

Retooling Medical Professional Liability

Healthcare debate raises new hopes for a better system



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From Pennsylvania Avenue to Main Street—from the halls of Congress to hundreds of town halls—from the CEOs of the nation's largest health insurers to the parents applying bandages to skinned knees, it seems that everyone, everywhere, is talking about the future of healthcare in this country. Many speeches have been given and many articles have been written about healthcare reform, mostly focusing on providing better care to more people in a cost-effective manner. Often overlooked in those discussions is one part of the system that could also use some retooling: the process used to adjudicate claims of medical negligence.

Under the medical professional liability (MPL) tort-based system currently in place, claims can take an average of three and a half to five years to reach resolution.¹ Of even greater concern are the high expenses associated with the drawn-out and adversarial nature of litigating cases in the courts. These costs are compounded over the lengthy time it takes to settle MPL claims, with the result that claimants often end up receiving only 39 cents of every dollar paid by healthcare providers to finance this system. More than 60% of the financing costs are eaten up along the way by fees for lawyers and expert witnesses, court costs, and insurance company overhead.²

At the same time, any dispassionate discussion of MPL reform must acknowledge that there is a legitimate need to ensure that individual claimants' rights are respected and protected and that the parties involved in a case can honestly interpret the facts and circumstances leading to the injury differently. Thus, we believe that some claims—those involving serious injury or even death—do need to be pursued within a structured legal process, regardless of cost or length of time needed to reach an appropriate resolution.

But do all MPL actions need to be handled in such a litigious and hostile manner? Could there be more flexible alternatives to the protracted and costly tort system now in place? Can we forge a new system for the adjudication of MPL claims—one that allows for speedy, amicable resolution with appropriate compensation when circumstances allow, and yet still provides an avenue for tort relief when that route is most appropriate?

Previous efforts have tended to narrowly focus on reforming the current MPL system. A report by the Robert Wood Johnson Foundation observed that “[w]hen no malpractice crisis exists, there is no interest in changing the system. And yet when a crisis does exist, the push is to limit monetary awards, not to make fundamental changes.”³

The broader national debate concerning healthcare reform could open the door to a new and more balanced dialogue on the issue of medical liability, one that acknowledges the legitimate concerns expressed by all stakeholders and leads, ultimately, to a new, more just and efficient process in the future.

We believe the primary goals for any truly effective and efficient system of resolving MPL claims should be to:

- compensate injured parties quickly, fairly, and appropriately in response to injuries received as part of any adverse medical event related to or caused by treatment
- encourage a transparent healthcare environment dedicated to quality improvement, so that all mishaps, misjudgments, and/or mistakes can be examined and discussed openly, leading to improved patient safety in the long term without exposing healthcare providers to non-meritorious lawsuits

A review of the many problems plaguing the MPL process makes clear how rarely, if ever, the current system delivers on either of these key objectives.

DRAWBACKS OF THE CURRENT SYSTEM OF RESOLVING MPL CLAIMS

1. Valuation of damages can obscure evaluation of negligence

The decision to file an MPL claim is a joint one between the injured party and his or her attorney. Because MPL cases are pursued on a contingency fee basis (i.e., the attorney only receives compensation if and when a monetary award is made, either through settlement

1 Based on Milliman analysis of nearly 80,000 individual medical malpractice claims; also in a report by Hoyt, Robert E. & Powell, Lawrence S. (April 25, 2006), “Pricing and Reserving Practices in Medical Malpractice Insurance,” p. 9. (Research support provided by the Physician Insurers Association of America [PIAA].) Retrieved August 21, 2009, from http://www.piaa.us/pdf_files/press_releases/PIAA_FTCR_04252006.pdf.

2 Based on Milliman analysis of more than 30 years of insurance industry data reported in state-required annual statements. See also: Studdert, David M., et al. (May 11, 2006), “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” *New England Journal of Medicine*; and “Improving Malpractice Prevention and Compensation System” (September 2007), a report on the results of 11 grants made by the Robert Wood Johnson Foundation to evaluate innovative malpractice reform systems.

3 “Improving Malpractice Prevention and Compensation Systems” (September 2007), *ibid.*

offer or jury finding, most often equal to a third of the award), the attorney's needs and interests may not coincide with those of the plaintiff.

