TRENDS IN MEDICAL MALPRACTICE INSURANCE, 1970-1985

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I

INTRODUCTION

Starting in late 1984 and becoming increasingly visible throughout 1985, a new "crisis" has emerged in the market for malpractice insurance for hospitals, physicians, and other health care providers.[1] The crisis has not struck evenly throughout the United States, but has become particularly severe in a small number of states and for a few surgical specialties. Amid the calls for relief and reform, it is useful to describe how the malpractice insurance system reacted to the similar "crisis" in the mid-1970's and to trace subsequent developments as a guide to where events might be headed over the next few years.

Critics of the current manner of indemnification for medical malpractice believe that American states operate a recovery "lottery."[2] Professor Jeffrey O'Connell describes the current system of tort law and insurance as "wasteful, cumbersome, expensive, dilatory, and most importantly, unfair."[3] In this situation, injured patients are the most likely losers but hospitals and physicians are also vulnerable to multimillion dollar awards and the prospect of energy-devouring litigation that can take years to resolve a particular case. Defenders of the current system counter that it might be less expensive than any alternative proposed so far.[4]

Some commentators blame one or another of the key players in the malpractice system: the physicians, the juries, the court system as a whole, the plaintiffs' attorneys, or the broader cultural expectations about medical care within the United States. Such broadsides make entertaining reading but lead

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Many of the observations in this article are based on the author's personal experience in the insurance industry.

1. This report draws not only on the cited works but also on other background data on trends. Sources for such background data are supplied in the footnotes.

2. *See, e.g.*, O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Legislative and Contractual Alternatives*, LAW & CONTEMP. PROBS., Spring 1986, at 125, 127.

3. O'Connell, *Let's Try a No-fault Approach*, U.S.A. Today, Dec. 6, 1985, § A, at 12.

4. *See, e.g.*, CAL. MEDICAL ASS'N AND CAL. HOSP. ASS'N, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY (D. Mills ed. 1977). The purpose of this study was to determine whether alternative compensation systems would be less expensive than the present tort system.

less easily to workable reforms. A more tempered view sees the current system as having serious flaws—such as overcompensation to some individuals and undercompensation to others who suffer a severe injury—but flaws that can be improved incrementally. Within the health care industry, many ideas have been suggested for specific legislative reforms and for changes in the delivery of care that could reduce injuries to patients.[5] Little of the commentary that appears in the press, however, deals with the causes or consequences of medical injuries: How and why do injuries occur? What are the resulting damages? How do they affect the patient and the health care system itself? The basic concerns of public debate about medical malpractice have been and continue to be primarily economic: How much will be paid to an injured patient and through what mechanisms? How can the physicians and hospitals affordably compensate medical injuries in the present system?

For many health care providers the key issues have been: Is malpractice insurance available at all and, if so, is it affordable?[6] This article examines how trends over the past decade have affected "availability" and "affordability," then outlines some future directions from the viewpoint of the insurance industry. One question implicit in this discussion is whether the crisis of the mid-1970's was "solved" or whether its symptoms simply receded for a few years.

II

THE 1970'S "CRISIS" AND INSURANCE RESPONSES

Sudden, sharp increases in the cost of medical malpractice insurance are not a new phenomenon in the mid-1980's. A detailed survey of the medical malpractice insurance market written in the early 1970's reported,

> The cost of a constant level of medical malpractice insurance coverage increased seven-fold for physicians, ten-fold for surgeons, and five-fold for hospitals between 1960 and 1972. The areas which showed the greatest increase in the cost of constant coverage over these years were California and New York City which increased over twenty-five percent faster than the nation.[7]

A comprehensive review of the mid-1970's malpractice crisis documented subsequent premium increases of up to 500% in some states. In others, major commercial carriers withdrew from the market entirely posing stark availability problems.[8]

Many factors contributed to the mid-1970's malpractice crisis, including the decline in the United States stock market in the early '70's, which thus reduced the capital and investment yields for insurance carriers; a catch-up for

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5. SPECIAL TASK FORCE ON PROF. LIAB. AND INS., AM. MEDICAL ASS'N, PROFESSIONAL LIABILITY IN THE '80S, REPORTS 1, 2 & 3 (1984-1985) (originally published as supplements to AM. MED. NEWS, Oct. 1984, Nov. 1984, Mar. 1985) [hereinafter AMA TASK FORCE].

6. *See generally id.*

7. Kendall & Haldi, *The Medical Malpractice Insurance Market*, in DEP'T OF HEALTH, EDUC., & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE & APPENDIX 494 (1973).

8. P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 97-117 (1985).

previously deferred rate increases; and gradually increased awareness of worsening loss patterns in frequency and severity of malpractice cases themselves. Rereading documents of that period shows that many problems and solutions of the mid-1970's have reappeared in the mid-1980's as well.[9]

After the mid-1970's malpractice crisis, broad organizational changes added new insurance companies and extra capacity to the system, changed patterns of risk financing, and modified the insurance contracts themselves. These changes in the aggregate kept malpractice insurance available after the wrenches of the mid-1970's.

A. Added Capacity Through New Insurance Companies

Nearly forty malpractice insurance companies were formed between 1975 and 1982 with the sponsorship of state medical societies and other physician groups.[10] Eleven state hospital associations also formed insurance companies, either in the United States or "offshore."[11] In part, these companies were formed to replace lost coverage in states where commercial companies had withdrawn entirely from the market. In part also, professionally sponsored companies reflected the belief of many physicians and hospitals that they could do the job better themselves. Involving knowledgeable and committed practitioners in administering malpractice coverage was thought likely to reduce adverse medical occurrences, to promote settlement of claims more quickly and fairly, and to improve the profession as a whole. Together, the professionally sponsored companies now account for over one-half of the $2 billion annual malpractice premium volume.[12] Fortunately, during the mid-1970's, reinsurance was readily available, so that the new companies that wrote only malpractice insurance could still spread their risk throughout the worldwide insurance market. These companies have made primary insurance available to doctors and hospitals in nearly all parts of the country. Usually coverage has been offered with limits up to $1 million per occurrence (that is, per injury), but sometimes higher or lower maximum limits would apply, depending on the geographic location of the insured.

Although professionally sponsored companies have been successful in maintaining a relatively stable and affordable market throughout the early 1980's, some weaknesses have become visible. Most physician- and hospital-sponsored carriers operate within a single state, and they tend not to compete

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9. *See, e.g.*, AM. BAR ASS'N, 1977 REPORT OF THE COMMISSION ON MEDICAL PROFESSIONAL LIABILITY 9-18; INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, BEYOND MALPRACTICE: COMPENSATION FOR MEDICAL INJURIES 7-27 (1978); M. REDISH, LEGISLATIVE RESPONSE TO THE MEDICAL MALPRACTICE CRISIS: CONSTITUTIONAL IMPLICATIONS (1977).

