Journal of Health Care Law and Policy

Volume 25 | Issue 1 Article 5

On the Cusp of the Next Malpractice Insurance Crisis

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ON THE CUSP OF THE NEXT MEDICAL MALPRACTICE INSURANCE CRISIS

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ABSTRACT

Medical malpractice claims are dwindling. Total payouts are far lower now than they were 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. But 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 which 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. 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 which 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 while 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.

I. INTRODUCTION

The profits of medical malpractice insurers have nearly disappeared in the last several years.[1] After years of decline, premiums are now rising, and industry experts warn that the market is hardening. In addition, experts worry that the

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1. *See infra* text accompanying notes 28, 39–45 and 148–167 (profits falling) and 108 (policyholder rates increasing).

COVID-19 pandemic has placed difficult burdens on overstretched health care providers—burdens that could lead to medical errors and more malpractice claims.[2] Yet, medical malpractice claims[3] and the number of paid claims have declined steadily for most of the last fifteen years.[4] The total amount paid to settle claims is thirty-six percent below its peak in 2002.[5] So, 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.[6] Although this eventually leads to dangerously low profits, carriers keep premiums low to preserve market share.[7] Eventually, the pressure on profits 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.[8] 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.[9]

During the 1974–78 hard market, California physicians went on a four-week strike, "causing public hospitals to overflow with patients" and leading to "a number of 'job actions' in other states."[10] In the 1985–86 hard market, many

2. *See infra* text in Part IV.D (discussing pandemic associated risks of error).

3. *See infra* text accompanying notes 28 (indicating that claims have declined). *See also Medical Malpractice*, INS. INFO. INST. (2012), https://www.iii.org/issue-update/medical-malpractice (reporting that the Ohio Department of Insurance found that from 2005 to 2012, total annual medical malpractice claims steadily decreased from 5,000 to 2,000).

4. *See infra* text accompanying notes 28 (indicating that paid claims have declined); Adam C. Schaffer et al., *Rates and Characteristics of Paid Malpractice Claims Among US Physicians by Specialty, 1992-2014*, 177 JAMA INTERNAL MED. 710, 710 (2017) ("From 1992-1996 to 2009-2014, the rate of paid claims decreased by 55.7%. . .").

5. *See infra* Fig. 3 and accompanying text.

6. Brian Marx, *Hard Market vs. Soft Market: The Insurance Industry's Cycle and Why We're Currently in a Hard Market*, PSA FIN., https://www.psafinancial.com/2013/01/hard-market-vs-soft-market-the-insurance-industrys-cycle-and-why-were-currently-in-a-hard-market/ (last visited Nov. 22, 2021).

7. *See* Richard G. Roberts, *Understanding the Physician Liability Insurance Crisis*, 8 FAM. PRAC. MGMT. 47, 48 (2002) (stating that medical malpractice insurance companies discounted their premiums below actuarial risk in order to obtain or preserve market share).

8. *See Harming Patient Access to Care: The Impact of Excessive Litigation: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce*, 107th Cong. 12 (2002) (statement of Travis Plunkett, Legislative Director, Consumer Federation of America) (finding that each time the cycle turns from a soft to a hard market the response by insurers is shifting from inadequate underpricing to unconscionable over pricing, cutting back on coverage and blaming large jury verdicts for the problem even though the crisis is caused by the insurers themselves).

9. *See generally* James R. Posner, *Trends in Medical Malpractice Insurance, 1970–1985*, 49 LAW & CONTEMP. PROBS. 37 (1986) (discussing the medical malpractice insurance crisis of 1970 and 1985).

10. J. ROBERT HUNTER ET AL., CONSUMER FED'N OF AMERICA & CTR. FOR JUST. & DEMOCRACY, HOW THE CASH-RICH INSURANCE INDUSTRY FAKES CRISES AND INVENTS SOCIAL INFLATION 36 (2020) (quoting *Malpractice 'job actions' spread*, FACTS ON FILE WORLD NEWS DIG. (1975)).

providers could not find coverage at any price.[11] Time Magazine ran a cover story, "Sorry, America, Your Insurance has been Canceled,"[12] and Congress held hearings.[13] During the most recent 2002–06 hard market, doctors again went on strike.[14] The president of the American Medical Association (AMA), 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."[15]

After the first crisis in the mid-1970's, at least half of the states responded with major tort reform legislation.[16] After the mid-1980's hard market, forty-six states enacted new or additional restrictions.[17] And after the third crisis in 2002–06, half of the states passed additional tort reforms which included new or lower damage caps.[18] In 2021, we are now on the cusp of yet another malpractice insurance crisis. While the financial statistics eerily resemble those leading into the 2002 crisis, some differences do 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.

II. NEW HARD MARKET IS EMERGING

Profits have fallen to dangerous levels in the medical professional liability (MPL) insurance sector and premiums are increasing.[19] The most pointed warnings come from publications that follow the insurance industry.[20] By using

11. *Id.* at 35.

12. *Id.* (citing George J. Church, *Nation: Sorry Your Policy is Canceled*, TIME, March 24, 1986, at 1–14).

13. *Id.* (citing *The Liability Insurance Crisis, Hearings Before the Subcomm. on Econ. Stabilization of the H. Comm. on Banking, Fin., and Urban Affs.*, 99th Cong. (1986)).

14. *See, e.g.*, Bruce Bartlett, *Doctors on Strike*, TOWNHALL (Feb. 28, 2003, 12:00 AM), https://townhall.com/columnists/brucebartlett/2003/02/28/doctors-on-strike-n744655 (stating that numerous doctors are going on strike to protest high medical malpractice premiums).

15. HUNTER ET AL., *supra* note 10, at 39 (quoting *AMA: To campaign for Malpractice Tort Reform*, AM. HEALTH LINE (2002)).

16. *Id*. at 44, 48.

17. *Id.* at 55.

18. *Id.* at 59.

19. *See infra* text accompanying notes 28, 39–45 and 148–167 (profits falling) and 108 (policyholder rates increasing).

20. *See generally Medical Malpractice Insurance*, NAT'L ASS'N OF INSURANCE COMM'RS, https://content.naic.org/cipr_topics/topic_medical_malpractice_insurance.htm (Nov. 16, 2021); MEDICAL LIABILITY MONITOR, https://medicalliabilitymonitor.com (last visited Nov. 22, 2021); *Medical Liability Research*, AMA ASS'N., https://www.ama-assn.org/practice-management/sustainability/medical-liability-market-research (last visited Nov. 22, 2021) (publications that follow medical malpractice liability insurance).

phrases such as "the reckoning is here"[21] and "the good times are ending,"[22] industry observers have concluded that a hard market is coming.[23] Many have concluded that premiums are climbing and are under pressure to continue to climb.[24] Matt Gracey, the CEO of malpractice insurance broker Danna-Gracey, believes that policyholder rate increases in the 5% range for smaller groups are on the lower end of the scale.[25] And large multispecialty groups have seen their rates go up by as much as 100% over the last eighteen months.[26] Mr. Gracey adds that "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."[27]

These worries are not just hype from the media and public relations consultants; they 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 warn of trouble ahead.[28] In 2019, according to the NAIC, the industry combined ratio—a key measure of profitability—reached its worse level in a decade.[29] In its April 2020 report, the

21. Katie Dwyer, *The Reckoning is Here for the Liability Market. Here's What Will Change*, RISK & INS. (Dec. 21, 2018), https://riskandinsurance.com/the-reckoning-is-here-for-the-medical-professional-liability-market-heres-what-will-change/.

22. Jeffrey Bendix, *What's happening with costs and claims in the wake of COVID-19*, MED. ECON. J., Oct. 13, 2020, at 10.

23. Susan J. Forray & Chad C. Karls, *A Hardening Market Arrives in Time to Greet a Global Pandemic*, INSIDE MED. LIAB.: MED. PRO. LIAB. ASS'N, 2020, at 46 ("The year 2019 marked a turning point for medical professional liability."); *The Current State of the Medical Malpractice Market*, PRAC. OF MED., MAGMUTUAL (Jan. 15, 2020), https://www.magmutual.com/learning/article/current-state-medical-malpractice-market/ ("[T]he medical malpractice segment is transitioning back to a hard market."); *Observers Say Medical Liability Market Beginning to Harden as Higher Jury Awards, Eroding Tort Reform Sink In*, BEST'S NEWS & RSCH. SERV., AM BEST INFO. SERVS. (Dec. 23, 2019, 1:52 PM), https://news.ambest.com/newscontent.aspx?refnum=222664&altsrc=9 ("In 2019, the market transitioned to a hardening market."); *The Property/Casualty Underwriting Cycle (Shallower Market Peaks and Valleys Ahead)*, SPECIAL REP., FITCH RATINGS (Nov. 13, 2019, 3:19 PM), https://www.fitchratings.com/research/insurance/the-property-casualty-underwriting-cycle-shallower-market-peaks-valleys-ahead-13-11-2019 ("The P/C market is in a hardening pricing phase…").

24. 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%203.

25. Bendix, *supra* note 22, at 12.

26. *Id.*

27. *Id.*

28. *See* NAT'L ASS'N OF INSURANCE COMM'RS, REPORT ON PROFITABILITY BY LINE BY STATE 149 (2020) [hereinafter NAIC, PROFITABILITY 2020**] (**showing declining profitability in medical professional liability); AM BEST, BEST'S MARKET SEGMENT REPORT: US MEDICAL PROFESSIONAL LIABILITY INSURANCE MARKET REMAINS IN FLUX 1 (2020) (indicating that the medical professional liability segment faces a negative outlook for 2020).

29. NAT'L ASS'N OF INSURANCE COMM'RS, U.S. PROPERTY & CASUALTY AND TITLE INDUSTRIES: 2019 FULL YEAR RESULTS 6 (2020) [hereinafter NAIC, PROPERTY 2020**]**.

