

**AN INTRODUCTION TO
MEDICAL LIABILITY INSURANCE ISSUES**

REPORT TO THE SJR 32 SUBCOMMITTEE ON MEDICAL LIABILITY INSURANCE

Prepared by David D. Bohyer, Research Director

September 2003



PO Box 201706
Helena, MT 59620-1706
PHONE: (406) 444-3064
FAX: (406) 444-3036
<http://leg.mt.gov/>

A study of medical liability insurance: background and purpose

In the waning days of Montana's 58th Legislative Session, the House and Senate overwhelmingly adopted Senate Joint Resolution No. 32. The resolution requested an interim study of "the costs and availability of liability insurance for health care facilities and health care providers associated with health care facilities". Subsequent to the adoption of SJR 32, the respondents to the interim study poll ranked SJR 32 as first among 13 interim studies. As a result of the ranking and other factors, the Legislative Council created a subcommittee to conduct the study, specifically, the SJR 32 Subcommittee on Medical Liability Insurance (Subcommittee).

During the summer of 2003, the Subcommittee's staff conducted a literature review of medical malpractice liability insurance (MMLI), reviewed committee minutes, articles, monographs, audits, and opinion pieces on the topic, and provided a sampling of the most relevant literature to the Subcommittee members as background material. This summary attempts to synthesize the material provided to the Subcommittee members as they prepare for the inaugural meeting, September 26, 2003, and to give a glimpse of other relevant components of a study of medical malpractice liability insurance.

The issues

As characterized in SJR 32, the study issues are relatively straightforward: recent experience with and alarm from increasing rates for medical malpractice liability insurance (MMLI); and public policy

options potentially available to address the problems identified. Indeed, testimony provided at hearings on SJR 32 noted that some health care facilities had experienced MMLI premium increases on the order of 1,000% or more over the past 2 or 3 years.¹ Montana is not alone, however, as other states reportedly are experiencing similar circumstances regarding MMLI.²

In addition to rising MMLI premiums, medical facilities and medical practitioners have also sounded the alarm that MMLI is becoming increasingly difficult to obtain, at any price, because insurers are leaving the MMLI market. For example, the American College of Physicians points out,

The St. Paul Companies of Minnesota (the nation's second largest medical insurance underwriter), PHICO, Frontier, and Reliance have announced that they would no longer write professional medical liability policies, leaving policies for well over 50,000 physicians and hospitals to expire.³

Nature and scope of the Montana medical liability insurance crisis

SJR 32, in the "whereas" clauses, lays out the basic premises for the resolution and study. In the first clause it states "...many health care providers in Montana are alarmed at the rising cost of liability insurance". In the third clause it states that the number of MMLI insurers "has

¹ *Minutes*, Senate Judiciary Committee, April 11, 2003, testimony of Senator Duane Grimes.

² See, e.g., *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, (GAO-03-702); "Medical Malpractice Reform High On States' Agenda", by Erin Madigan, at Stateline.org; URL www.stateline.org/story.do?storyId=317849, July 29, 2003; "Priority Issue -- Professional Liability Insurance Reform", American Osteopathic Association, URL <http://www.aoa-net.org/Government/stateaffairs/stategov.htm>.

³ "Professional Liability Reform", American College of Physicians, available on line at URL http://www.acponline.org/hpp/liability_ref.htm.

declined significantly in the past few years". The first statement refers to a price component of the crisis while the second statement refers to an availability component. Each of the components is testable because some MMLI price and availability data are available. Beyond the price and availability components, there is a third component, at least, which is identified in subsections (2) and (4) of the first "resolved" clause: policy options that may be available to Montana's Legislature to address causal factors of the MMLI crisis. Inherent in the third component is a review of steps that Montana has undertaken previously to address similar crises in the past.⁴

A broader view

Presenting a multistate viewpoint, the Council of State Governments (CSG) has recently published a report that characterizes the crisis somewhat differently from SJR 32. As CSG reports it,

