The Forgotten Third: Liability Insurance And The Medical Malpractice Crisis

The surest way for malpractice to be placed on the national agenda may be for Medicare to take ownership of it.

by William M. Sage

ABSTRACT: Although the most visible manifestations of medical malpractice involve patient safety and the legal process, the availability and affordability of liability insurance largely determine the direction of medical malpractice policy. Scientific and industrial developments since the first modern malpractice crisis in the 1970s reveal major problems with the structure and regulation of liability insurance. Comprehensive reforms that approach medical malpractice insurance as a health policy problem are needed, and the Medicare program may have a major role to play.

The mosaic of rules, incentives, and institutions that we call a medical malpractice system involves three core activities: medical care, tort law, and liability insurance. Over the past thirty years legislative intervention has focused almost entirely on changing tort law—either its substance (for example, caps on damages) or its procedure (for example, shorter statutes of limitations)—to reduce the likelihood of litigation and moderate its financial impact. Current proposals represent more of the same, plus a heavy dose of patient-safety rhetoric. However, the “malpractice crises” that provoke provider unrest, public concern, and reform legislation are first and foremost insurance crises. Rapid rises in the cost of liability insurance (especially for physicians) and reductions in the availability of coverage are what bring the malpractice system under scrutiny.

Ironically, the liability insurance system itself has been spared serious analysis from a health policy perspective. The politics of liability insurance have been dominated by the offspring of the crisis of the 1970s: provider-sponsored carriers begotten by medical societies and hospital associations after commercial insurers had abandoned their members. Because of this heritage, the implicit relationship between public policymakers and these companies has been one of appeasement, not accountability. Especially in crisis periods, legislators offer tort reforms and

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outright subsidies to entice private liability insurers back into markets and expand their underwriting capacity rather than dispassionately assessing their effectiveness.

In this paper I argue that the insurance component of the medical malpractice system has not kept pace with changes in the health care system since the 1980s and that a reconfiguration of medical liability insurance to meet the demands of twenty-first-century health care financing and delivery is long overdue. This paper summarizes the crisis-driven history of medical liability insurance, identifies health policy developments that have exposed serious flaws in liability insurance markets, and suggests measures to improve both private risk bearing and government oversight. Changing standards and processes for malpractice litigation and patient safety will have lasting social benefits only if they are accompanied by equivalent innovations in risk bearing.

**Historical Determinants**

A source of frustration for efforts to link malpractice policy with overall health policy is that liability insurance and health insurance derive from different historical and theoretical premises. During the past century, health care has evolved from a self-regulating professional endeavor focused on personal service to an externally regulated industrial and social enterprise. Impelled by Medicare, Medicaid, and employer-based coverage, first-party health insurance has navigated this transition with reasonable success. Third-party liability coverage—which has the limited purpose of shielding its clients from the financial costs of litigation initiated by others—has not.

Physician malpractice coverage in particular remains mired in pre-industrial medical care and the ordinary law of negligence: A physician with a duty to a patient who fails to meet the prevailing “standard of care” is liable in civil litigation for any resulting injury. When health care goes awry and a patient sues, liability insurers representing individual physicians defend or settle most claims. Physician defendants are happiest if few claims arise, fewer claims are validated by verdict or settlement, and still fewer claims are publicized. Accordingly, the prudent insurer and its counsel urge secrecy, dispute fault, deflect responsibility, and make it as slow and expensive as possible for plaintiffs to continue the fight.

As a result, claims involving serious injury (the only category for which litigation is a realistic option) often take five or more years to resolve, with predictable consequences. Information about the cause of injuries is denied patients and families for prolonged periods, compensation is unavailable when it is most needed, and quality feedback to providers is attenuated to the point of uselessness. Delay also exacerbates volatility in premiums by increasing legal uncertainty and making malpractice insurers more dependent on investment income for profitability. The contrast between this fragmented, dilatory, adversarial environment and the Institute of Medicine’s (IOM’s) futurist vision of a safe, effective, patient-
centered, timely, efficient, and equitable health care system based on institutional quality improvement could hardly be more stark.5

How did a seemingly sensible system for protecting physicians’ assets acquire such counterproductive traits? Why is liability insurance so prone to severe if intermittent crises of availability and affordability? History offers several insights.

