# Liability premium increases may offer opportunities for change

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Physicians across the country have seen dramatic increases in their 2001 and 2002 malpractice premiums. For some surgeons, these are the first substantial rate hikes in quite a few years.

Recent national news reports have speculated that the surge in malpractice insurance premiums could lead to a crisis in the availability of health care services. What is being done to stem this tide? Is this a problem that each state should attempt to solve on its own? Or is this a national problem that should be addressed by the federal government?

***Malpractice premiums rising***

Some physicians are now having trouble obtaining medical malpractice insurance, and those surgeons who are fortunate enough to find it are often charged rates that are substantially higher than in previous years.

According to the *Medical Liability Monitor,* one malpractice insurer charged Philadelphia, PA, general surgeons $35,523 for medical malpractice insurance coverage in 2001. This represented a 69 percent increase over the 2000 rates. While Pennsylvania physicians have seen some of the highest percentage increases, they are not alone. In Los Angeles, CA, medical malpractice insurance for a general surgeon that cost $35,110 in 2000 rose to $42,181 in 2001—a 20 percent increase.[1]

These alarming rate hikes are not limited to large cities. In Portland, OR, general surgeons saw their malpractice premiums increase by as much as 55 percent. In Charleston, WV, general surgeons experienced premium increases of up to 32 percent.[1]

Of course, general surgery is not the only affected specialty. Obstetrician-gynecologists and emergency physicians have also seen large increases in their malpractice insurance rates, as have other specialists who traditionally have not been considered members of the high-risk insurance classes. For example, some internists in Chicago, IL, saw their malpractice insurance premiums rise by as much as 17 percent last year.[1]

While specific data are not yet available for 2002 premiums, surgeons have reported increases at even higher rates.

### *Carriers leave the business*

The rising cost of offering medical malpractice insurance has not only led to large rate hikes, but has also prompted some companies to leave the medical malpractice insurance market. The greatest impact on physicians may be felt by the departure of St. Paul Companies from the market. On December 12, 2001, St. Paul, the second largest medical malpractice insurer in the country, announced that it would withdraw from the medical malpractice business. According to St. Paul, "The company is forecasting that medical malpractice will generate a 2001 underwriting loss of approximately $940 million."[2]

### *Physicians change practices*

The combination of rising insurance costs and decreasing insurance availability is reportedly causing some physicians to retire early, relocate, or drastically change their practices. The *Washington Post*, for example, recently ran a story about physicians in Mississippi who are being forced to drop obstetrics from their practices because of prohibitive increases in their malpractice insurance costs.[3] It also has been reported that a group practice in Delaware County, PA, will no longer perform surgery or take trauma call because they can't afford the malpractice insurance. One could speculate that the combination of a resurgent malpractice premium crisis and the continuing downward spiral in payments for key surgical services will lead to a proliferation of stories like these.

### *National tort reform*

To help control the premium increases, the College has been urging Congress to pass a series of medical liability reforms. In fact, six times in the past 10 years, the U.S. House of Representatives has passed these reforms as provisions of other health care-related bills. The efforts to pass national medical liability reform has not found as much support in the Senate, however, where no reforms have been passed to date.

Most recently, the issue of medical liability reform was brought before the House in the summer of 2001, during debate on the Patients' Bill of Rights (PBR). The leading PBR proposal contained provisions that would allow patients to sue their health plans in certain circumstances. While this provision was controversial, it led to a compromise that included a cap on noneconomic damages for lawsuits brought against health plans. The College and other leading health care groups subsequently argued that a cap on health plan liability would lead to situations where physicians were left with the "deep pockets." To alleviate this inequity, Rep. Bill Thomas (R-CA) introduced an amendment that included all of the medical liability reforms the College supports. Unfortunately, the amendment failed by a vote of 207 to 221.

In addition to the Thomas amendment, legislation on this topic has been introduced by Reps. Jim Greenwood (R-PA) and Patrick Toomey (R-PA). Legislation to put in place needed medical liability reforms also has been introduced by Sen. Mitch McConnell (R-KY).

### *State tort reform*

States have had varying degrees of success in passing medical liability reforms. For some, legislative victories have been tempered by rulings from state supreme courts that have found some medical liability reform laws unconstitutional.