Medical malpractice is a three-pronged problem. First, there are the medical care providers whose mistakes lead to medical malpractice claims. Second, the legal system requires a great deal of time, effort and money to determine fault, so it's an inefficient means of settling malpractice claims. Third, the medical malpractice insurance industry raises and lowers premiums, not based on a physician's track record, but partly on the ups and downs of the national economy.⁵

If the guidance provided by SJR 32 and by CSG is blended, certain information may have to be examined in terms of medical practice, the

⁴ The SJR 32 Subcommittee on Medical Liability Insurance will examine policy options at its meeting tentatively scheduled for Thursday, November. The 54th Legislature (1995) adopted an array of "tort reforms" that resulted, in part, from a study conducted during the 1993-94 interim. See *Medical Malpractice and Tort Reform: Issues of Insurance Costs, Coverage, Caps and Compensation*, Montana Legislative Council, pub., December 1994.

⁵ *Medical Malpractice Crisis*, Council of State Governments, Lexington, KY, April 2003 (revised May 2003), p.1.

legal environment, and the MMLI industry. Some of the information is readily available, but only some.⁶ Therefore, the Subcommittee may find it difficult to reach consensus findings and, in particular, consensus conclusions that can be vigorously supported with data and empirical evidence.

Laying a foundation

Proposing a solution before identifying the problem to be solved is generally not a good idea. A rational place to begin a study of MMLI is to establish whatever factual information can be established. However, "facts" alone are likely to be insufficient for the Subcommittee to reach meaningful findings and conclusions. A legislative staffer from California, a state that has a long history of public policy interaction with medical malpractice issues, characterizes his experience and observation quaintly:

... the med mal issue is characterized by absolutely contradictory information by both sides, and sorting out the reality and fact is difficult.

John Miller, Staff, California Senate Office of Research

The literature seems to support Miller's contention.⁷ Consequently, the reported facts will, first, have to be understood within the context of their origins, i.e., the age-old who, what, what, when, where, why and how.

⁶ *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, pp. 22, 45,. (GAO-03-702); *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 17-21. (GAO-03-836)

⁷ See, e.g., "Beyond MICRA: New Ideas for Liability Reform", American College of Physicians, on line at URL <http://www.acponline.org/hpp/pospaper/micra.htm>, undated; "The Impact of Medical Malpractice Insurance and Tort Law on Washington's Health Delivery System", Washington State Medical-Education and Research Foundation, September 2002; "Confronting the Myths on Medical Liability Reform", American Medical Association, position paper, undated; "MICRA vs. Prop. 103", American Medical Association, position paper, undated; *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, by Mimi Marchev, National Academy for State Health Policy, July 2002; *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices* by J. Robert Hunter and Joanne Doroshov, Center for Justice and Democracy, Washington, DC, 2002.

Second, policymakers and others must determine how those facts may relate to public policy options for the state.

The insurance component of the crisis

A cost crisis

It is difficult to establish the breadth and depth of the MMLI cost crisis in Montana. Understandably, it would be alarming for a hospital administrator to see the MMLI premium for his or her facility increase from \$9,000 in one year to \$90,000 only 2 years later or from \$8,000 to \$66,000 in a similar time frame.⁸ What these two examples don't disclose, unfortunately, are any other factors that may have affected the changes in premiums.

Aggregated data for Montana show that the total net premiums for MMLI in Montana rose from about \$16.95 million in 1998 to \$22.85 million in 2002⁹. At nearly \$6 million or 34% (nominal) over the 5-year period, the increase is notable. However, if run-of-the-mill inflation is factored in at approximately 2.5% annually over the 5-year period, the "real" or "inflation-adjusted" change in net premiums would be about \$4.15 million or 24.4% over the 5-year period. Stated differently, the annual increase in total MMLI net premiums in inflation-adjusted terms from 1998 through 2002 would be about 5.6% per year.

An availability crisis

With respect to the MMLI availability component, the announcement in

⁸ Testimony of John Flink, Montana Hospital Association, *Minutes*, Senate Judiciary Committee, April 11, 2003.

⁹ From "1998-2002 Detail Business in the State" (series) , State Insurance Commissioner, Helena, MT.