10. *See* AM. MEDICAL ASSURANCE CO., 1985 USA DIRECTORY—PHYSICIAN-OWNED, MEDICAL SOCIETY-CREATED PROFESSIONAL LIABILITY INSURANCE COMPANIES (9th ed. 1985).

11. RISK PLANNING GROUP INC., CAPTIVE INSURANCE COMPANY DIRECTORY 126-68 (1983).

12. *General Liability and Medical Malpractice Insurance Marketing*, BEST'S REV., Oct. 1984, at 92, 94; *General Liability and Medical Malpractice Insurance Marketing*, BEST'S REV., Sept. 1985, at 16, 18. The $2 billion 1984 premium does not include self-insurance funding offshore premiums, or reinsurance. *See infra* text accompanying note 33.

among themselves. These companies are encountering in the mid-1980's many of the same pressures as traditional multiline carriers: many instances of severe losses, the need to add to loss reserves, and poor financial results requiring the infusions of new capital and large rate increases. Although many medical society and hospital association-sponsored companies will prove to be viable over the next decade, there will also be pressure on others to add new lines of insurance, to consolidate, and to expand across state lines. The general picture of losses and premiums in these companies is that they are being pushed upward by the same forces that affect commercial carriers.

B. Mandated New Capacity Through Patient Compensation Funds and Joint Underwriting Associations

Also in the mid-1970's, many state governments created new capacity to underwrite malpractice coverage by providing for broader pooling of risks and inducing or requiring insurers or providers to underwrite the pool. At least eleven states created Patient Compensation Funds (PCF's), states as diverse as Hawaii, Kentucky, Florida, Indiana, Kansas, Louisiana, Pennsylvania, New Mexico, North Dakota, Wisconsin, and South Carolina.[13] PCF's establish a broad risk pool and helped spread the impact of large losses. For example, a state may require that physicians must insure the first $100,000 of damage, but that awards above that amount will be paid out of the PCF. A PCF may be administered publicly or by a private insurer under contract. Funding comes from health care providers themselves in two ways. The PCF reserves are built by imposing surcharges on the underlying primary policies of all participating providers (for example, twenty-five percent of premium). If the funds prove insufficient to meet awards, some PCF's are authorized to make retroactive assessments on all policyholders.

PCF's thus automatically make high-limit coverage available, but providers retain risk because of the assessment power. Hence, a major issue over time is whether the initial surcharge funding is sufficient. PCF's typically operated on a "pay-as-you-go" basis and did not try to set surcharges on an actuarial basis. Often, insufficient regard was given to the extent of future awards inherent in the "long tail" of the malpractice insurance business. Part of the problem for the PCF's was that in their early years, low surcharges were set at only ten to twenty percent of the primary policy, and in some years no surcharges were assessed at all because of providers' political objections to a highly visible build-up of reserves before large claims began coming in.

The contrasting experiences in Florida, Kansas, and Pennsylvania provide a useful illustration: In Florida and Kansas, the PCF offered unlimited coverage above $100,000 per occurrence in the early years, whereas Pennsylvania's PCF ("catastrophe fund") established a maximum amount of $1 million per occurrence (over the provider's primary $100,000). In the

13. *See* AM. INS. ASS'N, MEDICAL MALPRACTICE INSURANCE REPORTS: SELECTED STATE STATUTES (1984).

early 1980's, all three of these states started to raise the attachment points from $100,000 per occurrence to $200,000 or more to help maintain their solvency. Both Kansas and Florida set upper limits of $10 million payable by their PCF. By the early 1980's, the surcharge percentages had started to move up, first to twenty-five percent, then to fifty percent and in some instances charges exceeded one hundred percent of the premium for the underlying, primary "layer" of coverage. Even with this funding pattern, there were still financial difficulties. The most severe was a complete collapse of the Florida PCF, and subsequent litigation between the PCF and its member hospitals and physicians to collect more than $100 million in disputed assessments to pay already incurred losses.

Joint underwriting associations (JUA's) bear many resemblances to the patient compensation funds. A JUA is a consortium of insurers in the jurisdiction which mandates it. All admitted carriers offering property and casualty coverage in the state must usually participate. It establishes a premium structure and by law provides coverage to all health care providers who pay the established rate. If the rate proves insufficient to meet awards, however, all insurers that are members of the JUA are subject to pro rata assessments. Thus, ultimate financial responsibility goes back to the member insurers of a JUA, rather than to the policyholders, as in a PCF.

JUA's were authorized in forty-three states to provide coverage for providers unable to purchase coverage from commercial insurers.[14] The intent in many states was to create only a "residual" market, that is, to utilize JUA's only as a last resort or on a temporary basis, especially for some high risk and high cost providers. By 1981, fifteen JUA's had been terminated or were operating only at a nominal level; others never even commenced active operation. As of mid-1985, only thirteen JUA's were in active operation. Many JUA's started seeing a new rush of business in mid-1985, as once again insurance availability became a problem in many areas for some providers.

The economic history of JUA's resembles that of the PCF's. Some JUA's attempted to set premium rates below levels of rate adequacy as actuarially estimated. Instead of acting as a residual market and charging premiums above the going rate, some JUA's have attempted to set a low ceiling on premiums, just as some PCF's resisted increases.[15] Although such cut-rate practices made coverage more affordable for their policyholders in the short run, these JUA's may have exacerbated the more general availability problem by pushing out other commercial insurers that could not offer coverage at comparable prices. The weakest aspect of the PCF's and JUA's has been their comparative inability to pass along the increasing cost of malpractice awards in a smooth fashion to their covered health care practitioners (or the public) because of the politics involved in rate setting.

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14. *See id.*

15. Among examples cited to the author by insurance underwriters were Texas and Massachusetts.

Beyond economics, PCF's and JUA's have another feature in common. Very few, if any, have made explicit attempts to reduce malpractice risks, either through professional underwriting to identify poor-risk providers in advance or through loss control, to avoid serious malpractice before it occurs. In that sense, the PCF's and JUA's were a palliative and did little to modify behavior within the health care industry itself.

Nevertheless, the PCF's and JUA's have served a useful public purpose. They have guaranteed availability of coverage to all, and have sometimes worked toward legislative changes on the state level, helping to revise the rules of the game governing malpractice claims and awards.

