

The Impact of Medical Malpractice Insurance and Tort Law on Washington's Health Care Delivery System

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The Growing Impact of the Medical Malpractice Insurance Costs on Washington's Health Care Delivery System

Medical practices in Washington state are in economic jeopardy.

As reported in the Washington State Medical - Education and Research Foundation (WSM-ERF) White Paper, *Washington's Ailing Health Care System: Continued Decline, Guarded Prognosis*, released in January 2002, medical practices of all sizes and types across the state are facing falling revenues, increased overhead and shrinking margins.

Several prominent group practices have ceased to exist, most notably the Memorial Clinic in Olympia and Everett Family Practice. At the same time the exodus of physicians from the state appears to be growing. As reported in the Foundation's previous white paper:

- Since 1998, the state medical association has seen a 31% increase in the number of its physician members moving out of state.¹
- More physicians are retiring, and at a younger age. Between 1996 and 2001, the number of retirements reported to Physicians Insurance increased 50% and the average age of these retirees dropped from 63 to 58 years of age.²
- Medical practices are finding it more difficult to recruit new physicians to the community.
- Increasingly, medical practices are being forced to restrict the types and numbers of patients they can accept.

A New Threat to Patient Care

Washington medical practices are struggling with an increase in required insurance paperwork, escalating administrative costs and inadequate payments from Medicare, Medicaid and private insurers. Now, a new threat to the continued viability of medical practices has emerged in the form of rapidly increasing professional liability insurance rates.

Driven by a dramatic rise in the size of jury awards, insurers are finding it increasingly difficult to provide this essential coverage. Compounding the problem, within the past twelve months two prominent professional liability insurers stopped underwriting coverage for Washington physicians and hospitals,³ citing their inability to sustain continued losses in light of the rising cost of settlements.

¹ WSMA membership transition report, January 10, 2002.

² Physicians Insurance, tracking report. This data is referenced as it is considered more reliable than retirements reported to either the Department of Health or the state medical association. Often physicians will maintain their state licensure or membership in their professional association even though they have stopped the actual practice of medicine.

³ Washington Casualty Company dropped an estimated 1300 physicians from coverage beginning in late 2001. Shortly thereafter, St. Paul Insurance Company announced it would cease underwriting medical malpractice nationwide.

An increasing number of medical practices report that malpractice insurance has, or shortly will, become unaffordable. The rising costs of liability insurance are forcing many practices to re-examine their ability to stay open or to offer all of the services their patients need.

Liability insurance premiums have increased steadily in Washington state in recent years, and are projected to grow further.

- Five years ago, the premium for a family physician not delivering babies and doing no surgery was \$7,547. Today, it has increased 29% to \$9,768. If the family physician also practices obstetrics, the annual premium can be as high as \$37,449.
- Over the same period, premiums for orthopedic surgeons have increased 30% from \$30,286 to \$39,243.
- For obstetricians, premiums have increased 39% from \$37,208 in 1998 to \$51,878 today.⁴

While not yet as high as in some states, premiums in Washington are projected to rise much further unless changes are made in the tort law system that currently drives losses.

The Impact of Rising Premiums on Patient Care

The WSM-ERF recently conducted a survey of all physicians in Washington state regarding their malpractice premiums. The survey was separated into three specialty categories: family physicians, obstetricians/gynecologists and all other specialties.

The survey demonstrated that many physicians are reaching a breaking point.

FAMILY PHYSICIANS:

Today the average premium for a full time family physician who provides labor and delivery services can range from \$10,758 (for fewer than 30 deliveries per year) to \$37,449 (for more than 100 deliveries per year).⁵ For a family physician who provides no labor and delivery services the average premium is \$9,768.⁶

In the recent WSM-ERF survey, when asked at what premium level they would drop labor and delivery services from their practices, 59% of family physician respondents said \$15,000 to \$30,000.