■ The 1960s: disequilibrium. In the early twentieth century, medical societies began defending their members against malpractice claims using a fraternal model of pooled resources typical of the “protective associations” of the age.6 Because litigation targeted better physicians (who had assets worth pursuing), not fringe practitioners, malpractice defense became incorporated into the medical community’s preference for self-governance and resistance to lay accountability. Customary practice defined the legal standard of care, and local physicians who testified against their colleagues were dealt with harshly (recent efforts to subject pro-plaintiff physician witnesses to professional discipline are disquieting reminders of this history).

Beginning in the 1960s this stable malpractice climate changed. Laws were liberalized, and testifying experts became more available. Consumerist, feminist, and environmentalist voices challenged both the established professions and corporate and government elites, and the latter groups found themselves increasingly at odds with physicians over rapidly growing health care spending. Litigation increased, but claims frequency against individual physicians still remained lower than in other “retail” lines such as automobile coverage, while the financial exposure associated with each claim (severity) was both higher and more variable.7 Insurers therefore found it difficult to price coverage accurately, a problem accentuated by the “systematic” risk of a change in the substantive law or the generosity of juries between when premiums were assessed and the much later date when a payout might occur. By the 1970s medical malpractice coverage had become a tough business for commercial insurers.

■ The 1970s: crisis of availability. The floodgates opened in 1975, as claims frequency and severity rose rapidly in the fragile investment climate of the post-oil-shock recession.8 Commercial insurers retrenched, leaving large numbers of physicians without coverage. Physicians organized “strikes,” highlighting the implications for patient access and demanding relief from suit. State legislatures responded with generous tort reform, such as California’s Medical Injury Compensation Reform Act (MICRA), aimed at restoring the commercial viability of private liability insurance. Medical societies helped fill the gap in availability by chartering mutual carriers, whose fortunes and interests would thereafter be closely aligned with those of their sponsoring organizations. States also addressed access to insurance directly, setting up joint underwriting associations (JUAs), guaranty funds, and publicly administered programs of umbrella coverage.

■ The 1980s: crisis of affordability. A second insurance crisis erupted roughly ten years later, manifested mainly by an upswing in price rather than unavailability of coverage.9 Physician-sponsored carriers remained solvent and committed to their
core customers, but the political settlements of the prior decade had eroded, and new legal risks were evident. Moreover, the “insurance cycle” was approaching a nadir of profitability because plummeting interest rates had reduced investment income, adding to pressure on premiums. Although the U.S. medical profession was arguably at its wealthiest stage, it successfully obtained tort reform in most states that had not previously enacted it. Carriers also continued their transition from “occurrence” to “claims-made” policies, thereby eliminating pricing uncertainty associated with changes in claiming behavior and jury sentiment between the date care was rendered and the date a claim was filed (often many years for injuries to newborns and children). Florida and Virginia adopted birth-injury compensation programs intended to remove these protracted and costly claims from the tort system.

The 1990s and beyond: a “perfect storm.” Today’s malpractice insurance crisis is arguably more severe than its predecessors, although the harshest effects are limited to certain specialties (such as obstetrics, surgery, radiology, and emergency medicine). The financial boom of the 1990s encouraged many carriers to compete for new geographic markets by relaxing underwriting criteria and lowering premiums. Claims frequency and severity, which had been overshadowed by the law and politics of managed care, began to trend upwards. In 2001 the largest commercial insurer, the St. Paul Group of companies, stopped writing new policies. Reversals of fortune as the economy slowed led to pullouts and insolvencies in many states, while solvent companies rejected riskier customers and raised premiums.

Simultaneously, global insurance shocks (including the terrorist attacks) made reinsurers reluctant to devote suddenly scarce capital to unpredictable areas such as medical malpractice. Rising reinsurance costs affect not only primary malpractice carriers but also hospitals and nursing homes that self-insure basic risk but purchase excess coverage. Price shocks for reinsurance are exacerbated by the publicity that attends the largest jury verdicts, which in tight markets leads insurance actuaries to make worst-case projections. For this reason, New York hospitals recently reversed position and persuaded the legislature to repeal periodic payment requirements that were generating high nominal damages against hospitals because of inflation adjustment.