Claims can cost many thousands of dollars to undertake. Attorneys are therefore understandably hesitant to take any case regardless of its legitimacy or the level of negligence involved—if they believe it will not result in an award large enough to cover their expenses. This is nothing more than simple economics.

This is unfortunate, however, as the patient injured through malpractice who requires \$20,000 to be made whole may be just as deserving as the more seriously injured patient who requires \$250,000 or more. The retired 82-year-old bachelor who has suffered a malpractice injury may deserve compensation just as much as does the 38-year-old single mother of three. Yet many plaintiff attorneys are unlikely to take on either of the former cases in each example because (a) one-third of \$20,000 is not a large enough fee, and (b) juries are not always as sympathetic to elderly claimants without families as they are to younger ones with dependents.

2. The adversarial nature of the tort system restricts and chills communication between the parties

Just as the current system discourages the filing and pursuit of many legitimate claims, it also encourages the filing of many claims where the adverse medical event in question was not the result of negligence.⁴

Because doctors and other healthcare providers know they can be sued successfully for harmful outcomes not related to any negligence on their part, they have generally been advised by their attorneys to *circle the wagons* when an adverse medical event occurs, i.e., they are told not to discuss such events openly with their patients. This denies doctors and other providers the opportunity to express empathy to the patient or family or explain what actually occurred immediately after the event.

When providers and claimants do finally get to be in the same room and listen to each other, it is most often in court or in the form of legal depositions taken in an attorney's office. Such encounters are technical, cold, and contentious, and do not offer the best environment in which to explain to a family how and why their loved one was injured or died.

3. Litigation is often a long and drawn-out process resulting in delayed compensation to deserving claimants

A timeline included in a 2006 report prepared for the Physician Insurers Association of America (PIAA) by Robert E. Hoyt, Ph.D., University of Georgia, and Lawrence S. Powell, Ph.D., University of Arkansas, estimates the length of time between the occurrence of an adverse medical incident and resolution to be about four

and a half years: one and three-quarter years from incident to reporting a claim, a little more than two additional years before court proceedings actually commence, then another six to nine months before final resolution.⁵

A review of nearly 80,000 individual claims of Milliman insurance company clients supports the Hoyt/Powell timeline. It found the average time from incident to the report of a claim to be one and a half to two years, and the average length of time from report to settlement another two to three years.

As these are averages, it is likely that more catastrophic injuries—regardless of whether negligence was involved—can take significantly longer to adjudicate. A 2006 Harvard School of Public Health study found that the average time between injury and resolution was five years, but noted that 33% of claims took six years or more.⁶

4. A jury trial may not be the best method of deciding complex medical issues

The issues and technical details that contribute to an adverse medical outcome are often highly complex, involving arcane medical terminology and revealing multiple fine shades of gray when it comes to identifying precisely the proximate cause of the injury and then laying blame. The esoteric nature of medical care cannot always be fully understood or fairly evaluated by laypeople with no formal training.

To compensate, expert witnesses are often engaged by both plaintiff and defense attorneys to explain and interpret what occurred. In addition to the time and cost this adds to the proceedings, *dueling* expert witnesses, each hired to present an interpretation that best supports the side paying their fee, often do little to uncover the truth of what actually happened. At best, they may cancel each other out. At worst, they serve to confuse members of the jury, who may not be able to understand how two *experts* could come to such widely divergent opinions.

5. Fear of lawsuits leads to a high cost for defensive medicine

Although difficult to quantify, it is widely accepted that the current MPL system encourages doctors and other healthcare providers to practice *defensive medicine*. i.e., to provide treatments, order tests, and make recommendations for which they do not see a legitimate medical need—solely to protect themselves from later charges of negligence.

Some estimates place the annual cost of defensive medicine in the hundreds of billions of dollars, with one report claiming such costs represent up to 9% of total spending on healthcare,⁷ many times more than the 1% spent on MPL premiums.⁸

4 A Milliman analysis of nearly 80,000 medical malpractice claims showed that 79% of claims were closed with no payment being made to the plaintiff.

5 Hoyt & Powell, *ibid.*

6 Studdert, *ibid.*

7 PriceWaterhouseCoopers (2008). *The Price of Excess: Identifying Waste in Healthcare Spending*. PWC's Health Research Institute.

