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Medical Malpractice Insurance: A Call for Efficiency

By Robert J. Walling, FCAS, MAAA and Shawna S. Ackerman, FCAS, MAAA

For the third time in the last thirty years, the U.S. medical malpractice insurance industry has found itself enduring a severe market disruption. This industry crisis has more than tripled medical malpractice premiums for some health care providers, bankrupted several leading insurers and limited access to health care services for residents of several states.

After evaluating different state medical malpractice liability reforms for state insurance regulators, legislative bodies and governmental insurance programs, Pinnacle Actuarial Resources, Inc. (Pinnacle) has identified proven reforms for boosting system efficiency and cutting costs.

These reforms include:

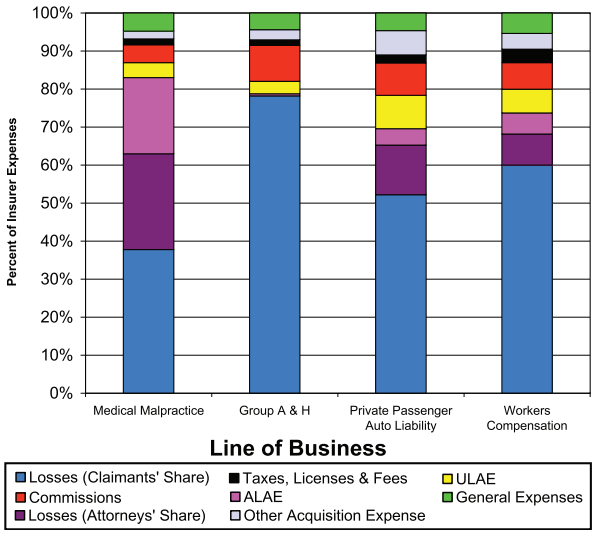
- Implementing "I'm sorry" physician apology laws
- Establishing birth-related neurological injury funds
- Adopting pre-litigation screening panels

Moreover, these reforms bring the added bonus of increasing the portion of insurance company expenditures going to injured patients.

Crisis Versus System Flaw

Beyond the factors leading to the market disaster, medical malpractice insurance faces a more fundamental flaw: The current system is incredibly inefficient. For purposes of this monograph, inefficient means that the insurance mechanism does not deliver a large enough portion of the insurance carriers' expenditures to the injured patient. As the following graphic shows (Figure 1), medical malpractice insurance currently delivers less than 40 cents per dollar of insurance company expenditures to injured patients. This is a much lower percentage than the 60 cents per dollar delivered to injured workers by workers' compensation insurance or the almost 80 cents delivered to group health insurance claimants.

Figure 1 – Insurance System Efficiency by Line



Source: Pinnacle analysis of 2004 annual statement data from AM Best Company

About the Authors

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Mr. Walling is a Principal and Consultant with Pinnacle Actuarial Resources, Inc., in the Bloomington, Illinois, office, and has worked in the insurance industry since 1989. He is a Fellow of the Casualty Actuarial Society and a member of the American Academy of Actuaries. He has served the CAS as Chairman of the Ratemaking Seminar Committee, Chairman of the Risk and Capital Management Seminar Committee, and Chairman of the New Fellows Committee.

Mr. Walling's specific medical malpractice experience includes developing a stochastic model for estimating Death, Disability & Retirement unearned premium reserves, costing studies related to patient compensation funds, surveys of state medical malpractice market conditions, legislative costing studies and reserve analyses supporting the financial examination of medical malpractice insurers and self insurance programs.

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Ms. Ackerman is a Fellow of the Casualty Actuarial Society (CAS) and a member of the American Academy of Actuaries. She has experience reviewing the regulatory compliance of medical malpractice rate filings in a number of states, evaluating the potential impact of proposed medical malpractice insurance reform legislation, evaluating factors that have contributed to medical malpractice insurance crises, and assessing the potential impact of different rate regulatory structures for medical malpractice insurance.

Improving the medical malpractice system means going beyond merely cutting costs. Consider caps on non-economic damages. There is no doubt that damage caps do result in one-time savings and can bolster insurance market stability, but they do not encourage delivering fair compensation in a more efficient manner. In fact, without additional reforms, caps reduce patient damage recoveries without any direct impact on other system costs.[1]

"I'm Sorry" Laws

Physician apology laws or "I'm sorry" laws are growing in popularity, as evidenced by the state legislation considered and passed in the last two years. It's easy to see why. Anecdotal evidence shows that physician apology laws appear to have the potential to reduce overall medical malpractice liability costs by lowering the amount of lawsuits, attorney fees and the claim costs. Additionally, studies show that physician apology laws encourage open communication, reporting and investigation of errors, thereby providing an opportunity to prevent future errors.

