

Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?

by Shirley Svorny

Executive Summary

Supporters of capping court awards for medical malpractice argue that caps will make health care more affordable. It may not be that simple. First, caps on awards may result in some patients not receiving adequate compensation for injuries they suffer as a result of physician negligence. Second, because caps limit physician liability, they can also mute incentives for physicians to reduce the risk of negligent injuries. Supporters of caps counter that this deterrent function of medical malpractice liability is not working anyway—that awards do not track actual damages, and medical malpractice insurance carriers do not translate the threat of liability into incentives that reward high-quality care or penalize errant physicians.

This paper reviews an existing body of work that shows that medical malpractice awards do track actual damages. Furthermore, this paper provides evidence that medical malpractice insurance carriers use various tools to reduce the risk of patient injury, including experience rating of physicians' malpractice premiums. High-risk physicians face higher malpractice insurance premiums than their less-risky peers.

In addition, carriers offer other incentives for physicians to reduce the risk of negligent care: they disseminate information to guide risk-management efforts, oversee high-risk practitioners, and monitor providers who offer new procedures where experience is not sufficient to assess risk. On rare occasions, carriers will even deny coverage, which cuts the physician off from an affiliation with most hospitals and health maintenance organizations, and precludes practice entirely in some states.

If the medical malpractice liability insurance industry does indeed protect consumers, then policies that reduce liability or shield physicians from oversight by carriers may harm consumers. In particular, caps on damages would reduce physicians' and carriers' incentives to keep track of and reduce practice risk. Laws that shield government-employed physicians from malpractice liability eliminate insurance company oversight of physicians working for government agencies. State-run insurance pools that insure risky practitioners at subsidized prices protect standard physicians from the discipline that medical malpractice insurers otherwise would impose.

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If caps on damages reduce insurance industry incentives to minimize the risk of patient injury, then consumers could lose important protections.

Introduction

Supporters of capping court awards for medical malpractice argue that caps will make health care more affordable. It may not be that simple. First, caps on awards may result in some patients not receiving adequate compensation for injuries they suffer due to physician negligence. Second, because caps limit physician liability, they can also mute incentives for physicians to reduce the risk of negligent injuries. Supporters of caps counter that this deterrent function of medical malpractice liability is not working anyway—that awards do not track actual damages, and medical malpractice insurance premiums do not reward high-quality care or penalize errant physicians with higher premiums.

This paper proceeds as follows. I begin with a review of the structure and regulation of the medical professional liability insurance industry. Next, for those unfamiliar with studies of the tort system and concerned that it fails to identify malfeasant physicians, I review the empirical literature that has found malpractice awards generally track injuries resulting from negligence. The next section reviews the conventional wisdom that says medical malpractice insurance companies do not “experience rate” (i.e., charge higher premiums to physicians who are more likely to injure patients). Drawing on interviews with underwriters and brokers, published sources, and an extensive review of state insurance company rate filings in California and elsewhere, I explain how the malpractice insurance industry uses underwriting and other tools to provide oversight and reduce adverse medical events. I conclude that important consumer protections could be lost were caps on economic and noneconomic damages to reduce insurance industry incentives to evaluate and minimize risk associated with the practice of medicine.

The findings in this paper have implications for several other public policies, including laws that shield government-employed physicians from malpractice claims, state malpractice insurance subsidies for high-

risk physicians (via state joint underwriting associations), and state licensing of medical professionals.

The Medical Malpractice Insurance Industry

Medical professional liability insurance is commonly referred to as malpractice insurance. State governments regulate medical malpractice insurance. Companies approved by state insurance departments are called admitted carriers. Admitted carriers must demonstrate financial stability and adhere to state regulations. They must seek state department of insurance approval for rates and forms. State guarantee programs protect injured patients against insurer insolvency.

Since the mid-1970s, the share of the medical professional liability insurance market held by traditional, for-profit, commercial insurers has declined as not-for-profit, physician-owned insurers’ share has grown. Other risk-transfer entities provide insurance to medical societies or physician groups.¹

Physicians denied coverage or dropped by admitted carriers turn to surplus-lines carriers. This includes physicians who have lost hospital privileges, those with a history of medical malpractice claims or drug or alcohol abuse, and physicians sanctioned by state medical boards. Medicare or Medicaid fraud can also be a ticket to the surplus-lines market.² Doctors with clean clinical records may be in the surplus-lines market because they practice in more than one state, have gone without insurance coverage for a time, or are using a new procedure not yet widely in use.