8 Milliman analysis of National Underwriter Insurance Data Services from Highline Data. Self-funding volume based on mid-range of industry estimates.

6. There is no proof that the threat of lawsuits deters injuries

One of the core arguments put forth by the defenders of the current tort system is that it encourages healthcare providers to be more careful and therefore less likely to make errors, but this claim has never been proven.

To begin with, healthcare providers are highly motivated to avoid errors for many obvious and compelling reasons that go beyond the purely economic.

Second, although MPL insurance premiums may impose a high cost to physicians, the vast majority have no recent malpractice claims. Individual physicians are not sued often and as a result claims histories can vary widely from year to year.⁹ Their premium rates, therefore, have only little to do with their individual past histories. Medical specialty and geographic location are much more decisive factors than track record when it comes to establishing MPL premium rates for most individual providers.

Third, regardless of specialty and geography, many doctors are part of a large group practice or work at hospitals. These institutions often purchase the necessary insurance and then internally allocate the cost to individual providers. Given the difficulty of predicting any individual provider's future claims along with the internal allocation procedures, individual doctors may not necessarily see a strong correlation between their claims history and the premium they pay.

Finally, even if the threat of having to pay out a large settlement or award could encourage doctors to be more careful than they already are, that dynamic does not operate universally under the current system. Once malpractice insurance is purchased it tends to be complete, without deductibles or coinsurance; rarely does the plaintiff attorney collect any monies beyond the MPL insurance policy limit. The current system, therefore, largely shields providers from the direct financial burden of large malpractice awards and so presents no real financial inducement for doctors to avoid making errors.

WHERE WE ARE NOW AND HOW WE GOT HERE

Over the years, an insurance mechanism comprising public and private insurers has evolved around the current, tort-based adjudication system.

Currently, there is a regulated commercial insurance marketplace with total direct written premiums of about \$11 billion annually. About two-thirds of this market comprises monoline specialty MPL insurers; the last third is made up of multi-line companies.

Because this side of the market is regulated by state insurance departments, there is publicly available and verifiable financial and claims data on all of the companies that participate within it. The

full size and extent of the captive, self-insured market, however, cannot be known with any degree of certainty. Estimates range from approximately as large as the public market (around \$10 billion) to nearly twice as large (\$20 billion).

Healthcare providers have experienced three significant increases in their MPL premiums over the past 35 years. The first occurred during the mid-1970s, the second in the mid- to late 1980s, and the third and most recent in the early to mid-2000s.

Each time rates have spiked, it has led to claims of a developing crisis in the MPL market, with providers asserting that a corresponding crisis in consumer access to healthcare is not far behind. Providers, they argue, will leave the field of medicine—or at least those specialties and regions most vulnerable to liability—for less litigious areas if rates continue to rise.

This has been true for certain disciplines in some areas of the country. For example, the *Los Angeles Times* reported that dozens of Las Vegas area physicians closed their offices in response to MPL insurance premium increases in 2002.¹⁰ During the mid-2000s, while some physicians left certain areas of the country in response to rate hikes; this occurred primarily in areas experiencing the sharpest rise in premiums. Other parts of the country did not see significant disruptions to their local healthcare delivery.

For their part, some opponents of reform claim that higher premiums are caused primarily by bad investments and intentional overcharging on the part of insurers,¹¹ assertions that do not hold up under scrutiny.¹²

ALTERNATIVES TO THE CURRENT SYSTEM

The modification to the current system that is most often supported by the medical community is caps on damages. Caps have been cited as one of the reforms most likely to lead to lower liability costs and ultimately reduce the premiums paid by providers.¹³ However, in order to meet the first objective outlined earlier of fairly and appropriately compensating the injured party, caps need to be designed in such a way as to ensure that the injured party's true economic needs are fully addressed.

In addition, to the extent that an injured party deserves monetary compensation for his or her non-economic needs (such as pain and suffering, loss of companionship, etc.), careful consideration must be given to balancing the needs of the individual with those of the broader community. Much debate has already occurred and undoubtedly will continue along this vein. In an effort to offer up additional alternatives, we will move to other possible, more structural changes to the current system.

9 Mello, M.M. & Brenna, T.A. (2002). Deterrence of medical errors; theory and evidence for malpractice reform. *Texas Law Review* 80:1595-638.