Figure 2 - "I'm Sorry" Legislation by State

"I'm Sorry" Legislation By State

State	Year Enacted	Bill	Notes
AZ	2005	SB 1036	Acts of Apology and Responsibility
CA	2001		Acts of Sympathy
CO	**2003**	**HB 1232**	**Acts of Apology, Sympathy and Fault**
FL	2004	90.4026	Acts of Sympathy
GA	2005		Acts of Apology and Regret
IL	2005	HB 4847	Acts of Apology and Explanation, with 72 Hour Time Limit
IA	2006 Pending	HB 2716	Acts of Apology and Sympathy
MA	1986/2005		Acts of Apology and Regret
MI	2006 Pending	HB 4259	Acts of Apology and Sympathy
MT	2005	HB 24	Acts of Apology and Sympathy
NC	2004	HB 669	Acts of Apology. Allows offers to undertake corrective or remedial treatment or actions, and gratuitous acts
OH	2004	HB 215	Acts of Apology and Sympathy
OK	2004	HB 2661	Acts of Apology and Sympathy
OR	2003	HB 3361	Acts of Apology and Regret
TN	2003		Acts of Sympathy
TX	1999		Acts of Sympathy
VA	2005		Acts of Sympathy
VT		Case Law provides immunity for apologies	
WA	2004	SB 6645	Acts of Apology
WY	2004	HB 1004/ SB 1004	Acts of Apology and Sympathy

The renewed legislative activity began with Colorado which, in 2003, passed a law that prohibits expressions of sympathy and full, fault-admitting apologies ("I'm sorry I did this to you") from being used as proof of liability. Previously, several states had enacted laws that excluded an expression of sympathy ("I'm sorry this happened") as proof of liability.

Even without a state law to cover physician disclosures and apologies, several organizations have practiced disclosure with reported success. The Veterans' Administration (VA) hospital in Lexington, Ky., is often cited as an example of effective medical error communications policy. The VA hospital goes one step further than Colorado in its approach to disclosure. Besides encouraging expressions of sympathy and admissions of fault, the VA actively seeks to disclose medical errors and offers direction on how to file a claim, e.g., "I'm sorry that I hurt you and here is what you need to do to file a claim."

This policy of extreme honesty, practiced since the late 1980s, has reportedly reduced lawsuits and settlement and defense costs. Only three cases have gone to trial in 17 years, with the average settlement being $16,000, compared to the national VA average of $98,000. Furthermore, cases are closed in two to four months instead of the usual two to four year average, which saves on defense costs.[2] Frequency at the Lexington hospital is in the upper quartile of comparable VA hospitals,[3] which shows that more patients are receiving compensation even as overall costs for the compensation system are on the decline.

COPIC Insurance Company, the largest medical malpractice carrier in Colorado, also demonstrates the effectiveness of the "I'm Sorry" approach. COPIC's program includes instructions for teaching doctors to discuss medical errors, say "I'm sorry" and make the patient whole. COPIC's training program is mandatory for all insureds. A coordinated claims process to more proactively make patients whole has also been developed. [4] In the four years that the program has been in effect, only two patients have sued while in the program. The program was initially limited to claims of less than $30,000 and is being expanded to large claims.[5]

Encouraging doctors to apologize for mistakes has also made a difference at the hospitals in

the University of Michigan Health System. Since implementing its program in 2002, the system's annual attorney fees have dropped from $3 million to $1 million. Malpractice lawsuits and notices of intent to sue have fallen from 262 filed in 2001 to about 130 a year.[6]

The big question, of course, is what will be the ultimate impact of a physician apology law on medical malpractice claims? Beyond a review of existing literature, Pinnacle did its own analysis to assess the impact of physician apology laws. To develop an estimate of the impact of a physician apology law, Pinnacle divided a closed-claim database into claims with a reported loss of $30,000 or less and those greater than $30,000.

From the anecdotal evidence reviewed, "I'm sorry" programs have led to a reduction in legal defense costs of 30% to 67%. When applying a 30% – 50% reduction in ALAE to smaller claims, this reduction translates to a 3.5% - 5.9% savings in total claim costs. This potential savings assumes that there are not currently "I'm sorry" programs in place. To the extent that states or risk management programs have already implemented some form of a physician apology program, the savings will be less.