Commissioners conclude that "medical professional liability writers enter the pandemic in *the worst financial position in over a decade*."[30]

An equally pessimistic report came from AM Best—a highly respected global credit rating agency specializing in the insurance industry—in April 2020.[31] AM Best announced a "negative" outlook for the medical professional liability (MPL) sector in both 2020 and 2021 after the field had experienced "notable deterioration" in 2019 and faced several challenges going forward.[32] In its view, the sector enters its "*weakest point in almost two decades*" and faces "dim prospects for … profitability."[33] The pandemic has magnified these fears. AM Best, in particular, has expressed serious concerns about the impact of COVID-19 on medical errors and on the industry's ability to implement planned rate increases, as discussed further below.[34]

The villains for this new hard market have already been chosen. Since 2019, industry publications have identified "nuclear verdicts"[35] and "social inflation"[36] as the culprits. But the facts point to a different culprit—the insurance cycle.[37]

A. Profits are Disappearing

According to NAIC, the industry's profits have declined steadily since their peak in 2010.[38] Figure 1 shows the decline in profits using a common metric called Profit on Insurance Transactions.[39] It takes into account both premiums and investment returns.[40] Profit on insurance transactions peaked at 27.4% of premiums in 2010 and has fallen since then to only 2% of premiums in 2019.[41] This is the lowest level reported since the eve of the 2002 malpractice insurance crisis, also shown in Figure 1.[42]

30. *Id.* at 15 (emphasis added).

31. *About Us*, AM BEST, https://www.ambest.com/about/index.html (last visited Nov. 22, 2021).

32. AM BEST, *supra* note 28, at 1.

33. *Id.* at 1, 3 (emphasis added).

34. *Id*. at 1; *see infra* text accompanying note 152.

35. *E.g.*, Amy Buttell, *Nuclear Verdicts Escalate: Verdicts rise as more awards exceed 100M*, INSIDE MED. LIAB. (2021), https://www.mplassociation.org/Web/Publications/Inside_Medical_Liability/Issues/2021/Q1/Articles/Nuclear_Verdicts_Escalate_Verdicts.aspx.

36. HUNTER ET AL., *supra* note 10, at 16–18.

37. *See infra* Part III (explaining the mechanics of the insurance cycle).

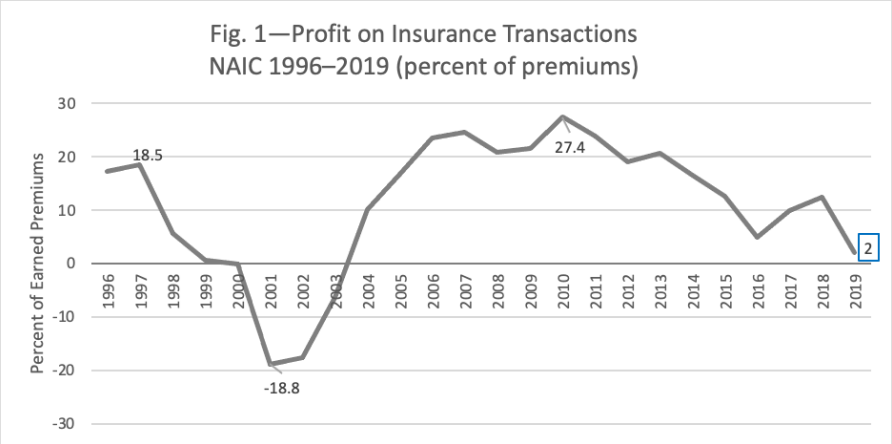
38. NAIC, PROFITABILITY 2020, *supra* note 28.

39. *Id.*

40. NATL. ASS'N. OF INSURANCE COMM'RS., REPORT ON PROFITABILITY BY LINE BY STATE IN 2011, at 5 (2012) [hereinafter NAIC, PROFITABILITY 2011] ("Profit on insurance transactions is equal to underwriting profits plus investment gain on insurance transactions minus estimated related federal income taxes."). It is commonly expressed as a percent of premiums. *Id*.

41. *See infra* Fig.1 (using data from 2019 which is the last set of data reported by NAIC).

42. *See infra* Fig.1.



If investment returns are set aside, the industry is *already* operating at a loss. Its premiums do not cover its operating costs (which include the costs of underwriting, selling, and settling claims), as shown in Figures 8 and 13, later in this article.[43] While Figure 1 shows that investment returns have preserved a 2% overall profit for the industry as of 2019, 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 they were when the 2001 crisis began. Likewise, the total amount spent by insurers to satisfy these claims dropped steadily from 2001 to 2010. Though the total spent has grown since then, the rate of growth has paralleled consumer and medical inflation. Here, too, the current levels are substantially below the levels from 2001.

1. A Sharp Drop in the Number of Claims

Patients are filing far fewer claims than they did before the last crisis.[44] A large 10-year analysis done by CRICO Strategies in 2018 found that claims dropped 27% in the ten-year period between 2007 and 2016.[45] The report analyzed over 124,000 MPL claims and reflected the MPL experience of over five-hundred hospitals and health care entities along with 180,000 physicians

43. NAIC, PROFITABILITY 2011, *supra* note 40, at 4.

44. *See infra* Fig. 8.

45. NAIC, PROFITABILITY 2011, *supra* note 40.

from commercial and captive insurers nationwide, representing approximately 30% of all United States medical malpractice claims and suits.[46] The report's authors called the decline "dramatic" and found that declines were "universal across many segments of health care delivery."[47] Overall, the frequency of litigation dropped from 5.1 cases per one hundred physicians to 3.7 cases.[48] OB/GYNs benefited the most with claims dropping 44%.[49]

This decline has mixed implications. While it may be good news for industry profits, it is a tragedy for victims of medical negligence since medical errors are not also declining.[50] 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.[51] Today, that fraction is even smaller.

2. A Declining Number of Paid Settlements

The number of paid claims against physicians and other health care practitioners declined steadily from 2001 to 2016 and has remained steady since then. As shown in Figure 2,[52] reliable data from NPDB show that the number of paid claims against all individual health care providers steadily declined after the 2001 crisis, shrinking from 19,772 paid claims in 2001 to 11,538 in 2019—a drop of 42%. For physicians alone (not shown), the decline has been even steeper, falling 47% between 2001 and 2019.[53]

46. *Id.* at 1.

47. *Id.* at 4.

48. *Id.*

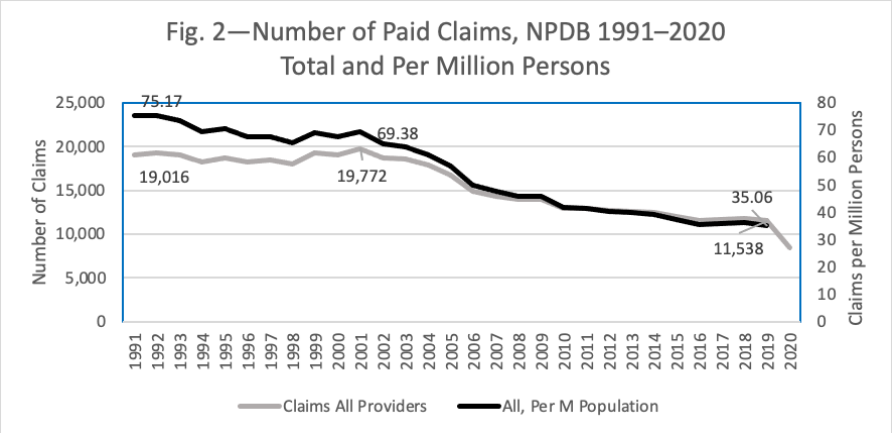
49. CRICO STRATEGIES, MEDICAL MALPRACTICE IN AMERICA: A 10-YEAR ASSESSMENT WITH INSIGHTS 4–5 (2018).

50. *Id.* at 12.

51. *Medical Liability: New Ideas for Making the System Work Better for Patients: Hearing on S. 1337 Before the S. Comm. On Health, Educ., Lab., and Pensions*, 109th Cong. 15 (2006) (statement of David Studdert, Associate Professor of Law and Public Health, Harvard University).

52. *See Data Analysis Tool*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/analysistool/ (last visited Mar. 8, 2021) (providing the number of health claims between 2001 and 2019). All payments made to settle claims against individual health care practitioners have been reportable to the NPDB since 1990. *Id.*

53. *Id.*



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% of the number of paid claims in that year.[54] When the statistics are adjusted to take population growth into account, the number of paid claims for all practitioners is now *less than half* of what it was in 1991 (47%).

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." [55] The study found that in 2014 one paid claim was reported each year for every one hundred physicians.[56] By 2019, only one claim was paid for every 28,572 Americans.[57]

These numbers, however, must be interpreted with some caution because the NPDB data have a weakness that may understate the number of claims paid on behalf of practitioners: payments on behalf of institutions, rather than individuals, need not be reported to the NPDB.[58] 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.[59] The extent of this corporate shielding is not yet known.

54. *Id.*

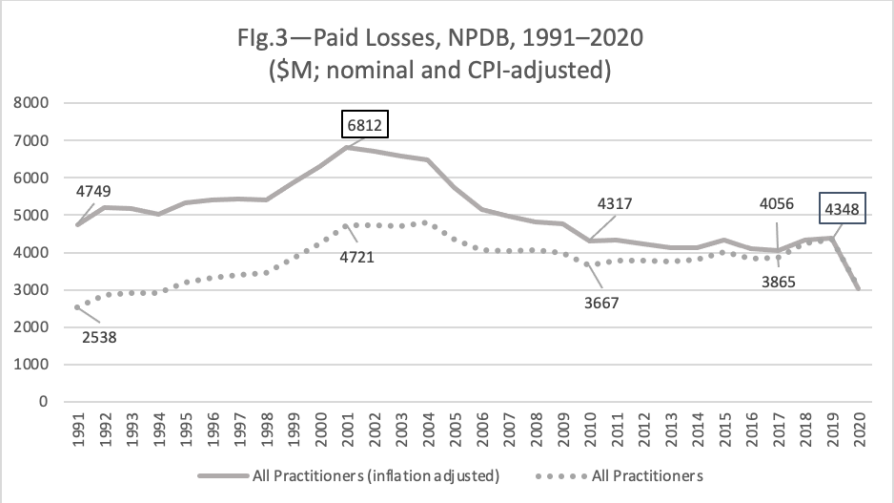
55. Schaffer et. al., *supra* note 4, at 712.

56. *See id.* at 710 (taking the number of paid claims in 2014—8.9 per 1000 physicians—and dividing it by ten).

57. *Data Analysis Tool*, *supra* note **Error! Bookmark not defined.**.

58. Schaffer et al., *supra* note 4, 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.

59. *Id*. at 714.



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 data sets presented by NPDB and AM Best.

