartz and N.K. Komesar, "Doctors, Damages, and Deterrence: An Economic View of Medical Malpractice," *New England Journal of Medicine* 298, no. 23 (1978): 1282–1289.
29. See, for example, S. Shavell, "A Model of the Optimal Use of Liability and Safety Regulation," *RAND Journal of Economics* 15, no. 2 (1984): 271–280.
30. See, for example, L. Dubay et al., "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics* 18, no. 4 (1999): 491–522; F. Sloan et al., "Effects of the Threat of Medical Malpractice Litigation and Other Factors on Birth Outcomes," *Medical Care* 33, no. 7 (1995): 700–714; and Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (Cambridge, Mass.: Harvard University, 1990), chaps. 8 and 10. For additional discussion concerning the paucity of published empirical work linking the threat of suit to lower rates of negligent adverse events (or a reduction in substandard medical care), see M. Mello and T. Brennan, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," *Texas Law Review* 80, no. 7 (2002): 1595–1637.
31. In some states plaintiffs can file a claim with its initial adjudication completed by a medical review panel. Plaintiffs can use this process for discovery, and if concurrence is received from the panel, the claim may proceed. Plaintiffs in other states must receive an expert (outside) validation or certificate of merit before the claim proceeds. Limited expenses are incurred under the first approach, while the latter approach provides some financial incentive not to file a claim with low likelihood of receiving a positive verdict.
32. The two most recent studies were conducted by W.K. Viscusi and P. Born, "Medical Malpractice Insurance in the Wake of Liability Reform," *Journal of Legal Studies* 24 (June 1995): 463–490, which evaluated the impacts through 1991; and by S. Zuckerman, R.R. Bovbjerg, and F. Sloan, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," *Inquiry* 27, no. 2 (1990): 167–182, which tracked the impact of state reforms through 1986.
33. NAIC, *Profitability Report* (Kansas City: NAIC, 2003).
34. See, for example, Viscusi and Born, "Medical Malpractice Insurance"; and Zuckerman et al., "Effects of Tort Reforms." Also see F. Sloan, P.M. Mergenhagen, and R.R. Bovbjerg, "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis," *Journal of Health Politics, Policy and Law* 14, no. 4 (1989): 663–689.
35. This is a standard measure of market concentration. It is simply the square of each firm's market share summed. Data on market shares were derived from the NAIC and from unpublished data from the Congressional Budget Office.
36. Data on state tort reform laws were initially developed using information from the Web site of a specialty law firm, McCullough, Campbell, and Lane, www.mcandl.com/states.html (30 July 2003). When information from this site was not clear, state insurance departments were asked for clarification. Finally, I compared these results with those used by the CBO to develop its estimates in developing H.R. 5, as seen at CBO, "H.R. 5: Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003," 10 March 2003, www.cbo.gov/showdoc.cfm?index=4091&sequence=0 (30 July 2003). The classification used in the analysis was identical to that used by the CBO.
37. I ran both fixed- and random-effects models for the premium and loss-ratio regressions. The results from the Hausman Test do not allow us to

reject the null hypothesis that coefficients estimated using random and fixed effects are the same. The fixed-effects estimate indicated that state award caps were associated with premiums that were 17.1 percent lower, and the random-effects estimate produced the same result. Thus, while the random-effects results are displayed, the fixed-effects results were the same for the tort-related variables. J.A. Hausman, "Specification Tests in Econometrics," *Econometrica* 46, no. 6 (1978): 1251–1271. Regression to the mean could also be an issue if states with high premiums adopting the award caps tended to return to the average over time. Thus, caps in high-premium states experiencing regression to the mean would appear more effective than laws in average- or low-premium states. Using 1985 data on states that had no award cap (about forty-five states), I estimated the premium regression (absent the tort variables). I estimated a second regression using the residuals (from the 1985 regression) as the dependent variable, a dummy set to 1 if the state ultimately adopted an award cap, as well as the other independent variables outlined in the text. If regression to the mean were an issue, the coefficient on the dummy variable would be positive and significant (that is, high-premium states adopted caps). The t-statistic on the dummy variable in this regression was –0.22. Since there was no apparent relationship here, there would be minimal (if any) bias due to regression to the mean. For a related test, see D. Dranove and K. Cone, "Do State Rate Setting Regulations Really Lower Hospital Expenses?" *Journal of Health Economics* 4, no. 2 (1985): 159–165.

38. The percentage changes reported here took each dummy variable from the log model and transformed them to a percentage change using the methods outlined in P. Kennedy, "Estimation with Correctly Interpreted Dummy Variables in Semi Logarithmic Equations," *American Economic Review* 71, no. 4 (1981): 801.

39. In a recent Georgia survey of physicians, a third of obstetrician/gynecologists and a fifth of family practitioners stated that they would stop performing high-risk procedures. Another 12 percent noted that they would not cover the emergency room in the future. *BNA's Health Care Policy Report* 11, no. 5 (2003): 162.

40. This means that premiums are lower than they would be in the absence of award caps. It does not imply that the premiums decline. Premiums in states with award caps have risen over time, but they are lower than they would be absent the award caps.

41. At issue is whether the reforms would reduce deadweight loss associated with defensive medicine and costs of administering the system and improve deterrence and compensation. Some commentators are dubious about the prospects. See P. Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* (Cambridge, Mass.: Harvard University Press, 1985). However, any such analysis must also consider the impact that high premiums have on the availability of and access to medical care services.

42. California Medical Association and California Hospital Association, *Report on the Medical Insurance Feasibility Study*, ed. D.H. Mills (San Francisco: CMA/CHA, 1977); and D. Studdert et al., "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care* 38, no. 3 (2000): 250–260. These studies have generally concluded that approximately 3.7 percent of hospital admissions are associated with an adverse event and that approximately a quarter of these are due to negligence.

# THE EVIDE

## Noneconomic Damage Caps Help Reduce Malpractice Insurance Premiums

By Richard S. Biondi and Arthur Gurevitch

**It's said that bad things come in threes,** and it looks as if medical malpractice crises are no exception. We are now officially entrenched in the third crisis since the mid-1970s. And if the first crisis was marked by the withdrawal of the Argonaut Insurance Co. from the malpractice market in 1975, then the current crisis may be said to have been highlighted by the December 2001 decision of St. Paul's to exit the market, followed by PHICO, Reliance, Frontier, and MIIX.

Several things have changed in the malpractice environment over the past 25 years. Most notably, the mid-1970s crisis led to a dramatic shift from commercial insurance companies to self-insurance and medical society-owned mutual insurance companies. The malpractice crisis of the mid-1980s resulted in significant tort reforms: many states updated joint-and-several liability laws, tightened statutes of limitations, modified collateral source rules, provided for period payment of damage awards, and limited contingency fees.

Much of the debate in the current crisis centers around the limitation of noneconomic damages, the so-called caps on pain and suffering. Under this reform, juries would be required to quantify economic damages (such as lost wages and medical expenses) and noneconomic damages. Most of the current proposals allow awarding of the full economic damages but limit noneconomic damages to a maximum predetermined amount, typically $250,000.

As evidence of the effectiveness of noneconomic damage caps, proponents point to California's 1975 Medical Injury Compensation Reform Act (MICRA), which introduced numerous malpractice reforms including the imposition of a $250,000 cap on pain and suffering. It's clear that malpractice premiums are significantly and dramatically lower in California than in many other comparable states.

# NCE IS IN

**Interstate data unequivocally support the premise that caps on noneconomic damages are an effective means of reducing malpractice costs.**

For example, according to *Medical Liability Monitor*, an obstetrician in Los Angeles had an annual premium of about $60,588 in 2002, while OB's in New York City and Miami paid $89,317 and $201,376, respectively.

Opponents of noneconomic caps, which include trial lawyers and so-called consumer advocates, contend that:

■ There is no malpractice claims crisis. In fact, they say, claims have not risen dramatically in the late 1990s.

■ Noneconomic caps and other tort reforms have no effect on premiums and presumably no effect on claims. Accordingly, they argue, California's lower malpractice rates are a consequence not of tort reform but of subsequently imposed insurance regulations.

■ The dramatic increase in malpractice premiums, the widespread unavailability of coverage, and the withdrawal (voluntary or otherwise) of insurance companies from the malpractice market is due to insurance company mismanagement and the drop in stock market returns.

■ Malpractice claims are increasing at the rate of medical inflation while the spikes in premium are driven by an insurance cycle.

We don't doubt that there's an insurance cycle, that stock market returns and bond yields have fallen, and that there have been some mismanaged malpractice companies. However, in this article, we've tried to determine the extent to which the malpractice insurance market is loss-driven and if it follows sound economic principles. Rather than use piecemeal, anecdotal data, we chose to quantify malpractice effects across states and over time.

One of the best sources of malpractice claims data is the National Practitioner Data Bank (NPDB). The NPDB was established in 1990 to aid physician credentialing organizations by

FIGURE 1 Growth in NPDB Malpractice Losses

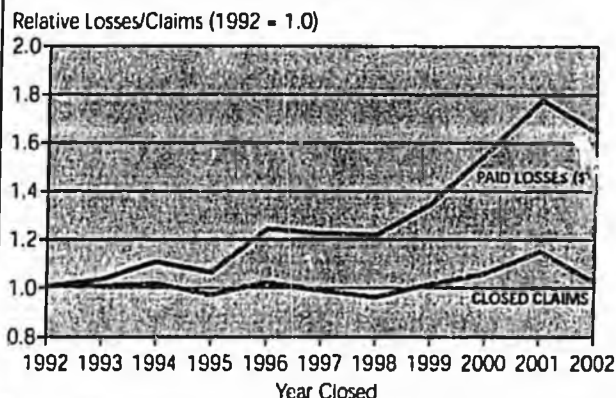
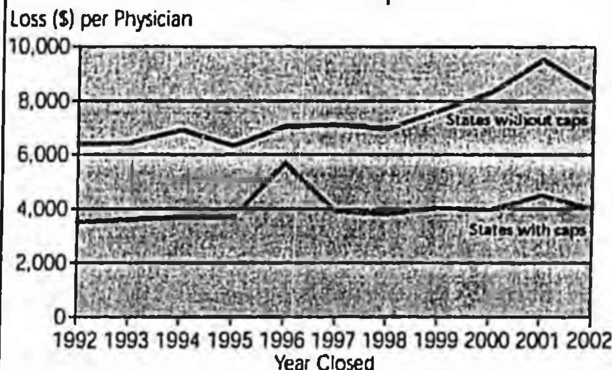



FIGURE 2 Average Loss per Physician in States With and Without Caps



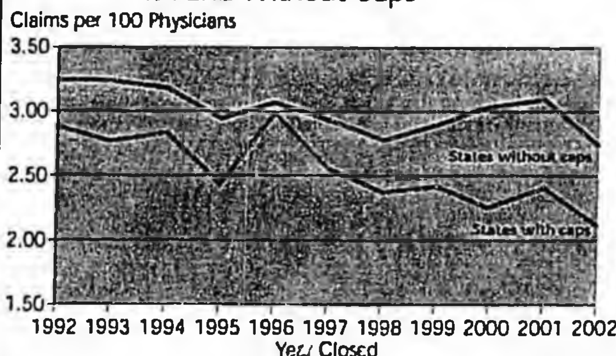



FIGURE 3 Malpractice Claims per Physician in States With and Without Caps

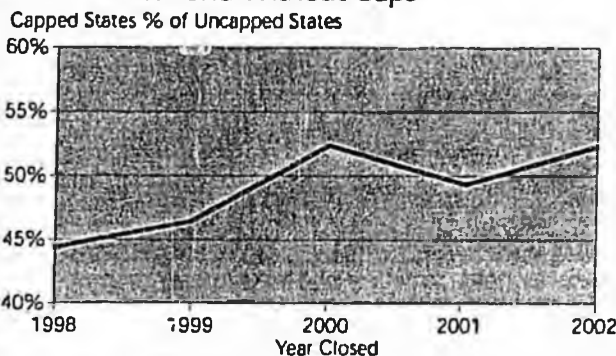



FIGURE 4 Differential in Loss per Physician in States With and Without Caps

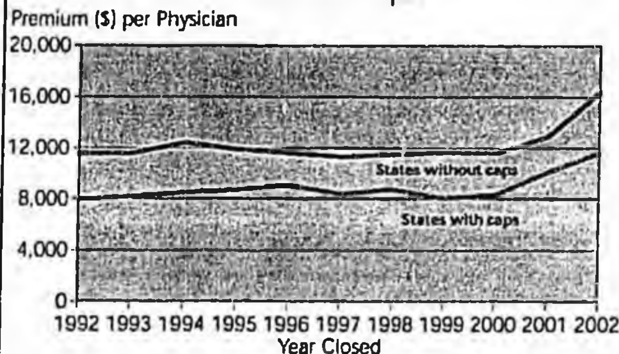



FIGURE 5 Malpractice Premium per Physician in States With and Without Caps

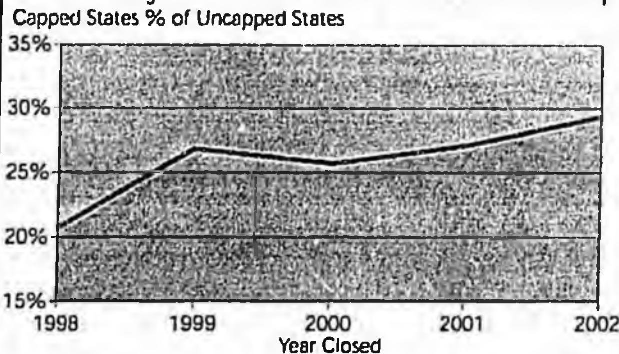



FIGURE 6 Differential in Malpractice Premium per Physician in States With and Without Caps

collecting data on malpractice claims and disciplinary actions against physicians. Most NPDB data are confidential; however, the NPDB releases unidentifiable claims data in the form of a Public Use Data File. Because of the legal mandate to report claims, the NPDB contains information on nearly every paid claim against physicians.

Working with the NPDB Public Use Data File, we approached our thesis by asking the following basic market questions:

### 1 Do claims data support the existence of a malpractice crisis?

Both the number of malpractice claims and the dollars of paid loss have grown since 1992, as fig. 1 clearly shows. Most noticeable is the dramatic jump in total paid losses at the end of the 1990s. We contend that this malpractice "crisis" is a reasonable label for a sustained 25 percent jump in payments over a two-year period!

### 2 Do tort reforms affect malpractice payments?

A more detailed look shows that malpractice losses are not uniformly high in every state. Fig. 2 shows that states with noneconomic damage caps have much lower NPDB losses per physician than do states without caps. Indeed, losses per physician in states with caps averaged 46 percent lower than states without caps.

### 3 Why do noneconomic damage caps have such a significant effect on per physician losses?

In general, caps on noneconomic damages apply only to verdicts and not specifically to settlements. Only a small minority of payments, perhaps as few as 5 percent, are made as a result of verdicts. However, a settlement is negotiated on the basis of the estimated cost of a claim as if it were to go to a verdict. Thus, if the cost of verdicts is reduced due to a cap, it follows that the cost of settlements will be reduced proportionately.

Second, noneconomic damages make up a surprisingly large percentage of total malpractice costs. Publicly available closed claim data from Texas and Florida (the NPDB doesn't distinguish between economic and noneconomic damages) indicate that noneconomic damages compose over two-thirds of the total cost of claims payments.

Third, caps generally apply to the total noneconomic damages for each medical malpractice occurrence, regardless of the number of physician and/or hospital defendants. So, for example, if $1 million of noneconomic damages are awarded to a claimant from an occurrence involving three physician defendants, it's assumed that the entire $1 million, not the allocated amounts to each of the three physician defendants, would be capped.

Fourth, noneconomic damage caps may have a secondary effect of reducing the frequency of malpractice cases. In an efficient economic environment, certain suits currently in the system might not be brought to court if the potential reward to the plaintiff—and the plaintiff's attorney—is too low. Fig. 3 shows that claim frequency is reduced by more than 15 percent in states with caps on noneconomic damages.

Finally, in addition to reducing the overall level of malpractice payments, tort reforms also reduce the growth rate of loss-

es (inflation or "trend"). Since 1998, the average losses per physician in non-tort-reform states increased at an average annual rate of 6.8 percent, while the annual increase in states with reforms has been 3.0 percent.

In contrast, during this period the consumer price index (CPI) increased at a 2.6 percent annual rate, and the medical CPI increased 4.2 percent per year. As a result of the different growth rates, the differential between losses for physicians in states with noneconomic caps and those in states without caps has grown from 44 percent to more than 52 percent since 1996 (fig. 4).

### 4 Do tort reforms affect malpractice premiums?

As an index of the total malpractice premium in each state, we examined the aggregate annual statement malpractice written premium (as reported by Thompson Financial Insurance Solutions) divided by the number of physicians in each state. This index lumps together hospital and physician premium. However, it should provide a reasonable estimate of malpractice premium growth, indexed to adjust for changes in the physician population.

Fig. 5 clearly shows that the premium in states with noneconomic caps is lower than in states without caps. The increase in premium didn't begin until after losses increased; it took insurance companies 18 to 24 months to process new claims data and to promulgate new rates (undoubtedly due to the filing and approval process).

The premium differential between states with caps and those without caps has also increased during the span of this most recent crisis (fig. 6). As with losses, it appears that tort reform has a relatively stronger impact as losses increase.

Note also that the premium differentials in fig. 6 are somewhat lower than the loss differentials shown in fig. 4. Is this because malpractice insurers are ripping off the insureds and pocketing the tort reform savings?

We don't think so. The premiums shown in fig. 6 include defense costs (LAE) and overhead costs. These costs do not decrease (or decrease less) as the result of noneconomic damage costs. Therefore, we would expect that the premium differential would track the loss differential but not be quite as extreme.

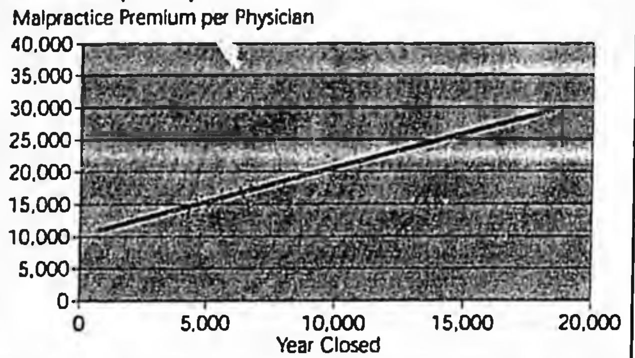
### 5 Are malpractice premiums rationally based on losses?

We have thus far shown that there has been a relatively sudden and dramatic increase in malpractice costs (a "crisis") and that states with noneconomic damage caps have lower claims and lower premiums than states without caps. But what of the more basic argument, that malpractice insurance is a (fundamentally) competitive market with market forces determining the rates?

Fig. 7 shows premium as a function of losses in 2002. The strong relationship shows that as losses increase, so does premium. Therefore, any type of reform that decreases losses should have a corresponding effect on premium.

Interstate data unequivocally support the premise that caps on noneconomic damages are an effective means of reducing malpractice costs. Noneconomic caps reduce malpractice payments, and malpractice payments are highly correlated with medical malpractice premiums.

**FIGURE 7** Relationship Between Loss and Premium (2002)




In general, factors that bring down losses, including tort reforms, get translated into premium savings regardless of an economic or insurance cycle.

1 2002 occurrence rates. LA - SCPIE. Miami - FPIC. NYC - MLMIC. From *Medical Liability Monitor*.
2 The NPDB does not distinguish economic and noneconomic damages.
3 As reported by Thompson Financial Insurance Solutions.

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# LIABILITY FOR MEDICAL MALPRACTICE: ISSUES AND EVIDENCE

## A JOINT ECONOMIC COMMITTEE STUDY

**Vice Chairman Jim Saxton (R-NJ)**

**Joint Economic Committee**
**United States Congress**

**May 2003**

**Executive Summary**

The past several years have witnessed a considerable increase in the cost and impact of medical malpractice litigation. The result has been higher malpractice insurance premiums for health care providers, which in turn has led to higher costs for the health care system as well as reduced access to medical services. In 2001, premiums for medical malpractice insurance topped $21 billion, double the amount ten years earlier.