10 Gorman, Tom (March 4, 2002). "Physicians Fold Under Malpractice Fee Burden." *Los Angeles Times*.

11 Sloan, Frank & Chepke, Lindsey (Spring 2008). "From Medical Malpractice to Quality Assurance." *Issues in Science and Technology On-Line*.

12 Hoyt & Powell, *ibid*. Chart on p. 4 demonstrates that total net income tracked closely with net underwriting income and not with net investment income, which rose independently and gradually during the period 1975-2005.

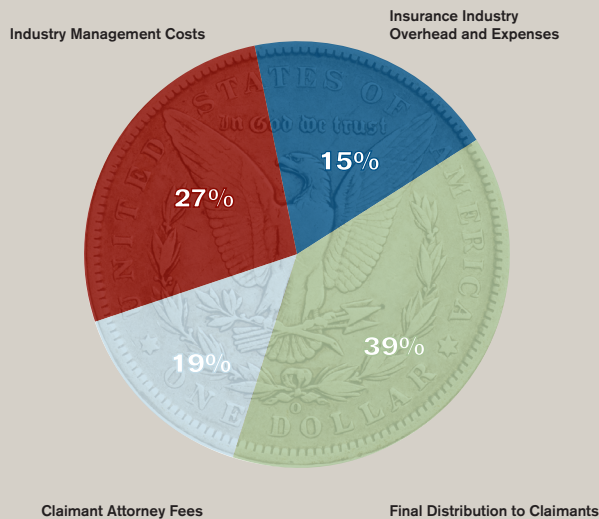
13 American Academy of Actuaries Issues Brief (Fall 2006).

WHERE THE MONEY GOES

Based on a Milliman analysis of more than 30 years of MPL insurance industry data, as reported to state insurance departments in annual financial statements, the distribution of how premiums are spent in the current tort system of adjudicating claims breaks down as follows:

- 27% is for the insurance industry’s claims management costs, which include:
 - 22% for defense counsel, expert witnesses, litigation technology fees, and other court costs
 - 5% for insurance company oversight of claims
- 15% is spent on insurance company overhead and expenses (e.g., agent commissions, state premium taxes, etc.)
- 19% pays for the claimant’s (plaintiff’s) attorney
- That leaves 39% for final disbursement to the claimant when the entire adjudication process has finally reached its conclusion three and a half to five or more years after the original incident¹⁴

MEDICAL PROFESSIONAL LIABILITY COSTS



Alternatives deserving consideration include:

- special injury funds
- medical or health courts
- established clinical guidelines
- no-fault insurance
- early intervention programs
- enterprise insurance

Special Injury Funds

While not an entirely new concept to MPL, special injury funds are programs operated by individual states to afford doctors and other healthcare professionals liability insurance coverage for specific injuries.

Special injury programs recognize that certain procedures are medically complex and that a bad outcome could result in catastrophic injury to the patient, often involving lifelong complications for the patient as well as the family. The costs associated with providing for the injured patients’ needs can easily add up to several million dollars. These injured patients are arguably those with the greatest and often most immediate needs, yet within the confines of the current adjudication system the patient commonly finds him- or herself mired *in the system* for many years as the attorney, along with the insurance company, both begin the multi-year process of preparing the case for trial. Given the economic stakes involved, both the patient’s attorney’s and the insurance company’s actions are understandable. What is not always understood, however (or at least not always kept at the forefront of the discussions), is the perspective of the patient.

Special injury funds can offer an alternative for just these types of claims and seem to work best when they are narrowly focused, managed like a true insurance vehicle with accrual-based financial considerations, and protected against outside political interference. Both Florida and Virginia have special injury funds currently in place that apply to claims involving birth-related neurological injuries.

The Virginia Birth-Related Neurological Injury Compensation Program, established in 1987, appears to be an effective way to compensate birth-related neurologically impaired children. According to a January 2003 report of the Joint Legislature Audit and Review Commission of the Virginia General Assembly, “[o]verall, it appears that the benefits offered by the program are generally more advantageous to birth-injured children than a medical malpractice award in Virginia.”¹⁵ The same report does, however, go on to list several challenges faced by the program, including one subheading that reads, *The Birth-Injury Fund Is Actuarially Unsound, Although There Is No Threat of Short-Term Deficit.*¹⁶

14 These figures are substantially confirmed by other studies that have examined the distribution of payments in the current medical malpractice liability system, including: Studdert, *ibid.*, which estimates that 46% ends up with claimants at resolution; and “Improving Malpractice Prevention and Compensation System,” *ibid.*, which estimates that only 40% makes its way to the claimant.