Figure 3 displays NPDB data showing a steady climb in both the nominal and CPI-adjusted values of payouts from 1991 to 2001, leading up to the last crisis, and then an equally steady decline in both nominal and CPI-adjusted dollars from 2002 to 2010.[60] The decline in nominal payouts ended around 2011, but payouts in real dollars continued to fall until 2017.[61] In both nominal and real dollars, payouts reached their bottom in 2017 and then rose slightly in 2018 and 2019. In CPI-adjusted dollars, the total amount paid in 2019 accounted for only 64% of the total amount paid in 2001.

It is useful, at this juncture, to look back at Figure 1 and note that profits began a steady descent in 2010 that has continued to the present day. Yet, Figure 3 shows that tort payout levels were stable between 2010 and 2017. The paradox posed by these statistics will be discussed further in Parts III and IV.

As with the data on paid claims, corporate shielding may mean that NPDB data failed to detect a recent rise in payouts. That risk is partially mitigated by data from AM Best, shown in Figure 4,[62] which indicates that real payouts by the

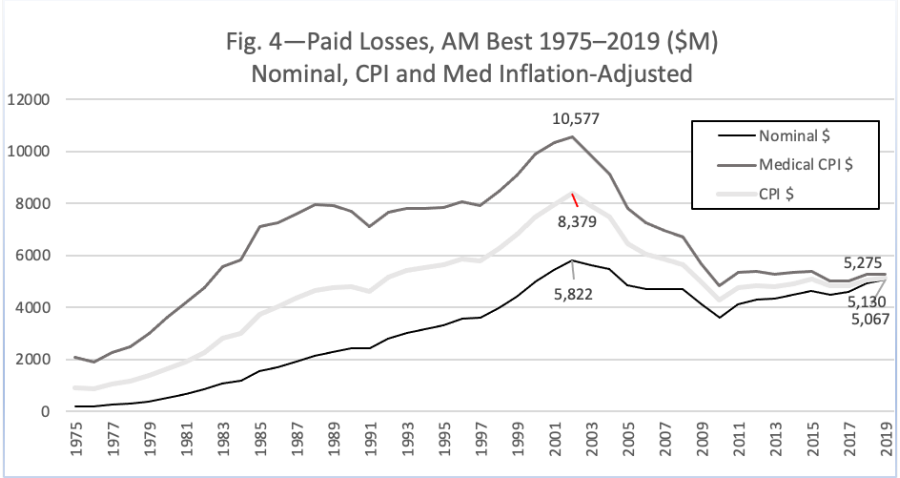
60. *Data Analysis Tool*, *supra* note 52.

61. *Id.*

62. HUNTER ET AL., *supra* note 10, at 24. *See generally* J. ROBERT HUNTER & JOANNE DOROSHOW, AMERICANS FOR INSURANCE REFORM, STABLE LOSSES/UNSTABLE RATES 2016, at 15 (2016) (reporting data used to create this figure). AM Best data for the last decade was provided to the author by AM Best staff.

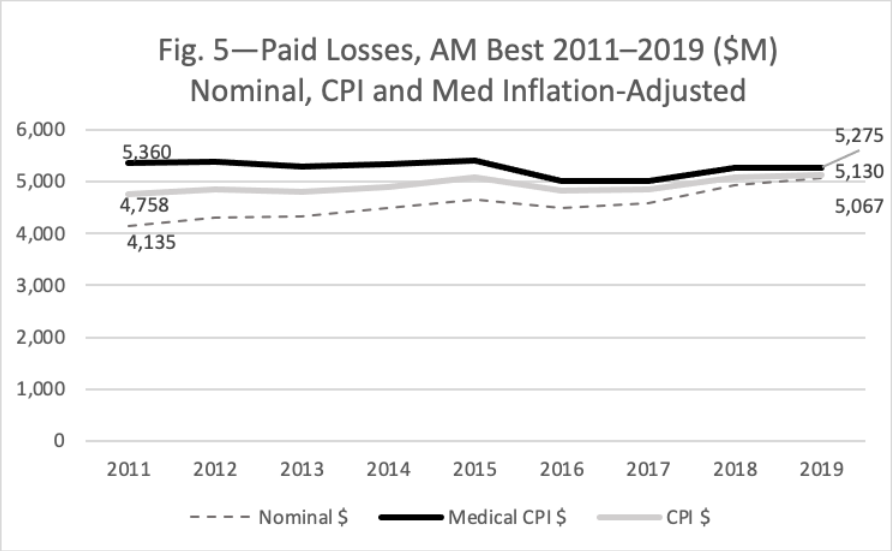
insurers shrank markedly from 2003 to 2011 and have risen quite gradually since then. The AM Best data, unlike the data from NPDB, include losses on liability insurance policies purchased by hospitals and other health care organizations, though it still does not include direct payments to claimants by self-insured health care organizations.

In the AM Best data set, shown in Figure 4, total paid CPI-adjusted losses in 2019 were 39% below their 2002 level.[63] In fact, the real payout levels of the last decade are the lowest since the early 1990s. When adjusted using the medical inflation index, payout levels are at their lowest level since the early 1980s.



But in the AM Best data, unlike the NPDB data, average payments in nominal dollars started rising in 2010–11,[64] as shown in Figure 5.[65] Since 2011, nominal payments rose 3% annually,[66] which is faster than consumer prices but slightly slower than the medical inflation that drives settlement costs up. These figures are consistent with the CRICO study of claims between 2007 and 2016, which found that median settlements rose along with consumer inflation, and that average payments outpaced consumer inflation but trailed medical inflation.[67]

63. *See supra* Fig. 4.
64. HUNTER ET AL., *supra* note 10, at 24; HUNTER & DOROSHOW, *supra* note 62, at 15.
65. Figure 5 was created with data shared by the CFA.
66. *See infra* Fig. 5.
67. CRICO STRATEGIES, *supra* note 49, at 8.



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 III, 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, a 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 regularly point to the growth of "nuclear verdicts" and the increasing severity of indemnity payments as the cause of declining profits.[68] 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."[69] In its annual survey, ASHRM/Aon found a "continual increase in large claim frequency of claims

68. Buttell, *supra* note 35.

69. Dwyer, *supra* note 21. *See also* Todd Shryock, *Which direction are malpractice rates headed and why?,* MED. ECON. (Sept. 27, 2019), https://www.medicaleconomics.com/view/which-direction-are-malpractice-rates-headed-and-why (noting both an increase and a surge in novel venues).

greater than $5M."[70] The CRICO study also found an increase in high-indemnity payments between 2007 and 2016, though it found they are "still rare."[71]

The perception that "nuclear" verdicts are driving down industry profits has given rise to complaints about "social inflation"—an alleged free-wheeling public attitude toward compensatory damages. In the spring of 2019, when the Consumer Federation of America (CFA) and the Center for Justice & Democracy (CJ&D) reviewed the language being used in the press, they found that references to nuclear verdicts and social inflation were still intermittent, but by late 2019, the entire industry seemed to have "gotten the memo."[72] This terminology has now made its way into the most respected industry publications. AM 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." [73]

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 a rate lower than medical inflation.[74]

Second, "nuclear" verdicts certainly do occur, perhaps more often than in the past and probably in new places.[75] But these awards, which are not common, are typically reduced, often substantially, by courts or in settlement before payment.[76] The CRICO study's findings mirror this sentiment:

> [E]xtraordinary 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.[77]

70. Virginia Jones et al., *Understanding Changes in the Medical Malpractice Insurance Market*, *in* AON/ASHRM HOSP. AND PHYSICIAN PRO. LIAB. BENCHMARK ANALYSIS 9, 9 (2019).

71. *See* CRICO STRATEGIES, *supra* note 49, at 9 (showing payments between $3 million and $11 million).

72. HUNTER ET AL., *supra* note 10, at 16.

73. AM BEST, *supra* note 28, at 23.

74. *See infra* Fig. 6.

75. *See, e.g.*, Shryock, *supra* note 69 ("[W]e're seeing, as an industry, more large verdicts in places that have never had one like that.").

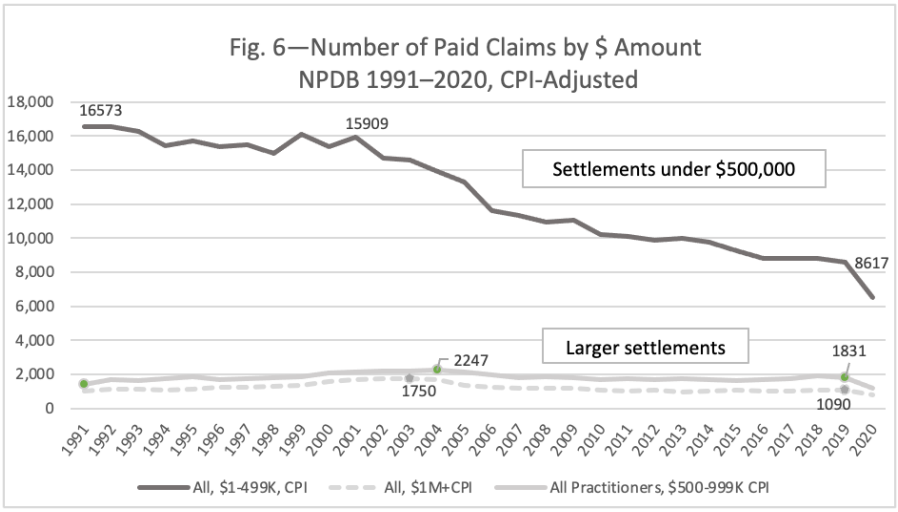
76. David A. Hyman et al., *Do Defendants Pay What Juries Award - Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988–2003*, 4 J. EMPIRICAL LEGAL STUD. 3, 5–7 (2007); Neil Vidmar, *Juries and Medical Malpractice Claims Empirical Facts versus Myths*, 467 CLINICAL ORTHOPEDICS & RELATED RSCH. 367, 373 (2009).

77. HUNTER ET AL., *supra* note 10, at 39–40 (quoting CRICO STRATEGIES, *supra* note 49).

Another industry publication observed that the largest verdicts do not "have an overall statistical effect on losses."[78]

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.[79] As a result, malpractice awards and settlements are strongly influenced by medical inflation. According to CRICO, the increase in median payment mirrors consumer inflation; furthermore, average payouts are rising more slowly than medical inflation.[80] As noted above, the AM Best data for the last decade show the same trend.[81] Since none of the parties complaining about the climb in damages are advocating for a cap on medical billing, it seems unfair to complain about payments that are driven in large part by the medical bills incurred to treat negligently injured patients.