This paper presents an analysis of the current medical malpractice system and examines the proposed federal reform legislation. The benefits of reforming of the medical liability system are significant and could:

- Yield significant savings on health care spending;
- Reduce unnecessary tests and treatments motivated out of fear of litigation;
- Encourage systematic reform efforts to identify and reduce medical errors;
- Halt the exodus of doctors from high-litigation states and specialties;
- Improve access to health care, particularly benefiting women, low-income individuals and rural residents;
- Produce $12.1 billion to $19.5 billion in annual savings for the federal government; and
- Increase the number of Americans with health insurance by as many as 3.9 million people.

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# LIABILITY FOR MEDICAL MALPRACTICE: ISSUES AND EVIDENCE

## I. INTRODUCTION

The past several years have witnessed a considerable increase in the cost and impact of medical malpractice litigation. Between 1994 and 2001, the typical medical malpractice award increased 176 percent to $1 million. The result has been higher malpractice insurance premiums for health care providers, which in turn has led to higher costs for the health care system as well as reduced access to medical services. In 2001, total premiums for medical malpractice insurance topped $21 billion, more than double the amount ten years earlier.

The liability system exists for two goals: to compensate the negligently injured, and to penalize and deter negligent acts. Unfortunately, in the medical arena the liability system fails on both accounts: the system does not direct appropriate compensation to victims of negligence, nor does it effectively deter negligent behavior. To the contrary, the medical liability system impedes efforts to improve patient safety, and may actually increase the number of errors. Moreover, the medical liability system imposes exorbitant costs on the health care system both directly and indirectly, costs that increase the number of Americans without health insurance and add to the federal deficit. Although some individuals fare well under the present system, the system as a whole does not meet the needs of the negligently injured or the general population. The negative aspects of the medical liability system have a particularly adverse effect on women, low-income individuals and rural residents.

For these reasons, medical malpractice reform has received considerable attention in the U.S. Congress and state legislatures. Reform of the medical liability system could yield significant benefits that could:

- Yield significant savings on health care spending;
- Reduce unnecessary tests and treatments motivated out of fear of litigation;
- Encourage systematic reform efforts to identify and reduce medical errors;
- Halt the exodus of doctors from high-litigation states and specialties;
- Improve access to health care, particularly benefiting women, low-income individuals and rural residents;
- Produce $12.1 billion to $19.5 billion in annual savings for the federal government; and
- Increase the number of Americans with health insurance by up to 3.9 million people.

This paper presents an analysis of the current medical malpractice system, focusing on the cost and impact excessive litigation has on the affordability and accessibility of health care. Legislative remedies are described, as well as the potential impact of such reforms.

## II. THE PRESENT SYSTEM FOR MEDICAL LIABILITY

The liability system has two ostensible goals: to compensate the negligently injured, and to deter negligent behavior In health care, the tort system allows individuals who are injured through the negligence of their health care provider to seek compensation through litigation. In theory, negligent behavior is deterred by making the negligent party bear the burden of the award.

Medical malpractice claims are mainly initiated in state courts. Although laws vary by state, in general the legal standard for malpractice has four elements:[1]

- The presence of a physician-patient relationship that establishes the duty of care;
- An adverse outcome (actual injury or harm);
- Negligence by the provider (failure to meet the standard of care); and
- Direct causality between the negligence and the adverse outcome

In the context of medical malpractice, negligence depends on "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm."[2] For doctors and other health care providers, this standard means that doctors should provide the level and type of care that is customary and usual in the medical community or in their specialty field.

The most common claim for medical harm is the medical malpractice claim, which applies directly to the negligent physician. However, medical malpractice is not the only legal option available to claimants seeking redress for damages.[3] Physicians are also open to claims of intentional torts.[4] Medical device and pharmaceutical manufacturers can be sued under such legal doctrines as product liability, negligence, strict liability and breach of warranty. Hospitals and managed care organizations, which may be exempt from many malpractice claims, can be sued under the principles of vicarious liability, joint and several liability and corporate negligence.

*Extent of Medical Malpractice*

The best estimates on the frequency of malpractice are based on two separate large-scale studies of hospitalizations, one in New York and the other in Colorado and Utah. Although the studies were done nearly a decade apart, they revealed remarkable similarities in the pattern of malpractice claims. In the New York study, based on 1984 data, 1.0 percent of hospitalizations

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[1] W. Page Keeton et al., *Prosser and Keeton on the Law of Torts*, 5th edition (St. Paul, MN: West Publishing Co., 1984), 164-165.
[2] American Law Institute, *Restatement (Second) of Torts* (St. Paul, MN: American Law Institute Publishers, 1965), §282.
[3] For a review of these issues, see: Dan B. Dobbs, *The Law of Torts* (St. Paul, MN: West Group, 2000), 666-671, 674-679; and U.S. General Accounting Office, *Medical Liability: Impact on Hospital and Physician Costs Extends Beyond Insurance*, GAO/AIMD-95-169 (September 1995), 21.
[4] Henry Cohen, "Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive and Noneconomic Damages," Congressional Research Service, Report RL31692, 2/6/2003.

were found to have injuries caused by negligence.[5] By comparison, the Colorado and Utah study, based on 1992 data, indicated that less than 1.0 percent of hospitalizations had injuries due to negligence.[6] The malpractice rate for the health care system as a whole is likely significantly lower.[7]

The incidence of malpractice, however, is quite distinct from the filing of malpractice claims. A defining feature of the medical liability system is that most events of malpractice do not result in a legal claim, and most claims of malpractice are not tied to any act of negligence. Overall, approximately 80 percent of malpractice claims show no signs of a negligent injury.[8] Conversely, only about 3 percent of injuries due to negligence result in a claim.[9] These figures suggest that the medical liability system malfunctions on a fundamental level.

It is not clear why such a small portion of negligent injuries lead to a malpractice claim. One possible reason is that the injury was too minor to warrant a lawsuit. Data show that most negligent injuries are only moderately incapacitating.[10] Another possible reason is that attorneys, who typically work on contingency fees arrangements, are only willing to take on claims for "attractive" clients (i.e., sympathetic victims with large damage claims). Alternatively, some people are simply not litigious in nature, or do not wish to damage a long-standing relationship with their doctor, especially if the doctor exhibits good communication and empathy skills. Yet another explanation is that patients simply do not recognize that they have suffered an injury due to negligence.

*The Market for Medical Liability Insurance*

The role of malpractice insurance is to pay for legal defense costs and damages inflicted through negligence by a doctor or medical professional. The market for malpractice insurance consists of two broad categories of insurance: conventional and alternative. The conventional market provides coverage through traditional insurance companies like A.I.G., C.N.A Insurance or the St. Paul Companies. Malpractice insurance purchased through traditional means totaled $7.2 billion in 2001.[11] This figure, however, excludes the much larger alternative market. The

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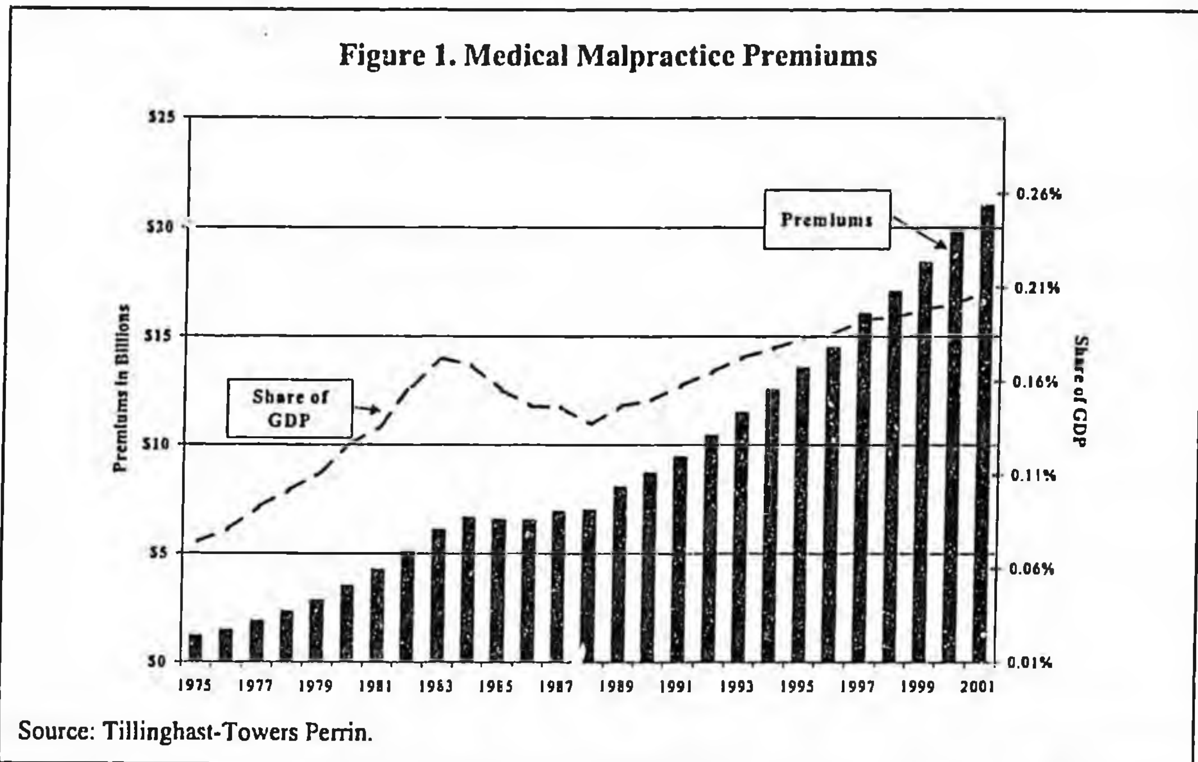
[5] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Studies of Medical Injury, Malpractice Litigation and Patient Compensation in New York* ([Cambridge, MA?]: 1990), 3.
[6] Eric J. Thomas et al., "Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado," *Medical Care* 38 (2000): 261.
[7] Preventable injuries are more likely to occur among more complicated cases, such as those requiring hospitalization. Presumably, therefore, medical care provided outside of a hospital setting would have a much lower rate of malpractice, thus lowering the overall rate.
[8] Published data indicate 83 percent of New York claims and 78 percent of the Colorado-Utah claims did not involve negligence. Harvard Medical Practice Study, 7-34; and David M. Studdert, Eric J. Thomas, Helen R. Burstin, Brett I.W. Zbar, E.J. Orav, and Troyen A. Brennan, "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care* 38 (2000): 253.
[9] Published data indicate that there was no malpractice claim for 97 percent of New York and 97 percent of the Colorado-Utah incidents of negligent injuries. Harvard Medical Practice Study, 7-37; and Studdert et al., 255.
[10] See A. Russell Localio et al., "Relation between Malpractice Claims and Adverse Events Due to Negligence," *New England Journal of Medicine* 325, no. 4 (July 1991), 247 (showing that 58 percent of negligent injuries required less than six months of recovery); and Thomas et al., 267 (showing that about 95 percent of negligent injuries resulted in non-permanent disability).
[11] A.M. Best data cited in Insurance Information Institute, *The I.I.I. Fact Book 2003* (New York, NY: Insurance Information Institute, 2002), 27.

**Figure 1. Medical Malpractice Premiums**




Source: Tillinghast-Towers Perrin.

alternative market comprises mechanisms such as joint underwriting associations, captive insurance companies and risk retention groups, all of which are ways groups of individuals, organizations or trade associations can come together and form an insurance company that they themselves run.[12] The alternative market for malpractice insurance is roughly twice as large as the traditional market. Altogether, total premiums for medical malpractice liability insurance amounted to $21.0 billion in 2001, according to the actuarial consulting firm Tillinghast-Towers Perrin.[13] Physicians purchased the bulk (60 percent) of malpractice insurance, followed by hospitals (28 percent) and other insureds (12 percent).[14]

Over the last ten years (1992-2001), premiums for medical malpractice insurance more than doubled, increasing an average of 8.1 percent per year. That rate is three times faster than the overall rate of inflation over the same period, and double the rate of inflation for medical care.[15] Relative to the size of the economy, measured as share of gross domestic product (GDP), malpractice insurance has increased every year since 1989 and stands three times the level it was in 1975. Figure 1 displays the pattern of premium levels and GDP share for 1975 to 2001.

Accompanying the rise in premiums has been a remarkable change in the structure of the malpractice insurance market. Most of the growth in malpractice insurance in the past decade has occurred in the alternative markets. Roughly 70 percent of premium growth over 1992-2001

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[12] For more information on alternative markets, see Conning & Co., *Alternative Markets: An Ever-Evolving Mosaic* (Hartford, CT: Conning & Co., 1999).
[13] Tillinghast-Towers Perrin, *U.S. Tort Costs: 2002 Update – Trends and Findings on the Costs of the U.S. Tort System* (New York, NY: Tillinghast-Towers Perrin, 2003), Appendix 2.
[14] *Ibid.*, 16.
[15] U.S. Department of Labor, Bureau of Labor Statistics, "Consumer Price Index," [March 2003], online at http://www.bls.gov/cpi/home.htm.

is attributable to the increase in alternative markets, versus just 30 percent due to traditional markets. The term alternative markets, as used in this paper, refers to forms of malpractice insurance that do not go through a traditional third-party insurer. Common alternative insurance mechanisms include self-insurance (where a firm or group of firms assume all or much of their risk exposure themselves), captive insurers (which are wholly-owned subsidiaries of the firms they insure) and risk retention groups (a group of firms or individuals that come together to form a limited-purpose insurer). Alternative forms of malpractice insurance are often created for the sole, dedicated purpose of providing such coverage and are controlled by the medical professionals they serve. Alternative insurers focus more on providing stable coverage rather than on maximizing profits, thus limiting the risk such organizations will exit the market due to adverse market conditions.[16] These features, combined with the decrease in the availability of traditional coverage described below, have made alternative markets a very popular source for malpractice insurance.

A crucial reason for the growth of the alternative market is rapid deterioration in the financial performance of the sector. For much of the 1990s, the medical malpractice line of insurance was highly profitable. This profitability attracted many firms to compete for malpractice coverage, moderating price increases. Recent trends, however, have created an environment that has reduced revenues and increased costs, causing medical malpractice to become one of the most unprofitable insurance lines. In 2001, malpractice insurers paid out $1.34 in claims and costs for every $1.00 it received in revenue (including investment income).[17]

Four factors account for the structural changes that undermined the profits of malpractice insurers, according to James Hurley of the American Academy of Actuaries.[18] First, a key component of the financial deterioration has been the escalating size of malpractice claims. The increase in the average cost of settlements and jury verdicts (discussed below), particularly very large awards, led to many rate increases. Second, insurers have faced increased reinsurance costs. Reinsurers, who provide insurance to insurance companies, posted weaker financial results in recent years, forcing them to charge their clients (i.e., insurers) higher rates. A third contributing factor has been deteriorating returns on the investment assets of insurers, although the overall impact of this factor has often been overplayed as stocks only account for about 15 percent of assets held by insurance companies. Finally, in the early and mid-1990s, insurer financial results benefited from favorable reserve development. In practical terms, what happened is that some money set aside for potential claims filed in the 1990s turned out to be unnecessary, and was eventually converted to profits. This short-term phenomenon has run its course and thus insurers no longer can count on this "bonus" profit.

Recent developments in the medical malpractice market reflect these trends. Of particular concern is the recent decrease in the availability of malpractice insurance. Weak financial results have driven several insurers from the market. According to the American

[16] For more information on these trends, see Conning & Co., *Medical Malpractice Insurance: A Prescription for Chaos* (Hartford, CT: Conning & Co., 2001), 6, 81-91.
[17] James Hurley, American Academy of Actuaries, Prepared Testimony to the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, 2/27/2003.
[18] *Ibid.*

Academy of Actuaries, the industry's premium capacity has dropped 15 percent.[19] The decrease in firms willing to provide malpractice insurance is evidenced by the complete withdrawal from the market of several malpractice insurers, including Phico, MIIX, Frontier and Reciprocal of America. In addition, St. Paul (the largest commercial insurer, covering 42,000 doctors) has ceased writing or renewing policies for malpractice.[20]

The combination of deteriorating profitability, reduced supply and the structural market changes has created an environment where coverage can be extremely difficult to obtain and in which reduced competition makes significant price increases more common. Moreover, these changes are not merely part of a short-term insurance cycle. Rather, the negative developments (such as increasing claim size and rising reinsurance costs) are likely to be permanent in nature while the positive developments that boosted profits in the past (such as favorable reserve development) are short-lived. In fact, insurers do not exit an insurance market completely simply due to short-term cycles. They only do so if the long-term outlook is so bleak as to make continued business operation untenable.[21]

The growth in aggregate premiums reflects the growth in premiums charged to individual doctors. Table 1 lists the median rate increases for medical liability insurance premiums for the last three years by area of practice.[22] As the data show, internists have experienced three consecutive years of at least 15 percent premium hikes. The typical rate increase has tripled for general surgeons and doubled for obstetricians/gynecologists (Ob/Gyn). The high cost of the current medical liability system most adversely impacts obstetricians, most surgical-related specialties (especially neurosurgeons), and emergency room physicians.[23]

**Table 1. Median Rate Increases in Malpractice Premiums by Specialty**

| | 2000 | 2001 | 2002 |
|---|---|---|---|
| Internists | 15.0% | 15.0% | 17.6% |
| General Surgeons | 9.6% | 14.6% | 29.1% |
| Obstetricians/Gynecologists | 7.0% | 12.5% | 15.3% |

Source: *Medical Liability Monitor*.

Although the direct payment of malpractice insurance premiums falls on the insured doctor or hospital, the costs are passed on to insured individuals, to one degree or another, in the form of higher premiums. In 2001, malpractice premiums averaged about $87 per insured individual, or close to $350 per family of four. These estimates do not include the costs of defensive medicine (treatment decisions motivated to avoid litigation rather than to benefit the patient), which can be three to six times greater than malpractice premiums. It is inevitable that those costs passed on to consumers adversely impact the affordability of health insurance.[24]

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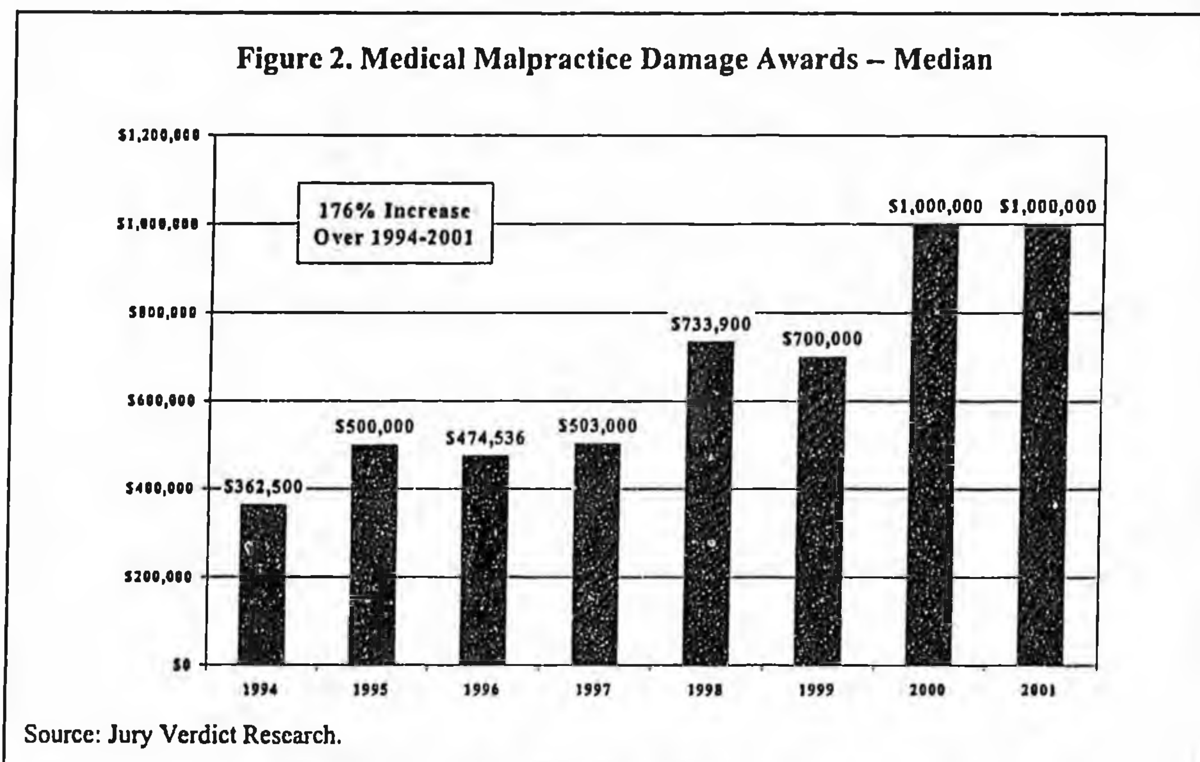
[19] *Ibid.*
[20] Joseph B. Treaster, "Doctors Face a Big Jump in Insurance," *New York Times*, 3/22/2002
[21] See Conning & Co., *Alternative Markets*, 65.
[22] Figures include only rate increases, though rate decreases in the past three years have become increasingly uncommon. "Hard Market Wallops Physicians; Average Rate Increases More Than Double Those in 2001," *Medical Liability Monitor* (October 2002); and "Medical Liability Rates Continue Their upward Swing," *Medical Liability Monitor* (October 2001).
[23] See *infra* notes 67 to 85.
[24] See the sections "Demand for Health Insurance: Impact on Affordability" and "Impact on the Number of Uninsured" below for a more detailed discussion of this effect.