15 Review of the Virginia Birth-Related Neurological Injury Compensation Program by the Joint Legislative Audit and Review Commission of the Virginia Federal Assembly (January 15, 2003), p. iv.

16 Joint Legislative Audit and Review Commission of the Virginia Federal Assembly, *ibid.*, p. v.

Medical or Health Courts

As noted earlier, the facts and testimony delivered at medical liability trials can become dense and arcane, difficult for lay juries to adequately evaluate. Some have proposed the establishment of special medical or health courts, which like family, bankruptcy, or landlord-tenant courts could be set up to hear only cases involving one type of legal conflict—in this case, medical liability claims.¹⁷

Special medical liability courts could go a long way toward speeding up resolution and reducing the costs of adjudication and the idea is worth further discussion, but there are issues that would have to be addressed. Would cases be heard by special judges alone, or by a predetermined pool of experts in the medical specialty relevant to the claim? It seems unlikely that any one judge, even one with medical training, could be fully conversant with enough areas of medicine to deal with all of the complexities involved in different cases.

Regardless of whether claims are heard by medically trained judges alone or judges and expert juries of medical professionals, the plaintiffs' bar is unlikely to agree to any system that appears to turn all of the decision-making power in the adjudication process over to the medical community. In February 2006, the House of Delegates of the American Bar Association passed a resolution specifically opposing the creation of *health care tribunals*.¹⁸

Established Clinical Guidelines

Clinical guidelines are not a new idea, but the idea of using them to shield doctors from malpractice lawsuits has gained some purchase of late. The idea is to establish a list of agreed-upon, evidence-based guidelines, which, if followed, would give physicians and other healthcare providers safe harbor from claims of malpractice. In addition, if physicians are in fact protected from medical negligence lawsuits provided they follow such guidelines, this could have an additional and significant benefit of reducing the level of defensive medicine that takes place.

Several versions of this idea have been attempted in the past, the largest of which was in the state of Maine in 1990, when the Maine legislature enacted the Medical Liability Demonstration Project. This program involved doctors working in four specialties,¹⁹ the majority of which participated in the program. The program reached its sunset and was not renewed as it proved less than successful.²⁰

Several significant obstacles complicate the role of clinical guidelines with regard to MPL:

- First, advances in medicine are ongoing, which requires constant review and updates to clinical guidelines.

- Second, guidelines often address the uncomplicated, *typical* case and patient conditions. As a result, legal arguments can be constructed (fairly or not) and may then be advanced that the guidelines are not definitively and precisely applicable. Or, in the event of an unusual case or unusual patient conditions, arguments might be advanced that deviation from guidelines constitutes inappropriate practice and therefore culpability.
- Finally, medical guidelines have not been developed for the totality of conditions and cases that may be presented.

Can these obstacles be overcome? The question might be rephrased: Can guidelines be held in the proper context? Clinical guidelines are intended to help inform physicians in the practice of quality, efficient care; they can play a role in moving toward a healthcare system founded on best observed medical practices. They are not a substitute for sound clinical judgment in specific cases—especially where unique or extenuating circumstances may be present.

So long as MPL claims continue to be handled through a highly adversarial process (versus a genuine fact-finding process) clinical guidelines may offer only limited help in retooling the MPL environment.

No-fault Insurance

No-fault-based compensation systems are currently used as a substitute for tort action in automobile liability and workers' compensation claims. Under the premise that there are claims involving negligence that never get filed because the damages are deemed *too small* as well as a number of claims not involving negligence that are vigorously, and expensively, pursued because of the potentially large award, a no-fault system theoretically would address both of these undesirable situations. Appropriately constructed, a no-fault system might be the best structure to address the first of the fundamental goals previously stated—to compensate the injured party in a timely and just manner. Further, as the entire reimbursement model for healthcare is being reexamined, this option might even be funded more broadly than directly from healthcare providers alone.

The idea of a true no-fault medical liability system may seem a radical one, but probably no less radical than when no-fault was first put forward as a method for managing workplace injuries. One can argue the relative merits of workers' compensation as a system, but it has been around in the United States for nearly a century now, and it seems to work well enough not to find itself in regular, widespread crisis.