Finally, the average settlement is rising because small medical malpractice claims are disappearing. The top line in Figure 6 shows the declining number of cases resolved for amounts under $500,000 in 2020 dollars.[82] Since 2001, their number has fallen 46%.



These smaller settlements have not been replaced by growth in larger settlements. As shown in Figure 6, large settlements constitute a surprisingly

78. Shryock, *supra* note 69 (quoting Bill Fleming).

79. *See* AM BEST, *supra* note 28, at 7 (pointing out the role of "rising medical loss costs" in driving loss ratios).

80. CRICO STRATEGIES, *supra* note 49, at 8.

81. *See supra* text accompanying note 66.

82. *See supra* Fig. 6.

small fraction of all claims and have remained a small fraction over the entire period.[83] The middle line shows settlements between half a million and one million dollars and the lowest line shows the number of settlements at or above one million in 2020 dollars.[84] Both categories have declined in frequency since their peak in 2003–04.[85] The number of settlements over one million in 2020 dollars has fallen by 38% since its peak in 2003.[86]

Small claims are also disappearing because malpractice cases have become extremely expensive to litigate.[87] As a result, plaintiffs' attorneys are screening their clients closely for large and readily proven economic loss.[88] That has caused an upward shift in the severity of claims being litigated which, in turn, should drive up the dollar value of the average settlement substantially.

To recap, fewer cases are being filed than ever before and smaller cases are dwindling dramatically, leading to fewer claims being resolved through settlement. Total payouts are significantly lower in real dollars than they were during the 2002 crisis. Why then is the malpractice insurance market hardening? That requires an understanding of the insurance business cycle.

III. 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. As explained in this Part III, the mechanics of the insurance business cycle 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 capitals.

In the insurance cycle, relatively long soft markets with low premiums swiftly transition into much briefer hard markets where premiums turn sharply upward.[89] 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.[90] Insurers can compete on price and still make robust profits due to the steep

83. *See supra* Fig. 6.

84. *See supra* Fig. 6.

85. *See supra* Fig. 6.

86. *See supra* Fig. 6.

87. NAIC, PROPERTY 2020, supra note 29, 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").

88. TOM BAKER, THE MEDICAL MALPRACTICE MYTH 59 (Univ. of Chi. Press, 2005) [hereinafter BAKER I]. *See* Schaffer et al., *supra* note 4, at 715 (noting that attorneys do not take small cases).

89. Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 436 (2005) [hereinafter *Baker II*].

90. *See infra* text accompanying notes 92–94.

premiums increase imposed during the panic of the hard market; in soft markets, insurers want premium dollars to invest.[91]

Investment returns are an especially important benefit of the MPL business model because MPL insurance has a longer gap between the sale of insurance and the payment of claims than most other lines of property and casualty insurance.[92] MPL insurers compete for premium dollars to invest by offering low prices and soft underwriting.[93] In fact, low premiums largely define a soft market.[94]

For a time, insurers can preserve profits by releasing surplus reserves that were accumulated during the last hard market.[95] At the peak of the 1975, 1986 and 2002 crises, for example, the industry overpredicted losses and, thus, excessively raised reserves and premiums.[96] This ultimately enabled insurers to extend the ensuing soft markets by gradually releasing redundant reserves to income.[97]

Figure 7 shows how the growth in reserves and premiums exceeded the growth of paid losses in 2002–06, providing a surplus which consequentially funded a soft market that has run from 2006 to the present.[98] In Figure 7, by comparing the steep increase in premiums and in reserves with the slight increase in payouts, we see that both premiums and reserves rose more than eventually was required.[99] As a result, premiums could be reduced during the ensuing soft

91. *Id.*

92. BAKER I, *supra* note 88, at 47.

93. *The Property/Casualty Underwriting Cycle*, *supra* note 23 ("Hard markets are fleeting as underwriting success attracts competition that leads to an erosion of favorable pricing conditions."). *See also* Sean Fitzpatrick, *Fear is the Key: A Behavioral Guide to Underwriting Cycles*, 10 CONN. INS. L. J. 255, 256 (2004) (explaining how insurers cut prices and loosen terms).

94. INS. INFO. INST., *Market Conditions: Cycles And Costs*, https://www.iii.org/publications/commercial-insurance/how-it-functions/market-conditions-cycles-and-costs (last visited Sep. 9, 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 II*, *supra* note 89, at 396.

95. HUNTER ET AL., *supra* note 10, 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 also* BAKER I, *supra* note 88, at 50 (explaining how the release of surplus reserves and strengthening of inadequate reserves affect profits).

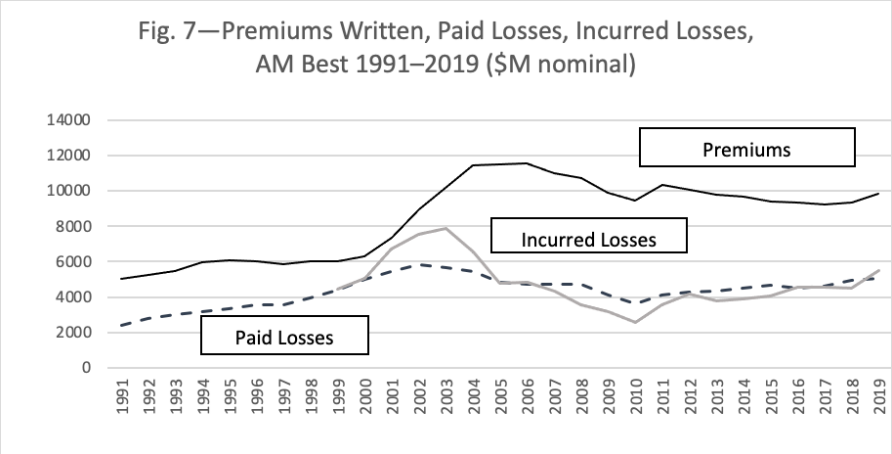
96. *See* BAKER I, *supra* note 88, at 53–54 (showing data for 1986 and 2001, and noting reports about 1975, but not data); HUNTER ET AL., *supra* note 10, at 7 ("[T]he extended soft market we have been in is also the result of excessive pricing and over-reserving that took place during the last hard market.").

97. HUNTER ET AL., *supra* note 10, at 2.

98. *See supra* note 63 (citing the sources of data in this article from AM Best).

99. *Id.* Incurred losses are the sum of loss payments and new reserves for future payments. *See* BAKER I, *supra* note 88, at 54 (noting the rise in incurred losses). Starting in 2001 and ending in 2005, incurred losses rose well above paid losses, reflecting a dramatic jump in reserves. *Id.* NAIC data show the same pattern: premiums and incurred losses rose far above paid losses. *Id.*

market to compete for market share and reserves could be released into income, thus preserving profits. The combination of the two revenue streams fueled the long soft market that is now ending. This also happened during the 1986 crisis, which suggests that this pattern is typical of the cycle rather than a circumstance that is unique to the 2001 hard market.[100]



Eventually, however, excess reserves are exhausted.[101] Meanwhile, inflation increases the cost of claims payments and operating expenses.[102] A soft market nears its end when these rising costs intersect with shrinking real premiums and the exhaustion of surplus reserves.[103] During that time, insurers are effectively selling coverage below cost.[104] Their predicament becomes dire when operational losses exceed investment returns, depleting surplus equity and reducing carrier ability to write new policies and to invest.[105] At this point, insurers need to raise premiums and reserves as the market moves from soft to hard.

Unfortunately for health care providers, the turn from a soft market to a hard one has always been sharp.[106] Afraid to be the first to raise premiums, insurers have typically tolerated eroding profits for several years, letting the

100. BAKER I, *supra* note 88, at 53–54.

101. *See* SCOTT E. HARRINGTON, *Tort Liability, Insurance Rates, and the Insurance Cycle*, *in* BROOKINGS-WHARTON PAPERS ON FIN. SERVS. 97, 101 (Robert E. Litan & Richard Herring eds., The Brookings Institution 2004) (declining profits leads to erosion of surplus).

102. *See infra* Part IV.B.1; Part IV.B.4.

103. *See infra* Part IV.B.1; Part IV.B.2.

104. *See Baker II*, *supra* note 89, at 396 (suggesting that selling below cost identifies a soft market).

105. HARRINGTON, *supra* note 101, at 119. *See* Fitzpatrick, *supra* note 93, at 261 (noting that robust interest rates can lengthen a soft market).

106. *See Baker II, supra* note 89, at 416 (showing that the transition is sharp).

pressure build.[107] When the pressure on profits is no longer tolerable, premiums spike, exploding like the cork in a bottle of poorly handled champagne. Unsurprisingly, doctors and hospitals are outraged and mystified; they question why the same coverage suddenly costs so much more.

The central puzzle of the insurance cycle is why carriers delay premium increases long enough for a crisis to ensue.[108] Tom Baker, a superb legal analyst of insurance markets, offers an explanation that emphasizes the psychology of insurance marketing and underwriting.[109] Baker's explanation also dovetails nicely with the industry view that highly competitive soft markets force carriers to keep premiums low. Due to this competition, when an insurer breaks from the pack, they lose business and market share.

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.[110] That fear puts pressure on the underwriters to keep their predictions of future losses low.[111] Low predictions of future losses keep reserve gathering low, enabling low premiums that fuel sales.[112] Indeed, these low premiums may be perceived as vital to be competitive.[113] This inclination is reinforced with employee pay incentives that reward increases in market share and the preservation of revenue, and do not reward calls for increased reserves or premiums.[114] These incentives extend all the way to the underwriters.[115]

Given the uncertainty associated with predicting future losses,[116] there is ample room for underwriter judgment to be affected. Consequently, carriers are "too optimistic about future losses for too long."[117] The result is a "winners curse" in which, the companies that win the market competition, have set prices so low that they have put themselves in financial danger.[118] Scott Harrington offers the possibility that only a few "aberrant" carriers are needed to lead the

107. *Id.* at 417. *See* HARRINGTON, *supra* note 101, at 119 (explaining how the industry delays its response).

108. HARRINGTON, *supra* note 101, at 119.

109. *Baker II*, *supra* note 89, at 417.

110. *See* BAKER I, *supra* note 88, at 56 (indicating a pressure to keep prices low).

111. *Id. See also* HARRINGTON, *supra* note 101, at 133 (noting revenue gains of the low-priced firms).

