

Having to Say You're Sorry

A More Efficient Medical Malpractice Insurance Model

FOR THE THIRD TIME IN THE PAST 30 YEARS, the U.S. medical malpractice insurance industry finds 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, we've 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; and adopting pre-litigation screening panels. Moreover, these reforms bring the bonus of increasing the portion of insurance company expenditures that goes to injured patients.

Crisis vs. 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 article, inefficient means that the insurance mechanism doesn't deliver a large enough portion of the insurance carriers' expenditures to the injured patient. As Figure 1 shows, 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.

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 don't 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.

One suggestion for improving efficiency with damage caps has been the simultaneous introduction of caps on

attorney contingency fees. Studies suggest about 75 percent of the reductions in net damages received by patients can be restored with caps on attorney fees, thus increasing system efficiency.

"I'm Sorry" Laws

Physician apology laws or "I'm sorry" laws are growing in popularity, as evidenced by the legislation considered and passed in the past 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 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.

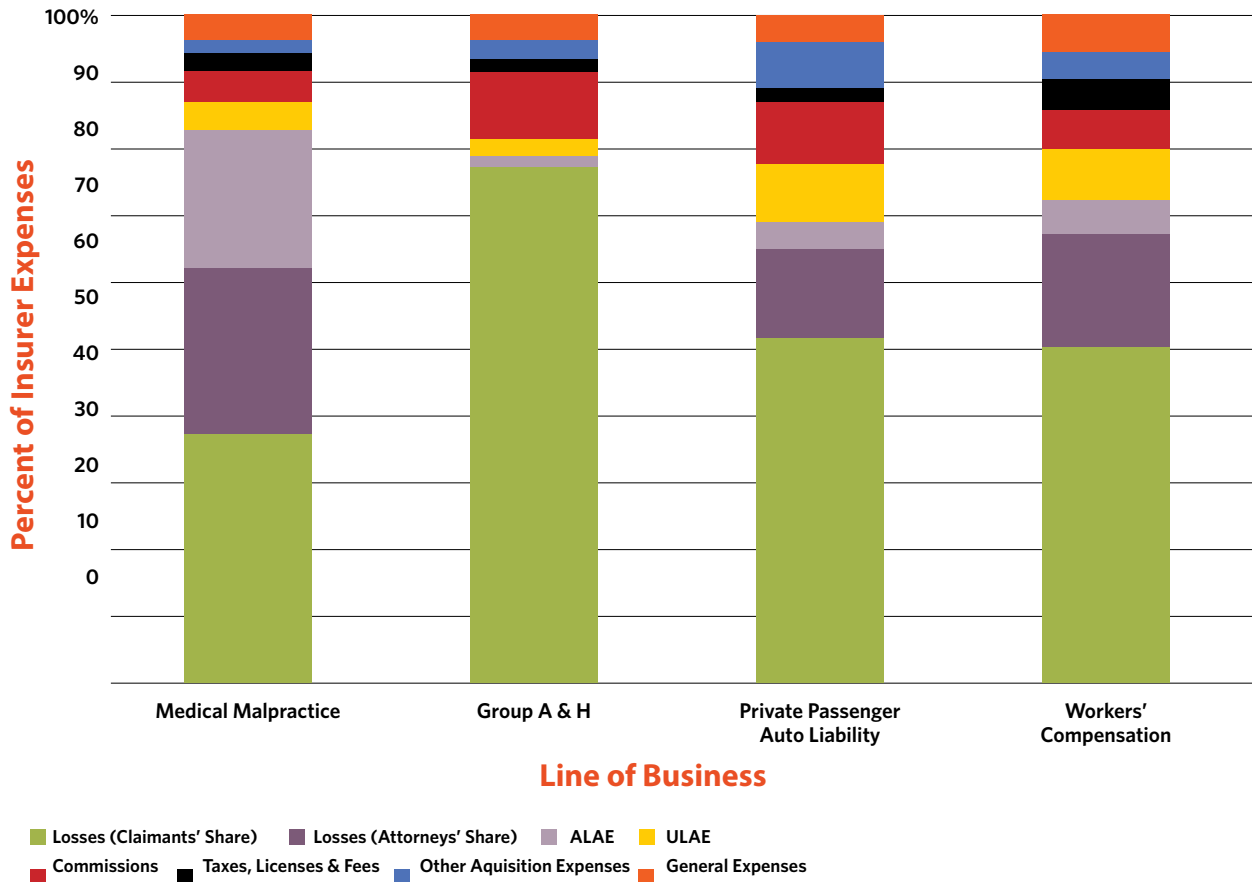
The renewed legislative activity began with Colorado, which, in 2003, passed a law that prohibits expressions of sympathy and full, fault-admitting apologies ("I'm sorry I did this to you") from being used as proof of liability. Previously, several states had enacted laws that excluded an expression 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 Bureau of Veterans Affairs (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 with the national VA average of \$98,000. Furthermore, cases are closed in two to four months instead of the usual