**Figure 2. Medical Malpractice Damage Awards – Median**




Source: Jury Verdict Research.

*Malpractice Damage Awards*

One of the key drivers of costs for medical malpractice insurance is the recent surge in the size of damage awards in lawsuits. As Figure 2 shows, the typical (median) damage award in medical malpractice cases jumped 176 percent from 1994 to 2001, according to the research firm Jury Verdict Research.[25] The latest data indicate that the median award amount now tops $1 million, representing annual growth of 15.6 percent per year over 1994-2001, while the average award reached $3.9 million in 2001. The Physician Insurers Association of America (PIAA), representing firms that provide insurance to physicians, estimates that the average out-of-court settlement in 2001 was approximately $299,000 per individual defendant,[26] although most malpractice claims involve at least two defendants.[27]

[25] Jury Verdict Research, *Current Award Trends in Personal Injury: 2002 Edition* (Horsham PA: LRP Publications, 2003), 18. The only alternative national source of annual data on malpractice settlements is the National Practitioner Data Bank (NPDB) in the U.S. Department of Health and Human Services. However, both the General Accounting Office and the Inspector General's office have reported on extensive data problems in the NPDB that make its data unreliable, incomplete and biased. U.S. General Accounting Office, *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability*, GAO-01-130 (November 2000); and U.S. Department of Health and Human Services, Office of the Inspector General, *Managed Care Organization Nonreporting to the National Practitioner Data Bank: A Signal for Broader Concern*, OEI-01-99-00690 (May 2001).

[26] Lawrence E. Smarr, Physician Insurers Association of America, Prepared Testimony to the Committee on the Judiciary, U.S. Senate, 2/11/2003.

[27] The median number of defendants in medical malpractice tort cases was 2.0 in 1996. U.S. Department of Justice, Bureau of Justice Statistics, *Tort Trials and Verdicts in Large Counties, 1996*, NCJ 179769 (Washington, DC: Bureau of Justice Statistics, 2000), 2.

There has also been a large jump in million-dollar verdicts. In 1995-97, a little more than one in three (36 percent) cases resulted in an award of $1 million dollars or more. By 1998-99, the rate of million-dollar awards reached 43 percent. By 2000-01, more than one-half (54 percent) of medical malpractice awards were at least $1 million dollars, and one-quarter of all awards today exceed $2.7 million.[28]

The basis of malpractice claims against physicians generally falls into one of three categories. Data from a large malpractice insurer indicate that failure to diagnose is the most common basis for a claim, at 28 percent of claims. Surgery-related claims account for 27 percent claims, and improper treatment 26 percent of claims.[29] The remaining 19 percent were for claims such as adverse reaction to anesthesia, injection site injuries and lack of informed consent.

Punitive damages are relatively infrequent in malpractice cases, occurring in 2 percent of cases during 1999-2001.[30] This figure somewhat understates the impact of such awards, however, since punitive damages can be enormous. A survey of jury verdicts in malpractice cases in 1996 found that the median amount of punitive damages, when awarded, was $2.5 million.[31]

The large majority of malpractice claims never reach a trial, as seen in Table 2. Three-fifths (61 percent) of claims are either dropped or dismissed, while one-third (32 percent) are settled out of court prior to trial.[32] Of those cases that do go to court, defendants prevail 60 percent to 80 percent of the time.[33] The relatively low success rate is consistent with the assertion that many malpractice claims are without merit. Even if most claims that reach trial lose, health care professionals still incur large costs to defend themselves. According to the Physicians Insurer Association of America, defense costs averaged close to $86,000 per claim in cases where the defendant won at trial (Table 2).[34] Even in cases where the claim was dropped or dismissed, defense costs averaged nearly $17,000.

**Table 2. Claims Disposition and Defense Costs**

| Claim Disposition | Share of Claims | Average Defense Cost |
|---|---|---|
| Dropped or Dismissed | 61% | $16,743 |
| Settled | 32% | $39,891 |
| Trial Verdict | | |
| Defense verdict | 6% | $85,718 |
| Plaintiff verdict | 1% | $91,423 |

Source: Physician Insurers Association of America.

In terms of compensation for negligent injuries, the system undoubtedly provides substantial compensation to some claimants, such as in cases of gross negligence or when the

[28] Jury Verdict Research, 43.
[29] U.S. General Accounting Office, *Medical Liability*, 20-21.
[30] Jury Verdict Research, 20.
[31] U.S. Department of Justice, 7.
[32] Smarr.
[33] Smarr (reporting a plaintiff recovery rate at trial of 20 percent); U.S. Department of Justice (reporting a plaintiff recovery rate at trial of 23.4 percent); and Jury Verdict Research, 46 (reporting a plaintiff recovery rate at trial of 39 percent).
[34] Smarr.

patient exhibits severe damages. However, there is evidence that the tort system provides uneven and inappropriate levels of payments. As noted above, the vast majority of negligent injuries do not lead to a claim. By definition, if injured parties do not file claims, then the tort system provides them with no compensation. Among those claims that are filed, the vast majority shows no signs of an injury or harmful event. If such claimants receive a payout, then the tort system is providing compensation to the wrong people. Even when legitimately injured parties are able to prove negligence, plaintiffs' lawyers routinely take 33 percent and sometimes 40 percent (or more) of that award as payment for legal fees.[35] The unevenness also stems from awards for pain and suffering. Since pain and suffering (or non-economic) damages are intrinsically impossible to measure objectively, the size of such payments varies considerably across homogenous groups of claims (i.e., different amounts for the same injury in different people).

A drawback of the medical liability system is the incentives for unwarranted, or nuisance, lawsuits. The potential for sizeable awards can lead to significant fraud and abuse of the tort system.[36] The large dollar size of successful action, the ability to seek non-economic pain and suffering awards, and the availability of contingency fees for plaintiffs' attorneys all could affect claiming rates. Although the data indicate that the number of claims has not climbed in recent years, these factors could encourage marginal cases to be pursued. Pain and suffering damages, in particular, could supply a powerful incentive to file nuisance claims. The tort system as a whole pays out more for pain and suffering than it does for measurable economic loss,[37] and it has been reported that up to one-half of all payments to individuals in medical malpractice claims are for pain and suffering.[38]

Another shortcoming of the malpractice liability system is the length of time negligently injured parties must wait before receiving payment. According to survey data gathered by Jury Verdict Research, there is a median wait of more than two years (25 months) between the time of the incident and the time the claim is filed. The litigation process, from date of filing to a jury verdict takes the typical claim another two years (26 months). Altogether, injured parties can expect to wait more than four years (51 months) between the time of the alleged malpractice incident and a jury verdict.[39] This prolonged wait has a particularly severe impact on low-income victims of malpractice. Such claimants may lack the financial resources to wait out the process and instead settle more quickly than might be warranted by their injury.

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[35] See Patricia M. Danzon, "Report on Awards for Noneconomic Loss," in *Medical Malpractice Policy Guidebook*, ed. Henry G. Manne (Jacksonville, FL: Florida Medical Association, 1985), 141-142 (reporting a median contingency fee of 38 percent for large medical malpractice claims); and Deborah R. Hensler et al., *Compensation for Accidental Injuries in the United States* (Santa Monica, CA: RAND, 1991), 135-136 (reporting a median contingency fee of 33 percent for accidental injury claims)

[36] Stephen J. Carroll, Allan F. Abrahamse, M. Susan Marquis, and Mary E. Vaiana, *Liability System Incentives to Consume Excess Medical Care* (Santa Monica, CA: RAND, 1995).

[37] Tillinghast-Towers Perrin, 17.

[38] Danzon, "Report on Awards for Noneconomic Loss," 136.

[39] Jury Verdict Research, 19-20.

## III. MEDICAL MALPRACTICE AND THE QUALITY OF HEALTH CARE

One of the primary goals of the medical liability system is to improve the quality of health care by penalizing negligent behavior. In order to accomplish this goal, the tort system must exhibit accuracy in both the assignment of negligence and in the size of damage awards. The available data on this aspect of the tort system strongly indicate that there is significant discrepancy between actual acts of negligence and tort-system-assessment of negligence. As previously noted, about 80 percent of malpractice claims exhibit no evidence of malpractice. In fact, most claims are not even tied to any injury.[40] The discordance between claims and negligence makes it very difficult, if not impossible, for health care providers to recognize and thereby avoid negligent behavior.

One study followed a sample of malpractice claims for a period of ten years to identify the relationship between negligence and payments to claimants.[41] The study's authors found that in cases where there was no evidence of negligence, 43 percent of claims resulted in payment for the claimant. By contrast, those claims where there was an injury caused by negligence, only 56 percent ended with payment. This evidence supports the contention that the tort system not only fails to compensate negligent injuries, but also fails to penalize negligent behavior.

Other evidence supports this conclusion. A 1997 study by Bryan Liang shows that doctors have little knowledge of the legal system, largely disagreed with jury verdicts in malpractice cases, and are unable to predict what juries will do in such cases. These findings led Liang to observe:

> If the actors within the incentive structure [i.e., doctors] and the lay agents who assess their behavior [i.e., juries] are under different understandings regarding appropriate versus inappropriate care, it is unlikely that the incentive structure goals of optimal deterrence and cost-effective provision of care will be fulfilled in any meaningful way.[42]

A range of other studies report findings consistent with this conclusion. For example, a 1996 study of family doctors in Florida found that better doctors (those with greater levels of medical knowledge) are more likely to be sued than other doctors.[43] Likewise, multiple studies have reported that good communication skills are more important than quality of care in predicting malpractice claims.[44] Other empirical evidence indicates that damage awards are more a function of injury severity than quality of care.[45]

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[40] Studdert et al., 253; Harvard Medical Practice Study, 7-36.
[41] Troyen A. Brennan, Colin M. Sox, and Helen R. Burstin, "Relation between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation," *New England Journal of Medicine* 335 (1996): 1963-1967.
[42] Bryan A. Liang, "Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department," *Cornell Journal of Law and Public Policy* 7, no. 1 (Fall 1997), note 6.
[43] John W. Ely et al., "Malpractice Claims against Family Physicians: Are the Best Doctors Sued More?" *Journal of Family Practice* 48, no. 1 (January 1999).
[44] Wendy L. Levinson et al., "Physician-Patient Communication: The Relationship with Malpractice Claims among Primary Care Physicians and Surgeons," *Journal of the American Medical Association* 227, no. 7 (February 19, 1997): 553-559; and Philip J. Moore et al., "Medical Malpractice: The Effect of Doctor-Patient Relations on

Taken as a whole, the medical liability system appears to be, quite simply, ineffective at consistently penalizing negligence. Appropriate acts of medical care can easily result in large damage awards, while true acts of negligence go unpunished. As one critic has observed, "It's like a traffic cop giving out lots of tickets to people not speeding and lots of speeders are not getting tickets."[46]

Given the dramatic increase in health care liability, an observer might suppose that health outcomes had deteriorated over the last several years. Ironically, however, the surge in medical malpractice litigation costs has occurred at the same time as a general improvement in key indicators of the health status of Americans. As seen in Table 3, there has been a marked decrease over the last decade in some of the leading causes of death in the U.S.[47] In addition, the infant mortality rate has improved by 25 percent and the average life expectancy at birth has increased by a year and a half.[48] These indicators suggest that health care in the U.S. is generally improving and dispels the notion that widespread negligence in medicine has hurt the overall quality of health care.

**Table 3. Mortality Rates, 1990-2000**

| | 1990 | 2000 | Change |
|---|---|---|---|
| Heart Disease* | 321.8 | 257.5 | -20.0% |
| Cancer* | 216.0 | 200.5 | -7.2% |
| Stroke* | 65.5 | 60.2 | -8.1% |
| Accidents* | 36.3 | 33.9 | -6.6% |
| Influenza & Pneumonia* | 36.8 | 24.3 | -34.0% |
| Infant Mortality† | 9.2 | 6.9 | -25.0% |
| Life Expectancy (years) | 75.4 | 76.9 | +2.0% |

* Age-adjusted death rate per 100,000 population.
† Deaths per 1,000 live births.
Source: U.S. Department of Health and Human Services.

While the above analysis indicates that health care liability fails as an effective deterrent to medical malpractice, an equally strong argument can be made that the liability system actually impedes improvements in the delivery of health care and may even increase the rate of errors. First, to the degree that the threat of legal liability induces doctors to practice defensive medicine, patients are subjected to additional tests and treatments which themselves expose patients to additional risk of injury. Moreover, medical liability can make doctors averse to recommending treatments that might be considered riskier, but that are also more medically appropriate.[49]

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Medical Patient Perceptions and Malpractice Intentions," *Western Journal of Medicine* 173, no. 4 (October 2000): 244-250.

[45] Henry S. Farber and Michelle J. White, "Medical Malpractice: An Empirical Examination of the Litigation Process," National Bureau of Economic Research Working Paper 3428 (September 1990) (showing that quality of care explains only a small portion of variance in award amounts, while injury severity exhibits much greater explanatory power); and Brennan, Sox, and Burstin (showing injury severity was more predictive of claims payments than was negligence).

[46] Troyen Brennan, as quoted by Samuel Jan Brakel, "Using What We Know about Our Civil Litigation System: A Critique Of 'Base-Rate' Analysis and Other Apologist Diversions," *Georgia Law Review* 31 (Fall 1996).

[47] Figures are death rates per 100,000 population, adjusted for population age differences over time. Data from the U.S. Department of Health and Human Services, National Center for Health Statistics, as reported in U.S. Census Bureau, *Statistical Abstract of the United States: 2002* (Washington, DC: Government Printing Office, 2002).

[48] U.S. Department of Health and Human Services, National Center for Health Statistics, *National Vital Statistics Report* (various issues).

[49] See generally, Bryan A. Liang, "The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal System," *Journal of Law, Medicine & Ethics* 29 (2001): 346-368.

Second, in many ways, medical liability deters health care providers from recognizing and reporting errors and working to prevent future mistakes. The legal setting in which malpractice claims occur is hostile to efforts to reduce error and improve safety. Current rules of evidence and discovery generally undermine reporting systems needed to systematically identify how and why errors occur.[50] A 2000 report by the Institute of Medicine found that the most important threat to patient safety was not simple human mistakes, negligence or incompetence, but rather human mistakes that result from poor system design, faulty maintenance and inadequate management.[51] Thus, addressing system failures are a crucial aspect to improving patient safety, and legal reform continues to be an inescapable element of such efforts.

The medical malpractice system also exacts a subtler toll on health care by eroding physician morale and damaging the doctor-patient relationship. In a 2002 survey, 87 percent of doctors felt that the overall morale of physicians had fallen in the last five years.[52] Low morale is important because it can reduce job satisfaction among physicians. Indeed, 58 percent of doctors report that their enthusiasm for practicing medicine has declined in the last five years.[53] As a result, doctors are more inclined to retire early or to shift their professions away from patient care. In addition, there is a tendency for malpractice fears to make doctor-patient relationships more adversarial. More than one doctor has reported that excessive litigation has fostered a sense of viewing each patient as a potential malpractice lawsuit rather than a patient in need of help.[54] Together, these trends make it difficult for doctors and patients to establish the kind of personal rapport necessary for better health care.

## IV. IMPACT OF THE MEDICAL LIABILITY SYSTEM ON HEALTH CARE COSTS

The problems in the medical liability system impose substantial costs on the U.S. health care system. Most apparent are the direct costs of premiums paid by health care providers. As noted previously, such premiums totaled $21 billion in 2001, and have doubled over the preceding ten years.

The indirect costs of the medical liability system are much larger than malpractice premiums. Principally, these costs manifest as the practice of defensive medicine by doctors and other health care professionals. Defensive medicine is defined as medical care that is primarily or solely motivated by fear of malpractice claims and not by the patient's medical condition alone. The effect can manifest as the prescription of increased diagnosis and treatment procedures beyond what is needed from a purely clinical perspective, and as the avoidance of

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[50] See Liang, "Adverse Event"; and Brian A. Liang, "Error in Medicine: Legal Impediments to U.S. Reform," *Journal of Health Politics, Policy & Law* 24, no. 1 (February 1999): 27-58.

[51] Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000), 55.

[52] Kaiser Family Foundation, *National Survey of Physicians* (May 2002), online at http://www.kff.org.

[53] *Ibid.*

[54] For some recent examples, see Joedy McCreary, "Residents Fear for Health Care as West Virginia Surgeons Continue Protest of Insurance Costs," *The Associated Press*, 1/8/2003; Rod Thomson, "In the Medical Malpractice Slugfest, the Patient Inevitably Gets Bruised," *Sarasota Herald-Tribune*, 2/17/2003; and Roberto Kusminsky, Raymond Goldsteen and James P. Boland, "Medical Malpractice Rational Test of No-Fault Patient Care Is Needed," *Charleston Gazette* (West Virginia), 12/14/2002.

procedures which might be appropriate from a clinical standpoint but whose risk-level discourages their use.

A large body of research has accumulated showing that medical malpractice liability causes doctors to practice defensive medicine.[55] In an authoritative study on defensive medicine, Stanford University researchers Daniel Kessler and Mark McClellan found that expanded malpractice liability significantly increased medical expenditures. Specifically, they found "that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications."[56] Based on national health expenditure data, Kessler and McClellan's estimates imply that medical liability reforms could have reduced defensive medicine expenditures by between $69 billion and $124 billion in 2001, or between 3.2 and 5.8 times the amount of malpractice premiums.[57] Importantly, the practice of defensive medicine does not produce measurable health benefits.[58]

Surveys of doctors provide additional evidence of defensive medicine.[59] According to a survey of 1,800 doctors published in the journal *Medical Economics*, more than three out of four (76 percent) doctors report that they practice defensive medicine.[60] In terms of the cost impact of defensive medicine, a large majority (68 percent) of respondents felt that defensive medicine increased the costs of their services by at least 6 percent. Another survey found that 79 percent of doctors order more tests than they would based solely on medical need, and 74 percent refer patients to specialists more often.[61]

A final cost of the medical liability system is the expense of administering the judicial system to handle malpractice claims. These expenses include both the cost of administering a

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[55] Robert J. Rubin and Daniel N. Mendelson, "How Much Does Defensive Medicine Cost?" *Journal of American Health Policy* (July/August 1994): 7-15; A. Russell Localio et al., "Relationship between Malpractice Claims and Cesarean Delivery," *Journal of the American Medical Association* 269, no. 3 (January 20, 1993): 366-273; U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-602 (Washington DC: Government Printing Office, 1994); Steven Shavell, "Economic Analysis of Accident Law," National Bureau of Economic Analysis Working Paper 9483 (March 2003); Daniel P. Kessler and Mark B. McClellan, "Medical Liability, Managed Care, and Defensive Medicine," National Bureau of Economic Research, Working Paper 7537 (February 2000); Lisa Dubay, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics* 18 (1999): 491-522; and Robert Quinn, "Medical Malpractice Insurance: The Reputation Effect and Defensive Medicine," *Journal of Risk and Insurance* 65, no. 3 (1998): 467-484. For an alternative view, see Laura-Mae Baldwin et al., "Defensive Medicine and Obstetrics," *Journal of the American Medical Association* 274, no. 20 (November 22/29, 1995): 1606-1610.