Future experiments with governmentally created payment mechanisms for malpractice must recognize the inevitable pressures on such entities from political sources. Although JUA's and PCF's are organized on a "not-for-profit" basis, they do not necessarily operate at lower total cost or greater effectiveness than other types of insurance entities. To the contrary, such a government overseen payment system may allow deficits to burgeon out of control, as more awards or higher awards are made for medical injuries. In short, PCF's and JUA's may have helped the availability problem but probably not the affordability problem over the long run.

C. Greater Risk Retention by Providers Through Self-Insurance and Captive Insurance Companies

One of the most visible mid-1970's changes was the widespread movement by medium-sized and large hospitals (those over 250 beds) to underwrite their own malpractice risks. Such self-coverage took the form of funded self-insurance programs, that is, virtual "bank accounts" kept to cover claims. Similarly, groups of health care providers established wholly-owned, and limited-purpose, or "captive" insurance companies. In other words, health care organizations "retained" more risk rather than "transferring" risk to conventional insurance companies. Self-insurance and captives had existed earlier, but the key factor facilitating the enormous growth in these methods of risk financing was the issuance of new reimbursement regulations by Medicare in 1977.[16]

According to a survey of bank trust departments, an estimated 750 to 1,000 hospitals had funded self-insurance programs by mid-1980.[17] Between 1977 and 1980 these institutions accumulated an estimated $1.5 billion to $2 billion of assets to pay for their malpractice losses.

On the positive side, many self-insured hospitals were prompted by direct liability for their own losses to embark on elaborate risk management and

16. HEALTHCARE FINANCING ADMINSTRATION, MEDICARE PROVIDER REIMBURSEMENT MANUAL §§ 2161-2163 (1984).

17. Estimates in this paragraph were taken from a national survey of 100 banks with the largest trust departments. Findings were presented at the annual meeting of the Risk and Insurance Management Society (RIMS), in April 1981. Marsh & McLennan, Survey of Major Banks with Hospital Self-Insurance Trust Funds (April, 1981) (unpublished study).

quality assurance programs. Moreover, self-insured hospitals benefited fiscally by no longer "trading dollars" with insurance companies to pay predictable losses, for which the hospitals could easily budget the expense. Self-insurance also avoided the insurers' "carrying charges," as well as premium taxes and other state regulation.

One weak point of self-insurance has been some early tendency toward complacency. Because medical malpractice claims are infrequent, and because previous coverage will continue for past incidents, even a large hospital will initially encounter only a relatively small number of serious events that raise the threat of a future adverse malpractice judgment. In such a hospital, effective precautions against malpractice, and funding for them, can easily be shunted to a lower priority than more immediate problems. At the extreme, a hospital may "play the averages," just as under conventional insurance, and simply not address the issues of malpractice liability.

Claims have now begun to emerge against self-insured institutions. These hospitals are consequently increasing their attention to claims management and legal defense. Data are not yet generally available to analyze how successful these programs have been in terms of long-run impact on the frequency or severity of self-insured claims, as compared with more conventional insurance claims. It is likely that a small number of self-insured hospitals will eventually face some very large losses that were not adequately funded, while most self-insured hospitals will continue to maintain a considerable cash reserve.[18]

Indeed, many self-insurance plans seem economically inefficient. The most common design of a self-insurance trust fund is for the single hospital involved to retain $500,000 or $1,000,000 of risk in each occurrence and above that to purchase excess liability coverage to some higher limits. By contrast, most physician-owned insurance companies—with thousands of policyholders and millions of dollars in annual premium cash flow and hence far less vulnerability to random fluctuations—typically retain a much lower amount, in the range of $200,000 to $500,000 per occurrence, beyond which risk is ceded to a reinsurance company.[19] Self-insurance thus appears to have reduced the total dollars available to spread risks within the conventionally insured health care industry.

"Captive" insurance companies have been a recognized part of the insurance industry since the 1950's. Typically, captives have been attractive to organizations that had difficulty in finding commercial insurance at affordable rates or to very large corporations that could derive financial and tax advantages from organizing their own insurance companies.

Because physicians and hospitals faced a severe availability problem in the mid-1970's, captives were a sensible option to consider. The companies sponsored by state medical societies and hospital associations are "limited

18. This prediction is based on the author's analysis of statistical techniques used for funding of self-insurance plans.

19. Personal communication from reinsurance intermediaries and underwriters.

purpose" insurance companies and are sometimes therefore considered to be "captives," although they operate under conventional insurance regulation. More frequently, captives are owned by a small group of providers and are established in domiciles with particularly favorable insurance laws, either "offshore" as in Bermuda or the Cayman Islands or in a selected state, such as Colorado or, most recently, Vermont. One directory of captive insurance companies lists twenty-six companies that primarily write hospital professional liability business, six that primarily write physician business, and fourteen organized by other types of health care providers (for example, dentists, chiropractors, and podiatrists),[20] in addition to the other companies sponsored by state hospital associations and medical societies.

It is difficult to compare the dollar volume of captives with self-insurance, because most captives are organized by groups of health care providers, ranging from two to more than 100 members, whereas self-insurance is typically for single hospitals. There are no published statistics for captives similar to those that the A.M. Best Company publishes for conventional carriers.

Interest in captives diminished from 1979 to 1983, when malpractice insurance was more readily available and affordable. Starting in late 1984, there has been renewed interest in captives in response to current market conditions.

Captive insurance companies are different in 1985 than they were in the 1970's, however, because acceptable reinsurance is not as readily available. Furthermore, regulatory and tax authorities are giving providers less leeway in creating such arrangements. Regulators are more sensitive to the need for adequate capital and surplus to provide a cushion against losses that develop more adversely than expected during the "long tail" of malpractice. The Internal Revenue Service has continued to resist the deduction of "premiums" paid to captives and to seek to collect taxes on captives' investment and operating incomes. Although captives were a significant mid-1970's development in providing additional capacity and greater availability to the sponsoring organizations, they will take a different form in the current environment.

D. Changes in Insurance Contracts: Claims-Made Insurance

Another mid-1970's development was the claims-made policy form. Such insurance contracts pay only for claims reported during the covered policy period. Because malpractice claims are ordinarily reported over a long period of time after the event (the so-called "long tail"), the effect is to charge the typical loss against a later year under the "occurrence" form. By utilizing a claims-made form, the insurance underwriters can keep their premiums better tuned to the actual development of claims indemnity and expenses, that is, raise premiums if the experience worsens, or keep premiums stable as long as

20. *See* RISK PLANNING GROUP INC., *supra* note 11, at 126-68.

experience looks favorable. The actuaries do not have to predict developments quite so far in advance.