ROBERT J. WALLING is a principal and consulting actuary with Pinnacle Actuarial Resources Inc. in Bloomington, Ill. SHAWNA S. ACKERMAN is a principal and consulting actuary with Pinnacle in San Francisco.

FIGURE 1—INSURANCE SYSTEM EFFICIENCY BY LINE



two-to-four-year average, which saves on defense costs. Frequency at the Lexington hospital is in the upper quartile of comparable VA hospitals, which shows that more patients are receiving compensation even as overall costs for the compensation system are on the decline.

COPIC Insurance Co., 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. In the four years the program has been in effect, only two patients have sued. The program was initially limited to

claims of less than \$30,000 and is being expanded to cover larger claims.

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.

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, we did our own analysis to assess the impact of physician apology laws. To develop an estimate of a physician apology law’s impact, we 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 between 30 percent and 67 percent. If we apply a 30 percent to 50 percent reduction in allocated loss adjustment expenses (ALAE) to smaller claims, this reduction translates to a 3.5 percent to 5.9 percent savings in total claim costs. This potential savings assumes that there are not currently “I’m sorry” programs in place. To the extent that risk management has already implemented some form of a physician apology program, the savings will be less.

Birth-Related Neurological Injury Funds

Another promising approach to reducing medical malpractice system costs is a

FIGURE 2—I'M SORRY LEGISLATION BY STATE

STATE	YEAR ENACTED	BILL	NOTES
Arizona	2005 Pending	SB 1036	
California	2001		
Colorado	2003	HB 1232	Allows not just words of sympathy but a full admission of fault
Florida	2001		
Georgia	2005	SB 3	
Illinois	2004 Pending	HB 4847	Allows any expression of grief, apology, or otherwise saying "I'm sorry" for adverse outcomes within 72 hours
Massachusetts	1986		
Michigan	2004	HB 5311	
Montana	2005	HB 24	
North Carolina	2004	HB 669	Also allows offers to undertake corrective or remedial treatment or actions, and gratuitous acts to assist affected persons
Ohio	2004	HB 215	
Oklahoma	2004	HB 2661	
Oregon	2003	HB 3361	
Tennessee	2003		
Texas	1999		
Washington	2004	SB 6645	
Wyoming	2004	HB 1004/ SB 1004	

specialized variation of the patient compensation fund (PCF). PCFs are commonly established to provide excess medical malpractice coverage.