In 1975, the California legislature passed a series of tort reforms that are known collectively as the Medical Injury Compensation Reform Act (MICRA). These reforms included a $250,000 cap on noneconomic damages, modifications to the collateral source rule, mandatory periodic payments of future damages, and a sliding scale for plaintiff attorneys' contingency fees. MICRA has been challenged a number of times, and in each case the California State Supreme Court has upheld the law.

Other states have not fared as well, however. For example, the Ohio legislature passed a series of medical liability reforms that were later found to be unconstitutional by the state's Supreme Court.

Supporters of medical liability reform have been unable to convince the Pennsylvania legislature to place a cap on noneconomic damages, which many believe is the crucial aspect of liability reform. Since the 1970s, that state has had a mandatory professional liability catastrophe fund. All Pennsylvania physicians pay into this fund, which is used to pay awards and claims that are not covered entirely by malpractice insurance. Due to the recent increases in jury awards, however, large shortfalls threaten the fund.

## Medical liability reforms supported by the College

1. Capping noneconomic damage awards, preferably at $250,000.
2. Modifying the collateral source rule to reduce the total awards by amounts from other sources, such as health insurance companies.
3. Shortening the statute of limitations for filing claims.
4. Limiting attorneys' contingency fees.
5. Eliminating joint and several liability, so a physician who is only partly at fault for an injury cannot be held liable for paying the entire judgment.

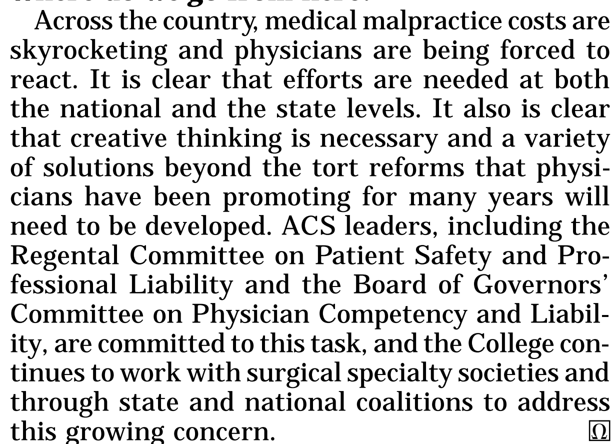
Some liability analysts describe West Virginia as "Tort Hell."[4] Because of the growing medical malpractice crisis in that state, the governor recently called the legislature into a special session in an effort to find a solution to the problem. The legislature passed a series of short-term solutions, but was unable to address the long-range implications of the issue and is expected to consider a variety of potential solutions in 2002.

### *Other dimensions*

Rising malpractice premiums are due at least in part to the large jury awards in many medical malpractice cases. According to Jury Verdict Research, the median award in a medical malpractice case has risen by 113 percent since 1994.[5] This increase stands in stark contrast to the change in the consumer price index, which has risen approximately 20 percent in the same time period.[6] An old problem, it has been speculated that the escalation in awards has only been made worse by the size of the awards granted in tobacco lawsuits in recent years.

At the same time that malpractice-related costs are rising, payments to physicians that are intended to reimburse them for these costs have not kept up. The Medicare physician fee schedule, which serves as the foundation for reimbursement rates under both public and private health plans, includes three components: physician work, practice expenses, and malpractice expenses. The foundation of the entire fee schedule is the principle that physician reimbursement should be based on the relative amount of resources required from them to provide each service.

The malpractice expense component represents the smallest fee schedule component, however, accounting for approximately 2 to 3 percent of the average service payment. The relative "weight" given to this component has in fact decreased since 1999, when it accounted for 5 percent of payments on average. This increase is small compared to increasing malpractice insurance premiums, which in many instances have been much gone up by more than 5 percent. Despite this rising cost to physicians, Congress has not allocated any new funds to fairly compensate them for this expense.



### *Where do we go from here?*

Across the country, medical malpractice costs are skyrocketing and physicians are being forced to react. It is clear that efforts are needed at both the national and the state levels. It also is clear that creative thinking is necessary and a variety of solutions beyond the tort reforms that physicians have been promoting for many years will need to be developed. ACS leaders, including the Regental Committee on Patient Safety and Professional Liability and the Board of Governors' Committee on Physician Competency and Liability, are committed to this task, and the College continues to work with surgical specialty societies and through state and national coalitions to address this growing concern. Ω

### *References*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