[56] Daniel P. Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine," National Bureau of Economic Analysis Working Paper 5466 (February 1996), 2.

[57] Calculation is based on the health services and supplies component of national health expenditures from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "National Health Expenditures," (2003), online at http://cms.hhs.gov/statistics/nhe/historical.

[58] Kessler and McClellan, "Medical Productivity," 25; Kessler and McClellan, "Defensive Medicine," 33; and Dubay, Kaestner, and Waidmann.

[59] For a review of some older surveys, see U.S. Congress, Office of Technology Assessment, Figure 3-3.

[60] "Once Burned, Twice Defensive," *Medical Economics* 76, no. 14 (July 26, 1999). See also, Berkeley Rice, "Medical Errors: Is Honesty Ever Optional," *Medical Economics* 79, no. 19 (October 11, 2002) (reporting the results of an ethics survey which found that 67 percent of physicians admit to practicing defensive medicine).

[61] Humphrey Taylor, "Most Doctors Report Fear of Malpractice Liability Has Harmed Their Ability to Provide Quality Care," The Harris Poll #22, 5/8/2002.

trial and the cost of providing a framework for filing and settling cases. Overall, medical malpractice cases account for about 12 percent of all tort cases decided by a trial, making such lawsuits the third most common type of tort settled in state courts.[62] However, only a small percentage of claims actually result in a jury trial, as the vast majority are settled out of court prior to trial. A precise estimate of administrative costs has not been done due to data limitations

## V. IMPACT OF THE MEDICAL LIABILITY SYSTEM ON ACCESS TO HEALTH CARE

The medical liability system reduces access to health care in the U.S. The first way medical malpractice affects access is by reducing the affordability of health insurance. By increasing expenditures, the system forces premiums higher, which in turn reduces the number of Americans with health insurance. The second impact is to reduce the supply of health care, such as inducing doctors to retire from medicine or to avoid high-litigation specialties or geographic areas.

*Demand for Health Insurance: Impact on Affordability*

Given the increase in health insurance premiums and costs described above, there will be an impact on the extent of health insurance coverage in the U.S. Generally speaking, there are two pools of people who will be affected. First, some individuals will choose not to purchase insurance due to the increase in premiums. Second, some individuals who would otherwise be willing to pay the higher premiums caused by medical malpractice will lose coverage if their employer decides to no longer offer health insurance as a benefit. The bottom line is that higher costs reduce the affordability and hence the demand for health insurance. Survey data indicate that three-quarters (74 percent) of the uninsured identify high costs as a major reason for going uninsured.[63]

Research also shows that firms' decision to offer health insurance benefits is sensitive to the price of health insurance. Small businesses are even more likely to drop health benefits in response to increased liability costs than are large firms,[64] and employees of small businesses are more likely to be uninsured than are employees of large businesses.[65] A 1997 report by the U.S. General Accounting Office found:

> Particularly for small employers, costs are cited as a key factor in their decision to drop coverage for their workers or to consider offering it. For those employing lower-wage workers, health premiums represent a significant share of total compensation.[66]

[62] The figure is based on a survey of the nation's 75 largest counties and does not include cases that were settled prior to trial. U.S. Department of Justice, 2.
[63] Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book* (May 2000), 35, online at http://www.kff.org/sections.cgi?section=kcmu.
[64] Jonathan Gruber and Michael Lettau, "How Elastic Is the Firm's Demand for Health Insurance," National Bureau of Economic Research Working Paper 8021 (November 2000).
[65] Kaiser Commission on Medicaid and the Uninsured, 25; and U.S. General Accounting Office, *Health Insurance: Characteristics and Trends in the Uninsured Population*, GAO-01-507T (March 2001), 8.
[66] U.S. General Accounting Office, *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures*, GAO/HEHS-97-122 (July 1997), 24.

Low wage workers are most vulnerable to such changes. First, such workers frequently work for small businesses, who already are less likely to offer coverage and are the most likely group of firms to drop health benefits in response to higher costs. Second, low wage workers often cannot afford to purchase private health insurance by themselves. Thus, when excessive malpractice litigation pushes up the cost of health insurance, low wage workers often bear the brunt of the impact.

*Supply of Health Insurance: Impact on Health Care Providers*

High malpractice costs have a detrimental impact on the supply of medical services by health care providers. There is extensive anecdotal evidence that doctors and hospitals have reduced the availability of health care in response to rising malpractice premiums.

- Arizona: The city of Bisbee, along the Mexican border, lost the maternity ward at its local hospital when malpractice rate increases led to four of the city's six obstetricians to stop delivering babies.[67]

- Florida: The number of insurers offering medical malpractice coverage dropped in half (from 40 to 20) over the past decade, pushing premiums up and reducing the availability of coverage.[68] Malpractice insurance premiums in 2002 averaged $201,376 for Ob/Gyns, while the average was $174,268 for general surgeons.[69] The Orlando Regional Medical Center is currently at risk of closing its trauma center due to the lack of neurosurgeons willing to work the emergency room.[70]

- Georgia: A recent study of Georgia physicians projected that 2,800 doctors in the state (or about one in five) would stop providing higher-risk procedures in order to reduce their liability exposure. One in three Ob/Gyns said they would limit their services (including delivering babies), and 11 percent would stop working in emergency rooms. Four percent of the state's doctors reported that high malpractice premiums have led them to retire early or leave the state. Overall, the study reported that malpractice premiums increased between 11 percent and 30 percent in the state.[71]

- Nevada: It has been reported that dozens of doctors have stopped practicing in the state due to the medical liability crisis.[72] The decision by St. Paul Companies to cease writing malpractice insurance left 60 percent of Las Vegas doctors seeking a new insurer, and 10 percent of the city's doctors are expected to quit or relocate as a result.[73] The crisis in Nevada was made particularly clear when the state's only Level 1 trauma center closed

[67] Tom Gorman, "Physicians Fold under Malpractice Fee Burden," *Los Angeles Times*, 3/4/2002.
[68] John Hillman, "Crisis Coast to Coast: Health-Care Providers and Regulators Urge Medical Liability Reform," *Best's Review*, September 2002.
[69] Smarr.
[70] Margaret Ann Mille, "Manatee Doctors, Nurses Rally for Cap on Malpractice Suits," *Sarasota Herald-Tribune*, 3/1/2003.
[71] Daniel Yee, "Study: Insurance Rates Affect Ga. Care," *The Washington Post*, 1/26/2003.
[72] Joelle Babula, "Doctors Call on Lawmakers to Revamp Liability Laws," *Las Vegas Review-Journal*, 3/5/2003.
[73] Tom Gorman, "Physicians Fold under Malpractice Fee Burden," *Los Angeles Times*, 3/4/2002.

for 10 days in July 2002, during which time the hospital's CEO warned the public to "Drive home carefully."[74]

- New Jersey: Medical liability premiums have been increasing 20 percent to 25 percent annually, and the Medical Society of New Jersey estimates that 3,000 physicians in the state are at risk of losing coverage due to reduced coverage by insurers.[75] Over a period of less than a year, three insurers – the MIIX Group, Phico and the St. Paul Companies – covering 55 percent of the state's doctors stopped writing coverage for malpractice, leaving doctors rushing to find new sources of insurance.[76]

- Pennsylvania: The state's largest malpractice insurer, the Phico Group, has been placed in liquidation, and the MIIX Group and Princeton Insurance have ceased writing new policies.[77] Rising malpractice costs have induced doctors to leave the state, retire early or stop performing certain procedures. Difficulty obtaining malpractice coverage caused Abington Memorial Hospital outside Philadelphia to close its trauma center for almost two weeks.[78] Among doctors hit the hardest, according to Pennsylvania Hospital, are radiologists specializing in mammography. The loss of radiologists in the state has resulted in waiting periods for routine mammographies of up to eight months.[79]

- Texas: Doctors along the Rio Grande river have experienced significant increases in malpractice premiums, with neurosurgeons paying up to $120,000 a year and Ob/Gyns paying up to $100,000 a year for coverage. Numerous surgeons, internists, and the only pediatric surgeon in El Paso have left the city. According to one physician, "The physicians along the Mexican border have a lower percentage of patients who are privately insured, and to have a line item like medical liability insurance go up 100 percent to 300 percent in a year's time is a lot for some practices to swallow."[80]

- West Virginia: High malpractice rates have contributed to about 5 percent of the state's doctors either retiring early or leaving the state. The Charleston Area Medical Center had to pay $2,000 daily in malpractice premium subsidies in order to retain the doctors necessary to keep its trauma center open. After the last emergency room neurosurgeon left Wheeling, the local hospital had to transport trauma patients by helicopter to other emergency rooms. The departure of St. Paul Companies from the malpractice insurance market has forced two-thirds of the state's doctors to seek coverage from other sources.[81]

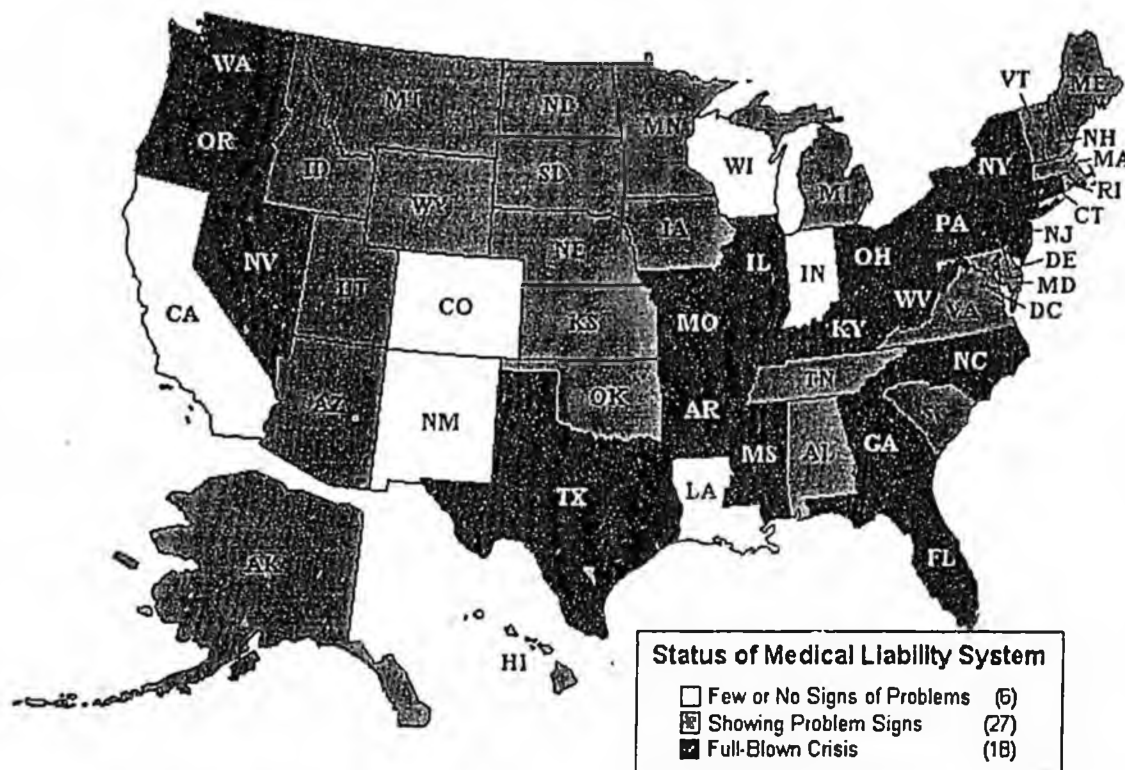
- Washington: Increased losses forced Washington Casualty Co., the state's largest provider of malpractice coverage to rural hospitals, into receivership. The firm provided

[74] Tony Batt, "UMC Official Says Crisis Is Far from Over," *Las Vegas Review-Journal*, 10/12/2002.
[75] Lynna Goch, "Medical-Malpractice Tort Reform Trouble Spots," *Best's Review*, December 2002.
[76] Joseph B. Treaster, "New Jersey Insurer Is Leaving Many Doctors Scrambling," *New York Times*, 5/10/2002.
[77] Lynna Goch, "Medical-Malpractice Tort Reform Trouble Spots," *Best's Review*, December 2002.
[78] Jeff Miller, "Rendell: Jury Award Caps Fall Short," *Morning Call* (Allentown, PA), 2/11/2003.
[79] Marian Uhlman, "Shortage of Radiologists, Technologists Creating Long Waits," *Philadelphia Inquirer*, 2/11/2003.
[80] John Hillman, "Crisis Coast to Coast: Health-Care Providers and Regulators Urge Medical Liability Reform," *Best's Review*, September 2002.
[81] Frances X. Clines, "Insurance-Squeezed Doctors Folding Tents in West Virginia," *New York Times*, 6/13/2002.

coverage to 46 hospitals and 20 community health clinics in the state, and covered 75 percent of the state's rural hospitals.[82] PedMac, which provides health care services to the poor, reported that its annual malpractice insurance costs increased by 150 percent,[83] and the average cost for malpractice coverage for hospitals increased 60 percent statewide.[84] A survey by the state medical association found that obstetricians have been hit hard, with 19 percent reporting that they have already stopped practicing obstetrics and 8 percent saying they plan to stop in the near future.[85]

Anecdotal evidence is confirmed by empirical evidence. A recent study found that the number of doctors at the state level is sensitive to the malpractice insurance costs: higher premiums reduce the number of practicing physicians.[86] A 1991 study of four Western states reported that medical liability problems resulted in decreased access to obstetric services, an effect found to be particularly harmful to poor women and rural residents.[87]

**Figure 3. Problems in Medical Liability in the U.S.**




Source: American Medical Association.

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[82] Carol M. Ostrom, "Malpractice Insurer Ordered into Receivership by State," *The Seattle Times*, 3/8/2003.
[83] "Bleeding No More," *Puget Sound Business Journal*, 11/22/2002.
[84] Julian Anderson, "Tort & Retort: Doctors Say They're Dogged by Rising Costs of Premiums and Jury Awards, While Attorneys Say It's Not Their Fault," *The Columbian* (Vancouver, WA), 2/9/2003.
[85] Washington State Medical-Education and Research Foundation, *The Impact of Medical Malpractice Insurance and Tort Law on Washington's Health Care Delivery System* (September 2002).
[86] Mark P. Gius, "An Examination of the Determinants of Physician Supply at the State Level," *Journal of Business and Economic Studies* 6, no. 1 (Spring 2000): 73-79.

The American Medical Association (AMA) has identified 18 states in which the medical liability system has created a crisis in health care.[88] Figure 3 displays those states that the AMA considers to be in full-blown crisis. The AMA lists another 26 states and the District of Columbia as showing signs of a serious medical liability problem, but that have not yet progressed to the crisis stage.

## VI. FEDERAL REFORM OF THE MEDICAL LIABILITY SYSTEM

Federal reform of the medical liability system consists of several interrelated provisions, described below. While one single change is unlikely to produce dramatic results, the combined effect of all the provisions could bring about meaningful benefits. The impact of the reforms would likely begin to manifest soon after passage into law. However, the complete impact would take time to fully manifest, depending on the actual date of enactment, judicial review and response by the insurance industry

The primary benefits of federal medical malpractice reform include budgetary savings for governments, fewer individuals without health insurance, and reduced national health care expenditures. Additionally, consumers would benefit from improved access to health care, as excessive malpractice premiums would no longer drive health care providers to raise prices, retire early, move out of state or avoid higher-risk specialties. A system less hostile to reporting and reviewing medical errors could also produce a system that would increase the effectiveness of error prevention and patient safety efforts.

Among those groups most benefiting from such changes are women, low-income households, and rural residents. Female patients are often put at a disadvantage in the current system because obstetricians pay some of the highest malpractice insurance rates of any specialty. The result has been fewer obstetricians that are able to afford continuing their obstetricics practice or to accept new obstetricics patients.[89] Low-income households suffer from the high cost of health insurance and are already more likely to lack private health insurance. Lower health insurance premiums would make coverage more affordable for the many working class families who earn too much to qualify for Medicaid.[90] Finally, rural residents generally live in areas with lower rates of physicians per capita. Thus, such residents already have limited options when it comes to health care. The faults of the current medical liability system only further reduce their health care access options.[91] All three groups stand to significantly benefit from reforms in the medical liability system.

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[87] Roger A. Rosenblatt et al., "Tort Reform and the Obstetrics Crisis: The Case of the WAMI States: Washington, Alaska, Montana, and Idaho," *Western Journal of Medicine* 154, no. 6 (June 1991): 693-699.

[88] The most important factor in determining the status of each state is the number of patients losing access to medical care. Other factors include early retirements among physicians, physicians leaving the state or limiting their provision of services, the state's legal and judicial climate, the cost and availability of malpractice insurance, and trends in jury awards and settlements. American Medical Association, "18 States Now in Full-Blown Medical Liability Crisis," Press Release (3/3/2003).

[89] See Rosenblatt et al.; and *supra* notes 67, 69, 71, 79, and 85, and accompanying text.

[90] See U.S. General Accounting Office, *Private Health Insurance*, 24; Gruber and Lettau; Kaiser Commission on Medicaid and the Uninsured, 11-14; and *supra* notes 39, 80 and 83, and accompanying text.

[91] See Rosenblatt et al.; and *supra* note 82 and accompanying text.

Medical liability reform has been attempted on numerous occasions at the state level. Reforms adopted at the state level include a range of policies, including caps on non-economic losses, changes in the statute of limitations, joint and several liability reform, punitive damage limits, and periodic payment of damages, among others. These efforts have yielded mixed results, depending on the strength and type of reforms, as well as whether state courts have overturned or limited some provisions.[92] However, some of the key reforms proposed at the federal level, including the cap on pain and suffering damages, have proven successful at producing savings when implemented.[93]

Perhaps the most successful example of reform at the state level is California. In the early 1970s, California suffered from rapidly escalating malpractice premiums that affected the quality and availability of care in the state. In response, California adopted the Medical Injury Compensation Reform Act (MICRA) in 1975.[94] MICRA contained several provisions, including a $250,000 cap on non-economic damages, binding arbitration on disputes, collateral sources offsets, limits on contingency fees, advance notice of malpractice claims, statute of limitations, and periodic payment of damages.[95] Although California still has problems with its malpractice system (including a high claiming rate), it has not experienced the same rate of growth in malpractice premiums. Over the period 1976-2000, medical malpractice premiums in California increased by 167 percent, while premiums for the rest of the nation rose by 505 percent.[96] This difference in premium growth suggests that similar reform at the federal level could have a potent effect as well.

*Components of the Federal Reform*

Federal legislation has been introduced in the 108th Congress that would significantly reform the medical liability system in the U.S.[97] The proposed legislation consists of several major provisions, summarized below. Existing state reform provisions would be largely left intact.[98]

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[92] For a state-by-state review of laws, court rulings and reforms, see Cohen; American Tort Reform Association, "Medical Liability Reform" [March 2003], online at http://www.atra.org/show/7338; McCullough, Campbell & Lane, "Summary of Medical Malpractice Law" [March 2003], online at http://www.mcandl.com/states.html; and American Medical Association, "Activity in the States" [March 2003], online at http://www.ama-assn.org/ama/pub/category/7470.html.

[93] See Patricia M. Danzon, *New Evidence on the Frequency and Severity of Medical Malpractice Claims* (Santa Monica, CA: RAND, 1986); Kessler and McClellan, "Defensive Medicine"; and Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reform on Physicians' Perceptions of Medical Care," National Bureau of Economic Analysis Working Paper 6346 (January 1998).

[94] Although MICRA was enacted in 1975, it was not until 1984 and 1985 that the courts upheld the key provisions of the reform.

[95] For a discussion of MICRA, see John Hillman, "The Right Reforms: Experts Call California's Medical Injury Compensation Reform Act a Medical-Liability Role Model," *Best's Review*, December 2002.

[96] Smarr.

[97] Representative James Greenwood (R-PA) introduced H.R. 5, "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003," on March 6, 2003. The U.S. House of Representatives passed the bill on March 12, 2003 by a vote of 229 to 196.

[98] Existing state reforms would be unaffected if they are stronger than the federal reform. In addition, any state limitation on non-economic or punitive damages, even if weaker than the federal reform, would remain unchanged.

- Unlimited Economic Damages: The legislation specifically states that there would be no limit on the amount of economic damages that injured parties can collect. This provision would not change current law.