In the mid-1970's, the claims-made style of insurance was adopted by the St. Paul Fire and Marine Insurance Company as well as by about one half of the physician-sponsored companies.[21] During these early years while occurrence coverage was still available, however, claims-made was perceived as a less desirable alternative from the viewpoint of many hospitals and many insurance brokers. In market terms, claims-made probably accounted for less than one-third the total premiums written.

Suddenly, in 1984, changes in the reinsurance market propelled claims-made toward fifty percent of the total premiums written. Further growth of up to seventy to eighty percent is extremely likely during 1985, as renewals and new reinsurance treaties take effect. Whether claims-made will completely replace occurrence coverage remains to be seen during 1986 and 1987, depending on the influx of new capital and the continuing development of losses.

What is the significance of the claims-made form in the decision to purchase insurance? Typically, the insurance company assumes multiple sources of risk, such as: (a) the risk of the injury to the patient, (b) the risk of claims being deemed meritorious in a future legal environment, (c) the timing risk of when compensation will be paid—whether in two years or in eight, and (d) the inflation risk—how much future medical expenses and lost wages will be ten, twenty, or more years from now (not to mention the nonunderwriting, *investment* risks taken on reserves invested before payment of claims). Claims-made carriers are willing to underwrite the risk of serious injuries to the patient, but they are also telling brokers and providers that they cannot predict the medical inflation rate far into the future; nor are they willing to estimate precisely how long they will hold the premium and earn investment income before paying the claims. Given these new caveats, insurers are still willing to make coverage available, but they are utilizing new contract wordings and concepts.

A number of other issues are emerging around the subject of claims-made[22] policies that will shape the negotiations between carriers, brokers, and the insureds during 1985 and 1986, such as how to underwrite the purchase of "tail coverage," the policy that covers future years' liability when a provider retires or changes carriers. For example, does coverage extend indefinitely into the future or only a few years? Is the limit exhausted or is it reinstated each year? How are claims reported? How should any of these "tail" definitions be rated for premium purposes? In short, claims-made insurance was a significant mid-1970's innovation that is undergoing change and receiving increased attention in the mid-1980's.

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21. *See* AM. MEDICAL ASSURANCE CO., *supra* note 10.

22. Claims-made insurance has been widely studied and debated through insurance industry organizations such as the Insurance Services Office (ISO), and in the trade press, such as *Business Insurance*. There has also been a parallel discussion in the London insurance market.

E. Changes in the Burden of Premium Payments: High-Risk Specialties

In the late 1960's and early 1970's, the highest risks in medical care were perceived to be anesthesia and orthopedic surgery. In the late 1970's and 1980's, the focus of risk has shifted. Technology and medical practices have evolved so that anesthesia seems a more controllable and predictable risk today, while birth-related injuries and neurosurgery are now seen as the most severe risks. Injured infants and other patients who would have died in earlier years are now being kept alive by the technology, but these individuals often survive only with expensive, ongoing lifetime care. Not only do injured people survive (longer) now, thus expanding medical risk, but the courts and society as a whole have also greatly expanded the basic scope of medical risk through the introduction of new concepts of negligence. Such new grounds for recovery include lack of informed consent and the expansion of corporate liability against the hospital, its officers, and the medical staff as a whole for the failure to supervise or to anticipate the consequences of medical treatment. Some medical practitioners, notably obstetricians, are caught by both trends, as society has expanded the boundaries of medical liability, and certain specialties have become exposed to more serious injuries arising out of patient care.

The expansion of risk in the high-rated specialties can be seen in the premium structure: a high-risk specialist formerly paid a premium perhaps five to seven times higher than the lowest risk classification. Now it is not infrequent that this relative disparity in premiums has doubled to ten or fourteen to one. Overall premiums have risen, and the increase has been even greater for the surgical specialties.

The lower risk classification physicians have not seemed particularly eager to help redress this imbalance and to share or spread the risks faced by the surgical specialties. The current regulatory system generally allows each insurance company to set its rates. This freedom leads to greater competition to attract the lowest risk physicians, and greater difficulty for specialties such as neurosurgery, obstetrics-gynecology, and thoracic surgery. Competitive pressures to prevent such "cream skimming," especially after the premium increases of the mid-1970's, have called for each specialty to pay premiums based very closely on its own "experience" and with less spreading of risk among specialties.

For the most part, the crisis symptoms of the period from 1974 to 1977 were in remission from 1978 to 1983. In most states, malpractice rates increased only moderately, stayed flat, or even showed declines. Some companies even returned dividends to the policyholders. The cost of "excess layer" insurance (that is, above $1 million per occurrence) dropped dramatically, often fifty percent or more in the early 1980's.[23] Total limits available increased, so that a hospital individually or in a group could obtain

23. Unpublished estimate of general market conditions by Marsh & McLennan.

coverage for damages as high as $50 million to $200 million.[24] Coverage was readily available for physicians and virtually all other types of health care providers. Special group and discount arrangements were often made available. A key objective of many health care providers during this time was to "shop around" to see how low premiums could be cut in the very competitive, "soft" market that prevailed.

One contrary trend, even during this "soft" market, was that a few companies tried to avoid offering higher limits. For example, from 1976 to 1985, Medical Liability Mutual Insurance Company (MLMIC) in New York resisted offering limits greater than $1 million per occurrence, in the belief that higher limits would only lead to higher awards and settlements. Similarly, in 1985, the Medical Protective Company reduced its maximum limit from $1 million to $200,000 per occurrence in the Chicago area, in an effort to put a brake on the increasing size of claims.

As the foregoing discussion of the five main 1970's changes shows, the changes made over the past decade have dealt primarily with insurance, risk, and payment mechanisms, rather than with the basic causes of malpractice incidents themselves.

III

TODAY'S RENEWED PROBLEMS FOR MANY MEDICAL PROVIDERS

Today, the malpractice situation is again viewed as a "crisis." Its nature and severity, however, are widely misunderstood. Perhaps "dilemma" is a better description of the situation in most areas, as discussed below. Commonly cited in the press as evidence of crisis are large increases in premiums, huge court awards, and jumps in the frequency and severity of claims. On closer analysis, problems appear severe or intractable mainly in a few geographical areas and medical specialties.

