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On the Cusp of the Next Medical Malpractice Insurance Crisis

Philip G. Peters, Jr.*

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Abstract

Medical malpractice claims are dwindling. Total payouts are far lower than during the 2002 crisis. Yet, insurance industry profits have been sinking for a decade and are nearly in the red. After a dozen years with a “soft” insurance market, we are now on the cusp of yet another malpractice insurance crisis.

How can profits be in peril if claims have dwindled and payouts are historically low? Answering that question requires an understanding of the insurance cycle. The cycle periodically transforms gradual increases in costs and gradual decreases in revenue into explosive increases in premiums.

The industry’s financial statistics today eerily resemble those leading into the 2002 crisis. However, some important differences also exist. Perhaps most importantly, the coronavirus pandemic introduces a variable that makes the current transition from a soft market to a hard one unique. In addition, industry representatives have recognized the signs of a hardening market earlier in the transition than they have in the past and that may enable them to engineer a less painful transition from a soft market to a hard one.

The stakes are high. After each of the three prior crises, physicians, hospitals, and insurers descended on state capitals and lawmakers responded with waves of restrictive tort reform.

This Article explains how we have come to sit on the cusp of a fourth medical malpractice crisis and examines the factors that will determine how soft our landing will be.

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INTRODUCTION

The profits of medical malpractice insurers have nearly disappeared. After years of decline, premiums are now rising. Industry experts warn that the market is hardening. In addition, experts worry that the COVID-10 pandemic has placed difficult burdens on overstretched health care providers--burdens that could lead to medical errors.

Yet, medical malpractice claims have declined steadily for most of the last fifteen years. So have the number of paid claims. The total amount paid to settle claims is forty percent below its peak in 2002. How can we be headed for another medical malpractice insurance crisis?

The answer lies in the mechanics of the insurance cycle. During the intense competition of a "soft market," carriers keep premiums down to acquire and retain customers. Although this eventually leads to dangerously low profits, carriers keep premiums low to preserve market share. The pressure on profits eventually becomes so strong that carriers across the sector raise premiums dramatically, creating a new "hard market" and causing cries of pain and outrage from hospitals and physicians. Since the rise of modern medical malpractice litigation in the 1960's, this cycle has produced a malpractice insurance crisis every ten or fifteen years.

The stakes are high. During the 1974-78 hard market, California physicians went on a four-week strike, "causing public hospitals to overflow with patients" leading to "a number of 'job actions' in other states."¹ In the 1985-86 hard market, many providers could not find coverage at any price.² Time Magazine ran a cover story, "Sorry, America, Your Insurance has been Canceled," and Congress held hearings. During the most recent 2002-2006 hard market, doctors again went on strike.³ The president of American Medical Association, Richard Corlin, claimed that limits on injured patients' rights to sue were needed because "[m]any practitioners, both generalists and specialists, just can't afford the liability premiums, forcing them to retire early, limit their practice or relocate."⁴

After the first crisis in the mid-1970's, at least half of the states responded with major tort reform legislation.⁵ After the mid-1980's hard market, 46 states enacted new or additional restrictions. And after the third crisis in 2002-2006, half passed additional tort reforms including new or lower damage caps.

We are now on the cusp of yet another malpractice insurance crisis. The financial statistics eerily resemble those leading into the 2002 crisis. At the same time, some important differences also exist. Perhaps most importantly, the coronavirus pandemic introduces a variable that makes the current transition from a soft market to a hard one unique.

This Article explains how we have come to sit on the cusp of a fourth medical malpractice crisis and examines the factors that will determine how soft our landing will be.

¹ J. ROBERT HUNTER, JOANNE DOROSHOW, AND DOUGLAS HELLER, HOW THE CASH-RICH INSURANCE INDUSTRY FAKES CRISES AND INVENTS SOCIAL INFLATION 36 (2020) [hereinafter HUNTER, DOROSHOW AND HELLER] (a report for the Consumer Fed. of America and the Ctr for Justice & Democracy)

² *Id.*

³ Bruce Bartlett, *Doctors on Strike*, TOWNHALL, Feb 28, 2003, [Doctors on strike by Bruce Bartlett \(townhall.com\)](https://townhall.com/columnists/brucebartlett/2003/02/28/doctors-on-strike).

⁴ HUNTER, DOROSHOW AND HELLER, *supra* note 1, at 12.

⁵ *Id.* at 36.

I. A NEW HARD MARKET IS EMERGING

Profits have fallen to dangerous levels in the medical professional liability (MPL) insurance sector and premiums are increasing.⁶ The most pointed warnings come from publications that follow the insurance industry. With phrases such as “the reckoning is here” and “the good times are ending,”⁷ industry observers have concluded that a hard market is coming.⁸ Many have concluded that premiums are climbing and are under pressure to continue that climb.⁹

Matt Gracey, the CEO of malpractice insurance broker Danna-Gracey, believes policyholder rate increases in the 5% range for smaller groups are on the lower end of the scale. Large multispecialty groups have seen their rates go up by as much as 100% over the last 18 months. He adds “every A-rated carrier specializing in malpractice insurance now is running a combined loss ratio of over 100%, meaning that for every dollar of premium they bring in they’re paying out more than a dollar, which means they have to raise their rates.”¹⁰

These worries are not just hype from media and public relations consultants. The concerns are shared by the most respected authorities in the field of liability insurance. Both the National Association of Insurance Commissioners (NAIC) and industry analyst AM Best are warning of trouble ahead.

The NAIC is the most authoritative source of industry data, compiling data from nearly 3,000 insurance companies responsible for over 95% of premiums written in the U.S.¹¹ In 2019, according to the NAIC, the industry combined ratio—a key measure of profitability-- reached its worse level in a decade.¹² In its April 2020 report, the Commissioners concluded:

Since 2014, the medical professional liability line has experienced rising loss costs and diminishing reserving redundancies due to increased claims severity and frequency that

⁶ See *infra* text at notes # (profits falling) and # (policyholder rates increasing).

⁷ Katie Dwyer, [The Reckoning is Here for the Medical Professional Liability Market. Here’s What Will Change : Risk & Insurance \(riskandinsurance.com\)](https://www.riskandinsurance.com), December 21, 2018.

⁸ E.g., Susan J. Forray and Chad C. Karls, , Med. Prof. Liab. Assn., *A Hardening Market Arrives in Time to Greet a Global Pandemic: The year 2019 marked a turning point for the medical professional liability (MPL) insurance industry*, INSIDE MED. LIABILITY (2d Qtr. 2020); MAGMUTUAL, *The Current State of the Medical Malpractice Market*, Jan. 15, 2020 (“the medical malpractice segment is transitioning back to a hard market”), <https://www.magmutual.com/learning/article/current-state-medical-malpractice-market/>; MAGMUTUAL; AM BEST, *Observers Say Medical Liability Market Beginning to Harden as Higher Jury Awards, Eroding Tort Reform Sink In* ([ambest.com](https://www.ambest.com)), December 23, 2019 01:52 PM (EST) (“In 2019, the market transitioned to a hardening market”); Fitch Ratings, *The Property/Casualty Underwriting Cycle (Shallower Market Peaks and Valleys Ahead)* ([fitchratings.com](https://www.fitchratings.com)), Nov. 13, 2019 - 3:19 PM ET (“The P/C market is in a hardening pricing phase”)

⁹ Gloria Gonzalez, *Medical malpractice insurers under pressure*, Best, BUS INS., May 7, 2019, <https://www.businessinsurance.com/article/20190507/NEWS06/912328310/Medical-malpracticeinsurers-under-pressure-AM-Best-report-3>.

¹⁰ Jeff Bendix, [What’s happening with cost and claims in the wake of COVID-19 | Medical Economics](https://www.medicaleconomics.com), October 2020, Vol. 97, Issue 14.

¹¹ NAIC, REPORT ON PROFITABILITY BY LINE BY STATE in 2019 1 (2020) [hereinafter NAIC by Line 2020]

¹² NAIC, U.S. PROPERTY & CASUALTY AND TITLE INDUSTRIES: 2019 FULL YEAR RESULTS (2020), [YE2019 Industry Report.pdf \(naic.org\)](https://www.naic.org) [hereinafter, NAIC 2020]

has contributed to negative underwriting results. As such, the medical professional liability writers enter the pandemic in *the worst financial position in over a decade*.¹³

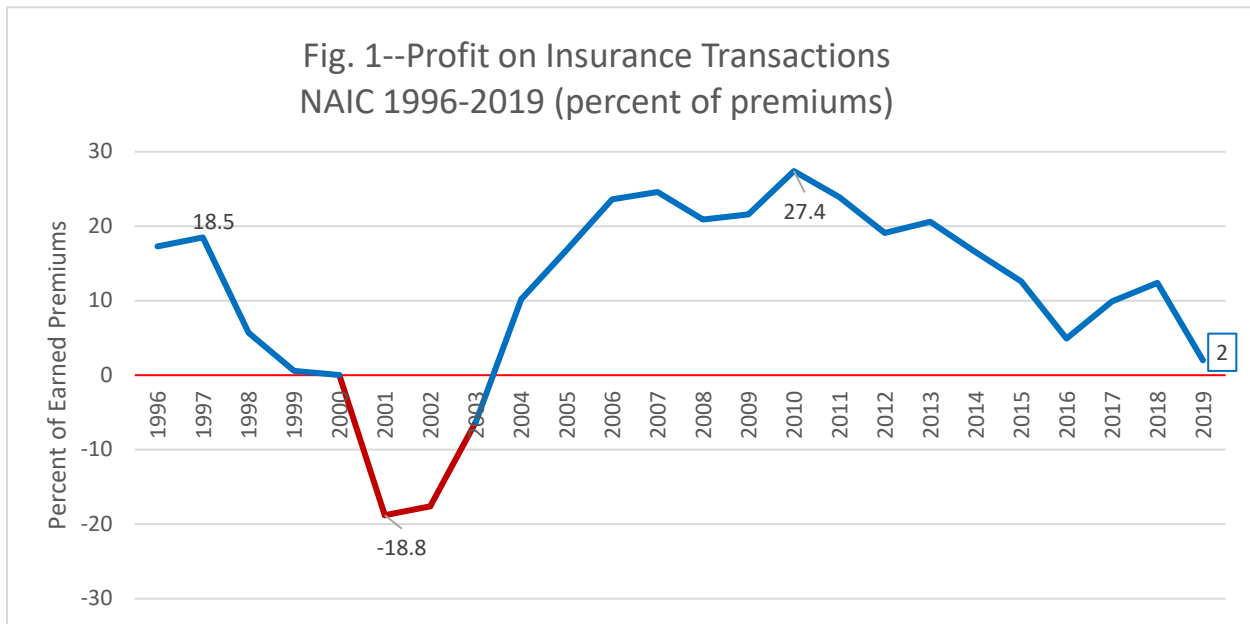
An equally pessimistic report came from Best in April 2020. Best is a highly respected global credit rating agency specializing in the insurance industry. Best announced a “negative” outlook for the medical profession liability sector (MPL) in 2020 and 2021 after the field had experienced “notable deterioration” in 2019 and faced several challenges going forward.¹⁴ In its view, the sector enters its “*weakest point in almost two decades*” and faces “dim prospects for ...profitability.”¹⁵

The pandemic has magnified these fears. Best, in particular, has expressed serious concerns about the impact of the COVID pandemic on medical errors and on the industry’s ability to implement planned rate increases, as discussed further below.¹⁶

The villains for this new hard market have already been chosen. Since 2019, industry publications have identified “nuclear verdicts”¹⁷ and “social inflation”¹⁸ as the culprits.

A. Profits are Disappearing

According to NAIC data, the industry’s profits have declined steadily since their peak in 2010. Figure 1 shows the decline in profits using a common metric called Profit on Insurance



¹³ *Id.* (emphasis added).

¹⁴ BUS. WIRE, [Best’s Market Segment Report: U.S. Medical Professional Liability Insurance Market Remains in Flux | Business Wire](#), April 29, 2020, 10:20 AM EDT.

¹⁵ AM BEST, MARKET SEGMENT REPORT: US MEDICAL PROFESSIONAL LIABILITY INSURANCE MARKET REMAINS IN FLUX, 1 (April 28, 2020) (emphasis added) (copy on file with the author) [hereinafter, BEST 2020].

¹⁶ *Id.* at 1. See *infra* text at notes #.

¹⁷ E.g., Amy Buttell, *Nuclear Verdicts Escalate: Verdicts rise as more awards exceed \$100M*,

INSIDE MEDICAL LIABILITY, First Quarter 2020, at 1, [Nuclear Verdicts Escalate Verdicts \(mplassociation.org\)](#)

¹⁸ HUNTER, DOROSHOW AND HELLER, *supra* note 1, at 16-18 (collecting references).

Transactions.¹⁹ It represents the ratio of revenue to expenses and takes into account investment returns along with premiums. It is commonly expressed as a percent of premiums.²⁰ Profit on insurance transactions peaked at 27.4 percent of premiums in 2010 and has fallen since then to only 2 percent of premiums in 2019 (the last year reported by NAIC). This is the lowest level reported since the eve of the 2002 malpractice insurance crisis, also shown in Figure 1.

If investment returns are set aside, the industry is already operating at a loss. Its premiums do not cover its operating costs (the costs of underwriting, selling and settling claims), as shown in Figures 8 and 13, later in this article. Investment returns have preserved a 2 percent overall profit as of 2019, but that too will disappear if operating losses continue to climb. These statistics explain why industry experts fear that the long soft market is finally turning hard.