- Cap on Non-Economic Losses: Awards for non-economic, also called pain and suffering, damages would be limited to $250,000. Currently, limits (if any) on non-economic damages vary by state.

- Statute of Limitations: The legislation would require malpractice lawsuits to be brought within three years of the date the injury manifested, or one year after the claimant discovers (or should have discovered) the injury, whichever occurs first. Children are entitled to exemptions from this limit. Statutes of limitations vary by state, and claims can be initiated years after the injury in many jurisdictions.

- Fair Share Rule (Joint and Several Liability): Each defendant would be liable for damages only in proportion to their share of responsibility. A defendant found to be 30 percent at fault for an injury, for example, would only be required to pay 30 percent of damages. Under current law, liable defendants can be required to pay for 100 percent of damages regardless of their actual share of fault.

- Collateral Sources Offset: Claimants would be permitted to recover claimed damages only once. Currently, claimants have the ability to recover the same damages from multiple sources.[99]

- Lawyers' Contingency Fees: Contingency fee arrangements would be limited to specific rates based on the size of the award, ranging from 40 percent on the first $50,000 to 15 percent of amounts over $600,000. Current practice is for plaintiffs' attorneys to take 33 percent to 40 percent of the total award or settlement as payment.

- Periodic Payment of Damages: Allows payments for future losses (such as expected rehabilitation costs) to be paid out over time rather than an immediate lump-sum payment. Under current law, defendants can be required to make immediate full payment.

- Punitive Damages: Punitive damages would be limited to double the amount of economic damages, or $250,000, whichever is greater. In addition, the bill would set a higher legal requirement before punitive damages can be awarded. Currently, limits (if any) on punitive damages vary by state.

*Impact on the Federal Deficit*

Medical liability reform would generate significant fiscal savings for the federal government. The budgetary impact results from the general reduction in the cost of health care and would affect both revenues and spending. On the revenue side, the government would

[99] In some cases, the right to subrogation can limit the net collection by the claimant.

collect additional income and payroll taxes. As the cost of tax-exempt employer-provided health benefits falls, employers will pass savings on to their employees in the form of taxable wages and benefits. The initial savings are relatively small, and increase over time as the full impact of the reforms takes hold. According to the Congressional Budget Office (CBO), these effects would result in about $3.0 billion in additional revenues over a ten-year period, including a $925 million boost for Social Security (Table 4).[100]

Government spending would also decrease due to medical liability reform. The primary savings would accrue to the Medicare and Medicaid programs, which would experience lower health care costs. In addition, the federal government would realize savings from lower costs of health benefits for federal employees. Reduced outlays from medical liability reform would total $15.1 billion in savings. Together, the increased revenue and reduced spending would produce more than $18 billion in direct savings over ten years for the federal government. State and local governments would also receive savings of about $8.5 billion over ten years.[101]

**Table 4. Direct Budgetary Savings from Medical Liability Reform (millions of dollars)**

| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2004-2013 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Income & Medicare Payroll Taxes | 10 | 70 | 170 | 210 | 220 | 230 | 250 | 270 | 290 | 330 | 2,050 |
| Social Security Payroll Taxes | 5 | 20 | 60 | 90 | 100 | 110 | 120 | 130 | 140 | 150 | 925 |
| Subtotal: Revenues | 15 | 90 | 230 | 300 | 320 | 340 | 370 | 400 | 430 | 480 | 2,975 |
| Outlays for Medicare & Medicaid | 170 | 480 | 910 | 1,250 | 1,570 | 1,820 | 1,990 | 2,130 | 2,220 | 2,350 | 14,900 |
| Outlays for federal employees | 2 | 10 | 20 | 20 | 20 | 30 | 30 | 30 | 30 | 30 | 230 |
| Subtotal: Outlays | 172 | 490 | 930 | 1,270 | 1,590 | 1,850 | 2,020 | 2,160 | 2,250 | 2,380 | 15,130 |
| **Total Savings** | **187** | **580** | **1,160** | **1,570** | **1,910** | **2,190** | **2,390** | **2,560** | **2,680** | **2,860** | **18,105** |

Note: Positive numbers indicate budgetary savings of either increased revenue or decreased outlays.
Source: Congressional Budget Office.

The budgetary savings presented in Table 4 only reflect the direct savings from lower medical liability premiums. As noted above, however, the medical malpractice system induces doctors to practice defensive medicine. As the federal liability reforms take hold, there will be a corresponding reduction in the practice of defensive medicine. As previously discussed, the cost of defensive medicine is estimated to be 3.2 to 5.8 times the magnitude of malpractice premiums.[102] Assuming that there is the same proportionate relationship between direct government savings and indirect government savings on defensive medicine, then there would be between $9.3 billion and $16.7 billion in additional budgetary savings in 2013 from reduced defensive medicine.[103] Combined annual budgetary savings from medical malpractice reform

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[100] The budget estimates presented here are for H.R. 5. U.S. Congress, Congressional Budget Office, "Cost Estimate for H.R. 5: Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2002," 3/10/2003.
[101] U.S. Congress, Congressional Budget Office, "Cost Estimate for H.R. 5," 8.
[102] See *supra* note 57 and accompanying text.
[103] The calculations behind these estimates (in billions) are: $9.26 = $2.86 * 3.24, and $16.67 = $2.86 * 5.83.

would total $12.1 billion to $19.5 billion a year. Over a ten year period (2004-20013), a total of between $67 billion and $106 billion in savings would accrue to the federal government in this manner.

*Impact on the Number of Uninsured*

By lowering the cost of malpractice insurance and reducing the practice of defensive medicine, medical liability reform will increase the number of Americans with health insurance. Not only does the demand for health insurance vary widely by individual and employer, but also the number of uninsured Americans is itself difficult to quantify.[104] In addition, the reduction in the number of Americans without health insurance will not occur overnight, as it will take time for the full effect of reforms to impact the insurance market. Any estimate of changes in the uninsured population suffers from a number of inherent problems. However, it is possible to arrive estimates based on estimated savings and the sensitivity of consumers to changes in insurance premiums.

The sensitivity of consumers to the price of health insurance is measured by what economists call "elasticity." In the context of this discussion, an elasticity measures the percent change in the purchase of health insurance for a 1 percent change in the price of health insurance. A substantial amount of research has accumulated attempting to quantify health insurance elasticity. Research reviewed for the present study (including surveys of the literature) suggests a range of price elasticities for health insurance.[105] The median of these estimates indicates that a 1 percent decrease in the price of health insurance results in a 0.40 percent increase in the number of insured individuals, or approximately 960,000 people.[106] This figure is notably more conservative than the 0.60 elasticity which CBO has used to estimate the effect of health care proposals.[107]

CBO estimates that the malpractice reforms described above would effect a 0.4 percent decrease in the price of health insurance. Assuming an elasticity of 0.40, the malpractice premium savings alone would, in time, increase the number of Americans with health insurance by approximately 385,000. An elasticity of 0.60 raises the direct impact to 578,000 persons. The estimated price change, however, only includes the savings from lower malpractice

[104] For example, one in five (18 percent) Medicaid recipients report themselves as uninsured. John Sheils, Lewin Group, Prepared Testimony to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 6/15/1999.
[105] Jean Marie Abraham, William B. Vogt, and Martin S. Gaynor, "Household Demand for Employer-Based Health Insurance," National Bureau of Economic Research Working Paper 9144 (September 2002); David M. Cutler and Richard J. Zeckhauser, "The Anatomy of Health Insurance," National Bureau of Economic Research Working Paper 7176 (June 1999); U.S. Congress, Congressional Budget Office, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals" (November 1993); Willard G. Manning and M. Susan Marquis, *Health Insurance: The Trade-Off between Risk Pooling and Moral Hazard* (Santa Monica, CA: RAND, 1989); Paul J. Feldstein, *Health Care Economics* (Albany, NY: Delmar Publishers, 1993), 149; and M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics* 14, no. 1 (May 1995): 47-63.
[106] Based on an estimated insured population of 240.9 million in 2001. U.S. Census Bureau, *Health Insurance Coverage: 2001*, Current Population Report P60-220 (September 2002), 13.
[107] U.S. Congress, Congressional Budget Office, "Behavioral Assumptions."

premiums and does not account for any changes in levels of defensive medicine, which are 3.2 to 5.8 times the magnitude of malpractice premiums.

Since there is no direct estimate of how the federal reform would affect health insurance prices through reduced defensive medicine, a proxy is necessary. The present analysis assumes that defensive medicine costs correlate with changes in the average price of purchasing insurance. Thus, the price effect of a 25 percent to 30 percent reduction in malpractice premiums (as estimated by CBO) would be matched by a similar proportional decrease in defensive medicine. Using this broader approach to estimated savings, the savings from lower malpractice premiums plus lower defensive medicine spending would reduce health insurance premiums by 1.70 percent to 2.73 percent.[108] Based on the 0.40 elasticity discussed above, the total impact of medical malpractice reform would be a reduction in the number of persons without health insurance of 1.6 million to 2.6 million.[109] With an elasticity of 0.60, the effect of the legislation would be to reduce the uninsured population by 2.4 million to 3.9 million persons.

*Impact on Total Health Care Expenditures*

The medical malpractice reforms described here could produce substantial savings in total spending on health care in the U.S. Public and private national health care expenditures for health services and supplies are projected to rise from $1.4 trillion in 2001 to nearly $2 trillion in 2006.[110] Reform of the medical liability system would generate savings in a number of areas. Kessler and McClellan's research indicates that medical liability reforms, such as those discussed here, would reduce health care spending by 5 percent to 9 percent, without an appreciable impact on health outcomes. Assuming the reforms are fully implemented after three years (i.e., by 2006), the gross savings would range from $99 billion to $178 billion.[111] However, an exact estimate of the net overall change in health care expenditures is difficult to make due to offsetting factors.

Factors that will reduce overall expenditures include lower medical malpractice insurance premiums, direct reductions in the cost of providing care, and reduced spending on defensive medicine. Other changes will result in increased spending on health care. For example, as noted above, a decrease in the average price of health insurance will result in more individuals purchasing health insurance. Although the average cost per policy will decrease, there will be more people buying policies. Similarly, some individuals who currently have health insurance may choose to use any savings to purchase expanded health insurance coverage.

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[108] Reduced spending on defensive medicine translates to an additional price reduction of between 1.30 percent (= 0.4 * 3.24) to 2.33 percent (= 0.4 * 5.83).

[109] These calculations are based on the number of insured Americans in 2001 and assume full implementation of the reforms. The true effects of the reforms may not be fully realized until some point in the future depending on the number of uninsured persons, the actual date of enactment, judicial review and response by the insurance industry. However, since projections of the uninsured population are not available, the only alternative is to estimate the impact as if the reform were fully implemented in 2001. The future impact on the number of uninsured would be proportional to the population when the effects of the reforms are fully realized.

[110] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "National Health Care Expenditures Projections," (2003), online at http://cms.hhs.gov/statistics/nhe/projections-2002.

[111] For comparison purposes, if the reforms had been fully implemented as of 2001, the gross savings would have been $69 billion to $124 billion.

The net effect of these factors will be a reduction in national health care expenditures, although the exact magnitude is unknown. The CBO analysis of medical malpractice reform legislation indicates that approximately 60 percent of gross spending reductions will be offset by increased spending by newly-covered individuals or expanded coverage for currently-insured individuals.[112] A rough approximation of the net reduction in health care expenditures, based on projected 2006 expenditures and assuming fully implemented reforms, puts the total between $39 billion and $71 billion annually.

## VII. CONCLUSION

The medical liability system in the U.S. suffers from several major shortcomings that adversely impact the negligently injured as well as the general population. The system fails to achieve either of its central goals: compensation and deterrence. First, the vast majority of negligent injuries do not lead to a claim. By definition, if injured parties do not file claims, then the tort system provides them with no compensation. Second, among those claims that are filed, the vast majority shows no signs of an injury or harmful event. If such claimants receive a payout, then the tort system is providing compensation to the wrong people. Third, when a legitimate claim is filed, the system typically takes years for the injured party to receive anything. Finally, even when legitimately injured parties are able to prove negligence, plaintiffs' lawyers routinely take 33 percent to 40 percent (or more) of that award as payment for legal fees. On balance, it seems clear that the medical liability tort system broadly fails as a means of compensating the negligently injured.

On the second goal – deterrence of negligent behavior – the tort system also fails to achieve its mission. Since most acts of medical malpractice do not result in a claim and most claims are not tied to actual negligence, the tort system is unable to convey to doctors the appropriate signals about the optimal level of care. Moreover, the litigious environment created by the tort system discourages the reporting of mistakes, which impedes efforts to identify and prevent medical errors. In fact, the threat of malpractice litigation induces doctors to practice defensive medicine, subjecting patients to unnecessary treatments and therapy.

This indictment of the tort system serves as the basis for medical liability reform. Reform efforts at the state level have had mixed results, with California being the best example of effective reform. If adopted, the federal reform discussed here could yield budgetary savings of more than $19 billion per year, reduce the number of Americans without health coverage by up to 3.9 million, and lead to an environment that is significantly more receptive to efforts to improve patient safety and reduce medical errors.

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[112] U.S. Congress, Congressional Budget Office, "Cost Estimate for H.R. 5," 6.

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# HEARTBEAT

The "Pulse" of ALASKA STATE MEDICAL ASSOCIATION MEMBERS Volume 105 Nov/Dec 2003

**Informed Consent**

## Recent Supreme Court Decision

A recent Alaska Supreme Court decision may impact how you provide informed consent.

Marsingill v. O'Malley (Supreme Court No. 5-9859, Opinion No. 5643, dated 11/22/02), according to several Anchorage defense attorneys, may provide for new standards for providing informed consent with a potential impact on the delivery of care in Alaska.

Attorney Howard Lazar wrote a letter to ASMA physician officers that expressed his analysis of this case, advice he would provide to physicians, and a suggestion that the issues raised be addressed by the Legislature.

The case, which was the subject of the decision, involved a call at night to a physician. The physician recommended that the patient go to the ER, but the patient chose not to go and subsequently lost consciousness and suffered permanent injuries. The basic issue was that a recommendation to go to the emergency room constituted a "treatment" and therefore needed appropriate informed consent. The most far-reaching corollary is that the Supreme Court stated that the informed consent must be in terms of what a "reasonable patient" would want to know about the treatment.

Mr. Lazar states in part, in his letter of 12/19/02, to ASMA's officials:

*"...How does this affect physician's practice and what a physician needs to do from this point forward? First, we must start with the idea that the overwhelming support of your peers concerning the appropriateness of any advice you give to a patient will not be enough to prevent you from having to go through a trial concerning that advice. In every instance and for virtually everything you do, you must first look to what the mythical "reasonable patient" would want to know. That can apply to telephone conversations, conversations in the hospital, or conversations in your office with your patients. I believe the most immediate concern involves the same situation Dr. O'Malley was involved with here – the telephone call in the middle of the night. Unfortunately, what is lost in all of this is that it doesn't really look to what a reasonable physician would say to a patient when confronted with a complaint over the telephone. Virtually anything you tell the patient can be misconstrued, and if the patient decides not to follow advice you provide, you can conceivably be held responsible for that patient's failure to follow that advice. Regardless of the nature of the complaint, if you decide to take a telephone call, I recommend a graduated approach with the ultimate goal being for the patient to report to the emergency department virtually every time you receive such a call. I would provide the patient with all conceivable scenarios with the reported symptoms until the patient agreed to go to the emergency department. I would specifically include statements to the effect that there is a reasonable chance the patient could die or suffer serious bodily harm by failing to go to the emergency department. I would have a dictaphone available at all times to enable you to document for your records what actually transpired in any of those telephone conversations. The safest method might simply be to inform the patient at the commencement of the telephone conversation that you are recording the conversation for purposes of your records, and then simply placing the tape of that conversation in your medical record, with transcription only occurring in the event there was a dispute that developed over the contents of the conversation. This method would not work if you were away from the home or office.*

*Alternatively, I would instruct answering services to simply play a pre-recorded message to all patients who call to the effect that any complaint they have may be serious, cannot be diagnosed on the telephone, and that they should proceed immediately to the emergency department for evaluation by an emergency physician. Using that approach, no questions can possibly exist concerning what transpired within the confines of the telephone conversation and there can be no "acquiescence".*

*Both approaches lessen a physician's ability to have a meaningful interaction with his patient in the context of reported complications or symptoms. Both approaches may dramatically affect patient census in the emergency department and will undoubtedly cause unnecessary visits to the emergency department by patients who truly do not need to go. Eventually, this approach may cause patients to cease calling physicians giving the limited meaningful information they can be provided. Unfortunately, I cannot see any alternative given the court's decision...."*

ASMA recommends that you contact both your professional liability insurance company and your attorney to seek guidance regarding "informed consent" in your practice in light of this decision.

The issues involved are important and ASMA is exploring ways, including legislation, to resolve them.

* * *

# HB
# 472
# (File 3 of 7)

# News Articles & Publications

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**PROFESSIONAL ISSUES**

# Where does money go in malpractice cases?

Quick View. Nov. 3, 2003.

*In a typical tort case, costs are broken down this way:*

| | |
|---|---|
| Plaintiff attorneys | 19% |
| Recovery (economic losses) | 22% |
| Recovery (noneconomic losses) | 24% |
| Defense attorneys | 14% |
| Administrative costs | 21% |

Source: Tillinghast-Towers Perrin, as published in a study by the Center for Legal Policy at the Manhattan Institute, "Trial Lawyers Inc., a Report on the Lawsuit Industry in America 2003"

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# America's Medical Liability Crisis: A National View

WA OR CA ID NV MT WY UT AZ ND SD NE CO NM KS OK TX MN IA MO AR LA WI IL MI IN OH KY TN MS AL GA FL SC NC VA WV PA NY VT ME NH MA RI CT NJ DE MD DC AK HI

States in crisis

States showing problem signs

States currently okay

American Medical Association

Physicians dedicated to the health of America

July 2003

AMA - Medical Malpractice Environment from a Practitioners Viewpoint
AMA has ranked the states in terms of their members ability to obtain Professional Liability coverage at an affordable rate –

| States in Crisis – | States Showing Problem Signs | States OK |
|---|---|---|
| Arkansas | Alabama | California |
| Connecticut | Alaska | Delaware |
| Florida | Arizona | Indiana |
| Georgia | Delaware | Louisiana |
| Illinois | Hawaii | New Mexico |
| Kentucky | Idaho | Wisconsin |
| Mississippi | Iowa | |
| Missouri | Kansas | |
| Nevada | Maine | |
| New Jersey | Maryland | |
| New York | Massachusetts | |
| North Carolina | Michigan | |
| Ohio | Minnesota | |
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| Wyoming | Oklahoma | |
| Wyoming | Rhode Island | |
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| | South Dakota | |
| | Tennessee | |
| | Utah | |
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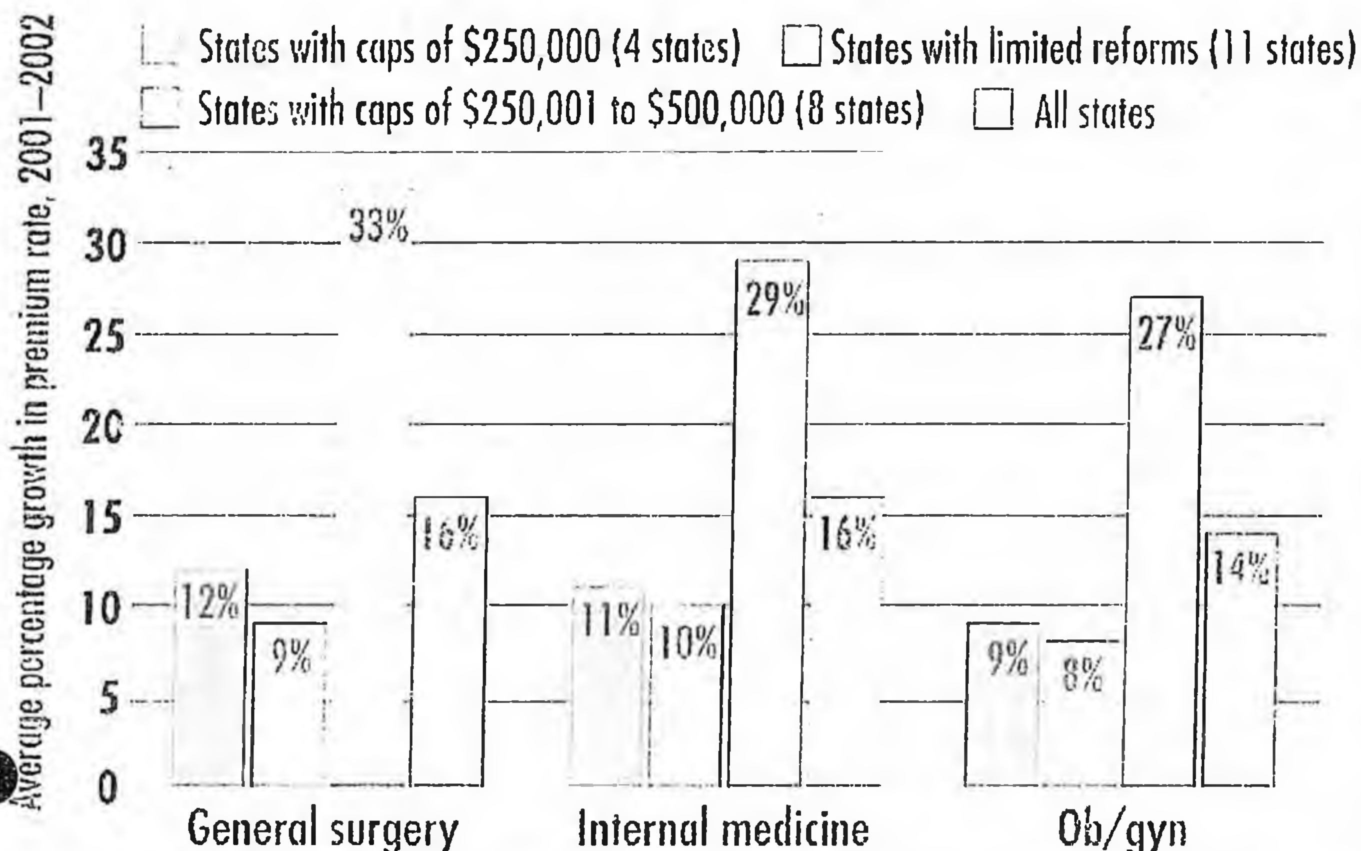
## STATE TORT REFORMS SLOW PREMIUM GROWTH

Recent premium growth was lower for three physician specialties in states with noneconomic damage caps




Note: GAO analysis of Medical Liability Monitor base premium rates, excluding discounts, rebates and surcharges, reported for the specialties of general surgery, internal medicine and ob/gyn. Premiums are adjusted for inflation to 2002 drivers.