Politics. In part because U.S. medicine prospered throughout (despite) this history, malpractice politics became more about ideology and self-interest than about health care. Malpractice reform is now a rallying cry in a larger political contest between the general business community and general trial lawyer and consumer interests over the effect of personal injury litigation on the U.S. economy and social fabric. Neither side has an interest in debating the subtleties of malpractice insurance because it defies expression as a clean narrative that supports or condemns the litigation enterprise. For their part, malpractice insurers rarely articulate the need for innovation in bearing liability risk but instead tend to assert parochial positions that echo the rhetoric of their physician-sponsors and protect the relatively narrow risk corridors they cover.
Health Policy Problems

The inadequacies of how medical providers and society bear malpractice liability are apparent when one considers deeper explanations for the current malpractice crisis. Various sources of “developments risk” reduce long-term insurability absent major alterations to the model under which liability coverage operates. Put simply, changes in the health care system since the 1970s belie the notion that another round of MICRA-style tort reform will suffice.

- Medical progress. Malpractice litigation reflects the overall success of modern medicine, not its failure. Medicine is no longer a predominantly charitable enterprise: Consumers who pay substantial amounts for health insurance and medical care have been conditioned to expect success and therefore are more likely to attribute poor results to misadventure than misfortune—as are the judges and jurors who control courtroom proceedings. Because of advances in diagnostic capability, even brief delays in initiating treatment may generate costly malpractice claims. Medical progress also greatly magnifies both economic and noneconomic damages through its effect on survival and future medical needs. For example, negligent neonatal care that preserved life but caused severe injuries in a premature infant might incur legal liability for millions of dollars in lost earnings, continuing medical care costs, and prospective pain and suffering. For risks of this magnitude to be supportable by a single physician’s malpractice insurance, risk pools must be large, reinsurance abundant, and collateral sources of payment such as first-party health and disability coverage relatively common.

- Medical errors. Medical progress includes greater sensitivity to quality failures. The IOM’s 1999 report, To Err Is Human, was largely an outgrowth of research commissioned during earlier malpractice crises, notably the Harvard Medical Practice Study of the early 1980s. Although current malpractice reform proposals purport to address patient safety, they ignore the implications of medical error for liability insurance beyond the possibility that publicity regarding errors will increase claims rates and jury awards. If medical errors are widespread, compensating injured patients takes on considerable social importance. Tort litigation is poorly equipped to accomplish this task because third-party liability insurers are preoccupied with deterring claims and contesting fault.

High error rates also confirm the importance of injury prevention. Particularly at the hospital or health system level, where most errors originate, improving safety requires more than the “litigation risk management” typically promoted by commercial malpractice insurers. Existing insurance arrangements also fall short with respect to individual physician quality. Traditional carriers lack the information necessary to “experience-rate” physicians based on their safety records. Insurers can use the blunt tool of refusing coverage to those whose claims records suggest that they should not be practicing. Even then, however, the effect on safety may be undercut if coverage is still available through a JUA—a state-sponsored insurer of last resort established on the assumption that physicians who had been
sued repeatedly for malpractice were not objectively bad but had spilled “blood in the water” that provoked a feeding frenzy among plaintiffs’ lawyers.

- **Industrialization.** Health care is far more industrial and corporate in its structure today than it was thirty years ago. Organizational change has gone hand in hand with scientific progress; health facilities, financing entities, diagnostic enterprises, and suppliers of medical technology and expert labor now play a role arguably no less important than that of physicians.

The major consequence of industrialization for malpractice insurance is that health care—like other sectors of the economy that have followed similar paths—has been subjected to a steady expansion of liability during the long periods of stability between crises, particularly for corporate providers. The tenfold increase in liability costs for long-term care facilities over the past decade, for example, reflects a combination of new legal risks and “catch-up” in insurers’ rating classifications, which until recently charged these providers the same rates paid by hotels and other hospitality businesses, notwithstanding their evolution from “nursing homes” to “skilled nursing facilities.” Industrialization also increases public demand for both market accountability and direct government oversight, which is at odds with the medical profession’s traditional reliance on self-governance.