B. The Paradox: Medical Malpractice Claims Are Declining

Medical malpractice litigation has been shrinking. Both the number of claims made and the number of claims paid have dropped far below their peaks. Paid claims against physicians are now roughly half as frequent as when the last crisis began in 2001. Likewise, the total amount spent by insurers to satisfy these claims dropped steadily from roughly 2001 to 2010. Though the total spend has grown since then, the rate of growth paralleled consumer and medical inflation. Here, too, the current levels are substantially below the levels of 2001.

1. A sharp drop in the number of claims

Patients are filing far fewer claims than they did before the last crisis. The best data come from a large 10-year analysis done by CRICO Strategies in 2018, finding that claims dropped 27% in the ten-year period between 2007 and 2016.²¹ The report analyzed over 124,000 MPL claims and reflected the medical professional liability experience of more than 500 hospitals and health care entities along with 180,000 physicians from commercial and captive insurers nationwide, representing approximately 30 percent of all US medical malpractice claims and suits.²²

The authors called the decline “dramatic” and found that declines were “universal across many segments of health care delivery.”²³ Overall, the frequency of litigation dropped from 5.1 cases per 100 physicians to 3.7 cases. OG/GYNs benefited the most with claims dropping 44%.²⁴

¹⁹ NAIC, REPORT ON PROFITABILITY BY LINE BY STATE. The data were collected from each of the annual reports for all reported years--from 2005 to 2019.

²⁰ NAIC 2012 Sample, REPORT ON PROFITABILITY BY LINE BY STATE IN 2011, at p. 5 (“Profit on insurance transactions is equal to underwriting profits plus investment gain on insurance transactions minus estimated related federal income taxes.”).

²¹ CRICO STRATEGIES, MEDICAL MALPRACTICE IN AMERICA: A 10-YEAR ASSESSMENT WITH INSIGHTS 4 (2018).

²² *Id.* at 1.

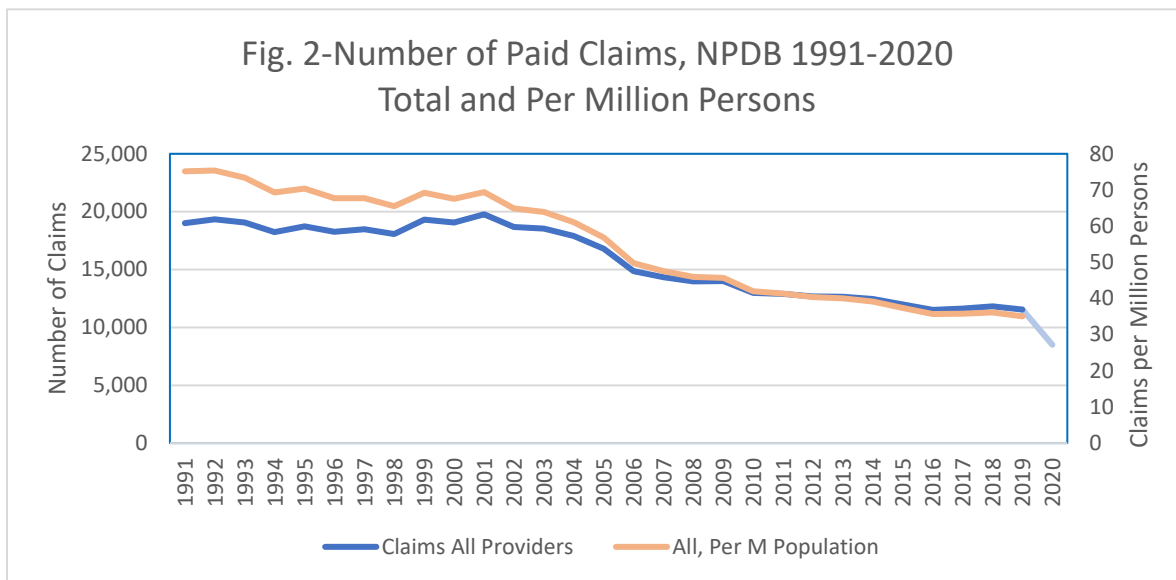
²³ *Id.* at 4.

²⁴ *Id.*

This decline is a decidedly mixed blessing. While this decline in claiming may be good news for industry profits, it is a tragedy for victims of medical negligence. Medical errors are not declining. The research on this issue is persuasive. Instead, pursuit of modest medical negligence claims is becoming more difficult, as discussed further below. Before the recent decline in claims, only a tiny fraction of negligently injured patients received any compensation. Today, the number is even smaller.

2. A declining number of paid settlements

The number of paid claims each year against physicians and other health care practitioners declined steadily from 2001 to 2016 and has remained steady since then. The best data come from the National Practitioner Data Base (NPDB). All payments made to settle claims against individual health care practitioners have been reportable to the NPDB since 1990. As shown in Figure 2,²⁵ NPDB data show that the number of paid claims against all individual health care providers (blue) steadily declined after the crisis of 2001, shrinking from 19,772 paid claims in 1991 to 11,538 in 2019—a drop of 42 percent.



For physicians (not shown), the drop has been even sharper, falling 47 percent between 2001 and 2019. Setting aside the low 2020 number as a pandemic aberration, the 2019 numbers are the lowest recorded since NPDB began collecting statistics in 1991, amounting to 61 percent of the number of paid claims in that year.

When the statistics are adjusted to take population growth into account (orange), the number of paid claims for all practitioners reported by NPDB is now *less than half* of what it was in 1991 (47%).

²⁵ NATIONAL PRACTITIONER DATA BANK, [The NPDB - Data Analysis Tool \(hrsa.gov\)](https://www.hrsa.gov/npdb) (last visited March 8, 2021).

A detailed review of the NPDB data from 1997 to 2014 found that “[t]he decrease occurred across all specialties, although the magnitude of the decline varied markedly by specialty, and was significant in each specialty except cardiology.”²⁶ The study found that in 2014 one paid claim was reported each year for every 100 physicians.²⁷ By 2019, only one claim was paid for every 28,572 Americans.

However, the numbers must be interpreted with some caution because the NPDB data have a weakness that understates the number of claims paid on behalf of practitioners. Payments on behalf of institutions, rather than individuals, need not be reported to the NPDB.²⁸ Some hospitals and health care organizations have recently begun to shield their affiliated providers from an adverse report to the data bank by settling a case with the understanding that claims against individual providers will be dismissed.²⁹ The extent of this corporate shielding is not known.

At present, however, the NPDB data is the best that we have. It shows a steady decline in the number of claims paid. Furthermore, that trend is consistent with the great reduction in the number of claims filed, discussed above, which was deduced directly from insurer files.

3. The total value of settlements is far below prior levels and is rising gradually.

The two best sources of national data on the total value of malpractice settlements are the National Practitioner Data Base, for individual providers, and AM Best, for statistics on losses paid by MPL carriers.

²⁶ Adam C. Schaffer, et al., *Rates and Characteristics of Paid Malpractice Claims Among US Physicians by Specialty, 1992-2014*, 177 JAMA INT. MED. 710, 717 (2017).

²⁷ *Id.* at 710.

²⁸ *Id.* at 714. Underreporting could also lead to an underestimation of payouts. But a study using the files of a large malpractice insurer found only small discrepancy. *Id.* at 717.

²⁹ *Id.*

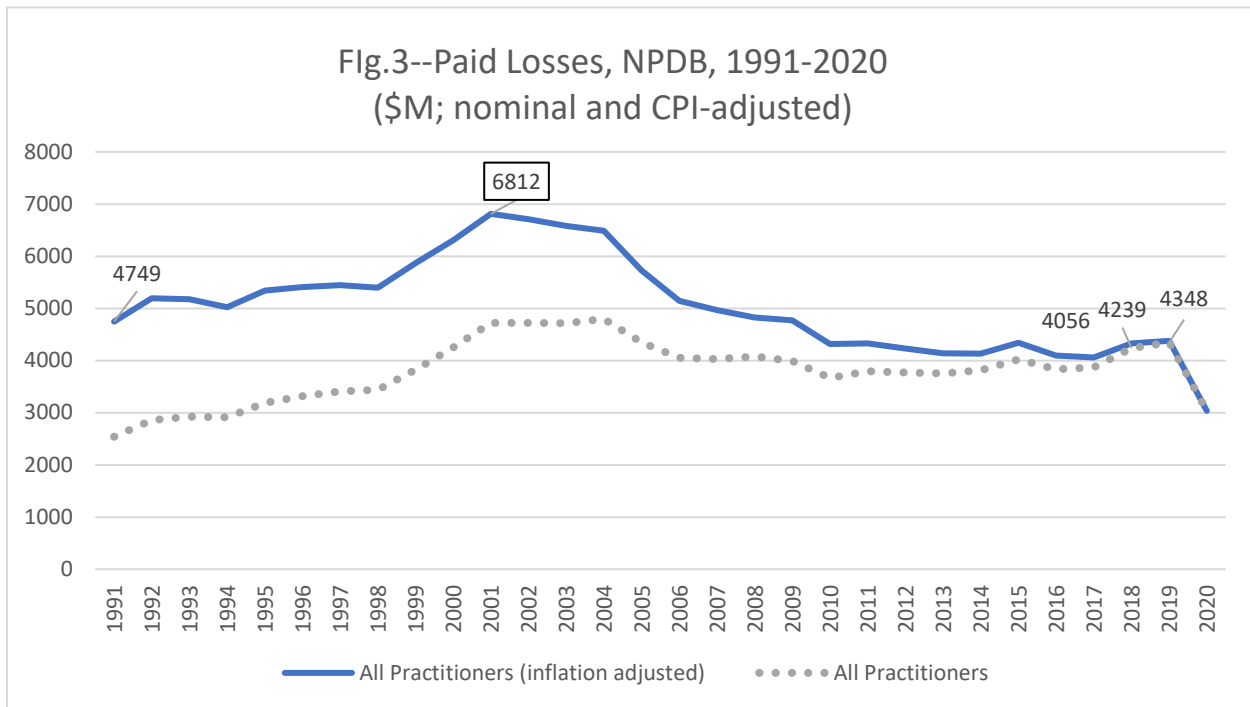
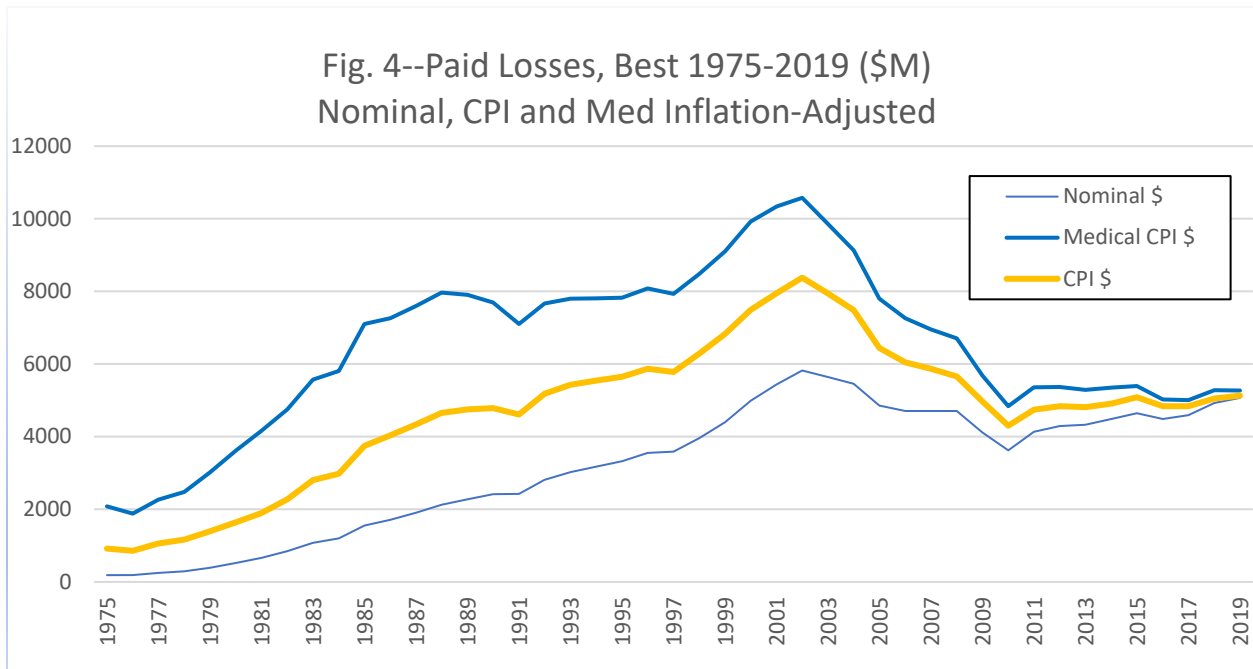


Figure 3 uses data from National Practitioner Data Bank. Those data show a steady climb in the value of payouts from 1991 to 2001, leading up to the last crisis, and then an equally steady decline in both nominal (dotted line) and CPI-adjusted dollars (solid line) from 2002 to 2010. Around 2010, nominal payouts leveled off, though payouts in real dollars continued to fall.³⁰ Payouts reached their bottom in 2017 in both nominal and real dollars and then rose slightly in 2018 and 2019. The total paid in 2019 amounted to only 64% of the total paid in 2001 in CPI-adjusted dollars.