Much of the published data have been provocative but leave ample room for alternative viewpoints and further elaboration. For example, the Jury Verdict Research reports reach conclusions about trends in payment based on an extremely small fraction of the total number of cases settled.[25] Most medical malpractice insurance companies settle ninety percent or more of their claims prior to trial and a jury verdict.[26] For another example, newspaper headlines about millions of dollars due to be paid over a claimant's lifetime may have no relationship to the actual dollars currently set aside by

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24. *Id.*

25. *See* Zuckerman, Koller & Bovbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, LAW & CONTEMP. PROBS., Spring 1986, at 85, 90.

26. JURY VERDICT RESEARCH, INC., INJURY VALUATION REPORTS NO. 251, TABLES OF VERDICT EXPECTANCY VALUES FOR DOCTOR'S MALPRACTICE 1202-04 (1981); JURY VERDICT RESEARCH, INC., INJURY VALUATION REPORTS NO. 252, TABLES OF VERDICT EXPECTANCY VALUES FOR MALPRACTICE HOSPITAL NEGLIGENCE 1246-49 (1981); *and* JURY VERDICT RESEARCH, INC., INJURY VALUATION REPORTS NO. 253, TABLES OF VERDICT EXPECTANCY VALUES FOR DOCTOR AND HOSPITAL MALPRACTICE 1282-85 (1981); NAT'L ASS'N OF INS. COMM'RS, MALPRACTICE CLAIMS, FINAL COMPILATION (M. Sowka ed. 1980) (medical malpractice closed claims 1975-1978).

an insurance company to fund or structure a stream of benefits that will be paid periodically. Even data on claims' severity and frequency can be misleading when they are reported based on the dates when claims are filed or paid without reference to the years in which the events occurred—and in which premiums were collected to cover them.[27] The discussion below touches on a number of insurance problems that have been overstated or misinterpreted in the press. It also touches on some related problems of how medical malpractice affects the insurance industry, as well as the serious impact of reduced availability of insurance.

A. The Insurance Cycle

In 1984, a sudden upswing in malpractice insurance prices began after a protracted "soft" market which had lasted four to six years instead of the more typical two to three years. These abrupt increases elicited understandably anguished responses from health care providers.

The insurance industry's natural behavior contributes to the continuing cycles of "crisis" and "remission." The high investment yields of the early 1980's and the influx of new carriers led to continued price cutting (below actuarially appropriate levels) through 1983. In 1984, the strong dollar reduced the amount of insurance and reinsurance capacity available from sources outside the United States (notably London),[28] and emerging losses in the United States finally forced companies to raise premiums.

The historical pattern of malpractice premiums and losses through 1983 is shown in Chart 1. The recent period of relatively "flat" total premiums can be seen as an anomaly in comparison to the expected long-term upward trend in the underlying costs of insurance.[29] Indeed, premiums are below losses (claims payments and direct expenses of making them), so that only investment income is available to cover all other expenses, profit, and taxes.[30] As of the end of 1983, overall increases in malpractice premiums of about twenty to forty percent seemed to be needed in order to bring premiums back into line with incurred losses across the country as a whole. The worst problem has occurred in those areas and for those providers who faced fifty to one hundred percent increases, as the loss picture deteriorated further in 1984-85. The data do not suggest, however, that such high rates of increase are likely to persist, because there are still inherently cyclical processes at work that should ease the problem by 1987 or so.[31]

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27. *See* AMA TASK FORCE, *supra* note 5, in REPORT 1 (1984), at 4-11.

28. American premiums are written in dollars, but the available capacity of the London market exists in pounds. In early 1985 the pound was worth about $1.10, compared to $1.80 in early 1984, which means that total capacity was reduced.

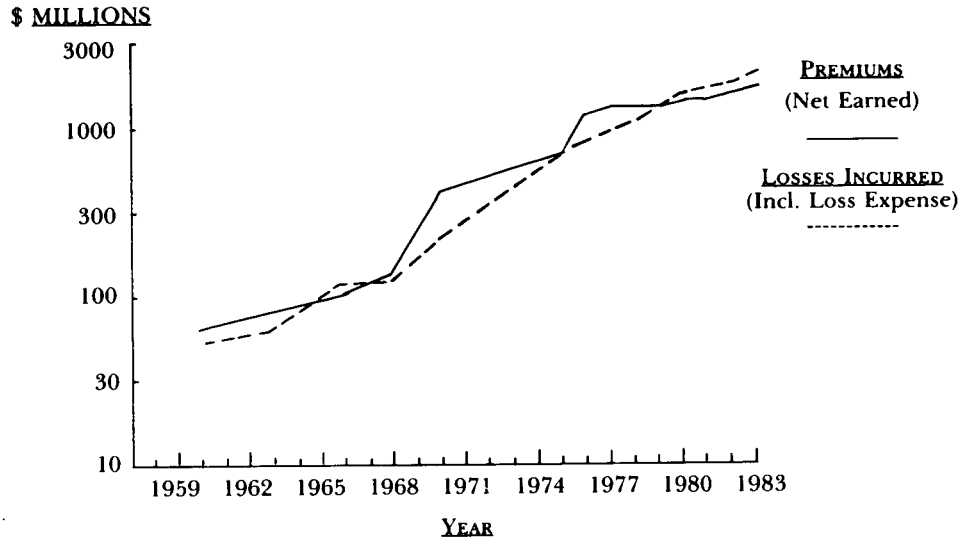
29. For many purposes, the chart calls for more analysis, because the data do not adequately measure such changes in recent years as hospitals taking large deductibles or setting up self-insurance trust funds or the growth of PCF's; nor do the data adjust for increases in limits.

30. *See* Roddis & Stewart, *The Insurance of Medical Losses*, 1975 DUKE L.J. 1281, 1285-89.

31. Blum, *Looking to the Future in Reinsurance*, VIEWPOINT, Autumn 1985, at 1, 1.

CHART 1

MEDICAL MALPRACTICE INSURANCE
Net Premiums Earned and Incurred Losses



Source: A.M. BEST, INSURANCE MGMT. REPORTS (9/28/81; 10/18/82; 12/29/84) HEW, SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE & APPENDIX (1973)

B. Malpractice Costs Are Not a Major Part of Total Health Care Costs But Affordability Problems Exist

Malpractice costs are in the range of $2 billion to $4 billion per year, as of 1984.[32] Approximately $2 billion of this amount represents premiums paid to U.S. insurance companies. The remaining $2 billion is a rough estimate of the amount of funds flowing outside the United States or, for example, into captive insurance companies, self-insurance trust funds, and deductibles.