112. *See Baker II*, *supra* note 89, at 397 (explaining that insurers use these predictions to estimate the level of reserves needed).

113. BAKER I, *supra* note 88, at 57.

114. *Baker II*, *supra* note 89, at 419–20. Even mutual companies are likely to have a bias toward protection of market share. *Id.* at 420.

115. *Id.* at 418.

116. *See generally Baker II*, *supra* note 89 (indicating uncertainties including 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).

117. BAKER I, *supra* note 88, at 50.

118. *Id.* at 58; HARRINGTON, *supra* note 101, at 120.

market down, generating the winners curse effects.[119] As a result, other insurers then feel obliged to follow the market down to preserve market share and premium revenue.[120]

Underwriters may also be 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.[121] Interestingly, the CFA and the CJ&D believe that today's widening chorus of warnings about a "hardening" market and "social inflation" is one way carriers ask each other whether it is time to start raising premiums *en masse*.[122]

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 Property and Casualty (P/C) industry has experienced nearly the same ups and downs as medical malpractice insurance.[123] Each spike in premiums for the P/C industry perfectly matches one of the three crises in the medical malpractice industry.

For the MPL sector, at least, the long soft markets seem attributable to the success of optimistic sales forces over more pessimistic actuaries.[124] During the final stages of a soft market, new policies are underpriced and, to enable that, under-reserved.[125] This occurred before both the 1986 and 2002 hard markets.[126] 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 such an opting out.[127]

As a result, pressure builds until it erupts sharply in the twin scourge of higher premiums and greatly increased reserves. While these two steps staunch the insurance industry's bleeding, they do so by transferring the financial pain to

119. HARRINGTON, *supra* note 101, at 120.

120. *Id.*

121. *See* BAKER I, *supra* note 88, at 57 (stating that herd behavior is a partial explanation).

122. HUNTER ET AL., *supra* note 10, at 16–18.

123. James Lynch, FCAS MAAA, Chief Actuary, *P/C Industry Overview and Outlook*, Presentation at Buckeye Actuarial Continuing Education 25 (Oct. 19, 2018) (presentation available at https://www.iii.org/presentation/p-c-industry-overview-and-outlook-101818).

124. BAKER I, *supra* note 88, at 50; *Baker II*, *supra* note 89, at 394, 414.

125. BAKER I, *supra* note 88, at 50, 54 ("[T]he insurance industry systematically underreserved in the years leading up to the [1986] crisis."); *Baker II*, *supra* note 89, at 414, 394 (explaining how policies are under-reserved and how there is a delay in adjusting premiums).

126. BAKER I, *supra* note 88, at 51–52.

127. Milt Freudenheim, *St. Paul Cos. Exits Medical Malpractice Insurance,* N.Y. TIMES (Dec. 13, 2001), https://www.nytimes.com/2001/12/13/business/st-paul-cos-exits-medical-malpractice-insurance.html.

physicians and hospitals who, 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.[128] In the prelude to both the 1986 and 2002 hard markets, real indemnity payments had been rising, but only gradually and steadily.[129] In addition, interest rates on investments were declining before the 2002 hard market.[130] These factors put gradual pressure on the soft market's low premiums. Yet, those pressures were ignored and able to reach crisis levels because insurers delayed raising premiums. Eventually the cork popped, and prices skyrocketed.[131]

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 expenses. 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. This suddenness disrupts the business models of the policyholders, especially doctors in high litigation specialties, like neurosurgery and obstetrics, whose premiums jump the most.[132]

The practice of under-reserving also plays an important role in the volatility of the insurance cycle; it is intimately tied to the problem of underpricing.[133] 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 under-reserving that took place in the final years of a soft market in order to keep premiums down.[134] The readjustment of reserves is especially momentous in the MPL sector because its long tail of open policies leaves a large volume of

128. *See* BAKER I, *supra* note 88,. at 53–54 (showing—in Chart 1—losses increasing gradually, rather than spiking).

129. *See supra* Fig. 4 (showing steady growth in nominal payouts from 1975 to 2001).

130. HARRINGTON, *supra* note 101, at 102.

131. *Baker II*, *supra* note 89, at 436 (noting that price spikes are simply an integral part of the insurance cycle).

132. BAKER I, *supra* note 88, at 46.

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

134. *See* HARRINGTON, *supra* note 101, at 103, 133 (stating that loss estimates must be adjusted upward).

business open to reassessment.[135] The combination of larger reserves on new policies and readjustment of reserves on old policies explains why incurred losses rose so quickly during the lead into the 2002 hard market.[136]

The aforementioned 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 reserves conclude and the premium spikes have had their impact.[137] This sharp drop in profits—albeit brief—increases the surface credibility of regulatory requests for premium increases and tort reform.[138] Consumer advocates even argue that over-reserving is intended to manipulate regulators.[139] According to the CFA, "the reserve increases in the years 2001–04 could have accounted for 60 percent of the price increases witnessed by doctors during the period."[140]

Second, reserve readjustments push premiums up higher than necessary to pay the predicted cost of *new* policies since premiums must also be raised to fund additional reserves on *old* policies. Conceptually, the insurance companies should not possess the market power to charge customers for past losses.[141] New competitors, who lack those losses, can then underprice them. However, the MPL market has barriers to swift market entry that allow existing carriers to do catch-up pricing.[142] As a result, reserving practices push premiums higher than anticipated losses require, thus magnifying 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 reserves than was ultimately required to pay claims.[143] 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 reserves set-asides higher than necessary to cover the 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.

135. BAKER I, *supra* note 88, at 50; *Baker II*, *supra* note 89, at 399, 408; HARRINGTON, *supra* note 101, at 103.

136. *See supra* Fig. 7.

137. BAKER I, *supra* note 88, at 50.

138. HUNTER ET AL., *supra* note 10, at 4.

139. *Id.*

140. HUNTER & DOROSHOW, *supra* note 62, at 10.

141. *Baker II*, *supra* note 89, at 414.

142. *Id.* at 413–14.

143. *See* BAKER I, *supra* note 88, at 54 (noting overprediction of losses); HARRINGTON, *supra* note 105, at 103 (showing in fig.4 that reported incurred losses rose far above actual developed losses before the 1986 and 2002 hard markets).

As a practical matter, these reserving practices are hidden from legislators and journalists as 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."[144] 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. In actuality, *reserves* have skyrocketed.[145] The extra reserves are just projections—human estimates of future losses.[146] These predictions are subject to all the ordinary human biases, including systematic optimism of the soft market and the overly pessimistic turn of the hard market.[147]

Ironically, the spiked premiums and growing reserves virtually guarantee high profits in the years immediately following the hard market's peak.[148] In fact, high profits are how Finch defines a hard market.[149] After the 2002–04 crisis, for example, the sector posted "record profits in 2007."[150]

Part IV will tackle the question of whether pressure is building for the next hard market.

IV. 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.[151] Premiums are climbing. Market forecasts are overwhelmingly negative.[152] Industry experts fear that COVID-19 will make matters worse. Their prognosis is so sour that they have already chosen the villain for this hard market: "social inflation."[153] Still, we may have time to avoid a full-scale crisis.

144. *See* Julia Kagan, *Losses Incurred* (July 23, 2021), https://www.investopedia.com/terms/l/losses-incurred.asp (last visited Dec. 1, 2021) (stating that incurred losses include "changes to loss reserves").

145. *See supra* Fig. 7 and accompanying text.

146. *See supra* text accompanying notes 103–117.

147. *See supra* text accompanying notes 103–117.

148. Fitzpatrick, *supra* note 93, at 256; INS. INFO. INST., https://www.iii.org/publications/commercial-insurance/how-it-functions/market-conditions-cycles-and-costs (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.").

149. *See The Property/Casualty Underwriting Cycle*, *supra* note 23 (equating high profits with a hard market). A hard market in the broad U.S. industry, with market conditions consistent with returns on capital above required rates, represents an uncommon occurrence." *Id*.

150. HUNTER & DOROSHOW, *supra* note 62, at 11 (citing *Solid Underwriting Undercut by MPLI's Investment Losses*, *in* AM BEST: BEST'S SPECIAL REPORT (2009)).

151. *See supra* Fig. 1 and *infra* Fig. 8.

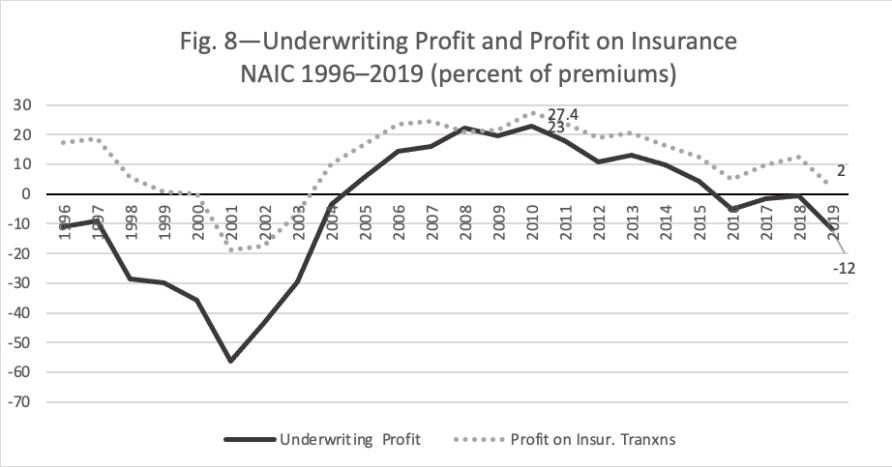
152. *See supra* text accompanying notes 20–34.

153. *See supra* notes 35–36.

A. The Long Soft Market is Ending

Between 2006 and 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 and reserves had grown quite dramatically.[154] As a result, the MPL industry enjoyed "decades of soft market conditions, driving competition for buyers and insurers." [155] That competition led to "[l]ow premiums, abundant capacity, and relaxed underwriting guidelines" which "allowed insurers to aggressively compete for increased market share."[156] Industry premiums steadily fell in unadjusted dollars until 2017.[157] For a while, insurers' large reserves allowed them to preserve profitability by gradually releasing reserves into income.

By 2014–16, the soft market was coming to an end. The sector's operating costs finally rose above its premium revenues. NAIC data show that underwriting profit had turned to underwriting loss in 2016, as shown in Figure 8. Unlike "profit on insurance," "underwriting profit" does not include investment gains, thus revealing that premiums have fallen below operating expenses.[158] The dotted line, which shows profit from insurance transactions, takes investment returns into account. AM Best, too, reported that MPL has experienced "aggregate underwriting losses in the past four years."[159]



154. *See supra* Fig. 1, Fig. 7.