It is useful, at this juncture, to look back at Figure 1 and note that profits began a steady descent in 2010 that continues to the present. Yet, Figure 3 shows that tort payout levels were stable between 2010 and 2017. That paradox will be discussed further in Parts II and III.

³⁰ NATIONAL PRACTITIONER DATA BANK, [The NPDB - Data Analysis Tool \(hrsa.gov\)](https://www.hrsa.gov/npdb/) (last visited March 8, 2021).

Here, too, corporate shielding may mean NPDB data failed to detect a recent rise in payouts. However, that risk is significantly mitigated by data from AM Best, which indicate that real payouts shrank markedly from 2003 to 2011 and have risen quite gradually since then. In Figure 4,³¹ the top blue line is adjusted for medical inflation, the middle yellow line is adjusted for CPI and the bottom gray line shows unadjusted “nominal” dollars. As of 2019, total paid CPI-adjusted losses (yellow) were 40 percent below their 2002 level. After adjusting for consumer inflation, the payout levels of the last decade are the lowest since the early 1990s. When adjusted using the medical inflation index (blue), payout levels are the lowest since the early 1980s.

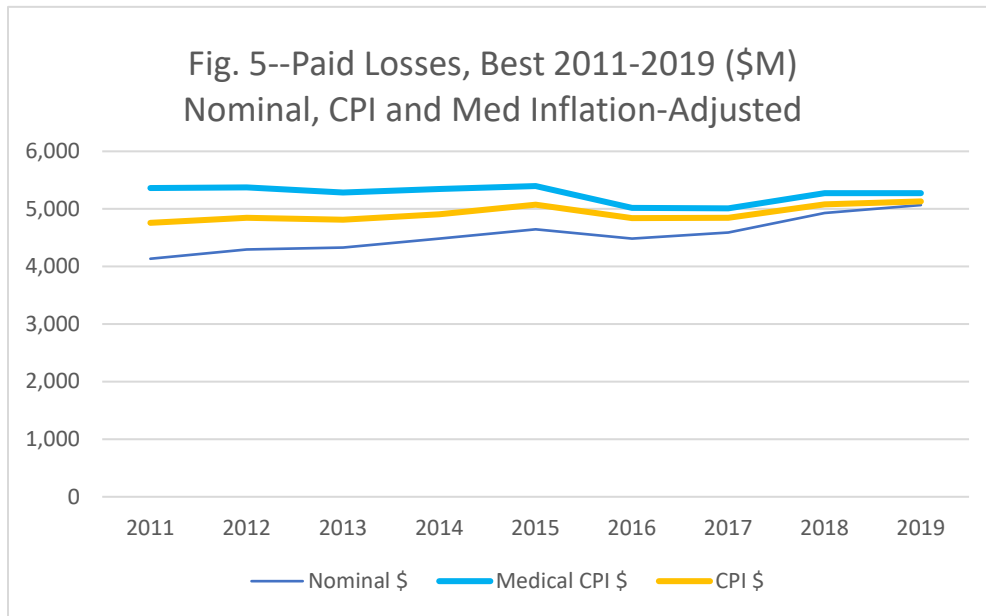


However, the Best data from the most recent years (2011-2019) show that *nominal* payments (gray) did begin to rise again in 2011 and have risen slowly for nearly a decade. This is shown in more detail in Figure 5, next.³² This is a more pessimistic picture than that drawn by the NPDB data, where the recent upturn did not begin until 2018. Nevertheless, the rate of growth has been modest. Nominal payments since 2011 have risen 3 percent annually,³³ only 0.8 percent faster than consumer prices (yellow) and more slowly than the medical inflation that drives settlement costs up (blue).

³¹ The AM Best data for this figure were compiled from HUNTER, DOROSHOW AND HELLER, *supra* note 1; J. ROBERT HUNTER AND JOANNE DOROSHOW, AMERICANS FOR INSURANCE REFORM (now the Consumer Federation of America), STABLE LOSSES/UNSTABLE RATES 2016 and private communications with AM Best (providing updated data for the years since 2011). I owe a thank you to the Consumer Federation of America and to Best for sharing data.

³² *Id.*

³³ See also AON/ASHRM HOSPITAL AND PHYSICIAN PROFESSIONAL LIABILITY BENCHMARK REPORT, Exec. Summary, 4 Oct. 2020, [2020-AonASHRM-HPL-Executive-Summary.pdf](#) (indemnity predicted to rise 3%).



As with the NPDB figures, this modest inflation-driven growth seems insufficient to trigger a new hard market, especially considering today’s historically low level of indemnity losses. Part II, however, will explain how the messy mechanics of the insurance marketplace transform gradual increases in nominal costs—costs that merely mirror inflation--into dramatic, sudden increases in premiums. In the logic of the insurance cycle, an historically low level of payouts is much less important than multiple years of declining profits, whatever their cause.

4. Average settlement size, “social inflation,” and “nuclear” verdicts

Voices in the industry point to the growth of “nuclear verdicts” and the increasing severity of indemnity payments as the cause of declining profits. One industry executive noted that “[o]ver the last three years there has been a steady uptick in judgments exceeding \$10 million, many coming in venues not traditionally considered high risk.³⁴ In its annual survey, ASHRM/Aon found a “continual increase in large claim frequency of claims greater than \$5M.”³⁵ The CRICO study also found an increase in high-indemnity payments of (\$3M–11M) between 2007 and 2016, though it found they are “still rare.”³⁶

The perception that “nuclear” verdicts are driving down industry profits has given rise to terminology that places the blame for the industry’s predicament on juries. Commentators now talk of “social inflation”—a free-wheeling public attitude toward compensatory damages. In the spring of 2019, when the Consumer Federation of American and the Center for Justice & Democracy reviewed the language being used in the press, they found that references to

³⁴ MAGMUTUAL, *supra* note 8. See also Todd Shryock, *Which direction are malpractice rates headed and why?* MED. ECON., Sept. 27, 2019, [Which direction are malpractice rates headed and why? | Medical Economics](#) (noting both an increase and novel venues).

³⁵ Virginia Jones, et al., Beazley Group and Aon, *Understanding Changes in the Medical Malpractice Insurance Market 1*, 9-12, Oct. 2020, [10604 HPL Benchmark Report R7.indd \(beazley.com\)](#)

³⁶ CRICO STRATEGIES, *supra* note 21, at 9.

nuclear verdicts and social inflation were still intermittent, but by late 2019, the entire industry seemed to have “gotten the memo.”³⁷ This terminology has now made its way into the most respected industry publications. Best’s 2020 report noted that the “vast majority of MPL companies have begun to see a rise in ‘nuclear’ verdicts and average indemnity losses that are much higher than historical averages.”³⁸

But this focus on rising *average* verdicts and settlements is misleading in at least four respects. First, total payouts determine industry profitability, not the average size of individual settlements. In the case of medical malpractice insurance, the number of payments has declined so markedly over the past twenty years that total payouts are still lower than during prior hard markets and are climbing at rate lower than medical inflation.

Second, “nuclear” verdicts certainly do occur, perhaps more often than in the past and probably in new places.³⁹ But these awards are typically reduced, often substantially, by courts or in settlement before payment.⁴⁰ Moreover, they are not typical. The authors of the CRICO study agreed, stating:

extraordinary jury awards draw media attention, pique the interest of reinsurers, and can skew the focus of patient safety improvements, but they remain rare. Per 1,000 cases closed, only one or two cases closed with more than \$5 million indemnity. Outlier payments (those exceeding \$11M) had a minimal impact on overall indemnity trends.⁴¹

Another industry publication observed, we “are not seeing it have an overall statistical effect on losses.”⁴²

Third, the rise in average payments can be fully explained by medical and consumer inflation. Past and future medical expenses constitute a major component of recoverable damages in medical malpractice cases, especially in states that have capped pain and suffering damages.⁴³ As a result, malpractice awards and settlements are strongly influenced by medical inflation. According to CRICO, the median payment has increased in line with consumer inflation and average payouts are rising more slowly than medical inflation.⁴⁴ As noted above, the Best data for the last decade show the same trend. Since none of the parties complaining about the climb in damages is advocating for a cap on medical billing, it seems unfair to complain about payments that are driven in large part by the medical bills of negligently injured patients.

³⁷ HUNTER, DOROSHOW AND HELLER, *supra* note 1, at 16.

³⁸ *E.g.* BEST 2020, *supra* note 15, at 23.

³⁹ *E.g.* Shyrock, *supra* note 34 (“we’re seeing, as an industry, more large verdicts in places that have never had one like that”).

⁴⁰ David Hyman, et al., *Do defendants pay what juries award? Post-verdict haircuts in Texas medical malpractice cases:1988–2003*. 4 J. EMPIRICAL LEG. STUD. 2007; Neil Vidmar, *Juries and Medical Malpractice Claims Empirical Facts versus Myths*, 467 CLIN. ORTH. RELAT. RES. 367, 373 (2009).

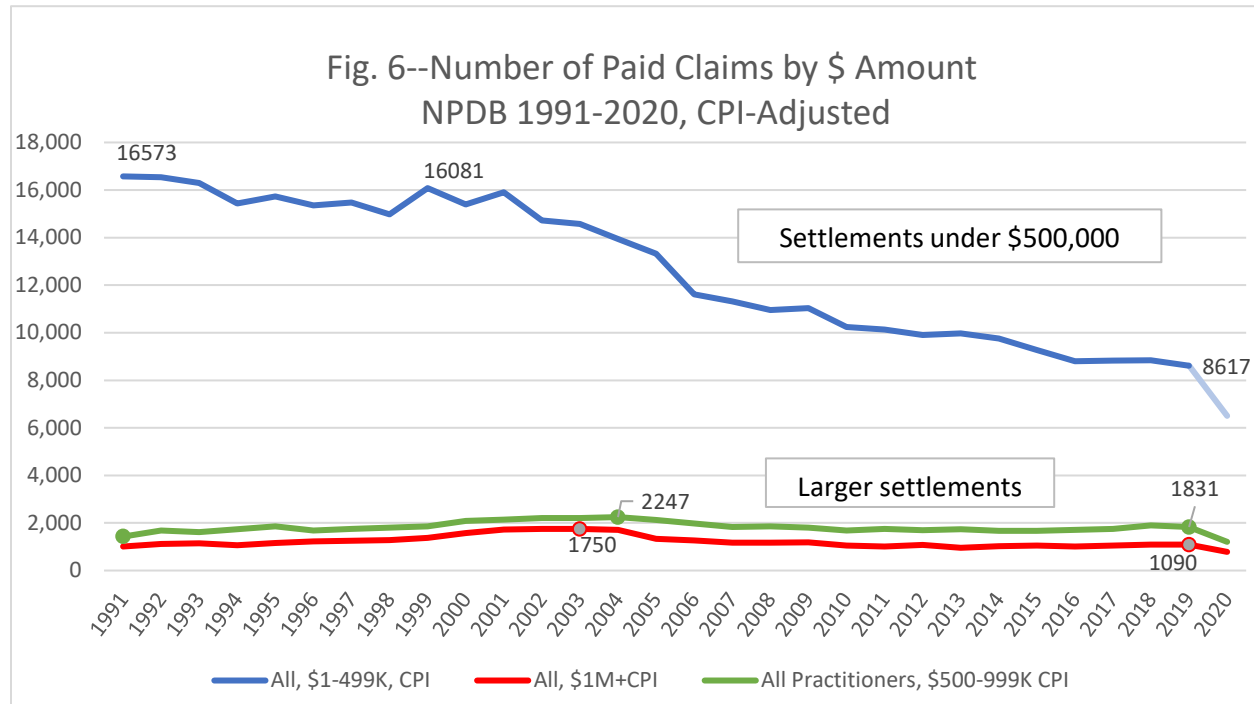
⁴¹ HUNTER, DOROSHOW AND HELLER, *supra* note 1, at 39-40 (quoting the CRICO study).

⁴² Shyrock, *supra* note 34 (quoting Bill Fleming, the chief operating officer for The Doctors Company).

⁴³ See BEST 2020, *supra* note 15, at 7 (pointing out the role of “rising medical loss costs” in driving loss ratios)

⁴⁴ CRICO STRATEGIES, *supra* note 21, at 8.

Finally, the average settlement is rising because small medical malpractice claims are disappearing. The blue line in Figure 6 shows the declining number of cases resolved for amounts under \$500,000 in 2020 dollars.⁴⁵ Since 2001, the number of these has fallen 46 percent.



These smaller settlements have not been replaced by growth in larger settlements. As shown in Figure 6, large settlements constitute a surprisingly small fraction of all claims and have remained a small fraction over the entire period. The green line shows settlements between half a million and one million dollars and the red line shows the number of settlements at or above \$1 million in 2020 dollars. Both categories have declined in frequency since their peak in 2003-04. The number of settlements over \$1 million in 2020 dollars (red line) has fallen by 38 percent since its peak in 2003.

Small claims are disappearing because malpractice cases have become extremely expensive to litigate.⁴⁶ As a result, plaintiffs’ attorneys are screening their clients closely for large and readily proven economic loss.⁴⁷ That has caused an upward shift in the severity of claims being litigated which, in turn, ought to drive up the dollar value of the average settlement substantially.

To recap, fewer cases are being filed than ever before; smaller cases are dwindling dramatically. Fewer claims are being resolved with payment. Total payouts are significantly

⁴⁵ NPDB, *supra* note 22.