December 2001¹⁰ of the St. Paul Companies' departure from the MMLI marketplace has been cited as a significant development in the MMLI market, markedly significant in some states and relatively significant nationwide.¹¹ Through 2002, however, St. Paul's departure from the market does not appear to have been that significant for Montana as a whole--at least not yet.

In 1998, for example, the St. Paul Companies accounted for about 12.5% of MMLI net premiums reported in Montana.¹² By 2002, the St. Paul Companies still accounted for about 8.3% of net premiums (MMLI).¹³ If the trend of declining net premiums attributable to St. Paul's continues, the situation could become more disconcerting. But absent a rapidly accelerated rate of decline, St. Paul's departure may not significantly impact the availability of MMLI in Montana.

From a statewide perspective of MMLI availability, available data show that there were 56 insurers offering MMLI in Montana in 1998, with 40 of them actually reporting net premiums. By 2002, the number of insurers offering MMLI had actually increased to 57, with 38 of them reporting net premiums from MMLI. Over the 5-year period, the number of MMLI insurers licensed and reporting net premiums in Montana has remained essentially constant.¹⁴

¹⁰ "The St. Paul Companies, Inc. Exits Certain Businesses", (December 12, 2001) in Key Developments at MSN Moneycentral, (URL <http://news.moneycentral.msn.com/ticker/sigdev.asp?Symbol=spc>)

¹¹ See *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, by Mimi Marchev, National Academy for State Health Policy, July 2002, p. 6. (esp. footnote no. 14.)

¹² "1998 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

¹³ "2002 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

¹⁴ "Detail Business in the State" (1998-2002 series) , State Insurance Commissioner, Helena, MT.

The severity of the crisis in Montana

One factor that calls into question the severity of an MMLI crisis in Montana is a recent report (August 2003) from the U.S. General Accounting Office. As stated in the audit report,

In the absence of reliable national sources of data concerning provider responses to rising malpractice premiums, we focused our review on nine states selected to encompass a range of malpractice premium pricing and tort reform environments. Five of these states [FL, MS, NE, PA, WV] were among those cited by AMA and other national health care provider organizations as malpractice "crisis" or "problem" states based on such factors as higher than average increases in malpractice insurance premium rates, physicians' reported difficulties obtaining malpractice insurance coverage, and reports of actions taken by providers in response to the malpractice-related pressures of rising premiums and litigation. The remaining four states [CA, CO, MN, **MT**] were not cited by provider groups as experiencing malpractice-related problems.¹⁵ (*Emphasis added.*)

Assuming that the GAO auditors correctly compiled and accurately reported their findings, at least the Montana Medical Association and some other Montana health care providers did not view Montana as a state contending with an MMLI crisis.¹⁶

Factors contributing to increased premium rates

To the extent MMLI premium rates and availability are resulting in a

¹⁵ *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 3. (GAO-03-836). The five states with reported (MMLI) problems are Florida, Mississippi, Nevada, Pennsylvania, and West Virginia. The four states without reported (MMLI) problems are California, Colorado, Minnesota, and Montana.

¹⁶ The "other entity" providing information on the cost/availability components in Montana was the Association of Montana Health Care Providers. (See *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, App. I, p. 42. (GAO-03-836).)

crisis across Montana or only in scattered localities or within certain medical specialties only, there are certain factors that may be causing the circumstances. For example, the U.S. General Accounting Office notes four separate categories of factors that contribute to changes in premium rates.

Insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates have all contributed to rising premium rates. First, among our seven sample states, insurers' losses have increased rapidly in some states, increasing the amount that insurers expect to pay out on future claims. Second, on the national level insurers' investment income has decreased, so that insurance companies must increasingly rely on premiums to cover costs. Third, some large medical malpractice insurers have left the market in some states because selling policies was no longer profitable, reducing the downward competitive pressure on premium rates that existed through most of the 1990s. Last, reinsurance rates for some medical malpractice insurers in our seven sample states have increased substantially, increasing insurers' overall costs. In combination, all the factors affecting premium rates and the availability of medical malpractice insurance contribute to the medical malpractice insurance cycle of hard and soft markets.¹⁷

Insurers' losses are, in a nutshell, the amount of net premium, investment, and other income taken in by an insurer minus the amount of claims paid out by the insurer over the same time period. Several studies have found that these losses are the primary contributor to higher MMLI.¹⁸

There are many variables that must be accounted for within the loss equation. To complicate matters, the ways in which changes in premiums, investment and other income, and claims paid and claims

¹⁷ See, e.g., *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, p. 15. (GAO-03-702)

¹⁸ *Ibid.*

incurred interact vary among insurers, jurisdictions (both individual states and within any given state), different practices or specialties, different facilities, etc. Additionally, the numerous variables can be directly or indirectly affected by various economic, demographic, scientific, technological, cultural, legal, and other influences.

Declines in investment income, the second factor cited, depends on numerous subfactors, including the type of insurer, the amount of investable principle, rates of return, duration of investment of principle, etc. For example:

- a "mutual insurance company" may not have access to the same types of investable capital that a publicly-traded insurance company has access to;
- when an insurer has large amounts of investable capital, it has investment options, e.g., certain privately placed bonds, convertible bonds, etc., that realistically are not options for insurers with less investable capital;
- a riskier investment typically carries a higher rate of return, but a company with a weak balance sheet cannot prudently accept the higher risk even when the anticipated return is also higher. An insurer with a strong balance sheet may be able to prudently invest in some higher-risk instruments without jeopardizing its solvency.
- longer-term fixed investments, including bonds, money markets, etc., typically have higher returns than comparable shorter-term fixed investments. An insurer with a strong balance sheet may prudently invest in longer-term, higher-return fixed instruments without unduly affecting viability; an insurer with a weaker balance sheet may not have the same luxury.
- when the stock market is healthy, the bond market is not. Perhaps

counter-intuitively, a weak bond market means that rates of return on debt instruments are higher than when the bond market is strong. Insurers rely primarily on debt instruments¹⁹, such as bonds, as investments and those types of investments generated relatively high returns during the 1990s. As the stock market

bubble burst in early 2000, the bond market began to rally and fixed-investment returns to insurers began to decline.

Unquestionably, there are other factors that can affect investment income. Understanding each of the (major) factors and how each of the factors interact, both for the MMLI industry as a whole and for individual insurers, is necessary to understand how the investment income factor can affect MMLI premiums.

The third factor, a less competitive climate, is a result of other factors as well, including a reduction in the numbers of available MMLI insurers. With less competition, it is easier for any of the remaining insurers to increase premium rates. Fewer providers in the MMLI market can occur for various reasons, including nonprofitability of the departed insurer's MMLI insurance line, an insurer's insolvency (bankruptcy), industry consolidation (mergers and acquisitions), etc. However, available data (2002) do not support the contention that there are fewer insurers in Montana.²⁰

Finally, the cost and availability of reinsurance also affects the pricing of MMLI. Reinsurance is insurance for insurers. Insurers purchase reinsurance to spread the risk of claims or losses in excess of those

¹⁹ Ibid., p. 4.

²⁰ "Detail Business in the State" (1998-2002 series) , State Insurance Commissioner, Helena, MT.

initially anticipated by the insurer.²¹ Whenever an "input" cost, such as reinsurance, of the MMLI premium increases, the MMLI premium must also increase if the profitability of the insurer or at least an insurance line is to be maintained.

The medical system component of the crisis

Without real and alleged malpractice by medical practitioners and medical facilities, there would be no need for MMLI and, hence, there would be no MMLI crisis. But medical errors do occur and those errors are sometimes the result of malpractice. As reported by the organization Public Citizen,

According to the Institute of Medicine (IOM), which completed a comprehensive report on the medical malpractice issue in 1999, medical errors "are a leading cause of death in the United States... At least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors. Deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).²²

The medical community, insurance companies, injured parties and others would prefer that malpractice did not occur at all. Because it does,

²¹ Some insurers not only purchase reinsurance but also sell reinsurance. Thus, the effects of major casualties, e.g., Hurricane Andrew or the events of September 11, 2001, can have considerable impact on the overall profitability of a given insurer. Notable, for example, the St. Paul Companies were reinsurers affected by 9/11/01.