155. Jones et al., *supra* note 70, at 9.

156. *Id.*

157. *E.g.*, Forray & Karls, *supra* note 23, at fig. 1. Loss of market to self-insurance could account for some of that decline. *Id.*

158. NAIC, PROFITABILITY 2020, *supra* note 28.

159. AM BEST, *supra* note 28, at 6.

Moreover, the combined ratio, another frequently cited profitability metric, went negative even earlier, in 2014.[160] Like the other metrics, it compares operating costs to premium revenue, but takes dividends into account. Thus, it shows a slightly more negative outlook than underwriting profits.[161] 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.[162]

Only the industry's investment returns have kept the sector profitable, as indicated on the dotted line in Figure 8, which shows profit from insurance transactions, a metric which considers investment income.[163] But by 2019, that measure of profitability had decreased to 2 percent. If this downward trend continues,[164] profit on insurance transactions will soon fall into negative territory—a place last visited in the hard market of 2002.

In addition, industry sources say that reserves have been steadily shrinking and now offer less protection against low operating profits.[165] That, too, is consistent with the end of a soft market.[166] In 2020, NAIC delivered 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.[167]

Finally, industry experts detect growing pressure for the industry to raise premiums.[168] In 2019, the Journal of Risk and Insurance lamented that "The Reckoning is Here for the Medical Professional Liability Market," noting "a decade's worth of price erosion."[169] Leo Carroll, the Senior Vice President and

160. NAIC, PROPERTY 2020, *supra* note 29, at 7.

161. Combined ratios turned negative somewhere between 2014 to 2016 depending on the data source, as shown in fig.13.

162. *Id.*

163. NAIC, PROFITABILITY 2020, *supra* note 28.

164. *See supra* Fig. 8.

165. AM BEST, *supra* note 28, at 9.

166. *Id.* at 5

167. NAIC, PROPERTY 2020, *supra* note 29, at 6. Page 7 shows a negative combined ratio since 2014. *Id*. at 7.

168. Amy Buttell, *Reinsurers Adjust to the Hardening Market, Pandemic: Nuclear verdicts, depressed margins weigh on industry,* INSIDE MED. LIAB. (2020).

169. *See* Dwyer, *supra* note 21 (stating that rates are increasing for providers, but especially for hospitals); José R. Guardado, *Policy Research Perspectives: Med. Prof. Liab. Ins. Pemiums: An Overview of the Market from 2010 to 2019*, *in* AM. MED. ASS'N POL'Y RSCH. PERSPS. 4 (American Medical Association ed., 2020), https://www.ama-assn.org/system/files/2020-02/prp-mlm-premiums.pdf [hereinafter *Guardado I*] (indicating that 26.5% of surveyed physicians reported increased premiums in 2019, the most since 2006, while only 5.1% of reported decreased premiums, the lowest in 10 years.").

Head of Healthcare at Berkeley Hathaway Specialty Insurance, concluded that the industry had waited too long to respond to its profitability challenges:

> 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*.[170]

AM Best's 2020 report found that "MPL insurers have been feeling rate pressure for several years."[171] The widely used national survey of physicians by Medical Liability Monitor found that the transition had already begun. In 2019, 26.5% of surveyed physicians reported increased premiums after a long period of being stable or even falling.[172] Similarly, a recent panel of experts urged caution "as claims increase and medical malpractice insurance rates surge."[173] Jean-Paul Rebillard, the president of a unit of Berkshire Hathaway, opined that "we find ourselves at an inflection point in the market cycle."[174]

A report from the Medical Professional Liability Association (MPLA) supports these observations, stating that "[r]ates 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."[175] A 2019 report from the American Society for Health Care Risk Management (ASHRM) 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."[176]

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 continued to rise in 2019 and 2020.[177] AM Best found that premiums collected from physicians grew in 2019, even though physicians migrated to

170. Dwyer, *supra* note 21.

171. AM BEST, *supra* note 28, at 5.

172. *Guardado I*, *supra* note 169, at 4.

173. Gavin Souter, *Captive Owners React to Hardening Medical Malpractice Market,* BUS. INS. (Jan. 28, 2020, 6:04 PM CST), https://www.businessinsurance.com/article/20200128/NEWS06/912332796/Captive-owners-react-to-hardening-medical-malpractice-market-World-Captive-Forum.

174. *Id*.

175. Forray & Karls, *supra* note 23, at 47.

176. Jones et al., *supra* note 70, at 14.

177. NATL. ASS'N. OF INSURANCE COMM'RS, COUNTRYWIDE SUMMARY OF MED. PROF. LIAB. INS., CALENDAR YEARS 2005–2019, at 1 (2020); NATL. ASS'N. OF INSURANCE COMM'RS, COUNTRYWIDE SUMMARY OF MED. PROF. LIAB. INS, CALENDAR YEARS 2004–2018, at 1 (2019); *Medical Malpractice Loss Trends: Data at a Glance*, CIPR NEWSLETTER (Center for Insurance Policy Research, NAIC), Aug. 2015, at 19–20; *Data at a Glance*, CIPR NEWSLETTER (Center for Insurance Policy Research, NAIC) July, 2013, at 29–30; AM BEST, *supra* note 28, at Ex. 2. *See supra* Fig. 7 (showing AM Best data on premiums for entire industry); Forray & Karls, *supra* note 23, at 47.

hospital employment in 2019, suggesting that premium *rates*—not just premiums collected—are climbing.[178]

Recently, the AMA released the results of a 2020 survey of physicians by the Medical Liability. In 2020, 31.1% reported an increase in premiums—more than any year since 2005.[179] Because the increase follows jumps of 13.7% in 2018 and 26.5% in 2019,[180] the AMA concluded the current upward trend is one "not seen in over 20 years." Although these numbers are still much lower than the rate of increase that occurred in the thick of the last crisis, the AMA saw the "early stages of a hard market."[181]

Today, redundant reserves are dwindling, premiums are starting to inch upward, and profits are near zero even after taking investment gains into account. Thus, the market for medical malpractice insurance is hardening. So, what are the factors that are driving profits down? Can we have a soft landing? And finally, 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 the industry's major expenses and income streams. Sustained adverse trends for any combination of them can put material pressure on premiums. This Section B 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 to steadily decline until 2018.[182] Cumulatively, premiums declined 35% since 2006 in adjusted dollars and 22% in unadjusted dollars, as shown above in Figure 7.[183] According to the MLPA, "premium decreased by $1.1 billion between 2006 and 2016—approximately 20% of the premium written at the beginning of that decade."[184] "To put that in perspective," observed the MPLA, "consider that in

178. AM BEST, *supra* note 28, at 5; Forray & Karls, *supra* note 23, at 47 ("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.").

179. *Medical Library Market Research*, AM. MED. ASS'N, https://www.ama-assn.org/practice-management/sustainability/medical-liability-market-research (last visited May 5, 2021); Jose R. Guardado, *Policy Research Perspectives*, *in* AM. MED. ASS'N 2 (2021), https://www.ama-assn.org/system/files/2021-03/prp-mlm-premiums-2020.pdf [hereinafter *Guardado II*].

180. *Guardado II*, *supra* note 179, at 2.

181. *Medical Library Market Research*, *supra* note 179, at 3.

182. *See supra* Fig. 7.

183. *See supra* Fig. 7.

184. Forray & Karls, *supra* note 23, at 47.

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%."[185]

At first, indemnity payments were shrinking in equal amounts, so profits remained near record highs despite the decline in premiums.[186] But the sharp decline in payouts ended in 2011.[187] At about the same time, paid losses and operating expenses both began to rise gradually in nominal (unadjusted) dollars.[188] Nevertheless, premiums continued to drop in nominal dollars until 2018 and then rose only modestly.[189] 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.[190] True to the textbook insurance cycle, the industry has allowed pressure on premiums to build.[191]

2. Exhaustion of Surplus Reserves

The industry maintained its profitability during the last half of this soft market, in part, by releasing redundant reserves.[192] However, releases have been getting smaller over the past few years; the Industry Trade Association concluded that "redundant reserves have been depleted."[193] According to AM Best, "reserve releases will no longer be sufficient to prop up the segment's calendar year results.[194] Berkshire Hathaway executive Leo Carroll put it another way: "[r]eserve redundancies are diminishing from prior years, so the market is no longer able to mask actual current year results."[195]

According to AM Best's calculations, over two-thirds of the deterioration of the combined ratio in 2019 was attributable to the release of fewer reserves.[196] If not for that release of reserves, the industry would have fallen into the red.[197] These facts justify the conclusion that shrinking reserve redundancies are a

185. *Id.*

186. *See supra* Fig. 1, Fig. 7.

187. *See supra* Fig. 1, Fig. 7.

188. *See supra* Fig. 1, Fig. 7.

189. *See supra* Fig. 7 (showing that the sole outlier year was 2011).

190. *See supra* Fig. 1.

191. *See supra* Part IV.B.4 (discussing payouts and premiums).

192. Forray & Karls, *supra* note 23, at 49.

193. *Id.*

194. AM BEST, *supra* note 28, at 9.

195. Dwyer, *supr*a note 21.

196. *See* AM BEST, *supra* note 28, at 8 (accounting for 8 points of an 11-point drop) and 9 (noting "erosion of reserve redundancies").

197. Forray & Karls, *supra* note 23, at 49 ("[T]he operating ratio of 97% would have pierced 100%, making the industry unprofitable.").

significant contributor to declining industry profits. Their apparent exhaustion will greatly increase the mounting pressure to raise premium 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.[198] These weakening returns probably contributed to the decline in profits over the past decade. Nevertheless, declining premiums and depleted reserve redundancies likely 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.[199] According to AM Best, indemnity payments have grown 20% in nominal dollars since 2011 (about 3% annually), but have been predominantly flat over the past decade after they are indexed to reflect the medical purchasing power of the settlements.[200] CRICO also found that increases fell below the rate of medical inflation.[201]

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."[202] Thus, the recent gradual inflation of indemnity payments has put pressure on profits because the industry has chosen not to pass them on to its customers; instead, the pressure is being allowed to build.