⁴⁶ See NAIC, U.S. PROPERTY & CASUALTY AND TITLE INSURANCE INDUSTRIES | 2018 FULL YEAR RESULTS at 7 (“the complexity involved in discovering negligence [for MPL claims] results in a higher percentage of premium going toward defense and cost containment expenses”)

⁴⁷ TOM BAKER, THE MEDICAL MALPRACTICE MYTH 59 (2005); Schaffer et al., *supra* note 27, at 715 (noting that attorneys don’t take small cases).

lower in real dollars than they were during the 2002 crisis. According to Best, but not NPDB, payments in real dollars began rise along with consumer and medical inflation in 2010. Inflation alone could explain that rise, as could the increasing severity of the cases remaining in the claims pool.

Why then is the malpractice insurance market hardening? That requires an understanding of the insurance business cycle.

II. THE INSURANCE CYCLE

How can profits be in peril if claims have dwindled and payouts are much lower than they were during the last hard market? Answering that question requires an understanding of the insurance business cycle. The mechanics of that cycle also explain why the turn from a “soft” market into a “hard” market typically involves a very sharp spike in premiums--so sharp that providers march on state capitols.

In the insurance cycle, relatively long soft markets with low premiums swiftly transition into much briefer hard markets where premiums turn sharply upward.⁴⁸ Then the market softens and the cycle repeats itself. During the initial years of the ensuing soft market, premiums are still high, and profits are too. Insurers can compete on price and still make robust profits due to the steep premiums increases imposed during the panic of the hard market. In soft markets, insurers want premium dollars to invest.

Investment returns are an especially important part of the MPL business model because medical professional liability insurance has a longer gap between the sale of insurance and the payment of claims than most other lines of property and casualty insurance (called a long “tail”).⁴⁹ MPL insurers compete for premium dollars to invest by offering low prices and soft underwriting.⁵⁰ In fact, low premiums largely define a soft market.⁵¹

As price competition continues, profits gradually shrink. For a time, insurers can preserve profits by releasing surplus reserves that were accumulated during the last hard market.⁵² At the peak of the 1975, 1986 and 2002 crises, for example, the industry overpredicted losses and, thus, raised reserves and premiums much more than proved

⁴⁸ Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 436 (2005).

⁴⁹ BAKER, *supra* note 47, at 47.

⁵⁰ Fitch Ratings, *supra* note 8 (“Hard markets are fleeting as underwriting success attracts competition that leads to an erosion of favorable pricing conditions.”); Sean Fitzpatrick, *Fear is the Key: A Behavioral Guide to Underwriting Cycles*, 10 CONN. INS. L.J. 255, 256 (2004) (insurers cut prices and loosen terms).

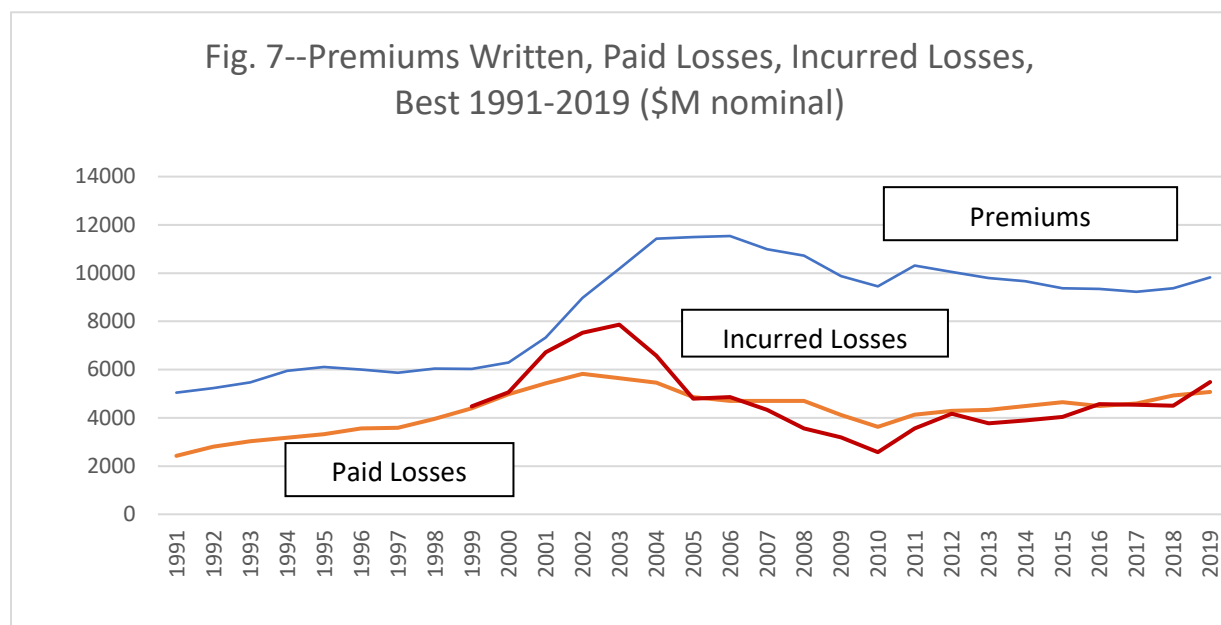
⁵¹ See Insurance Information Institute, [Market Conditions: Cycles And Costs | III](#) (March 11, 2021) (“The property/casualty (P/C) insurance industry cycle is characterized by periods of soft market conditions, in which premium rates are stable or falling and insurance is readily available, and by periods of hard market conditions, where rates rise, coverage may be more difficult to find and insurers’ profits increase.”). Tom Baker distinguishes hard markets from soft markets by whether premiums are above cost (hard) or below cost (soft). Baker, *supra* note 48, at 396.

⁵² HUNTER, DOROSHOW AND HELLER, *supra* note 1, at 2 (“The excessive reserves of the previous hard market in the early 2000s are still being released by insurers even as they spike current reserves to create false support for price increases.”). See BAKER, *supra* note 47, at 50 (explaining how the release of surplus reserves and strengthening of inadequate reserves affect profits).

necessary.⁵³ That enabled insurers to extend the ensuing soft markets by gradually releasing redundant reserves to income.

Figure 7 shows how reserves and premiums grew much more than paid losses in 2002-2006 and provided a surplus which then funded a soft market that has run from 2006 to the present.⁵⁴ This also happened in 1986.⁵⁵ The premium jump is shown in blue. The increase is revealed by comparing the orange line for paid losses with the red line for “incurred losses.” Incurred losses are the sum of loss payments and new reserves for future payments. Starting in 2001 and ending in 2005, incurred losses (red) rose well above paid losses (orange), reflecting a dramatic jump in reserves.⁵⁶ Both premiums and reserves rose more than eventually was required. As a result, premiums could be reduced during the ensuing soft market to compete for market share and reserves could be released into income. The combination of the two revenue streams fueled the long soft market that is now ending.

NAIC data show the same pattern as the Best data in Figure 7; premiums and incurred losses rose far above paid losses. The NAIC data are shown in Figure 12 in the Appendix.



Eventually, however, excess reserves are exhausted. Meanwhile, inflation increases the cost of claims payments and operating expenses. A soft market nears its end when these rising costs intersect with shrinking real premiums and the exhaustion of surplus reserves. During that

⁵³ BAKER, *supra* note 7, at 53-54 (showing data for 1986 and 2001, and noting reports about 1975, but not data); HUNTER, DOROSHOW AND HELLER, *supra* note 1, at 7 (“the extended soft market we have been in is also the result of excessive pricing and over-reserving that took place during the last hard market”). Next draft: Add fact that carriers had underreserved during the soft market and, at the turn, decide to correct this error, p54; underreserving allows low prices and decent profit in soft market, 56, just like release of old reserves, but adds to explosiveness of transition to hard market.

⁵⁴ See *supra* note 31 (citing the sources of data in this article from AM Best).

⁵⁵ See *supra* note 53.

⁵⁶ See also BAKER, *supra* note 47, at 54 (noting the rise in incurred losses).

time, insurers are effectively selling coverage below cost.⁵⁷ Their predicament becomes dire when operational losses exceed investment returns, depleting surplus equity and reducing carrier ability to write new policies and to invest.⁵⁸ At this point the market moves sharply from soft to hard. Figure 1, above, shows how profits fell to this level right before the 2002 crisis and how profits are approaching that juncture now.

Unfortunately for health care providers, the turn from a soft market to a hard one has always been sharp. Afraid to be the first to raise premiums, insurers have typically tolerated eroding profits for several years, letting the pressure build. When the pressure on profits is no longer tolerable, premiums spike sharply, exploding like the cork in a bottle of poorly handled champagne. No wonder doctors and hospitals are outraged and mystified. Why does the same coverage suddenly cost much more?

The central puzzle of the insurance cycle is why carriers delay the premium increases so long that a crisis ensues.⁵⁹ Tom Baker, a superb legal analyst of insurance markets, offers an explanation that emphasizes the psychology of insurance marketing and underwriting. It also dovetails nicely with the industry view that highly competitive soft markets force carriers to keep premiums low. To break from the pack is to lose your business.

The story goes like this. When the soft market begins to lose its energy, industry sales managers and sales staff are afraid to be the first to raise premiums and lose market share.⁶⁰ That puts pressure on the underwriters to keep their predictions of future losses low.⁶¹ Doing so will keep reserves low and, thus, allow the low premiums that fuel sales.⁶² Indeed, these low premiums may be perceived as vital to compete.⁶³ This inclination is reinforced with pay incentives that reward increases in market share and the preservation of revenue, and do not reward calls for increased reserves or premiums.⁶⁴ These incentives extend all the way to the underwriters.⁶⁵

Given the uncertainty associated with predicting future losses,⁶⁶ there is ample room for underwriter judgment to be affected. As a result, carriers are “too optimistic about future losses for too long.”⁶⁷ The result is a “winners curse” in which the companies which win the market competition have set prices so low that they have put themselves in financial danger.⁶⁸ Scott Harrington offers the possibility that only a few “aberrant” carriers are needed to lead the

⁵⁷ Baker, *supra* note 48, at 396 (selling below cost identifies a soft market)

⁵⁸ See Harrington, *Tort Liability, Insurance Rates, and the Insurance Cycle*, BROOKINGS-WHARTON PAPERS ON FINANCIAL SERVICES: 2004 97, 119; Fitzpatrick, *supra* note 50, at 261 (noting that robust interest rates can lengthen a soft market).

⁵⁹ *Id.*

⁶⁰ BAKER, *supra* note 47, at 56 (pressure to keep prices low).

⁶¹ *Id.* See Harrington, *supra* note 58, at 133 (noting revenue gains of the low-priced firms).

⁶² Baker, *supra* note 48, at 397 (insurers use these predictions to estimate the level of reserves needed).

⁶³ BAKER, *supra* note 47, at 57.

⁶⁴ Baker, *supra* note 48, at 420. Even mutual companies are likely to have a bias toward protection of market share.

⁶⁵ Baker, *supra* note 48, at 418.

⁶⁶ Baker, *supra* note 48, at 396 (“Insurers must predict a universe of variables such as future claiming trends, the severity of injuries which will lead to suits, the dollar value of those injuries to juries, the odds of new medical developments that will increase malpractice claims, the rate of medical inflation, changes in legal rules including the standard of care, any changes in the cost of defense, and future investment returns.”) See also *id.* at 410, 423.

⁶⁷ BAKER, *supra* note 47, at 50.

⁶⁸ BAKER, *supra* note 47, at 58; Harrington, *supra* note 58, at 120.

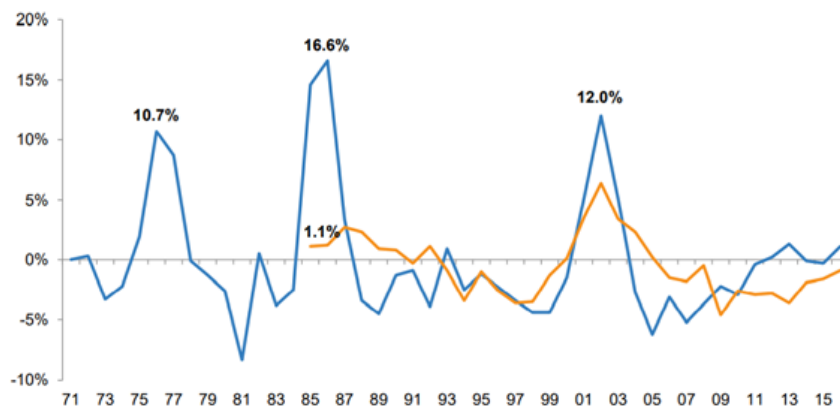
market down, generating the winners curse effects.⁶⁹ Other insurers then feel obliged to follow the market down to preserve market share and premium revenue.⁷⁰

Underwriters may also be understandably reluctant to render internally unpopular opinions that differ from those being made by underwriters at other companies. Herd mentality makes it seem much safer to wait until the rest of the pack is ready to raise prices.⁷¹ Interestingly, the Consumer Federation of America and the Center for Justice and Democracy believe that today's widening chorus of warnings about a "hardening" market and "social inflation" is one way that carriers ask each other whether it is time to start raising premiums *en masse*.⁷²

This suggestion of group psychology and shared communication may also provide a clue to one of the remaining mysteries of the insurance cycle: why are the peaks and troughs of the insurance cycle so closely aligned across the many lines of casualty insurance? Despite such disparate lines as auto, surety, fire, crop, homeowners, inland marine, workers compensation, and product liability, the overall P/C industry has a cycle that mirrors that of medical malpractice insurance, as shown in the following chart from the Insurance Information Institute.⁷³ Each peak in premium increases for the P/C industry perfectly matches one of the three crises in the medical malpractice industry.