- **Revenue base.** Industrialization poses two major challenges for malpractice insurance. One is the limited financing base for insuring legal risk through current institutions. For hazardous activities engaged in by typical commercial firms, liability is borne in rough proportion to revenue. This lodges costs with the wealthiest and therefore most efficient risk-bearers, assures that resources will be available to compensate victims, and reduces hazard levels by building the chance of injury into the price of the product or service they sell. Despite overall industrialization in health care, physicians by and large remain independent economic actors. Compensation for medical injury is paid mainly by physicians’ malpractice insurance because physicians still plausibly control roughly two-thirds of health spending through their ordering and referral decisions, and tort law holds physicians primarily responsible for the care that patients receive. However, physician services account for less than 15 percent of national health spending, creating a trillion-dollar gap between physicians’ revenues and total revenues because of sustained medical inflation. The medical profession is insufficiently capitalized to fund insurance for such a large multiple of earnings, particularly when the burden falls mainly on a few specialties. Although hospitals and other corporate providers pay substantial additional amounts for their own liability coverage, some of that investment goes to protect against punitive damages instead of substituting for physician liability.

- **Risk pooling.** A second challenge of industrialization is volatility arising from inadequate risk pooling among different groups of physicians. Liability insurance is typically priced according to the frequency and severity of paid claims associated with a physician’s specialty and practice location (class rating). Physicians who perform risky surgery on younger patients whose legal damages are potentially great
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(for example, orthopedists and neurosurgeons), deliver babies who might suffer lifelong disability (for example, obstetricians), or diagnose life-threatening but potentially treatable diseases (for example, mammographers) pay much more for liability coverage than physicians who treat older patients, avoid invasive procedures, or treat self-limiting ailments. These effects are magnified during crisis periods, as carriers abandon marginal markets and customers while applying increasingly conservative standards to physicians with whom they continue to do business.

Class rating is individually rational for insurers selling policies to large numbers of solo or small-group physicians but breaks down the ability of the health care system as a whole to reduce risk-bearing costs. Modern medicine is a collaborative enterprise; society gains nothing by discouraging physicians from entering high-liability fields such as obstetrics or neurosurgery. Neither does the current system offer meaningful incentives for specific physicians to improve safety; experience rating at the individual physician level is too imprecise to be effective. Finally, sharing liability costs to a greater degree among physicians (and other providers) would not threaten classic adverse selection against insurers because coverage is not voluntary. Although only a few states mandate that physicians carry malpractice insurance, hospitals and managed care organizations generally protect their own assets by obligating affiliated physicians to purchase such coverage. The only plausible justification for class rating (and geographic classification), therefore, is based on fairness, not efficiency: Urban specialists often earn more than family practitioners in outlying areas. However, some lucrative specialties pay far less than others, and inner-city providers incur higher costs than their wealthier suburban counterparts.

Cost containment. The public and private investments that created the “medical-industrial complex” also induced both government and private insurers to control expenses more tightly, which in turn provoked a backlash from consumers and voters. Importantly, these events coincided, more or less, with the period between the malpractice crisis of the 1980s and the present. Two decades of cost containment affecting health insurance have important implications for malpractice insurance. Rising rates of uninsurance and restrictions on covered benefits expose liability insurance (along with workers’ compensation) as one of the few remaining unconstrained sources of health care financing for severe injury. The principal method used to contain costs—managed care—also reduces patients’ and jurors’ trust in medical providers and taints bad outcomes with commercial motivation, potentially increasing the rate and magnitude of claims, settlements, and verdicts and raising the specter of punitive damages.