For the most part, surplus-lines carriers are not as heavily regulated as admitted carriers nor backed by a state guarantee fund.³ Because they are not required to file forms and rates, they may change rates or policy terms as conditions warrant. This allows them to design insurance products for nonstandard risks.⁴

The number of physicians in the surplus-lines market depends on the medical malpractice insurance cycle.⁵ In a buyers’ market, the

so-called soft market, admitted carriers take on more risky physicians. Today, an aging soft market has led many admitted carriers to expand the set of physicians they will cover, crowding out the surplus-lines carriers. CNA HealthPro underwriting director Tim Vlazny estimates that the share of premiums attributed to doctors in the surplus-lines market can be as low as 1 percent in a soft market and as high as 10 percent in a hard market.⁶

Are Malpractice Awards and Settlements Haphazard?

Tort law serves two functions. The first is to compensate individuals who are harmed by others. The second is to deter harmful behavior. If the medical malpractice system is working properly, court verdicts (and settlements motivated by previous verdicts) would not only compensate patients who suffer due to physician negligence but would also deter future harmful events. The medical malpractice system's ability to deter negligence depends first on the accuracy of court judgments and awards.⁷ If awards and settlements are random, there can be no deterrent effect, making the whole system a costly way to compensate victims of negligence.⁸

Researchers have found that awards are not haphazard. The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims. Plaintiffs' attorneys, paid on a contingency basis, filter out weak cases. Patients who file valid claims are likely to collect, generally through out-of-court settlements. Though some unfounded claims do result in settlements or the rare court award, the dollar amounts are smaller than they would be for similar injuries that result from physician negligence.⁹

The fact that settlement is common suggests courts are providing good signals as to when plaintiffs will prevail. Under these conditions, insurance companies assess the validity of claims and settle valid claims rather than go to court. The fact that defendants win most court trials makes sense if defen-

dants (providers and insurers) generally settle valid claims out of court.

Another common criticism of the medical malpractice system is that few cases of negligence result in claims. This could be partially explained by the fact that in most cases of negligence the damages are minimal. A prominent study found that nearly 80 percent of patients who suffered a negligent injury either recovered fully within six months or were very old. Both factors indicate relatively small financial losses, which can discourage patients from filing a claim.¹⁰ The evidence suggests that the majority of claims are heavily concentrated among a small percentage of practicing physicians.¹¹ So if more cases of negligence or substandard care were to result in claims, the set of defendants would not likely differ significantly from the set of high-risk professionals that the current system already identifies.

Critics of the system point to the fact that many initial claims do not involve negligence. This can be explained by patients and their attorneys seeking to gather information about the level of negligence associated with an injury. Once discovery shows a small likelihood of success, many plaintiffs drop their claims.¹²

Critics of the medical malpractice system point to its high administrative costs.¹³ High legal fees may reduce the system's efficiency by leading insurers to settle meritless claims and by deterring some injured patients from filing valid claims. Yet, as economist Patricia Danzon observes, the bulk of administrative costs are limited to the small fraction of cases that go to court. Meanwhile, the deterrent effect influences all medical practice.¹⁴

Although the conventional wisdom is that lawsuits keep doctors from discussing problems and reporting errors, David Hyman and Charles Silver credit lawsuits with starting discussions that improve care.¹⁵ They write that high malpractice premiums motivated the American Society of Anesthesiologists to launch a patient safety campaign that resulted in a dramatic reduction in surgical anesthesia-related injuries and deaths in the United States. They point to a hospital that did not

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take efforts to reduce infection rates until it faced significant costs of litigation; it was litigation costs that motivated the hospital to improve sanitary procedures and resulted in a near elimination of hospital-borne infections.

The Conventional Wisdom: Malpractice Insurance Is Not Experience Rated

If the tort system is to steer providers in the direction of higher-quality care, accurate awards are necessary but not sufficient. Physicians must receive information about how to avoid liability risk and face incentives to act on that information.¹⁶ If malpractice insurance premiums reflect a physician's or a physician group's claims experience or other factors related to the risk of injuring a patient through negligence, then premiums will act as signals that steer physicians toward higher-quality care: the hope of reducing their premiums will encourage high-risk physicians to reduce their risk of injuring patients. If insurers do not experience rate premiums, those signals would not exist and the tort system's deterrent effect would be muted.