This amount is a small portion of the total costs of hospital and direct physician care, which now exceed $300 billion per year.[33] Although the percentages for malpractice have increased in recent years, most of the added expense can be passed through to patients and third party payers. Recent premium increases for malpractice insurance follow a number of years with minimal change, and are not in themselves a significant cause of increased health care costs. This overall comparison is illustrated in Chart 2.

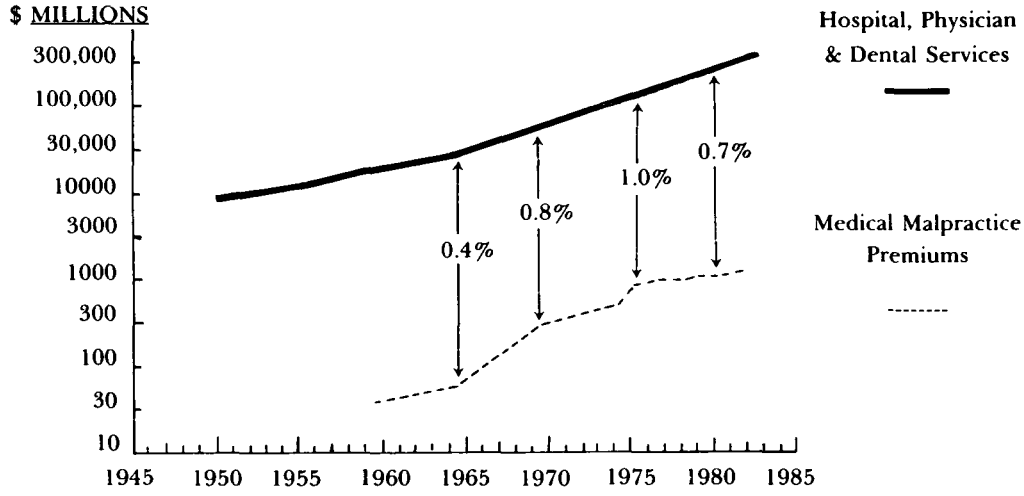
In the aggregate, even after adding an increment for self-insurance's contribution, malpractice costs are not a major cost factor for most hospitals, or even for many doctors. Of course, there are exceptions, but much of the

32. *General Liability and Medical Malpractice Insurance Marketing*, BEST'S REV., Sept. 1985, at 108.

33. Total U.S. health care costs exceeded $350 billion in 1983. Estimates used here subtracted out the expenditures for nursing homes, prescriptions, government public health, and other activities not closely related to the payment of malpractice premiums. *See* Gibson, Waldo & Levit, *National Health Expenditures, 1982*, HEALTHCARE FINANCING REV., Autumn 1983, at 1, 1.

CHART 2

EXPENDITURES FOR PHYSICIANS & HOSPITAL SERVICES
Compared with Medical Malpractice Premiums



Source: HCFA REV., Spring 1984
A.M. BEST, INSURANCE MGMT. REPORTS (9/28/81; 10/18/82; 12/29/84) HEW, SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE & APPENDIX (1973)

problem in malpractice insurance has been the shock of sudden increases. The average hospital spends about one percent of its revenues on malpractice insurance. The American Medical Association estimates that the average physician spends about four percent of pretax gross income on malpractice insurance.[34] In general, the affordability problem is most severe in five states: California, Florida, Illinois, Michigan, and New York. In 1984, the average premium in New York was $12,500, and in Florida, $13,500.[35] For surgical specialties, however, the costs were higher. In some states, surgeons can spend fifteen to twenty percent of their gross income on malpractice insurance.[36] Obstetricians in Maryland paid 1985 premiums of $36,000-$49,000, depending on territory and coverage limits. On Long Island, obstetricians paid $68,100 for the year beginning on July 1, 1984, for standard coverage and the provisional premium rose to more than $100,000 in 1985. Both of these examples are from medical society-sponsored

34. AM. MEDICAL ASS'N, SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE (1985). This figure is derived by taking the average malpractice insurance premium of $7,900, *id.* at Table 5, and dividing it by the sum of the mean physician income of $108,400, *id.* at Table 38, and the mean professional expenses of $92,600, *id.* at Table 33. These statistics reflect 1984 figures obtained by the American Medical Association in its Socioeconomic Monitoring System Survey.

35. *See* AM. MEDICAL ASSURANCE CO., *supra* note 10.

36. Many state medical societies or specialty societies have surveyed their members and derived similar figures. One example is the Obstetrical and Gynecological Society of Maryland, where estimated malpractice premiums average 20% of gross income. Annual Symposium, Obstetrical and Gynecological Society of Maryland, Johns Hopkins Hospital, Oct. 6, 1985 (unpublished survey of the Society's members).

companies.[37] The St. Paul Fire and Marine Insurance Company average premium for obstetricians nationwide was nearly $18,000 in 1984, ranging from $6,300 in Arkansas to $45,700 in Miami, Florida.[38] (St. Paul does not insure physicians in New York.) Data on gross and net incomes of physicians are difficult to obtain and interpret, in large part because of wide variations in income between individuals at the beginning, middle, and later years of their career. *Medical Economics* surveys physicians' incomes each year and reported 1984 gross practice income nationwide averaged approximately $237,000 for surgical specialists, and $160,000 for nonsurgical specialists. The highest twenty-five percent of physicians earned net practice income before taxes of at least $150,000, the median net practice income was $102,000, and the lowest twenty-five percent earned less than $70,000.[39] For new practitioners, medical school faculty members, and other health care professionals in practice who have lower than average incomes, the cost of insurance can be virtually unaffordable.

C. Availability of Insurance—Another Aspect of the Insurance Cycle

As a parallel to the pattern of increasing premiums, the picture in early 1985 was of suddenly shrinking numbers of companies willing to write malpractice insurance, lower limits of insurance available, and heightened fear of insolvencies among insurance companies.[40] The resulting availability problem for providers has been most severe and apparent to hospitals. During the "soft" market, hospitals and doctors could focus on trying for low cost because they faced an extreme "buyers' market." A health care provider could purchase whatever limit—that is, capacity—was desired, with an unparalleled breadth of coverage, for almost any imaginable exposure. The extent of negotiation was to see which insurance company would cut the previous premium by the greatest amount.