²² *Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies Not the Legal System*, Public Citizen, Washington, D.C., 2001, p. 3. (Originally from Institute of Medicine, *To Err is Human: Building a Safer Health System*, Washington D.C., National Academy Press, 1999, p. 26.)

however, the ways in which the medical community is "regulated" or "policed" may have implications for MMLI rates and availability and for public policy options.

The legal system component of the crisis

If doctors, hospitals, insurers, attorneys and other stakeholders in the MMLI crisis can agree on anything, it would probably be that truly injured parties deserve just compensation for the injury. But the devil is in the details and whatever agreement might exist initially ends quite abruptly.

Disbelief is probably as good a description as any of the initial reaction many people have when they hear of a case in which the injured party reportedly receives an award that is seemingly exorbitant given the reported extent of the injury. A second reaction may be disillusionment with a legal system or process that concludes with a seemingly irrational result, for example, the often-reported McDonald's coffee case.²³

As frequently derided as it is, the legal system comes into the picture only if an injured party believes that his or her injury is the result of malpractice and, subsequently, that adequate compensation for the injury is not forthcoming without resorting to legal means. Instances of malpractice for which claims are made are in the significant minority, however. Specifically with respect to injury as a result of medical malpractice, estimates of the number of claims filed range from about 1

²³ "The 'McDonald's Coffee Case' and Other Fictions", Center for Justice and Democracy, NY, NY, undated. This case involved a woman who had spilled a cup of McDonald's coffee in her lap. It was initially and repeatedly reported that she had been awarded \$3 million for the mishap, i.e., \$200,000 in compensatory (actual) damages and \$2.7 million in punitive damages. Penultimately, the judge reduced the award to approximately \$640,000, i.e., \$160,000 actual and \$480,000 punitive. Subsequently, the parties entered a post-verdict settlement.

claim for every 6 injuries²⁴ to 1 claim for every 8 injuries.²⁵ Additionally, estimates of the likelihood that a claim results in compensation to the plaintiff range from about 1 in 2 to 1 in 4 of the claims filed.²⁶

Differences of experience and opinion

In addition to the issue of the frequency of claims made for medical malpractice is the related issue of the severity of claims. In a 2002 study commissioned by the U.S. Department of Health and Human Services, the need for tort reform at the national level is seen as crucial.

... Increasingly, Americans are at risk of not being able to find a doctor when they most need one because the doctor has given up practice, limited the practice to patients without health conditions that would increase the litigation risk, or moved to a state with a fairer legal system where insurance can be obtained at a lower price.

This broken system of litigation is also raising the cost of health care that all Americans pay, through out-of-pocket payments, insurance premiums, and federal taxes. Excessive litigation is impeding efforts to improve quality of care. Hospitals, doctors, and nurses are reluctant to report problems and participate in joint efforts to improve care because they fear being dragged into lawsuits, even if they did nothing wrong.

Increasingly extreme judgments in a small proportion of cases and the settlements they influence are driving this litigation crisis. At the same time, most injured patients receive no compensation.²⁷

²⁴ *Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies Not the Legal System*, Public Citizen, Washington, D.C., 2001, p. 4.

²⁵ *Medical Malpractice: Perceptions and Misperceptions*, American Bar Association, Feb. 1995, p. 8. One report on MMLI suggests that the likelihood of compensation being paid to an injured party may be as remote as 3%, i.e., only 3 of 100 injured parties actually receive compensation. (*Medical Malpractice Crisis*, Council of State Governments, April 2003, p. 9.)

²⁶ See, e.g., *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, by Mimi Marchev, National Academy for State Health Policy, July 2002, p. 3.