5. Rising Costs of Defending, Underwriting and Selling

The cost of selling policies and defending claims has grown slowly but steadily over the past decade as a percentage of premiums. The combination of internal claims adjustment and outside defense cost is called the loss adjustment

198. NAIC, PROFITABILITY 2020, *supra* note 28; NAIC, PROFITABILITY 2008, at 38; NAIC, PROFITABILITY 2016, at 38.

199. *See supra* Fig. 3.

200. *See supra* text accompanying note 32 (describing nominal payment data).

201. CIRCO STRATEGIES, *supra* note 49.

202. HUNTER ET AL., *supra* note 10, at 18. BEST also places some of the responsibility on medical inflation. AM BEST, *supra* note 28, at 7 ("Rising medical loss costs . . . had pressured loss and LAE ratios over the last few years.").

expense (LAE).[203] According to NAIC, LAE consumed 7.3 more cents of every premium dollar in 2019 than it did in 2010.[204] Costs of selling insurance also rose, consuming an extra 3.2 cents of each premium dollar.[205] Together, they accounted for about ten points in the drop of the underwriting profit ratio, which fell twenty-four points between 2010 and 2018 and another eleven points in 2019.[206]

By 2019, defense costs consumed a remarkable 30% of every premium dollar and selling expenses used 12%.[207] 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. Yet, premiums steadily declined.[208]

6. Adding It All Up

Although claims are substantially below their peak in 2001–02 and real 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 an increase in defense costs and sales costs, the exhaustion of reserve redundancies, a decline in investment returns, and the ongoing impact of medical inflation on indemnity payments; yet real premium volume still mirrors the level it was at in 2000. AM Best reached the following conclusions about current pressures on profitability:

> 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) . . . 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.[209]

203. *Loss Adjustment Expense Law and Legal Definition*, USLEGAL, https://definitions.uslegal.com/l/loss-adjustment-expense/ (last visited Nov. 21, 2021).

204. *See* NAIC, PROFITABILITY 2010, at 38; NAIC, PROFITABILITY 2019, at 40.

205. NAIC, PROFITABILITY 2020, *supra* note 28. Data from AM BEST cover fewer years but show a similar upward trend in underwriting expenses. *See* AM BEST, *supra* note 28, at Ex. 5 (underwriting expense ratios increasing from 23.7% in 2015 to 25.6% in 2019).

206. *See supra* Fig. 8.

207. NAIC, PROFITABILITY 2020, *supra* note 28.

208. *See supra* Part IV.B.1.

209. AM BEST, *supra* note 28, at 5–7.

The AM Best study concluded that "reserve releases will no longer be sufficient to prop up the segment's calendar year results."[210] Consequently, prices will need to rise.[211]

The MPL sector may once again have waited too long to raise its premiums. Industry defenders contend that there is always considerable guesswork in determining when a soft market has ended.[212] For example, 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."[213] However, the analysis untaken in this article shows that carriers now have the tools to recognize the signs and to determine when prudent preventive action should be taken.[214]

After the 2002 hard market, Lloyd identified the insurance cycle as the top challenge facing the insurance industry and undertook an extensive study.[215] In a 2006 report *Managing the Insurance Cycle*, it identified seven key steps, including the following two:

> [1] Don't follow the herd. Insurers need to be prepared to walk away from markets when prices fall below a prudent, risk-based premium . . . [2] 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.[216]

Both recommendations emphasize better market discipline when prices are falling too low, including the removal of employee incentives to prioritize market share over profitability.

Rolf Tolle, Lloyd's Director of Franchise Performance, added that, "[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.[217] But at Lloyd's we believe that insurers now have the information and the tools they need to manage

210. *Id.* MPLA also emphasized the impact of depletion of redundant reserves. Forray & Karls, *supra* note 23, at 48.

211. *Id.* at 9 ("pricing will be needed to generate improved calendar year underwriting results").

212. *See supra* note 111 (laying out the many sources of uncertainty).

213. Julia Kagan, *Underwriting Cycle,* INVESTOPEDIA (July 31, 2021), https://www.investopedia.com/terms/u/underwriting-cycle.asp.

214. Several other commentators have called for more discipline from carriers in underwriting and pricing. *Id.*

215. *Seven Steps to Managing the Cycle*, INSURANCE-CANADA.CA (July 12, 2006), https://www.insurance-canada.ca/2006/07/12/seven-steps-managing-cycle/.

216. *Id*. The seven steps are: don't follow the heard, 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*.

217. *Id.* (quoting Rolf Tolle).

the cycle much more effectively."[218] Tolle concluded that "[t]here is nothing complex about the cycle. It is about having the courage of your convictions to act with strength."[219] 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."[220]

However, the insurers who are first to raise premiums are likely to lose customers.[221] Lloyds believes that carriers should walk away from a line of business when these conditions are present. However, the CFA and the CJ&D offer a different solution—more regulatory scrutiny during rate setting, especially during the transition into a hard market; but only a few states have taken that step.[222] New York reportedly experienced some success moderating the cycle by limiting price increases in hard markets and price decreases in soft markets.[223] While more experimentation of this kind is needed, New York unfortunately ended its efforts in 2004. As a third option, Tom Baker and I each proposed adopting exclusive enterprise liability.[224] Shifting tort liability exclusively to hospitals and integrated health care organizations will transfer liability to parties who are better able to buffer themselves against the disruptions of the insurance cycle. Collective enterprise liability will also spare high-risk specialists from shouldering a disproportionate share of the health care system's liability costs. It might also dampen the extraordinary anger felt by the physicians who practice in those specialties. At present, the industry is gradually evolving in this direction,[225] but it's not clear whether the trend will continue.[226]

The fourth and most appealing option is self-insurance for health care organizations that can afford it; an organization which insures itself and its providers is no longer subject to the cycle because the organization is not competing in the insurance market and, thus, is not facing existential pressure to

218. *Id.*

219. *Insurance Cycle*, HANDWIKI, https://handwiki.org/wiki/Insurance cycle (last visited Mar. 21, 2021).

220. Kagan, *supra* note 213.

221. BAKER I, *supra* note 88, at 57.

222. *See* EMILY GOTTLIEB & JOANNE DOROSHOW, BRIEFING BOOK MEDICAL MALPRACTICE: BY THE NUMBERS 71–73 (2020) (describing laws in California and Illinois). AM Best also recommends innovation to reduce defense costs. AM BEST, *supra* note 28, at 23.

223. *Id.*

224. BAKER I, *supra* note 88, at

225. *See* Carol K. Kane, *Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020 in* AM. MED. ASS'N POL'Y RSCH. PERSPS. 7–8 (American Medical Association ed., 2021) [hereinafter *Kane I*] (indicating that in 2020, 50.2% of physicians were employees and 40% worked for hospitals).

226. Carol K. Kane, *Policy Research Perspectives Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees in* AM. MED. ASS'N POL'Y RSCH. PERSPS. 7 (American Medical Association ed., 2019) [hereinafter *Kane II*] ("[C]aution should be taken in assuming current trends will continue indefinitely").

match price cuts. Instead, each health care system can raise and lower its reserves each year to reflect the ebb and flow of its claims experience, expenses, and investment returns. Consequently, the organization is no longer faced with periodic inexplicable spikes in premiums.

In the meantime, however, the insurance cycle continues. Brief explosive corrections follow periods of cutthroat competition and widespread underpricing.[227] The market is on the verge of that transition once again. Gradual growth in all expenses (including underwriting, selling, defending, and indemnifying), coupled with a gradual decline in all revenue streams (premiums, reserve releases, and investment returns) places growing and continuing pressure on profits.

C. Will There Be a Soft Landing?

Despite a hardening market, some industry representatives believe that risk of a crisis is lower today than immediately before the crisis of 2002. For example, Bill Burns and Alyssa Gittleman of the global investment management firm Conning, highlight increased policyholder surplus and the prominence in reinsurance coverage today in comparison to the market in 2002.[228]

Reinsurance hedges against losses and frees up capital to write more insurance contracts.[229] Its increased use today should provide some protection for retail carriers to the modest extent that indemnity payments drive the loss of profits.[230]

Policyholder surplus also provides a margin of safety against unexpected losses. In a publicly held company, this is called equity or net worth.[231] In 2019, the MPL sector's unrealized capital gains lifted industry surplus about 4.3% to $18.8 billion, despite the existence of an underwriting loss for the year.[232] According to data from the MPLA, policyholder surplus is three times larger today than it was in 2001.[233] Theoretically, these surpluses could be used to

227. *See supra* Part III.

228. *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 (Oct. 3, 2019), https://www.prweb.com/releases/medical_liability_monitors_2019_annual_rate_survey_indicates_a_medical_malpractice_insurance_premiums_rising_but_are_we_headed_for_a_real_hard_market/prweb16617262.htm. 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. *Id.*

229. Caroline Banton, *Reinsurance*, INVESTOPEDIA, https://www.investopedia.com/terms/r/reinsurance.asp (July 30, 2020).

230. However, anecdotal accounts of reinsurers leaving the MPL sector have surfaced. *See* Buttell, *supra* note 35 (interviewing Andy Firth, president of MIEC, a mutual MPL insurer).

231. AM BEST, *supra* note 28, at 11–12.

232. *Id.* In MPLA's annual survey, surplus rose about three percent in 2019 from about $13.6 billion to $14.0 billion despite the year's underwriting losses. Forray & Karls, *supra* note 23, at 49.

233. Forray & Karls, *supra* note 23, at 49.

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.[234] St Paul was the largest carrier in the market and stranded over forty-thousand physicians.[235] In 2003, Farmers Insurance Company exited the market as well.[236] Thereafter, "the market stiffened up and prices went up."[237] Nothing on a similar scale has occurred in recent years.

The MPLA also identifies other factors which could temper the transition. For example, lower claims frequency levels in today's market "ha[ve] 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."[238] The authors of that report, Forray and Karls, further explain:

> 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.[239]

"What makes the last ten years different," adds AM Best, "is that the deterioration [in underwriting profits] has been gradual rather than sudden."[240]

In addition, the COVID-19 pandemic may make it politically inexpedient for insurance companies to dramatically raise premiums for physicians and hospitals. This public relations obstacle could force carriers to use their available surplus to subsidize more gradual increases in premiums than would otherwise occur.