Three Hard Markets in the Last 45 Years

Net Premium Growth (All P/C Lines) Minus Nominal GDP, Annual Change



▼ The three "hard markets" in this 45-year span were in 1976–77, 1985–86, and 2001–03.

Sources: A.M. Best (1971-2017), ISO (2014-16), A.M. Best, Insurance Information Institute (1986-1994); U.S. Commerce Dept., Bureau of Economic Analysis; Insurance Information Institute calculations.

⁶⁹ Harrington, *supra* note 58, at 120.

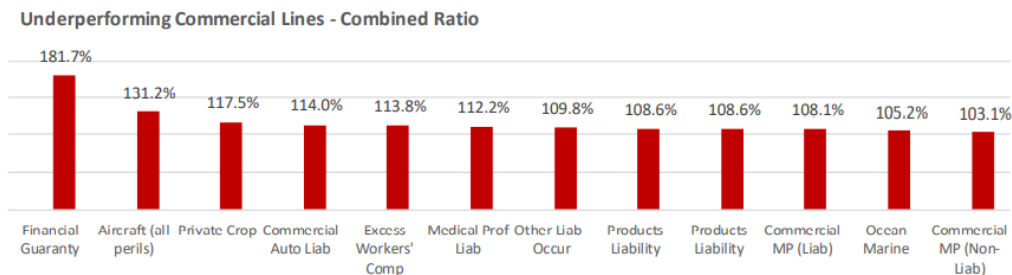
⁷⁰ *Id.*

⁷¹ BAKER, *supra* note 47, at 57 (stating that herd behavior is a partial explanation).

⁷² HUNTER, DOROSHOW AND HELLER, *supra* note 1, at 16-18.

⁷³ James Lynch, *P/C Industry Overview and Outlook*, presented at Buckeye Actuarial Continuing Education, October 19, 2018, [P/C Industry Overview and Outlook | III](#) (last visited May 4, 2021). Lynch was the chief actuary of the Insurance Information Institute. The yellow line is GDP growth. *Id.*

Today, too, the woes of the MPL sector are widely shared. The next chart is from the NAIC and it shows twelve P/C sectors, including medical professional liability insurance, where operating expenses were more than 100 percent of premiums in 2019. A hard market is coming for many sectors.



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Something is driving the sectors toward joint experience, much like two pendulums oscillating on a single bar. Perhaps it is a combination of shared psychology and shared information. Perhaps other common factors like investment returns have more influence than widely understood. That is a question for another time.

For the MPL sector, at least, the long soft markets seem attributable to the success of optimistic sales forces over more pessimistic actuaries.⁷⁴ During the final stages of a soft market, new policies are underpriced and, to enable that, under-reserved.⁷⁵ This occurred before the 1986 and 2002 hard markets.⁷⁶ More realistic firms are destined to watch from the sidelines until the pressure on the “winners” becomes unbearable. St. Paul’s withdrawal from the market on the cusp of the 2002 crisis may represent just such an opting out.

As a result, pressure builds until it erupts sharply in the twin scourge of higher premiums and greatly increased reserves. These two steps staunch the insurance industry’s bleeding but transfer the financial pain to physicians and hospitals. They, in turn, are shocked and angered by the sudden and dramatic increases in their malpractice insurance premiums. When they are told that plaintiff’s attorneys and runaway juries are to blame, health care providers add their considerable credibility and political power to that of the insurance industry and lobby for tort reform.

Yet, the explosive force of a malpractice hard market is usually a product of prior underpricing and its companion, under-reserving, not a sharp increase in claims costs.⁷⁷ In the prelude to both the 1986 and 2002 hard markets, real indemnity payments had been rising, but gradually and steadily (Fig. 5). In addition, interest rates on investments were declining before

⁷⁴ BAKER, *supra* note 47, at 50 (underpricing). See Baker, *supra* note 48, at 414 (under-reserving) and 394 (delay in adjusting premiums).

⁷⁵ *Id.* at 50, 54 (“the insurance industry systematically under-reserved in the years leading up to the [1986] crisis”); Baker, *supra* note 48, at 414 (under-reserving) and 394 (delay in adjusting premiums).

⁷⁶ BAKER, *supra* note 47, at 51-52.

⁷⁷ BAKER, *supra* note 47, at 53-54 and Chart 1 (losses increased gradually, rather than spiking).

the 2002 hard market.⁷⁸ These factors put gradual pressure on the soft market's low premiums. Yet, those pressures were ignored and allowed to build to crisis levels because insurers delayed raising premiums. Eventually the cork popped, and prices skyrocketed. As Baker notes, price spikes are simply an integral part of the insurance cycle.⁷⁹

Because hard markets arise out of gradually increasing pressure on profits, they can occur even in times like ours—when claims and payments are at historically low levels. The pressure on profits that builds in advance of each hard market can be caused by negative changes in any of the MPL sector's major streams of revenue or expense. The dark magic of the insurance cycle is that it converts gradual declines in revenue and gradual increases in expenses into sudden and steep price increases. That suddenness disrupts the business models of the policyholders, especially doctors in high litigation specialties like neurosurgery and obstetrics whose premiums jump the most.⁸⁰

The practice of underreserving also plays an important role in the volatility of the insurance cycle; it is intimately tied to the problem of underpricing.⁸¹ As the market shifts from soft to hard and premiums begin to rise, underwriters not only raise the reserve levels for new policies, but they also correct the underreserving that took place in the final years of a soft market in order to keep premiums down.⁸² The readjustment of reserves is especially momentous in the MPL sector because its long tail of open policies leaves a large volume of business open to reassessment.⁸³ The combination of larger reserves on new policies and readjustment of reserves on old policies explains why incurred losses rose so quickly during lead into the 2002 hard market, as shown in Figure 7, above.

This readjustment has multiple effects. First, profits plummet because the sums set aside as reserves count against income. As Baker says, "profits fall off a cliff"—at least until the catch-up reserving concludes and the premium spikes have their impact.⁸⁴ This sharp drop in profits—albeit brief—increases the surface credibility of regulatory requests for premium increases and tort reform.⁸⁵ Consumer advocates even argue that overreserving is intended to manipulate regulators.⁸⁶ According to the Consumer Federation of America, the "reserve increases in the years 2001 to 2004 could have accounted for 60 percent of the price increases witnessed by doctors during the period."⁸⁷

Second, reserve readjustments push premiums up even higher than would be necessary to pay the current predicted cost of *new* policies. The additional premium is needed to fund additional reserves on *old* policies. In theory, the insurance companies should not possess the

⁷⁸ Harrington, *supra* note 58, at 102.

⁷⁹ Baker, *supra* note 48, at 436.

⁸⁰ BAKER, *supra* note 47, at 46.

⁸¹ *Id.* at 56. As Baker observes, underpricing and under-reserving go hand in hand and set the stage for the tectonic shift.

⁸² See Harrington, *supra* note 58 at 103, 133 (loss estimates must be adjusted upward). Baker notes that the capital markets favor swift correction of reserving problems. Baker, *supra* note 48, at 420.

⁸³ BAKER, *supra* note 47, at 50.; Baker, *supra* note 48, at 399, 408; Harrington, *supra* note 58, at 103.

⁸⁴ BAKER, *supra* note 47, at 50.

⁸⁵ HUNTER, DOROSHOW AND HELLER, *supra* note 1, at 4.

⁸⁶ *Id.*

⁸⁷ HUNTER AND DOROSHOW, *supra* note 31, at 11.

market power to charge customers for past losses.⁸⁸ New competitors who lack those losses can underprice them. But the MPL market apparently has sufficient barriers to swift entry to make this quick catch-up pricing possible.⁸⁹ As a result, reserving practices push premiums much higher than current operating costs require and thus greatly magnify the disruptiveness of the shift to a hard market.

Third, the shift in reserve practices helps fund the coming soft market. In each of the three prior MPL hard markets, insurers set aside more in reserves than was ultimately required to pay claims.⁹⁰ This consistency suggests that the systematic optimism of the soft market is replaced by systemic pessimism when a soft market turns hard. This pessimism pushes premium hikes and reserve set-asides higher than necessary to cover actual operating costs. The silver lining is that these excess reserves can be released during the second half of the soft market to maintain profits even as companies cut premiums to chase market share and revenue to invest.

As a practical matter, these reserving practices are hidden from legislators and journalists. They are not listed separately in the usual media reports of industry profitability. Instead, reserves are counted as losses and included in the industry's count of "incurred losses." To the uninitiated, the sharp increase in incurred losses that surfaces during the initial years of a hard market gives the mistaken impression that claims payments have skyrocketed. Instead, reserves have skyrocketed. The extra reserves are just projections—human estimates of future losses. These predictions are subject to all the ordinary human biases, including the systematic optimistic of the soft market and the overly pessimistic turn of the hard market.

Ironically, the spiked premiums and growing reserves virtually guarantee high profits in the years immediately following the hard market's peak.⁹¹ In fact, high profits are how Finch defines a hard market!⁹² After the 2002-2004 crisis, for example, the sector posted "record profits in 2007."⁹³ Figure 7, above, shows why.

Is pressure building for the next hard market? That is the subject of Part III.

III. ARE WE ON THE VERGE OF A CRISIS?

The medical malpractice market is unquestionably hardening. Profitability is at its lowest level since the last hard market. Premiums are climbing. Losses are rising. Market forecasts are overwhelmingly negative. Industry experts fear that COVID-19 will make matters worse. Their prognosis is so dour that they have already chosen the villain for this hard market: so-called "social inflation." Still, we may have time to avoid a full-scale crisis.

⁸⁸ Baker, *supra* note 48, at 414.

⁸⁹ *Id.* at 413-14.

⁹⁰ BAKER, *supra* note 47, at 54 (noting overprediction of losses); Harrington, *supra* note 58 at 103 and Fig. 4 (showing that reported incurred losses rose far above actual developed losses before the 1986 and 2002 hard markets).

⁹¹ Fitzpatrick, *supra* note 50, at 256. See also INS. INFORMATION INSTITUTE, [Market Conditions: Cycles And Costs | III](#), last visited Apr. 22, 2021 ("The prospect of higher profits draws more capital into the marketplace, leading to more competition and the inevitable down phase of the cycle.").

⁹² Fitch Ratings, *supra* note 8 (equating high profits with a hard market).

⁹³ HUNTER AND DOROSHOW, *supra* note 31, at 11.

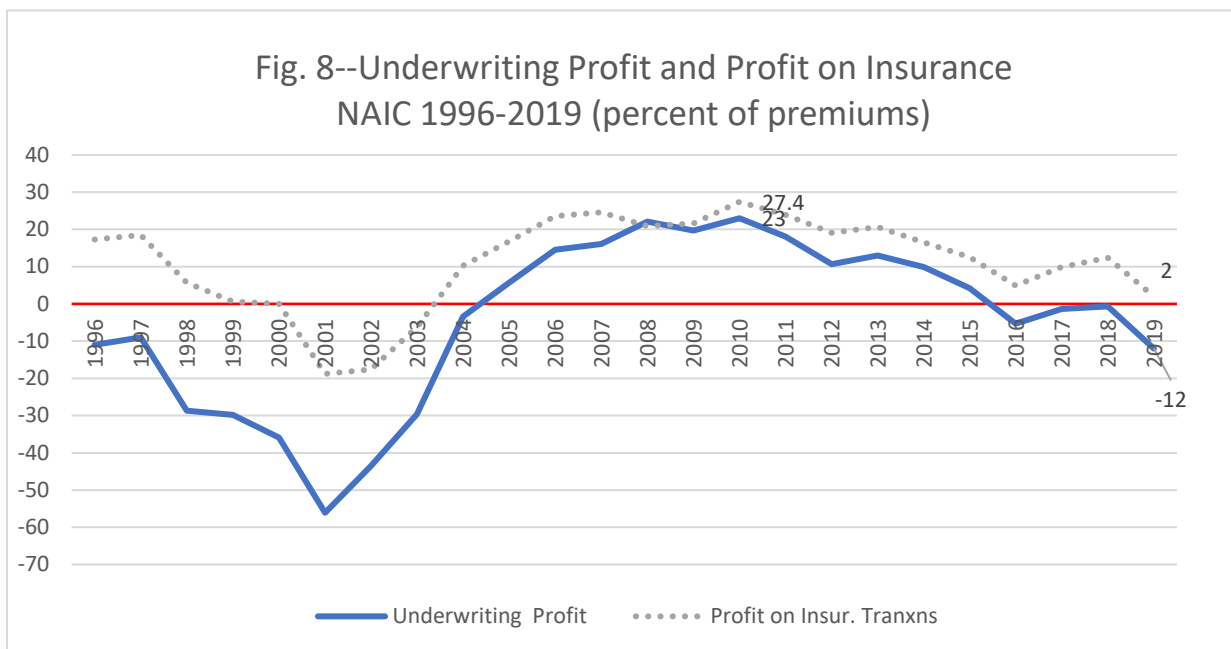
A. The Long Soft Market is Ending

Between 2006 and roughly 2015, health care insurers and their policyholders enjoyed a long soft market. In the beginning and middle of that market, premiums and profits were extremely high (Figs. 1 & 7) and reserves had grown quite dramatically. As the market turned soft around 2006, Industry premiums steadily fell in unadjusted dollars until 2017,⁹⁴ though loss of market to self-insurance could account for some of that decline.⁹⁵ At the same time, insurers' large reserves allowed them to preserve profitability by gradually releasing reserves into income.