Of all family physicians surveyed, including those who do not practice labor and delivery services:

- 21% said they would retire from family practice if their premium reached \$31,000 to \$40,000.
- 70% said they would move their practice to another state if their premium reached \$31,000 to \$40,000.
- 53% said they would choose another career if their premium reached \$31,000 to \$40,000.

⁴ Physicians Insurance, January 2002. All premiums are for \$1 million limits. All premiums are undiscounted. Physicians qualifying for discounts pay lower premiums. Many physicians have lost eligibility for premium discounts during this time period, resulting in even higher premium increases.

⁵ Weighted average premiums, for mature policies, based on 2002 filed rates, Physicians Insurance.

⁶ Ibid.

OBSTETRICIANS/GYNECOLOGISTS:

Today the average premium for an obstetrician/gynecologist (OBGYN) in Washington state is \$41,600.⁷

In the OBGYN survey:

- 54% said they would drop obstetrical services from their practice if their premium level reached \$40,000 to \$70,000.
- 19% noted they have already stopped practicing obstetrics and another 8% plan to drop obstetrical services in the near future.
- 9% noted that they are or are considering moving out of state and another 5% said they are retiring in the near future.
- 44% said they would retire if their premiums reached \$50,000 to \$70,000.
- 53% claim they would move their practice to another state if their premiums reached \$50,000 to \$70,000.
- 33% said they would choose another career if their premiums reached \$50,000 to \$70,000.

The Washington State Professional Liability Insurance Market

Six years ago the major underwriters of physician medical malpractice insurance coverage in Washington state were: Physicians Insurance, The Doctors Company, Washington Casualty Company, and CNA.

Since that time several companies have left the Washington market. The two most notable have been:

- In 1997, CNA pulled out of the Washington market, leaving about 1,100 physicians seeking coverage.
- Late in 2001, Washington Casualty Company, then the second largest carrier for physician business in Washington state, decided to pull out of the physician market, leaving approximately 1300 physicians seeking coverage.

While not impacting Washington physicians as much as hospitals, nursing homes, and various other health care facilities, St. Paul Insurance Company—for decades the leader in physician and other medical malpractice insurance across the nation—concluded it could not sustain its losses in this line of business and announced in 2001 that it was dropping all of its medical malpractice insurance business nationwide, representing over \$500 million in annual premiums.

The Washington experience mirrors what is happening in other sections of the country.⁸

- Since 1998, four companies specializing in medical malpractice—Associated Physicians Insurance Company (APIC) based in Illinois, PHICO Insurance Company based in Pennsylvania, Physicians Insurance Company (PIC) based in Pennsylvania, and PIE Mutual Insurance Company based in Ohio—have become insolvent.

⁷ Ibid.

⁸ <http://www.insurance.state.pa.us/statliq/companies/pic.php>;
http://www.insurance.state.pa.us/html/phico_liq.html;
http://www.ohioinsurance.org/factbook2001/chapter7/chapter_7f.htm;
<http://www.state.il.us/ins/pressRelease/pr01/pr08-16-01.htm>

- Earlier in 2002, a fifth company, Medical Inter-Insurance Exchange (MIIX), a large company specializing in medical malpractice insurance in New Jersey, went into voluntary liquidation and has begun efforts to capitalize a new company by seeking capital contributions from New Jersey physicians.
- American Physicians Assurance, based in Minnesota, recently announced it's pulling out of the Florida market. The insurer currently writes about 2,200 policies in the state.⁹

A Brief History: How We Arrived At This Point

Medical malpractice claims were relatively uncommon until the 1970s. In the 40-year period between 1935 and 1975, 80% of all medical malpractice lawsuits were filed in the last five years of that period.¹⁰ In the mid 1970s, rapidly increasing losses forced many of the commercial insurers to leave the medical malpractice insurance marketplace. This void was quickly filled by physician and other provider owned/controlled specialty insurers funded by the doctors and entities they were to insure.