17 See also www.commongood.org.

18 Resolution adopted by the House of Delegates of the American Bar Association (February 13, 2006).

19 U.S. General Accounting Office (GAO) report (October 1993). "Medical Malpractice, Maine's Use of Practice Guidelines to Reduce Costs." The four disciplines were anesthesiology, emergency medicine, obstetrics, and radiology.

20 A report to the Maine Bureau of Insurance based on analysis conducted by the author and fellow Milliman consulting actuary Robert L. Sanders, FCAS, MAAA, found no cost savings attributable to the program; see In re: Rural Medical Access Program (Docket No. INS 00-3044), Order as to Required Assessment, filed by Alessandro A. Luppa, Superintendent of Insurance, State of Maine, December 19, 2000.

Early Intervention Programs

Often, all an injured patient and family may really want is to hear an explanation and perhaps apology from the doctor and to receive a reasonable monetary award—one that will see to his or her immediate medical and other needs with regard to recovery from the event. In an effort to facilitate this type of exchange, as many as 35 states and the District of Columbia have passed what are called *I'm Sorry* laws allowing a physician to discuss openly an adverse outcome with a patient and express empathy.²¹

Along these lines, one MPL insurer has instituted a progressive approach toward managing the physician-patient dialogue in the wake of an adverse outcome. Known as the 3Rs Program, the COPIC Insurance Company encourages its physician insureds to reach out proactively to patients in a structured way to discuss what occurred and how it might have resulted in the adverse medical outcome.

In addition to providing an opportunity for immediate and more direct communication, the 3Rs Program provides up to \$25,000 for reimbursement of medical costs, plus another \$5,000 to help compensate for the patient's loss of time that often accompanies an adverse outcome. One key element to the program is that at no time does the patient relinquish his or her right to bring a formal malpractice claim in the future, even if they have received compensation under the 3Rs Program.²²

Enterprise Insurance

With enterprise insurance—sometimes referred to as *channeling*—providers obtain their MPL insurance through the hospitals, clinics, or healthcare centers where they work. The enterprise takes on the responsibility of insuring against all adverse events that might occur on its premises, and apportions the cost of the premium among its provider staff.

This approach acknowledges that medical errors can be the result of more than one action or treatment decision undertaken by a chain of personnel in an institutional setting, often making it difficult to determine which act or individual was most responsible for the injury or harm.

Enterprise insurance offers the possibility of decreasing the number of medical liability claims by incenting healthcare organizations to create quality assurance programs to improve patient safety and reduce errors. Further, these healthcare facilities typically have more resources and are more accustomed to formalizing and institutionalizing policies and procedures than individual physicians.

CONCLUSION

These are just a few of the promising innovations for revamping medical professional liability that need to be discussed and explored further. Some will prove viable, some will not. What's important is that the discussion has begun and events are encouraging more flexibility on all sides of the issue.

The best solution is most likely a process that does not lock every claim into a pitched legal battle, but which can adapt nimbly and respond appropriately in the wake of adverse medical incidents. Some combination of the best of the ideas being put forward could achieve buy-in from all sides and bring greater efficiency and cost reduction to the entire medical liability system.

In exploring and evaluating all of these possible ideas, we believe it is important to keep in mind that the two most important criteria for any new system must always be:

- ensuring access to and fairness within the adjudication system, so that all patients who experience medical errors can obtain the resources and help they quickly need to recover
- promoting ongoing quality assurance and continuous improvement in medical care to reduce the potential for future harm to all patients

While the problems associated with the current medical professional liability system are not new, there does seem to be a greater opportunity than ever to fundamentally alter it under the broader healthcare reform that is currently being debated across this country.

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Milliman is a producer of clinical guidelines, the Milliman Care Guidelines.[®] Milliman is also a prominent consultant to the medical professional liability insurance industry.

21 McDonnell, William M., MD, JD & Guenther, Elisabeth, MD, MPH (December 2, 2008). "Narrative Review: Do State Laws Make It Easier to Say 'I'm Sorry?'" *Annals of Internal Medicine*.

22 COPIC (Fourth Quarter 2009). "Recognize, Respond, Resolve: A successful approach to disclosure." *Physician Insurer*.

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