²⁷ *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System*, U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, July 24, 2002, p. 1. On line at URL

Similar to other aspects of the crisis, there is fundamental disagreement about historical and recent changes in the severity of claims. For example, the U.S. General Accounting Office states:

... the average reported claims payment made on behalf of physicians and other licensed health care practitioners in 2001 was about \$300,000 for all settlements, and about \$500,000 for trial verdicts.²⁸

BusinessWeek online, an affiliate of *Business Week* magazine, gives a second opinion on the tort reforms being discussed at the national level:

The size of damage claims paid out by physician insurers has been more or less steady since 1991, according to the National Practitioner Data Bank, a government service that tracks doctor errors and malpractice claims. The mean payout was \$135,941 in 2001, up 8.7% from \$125,000 a year earlier. Over 10 years, malpractice payouts have grown an average of 6.2% a year.

Guess what? That's almost exactly the rate of medical inflation: an average of 6.7% between 1990 and 2001, according to the *Journal of Health Affairs*. It's also worth noting that, nationwide, malpractice payouts by physicians and their insurers were a mere \$4.5 billion in 2001--less than 1% of the country's overall health-care costs of \$1.4 trillion. They have risen slowly, if steadily, since 1996, when the total was \$3.5 billion.²⁹

The American Osteopathic Association asserts:

[A] report by Jury Verdict Research has shown that jury awards and verdicts doubled from 1995 to 2000. The median award in 1995 was

<http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>

²⁸ *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 8. (GAO-03-836).

²⁹ "Commentary: A Second Opinion on the Malpractice Plague", by Lorraine Woellert, *BusinessWeek online*, March 3, 2003.

\$500,000. Six years later in 2001 (the latest figure available), the median award was \$1 million, after increasing by more than 40 percent in 2000.³⁰

On the same topic, Weiss Ratings, Inc.³¹, claims otherwise:

The median payout in states without caps surged 127.9 percent, from \$65,831 in 1991 to \$150,000 in 2002. In contrast, the median payout grew by 83.3 percent in states with caps, from \$60,000 to \$110,000. Likewise, in states without caps, the median payout for the entire 12-year period was \$116,297, ranging from \$75,000 to \$220,000, while the median payout for states with caps was 15.7 percent lower, or \$98,079, ranging from \$50,000 to \$190,000.³²

And, finally, from Americans for Insurance Reform:

New insurance industry data and analysis...shows that the average medical malpractice insurance payout, or closed claim, has been only \$28,524 over the last decade. Payouts in 2001 follow the same low pattern. This figure includes all jury verdicts, settlements and other costs used by insurers to fight claims in court. Moreover, medical malpractice insurers are paying nothing in 77 percent of all claims filed; in the 23 percent of cases where insurers pay anything, the average claim is only \$107,587. According to the Harvard Medical Practice Study, only one in eight malpractice victims ever files a claim for compensation.³³

³⁰ *Priority Issue: Professional Liability Insurance Reform*, AOAnet, no author or date. On the internet at URL <http://www.aoa-net.org/Government/stateaffairs/stategov.htm>.

³¹ Weiss Ratings, Inc., is, according to its website, evaluates "the financial stability of over 16,000 financial institutions, including banks, insurance companies, HMOs, and securities brokers. Weiss also rates the risk-adjusted performance of over 12,000 mutual funds including stock funds, bond funds, and money market funds, and over 9,000 common stocks." Source: http://www.libraryresource.com/entries/weiss_ratings_inc.,insurance.shtml

³² "Medical Malpractice Caps Fail to Prevent Premium Increases", Weiss Ratings, Inc., June 3, 2003, on line at URL http://weissratings.com/News/Ins_General/20030602pc.htm

³³ "New Study Shows Average Medical Malpractice Payout over Last Decade Only \$28,524; New Data Reveals Same Trends in 2001", Americans for Insurance Reform, January 23, 2003, on line at URL <http://www.centerjd.org/air/pr/release030123.html>.