One commentator described the soft market this way:

The MPL insurance marketplace previously enjoyed decades of soft market conditions, driving competition for buyers and insurers. Low premiums, abundant capacity, and relaxed underwriting guidelines allowed insurers to aggressively compete for increased market share.⁹⁶

By 2014-2016, however, the soft market was ending. The sector's operating costs had finally risen above its premium revenues. NAIC data show that underwriting profit had turned to underwriting loss in 2016 (blue), as shown in Figure 8, below. AM Best reported that MPL has experienced "aggregate underwriting losses in the past four years."⁹⁷



⁹⁴ See, e.g., Forray and Karls, *supra* note 8, at Fig. 1.

⁹⁵ Forray and Karls, *supra* note 8.

⁹⁶ Jones, *supra* note 35, at 9.

⁹⁷ BEST 2020, *supra* note 15, at 6.

Moreover, the combined ratio, another frequently cited profitability metric, went negative even earlier—in 2014.⁹⁸ It, too, compares operating costs to premium revenue, but takes dividends into account and, thus, tends to show a slightly more negative outlook than underwriting profits.⁹⁹ The data for combined ratios are shown in the Appendix in Figure 13. Both ratios indicate that the medical malpractice insurance business is not currently paying its own operating expenses and has not done so for several years.

Only the industry's investment returns have kept the sector profitable, as indicated in the gray dotted line in Figure 8 showing profit on insurance transactions, a metric which does consider investment income.¹⁰⁰ But the buffer of investment gains was barely enough to keep this metric positive in 2019 (2% of premiums). And the trend suggests that profit on insurance transactions will soon follow underwriting profit into negative territory—a place last visited in the hard market of 2002, also shown in Figure 8.

In addition, industry sources say that reserves have steadily been shrinking and now offer less protection against low operating profits.¹⁰¹ That, too, is consistent with end of a soft market.¹⁰²

A 2020 NAIC report gave a negative assessment:

Since 2014, the medical professional liability line has generated negative underwriting results due to rising loss costs and diminishing prior year reserve takedowns. For the current year, the combined ratio worsened 8.0-points to 112.2%—a 10-year high. Results could continue to worsen as medical professionals may have increased liability exposure related to COVID-19.¹⁰³

Finally, industry experts are detecting building pressure to raise the premiums paid by policyholders.¹⁰⁴ In 2019, the journal *Risk & Insurance* lamented that “The Reckoning is Here for the Medical Professional Liability Market,” noting “a decade’s worth of price erosion.”¹⁰⁵ Leo Carroll, the Senior Vice President and Head of Healthcare at Berkeley Hathaway Specialty Insurance, concluded that the industry had waited too long to respond to its profitability challenges:

⁹⁸ NAIC 2020, *supra* note 12, at 7.

⁹⁹ Combined ratios turned negative somewhere between 2014 to 2016 depending on the data source, as shown in Figure 13 (Appendix).

¹⁰⁰ NAIC, PROFITABILITY BY LINE BY STATE, *supra* note 19.

¹⁰¹ BEST 2020, *supra* note *15, at 9. The impact was especially sharp in 2019 when the positive impact of releases on the combined ratio fell from 15.6 points in 2018 to 7.6 in 2019. *Id.* and Exhibit 6.

¹⁰² BEST 2020, *supra* note 15, at

¹⁰³ NAIC 2020, *supra* note 12, at 6. Page 7 shows a negative combined ratio since 2014.

¹⁰⁴ Amy Buttell, *Reinsurers Adjust to Hardening Market, Pandemic; Nuclear verdicts, depressed margins weigh on industry*, INSIDE MED. LIABILITY (4TH Qtr. 2020), [Reinsurers Adjust to Hardening Market Pandemic \(mplassociation.org\)](https://www.mplassociation.org).

¹⁰⁵ Dwyer, *supra* note 7 (rates are increasing for providers, but especially for hospitals); see JOSE R. GUARDADO, MED. PROF. LIAB. INS. PREMIUMS: AN OVERVIEW OF THE MARKET FROM 2010 TO 2019 at 2 (AMA Policy Research Perspectives 2020), [PRP: Medical professional liability insurance premiums: An overview of the market from 2010 to 2019 \(ama-assn.org\)](https://www.ama-assn.org) (28.5% of surveyed physicians reported increased premiums in 2109, the most since 2006, while only 5.1% reported decreased premiums, the lowest in 10 years.”)

Over the past several years, there has been a good deal of rationalizing and failure to timely respond to about deteriorating conditions and poor results, and a reluctance to make corrections needed for the overall health of the marketplace. Now we're reaching a point where the industry is behind, and *serious improvements are necessary*.

Best's 2020 report stated "MPL insurers have been feeling rate pressure for several years."¹⁰⁶ The widely used national survey of physicians by Medical Liability Monitor found that the transition had already begun. In 2019, 28.5% of surveyed physicians reported increased premiums in 2109, the most since 2006, after a long period of being stable or even falling.¹⁰⁷ Similarly, a recent panel of experts urged caution "as claims increase and medical malpractice insurance rates surge."¹⁰⁸ And Jean-Paul Rebillard, the president of a unit of Berkshire Hathaway, opined that "we find ourselves at an inflection point in the market cycle."¹⁰⁹

A report from the Medical Professional Liability Association (MPLA) supports these observations, stating: "Rates began to increase in 2019 and are likely to continue to increase at a faster clip in 2020. Certain markets may see double-digit rate increases."¹¹⁰ A 2019 report from the American Society for Health Care Risk Management and Aon concluded that most hospitals "have benefited from years of declining rates, combined with significant exposure increase. However, this is not sustainable in the current marketplace."¹¹¹

The price increases being reported by policyholders are starting to appear in figures for industry premium volume as well. Premium volume began to rise in 2018 and rose still higher in 2019 and 2020.¹¹² Best found that premiums collected from physicians grew in 2019, even though physicians migrated to hospital employment in 2019, suggesting that premium rates—not just premiums collected—are climbing.¹¹³

Profits are near zero—even after taking investment gains into account. Redundant reserves are dwindling, and premiums are starting to inch upward. The market for medical malpractice insurance is hardening.

¹⁰⁶ BEST 2020, *supra* note 15, at 5.

¹⁰⁷ GUARDADO, *supra* note 105, at 2.

¹⁰⁸ Gavin Souter, [Captive owners react to hardening medical malpractice market | Business Insurance](#), Jan. 28, 2020.

¹⁰⁹ *Id.*

¹¹⁰ Forray and Karls, *supra* note 8.

¹¹¹ Jones, *supra* note 8, at 14.

¹¹² NAIC, COUNTRYWIDE SUMMARY OF MED. PROF. LIAB. INS., CALENDAR YEARS 2005-2019 (2020); NAIC, COUNTRYWIDE SUMMARY OF MED. PROF. LIAB. INS, CALENDAR YEARS 2004–2018 (2019); Jennifer Gardner, NAIC, *Medical Malpractice Loss Trends: Data at a Glance*, CIPR Newsletter, Aug. 2015, 19, 20 (Center for Insurance Policy Research, NAIC) (Calendar Years 2000-2014); NAIC Research and Actuarial Dept., *Data at a Glance*, CIPR Newsletter, July 2013, 20, 29-30 (Center for Insurance Policy Research, NAIC) (Calendar Years 1991-2012); BEST 2020, *supra* note 15, at Ex. 2 (premiums for the Best composite); Fig. 7, *supra* (showing Best data on premiums for entire industry); see Forray and Karls, *supra* note 8, at Figure 1.

¹¹³ BEST 2020, *supra* note 15, at 5. See also Forray and Karls, *supra* note 8 ("Declining rate levels were only one factor driving premium decreases during this time frame. Also contributing to the lower level of premium was the loss of business to self-insurance mechanisms. Throughout this time frame, MPL companies lost business due to healthcare system acquisitions of both hospitals and physician practices, which typically then joined the self-insurance mechanisms of these systems.")

This Part now turns to three follow-up questions. First, what are the factors that are driving profits down? Second, can we have a soft landing. Third, what role will the pandemic play in the severity of this hard market?

B. What Is Driving Profits Down?

Insurance industry profits are driven by a limited set of major expenses and income streams. Sustained adverse trends for any combination of them can put material pressure on premiums. This part searches for the factors contributing most heavily to the industry's recent decade of declining profits, looking first at revenue sources and then at expenses.

1. Inadequate Premiums

About four years after the hard market of 2002 began, premiums began a steady decline that lasted until 2018. Cumulatively, premiums declined 35 percent since 2006 in adjusted dollars and 22 percent in unadjusted dollars, as shown above in Figure 7 and in the Appendix (Fig. 13). According to the Medical Liability Professional Association, the trade association for the MPL sector, "premium decreased by \$1.1 billion between 2006 and 2016—approximately 20% of the premium written at the beginning of that decade."¹¹⁴ "To put that in perspective," observed the MPLA, "consider that in the 40-year history of the MPL industry no other period of decreasing premium has lasted longer than two years and the greatest consecutive-year premium reduction was 7%."¹¹⁵

At first, indemnity payments were shrinking an equal amount so profits remained near record highs despite the decline in premiums (Figs. 1 & 7). But the sharp decline in payouts ended in 2011. About the same time, paid losses and operating expenses both began to rise in nominal (unadjusted) dollars. Nevertheless, premiums continued to drop in nominal dollars until 2018 (Fig. 7) and then rose only modestly.¹¹⁶ Because premiums did not rise despite the growth of both paid losses and operating costs, all three profit ratios began a steady decline in 2011 that has continued with little interruption to the most recent reporting period (Fig. 1).

The scale of the recent premium increases was insufficient to reverse the slide in profits. As a result, Best's 2020 report maintains a negative outlook on the MPL segment owing in part to "rate adequacy."¹¹⁷

These data demonstrate that the industry's large reduction in premiums over the last fifteen years has been a major contributor to its declining profits today. Its delay in raising premiums after 2011, when losses and operating costs began to climb, is particularly notable. True to the textbook insurance cycle, the combination of market pressure and human behavioral tendencies has allowed pressure on premiums to build.

2. Exhaustion of Surplus Reserves

¹¹⁴ Forray and Karls, *supra* note 8.

¹¹⁵ *Id.*

¹¹⁶ The sole outlier year was 2011.

¹¹⁷ BEST 2020, *supra* note 15, at 1.

The industry maintained its profitability during the last half of this soft market, in part, by releasing redundant reserves.¹¹⁸ But releases have been getting smaller over the past few years; the industry trade association concluded that “redundant reserves have been depleted.”¹¹⁹ According to Best, “reserve releases will no longer be sufficient to prop up the segment’s calendar year results.”¹²⁰ Berkshire Hathaway executive Leo Carroll put it this way:

Reserve redundancies are diminishing from prior years, so the market is no longer able to mask actual current year results. While in the past a carrier could have been buffered by prior year results, that’s no longer an option to the same extent.¹²¹

According to Best’s calculations, over two-thirds of the deterioration of the combined ratio in 2019 was attributable to the release of fewer reserves.¹²² If not for that release of reserves, the industry would have fallen into the red.¹²³

These facts justify the conclusion that shrinking reserve redundancies are a significant contributor to declining industry profits. Their apparent exhaustion will greatly increase the mounting pressure to raise rates significantly.

3. *Declining Investment Returns*

NAIC data show a gradual decline in investment returns over the past fifteen years. Returns on the investment of reserves dropped from a high of 18-19% of premiums in the early years of the soft market to 13-14% in the last several years, with large one-time dips in 2008 and 2016.¹²⁴ (Appendix Figure 14.) Investment returns on net worth also declined gradually over that period but were much lower and less volatile. These weakening returns probably contributed to the decline in profits over the past decade. Nevertheless, declining premiums and depleted reserve redundancies probably played a more important role.

4. *Rising Indemnity Payments*

After declining for a decade, total inflation-adjusted payouts reported by the NPDB stabilized in 2010 and began to rise again in 2018-19, when the total amount rose slightly more than the consumer price index.¹²⁵¹²⁶ According to Best, indemnity payments have grown 20

¹¹⁸ Forray and Karls, *supra* note 8.

¹¹⁹ *Id.*

¹²⁰ BEST 2020, *supra* note 15, at 9.

¹²¹ Dwyer, *supra* note 7.

¹²² BEST 2020, *supra* note 15, at 8 & Ex. 6 (accounting for 8 points of an 11-point drop) and 9 (noting “erosion of reserve redundancies”).

¹²³ Forray and Karls, *supra* note 8 (“the operating ratio of 97% would have pierced 100%, making the industry unprofitable”).

¹²⁴ NAIC, PROFITABILITY BY LINE BY STATE, *supra* note 19.

¹²⁵ See *supra* text at notes 30.