Source: General Accounting Office

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THE NEWSPAPER FOR AMERICA'S [illegible]

PROFESSIONAL ISSUES

# Tort crisis spreads, few signs of abating

**But reforms enacted in some states did provide a few bright spots in 2003.**

By Tanya Albert, *AMNews* staff. Dec. 8, 2003.

Rallies to express outrage over medical liability insurance rates. Marathon legislative sessions debating tort reform. Countless calls and letters [illegible] lawmakers explaining that high rates and fewer insurers to choose from are detrimental for physicians already seeing low payments from Medicare, Medicaid and managed care.

It's been a busy year for physicians battling the medical liability insurance crisis. And doctors in many states say [illegible] worse position as 2003 draws to a close than they were [illegible] started.

With this article
- Most states in or approaching a liability crisis
- Setting limits
- See related content
- Topic: Liability crisis
- Regional news: States

Local newspapers in Miss[illegible] Wyoming and other states carry stor[illegible]icians closing their doors. The A[illegible] states to its crisis list, bringing [illegible]

And next year is shaping [illegible] of the same.

"Over this past year, the [illegible] to access to care for patients, has wo[illegible] AMA President Donald J. Palmisano, MD, who has spe[illegible] crisis-crossing the nation stumping for tort reform. "W[illegible] reforms, the crisis will get worse, and patient ac[illegible] continue to decrease."

**5 states in 2003 enacted reforms with caps on**

After seeing initial sig[illegible] problems this year, Maryland, Wyo[illegible], Illinois and Kentucky fear tha[illegible] the verge of even bigger headaches [illegible]

"Joliet, Kankakee, you [illegible] it's all over the

**noneconomic damages.**

state," said Illinois State Medical Society President William E. Kobler, MD.

In November, two neurosurgeons in Rockford, Ill., announced that they were giving up practice. A number of physicians have given up obstetrics, and anesthesiologists and neurosurgeons have stopped practicing in parts of southern Illinois.

Obstetricians and neurosurgeons in Missouri have seen the impact as well. In early 2003, there were 98 neurosurgeons practicing, said David F. Jimenez, MD, president of the Missouri State Neurosurgical Society. As he gears up for another study of the situation, he expects to find at least 10% fewer practicing in the state now.

"It's definitely affecting care," Dr. Jimenez said.

In Maryland, several insurance companies have left, obstetricians in rural areas are leaving, and the shore area has lost some of its most experienced OBs, said T. Michael Preston, Maryland State Medical Society executive director. For the first time, none of the graduates from the University of Maryland School of Medicine went into obstetrics, he said. Neither that school nor Johns Hopkins School of Medicine filled their OB residency slots on the first round.

**19 states are in a medical liability crisis.**

"We're on the cusp of a real crisis here," Preston said.

In Wyoming, the state Legislature-created Wyoming Healthcare Commission found that there hasn't yet been a mass exodus of physicians, but physicians are slowly and steadily leaving the state.

And in Kentucky, obstetrical care is increasingly difficult to find. Family physician Steven Sartori, MD, is part of an eight-physician group that had to give up obstetrics. They were the only physicians delivering babies at Knox County Hospital in Barbourville, which boasts a new nursery and new labor and delivery rooms.

"The place is beautiful, and now it's sitting empty," Dr. Sartori said. "Patients are having to drive farther for care."

## Caps pass in five states

Physicians in 2003 saw an increase in the public's and lawmakers' awareness of the problems created when liability insurance becomes unaffordable or unavailable. And they succeeded in getting reforms that included caps passed in five states.

"It's a gain over the previous year when only three states passed a cap," said Kathryn Moore, director of state legislation for the American

College of Obstetricians and Gynecologists.

Texas passed comprehensive reforms that included the $250,000 cap on noneconomic damages that physicians say is essential to controlling costs. Voters then approved a constitutional amendment so that the law won't be subject to court challenges.

Legislatures in Idaho and West Virginia reduced existing noneconomic damage caps to the coveted $250,000 mark. Florida adopted a $500,000 cap for physicians in most cases, and Oklahoma established a $300,000 cap for care involving pregnant women and for emergency care.

Although tort reform doesn't mean instant relief, Texas doctors say they believe an end is in sight.

"Every physician in Texas got six inches taller," said Texas orthopedic surgeon David Teuscher, MD, vice president of the Jefferson County Medical Society.

"Physicians are practicing with a little more relief now," added Juan Jimenez, MD, a general surgeon from McAllen, who was active in getting Texas' tort reform passed.

### On the 2004 agenda

Doctors will continue pushing tort reform at state and federal levels.

Legislative battles are expected in Maryland, Missouri, Connecticut, Washington and Kentucky, to name a few. And many are hoping for relief on the federal level because state laws make it too difficult to put meaningful reform in place. Several states need a constitutional change to enact a cap on damages. Others, such as Illinois, have a Supreme Court that has struck down reforms in the past and is nearly guaranteed to strike it down again.

A federal bill with a $250,000 cap passed the House in the spring, but a similar bill failed in the Senate. The AMA and others expect the bill to come back before the Senate in 2004.

"The pressure," Dr. Palmisano said, "is going to build to do something very quickly as states continue to melt down."

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## ADDITIONAL INFORMATION:

### Most states in or approaching a liability crisis

The American Medical Association this year added seven states -- Arkansas, Connecticut, Illinois, Kentucky, Missouri, North Carolina and Wyoming -- to its list of states that are in a medical liability insurance crisis, bringing the total to 19.

The Association in 2003 also elevated two states -- Hawaii and Rhode Island -- to the "showing problem signs" category. As the year draws to a close, that leaves six states that are considered to be "OK" because of tort reforms in place.

**In crisis:** Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, Wyoming

**Showing problem signs:** Alabama, Alaska, Arizona, Delaware, Hawaii, Idaho, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia

**Currently OK:** California, Colorado, Indiana, Louisiana, New Mexico, Wisconsin

Source: American Medical Association

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## Setting limits

The AMA considers a $250,000 cap on noneconomic damages essential to tort reform. Here's how state legislatures that enacted tort reform in 2003 handled these "pain and suffering" damages caps.

**Florida** adopted a $500,000 cap for individual physicians in most cases and a $1 million cap that one or more plaintiffs can collect against multiple physicians.

**Idaho** rolled back an existing $400,000 cap to $250,000. Starting July 1, 2004, that cap will be adjusted annually based on the average annual wage.

**Oklahoma** established a $300,000 cap for pregnancy, labor and delivery or immediate postpartum care cases; and emergency department care or follow-up medical services. It sunsets in five years.

**Texas** passed a $250,000 cap per claimant, no matter how many defendant physicians. Voters later approved a constitutional change that

makes the cap constitutional.

**West Virginia** reduced an existing $1 million cap to $250,000 for most cases. The limit will be adjusted annually for inflation up to $375,000 per occurrence.

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May 2003 - Volume XVI, Number 5

# Worsening of Med Mal Market Expected to Continue in 2003 – Rate Increases Likely

by **Medical PL Symposium Recap Article**

Deterioration in operating profitability, weakened capitalization, inadequate loss reserves and greater retention levels continue to wreak havoc on the medical malpractice market, making it more challenging for those insurers willing to write new business, panelists told the PLUS Medical PL Symposium.

Victor T. Adamo, JD, president, ProAssurance Corporation, noted that premium increases and stricter underwriting decisions have added more pressure and more staff demands. "For the survivors in the business, there is the burden of constantly conveying bad news," he said. "Investments no longer provide a major advantage in long-tail lines. For reinsurers, it means more business and less relationship."

According to Adamo, rate adequacy is critical to companies avoiding price-driven markets and there are also regulatory barriers. "Unreasonable regulators are causing time-consuming approval and review processes."

Adamo explained that there is over $1 billion of displaced premium in the market and that it is unclear whether small start-ups may be able to grow surplus enough to make a meaningful contribution to capacity. "A financial crunch restricts capital growth."

Looking at hospital medical professional liability from the excess insurers' perspective, Judy Hart, executive vice president, Endurance Specialty Insurance, Ltd., said that volatility never seems to go away, but is increasing further. "Next to earthquake insurance, medical malpractice is the most dangerous line of insurance."

According to Hart, for 2003, there are further rating downgrades, additional retrenchment and withdrawal from the market and continued pricing and retention increases. "There is also new capacity and greater consideration of alternative options by clients with predictable loss exposure. Increased risk financing expenditures will cause greater clinical risk management and proactive claims defense."

Hart noted that the tort system is out of control. "Tort costs in the U.S. consumed two percent of GDP annually on average since 1990 and is expected to rise 2.4 percent of GDP by 2005," she said. "The tort system is extremely inefficient. Only 20 percent of the tort dollar compensates victims for economic losses and at least 58 percent of every tort dollar never reaches the victim."

Hart, who sees med mal as a market "correction" rather than a "crisis," said that the sophistication of the plaintiff's bar, a trial bar flush with cash and an erosion of tort reform to accept junk science have been factors driving severity. "There are some deep judicial 'pits' and a jury desensitization to 'deep pockets syndrome.' There are also some corporations that just do really dumb things."

In order to meet the challenges, Hart says first-rate underwriting and claims management knowledge are needed. "This is a great opportunity to learn from our mistakes. World class selling and negotiation skills are critical and health care specialists with technical expertise who can rise to the top will make a difference."

Matthew G. Fay, FCAS, MAAA, senior vice president, Converium, predicted that the medical malpractice market was going to get worse before it got better. "Loss ratios will continue to deteriorate," he said. "Reserve deficiency will wreak havoc on income statements and hurt companies. That's why it's so important to stay up to date."

Fay said that with the hardening of the market more reserve strengthening is on the way. "Increases on the primary side weren't enough and will continue to drive rates up higher," he said. "Without tort reform, there will be a more severe second round of rate increases. The industry has done a tremendous amount of work to get us back in place, but we have to pay more attention to rates."

Looking at the provider/captive market perspective, Anthony Mercurio, managing director, Marsh Healthcare Practice, said that there are differences in the hard market today than in the past that compound the problems. "In the past, most insurance buyers were imbedded in a cost-plus system. Today, it's not true. We're not going to be as elastic as we were in the past."

Mercurio said that there are alternatives in the market such as self-funding, group captives, PRUE captives and others. "While we're not immune from increased severity and lower investment returns on funded assets, ROI expectations are lower. In addition, many have engaged in a focused effort to reduce losses, most have lean budgets and have a camaraderie among their members that is very impressive."

Mercurio added that tort reform needs to be implemented at the grass roots level. "It has to start with doctors."

The panel was moderated by Paul A. Greve, Jr., RPLU, Senior Vice President at Willis Healthcare Practice.

**Evaluation**

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Industry Library Article

# Medical Professional Liability - Not for the Faint of Heart

by **Deborah Ropelewski**

The A.M. Best 2003 Property/Casualty Review Preview(1) proclaimed that "Given the continued deterioration in operating profitability, weakened capitalization, uncertainty in the adequacy of loss reserves because of the heightened severity of claims and adverse trends, increased reinsurance costs and greater retention levels, A.M. Best views the outlook for the medical malpractice sector as negative." And if that's not enough to scare you, The Insurance Information Institute, based on A.M. Best's combined ratio data, estimates that Medical Professional Liability is one of the most dangerous lines of insurance, second only to earthquake (property) coverage.

The 2003 Conning Research and Consulting Study, "Medical Malpractice- Anatomy of a Crisis 2003,"(2) identified four key dimensions to the ongoing financial crisis being experienced by the Medical Professional Liability (MPL) industry:

1. A sustained escalation of underwriting losses,
2. A decline in investment income,
3. An epidemic of national proportions, and
4. There are emerging marketplace issues as carriers withdraw from the business and suffer rating downgrades.

It goes on to say, "Barring significant and rapid reform, we forecast no end to the industry's current financial problems. If, as expected, industry combined ratios remain at or near 2001 levels, the cumulative impact of a multiyear period of underwriting losses will be to deplete the industry's capital."

Perhaps it would help to take a closer look at the four issues that the Conning study(2) has identified, in order to glean a further understanding of what is happening in the MPL industry today.

## A SUSTAINED ESCALATION OF UNDERWRITING LOSSES

The Conning study(2) makes the observation that "the root cause of today's crisis can be found in severity, i.e., a higher level of loss per paid claim." Whether you look at the data from the PIAA data-sharing project or individual company data, it will typically bear out the fact that frequency has either remained flat or even declined over the last few years. The Conning Study(2) indicates that the frequency, measured in terms of number of claims per 1000 doctors, declined from a high of 57 per 1000 doctors in 1996, to less than 50 per 1000 doctors in 2001. Severity, however, is quite another matter:

- A study done for the U.S. Department of Health & Human Services (HHS) dated July, 2002(3), indicates that the average award rose 76% in the period from 1996 to 1999. The median award increased 6.7% from 1998 to 1999, and another 43% in 1999-2000, or from roughly $750,000 to $1,140,000 in the two-year period from 1998-2000.

- The HHS study(3) notes that Jury Verdict Research data(3) reflects that the average jury award went from $1,140,000 in 1994 to $3,480,000 in 2000- a whopping 305% increase!

- The PIAA Data Sharing Project(4) illustrates that in 1985 less than 10% of all paid claims were

over $250,000; by 2001 the number had jumped to over 40%. Likewise, less than 5% of all paid claims in 1985 were over $500,000, but this had increased to over 25% by 2001.

**A DECLINE IN INVESTMENT INCOME**

Lower interest rates continue to depress the companies' investment income, and the days in which investment income could help to offset, at least partially, the underwriting losses are becoming a distant memory.

Not only are the returns so much lower than those enjoyed in years past, but the timeframe within which a company may invest the funds until the resolution of a claim is being compressed over time, further reducing the flow of investment income. Jury Verdict Research, as noted in the HHS study(3) reports that:

- The average number of months from the date an incident occurs until trial had dropped from 61 months in 1994 to 45 months by the year 2000.

- The average number of months from filing of a suit to date of trial had dropped from 36 months to 24 months in the same period. In many states this is the direct result of the "fast track" measures that have been enacted to bring cases to trial on a more timely basis.

**AN EPIDEMIC OF NATIONAL PROPORTIONS**

Data published by the American Medical Association in March 2003(5) depicting availability issues for MPL indicates that they consider Washington, Oregon, Nevada, Texas, Mississippi, Georgia, Florida, New York, Pennsylvania, Ohio, and West Virginia to be states "in crisis." Most other states, with nine possible exceptions, are considered to be "showing problem signs." "Problem signs" can be a euphemism for either affordability or availability.

The states "in crisis" share several key characteristics:

- These were states where the lead carriers exited the business – St. Paul, MIIX, PHICO, Frontier, Reciprocal of America/Doctors Insurance Reciprocal, etc.

- Many of these states have seen their claims severity magnified in the excess layers; a good example of this is Mississippi. The HHS Study indicates that before 1995, MS had no awards over $9,000,000. Since 1995, MS has had 21 verdicts at or over $9,000,000.

- These states have seen practice patterns changing as a result – the physicians are practicing more defensive medicine, MDs are abandoning high risk procedures, leaving the state, or even retiring from practice altogether.

**EMERGING MARKETPLACE ISSUES**

There have been several waves of companies leaving the MPL marketplace since the mid-to-late 1990s. The first round included PIE, PIC, and ICA, among others. PHICO and Frontier were taken over by regulators in August 2001, and in December 2001 St. Paul made the monumental announcement that they would no longer write MPL business. According to A.M. Best's August 5, 2002 Statistical Study(6), St. Paul was the second largest writer of MPL, with almost $600 million in 2001 written premium. Their announcement was followed by the demise of Reliance and Reciprocal of America/Doctors Insurance Reciprocal, and Washington Casualty was placed in Receivership for purposes of rehabilitation. In all, over $1 Billion of premium was displaced by these departures. Most recently, OHIC, MLMIC, and Princeton were downgraded by A.M. Best, with negative outlooks.

The companies that remain simply do not have the capacity to write all the business that is made available to them. Many that had enjoyed low Written Premium-to-Surplus ratios in the recent past now find their surplus stretched to an extent that they would have never thought possible, and much of that is just due to rating actions in the past few years that have significantly increased the written premiums on their existing books of business. This has been exacerbated by deteriorating results

due to development on prior years, and the companies have had difficulty in finding ways to increase surplus to finance additional premium growth. Primary insurers have returned to underwriting discipline and find themselves having to carefully and consciously allocate what surplus they do have available, if any.

At the PLUS MPL Symposium in March, 2003, Matthew Fay, FCAS, MAAA, Senior Vice President and Chief Underwriting Officer for Converium, predicted that loss ratios and, therefore, the market would continue to deteriorate before things began to improve. Mr. Fay believes that the severity trends that many companies are utilizing for their projections are inadequate, in light of increasing medical costs and claim trends. Because of the negative effect of compounding, if the assumed trend is off by even a few percentage points, it can significantly understate the amount of reserve strengthening that is required. In addition, he believes that many companies are using overly optimistic interest rate assumptions, which further distort their projections.

**SO WHAT IS THE REINSURERS' RESPONSE?**

As with the primary companies that they reinsure, the reinsurers are also tightening their underwriting, claims, and financial scrutiny of the companies they choose to reinsure. For new clients, pre-quote underwriting, claims, and in some cases, financial audits have become a prerequisite to doing business. At the same time, even existing clients are experiencing a more aggressive audit timetable than they have seen in the past.

Virtually all working layer – usually defined as the first $1 or $2 million of coverage – MPL reinsurance is provided in the form of Excess of Loss reinsurance. Most of the contracts include a "per loss" cover that applies on an "each and every loss" basis, and a "Clash" provision for those instances in which more than one insured and/or policy may be involved in the same medical incident. Primary programs are seldom written on a quota share basis except in rare instances. Even then, it is most commonly utilized on fronted programs, which are in and of themselves few and far between in the current marketplace.