This “crisis of availability” was relatively short lived, as physicians and others contributed capital to support the efforts of their state medical and hospital associations, among others, to start as many as 100 specialty carriers across the country. The new firms were not expected to succeed where the giant commercial companies could not find success, but they did. They quickly grew in number and size to insure about 60% of the market nationally today.¹¹

Following this trend the Washington State Medical Association (WSMA) and physicians formed their own company, Physicians Insurance,¹² in 1982 in response to increasing costs of insurance (and the reluctance of the major carrier of physician coverage in the market at that time, AETNA, to share its claims loss data with physicians and the state medical association).

Data available from the predominant underwriters of this coverage in Washington—Physicians Insurance A Mutual Company, owned by its physician policyholders, and the Doctors Company, another physician controlled carrier—demonstrate that the fundamental problems are based on the vagaries and distortions of the tort system.

Responding to the rise in medical malpractice claims in the 1970s, the state medical association and others were successful in passing several pieces of legislation in the state legislature, which helped avert a crisis of availability. These included provisions to:

- Codify the law of medical negligence and informed consent in RCW Chapter 7.70 (*this clearly defined the only permissible causes of action for liability arising from the delivery of health care services*).
- Codify the statute of limitations and creating an eight-year statute of repose in RCW 4.16.350 (*barring lawsuits 3 years after treatment, or 1 year after discovery, but no more than 8 years after treatment. But the courts subsequently threw out the 8-year limit*).
- Allow physicians and other providers to offer to pay medical expenses of patients without thereby admitting liability (RCW 5.64.010) (*which meant that physicians could waive their bills without that action being used against them in court*).

⁹ Medical Economics Magazine, August 9, 2002.

¹⁰ “Professional Liability in the ‘80s,” Report 1, American Medical Association, 10, 84, p4.

¹¹ http://www.thepiaa.org/about_piaa/what_is_piaa.htm

¹² Formed initially as a reciprocal exchange, later modified to a mutual company—owned by its policyholders—in 1999.

- Bar a statement of the damages claimed in a publicly filed complaint (RCW 4.28.360) (*this reduced the inflammatory publicity that used to result when the media reported the dollar figure*).
- Allow evidence of collateral source payments in medical negligence cases (RCW 7.70.080) (*intended to reduce awards for expenses already paid by others, but allowing plaintiff to put in evidence of a duty to repay those benefits received from others*).

But the changes in tort law were not sufficient. In the early to mid-1980s the malpractice market faced yet another crisis—a “crisis of affordability.”¹³

Malpractice carriers faced mounting losses, with unexpected increases in paid claim frequency (the number of paid claims) and severity (the amount of indemnity payment). Malpractice companies began imposing severe premium increases to cover projected losses, while others simply left the market.

This had a direct impact on physicians. Premium increases ranged from 15-59% in 1985 and a further 35-60% in 1986.¹⁴

At the same time, groups outside of health care became increasingly concerned about their own liability insurance costs—and the availability of coverage at all—due to increasing litigation in the areas of product liability and general liability. Childcare centers were forced to close. Ski resort operators faced closure. Little League baseball was threatened.

A political battle began to brew in a number of state legislatures over enactment of tort law reforms aimed at moderating the increases in frequency and severity of liability claims while protecting the rights of injured parties to seek redress for their economic damages resulting from negligence. In Washington state these reform efforts were strongly supported by a coalition of organizations representing the business community, municipalities and others.¹⁵

The Washington state legislature ultimately passed the “The Liability Reform Act of 1986.” The Act included provisions to:

- Cap non-economic damages (*limit varied based on the average annual wage in the state and the life-expectancy of the injured party*).
- Establish a new statute of limitations for medical negligence (*intended to reduce the very long limit for claims on behalf of minors*).
- Provide for some modification to joint and several liability (*so when plaintiff is at fault, liable defendants will only have to pay for that portion of the total damages the jury concludes they caused*).
- Allow structured settlements (*so some future damages do not have to be paid immediately*).
- Eliminate “negligence per se” for most violations of duties imposed by municipal ordinances, state statutes, and state regulations (*so the plaintiff retains the burden of proving negligence in such cases*).