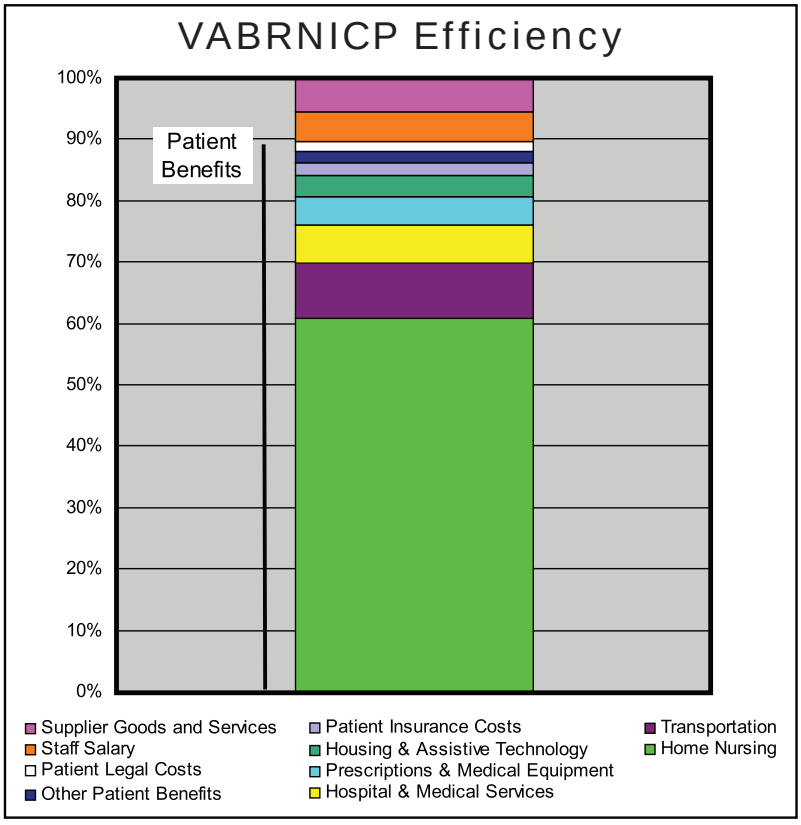
Birth-Related Neurological Injury Programs

Another approach showing a lot of promise for reducing medical malpractice system costs is a specialized variation of the patient compensation fund (PCF). PCFs are commonly established to provide excess medical malpractice coverage. In New Mexico, for example, insurers can choose to participate in a voluntary program where the PCF is responsible for unlimited medical costs and other economic damages and non-economic damages up to a damage cap. This coverage applies above the insurer's primary coverage of $200,000 per occurrence and $600,000 in the aggregate. Insureds under this program pay a PCF assessment through their insurer.

Generally, PCFs do not materially improve system efficiency but rather enhance the stability of insurer loss results and availability of reinsurance during hard market conditions. However, there is a specific type of PCF, called a birth-related neurological injury compensation program (BRNICP), that does significantly improve efficiency. This can be seen in the following graph (Figure 3) that shows the Virginia BRNICP achieved an efficiency of about 88% in 2004. Unlike broader PCFs, these funds only deal with a specific type of injury – typically birth-related injuries resulting in both physical and mental disabilities. Unlike other PCFs, BRNICPs change the applicable liability laws. The typical tort law for medical malpractice claims is replaced by a "no-fault" type statute. This legal approach ensures that attorney fees are extremely limited in these severe claims. Furthermore, the benefits these claimants receive are usually significantly better than benefits received through a tort-based system.

The intent of this type of legislation is to view birth-related injuries as a statewide health issue that needs to be addressed as a matter of public welfare, not one of liability and lawsuits. This broader view encourages a variety of other funding mechanisms such as assessments of non-participating healthcare providers and many lines of insurance premiums. These funds significantly reduce medical malpractice insurance costs for physicians in birth-related specialties in states with these funds.

Figure 3 - VABRNICP Efficiency



There are currently two BRNICPs, the Florida Birth-Related Neurological Injury Compensation Association (NICA) and the Virginia Birth-Related Neurological Injury Compensation Program (VABRNICP). They were both created in 1987-88 as an exclusive remedy for this very specific type of injury. The benefits under the Virginia program demonstrate how this approach can be more generous than a tort award (Figure 4 on the next page).