Searching for causal factors

Identifying the specific cause or causes of rising premiums is, at best, elusive. On the one hand, representatives of medical facilities and medical providers and various insurers have identified the costs of tort actions, both those that are settled and those that are litigated, as a primary driver in spiraling MMLI costs.³⁴ In one release, the American Medical Association leaves few questions about its position:

Today's report also puts to rest two other trial lawyer smokescreens: that insurance company gouging and/or stock market losses have caused the medical liability crisis. Today's report makes clear that bonds make up 80 percent of insurers' investments and that 'no medical malpractice insurers experienced a net loss on their investment portfolios.' The GAO report also states that insurer 'profits are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates.' It also notes that insurance regulators in most states have the authority to deny excessive premium rates.³⁵

The American Tort Reform Association, a compatriot of the AMA, apparently holds similar views:

The fact is that medical malpractice insurance premiums have skyrocketed because both the frequency and severity of claims are

³⁴ "Warning to Senate Judiciary Committee to Curb Medical Liability Excesses", American College of Physicians, on line at URL http://www.acponline.org/hpp/liability_excess.htm.

³⁵ "Increasing lawsuit awards are the main cause of skyrocketing liability insurance rates", attributed to Donald J. Palmisano, MD, AMA President, July 28, 2003. URL www.ama-assn.org/ama/pub/article/1617-7913.html. The "report" referred to in the statement is a report prepared by the U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, (GAO-03-702).

on the rise.³⁶

And the American Academy of Dermatology Association echoes the sentiment:

The root cause of this problem [*rising premiums*] is the unrestrained escalation of jury awards and settlements. These awards and settlements are driving up liability insurance premiums for physicians, including dermatologists, and are forcing insurance companies out of the business of providing medical liability insurance.³⁷

Objection

On the other hand, the contingent of the Bar often referred to as "trial lawyers" has a different perception of the causes of rising rates, particularly as malpractice awards or malpractice litigation in general are characterized as direct "causes" of the MMLI crisis.

Investment income is down, and as a result, the insurance industry is now charging higher medical malpractice premiums. The American Medical Association (AMA) is calling for federal legislation that preempts state medical professional liability laws to limit compensation to patients injured by malpractice because the AMA assumes such limits will reduce malpractice rates. However, there is no evidence that limiting compensation to injured patients will have a real impact on malpractice rates. The AMA is carrying on a multi-million dollar public relations campaign to gain public support for such federal legislation and for tort law changes at the state level.

... The ABA urges the legal and medical professions to cooperate in seeking a solution to medical liability problems and maintains that federal involvement in the area is inappropriate. In particular, the ABA opposes caps on pain and suffering awards,

³⁶ "John Edwards Botches the Facts on Medical Liability", American Tort Reform Association, May 23, 2003 on line at URL <http://www.atra.org/show/7568>.

³⁷ "Medical Liability Reform Talking Points", American Academy of Dermatology Association, Gov't Affairs, 2003, on line URL http://www.aadassociation.org/Medical_Liability_Reform_TP.html

supports retaining current tort rules on malicious prosecution, collateral sources and contingent fees, and believes that the use of structured settlements should be encouraged. It also supports certain changes at the state level in the areas of punitive damages, jury verdicts and joint and several liability.³⁸

The ABA's perception is apparently shared by researchers at the Center for Justice and Democracy:

... *[research]* indicates that there is a modest rise in insurance rates/loss costs from the adoption of mid-range tort reforms for the Medical Malpractice category. That is, the underlying costs, which ultimately drive insurance prices, are impacted upwardly by mid-range medical malpractice tort law changes of the type adopted in this nation since the liability insurance crisis of the mid-1980s. This is counter-intuitive. While there does appear to be a reduction in rates/loss costs from severe tort law changes in medical malpractice, compared to the changes in categories 1 and 2, the mixed results confuse any conclusion. One reasonable conclusion is that no clear evidence of tort law change impacting insurance prices is determinable from these data.³⁹

Options for state policy makers

State policy makers have various options that may or may not affect MMLI premiums. For Montana policy makers, some of those options were visited in previous MMLI crises in the 1970s and 1980s and, most recently, revisited in the 1993-94 interim, including some of the options that are being strenuously advocated and, simultaneously, strenuously resisted at the national level. In the spirit of the SJR 32 direction to review measures adopted by other states to address the liability insurance

³⁸ "Tort Law: Medical Professional Liability", 2003 Legislative Priorities, American Bar Association, July 23, 2003, on line at URL <http://www.abanet.org/poladv/priorities/mpl.html>.