Financial resilience. A related problem is that Medicare and private reim-
Bursegment rates have become insensitive to the short-term increases in providers’ input costs that occur in volatile malpractice insurance markets. In previous crises, threats of physician exit and hospital closure from malpractice pressures were largely rhetorical because rising costs were quickly passed through to patients and payers. The health care system is plausibly more efficient than it was twenty years ago, but it is also less resilient and therefore more likely to suffer localized disruptions in service when liability premiums spike. Managed care organizations obtained steep discounts from physicians in the 1990s when malpractice premiums were stable, and they are reluctant to renegotiate reimbursement rates because of recent malpractice premium increases. Medicare’s formulas for paying physicians nominally incorporate malpractice expense but have been subject to overriding federal budget constraints. Under the competitive conditions that now prevail, medical care providers rather than consumers will often bear the lion’s share of increased insurance costs, while redundant (reserve) capacity in many communities and specialties has been depleted. In other words, the economics of today’s health care system make the question of access to health services in a malpractice crisis one to be taken seriously.

What Should Be Done

Medical malpractice reform should be focused on better integrating liability coverage into the professional, commercial, and regulatory framework of health care financing and delivery.

**The private sector.** One can discern a general direction to the structure of private malpractice coverage. By and large, commercial insurers not otherwise connected to the health care system lost interest in the malpractice market during the crisis of the 1970s, to be replaced by carriers sponsored by professional groups of physicians or hospitals. Many of these entities evolved into sophisticated profit-making businesses in their own right, paralleling the overall reorientation of the health care system to market governance. Concurrently, medical industrialization (particularly in hospitals) generated greater use of alternative coverage arrangements—for example, self-insurance (retention), captive insurers, and formal risk-retention groups—that more closely align risk management with financial and clinical management within discrete provider institutions.

From a health policy perspective, these are salutary developments. Physician mutual carriers offer a transitional though valuable form of coverage. They are strongly committed to the malpractice market and therefore less likely to abandon it in troughs of the insurance cycle but are poorly diversified, suboptimally capitalized, and overly beholden to broadly constituted sponsoring organizations and the lowest-common-denominator professional politics they tend to espouse. Proximity to professional practice may improve patient safety and injury prevention, especially for single-specialty insurers. In anesthesiology, for example, liability insurers have accelerated the spread of clinical best practices and safety tech-
nologies, such as pulse oximetry. On the other hand, single-specialty coverage exacerbates the unequal distribution of legal risk among physicians. For example, pulse oximetry keeps obstetric anesthesia premiums affordable not only because it protects patients, but also because it deflects responsibility for hypoxic injury to newborns from anesthesiologists to obstetricians.

Coverage linked to medical institutions is more promising, particularly if physicians and hospitals have a common organizational and financial interest in reducing patient injury and managing liability risk across a spectrum of clinical services. As has been observed by proponents of “enterprise liability,” institutional coverage has several potential advantages over traditional liability insurance. Unlike individual physician coverage, institutional costs are based on risk experience, which gives liability a degree of deterrent effect notwithstanding the vagaries of the insurance cycle. In addition, physician liability costs can be more equitably distributed across specialties, and between professional and institutional revenue streams, when (as in academic health centers today) physicians share a common interest in the success of an institution and imputed malpractice premiums are part of a general negotiation over compensation and allocation of overhead. Medical institutions are also well positioned to craft contractual alternatives to malpractice litigation (for example, arbitration and no-fault payment) that reduce volatility in liability costs and to mirror those arrangements in agreements with managed care organizations and other health care payers.

The severity of the current crisis is having a mixed impact on these trends. On one hand, retrenchment by traditional carriers creates competitive space for new organizational forms. On the other hand, a tight global reinsurance market makes innovative approaches to risk pooling more expensive and therefore less likely to be attempted.

State government. States, not the federal government, are the principal regulators of insurance. Insurance regulation exists primarily to maintain solvency and to monitor conduct in marketing coverage and responding to claims, which assure that policyholders receive the benefits they expect from their premium contributions. States should pay close attention to the health care system’s need for stability in economic downturns, which simultaneously threaten health care financing and raise liability premiums. Aggressive price cutting by insurers to win customers at peaks of the insurance cycle can backfire when economic conditions change. Even rate regulation (which occurs in roughly a third of states) can hasten insolvency if regulators are overly responsive in good times to “consumer” preferences for low premiums, as is often the case for automobile insurance.