Some typical changes or restrictions in terms currently being seen include:

- One-year contracts only. After 9/11, multi-year contracts, even those with provisions for annual re-negotiation, quickly became unavailable.

- Increased "Per loss" and "Clash" retentions.

- Reduce (or even eliminate) coverage for ECO/XPL losses – i.e. if they were covered at 90% in previous contracts, that is reduced to 80% or even lower.

- Imposition of aggregate limits of liability or loss ratio caps.

- Flat rate contracts moved to loss-sensitive rating mechanisms, with a Provisional Premium expressed as a percentage of the underlying premium charged initially; subsequently premium is adjusted based on the actual experience in the reinsurance layer.

That being said, in 2003 we have seen some isolated cases of reinsurance terms easing slightly. If a reinsured company has remained relatively stable, in terms of exposures, AND their Written (and, therefore, Earned) Premium has significantly increased due to the underlying rate increases, reduced reliance on discounting, etc. For companies such as this, a few may actually have seen some relief in the Provisional and the Minimum Rates, which are expressed as a percentage of premium for these Excess of Loss Contracts. That is, given a stable exposure base, a lower percentage of a significantly higher Written Premium still yields higher Minimum, Provisional, and Maximum Premiums.

In conclusion, the key reinsurers that are dedicated to the Medical Professional Liability industry have made a renewed commitment to underwriting and pricing integrity and discipline over the past few years. One of their primary responsibilities going forward will be to monitor and evaluate the ongoing financial viability of their reinsureds, as reflected in responsive rate actions, their loss projections based o· prior years' losses, and investment income assumptions, among other

measures. Given the current climate and experience in our industry it is unlikely that the MPL reinsurance market will become significantly less restrictive in the near future.

***This article was first published in Vol. 10, Issue 4 of the Journal of Reinsurance and is reprinted with permission of the Intermediaries & Reinsurance Underwriters Association.***

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**Evaluation**

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Industry Library Article

# The Rising Cost of Medical Malpractice Claims – A Look behind the Numbers

by Dawn Dinkins

It has been well publicized that jury awards in medical malpractice suits have skyrocketed in recent years. The trend toward rising awards is supported by the 2000 Edition of Jury Verdict Research's Current Awards Trends in Personal Injury, which indicates that the median medical malpractice award increased from $500,725 in 1997 to $800,000 in 1999, an increase of 60%. 45% of awards are now over $1,000,000. Settlements showed a similar trend, with median settlements climbing from $400,000 in 1997 to $650,000 in 1999 - a growth of over 60%. According to the study, median awards were highest in childbirth cases ($2,000,000), medication error cases ($636,844), and failure to diagnose cases ($625,000). Even more alarming is the fact that the award mean almost doubled from $1.9 million in 1997 to $3.4 million in 1999. There is no question that loss severity in medical malpractice claims has increased significantly, even though frequency for the most part has remained flat. However, identifying the reasons why awards are so much higher is difficult. Experts point to several factors, such as managed care, the nursing home crisis and public attitudes as some of the reasons behind the escalating severity.

**Managed Care:** The conversion to managed care has profoundly affected the loss results in medical malpractice. According to a new study by Conning & Co., "Medical Malpractice Insurance, A Prescription for Chaos 2001," the short answer as to what is behind the increasing verdicts is managed care. The study indicates that the shift in health care delivery to cost-contained managed care has moved medical malpractice from "a world dominated by committed medical acts to one of omitted ones." Claims for alleged failure to diagnose are one of the leading causes of action today. Increased outpatient treatment under managed care has placed more responsibility on patients to ensure that they are taking the appropriate medication. This has shifted the burden away from healthcare professionals and has resulted in increased large losses for medication errors.

Another significant driver of adverse loss trends is the erosion of communication with patients within all sectors of the healthcare system. Primary care physicians are pushed to see more patients, negatively impacting the quality of care. The loss of intimate relationships between patients and their doctors due to the limited time being spent during visits has contributed to the increased number of suits for failure to diagnose and medication errors. Studies have shown that physicians who spend more time with their patients are less likely to be sued. However, since increasing the time spent with each patient decreases the number of patients that can be seen, it is unlikely that many physicians whose incomes are suffering as a result of managed care will change their ways.

**Nursing Homes and Hospitals:** According to the Conning & Co. study, nursing homes have experienced what may be the medical malpractice equivalent of the "perfect storm." Florida has been especially problematic, with loss costs per occupied bed rising to $6,283 in 1999 - eight times the national average of $809 (source: 2001 AON Worldwide Actuarial study of nursing homes.) The same study indicates that the average size of a nursing home claim in Florida in 2000 was $455,000, three times higher than the rest of the country. Texas was a close second with an average value of $399,000. (The average value for the rest of the country was $112,000.) Verdicts have been stunning, with awards easily topping the eight to nine figure range. Legislative changes such as establishing minimum quality of care standards and strong patient's bill of rights, (Florida and Texas), difficulties in attracting and retaining qualified staff, and the easy availability of Internet access to information about nursing homes and physicians' medical malpractice histories have fueled the frequency and severity of losses. There is already evidence that the problems of Florida

and Texas are spreading to other states like California, Arkansas and Mississippi. With the aging population, the negative publicity surrounding nursing homes and aggressive trial lawyers, nursing home losses will continue to be a veritable "black hole" for medical malpractice insurers.

While nursing homes have experienced rapid increases in verdict/settlement values, hospitals are also experiencing similar difficulties. A study done by the Medical Underwriters of California in 1999 found that despite a cap of $250,000 for non-economic damages, there was a record high thirty-eight awards or settlements of $1 million or more. Thirty-one of those cases arose from incidents involving hospitals. The average indemnity loss was $4,047,341, which was more than double the average of the prior year of $1,227,536. Hospitals are targets by trial attorneys due to the higher limits they typically carry, making them a "deep pocket." Most physicians do not have coverage of more than $1,000,000; thus trial attorneys will seek to involve the hospital in the hopes of tapping the larger policy. The Conning & Co. study also notes that hospitals face growing exposure due to the increased use of emergency rooms as replacements for primary care physicians for many patients. This has shifted the focus of medical malpractice claims from physicians to ERs.

**Public Attitude:** Jury attitude toward the medical community is perhaps the most obvious factor influencing the size of verdicts. This is due in part to the negative public perception of managed care and the publicity generated by large medical malpractice verdicts, which have made the public aware of the vulnerability of health-care professionals. Some juries appear to be replacing the applicable standard of care with an expectation of perfect care, feeling that physicians should be able to diagnose and treat all medical conditions regardless of a patient's prior history or lack of symptoms. However, on a more fundamental level it is clear that juries today have become desensitized as to the value of $1 million. Multi-million dollar verdicts are more common today and are on the minds of jurors when deciding damages.

While verdicts are high and the factors driving severity costs are not easily solved, insurers can mitigate the cost of medical malpractice claims through aggressive use of alternative dispute resolutions. The use of mock juries and shadow juries can be a useful tool in the evaluation of damages and defense strategies. Strong communication with insureds during the life of the claim is crucial and will go a long way toward achieving good resolutions. However, adhering to strict underwriting guidelines will weed out many problematic risks and therefore prevent these claims from occurring – the best way for insurers to limit their exposure.

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# Greater Risk Control Measures, Tort Reform Will Improve Hospital Professional Liability Market

by **Medical PL Symposium Recap Article**

Dramatically higher premium increases and risk retention requirements have added financial pressures to an industry segment that is already strained. Facilities are going bare, self-insuring or reducing limits of coverage. It is only through greater risk control measures, prudent underwriting and tort reform that hospital professional liability will recover, panelists told the PLUS Medical PL Symposium.

James D. Hinton, vice president, Risk & Insurance, HCA, Inc., noted that the physician malpractice crisis has had a tremendous impact on hospitals. "Hospitals are requested to lower or eliminate insurance requirements and more physicians are going bare in Texas and Florida," he said. "Physicians are relocating, retiring early or curtailing their practice," he added. "Hospital recruiting costs are up, service cutbacks are being made in some situations and employment of physicians is trending up again."

According to Hinton, the market has seen dramatically higher retentions, a formation of new captives and risk retention groups and insurance costs rising faster than hospital revenues. "For buyers, there is a tremendous amount of frustration," he said. "There is little evidence of underwriter judgment and little differention of risks. In addition, there are too many data requests, which are often irrelevant and there is diminished value of long term relationships."

Hinton noted that the crisis in the medical malpractice market is not an insurance problem. "They're not at fault. It is the legal system and astronomical jury awards that need to be addressed."

Going forward, the outlook for HPL underwriting should be positive, Hinton said. "Loss results will improve because of patient safety initiatives, a renewed focus on loss prevention and tort reform. Severity is impacting the market. That's where tort reform can make a huge difference for hospitals."

Using Ohio as a paradigm of what is happening in the med mal market throughout the country, D. Brent Mulgrew, J.D., executive director, Ohio State Medical Association, noted that malpractice insurance rates in Cleveland are among the highest in the nation. "Physicians are frustrated," he said. "They feel the system has been unresponsive and mismanaged. We all are potential patients. If we fail, the system will crash."

According to Mulgrew, the impact has resulted in increased expenses. "Revenue remains flat to declining. There has also been a decreased access to patient care. Ninety-six percent of doctors are discontinuing some procedures, 15 percent are leaving for less litigious areas and 51 percent are quitting the practice altogether."

Mulgrew noted that the passage of SB 281 may help. The bill, which limits non-economic damage awards in the vast majority of cases to $350,000, also requires attorney contingency fees to be reviewed by a probate court if the fees exceed the non-economic damage awards. "SB 281 removes joint and several liability. In most cases, a physician who is named in a suit will only be held liable for the portion of the claim for which the doctor may be responsible."

Mulgrew said that SB 179 also provides a broader base of peer review protections and allows

health care entities outside the traditional hospital setting to establish peer review committees. "The activities are protected from discovery during litigation."

The impact of these bills, according to Mulgrew, will not mean a reduction in rates or trends. "There will be a selective underwriting of risks and specialties and a creation of new non-standard market options."

Looking at the long-term care liability impact, Michael R. Walton, president, AMWINS HealthCare, noted that liability insurance availability and affordability issues are severe. "There is a continued aggressiveness of plaintiffs' attorneys in soliciting cases and extraordinary jury awards."

According to Walton, the "broad brush" underwriting approach being used is inappropriate. "Many suffer for the sins of a few," he said, adding, "risk assessment tools and methodologies are inaccurate, faulty and subjective. Base rates are set according to geographical location, facility size, and percentage of more acute residents. Minimal or no consideration is given toward the level of quality care orthe type of ownership."

Walton noted deficiencies in hospitals include failure to follow physicians' orders, failure to treat, physical or verbal abuse, medication error, failure to monitor adequately and failure to diagnose. He said there are also concerns with the analysis and accuracy of Online Survey, Certification and Reporting (OSCAR) data. "Simple counts of survey deficiencies can be misleading unless the scope, severity and type of each deficiency is considered," he said. "In a recent analysis of 16,698 OSCAR assessments, six percent of facilities report total census numbers not equal to the total number of residents calculated from other OSCAR items."

Walton said that there are better ways to measure quality and risk. "OSCAR analysis can be improved by using geographical adjustment, severity adjustment, focus on litigation risks and other methods," he said. "We need to utilize advanced methods of assessing, managing and defending the long-term care quality and associated risk and we need to eliminate the subjectivity in the data. We are making advancements with underwriters in this area."

The panel was moderated by Sarah Lawhorne, Esq., deputy insurance commissioner of Pennsylvania.

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Industry Library Article

# Emerging Trends In Medical Professional Liability

by Edwin Scherlis

INTRODUCTION

As we enter the new millenium, we note that the traditional lawsuits against doctors for medical malpractice are not only increasing, but other healthcare providers and related entities are being drawn into the fray.

We note with considerable interest that managed healthcare has become so prevalent in most areas that the health maintenance organizations ("HMOs") are being named as defendants by injured claimants along with the doctors and the hospitals. The HMOs have attempted to limit the scope of their liability by pleading that ERISA, the federal statute relating to job-related benefits, should supersede state law as we know it. At this point, these attempts have been failing and the courts have ruled that claims relating to the quality of medical care do not fall within the scope of ERISA. The HMOs and other managed care entities have arguably invited the constant attack where medical malpractice has occurred because of their advertising ("We hire only the best and most competent physicians..."), their capitation agreements (doctors are forced to see too many patients...), and bonus agreements (save money on referrals and diagnostic tests and share in the savings at the end of the year...). Because the people, who are developing an animosity toward the HMOs, sit in our juries, we can anticipate verdicts directly against the managed care providers in the future.

Who among us has not seen the statistics reflecting the "aging of America." The growing number of geriatrics in our society will not only place a strain on our Social Security system, but will require an enormously expanded health system in the nature of nursing homes, hospices, assisted living facilities, convalescent homes, and the like. With the growth of these residential care units comes the need for qualified staffing, competent medical care, and active paramedical care. It, therefore, follows that accidents and mistakes will increase and this will expand the number and type of claims and lawsuits filed against these facilities. We are witnessing this trend already.

The law relating to the duties and obligations of nursing homes and similar facilities is now developing beyond the simple "duty of reasonable care." Medicare patients are entitled to certain protections as set forth in the federal statutes. Each state has statutes, rules, and regulations which must be followed by the personnel at each facility. Superimposed upon these obligations are the obvious facts that the residents of these facilities require significant care and monitoring but that staffing problems invite mistakes and malpractice.

The liability of hospitals has similarly been expanded by many courts. While at one time those physicians with staff privileges at hospitals were obliged to bear responsibility alone for acts and omissions committed on the hospital premises, hospitals now face corporate liability independent of that of the physician for negligent acts which take place within its four walls. In many instances, the hospital has become almost a guarantor of the quality of care to be provided by the physician.

The concept of liability rising out of "informed consent" cases is similarly on the rise. In situations where the best medicine was practiced, a physician may still face liability if the patient can prove that there was some risk or alternative which was not discussed prior to the procedure. In addition, the nature of activity that requires informed consent has been expanded. At one time it was limited to surgical procedures but has now been extended to blood transfusions, angiography, and other

procedures which are traditionally non-surgical.

While the basic legal requirements necessary for a successful plaintiff remain the same (duty-breach-damages), the manner in which the claimant can reach the jury has been eased by the court. At one time the plaintiff had the burden of proof of demonstrating that the patient would have refused the operative procedure had all risks been known. Now, the healthcare provider faces responsibility for all problems relating to the surgery, whether it was performed properly or not, even when the material risks were not discussed with the patient beforehand. The patient need not testify that he or she would have refused the treatment.

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# Turmoil in the Medical Malpractice Insurance Market

by Paul Greve, Jr., JD, RPLU

The medical malpractice insurance industry has been in a state of turmoil in the last two years. Premiums have skyrocketed for institutional and individual providers thereby affecting the delivery of health care services in a number of states. Not since the 1970s have the national news media devoted so much coverage to the subject of medical malpractice. There have been featured reports on the network evening news, articles in the Wall Street Journal, USA Today, and other major newspapers, and periodical coverage in publications such as Forbes and U.S. News & World Report. Physicians have organized widely reported demonstrations in support of tort reform in Ohio, Florida, and Texas.(1)

Nationally, soaring verdicts and settlements have caused a significant deterioration of many carriers' results. Jury attitudes and the failure of tort reform in the majority of states have contributed to the poor results. The product was underpriced in the mid-to-late 1990s simultaneous with the rise in claim severity.(2) Investment income is down significantly since the mid-1990s, thereby exacerbating the pressure on carriers' bottom lines. Reserve redundancy has been virtually eliminated as a method to improve results, with a number of carriers needing to strengthen reserves. Medical malpractice insurance is the worst performing line of property/casualty insurance, according to A.M. Best.(3) The industry's combined ratio was 139% in 2001 and projected to go higher in 2002.(4)

The medmal insurance industry's struggles were highlighted when the largest writer of malpractice insurance by premium volume, St. Paul, announced its withdrawal in December 2001. PHICO, once a major player nationally, was placed in liquidation by Pennsylvania regulators in February. The elimination of these two carriers caused a marked reduction in capacity, especially at the primary insurance level. A number of other malpractice carriers have received significant ratings downgrades by A.M. Best since the beginning of this year, including SCPIE, MIIX, and ROA. Those carriers still able to write new business became swamped with potential new account volume and some have had to curtail their underwriting due to an imbalance of premium to surplus. Over the last few years there has also been more turnover in the executive suites of malpractice carriers than ever before.

Hospitals and physicians have found coverage difficult to find and very expensive in certain states, particularly: Nevada, West Virginia, Pennsylvania, Florida, and Texas, among others. Certain physician specialties have been more severely impacted by adverse national loss trends, such as emergency medicine, obstetrics, and radiology. Primary care physicians have seen many claims alleging failure to diagnose. There have been bona fide reports of curtailed services, especially deliveries in rural areas, due to the cost of malpractice insurance.(5) The AMA has published a list of twelve states where physicians are leaving the practice of medicine, taking early retirement, or discontinuing high-risk services: Washington, Oregon, Nevada, Texas, Mississippi, Georgia, Florida, West Virginia, Ohio, Pennsylvania, New York, and New Jersey.(6) Institutional insureds have been dramatically affected, especially nursing homes. Coverage for nursing homes is very difficult to find and more expensive than other segments of medical malpractice insurance.(7)

Malpractice insurance carriers have responded in a number of ways in an attempt to restore profitability. These include withdrawal from this line of insurance, double to triple digit rate increases, restrictive underwriting of certain classes of business and in certain territories, raising

attachment points/mandating deductibles, and offering lower limits of liability.

In the 1970s and 1980s, malpractice insurance industry results improved with tort reform initiatives and rate increases. Many industry experts are not as hopeful for tort reform in 2002, due to the political power of the trial bar and a judiciary that has often ruled unfavorably on the constitutionality of such legislation. Without tort reform, it will be very difficult for carriers to know that the premiums charged in 2002 will be adequate to pay claims over the typical 3-5 year time frame for malpractice claims resolution. There currently is a federal tort reform bill that was introduced in Congress in April. It is modeled on California's MICRA legislation, especially a $250,000 cap on pain and suffering.(8) The bill faces the significant hurdle of passage by a Democratic-controlled U.S. Senate.

If we try to use a crystal ball and project future industry trends, what are some of the negative and positive factors medical malpractice carriers must face?

**Negative Factors**

***Rate Adequacy.*** Only time will tell whether the substantial rate increases being taken will restore profitability in the long term. There is at least some concern that they are being offset by the dramatic rise in the number of large awards and settlements.

***Jury Attitudes.*** Juries appear to be far less reluctant to give large awards due to such societal influences as lottery winnings and sports salaries. There has also been the negative influence of publicity about medical errors. Thus, the industry faces the recent and unprecedented problem of "frequency of severity": The rapidly escalating number of large awards.

***The Failure of Tort Reform.*** Very few states have a favorable tort climate due to the absence of legislation or case law overturning tort reform. The prospects for federal tort reform are not promising in the near term.

***Inadequate Medicare/Medicaid Reimbursement.*** Nursing homes and hospitals struggle with providing adequate staffing while physicians may try to increase patient volume. Both scenarios can potentially reduce patient safety. Inadequate reimbursement squeezes insureds at the same time that their expenses soar from increased malpractice premiums. Less money is also available for needed patient safety initiatives.

***Rapidly Rising Health Care Costs.*** These are again rising much faster than inflation, and affect indemnity payments to injured patients.

***Migration to the Plaintiff's Bar.*** Many rising stars in defense firms have left to go to the plaintiff's side where they need not keep track of their billable time nor seek permission for travel to depositions, etc. The potential for large awards with 40-50% in fees to the plaintiff's lawyer is a huge incentive to switch sides. The scarcity of capable defense lawyers could become a serious issue in the future.

**Positive Factors**

***The Cyclical Nature of Medical Malpractice.*** Certainly there have been peaks and valleys since the mid-1970s, and the industry results were actually substantially worse in the mid-1980s than today. Medical malpractice then became the most profitable line of property-casualty insurance. History would seem to indicate that profitability could be restored in time.

***Renewed Emphasis on Pricing, Terms, and Conditions.*** Many carriers lost this discipline in the 1990s in an effort to obtain market share. It is hoped that mandatory deductibles and higher attachment points will require providers to increase their efforts to reduce patient injuries. More providers will consider some degree of self-insurance than ever before, voluntarily or involuntarily.