234. Shryock*, supra* note 69.

235. Bruce Japsen, *Why Doctor Malpractice Premiums Stopped Rising*, FORBES (Oct. 10, 2018, 8:46 AM), https://www.forbes.com/sites/brucejapsen/2018/10/10/why-doctor-malpractice-premiums-stopped-rising/?sh=603e0711517b; Charles A. Wilhoite & Scott R. Miller, *The Transitioning Medical Professional Liability Market—Challenges in Valuing a Medical Professional Liability Company*, WILLAMETTE MGMT. ASSOCS.: INSIGHTS 85 (Summer 2013).

236. Wilhoite & Miller, *supra* note 235, at 85, 86.

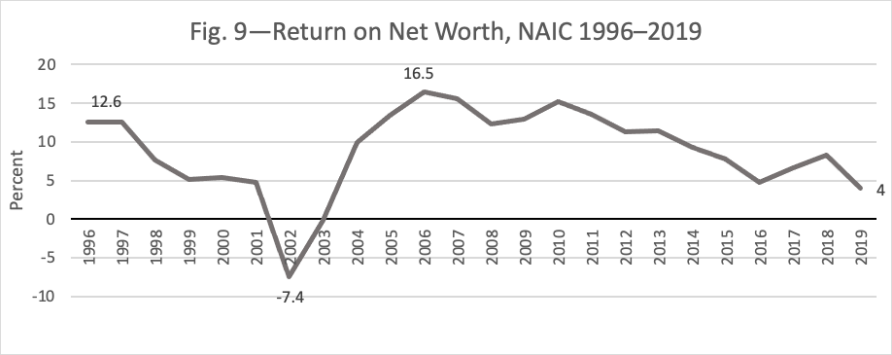
237. Shryock, *supra* note 69.

238. Forray & Karls, *supra* note 23, at 48, 50.

239. *Id.* MPLA qualifies its hope for a soft landing by warning that "certain market segments are likely to experience double-digit rate increases during 2020 and perhaps 2021." *Id.* at 50.

240. AM BEST, *supra* note 28, at 13.

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 a soft to a hard market. Figure 8, above, shows that the difference between the gradual profit decrease from 2010 to the present has not yet reached the deep losses that occurred in 2002.[241] At the end of 2019, the sector also maintained a positive return on net worth, as shown in Figure 9, below. Both metrics fell much further during the last hard market.[242] The current moderate decrease suggests that the MPL sector may have time to raise premiums and reserves gradually, rather than steeply. And the current cross-talk about social inflation encourages sector-wide price increases, rather than risky, individual actions.



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

> [I]f 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 . . . 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.[243]

In short, the market may experience a softer landing in the coming years than it did during the 2002 shift due to lower payout levels, gradual rather than sudden profit erosions, increased reinsurance utilization, substantially larger industry surplus, current politics, and early warnings. However, the impact of the COVID-19 pandemic on malpractice litigation remains a wild card.

241. *See infra* Fig. 8; AM BEST, *supra* note 28, at 13.

242. *See supra* Fig. 9.

243. Shryock, *supra* note 69.

D. The Wild Card: COVID-19

The possibility of an insurance crisis is amplified by the uncertainty resulting from the COVID-19 pandemic. Both NAIC and AM Best believe the pandemic poses a serious risk to the industry.[244] 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 were altered or relegated to telemedicine.[245]

AM Best thoroughly examined the risks posed by the pandemic. Its assessment is very pessimistic and emphasizes how providers became and have remained overwhelmed during admission surges of patients with serious conditions.[246] The surges have caused hospital overcrowding, shortages of intensive care beds, and the use of makeshift facilities.[247] Rising patient-to-doctor ratios meant that exhausted providers continuously worked more hours on little rest.[248] Delays in treatment and reliance on telemedicine became more common, both of which raise the risk of missed diagnoses.[249] In addition, the provider shortage forced the recruitment of less experienced providers who were not trained in the treatment of infectious diseases.[250] Hospitals struggled with inadequate supplies, staffing, and hospital space.[251] Law professor Nicolas Terry's analysis identifies a similar set of risks and adds improvised equipment and untested drug use.[252] Each of these factors increase the likelihood of additional medical errors.

Overall AM Best is pessimistic, concluding that the "already dim prospects for the segment's profitability have been clouded by COVID-19."[253] The Medical Professional Liability Association believes the coronavirus has "brought the arrival of a hardening market."[254]

Yet, several factors could prevent a pandemic-related surge in claims. AM Best concedes that the current sentiment toward health care providers, the absence of a well-established standard of care, and the enactment of tort immunity legislation may stave off an intense claim surge.[255] AM Best even

244. NAIC, PROPERTY 2020, *supra* note 29, at 6; AM BEST, *supra* note 28, at 1–2, 10.

245. NAIC, PROPERTY 2020, *supra* note 29, at 15.

246. AM BEST, *supra* note 28, at 1. AM Best also worries about the impact on provider ability to pay premiums. *Id.* at 3.

247. *Id.* at 1.

248. *Id.*

249. *Id.* at 2.

250. *Id.* at 1.

251. *Id.*

252. NICOLAS P. TERRY, ASSESSING LEGAL RESPONSES TO COVID-19, 199, 200 (Scott Burris et al. eds., 2020) [hereinafter TERRY I].

253. AM BEST, *supra* note 28, at 3.

254. Forray & Karls, *supra* note 23, at 50.

255. AM BEST, *supra* note 28, at 2–3.

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."[256]

Law professor Nicholas Terry conducted a thorough review of state and federal immunity laws and found The Public Readiness and Emergency Preparedness Act of 2005 remains the only important, federal-level shield.[257] The act governs "covered countermeasures," such as drugs, devices, personal respiratory protective devices, and vaccines.[258] The Department of Health and Human Services (HHS) ruled that the Act's protections also cover the decision against countermeasure usage, but at least one district court disagreed.[259] Even if HHS's position is ultimately affirmed by the courts, 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. If HHS is wrong, then misdiagnosis is also unprotected.

More helpful to providers are the liability shields enacted in twenty-four states as of January 2021.[260] These laws are broader because they focus on the overall diagnosis and treatment of COVID-19,[261] rather than primarily on drugs and devices. Terry notes that these laws may protect providers who worked beyond their scope of training or licensure.[262] As a result, the state immunity laws will preclude successful claims by many victims of COVID-related medical negligence.

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."[263] 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 health care professionals take reasonable care.[264] Patients can and did die in huge numbers despite access to state of the art medical care.[265] Indeed, the state of the art was

256. *Id.* at 2.

257. NICOLAS P. TERRY, COVID-19 POLICY PLAYBOOK: LEGAL RECOMMENDATIONS FOR A SAFER, MORE EQUITABLE FUTURE 191, 192–94 (Scott Burris et al. eds., Vol. 2, 2021) [hereinafter TERRY II].

258. *Id*. at 192.

259. *Id.* (citing *Lutz v. Big Blue Healthcare, Inc*, 480 F. Supp. 3d 1207 (D. Kan. 2020)).

260. *Id.* at 193.

261. *Id*.

262. *Id*. However, the liability shield boundaries leave many areas for interpretation, such as their application to non-COVID patients whose care was interrupted or altered by the pandemic, and their application to COVID patients who were injured by delays and poor hospital conditions rather than their medical "treatment."

263. TERRY I, *supra* note 252, at 201.

264. TERRY II, *supra* note 257, at 192.

265. *See* CTR. FOR SYS. SCI. & ENG'G, *COVID-19 Dashboard*, JOHNS HOPKINS, https://coronavirus.jhu.edu/map.html (Nov. 23, 2021) (reporting global deaths from COVID-19).

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 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.[266]

Overall, the predictions of a wave of COVID-based litigation were likely unduly pessimistic. Nevertheless, the uncertainties associated with the pandemic may cause underwriters to panic. Given the fears expressed about the pandemic's impact on MPL insurance,[267] 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 waiting for the claims data from 2022, when the earliest statutes of limitations will expire. In the interim, 2021 data on premiums and incurred losses reserves will 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

V. CONCLUSION

Claims and payments are far below their peaks and are merely rising along 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, including; declining premiums; depletion of surplus reserves; the rising costs of selling, underwriting, and defending policies; and a recent inflation-driven increase in payouts. Investment income has kept the sector in the black, but barely.

At the same time, today's insurance market differs in several important respects from the 2002–06 hard market. The industry's finances today are more secure, and the start of the hard market is less sharp.[268] Most importantly, carriers are discussing the problem early in the turn from a soft market to a hard one.[269] Much will turn on the use that carriers make of that information. Will carriers risk raising premiums before absolutely forced to do so? If so, carriers may reduce the risk of hasty over-reserving by spreading premium increases over a larger span of years.

One crucial uncertainty is the impact of COVID-19 on claiming. At the very least, the pandemic produced unprecedented turbulence in health care delivery.

266. *See* AM BEST, *supra* note 28, at 3 (noting decline in specialty work); Buttell, *supra* note 168.

267. *See supra* notes 243–252 and accompanying text.

268. *See supra* text accompanying notes 228-245.

269. *See supra* Part II.

COVID-19's uncertain impact on errors and claiming places pressure on underwriters for raising reserves and premiums. If they do, the market will harden more painfully than would otherwise be necessary.

The stakes are high. If the medical malpractice insurance market has a hard landing, providers and patients—not insurers—will suffer the cost, even though the crisis resulted from industry underpricing, not a sharp increase in physician errors or patient claims.

Insurers will tell angry doctors and hospitals that juries are to blame. Once again, negligently injured patients will be asked to give up their rights in order to keep physician premiums down, effectively subsidizing those premiums with their own injuries. This article demonstrates that taking away victims' rights will not solve anything.

Three malpractice insurance crises have already occurred, each of which has produced significant tort reform across the country.[270] Thereafter, errors continued unabated, but claims shrank dramatically along with redress.[271] Payouts fell to historically low levels[272] and the protection of patients with meritorious cases was materially weakened by tort "reform." But the cycles did not end because jury awards are not the problem. Competitive strategies that keep premiums from keeping up with inflation are the culprit. This article illustrates how this happens and provides the information necessary to identify the true causes of the next hard market.

As we teeter on the cusp of a fourth crisis, the industry has the tools to take us in for a soft landing. So far, however, the talk in the industry revolves around "nuclear verdicts" and "social inflation," not judiciously raising premiums and reserves in a manner that allows profits to recover without causing another crisis. The choice is theirs. But lawmakers should not listen to calls for further tort reform.

270. *See supra* notes 17–19 and accompanying text.

271. *See supra* Part II.

272. *See supra* Part II.