During 1985, the concern of hospitals has shifted toward the question of capacity: How can they find coverage for the total limits they want? If an institution had $30 million or $50 million aggregate limits in 1984, what will it need in 1986, and what will be available? By contrast, physicians have typically bought malpractice insurance only up to policy limits of $1 million per occurrence, and $3 million annual aggregate, and these amounts have still usually been available. One exception to this pattern was nurse midwives. In 1985, nurse midwives were faced with malpractice policies being unavailable

37. Medical Liability Mutual Insurance Co. and Medical Mutual Liability Insurance Society of Maryland.

38. ST. PAUL FIRE & MARINE INSURANCE CO., PROFESSIONAL LIABILITY IN OBSTETRICS (1985). These figures are for mature claims-made policies, $1 million/$1 million limit, based on a study of their own closed claims involving obstetrical deliveries.

39. Owens, *Doctor Earnings: The Year of the Big Surprise*, MED. ECON., Sept. 1985, at 194 (similar articles appear each year).

40. International Childbirth Education Association, Conference, Washington, D.C., July 1985.

or obtainable only at a cost of $15,000 to $30,000, when their average yearly income was approximately $25,000.[41]

One reason that insurance companies are reducing their involvement in medical malpractice is increasing concern about the difficulty of projecting loss payments, given the "long tail" of loss development. For example, the Employers of Wausau company stopped writing malpractice insurance in 1973. Between 1982 and 1984, however, the company added $200 million in loss reserves for malpractice resulting from their previous exposure. Such delays in recognizing losses distort the operation of an insurance company and raise questions about whether all the reinsurers will be around at the time when claims and expenses are paid.

The overall impact on malpractice insurance has been to reduce the number of companies offering the coverage and the amount of coverage available by more than half.[42] The malpractice market has shifted from an extreme "buyer's market" to a "seller's market" in which a few insurance companies are swamped with business and can be extremely selective about what coverage they will offer, to whom, and at what price. This general contraction has affected virtually all varieties of liability insurance throughout the U.S. market, reaching far beyond medical providers into other industries such as chemicals and pharmaceuticals, as well as other lines of insurance, including products liability and directors' and officers' liability.

D. Malpractice Costs Increase Because the Number of Injuries Is High Even While the Quality of Medical Care Is Good

The major underlying force driving malpractice costs is the number of "compensable injuries" that occur. Many more injuries occur than are ever compensated. Indeed, the liability system acts effectively to reduce the total payments. Change to a "no-fault" system could lead to greater outlays than under the present system. These points have been made repeatedly and eloquently by Don Harper Mills since his pioneering work in California to measure these concepts.[43]

Every serious observer of the malpractice situation will concede that large numbers of injuries that occur, and that society deems many of these to be "compensable." This situation is illustrated in Figure 1, adapted from Dr. Mills's work: the intersection of injuries and negligence equates to "potential liability" or "compensable events." Figure 2 expands the perspective to illustrate how actual claims and ultimate payments are superimposed on a much larger number of injuries. When a relatively small fraction of injured

41. CONNING & CO., REINSURANCE INSECURITY: A FOCUS OF CONCERN IN THE 1980'S (1984). For ongoing reporting with examples of these problems, see issues of *Business Insurance.*

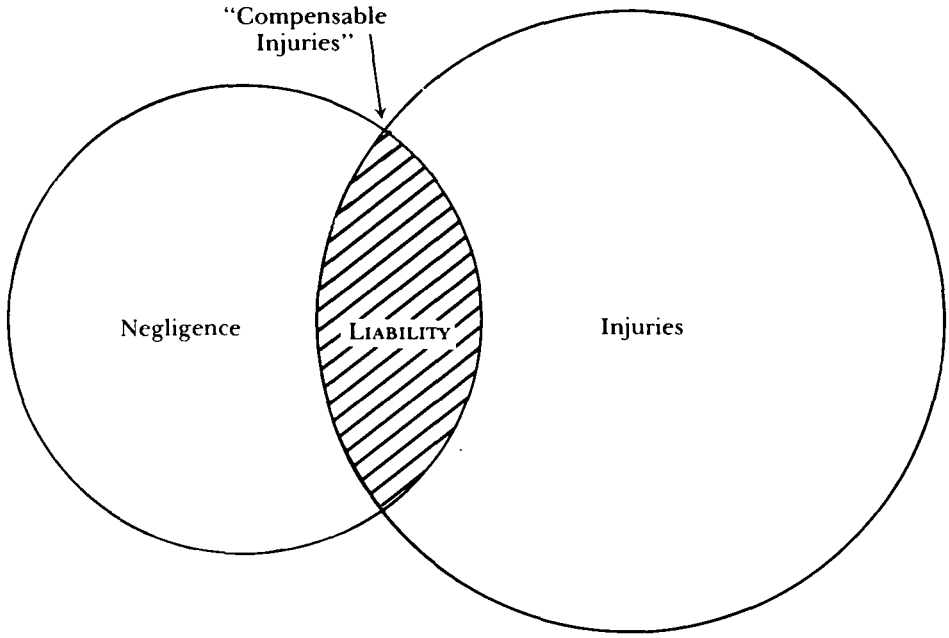
42. See the November 1985 issue of *Business Insurance* and other issues on malpractice insurance and reinsurance conditions.

43. *See* CAL. MEDICAL ASS'N AND CAL HOSP. ASS'N, *supra* note 4.

patients ends up with compensation, observers such as Professor O'Connell characterize the process as the "malpractice lottery."[44]

FIGURE 1

MEDICAL INJURIES, NEGLIGENT CONDUCT & MALPRACTICE CLAIMS



Even while acknowledging the frequency and severity of serious injuries, most observers would probably also agree that the quality of medical care on an aggregate level in the United States is rather good. The probability of a serious mistake that leads to damages over $1 million is about one in 100,000 hospital patients, and even lower in the doctor's office.[45] For high risk areas of medical care, such as obstetrics, there is a probability of approximately one in 10,000 pregnancies leading to serious claims.[46] In everyday life, people faced with such probabilities will often assume the risk without calling it a "crisis," or feeling that the quality is essentially flawed.