³⁹*Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices* by J. Robert Hunter and Joanne Doroshov, Center for Justice and Democracy, NY, NY, 2002, p 17.

problems, recent action in Florida included examining many options considered by other states. In Florida, the Governor's Select Task Force on Health Care Professional Liability Insurance ultimately made 60 recommendations distributed across five categories,⁴⁰ but only *after* conducting 10 meetings over a 5-month period and investing considerable time, energy, and resources. As described by the Task Force's chairman,

... the task force studied the history of medical malpractice and the current medical malpractice crisis in Florida, heard extensive testimony from healthcare providers and malpractice victims at hearings throughout the state, read hundreds of letters from concerned citizens, and conducted our own independent research of published studies and relevant literature.⁴¹

Looking ahead

The SJR 32 Subcommittee will meet five times over a 10-month period during which it will conduct its work. At the Subcommittee's meeting tentatively scheduled for November 20, 2003, the focus will shift from the broad-brush information presented herein and which will follow at the September 22 meeting to the legal foundations of medical liability in Montana and to specific alternatives that have been or are being considered elsewhere.

Using the Florida initiatives as a broad outline, elements remaining within the category of establishing a factual foundation of MMLI in Montana, the Subcommittee may consider examining the same or similar broad categories.

⁴⁰ *Governor's Select Task Force on Healthcare Professional Liability Insurance*, final report, pp. vii - xvi.

⁴¹ John C. Hitt, Chairman, *Governor's Select Task Force on Healthcare Professional Liability Insurance*, January 29, 2003 letter of transmittal of the Task Force's report.

Healthcare quality. If this category becomes a focus, various statistical and other information must be compiled and analyzed regarding the nature and scope of medical malpractice in Montana. Included in this category might be an examination of the law and practice regarding the reporting of medical errors, both committed and observed; various patient safety initiatives; health care or patient safety "demonstration projects"; reviewing statutory or other requirements for patient safety in medical facilities; within the insurance code, potential changes intended to reduce MMLI premiums; and educating the public on health care.

Physician discipline. Examining this category will involve compiling and reviewing statistical and other information on the extent to which medical errors are committed, observed, and reported and that might be preventable. Subcategories might include quasi-judicial review initiatives; clarifying the scope of regulatory or licensing authorities regarding standards of care; the establishment or codification of standards of care; periodic independent review of physician discipline; the confidentiality of certain, particularly sealed, records regarding medical error; physician profiles; mediation initiatives; burden of proof requirements in disciplinary proceedings; and use of the Internet to promote and ensure systemic integrity.

The need for tort reform. Topics falling under this rubric might include measuring the effects of existing "tort reforms" enacted previously in Montana or elsewhere; visiting or revisiting the efficacy of previously adopted or considered reforms; various aspects of civil procedures regarding medical malpractice claims; qualifications of expert witnesses; liability for emergency services; sovereign immunity from medical malpractice under certain circumstances; payment of damages; pre-lawsuit initiatives; and plaintiff attorney fees.

Alternative dispute resolution. This category could include reviewing

mandatory mediation models or voluntary binding arbitration initiatives.

Insurance reform. Included under this heading might be such matters as bad faith; alternative insurance products; and insurance company regulation.

In order to maximize the likelihood of the Subcommittee achieving successful outcomes from the SJR 32 study, the members must focus their attention on the nature and scope of the crisis *in Montana*. They must first reach some level of consensus on the causal relationships between various factors and the MMLI crisis *in Montana* and, subsequently, on the ability of state policy makers to effect positive changes in the causal factors *in Montana*.

Upon successful completion of those elements of the SJR 32 study, the Subcommittee can finally turn its attention to options, prescribed through legislation if appropriate or necessary, that may be proposed to address the causal factors.

SJR32\summary 1.wpd

CI0429 3260dbca.