¹²⁶ Similarly, the CRICO study found that average settlements were rising at a rate between the consumer and medical rates of inflation. See *supra* text at notes 44.

percent in nominal dollars since 2011 (about 3 percent annually), but have basically been flat over the past decade when they are indexed to reflect the medical purchasing power of the settlements.¹²⁷

Though the recent increases are explained by inflation, they are nonetheless a potential source of pressure on profits because premiums were not raised to reflect this expense. S&P Global, a business consulting company, explicitly noted the sector's failure to account for inflation, stating that "[p]erhaps the fact that losses are now piercing the excess casualty layer is more of a function of general inflationary loss experience rather than rising social inflation."¹²⁸

Thus, the inflationary growth of indemnity payments has put pressure on profits, given the failure to raise premiums.

5. *Rising Costs of Defending, Underwriting and Selling*

The cost of selling policies and of defending claims has grown slowly but steadily over the past decade as a percent of premiums. The combination of internal claims adjustment and outside defense cost is called the loss adjustment expense (LAE). According to NAIC, LAE consumed 7.3 more cents of every premium dollar in 2019 than it did in 2010. Costs of selling insurance also rose, consuming an extra 3.2 cents of each premium dollar.¹²⁹ Together, they accounted for about 10 points in the drop of the underwriting profit ratio, which fell 24 points between 2010 and 2018 and another 11 points in 2019 (Fig. 8).

By 2019, defense costs consumed a remarkable 30 percent of every premium dollar (a topic for another day) and selling expenses used 12 percent.

Because these figures represent the portion of premiums consumed by these expenses, some of the increase could simply be a function of declining premiums. However, the rest—perhaps, the bulk—represents an actual increase in costs. Those increasing costs put additional pressure on profits in the absence of rising premiums.

6. *Adding It All Up*

Even though claims are substantially below than their peak in 2001-02 and payouts are stable, profits are under stress and premiums are expected to rise. The key cause is a long-standing and intensely competitive market in which insurers did not believe that they could risk raising premiums despite several worrisome trends which should have led them to do so.

Since 2010, the industry has seen rising defense costs, rising sales costs, the exhaustion of reserve redundancies, declining investment returns and the ongoing impact of medical inflation on indemnity payments. But real premium volume still sits at about the level of the year 2000.

¹²⁷ See *supra* text at notes 32.

¹²⁸ HUNTER, DOROSHOW AND HELLER, *supra* note 1, at 18. Best also places some of the responsibility on medical inflation. BEST 2020, *supra* note 15, at 5 ("Rising medical loss costs. . .had pressured loss and LAE ratios over the last few years").

¹²⁹ NAIC, PROFITABILITY BY LINE AND STATE, *supra* note 19. Data from AM Best cover fewer years but show a similar upward trend in underwriting expenses. See BEST 2020, *supra* note 15, at Ex. 5.

A.M. Best reached these conclusions about current pressures on profitability:

Rising medical loss costs, along with relentlessly challenging and competitive market conditions, had pressured loss and LAE ratios over the last few years, before an even larger increase in 2019. . . The deterioration in underwriting results [in 2019] was due primarily to a slight rise in underwriting expenses and losses and loss adjustment expenses (LAE), along with an 11% drop in net premiums earned (NPE).¹³⁰

Soon, given the confluence of these factors, reserve releases will no longer be sufficient to prop up the segment's calendar year results, which has been the norm for some time. That means more effective risk selection, risk classification, individual account underwriting and pricing will be needed to generate improved calendar year underwriting results.¹³¹

The industry trade association, MPLA, emphasized the impact of depletion of redundant reserves and the increases in operating expenses:

Declines in reserve releases drove this deterioration in the operating ratio and increases in underwriting expenses exacerbated it. ... With a combined ratio above 100% for each of the past four years, the industry now relies on its investment income for its profitability.¹³²

The MPL sector may once again have waited too long to raise its premiums.

Industry defenders argue that there is always considerable guesswork in determining when a soft market has ended. Investopedia says “[m]ost insurance industry watchdog organizations believe that underwriting cycles are inevitable due to the inherent uncertainty of matching insurance prices to future losses.”¹³³

However, the analysis undertaken in this article shows that carriers now have the tools to recognize the signs and determine when prudent preventive action should be taken. Several other commentators have called for more discipline from carriers in underwriting and pricing.¹³⁴ After the 2002 hard market, Lloyd's named the cycle the top challenge facing the insurance industry and undertook an extensive study.¹³⁵ In a 2006 report *Managing the Insurance Cycle*, it identified seven key steps, including these two:

Don't follow the herd. Insurers need to be prepared to walk away from markets when prices fall below a prudent, risk-based premium.

¹³⁰ BEST 2020, *supra* note 15, at 5.

¹³¹ *Id.* at 9.

¹³² Forray and Karls, *supra* note 8.

¹³³ Investopedia, [Underwriting Cycle Definition \(investopedia.com\)](https://www.investopedia.com/terms/u/underwriting-cycle-definition/) (accessed March 18, 2021).

¹³⁴ *Id.*

¹³⁵ *Id.*

Get smarter with underwriter and manager incentives. Incentives for key staff should be structured to reward efficient deployment of capital, linking such rewards to target shareholder returns rather than volume growth.”¹³⁶

Rolf Tolle, Lloyd’s Director of Franchise Performance, added “[i]n the past, insurers have simply accepted the insurance cycle, seeing it as a force of nature with an uncontrollable impact on their business. But at Lloyd’s we believe that insurers now have the information and the tools they need to manage the cycle much more effectively.”¹³⁷ Tolle concluded that “[t]here is nothing complex about the cycle. It is about having the courage of your convictions to act with strength.”¹³⁸

Similarly, Investopedia observed that “[t]he underwriting cycle perpetuates because a majority of insurance companies place short-term gains over long-term stability without concern for what happens when the soft market ends.”

Unfortunately, this demand for greater discipline may not be a realistic option. As Baker points out, insurers may only have a choice between offering insurance at the going price or leaving the market (Baker, 57). Insurers who simply raise premiums are likely to lose customers to the companies that do not.

The Consumer Federation of America and the Center for Justice & Democracy have offer a different solution--more regulatory scrutiny during rate setting, especially during the turn to a hard market--but only a few states have taken that step.¹³⁹ New York reportedly experienced some success moderating the cycle by limiting price increases in hard markets and price decreases in soft markets, an idea that has also been proposed by J. Robert Hunter, now with the Consumer Federation of America. But New York apparently ended that effort in 2004. More experimentation of this kind is needed.

Both Tom Baker and I have proposed the adoption of exclusive enterprise liability as a third option. Shifting liability exclusively to hospitals and integrated health care organizations will not moderate the cycles, but it will transfer liability to parties who are better able buffer themselves against the disruptions. Collective enterprise liability will also spare high-risk specialists from shouldering a disproportionate share of the health care system’s liability costs. Hopefully, it will also dampen the extraordinary anger felt by the physicians who practice in those specialties. But no court or legislature has expressed even passing interest in this proposal.

Thus, the insurance cycle continues. Periods of cutthroat competition and widespread underpricing are followed by brief explosive corrections. We are on the verge of that transition

¹³⁶ Insurance Canada, [Seven steps to managing the cycle - Insurance-Canada.ca - Where Insurance & Technology Meet \(insurance-canada.ca\)](https://www.insurance-canada.ca/en/where-insurance-technology-meet) (July 12, 2006). The seven steps are: don’t follow the herd, invest in the latest risk management tools, don’t let surplus capital dictate your underwriting, don’t be dazzled by higher investment return, don’t rely on ‘the big one’ to push prices upwards, redeploy capital from lines where margins are unsustainable, and get smarter with underwriter and manager incentives. *Id.*

¹³⁷ *Id.*

¹³⁸ Wikipedia, [Insurance cycle - Wikipedia](https://en.wikipedia.org/wiki/Insurance_cycle) (accessed March 21, 2021).

¹³⁹ EMILY GOTTLIEB & JOANNE DOROSHOW, BRIEFING BOOK MEDICAL MALPRACTICE: BY THE NUMBERS 67-70 (describing laws in California and Illinois) (March 2020). Best also recommends innovation to reduce defense costs. BEST 2020, *supra* note 15, at 23.

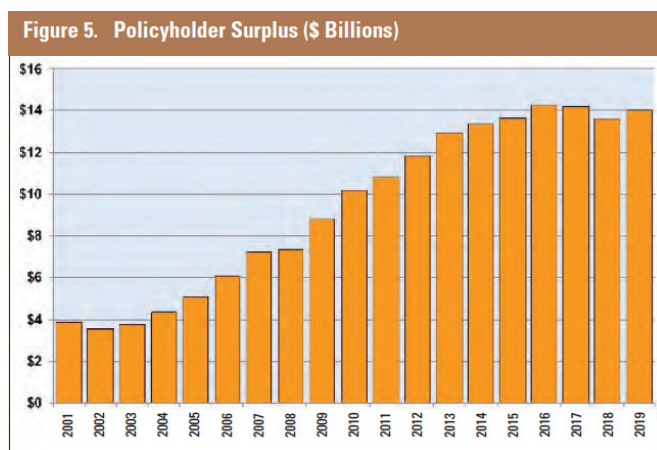
today. Gradual growth in all expenses (underwriting, selling, defending, and indemnifying) along with a gradual decline in all revenue streams (premiums, reserve releases, and investment returns) have placed growing and continuing pressure on profits.

C. Will There Be a Soft Landing?

Though the market is hardening, some industry representatives believe that risk of a crisis are lower today than they were immediately before the crisis of 2002. For example, Bill Burns and Alyssa Gittleman of the global investment management firm Conning point to the presence of more policyholder surplus and reinsurance coverage today than in 2002.¹⁴⁰

Reinsurance transfers a portion of the insurer's risk to another insurer. This practice hedges against losses and frees up capital to write more insurance contracts.¹⁴¹ It's increased use today should provide some protection for retail carriers to the modest extent that indemnity payments drive the loss of profits.¹⁴²

Policyholder surplus also provides a margin of safety against unexpected losses. In a publicly held company, this is called equity or net worth. In 2019, the MPL sector's unrealized capital gains lifted industry surplus about 4.3 percent to \$18.8 billion, despite the existence of an underwriting loss for the year.¹⁴³ Figure 5 from the MPLA shows that policyholder surplus is three times larger today than it was in 2001.



Theoretically, these surpluses could be used to temper the shift to a hard market. In publicly held companies, however, this strategy would shift some of the cost of a hard market onto shareholders, making its use less likely.

The current capital capacity of the MPL sector may also soften the landing. So far, the sector has avoided the departure of major carriers from the market. This contrasts with 2002-03, when St. Paul Fire and Marine stopped selling malpractice insurance.¹⁴⁴ St Paul was the largest carrier in the market and stranded over 40,000 physicians.¹⁴⁵ In 2003, Farmers Insurance

¹⁴⁰ PRWeb, [Medical Liability Monitor's 2019 Annual Rate Survey Indicates a Medical Malpractice Insurance Premiums Rising, But Are We Headed for a Real Hard Market? \(prweb.com\)](#), CISION (Oct. 3, 2019) (last visited May 4, 2021). At the same time, the authors acknowledge some similarities to 2002 such as the MPL industry's operating ratio, return on equity, declining loss reserve margins, use of schedule credits and declining competition.

¹⁴¹ Investopedia, [Reinsurance Definition \(investopedia.com\)](#) (accessed March 23, 2021).

¹⁴² However, anecdotal accounts of reinsurers leaving the MPL sector have surfaced. Buttell, *supra* note * (interviewing Andy Firth, president of MIEC, a mutual MPL insurer).

¹⁴³ BEST 2020, *supra* note 15, at 11-12. In MPLA's annual survey, surplus rose about 3 percent in 2019 from about \$13.6 billion to \$14.0 billion despite the year's underwriting losses. Forray and Karls, MPLA, *supra* note 8.

¹⁴⁴ Shryock, *supra* note 34.

¹⁴⁵ Bruce Japsen, [Why Doctor Malpractice Premiums Stopped Rising \(forbes.com\)](#) (Oct 10, 2018, 08:46am) (last visited May 4, 2021); Charles A. Wilhoite & Scott R. Miller [The Transitioning Medical Professional Liability](#)

Company exited the market as well. Thereafter, “the market stiffened up and prices went up.”¹⁴⁶ Nothing on a similar scale has occurred in recent years.

The MPLA also offers other factors which could temper the transition. For example, the lower level of claims frequency in today’s market “has put MPL rates in a better position than they were 20 years ago” and “the degree of rate inadequacy [is] less, and present in fewer locales, in this most recent soft market than in the previous soft market.”¹⁴⁷ The authors of that report, Forray and Karls, explain further:

In the early 2000s, the start of the hard market was steep and quick, with double-digit rate increases common across states and carriers. In contrast, rate increases in the emerging hard market are expected to be smaller and to vary more across markets. As noted earlier, recent rate inadequacies have been less—both in magnitude and geographic spread—than in the preceding soft market of the late 1990s, placing less pressure on rates now.¹⁴⁸

“What makes the last ten years different,” adds Best, “is that the deterioration [in underwriting profits] has been gradual rather than sudden.”¹⁴⁹ MPLA qualifies its hope for a soft landing with a warning that “certain market segments are likely to experience double-digit rate increases during 2020 and perhaps 2021.”¹⁵⁰ However, the MPLA apparently believes that these premium increases will do the job, as it expects profitability “to improve” despite “greater uncertainty ahead.”¹⁵¹

In addition, the COVID-19 pandemic may make it politically inexpedient for insurance companies to dramatically raise the premiums paid by physicians and hospitals. Health care providers were 24/7 rescuers during the pandemic. That public relations obstacle could force carriers to use their available surplus to subsidize more gradual increases in premiums than would otherwise occur.