However, the changes in tort law were short lived. In 1989, the Washington State Supreme Court ruled that the cap on non-economic damages did not conform to the state’s constitutional requirements for trial by jury because “the measure of damages is a question of fact within the jury’s province.”¹⁶

¹³ It is worth noting that in this time period there was adequate “elasticity” in the delivery system to cover the increasing premium burden and to shift costs within medical practices in order to maintain operations.

¹⁴ Testimony before the Washington State Senate Judiciary Committee, January 23, 24, 28 and 30, 1986 by WSMA President Edmund W. Gray.

¹⁵ The Liability Reform Coalition was comprised of various associations representing local governments such as cities and counties, many professional trade associations including the WSMA and the WSHA, various self-insurance funds, and pharmaceutical firms, Boeing, Weyerhaeuser, Association of Washington Business, and several property/casualty insurers.

¹⁶ *Sofie vs. Fibreboard Corporation*, 112 Wn.2d 636 (1989).

Subsequent decisions by other courts undermined the statute of limitations and the statute of repose. The reform aimed at capping the time in which claims can be brought on behalf of minors was eliminated by a decision that the statute did not really say what it meant to say.¹⁷ The statute of limitations was weakened in cases of continuing treatment over many years.¹⁸ Finally, the statute of repose was found unconstitutional.¹⁹ These decisions resulted in the elimination of three primary determinants of the predictability of claims frequency.

In spite of the loss of the cap on non-economic damages in the 1989 *Sofie* case, the rate of increase in the frequency and severity of claims moderated in the late 1980s and the first half of the 1990s, perhaps due to a broader public recognition that large awards increased the cost of the delivery of health care and threatened the viability of their own physician's practice. However, this sentiment was short-lived.

Over time, the absence of fundamental tort law reform had a direct impact on the medical malpractice insurance market. During the last half of the 1990s the seeds of the current evolving crisis were planted.

The average claim payments began to rise again, as did the cost of reinsurance, which normally covers the "top layers" of large claim payments.²⁰

The average loss and loss adjustment expense paid on claims underwritten by the medical malpractice industry experienced a compound annual growth of 6.9% during the decade of the 1990s (compared to the average annual rise in general inflation which was 2.6%).²¹ Between 2001 and the first half of 2002, the average paid claim at Physicians Insurance rose 48.5%.²²

In 2001, in Washington alone, seven medical malpractice verdicts or settlements were reported in excess of \$1 million; they totaled \$44.7 million, ranging from \$1.2 million up to \$16.2 million.²³

From 1999 to 2000, nationwide, the median jury award rose 43%.²⁴ Since 1996, the median indemnity paid—the amount that reflects both jury and out of court settlements—increased by 48%.²⁵ In 1999-2000, 52% of all jury awards were in excess of \$1 million.²⁶

The Larger Societal Picture

It is an ethical imperative for physicians to have a means of compensating patients injured by negligence in the delivery of medical services. Accordingly, physicians understand and expect patients to be compensated for their legitimate losses in a prompt and fair manner, and the medical profession has historically supported this view.

¹⁷ *Gilbert vs. Scared Heart*, 127 Wn.2d 370 (1995).

¹⁸ *Caughell v. Group Health*, 124 Wn.2d 217 (1994).

¹⁹ *DeYoung vs. Providence Medical Center*, 136 Wn.2d 136 (1998).

²⁰ Customarily an insurance company will directly insure—agree to cover the loss of—an initial amount. Beyond this point, the company relies on the reinsurance market to cover its risk exposure. The use of reinsurance to further spread risk and ameliorate losses goes back to the beginnings of the insurance industry and applies to all forms of insurance coverage.