States should further integrate regulation of malpractice insurance with regulation of health care providers and managed care organizations. The principal goals should be to increase the speed with which patient injuries are identified and acknowledged, to focus the claims process more on the needs of patients and families (that is, to give liability coverage more of a first-party than a third-party
char
acter), and to link liability risk management with clinical quality improvement at the institutional level.

States also should rethink their commitments to risk pooling. Traditional interventions such as JUs and guaranty funds are either irrelevant or counterproductive to maintaining public access to high-quality health care. Similarly, some state-sponsored patient compensation funds (PCFs) create an overhang of unreserved liability that induces existing physicians to retire early and discourages new entrants. Instead, state regulators should distribute liability costs more equitably among physicians and other health care providers by encouraging the formation of new, diversified risk pools; monitoring health insurance contracting and reimbursement practices; prohibiting subrogation claims by health insurers against malpractice defendants; and promoting other sources of coverage for the economic costs of catastrophic injury to patients. Tort reform—modification of the adversarial system of civil justice—will often be necessary for these efforts to succeed but should further the core health policy goals of reducing and compensating injury. As several commentators have suggested, some states may eventually conclude that both health care providers and the public would be better off in a system of strict liability (usually but oddly called “no-fault”), akin to workers’ compensation, that avoids the expense and unpredictability of litigation.

The federal role. An expanded federal presence in medical liability coverage is inevitable and desirable for three reasons. First, the cost of reinsurance is a major precipitant of the current crisis, and reinsurance is a national and international issue. Furthermore, only the federal government has the fiscal capacity to substitute public for private reinsurance, which could rapidly and affordably relieve financial strains on health care providers, particularly hospitals. Second, many coverage innovations are being developed at the individual institutional level rather than through corporate structures familiar to state regulators. The federal government has been the principal regulator of risk-retention groups since the 1980s crisis and could leverage that experience to help providers devise more effective risk-bearing strategies, particularly if it played a larger role in reinsurance. Third, the center of gravity for health care generally has moved from the states to the federal government since the 1960s, particularly in terms of funding collective responsibility for medical progress and distributing benefits in ways that reduce pernicious disparities among states. At one time, widely varying costs of medical liability may have reflected legitimate state-level choices about legal rights and remedies. Today, however, the malpractice system is so deeply entwined in the health care system that national priorities for the latter require comprehensive reform of the former.

Two avenues for federal intervention seem possible. One option is for the federal government to support state-based malpractice reforms that would replace litigation with a more rational system for reducing injury rates and compensating injured patients. The IOM, responding to a request from the U.S. Department of Health and Human Services, outlined demonstration projects of this sort in
The IOM proposal envisioned a greater federal role in providing subsidized reinsurance. It also conferred insurance subsidies and immunities from tort litigation selectively on health care organizations that had demonstrated capacity to improve quality of care and be accountable to patients.

A second, even more promising option is for the federal government to propose a comprehensive restructuring of malpractice claims involving Medicare and Medicaid patients, which could then set the standard for the rest of the health care system. The surest way for malpractice to be placed on the national health policy agenda is for Medicare to take ownership of it. Medicare-led reform, which could take advantage of Medicare’s established systems of administrative adjudication, would link the process of identifying and compensating avoidable injuries to Medicare’s other quality improvement initiatives and would incorporate liability insurance into Medicare payment formulas. Prompt resolution of claims would be hugely advantageous to seniors compared with suffering delays of several years in courtroom proceedings. Making malpractice policy through Medicare policy would also focus the political process on the health policy impact of liability reform, rather than allowing lobbyists on both sides of the aisle to exploit public concern about health care for general partisan advantage.

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NOTES


10. Bovbjerg and Bartow, “Understanding Pennsylvania’s Medical Malpractice Crisis.”

11. The shift from occurrence to claims-made policies, which earlier stabilized insurance markets, may have made things worse over time by making it easier for insurers to enter and exit markets on short notice.