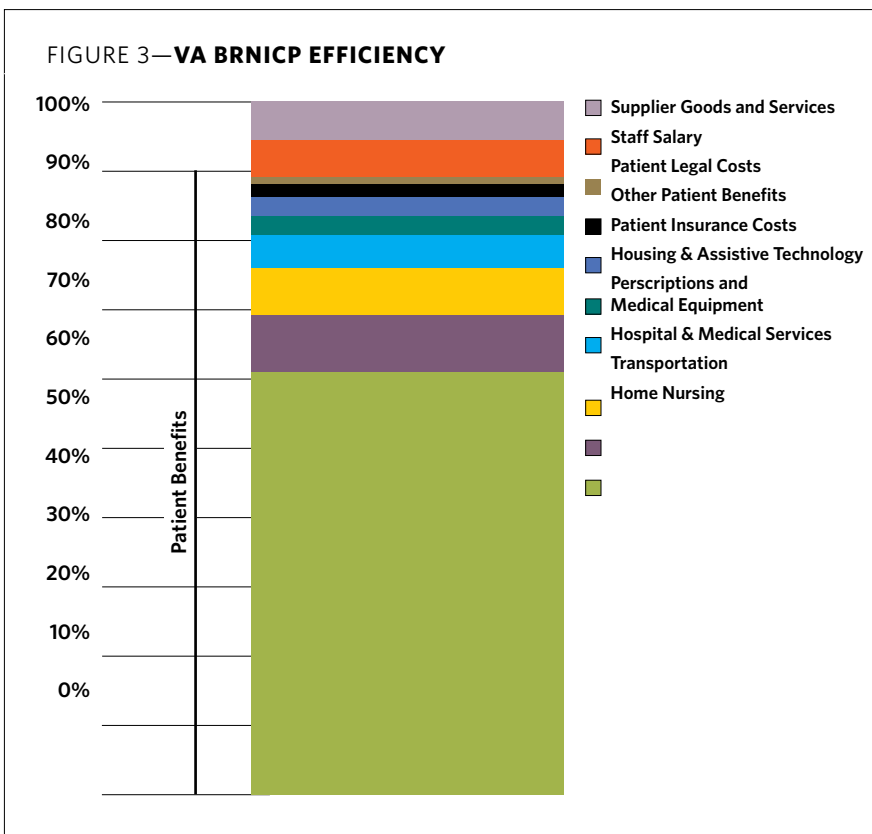
In New Mexico, for example, insurers can choose to participate in a voluntary program in which the PCF is responsible for unlimited medical costs and other economic damages and non-economic damages up to a damage cap. This coverage applies above the insurer's primary coverage of \$200,000 per occurrence and \$600,000 in the aggregate. Insureds under this program pay a PCF assessment through their insurer.

Generally, PCFs don't 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 Figure 3, showing that the Virginia BRNICP achieved an efficiency of about 88 percent in 2004. Unlike broader PCFs, these funds deal only 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 health care providers and many lines of insurance premiums. These funds significantly reduce medical

FIGURE 3—VA BRNICP EFFICIENCY



malpractice insurance costs for physicians in birth-related specialties in states with these funds.

There are currently two BRNICPs, the Florida Birth-Related Neurological Injury Compensation Association (NICA) and the Virginia Birth-Related Neurological Injury Compensation Fund (VABRNICF). 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 is more generous than a tort award (see Figure 4).

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

- improves significantly one aspect of the system's efficiency;
- provides stability for one of medical malpractice's most difficult specialties, obstetrics and gynecology
- allows competitive market forces to continue to operate as broadly as possible; and
- 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 before trial. Their recommendations, depending on the state, can be binding or non-binding and encourage pre-trial settlements.

After performing an analysis of the potential impact of mandatory prelitigation screening panels on the judicial process, we found the panels can reduce expected medical malpractice losses by up to 9 percent. 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 doesn't.

Inflation-adjusted closed-claims data from both states were sorted by the size

of the indemnity payment. We identified several important similarities. In both states, 78 percent 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. 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 with neighboring states.

We concluded, therefore, that introducing prelitigation screening panels to the state currently without panels would reduce average ALAE severity for claims closed with no indemnity payments and payments less than \$25,000 to levels similar to the other state. If the panels were able to achieve only this improvement, expected medical malpractice losses would be reduced by approximately 9 percent. The results of the analysis don't 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—"I'm sorry"/physician apology laws, birth-related neurological injury funds, and prelitigation screening panels—legislators and regulators can work together to stabilize premiums and better deliver compensation to injured patients. ●

FIGURE 4—VA BRNICP BENEFITS

- ▶ Lifetime medical treatment
- ▶ Lifetime hospital care
- ▶ Lifetime prescription benefits
- ▶ Rehabilitation/therapy
- ▶ Residential and custodial care, including nursing home health care
- ▶ Compensation for lost wages (ages 18-65)
- ▶ Special equipment (vans, wheelchairs, beds, medical appliances, etc.)
- ▶ Housing allowance
- ▶ Reasonable claim filing costs (including attorney fees)
- ▶ Medically necessary travel expenses
- ▶ Augmentative communication technology
- ▶ Family counseling
- ▶ Funeral expenses

Resources

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