²¹ Physicians Insurance Association of America.

²² Physicians Insurance.

²³ *Jury Verdicts Northwest*, all issues, 2001.

²⁴ "AHA Trend Watch", June 2002, Vol. 4, No. 3.

²⁵ *Ibid.*

²⁶ "2001 Current Award Trends in Personal Injury", *Jury Verdict Research*, 2002.

While various solutions to this problem are discussed later in this paper, there is a new development—the seriousness of which threatens an already increasingly fragile health care delivery system.

As professional liability insurers pass along their increasing costs to physicians in the form of higher premiums, those expenses will soon force physicians out of the practice of medicine entirely or force higher risk specialists to cease performing deliveries and other vital procedures. The ability of medical practices to absorb significant rate increases is much less today than was the case in the 1980s.

As a result of the exit of Washington Casualty Company and St. Paul Insurance Company from the physician market, the Washington State Insurance Commissioner has worked with the remaining companies doing business in the state to form a voluntary Market Assistance Plan (MAP) to try to find coverage for those unable to obtain insurance coverage.

The voluntary MAP is an attempt to solve one aspect—a “symptom,” actually—of the underlying problem. While a laudable effort to provide some short-term help, it does not address the underlying failures of the existing tort law system.

The most pronounced failure of the tort system is its “lottery mentality” and the incentives that promote and inflate claims and suits without merit.

In some respects society has become desensitized to the “value” of money, just as it has to violence. The sum of \$1 million is no longer considered much money in a society that sees companies award lucrative multi-million dollar stock options to their executives and employees, or professional athletes making \$10 million or more per season.

Plaintiff attorneys have worked hard and successfully to stop tort reform in the state legislature, the Congress, and the courts. The national tobacco and asbestos litigation in recent years has given it unprecedented resources with which to fight to preserve the current tort system.

What Can Be Done to Avert the Recurring Crises of Affordability and Availability in the Medical Malpractice Market?

Demonstrable improvements for patients and physicians, and the delivery system, are confirmed by the California MICRA experience and by the Colorado experience.

The 1989 ruling of Washington state’s Supreme Court in the Sofie case effectively eviscerated, for the present, the most significant reform—a cap on non-economic damages—at the state level.

Thus, fundamental reform of the tort law system must take place at both the state and federal level. One prominent bill before Congress, HR 4600 sponsored by Pennsylvania Representative James Greenwood, (R- Penn) would:

- Award injured patients **unlimited** economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);
- Award injured patients non-economic damages of up to \$250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on such damage awards, whether higher or lower than those provided for in the federal bill;
- Encourage the use of alternative dispute resolution such as mediation and arbitration;
- Reduce double recovery of damages already being paid by third parties such as health and disability income insurers;

- Establish a “fair share” rule that allocates damage awards fairly and in proportion to a party’s degree of fault; and
- Establish a sliding scale for attorneys’ contingent fees, thereby increasing the recovery for patients.

Similar bills have been passed out of the House of Representatives several times since 1995. All have died in the Senate.

If it proves impossible to adopt nationwide reforms based on California’s proven system, society will have to consider a number of new approaches. Some might include:

1. Removing medical malpractice from the tort system and set up an administrative dispute resolution process using physicians and other health care providers to evaluate the merit of claims. This approach would include limits on non-economic damages and attorney fees.
2. Eliminating the contingency fee when there is no contingency (i.e., when liability is not disputed and damages, at least up to a certain amount, are not debatable).
3. Capping contingency fees for plaintiff attorneys.²⁷
4. Repealing the collateral source rule so expenses paid by others are not recoverable as damages.
5. Requiring proof of medical malpractice by “clear, cogent, and convincing evidence” instead of a mere preponderance of the evidence.
6. Promoting greater patient safety and reducing the culture of blame by requiring full disclosure of unexpected adverse events (and “near misses”) so the causes of medical errors can be scientifically studied and the results disseminated. This should entail, in exchange, granting limited immunity to health care providers and facilities, allowing recovery only for economic damages unless the required disclosure did not occur.