Finally, the most hopeful sign of a softer landing is the widespread recognition of the danger at a relatively early moment in the turn from soft to hard market. Figure 8, above, shows that the long slide in profits from 2010 to the present has not yet reached the deep losses that occurred in 2002. Profits on insurance transactions were still in positive territory at the end of 2019. So, too, was the sector’s return on net worth, as shown in Figure 11, below. Both metrics fell much further during the last hard market. That suggests that the MPL sector may have time to raise premiums and reserves gradually, rather than steeply. It’s current cross-talk about social inflation may enable the sector to act collectively, rather than act alone and risk losing customers.

[Market—Challenges in Valuing a Medical Professional Liability Company \(willamette.com\)](#) INSIGHTS 85 (Summer 2013).

¹⁴⁶ Shryock, *supra* note 34.

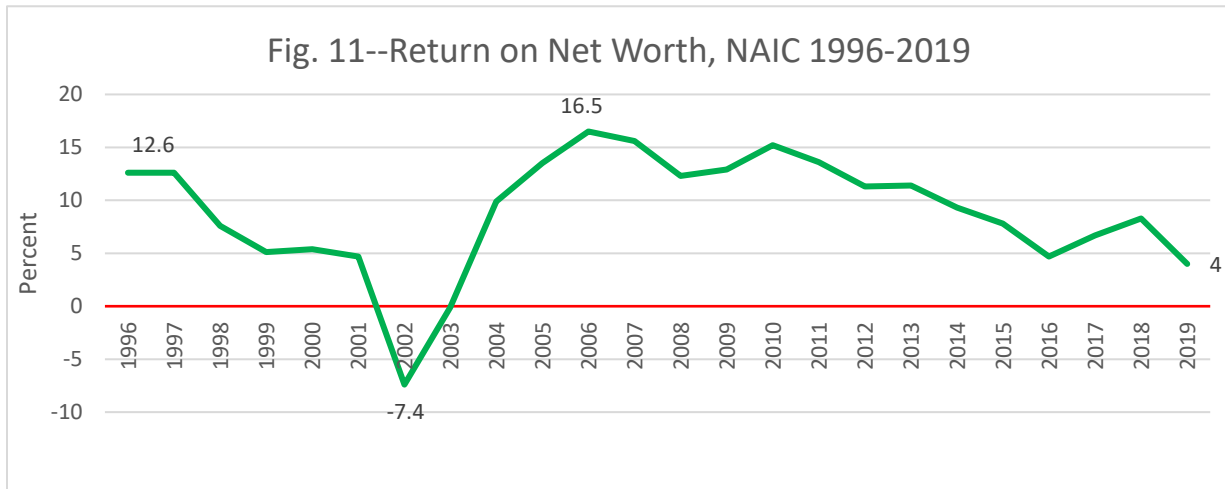
¹⁴⁷ Forray and Karls, *supra* note 8.

¹⁴⁸ *Id.*

¹⁴⁹ BEST 2020, *supra* note 15, at 13.

¹⁵⁰ Forray and Karls, *supra* note 8.

¹⁵¹ *Id.*



In late 2019, Bill Fleming, the chief operating officer for The Doctors Company, the nation’s largest physician-owned medical malpractice insurer said:

Part of our strategy and goal there is to not be disruptive. But if we don’t raise rates a little bit when it’s necessary, that builds up pressure that eventually results in a large increase, which is very disruptive from a customer perspective. Our hope and expectation is that a small increase is more tolerable over time than a single large increase that is disruptive to a budget. . . I think the industry needs to find a way to take reasonable increases that can be absorbed into practices and health systems rather than continue to defer the need to a time when you have no choice but to take a very large increase that’s disruptive not just to the marketplace, but to practices all over the country.”¹⁵²

These multiple factors—a much lower level of payouts than in 2002, the gradual rather than sudden erosion of profits, wider use of reinsurance, a substantially larger industry surplus, the politics of the moment, and the early warnings—could lead to a softer landing than occurred in the past.

The wild card, of course, is the impact of COVID-19 on malpractice litigation.

D. The Wild Card: COVID-19

The prospects for an insurance crisis are amplified by the uncertainty resulting from the COVID-19 pandemic. Both the NAIC and AM Best have explicitly and strongly warned of the risks to industry finances posed by the pandemic.¹⁵³ They worry that COVID-19 exigencies have impacted medical professionals’ ability to provide effective care, both to COVID-19 patients and to elective patients whose care schedules have been altered or relegated to telemedicine.¹⁵⁴

¹⁵² Shryock, *supra* note 8.

¹⁵³ NAIC 2020, *supra* note 12, at 6, 15.

¹⁵⁴ *Id.* at 15.

Best has undertaken the most thorough examination of the risks pose by the pandemic and its assessment is very pessimistic. Its analysis emphasizes the fact that providers were overwhelmed at times by the surge of patients in serious condition.¹⁵⁵ The surge caused hospital overcrowding, shortages of intensive care beds, and the use of makeshift facilities. With the rise in patient-to-doctor ratios, providers were exhausted while at the same time working more hours with little rest. Delays in access to care were more common, as was reliance on telemedicine. Both raise the risk of missed diagnoses. In addition, the shortage of providers forced the recruitment of less experienced providers who had not been professionally trained in infectious diseases. Hospitals struggled with inadequate supplies, staffing, and hospital space. Law professor Nicolas Terry’s analysis identifies a similar set of risks and adds to it the use of improvised equipment and untested drugs.¹⁵⁶ Each of these factors may have produced additional medical errors.

Summing up, AM Best is pessimistic, concluding that the “already dim prospects for the segment’s profitability have been clouded by COVID-19.”¹⁵⁷ The Medical Professional Liability Association believes the coronavirus has “brought the arrival of a hardening market.”¹⁵⁸

Yet, several factors could prevent a pandemic-related surge in claims. Best concedes that providers might be helped by “current sentiment toward health care providers,” the absence of a well-established standard of care, and the prospect of tort immunity legislation.¹⁵⁹ Best even speculates that “few lawyers are likely to take on lawsuits against healthcare providers related to COVID-19, owing to healthcare provider sentiment and the difficulties of determining the standard of care.”¹⁶⁰

Law professor Nicholas Terry has undertaken the most thorough review of the state and federal laws immunity laws.¹⁶¹ At the federal level, he found that the only important shield is provide by The Public Readiness and Emergency Preparedness Act of 2005. It governs “covered countermeasures,” such as drugs, devices, personal respiratory protective devices, and vaccines.¹⁶² The Department of Health and Human Services has ruled that its protections should also extend to the decision not to use countermeasures, but at least one district had court disagreed. 185. Even if HHS is authoritative on this issue, the law still omits many of the likely sources of adverse events, such as overcrowding, poor hygiene, understaffing and exceeding the scope of a practitioner’s training or licensure. And if HHS is wrong, misdiagnosis is also unprotected.

¹⁵⁵ BEST 2020, *supra* note 15, at 1. The entire paragraph is based on this analysis. Best also worries about the impact on provider ability to pay premiums. *Id.* at 3.

¹⁵⁶ Nicholas P. Terry, *Liability and Liability Shields* in ASSESSING LEGAL RESPONSES TO COVID-19 199, 200 (S. Burris, et al., eds., 2020), <http://www.covid19policyplaybook.org184> (last accessed January 12, 2021).

¹⁵⁷ BEST 2020, *supra* note 15, at 3.

¹⁵⁸ Forray and Karls, *supra* note 8.

¹⁵⁹ BEST 2020, *supra* note 15, at 2-3.

¹⁶⁰ *Id.* at 3.

¹⁶¹ Nicolas P. Terry, *Liability, Liability Shields, and Waivers* in COVID-19 POLICY PLAYBOOK (II): LEGAL RECOMMENDATIONS FOR A SAFER, MORE EQUITABLE FUTURE 184 (S. Burris et al., eds.) (March 2021), WWW.COVID19POLICYPLAYBOOK.ORG. Preprint also available at : <https://ssrn.com/abstract=3809455>.

¹⁶² *Id.* at 185.

More helpful to providers are the liability shields enacted in 24 states as of January 2021.¹⁶³ These laws are broader because they focus on the overall diagnosis and treatment of COVID-10,¹⁶⁴ rather than primarily on drugs and devices. Terry notes that these laws may protect providers who worked beyond their scope of training or licensure.¹⁶⁵

But the boundaries of these laws leave many areas for interpretation, such as their application to non-COVID patients whose care was interrupted or altered by the pandemic, as well as patients injured by delays and poor hospital conditions that are not directly related to the “treatment” of their COVID-10. Even so, the immunity laws will take a large fraction of the bad outcomes caused by negligence out of the tort system in the states that have enacted them. That makes the concern expressed by Best and the MPL Association seem unduly pessimistic.

Furthermore, COVID-19 lawsuits will be difficult to win. Terry points out that physicians will offer evidence of “extenuating circumstances at the height of the pandemic such as emergency rooms operating well above capacity and shortages of ICU beds and ventilators.”¹⁶⁶ In addition, patients will often have difficulty proving that reasonable care would have produced better outcomes. Patients can contract COVID-19 in hospital settings even when reasonable care is taken.¹⁶⁷ Patients can and did die in huge numbers despite access to state of the art medical care. Indeed, the state of the art was often learned by trial and error. Thus, both breach of care and causation will be difficult to prove.

At the same time, insurers and providers will benefit from pandemic’s reduction of the number of bad outcomes associated with elective procedures. The pandemic effectively shut down elective care in many hospitals for several months, thereby reducing the population of surgeries and invasive diagnostic procedures that normally form a significant part of the malpractice caseload.¹⁶⁸ Many bad outcomes may have been avoided.

Overall, the warnings of a wave of COVID-based litigation were unduly pessimistic...

However, this does not guarantee a soft landing. The uncertainties associated with the pandemic may cause underwriters to panic. Given the fears being expressed about the pandemic’s impact on MPL insurance, underwriters may *anticipate* a surge of claims. If they do, their *prediction* will drive premiums and reserves up, finalizing the turn into a hard market, whether or not the surge of COVID cases ever materializes.

As a result, we are left to wait on the data from 2000, 2001 and 2002. The pandemic’s impact on claims will not be measurable until at least 2022, when the earliest statutes of limitations will expire. However, data on premiums, incurred losses reserves, and paid losses will be available sooner and may reveal whether insurance companies are *predicting* a crisis. Incurred losses will be an especially important indicator as it will reveal whether underwriters are rewriting reserves.

¹⁶³ *Id.* at 186.

¹⁶⁴ *Id.* at 186-87

¹⁶⁵ *Id.* at 186.

¹⁶⁶ Terry, 2000, *supra* note 155, at 200.

¹⁶⁷ Terry, 2021, *supra* note 160, at 188.

¹⁶⁸ BEST 2020, *supra* note 15, at 3 (noting decline in specialty work); Buttell, *Reinsurers Adjust*, *supra* note 104 (accord).

As this page was being written, the American Medical Association released the results of a 2020 survey of physicians by the Medical Liability. In 2020, 31.1 percent reported an increase in premiums--more than any year since 2005.¹⁶⁹ Because the increase follows jumps of 13.7 percent in 2018 and 26.5% in 2019,¹⁷⁰ the AMA concluded that we are in an upward trend “not seen in over 20 years.” Although these numbers are still much lower than those in 2004 and 2004, the AMA saw the “early stages of a hard market.”¹⁷¹

CONCLUSION

Claims and payments are far below their peaks and are rising in line with inflation. Yet, insurer profits have been sinking for a decade and are nearing negative levels. Multiple factors have contributed to the steady decline in profits. They include a long period with declining premiums, the depletion of surplus reserves, the growing expenses of selling, underwriting, and defending policies and a recent inflation-driven increase in payouts. In the past few years, investment income has kept the sector in the black but barely.

At the same time, today’s insurance market differs in several important respect from the hard market of 2002-2006. The industry’s finances are more secure and the rise in expenses less steep. Most importantly, carriers are discussing the problem early in the turn from a soft market to a hard one. Much will turn on the use that carriers make of that information. Will they take the risk of raising premiums before absolutely forced to do so? If they do, they can spread the increases in premiums over more years and reduce the risk of hasty over-reserving. Data for 2000 and 2001 will help answer those questions.

One crucial uncertainty is the impact of COVID-19 on claiming. At the very least, the pandemic has produced unprecedented turbulence in health care delivery. Its uncertain impact on errors and on claiming will place pressure on underwriters to push up reserves and premiums. If they do, the market will harden more painfully than would otherwise be necessary.

¹⁶⁹ Am. Med. Assn., [Medical liability market research | American Medical Association \(ama-assn.org\)](https://www.ama-assn.org) (last visited May 5, 2021); Jose R. Guardado, Am. Med. Assn., [Policy Research Perspectives: New data show the highest prevalence of Medical Liability Premium increases \(ama-assn.org\)](https://www.ama-assn.org)

¹⁷⁰ Jose R. Guardado, Am. Med. Assn., [Policy Research Perspectives: New data show the highest prevalence of Medical Liability Premium increases \(ama-assn.org\)](https://www.ama-assn.org) at 2.

¹⁷¹ Am. Med. Assn., *supra* note 169.

APPENDICES