***The Influx of New Capital.*** The number of new companies entering this line is encouraging. Most are providing additional reinsurance and excess lines capacity, although they are being selective as to new business and attachment points. Ease of entry is a factor here since primary insurance

requires far more of a commitment in the way of resources and regulatory compliance. Some of these markets have stated an intention to enter the primary insurance market in time.

***Frequency Is Flat.*** Loss costs are being driven by severity. Jury Verdict Research reported a 43% rise in the median medical malpractice award between 1999 and 2000, hitting the highest median ever of $1 million.(9) There does not appear to be any significant national increase in claims volume.

***Renewed Efforts at Tort Reform.*** Carriers are increasing their efforts and are being joined at the state and national level by health care industry organizations with significant clout, such as state medical societies and hospital associations, the American Medical Association and the American Hospital Association. The argument that must successfully be made to federal and state legislators is that the lack of tort reform in many states will adversely impact the availability and affordability of health care services such as obstetrics and trauma.

***Increased Focus on Patient Safety.*** The future has never been more promising for proven risk management initiatives. Evidence-based patient safety standards and emerging technologies, such as the use of bar coding for medication administration or computerized physician order entry, hold the promise of reducing the incidence of patient injuries.

Many in the malpractice insurance industry think that a return to stability is at least two years away. While the two most critical factors in restoring stability may be adequate pricing and tort reform, all carriers will be influenced in some way by these negative and positive factors over the next two years.

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GOVERNMENT & MEDICINE

# Texas tort reform vote signals lower liability rates

**Physicians believe a constitutional amendment will ease the state's medical liability crisis.**

By Damon Adams, *AMNews* staff. Oct. 6, 2003.

Passage of a Texas medical malpractice ballot initiative appears likely to produce the impact physicians desired -- a decrease in liability premiums. And doctor groups hope that the measure's success will spur similar action in other states.

"It's going to send a message all over the nation that it can be done. This will give greater impetus to other states," said AMA President Donald J. Palmisano, MD. The AMA contributed $100,000 to support the initiative, called Proposition 12.

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The measure amends the Texas Constitution to allow caps on noneconomic damages in medical malpractice lawsuits. Within days of the vote, some insurers announced plans to reduce liability insurance rates.

For example, Texas Medical Liability Trust, the state's largest medical liability insurer, said it would cut premiums 12% beginning Jan. 1, 2004.

"We believe the 12% [reduction] is really just the start," said W. Thomas Cotten, president and CEO of physician-owned TMLT, which has about 10,800 policyholders. "Hopefully, the number of carriers will increase so there will be more sources of competition. With that competition, carriers will need to reduce their rates."

The Doctor's Company, a medical liability insurer based in Napa, Calif., plans at least a 12% reduction on $1 million policies in Texas, said Richard E. Anderson, MD, company chair. With 2,000 physician policies in the state, the insurer is looking at other potential savings to doctors and hopes to write more policies, he said.

"I guarantee the rates will be lower than they otherwise would have been," Dr. Anderson said.

State Rep. Joe Nixon said insurers' premium cuts would save doctors about $100 million a year.

Now that the amendment has passed, state leaders said, some doctors will feel secure enough to go back to practicing high-risk procedures. Medical students and practicing doctors will be less likely to leave Texas, said Charles W. Bailey Jr., MD, president of the Texas Medical Assn. and a Houston plastic surgeon.

"The real winners of this election are the people of Texas, who can be more certain that their doctor will be there for them when they're sick or injured," he added.

But opponents of the measure said it strips juries of their power and gives it to special interests. They are watching to see if insurers follow through on promises to lower rates.

"There is no guarantee that's going to happen," said Abby Sandlin, deputy director of Texas Watch, a group that is part of Texans Against Proposition 12. "We've had empty promise after empty promise from insurers over the decades. Now is the time they are going to have to put up."

The Medical Protective Co. in Fort Wayne, Ind., is still exploring whether to change its rates.

"We are assessing the impact this will have on our rates," said John Novaria, spokesman for the company, which has 7,000 physician policyholders in Texas.

### Heading off a legal challenge

Earlier this year, the Texas Legislature passed a law placing a $750,000 cap on noneconomic damages in medical malpractice lawsuits. It limited an individual physician's liability to $250,000.

Knowing the law would face a legal challenge, legislators called for a ballot measure, Proposition 12, to ratify the Legislature's cap on noneconomic damages in civil lawsuits. A similar cap was passed in 1977, but after a legal challenge, the Texas Supreme Court found it unconstitutional.

**Some liability insurers already plan to**

Supporters and opponents of Proposition 12 waged media campaigns to woo voters. The two camps spent more than $13 million on television commercials and mailings. About 12% of Texas' 12 million registered voters cast

**cut rates 12%.**

ballots Sept. 13. The measure passed narrowly, with 51% supporting it and 49% opposing it.

Supporters said the amendment means the cap would survive any legal challenge.

"I'm extremely relieved we came out on the positive side of it. It was a very intense media campaign," Dr. Bailey said. "The key thing is it will at least hold premiums at their current level so we can stop this escalation."

The passage of Proposition 12 will benefit Texas' liability insurance market in other ways, proponents said. "The stability in the state will allow other medical insurers an opportunity to come sell their policies in Texas," said Nixon, who sponsored the legislation on damage caps.

Since the vote, the Texas Dept. of Insurance said no insurers had contacted the agency about coming back to a state that once had 17 medical liability insurers and now has only a handful left. That likely will change.

"We fully expect that companies will return to Texas," said department spokesman Jim Hurley.

But for some doctors, it's too late.

"The doctors that already left or have gone out of practice will not go back into practice," said David Schneider, MD, president of the Texas Academy of Family Physicians. "Once you've made that decision to change your life, you won't come back."

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## ADDITIONAL INFORMATION:

### Voters have spoken

The ballot question for Proposition 12: "The constitutional amendment concerning civil lawsuits against doctors and health care providers, and other actions, authorizing the Legislature to determine limitations on noneconomic damages." The results:

**In favor:** 51%
**Against:** 49%
**Statewide voter turnout:** 12.2%

Source: Texas Secretary of State

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## Weblink

Texas Medical Assn. information on Proposition 12
(www.texmed.org/prop12/yes.asp)

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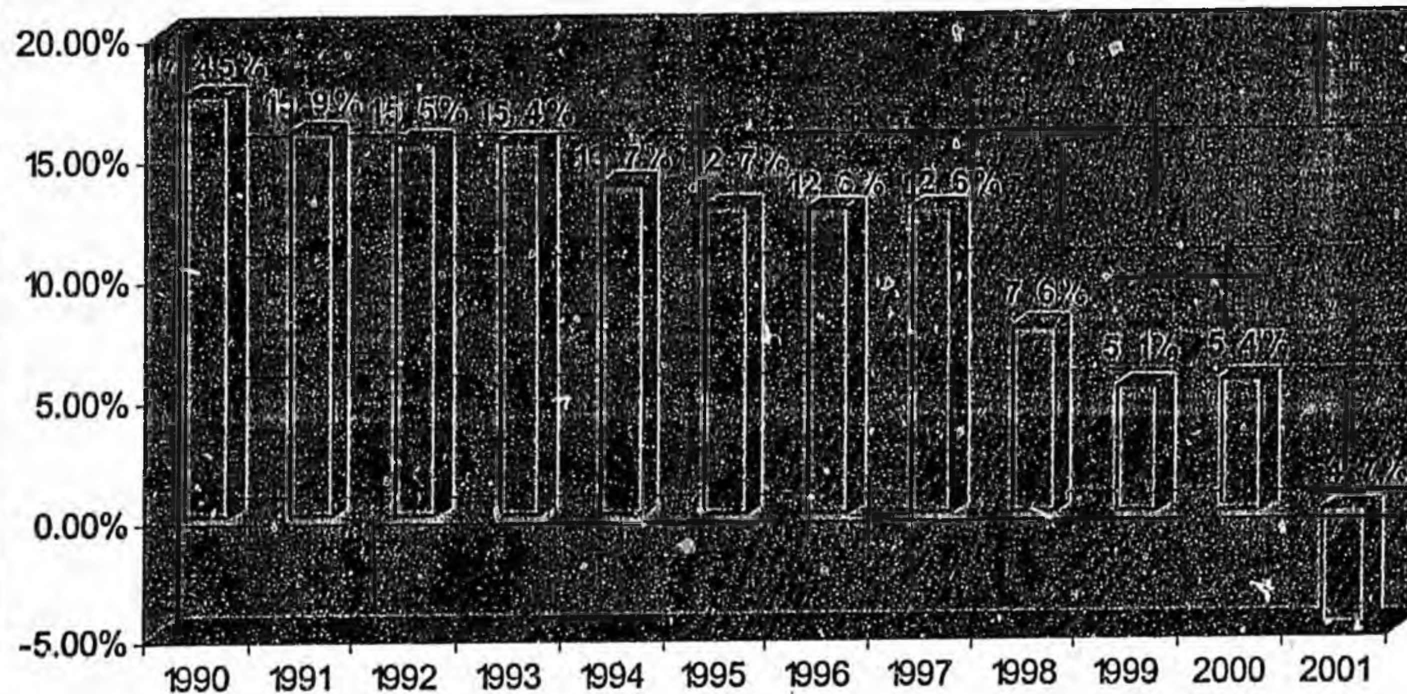
# Carrier Results –
# Percent Of Profit On NWP




Source: U.S. General Accounting Office analysis of National Association of Insurance Commissioners Data

# Malpractice Premium Comparison by State

| 1970 | California | Florida | Nevada | United States |
|---|---|---|---|---|
| Total premium | $228,451,000 | $18,357,000 | $1,978,000 | $1,182,000,000 |
| 1970 Pop. | 19,971,069 | 6,791,418 | 488,738 | 203,302,031 |
| % US Pop. (1) | 9.8% | 3.3% | 0.2% | 100.0% |
| % US Premium | 19.3% | 1.6% | 0.2% | 100.0% |
| **Premium /Person** | **$11.44** | **$2.70** | **$4.05** | **$5.81** |
| 1980 | | | | |
| Total premium | $629,448,000 | $173,522,000 | $3,311,000 | $3,435,000,000 |
| 1980 Pop. (2) | 23,667,764 | 9,746,961 | 800,508 | 226,542,199 |
| % US Pop. | 10.4% | 4.3% | 0.4% | 100.0% |
| % US Premium | 18.3% | 5.1% | 0.1% | 100.0% |
| Prem. Dollars (3) | $327,312,960 | $90,231,440 | $1,721,720 | $1,786,200 |
| % Change Prem. Dollars (3) | 43.3% | 391.5% | -13.0% | 51.1% |
| **Premium /Person** | **$26.60** | **$17.80** | **$4.14** | **$15.16** |
| Premium /Person (3) | **$13.83** | **$9.26** | **$2.15** | **$7.88** |

Source: NAIC Insurance Company Profitability Reports 1976 to 2000; US Census; CPI Calculator

(1) 1970 Census
(2) 1980 Census
(3) Adjusted for Inflation per CPI
(4) 2000 Census

# Malpractice Premium Comparison by State

| 2000 | California | Florida | Nevada | United States |
|---|---|---|---|---|
| Total Premium | $609,712,000 | $505,535,000 | $508,000,000 | $5,549,552,000 |
| Population | 33,871,648 | 15,982,378 | 1,998,259 | 281,421,906 |
| % US Pop. (4) | 12.0% | 5.7% | 0.7% | 100.0% |
| % US Premium | 11.0% | 9.1% | 9.2% | 100.0% |
| Prem. Dollars (3) | $201,204,960 | $166,826,550 | $167,640,000 | $1,831,352,160 |
| % Change since 1976 in Premium Dollars (3) | **-11.9%** | **808.8%** | **8375.2%** | **54.9%** |
| % Change since 1986 in Premium Dollars (3) | **-38.5%** | **84.9%** | **9636.8%** | **2.5%** |
| **Premium/ Person** | **$18.00** | **$31.63** | **$254.22** | **$19.72** |
| Premium/Person (3) | $5.94 | $10.44 | $83.89 | $6.51 |
| % Change in Premium/Person | **-51.9%** | **386.2%** | **2072.9** | **111.9%** |

Source: NAIC Insurance Company Profitability Reports 1976 to 2000; US Census; CPI Calculator

(1) 1970 Census
(2) 1980 Census
(3) Adjusted for Inflation per CPI
(4) 2000 Census

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PROFESSIONAL ISSUES

# Physicians feel double-digit pain as liability rates continue to rise

**Some doctors are seeing bigger bills than reflected in the raw numbers as companies continue to eliminate discounts and tighten underwriting.**

By Tanya Albert, *AMNews* staff. Nov. 10, 2003.

Internists, general surgeons and obstetrician-gynecologists in the Miami area are paying the highest professional liability insurance rates for those specialties in the nation, according to a new report.

The next highest rates for those specialties are found in Michigan, Illinois, Texas and Pennsylvania.

With this article
- Pain scale
- Taking the hit
- How low did they go
- See related content
- Topic: Liability crisis

Nationwide, rates are on the rise. More than half of the internists, general surgeons and ob-gyns out there -- 58.2% to be exact -- saw double-digit insurance rate increases of 10% to 49% between 2002 and 2003.

Slightly more than 1% of those specialists saw increases of 100% or more.

But there is some good news: 22.6% of physicians in those three specialties saw no increase, and some saw a decrease in rates over the past year.

The lowest rates in the nation for internists, general surgeons and ob-gyns are in Idaho, Minnesota, Nebraska, South Dakota and Richmond, Va.

**Liability insurance payout rates are increasing**

This is according to the latest state of the union for medical liability insurance rates from "2003 Rate Survey" by the *Medical Liability Monitor*. The data, which the monthly newsletter has collected annually since 1991, are based on 641 rates insurance companies

**7% a year.**

reported that can be compared with 2002 data. Companies report their mature claims-made manual rates in effect July 1 with $1 million/$3 million limits.

The information collected from 40 insurance companies provides the most comprehensive look at the amount physicians are paying for their insurance. The report also offers a glimpse at what doctors can expect in the coming year. And 2004 doesn't look to be much better than its most recent predecessors. About 83% of the companies surveyed believe they will need additional large increases next year, according to the report. Many of those companies believe those increases will be in the double digits although they hope they won't be as high as they have been in recent years.

"The rate survey shows what we expected," said Larry Smarr, president of the Physician Insurers Assn. of America. "And I agree with the headline [on the report] 'No end in sight.' "

Rates will continue to rise because they are based on losses that companies pay out, and right now that number is rising 7% annually, he said. On top of that, low interest rates force insurers to collect more money through premiums.

But raw numbers don't tell the whole story, *Medical Liability Monitor* editor Barbara Dillard said.

### More expensive, harder to get

In addition to increases in rates, physicians are seeing fewer discounts than they once did.

"Discounts for risk management have gone away," Smarr said. So too have dividends that physician-owned companies historically have offered doctors to help offset premiums.

**58% of internists, ob-gyns and general surgeons saw liability insurance hikes of 10% to 49% from 2002 to 2003.**

The *Medical Liability Monitor* survey also notes that companies are increasingly requiring physicians to buy tail coverage that may once have been included in premiums and that some companies are limiting corporate coverage.

"All of these things mean that a bill that an individual doctor is getting this year may be an even bigger increase for him than it looks on the rate survey," Dillard said.

In addition, physicians are finding it more difficult to find insurance.

In all, 14 companies who responded to the survey said they withdrew or severely restricted new writings in some states. And companies that are staying in the market are continuing to restrict who they will cover.

According to the *Monitor's* survey of 40 companies:

- 73.5% said they are tightening their underwriting.
- 48.6% said they are not renewing more physicians than they did last year.
- 20% said they are restricting coverage in one form or another, such as no longer covering punitive damages.

As rates keep rising and insurance becomes harder to find, physicians and insurers continue to push their state legislatures and Congress to enact tort reform that includes a $250,000 noneconomic damages cap. This, they believe, will help stabilize insurance rates.

**Insurers have stopped offering discounts for risk management.**

The survey showed states without noneconomic damages caps generally saw larger rate increases than states with caps. For example, ob-gyns, internists and general surgeons in Pennsylvania saw a 25.8% to 73% increase in rates; those specialists in Illinois saw a 25% to 50% increase and New York physicians saw a 7.3% to 12.7% hike.

In states with caps, Indiana and Louisiana physicians saw a 3.9% to 21.8% increase and Colorado physicians saw a 12.7% to 38% increase, the survey showed. Some Wisconsin physicians saw as much as a 12.7% increase, but some saw a 14.2% decrease. Wisconsin adopted reforms, including a patient compensation fund, in 1975. It added a $350,000 adjustable noneconomic damages cap in 1995 that now stands at $410,000.

"We had the foresight to do something for the people and they look after us," said Ft. Atkinson, Wis., orthopedic surgeon Walter Moritz, MD, who helped craft the original Wisconsin legislation and is vice chair of the state's patient compensation fund. "It's fantastic to be in Wisconsin and practicing medicine."

The medical community looks toward California tort reform as the gold standard when trying to get laws passed elsewhere. Some California doctors in the three specialties on which the survey focused saw no increase in rates between 2002 and 2003, but some saw as much as a 54% hike in one year.

Even so, California physicians still pay significantly less than counterparts in other states. For example, internists in Dade County, Fla., paid 133.7% more for their insurance than internists in Los Angeles, according to the survey. General surgeons in Dade County paid 285.1%

more than their counterparts in Los Angeles and ob-gyns in Dade County paid 220.2% more than ob-gyns in Los Angeles.

At the state and federal levels, "we need tort reform," Smarr said.

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## ADDITIONAL INFORMATION:

### Pain scale

A comparison of liability rates for internists, general surgeons and obstetrician-gynecologists for 2002 and 2003 shows that some actually fell 16%, while others soared 144.2%. Of the 641 rates that were compared, most showed increases.

- 1.2% of insurers increased rates 100% or more.
- 1.1% increased 70% to 99%.
- 3.7% increased 50% to 69%.
- 26.8% increased 25% to 49%.
- 31.4% increased 10% to 24%.
- 13.1% increased 1% to 9%.
- 20.3% kept rates the same.
- 2.3% decreased rates.

Note: Percentages have been rounded.

Source: Medical Liability Monitor, 2003 Rate Survey

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### Taking the hit

Of the states with the highest liability insurance rates for select specialties, Florida, Illinois and Pennsylvania are on the AMA's list of crisis states. Michigan is listed as a state showing problems.

| | 2002 | 2003 | Increase |
|---|---|---|---|
| **Internists** | | | |
| Florida (Dade County) | $56,153 | $65,697 | 17% |
| Michigan (Wayne County) | $45,761 | $50,063 | 9.4% |
| Illinois (Cook County) | $31,722 | $41,238 | 30% |

| | | | |
|---|---|---|---|
| **General surgeons** | | | |
| Florida (Dade County) | $174,268 | $226,542 | 30% |
| Michigan (Wayne County) | $107,139 | $154,165 | 43.9% |
| Pennsylvania (Philadelphia) | $104,388 | $131,348 | 25.8% |
| **Obstetrician-gynecologists** | | | |
| Florida (Dade County) | $201,376 | $249,196 | 24% |
| Michigan (Wayne County) | $140,917 | $154,165 | 9.4% |
| Pennsylvania (Philadelphia) | $116,388 | $152,730 | 31.2% |

Source: *Medical Liability Monitor*, 2003 Rate Survey

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## How low did they go

States with the lowest medical liability rates for specific specialties.

| | 2002 | 2003 | Increase |
|---|---|---|---|
| **Internists** | | | |
| Nebraska | $2,786 | $2,786 | 0% |
| Virginia (Richmond) | $2,920 | $2,920 | 0% |
| Minnesota | $2,700 | $3,375 | 25.0% |
| **General surgeons** | | | |
| Minnesota | $8,717 | $8,717 | 0% |
| Virginia (Richmond) | $9,384 | $9,384 | 0% |
| Nebraska | $9,474 | $9,474 | 0% |
| **Obstetrician-gynecologists** | | | |
| South Dakota | $13,325 | $14,662 | 10.0% |
| Virginia (Richmond) | $14,907 | $14,907 | 0% |
| Nebraska | $12,674 | $16,194 | 27.8% |

Source: *Medical Liability Monitor*, 2003 Rate Survey

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