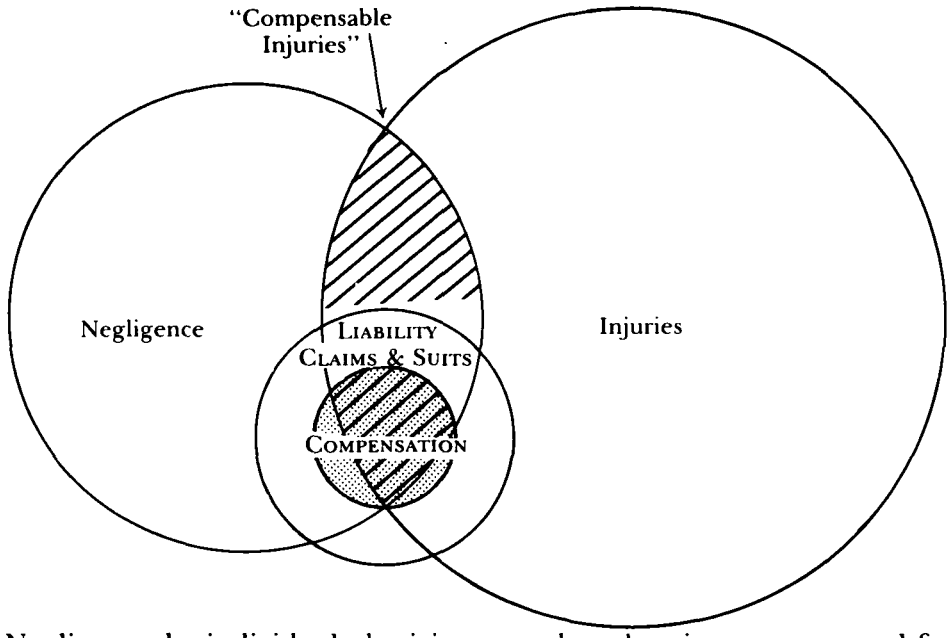
44. *See* O'Connell, *supra* note 2, at 127.

45. Author's estimate based on 35 million admissions to general care hospitals and over 200 million office visits, out of which 100 to 200 publicly known settlements and awards over $1 million can be identified. If one assumes an equal number of unpublicized settlements, then 200-400 cases over $1 million per year in relation to 35 million admissions generates a probability of approximately one in 100,000.

46. Author's calculation, based on ST. PAUL FIRE & MARINE INSURANCE CO., *supra* note 38, which collected data on 220 closed claims involving birth-related injuries from 1980 to 1982, in relation to policies in force and number of births annually.

FIGURE 2

MEDICAL INJURIES, NEGLIGENT CONDUCT & MALPRACTICE CLAIMS



Negligence by individual physicians may be a less important causal factor than more general "system failures," that is, mistakes resulting from the interaction of a number of individuals within an institution as complex as the typical hospital. Without trying to suggest how many injuries, if any, should occur, it must still be acknowledged that in any health care system there will be bad outcomes and serious injuries. It is incumbent on both the critics and the defenders of the current system to formulate a set of criteria by which medical practice and malpractice can be judged.

Efforts to improve medical practice can take many forms. Risk management and quality assurance in the hospital setting typically deal with identifying and evaluating situations that can result in serious damage to patients, with formulating strategies to reduce or avoid such damage before it occurs, and with measuring and monitoring performance to lessen the probability of recurrence. Recognized professional specialties have developed in such areas.[47] Some of the work on risk management and quality assurance tries to identify specific individuals who perform inadequately—that is, the proverbial "bad apples." Other efforts establish operational systems involving many individuals, hospital departments, written procedures, and

47. More detail on the scope of and specific activities in the field of Risk Management is offered by the Risk and Insurance Management Society (RIMS) in periodic publications such as *Risk Management*. Quality assurance activities are presented in detail in such publications as *Quality Review Bulletin*, published by the Joint Commission on Accreditation of Hospitals. A professional group which draws both hospital risk managers and quality assurance specialists is the American Society of Hospital Risk Management (ASHRM), which is part of the American Hospital Association.

policies which together can reduce the probability of serious injury to patients.

This article is not intended to summarize all the work currently under way in risk management and quality assurance. The basic point here is that such efforts are usually directed more closely at the cause-and-effect processes relating to injuries within the health care setting rather than just the dollars-and-cents symptoms of today's malpractice crisis. As physicians and hospitals increasingly utilize risk management and quality assurance specialists, their success or failure will partly determine the extent and the timing of the next malpractice crisis, perhaps in the early or mid-1990's.

IV

CONCLUSION

LOOKING TO THE FUTURE: INCREMENTAL CHANGES IN THE LEGAL SYSTEM, INSURANCE MECHANISMS, AND PATTERNS OF MEDICAL PRACTICE

Tort reform and other legislative changes will be a highly visible concern during 1985 and 1986. Other articles in this symposium deal with this broad subject in detail. Based on the history of the 1970's, rather modest expectations should be held about the magnitude of changes likely to occur through legislative action. Long lists of potential legal reforms have been recommended by health care providers and are being considered in many state legislatures. Most of these ideas were also proposed in the period from 1973 to 1978. It remains to be seen which, if any, will be successful.

One change that has received considerable attention and increased acceptance is the use of periodic payments or "structured settlements." In a structured settlement, most of the special damages are paid out as they are incurred over time, rather than as a lump sum. Thus, future medical expenses and many types of economic losses can be paid more accurately for the injured person with less guesswork about life expectancy and the effects of inflation. This change will probably be adopted much more widely.

Joint hospital and physician programs are another alternative. After some initial publicity during the soft market from 1978 to 1983, these plans have receded from view in the past year. They were based heavily on cash-flow calculations, inexpensive excess insurance, and an enormous amount of total capacity available. Each of these factors has changed. Nonetheless, hospitals still appear to have "deeper pockets" than the individual physicians, and hence greater capacity to bear risk directly. The idea will probably reemerge.

Competitive pressures will continue among insurance companies. Claims-made coverage will predominate in the area of medical professional liability, as it already has for many years for other professionals. Insurance regulators will probably try to control the insurance marketplace from the sidelines rather than to jump in as a payer of last resort. There may be some new controls over reinsurance.

Some health care providers will focus on the most severe and the most frequent "compensable events." One approach may be to pay for a few well-defined injuries outside the current litigation system. There will be ongoing efforts to prevent and control risks as well as to assure the overall quality of care. Nevertheless, when sick people go for treatment, perfect or even acceptable outcomes cannot always be expected. Injuries will still occur. For the immediate future the emphasis will continue on effective postinjury claims management and legal defense.

As a concluding observation, the last malpractice crisis dealt with the availability and affordability of insurance through the formation of professionally sponsored insurance companies and the growth of captives and self-insurance, as well as other developments discussed above. The current challenge is to find new ways to gain more "mileage" from funds paid out of medical injuries, more equity from funds paid in as premiums, and, hopefully, a reduction in the frequency and severity of injuries.

It will be interesting in a few years to look back and review the results of current efforts and to examine what balance emerges: To what extent will our efforts succeed in changing the "rules of the game," or alternatively, will we continue to rely on the jousting among lawyers as the best we can do?