A Brief History of Tort Law Reform Elsewhere

Liability insurance is intended to provide a source of funding for the needs of patients who experience an adverse outcome as a result of negligent medical care provided by a doctor and/or within a facility. Physicians purchase coverage to protect themselves from the cost of suits and judgments that may result from adverse outcomes.

In the current tort system, there is little direct correlation between the objective of meeting the needs of those who may be injured as a result of medical negligence and the cost of suits and judgments filed by those who have experienced a poor outcome.

Less than half of the total “cost” of the system actually goes to the injured patient.²⁸

Over the past twenty-five years a number of states have adopted liability reform laws, and two of the most successful have been California and Colorado. During the crisis in the mid-1970s, California adopted a comprehensive health care liability reform package—known as MICRA (Medical Injury Compensation Reform Act)—which included a \$250,000 cap on non-economic damages, reduced recovery of expenses or benefits paid by health insurers and other third parties, and a sliding scale reduction of the allowable contingency fee.

²⁷ Much of compensation in the health care system—Medicare payments to physicians is a notable example—already is capped by government rule.

²⁸ Karen Ignani, Knight Ridder/Tribune, 1/21/02

These reforms have survived all court challenges in California and have had a dramatic impact beneficial to patients and providers.

- Physicians' medical malpractice insurance premiums in California went from the highest in the nation in most specialties to the median or even lower. From 1976 to 2000, medical malpractice insurance premiums in the United States rose 505%. In California during the same time period, premiums rose only 167%.²⁹
- Injured patients can recover more of their economic damages without having to pay excess fees to their attorneys. In California, plaintiffs receive 17% more of the total award than under traditional contingency arrangements. Yet, plaintiff attorneys are still amply rewarded, receiving more than \$220,000 of a \$1 million settlement.³⁰
- The proceeds of a \$1 million judgment with MICRA reforms in place that reach the injured patient are from \$111,000 to \$278,000 higher than in states without such reforms.³¹
- Cases are more readily settled with the elimination of the motivation for injured patients and their attorneys to seek higher and higher, outsized awards. The average time to settle a claim in California is about 2.0 years compared to an average of 2.6 years in states without such reforms.³²

The Colorado experience has been similar in that premiums have been greatly moderated, in fact reduced by about 59% when adjusted for inflation. For example, the average premium paid in Colorado for a \$1 million/\$3 million policy was \$18,535 in 1986 (or \$27,566 when adjusted to 1998 dollars),³³ and was \$11,400 in 1998 (or, \$7,665 when adjusted to 1986 dollars).³⁴

Colorado adopted its "Health Care Availability Act" in 1988. It contains MICRA-like reforms, and it has demonstrably moderated premiums in Colorado. Average premiums increased from 20% up to 73% annually from 1984 through 1988. After passage, premiums dropped at least 4.5% for each of the next five years. Since 1993, premium increases have ranged from as low as 1.3% to as high as 9.0% per year.³⁵

How Liability Insurance Premium Rates are Set

The process for setting rates is straightforward. Customarily, an outside actuarial firm annually analyzes a company's claims experience and recommends rate adjustments for the next calendar year.

The analysis includes review of historical losses, not including the most recent year, in order to determine loss trends. If historical losses are trending upward by, for example 5%, it is likely that future losses will trend 5% higher as well. Based on this analysis, the actuary makes an educated projection of the cost of future losses.

²⁹ Analysis prepared by the Physician Insurers Association of America, "Debunking the May 29, 2002 Malpractice Premium Analysis Published by the Center for Justice & Democracy," June 27, 2002.

³⁰ Physician Insurers Association of America, "Medical Malpractice Claim Expenses, 1999".