Figure 4 – VABRNICP Benefits

For eligible claims, the VABRNICP covers:

- **Lifetime Medical Treatment**
- **Lifetime Hospital Care**
- **Lifetime Prescription Benefits**
- **Rehabilitation/Therapy**
- **Residential & Custodial Care, including Nursing & Home Health Care**
- **Compensation for Lost Wages (Ages 18-65)**
- **Special Equipment (Vans, Wheel Chairs, Beds, Medical Appliances, etc.)**
- **Housing Allowance**
- **Reasonable Claim Filing Costs (including Attorney's Fees)**
- **Medically Necessary Travel Expenses**
- **Augmentative Communication Technology**
- **Family Couseling**
- **Funeral Expenses**

These programs appear to be a limited government intervention into the insurance market that:

1) improves significantly one aspect of the system's efficiency,
2) provides stability for one of medical malpractice's most difficult specialties – OB/GYNs,
3) allows competitive market forces to continue to operate as broadly as possible, and
4) increases competition because of the increased predictability of OB/GYN losses.

Prelitigation Screening Panels

Prelitigation screening panels, a common element in many broad medical malpractice reforms, are another proven effective way to improve efficiency and reduce legal costs. These panels review the merits of medical malpractice claims prior to trial. Their recommendations can be binding or non-binding and encourage pre-trial settlements.

Pinnacle found that mandatory prelitigation screening panels can reduce expected medical malpractice losses by up to 9%. This finding is based on a comparison of industry closed claim databases of two states with very similar claims characteristics. One state uses panels; the other does not.

Inflation-adjusted closed claims data from both states were sorted by the size of the indemnity payment. Pinnacle identified several important similarities. In both states, 78% of claims were closed without an indemnity payment. Likewise, the distribution of claims with indemnity payments is very similar and the average severity of claims with indemnity payments is quite comparable.

The differences between the states revealed the impact of prelitigation screening panels. For the state without panels, claims closed without indemnity payments or payments of less than $25,000 have significantly higher ALAE and therefore lower efficiency for smaller claims. Mandatory prelitigation screening panels, however, validate the merits of claims and eliminate frivolous claims. This reduces the need for attorney involvement and significantly lowers loss adjustment expense, Pinnacle concluded. Many of the stakeholders in the state with mandatory panels view the panels as a significant contributor to the relative success of their medical malpractice system compared to neighboring states.

Pinnacle's analysis, therefore, concluded that introducing prelitigation screening panels would reduce average ALAE severity for claims closed with no indemnity payments and payments less than $25,000. If the panels were only able to achieve this improvement, expected medical malpractice losses would be reduced by approximately 9%. The results of the analysis do not factor in the likelihood that panels would reduce claim frequency by discouraging meritless claims.

Conclusion

The medical malpractice insurance system is again facing a crisis, but with this comes the opportunity to improve the system. By implementing proven strategies, such as "I'm sorry"/physician apology laws, birth-related neurological injury programs and prelitigation screening panels, legislators and regulators can work together to stabilize premiums and better deliver compensation to injured patients.

For more information on how Pinnacle can help with medical malpractice system solutions, please contact Robert Walling at 309-665-5010 or rwalling@pinnacleactuaries.com, and Shawna Ackerman at 415-439-5226 or shawnaa@pinnacleactuaries.com.

1 Studies such as Pace, Nicholas M. et al., Capping Non-Economic Awards in Medical Malpractice Trials – California Jury Verdicts Under MICRA, 2004 RAND Corporation, www.rand.org/publications/MG/MG234/ suggest about 75% of the reductions in net damages received by patients can be restored with simultaneous introduction of caps on attorney contingency fees.
2 "Why Sorry Works! – Overview of Sorry Works Programs for the Medical Malpractice Crisis," http://www.victimsandfamilies.com/Sorry.phtml
3 Kraman et al. Risk Management: Extreme Honesty May Be the Best Policy, Annals of Internal Medicine, Vol. 131: No. 12; 963-967.
4 COPIC TOPICS, No. 94, October 2004
5 Brand, Rachel, Rocky Mountain News, 4/1/2004, "Medical insurance company seeks more disclosure, cut in malpractice lawsuits" www.cortezjournal.com/asp-bin/article_ generation.asp?article_type=biz&article_path=/business/biz040401_3.htm
6 Tanner, Lindsey, Associated Press, 11/12/2004, "Doctors get advice to own up to mistakes."