³¹ Californians Allied for Patient Protection, www.micra.org/quickfacts.htm; Health Care Liability Alliance, "Why Trial Lawyers' Arguments against MICRA are Wrong"; 2002, www.hcla.org/html/micratrial.htm

³² "The California Story"; Californians Allied for Patient Protection, 2002.

³³ "Annual Urban Price Index"; Department of Labor, Bureau of Statistics, The Doctors Company, June 2002.

³⁴ Ibid.

³⁵ "The Story of Medical Malpractice Tort Reform in Colorado"; COPIC Insurance Company, 2002.

This projection is then discounted by the amount of investment income that will be earned while claims go through the multi-year process of adjudication. This discount is then deducted from the actuary's projection of the cost of future losses.

Added to the projected cost of future losses are the two components of the company's operating overhead—underwriting expense and unallocated claims expense. These two components of operating overhead are often funded by investment income.

Future rates are based on the expected cost of future losses only. If historical losses turn out to be higher than expected, no "catch up" is made in the future rate. Similarly, if historical investment income turns out to be lower than expected, no "catch up" is included in the future rate. If historical losses turn out to be less than expected, mutual companies will often, where feasible financially, return the excess premiums to the policyholders through dividends.

At Physicians Insurance, Washington's largest underwriter of medical professional liability insurance, the filed premium increases for the past five years have been painful, though relatively modest:

1998	4.5%
1999	7.7%
2000	4.4%
2001	6.0%
2002	8.6%

However, most physicians have seen significantly higher increases as previously justified discounts are reduced or eliminated due to new data showing the discounts are no longer justified by loss experience. Premiums have increased more for some specialties with worse loss experience, and premiums for limits above \$1 million have increased at a faster rate because of the increasing frequency of higher awards.

Over the past year, those physicians formerly insured by companies leaving the market have sometimes faced premium increases of 30% or more. Despite all these premium increases, it remains very problematic whether any liability insurance company in Washington can break even in 2002 and in the future.

The Role of Investment Income

Most professional liability insurers maintain very conservative investment portfolios comprised almost entirely of high-grade bonds. The objective is preservation of capital (reserves and surplus) and the generation of investment income to fund—along with premium income—the payment of claims.

Recently, market interest rates declined to historical new lows, cutting the earning power of investments and increasing the need for premium revenues. The combination of accelerating losses and declining investment returns has provided "the perfect storm" for medical malpractice insurers.

However, that "perfect storm" has nothing to do with the often-asserted claim by some that companies are trying to make up for losses in the stock market. That is because the typical investment portfolio has a very small exposure to equities.

Reduced investment income is not driving the rate increases being felt today. If projected lower investment income were the only cause of rate increases, those increases would be about 3-4%. Clearly, the rapidly rising trend in loss severity is the most significant cause of higher premiums.

A survey of 34 medical liability insurers across the country indicates a net operational loss of 10% for 2001.³⁶ This follows a profit of 9% in the prior year. Even if the carriers are successful in implementing rate increases through the end of 2002, they are still faced with long-term increases in claim severity.

The Consequences of a Failure to Act

Ultimately, society must decide how this problem is to be resolved.

If affordability of insurance isn't yet deemed a crisis in this state, it will eventually become one and that leads inevitably to lack of access. Unfortunately, with the decrease in physician reimbursement and increased overhead cost, the ability to pay premiums will continue to diminish.

The 27-year experience with reasonable tort reform in California and in Colorado—proves that it is possible to pay the cost of unlimited verdicts for actual losses, if the lottery aspect of non-economic damages is limited to a reasonable level.

The current health care delivery system is increasingly fragile.

If society wishes to have unlimited awards, it must face the prospect of unlimited premiums which will mean unlimited health care costs and correspondingly limited access to health care.

The public and policymakers face a choice: Reasonably limit awards or face a crisis in patient access to health care.

³⁶ Physicians Insurance study, based on statutory financial statements of 34 companies, most of which are members of the Physicians Insurance Association of America (PIAA), August, 2002.