The decades-old conventional wisdom holds that medical malpractice insurers rarely adjust premiums to reflect an individual physician's risk. An influential 1981 article by economist John Rolph concluded that "merit rating" was "a practice not now employed in the malpractice insurance industry to a significant degree."¹⁷ About the same time, Patricia Danzon reviewed a nationwide sample of premiums paid between 1974 and 1976 and found no surcharges based on claims histories, concluding, "these data suggest that, at least in the group programs, more merit rating is feasible than in fact occurs."¹⁸ In the early 1990s, economist Frank Sloan and colleagues reported the findings of a 1980s survey of 14 medical malpractice insurance companies, in which the majority of firms had "either completely abandoned experience rating . . . or maintained a program of limited scope."¹⁹

Sloan concluded that "there has been considerable resistance to experience rating in the medical malpractice line."²⁰ Paul Weiler and colleagues concluded, "experience rating has not found much favor with the carriers that insure individual doctors against malpractice suits."²¹ In 1998 Sloan and Randall Bovbjerg wrote, "there is little experience-rating in the medical malpractice field, even where there are claims."²² In 2001 economists Gary Fournier and Melayne McInnes wrote that experience rating "is rarely found."²³ In 2008, Sloan and Lindsey Chepke wrote, "experience rating of premiums is rare for medical malpractice insurance. Thus, in general, physicians with relatively adverse medical malpractice records pay the same premiums as others."²⁴ Among other places, the conventional wisdom appears in literature reviews by the Robert Wood Johnson Foundation ("experience rating is not widely used. . . . Physician malpractice premiums . . . are usually priced according to the physician's specialty and geographic location") and U.S. Congressional Budget Office ("premiums for malpractice insurance generally are not adjusted on the basis of an individual physician's claim history").²⁵

Economic Theory vs. the Conventional Wisdom

Economic theory predicts that the practice of charging the same average premium to low-risk and high-risk physicians would not persist for long in a competitive market. Eventually, a competing insurer would lure away low-risk physicians with the promise of lower premiums, and premiums for high-risk physicians would rise as a result. Economic theory also predicts carriers will continue to invest in underwriting so long as spending an additional dollar on underwriting yields more than one dollar of revenue. Economists generally acknowledge that experience rating could improve the quality of care and the functioning of the tort system.²⁶

The apparent lack of experience rating therefore presents something of a puzzle. To

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explain why experience rating has not taken hold in this market, some cite carriers, who say that experience rating “would not work well with low-frequency, high-severity losses as occur in medical liability, which may take a long time to settle.”²⁷ Others cite the high cost of underwriting.²⁸ I will address these explanations after reviewing the evidence of experience rating.

When I was told by an insurance industry professional that medical malpractice insurance is experience rated, I undertook an intensive investigation.²⁹ I conducted lengthy interviews with underwriters and brokers, scoured published sources, and read all of the medical malpractice insurance rate filings in California. It turns out that the conventional wisdom is wrong. The malpractice insurance market does in fact adjust premiums to reflect physician risk, both within and across carriers. This forces high-risk physicians to bear the cost of the added risk they pose and creates incentives for those physicians to practice safer medicine. Carriers engage in other activities, often tied to underwriting, that also reduce patients’ risk of negligent injury.

Underwriting

Initially, when physicians seek insurance, and then on an annual basis, medical malpractice insurers require them to provide information that allows the insurance underwriter to assess liability risk. Insurers ask physicians questions about their practice profile, including whether they perform or assist with surgery, the type of medicine they practice, the number of patients they treat, specific medical techniques and procedures they use, and where they practice.³⁰ Applicants describe their education and provide a list of hospitals where they are permitted to practice. Applicants must report whether they have ever been denied status as a medical student, a license to practice medicine, a license to prescribe narcotics, hospital privileges, membership in a professional society, or medical professional liability insurance

and whether any one of these has ever been restricted, suspended, revoked, or voluntarily surrendered. Physicians must report whether they are specialty-board certified, have ever failed a specialty board certification test, or have ever been denied certification by a specialty board. Physicians must complete a form for every claim filed against them, including information about damages paid and defense costs to their insurer at the time, and any claims they expect to be filed. Physicians must report any history of alcoholism, mental illness, or narcotics addiction, or any criminal history. Lying on one’s application is grounds for denial of a claim.³¹

Insurance underwriters scrutinize the information in a physician’s application. According to Tim Vlazny, the underwriter’s job is to “verify, verify, verify.”³² Preferred carriers, those with the strictest underwriting guidelines, may go so far as to search county records. This alerts them to claims before they are reported to public databanks.³³ Information also comes from the so-called “loss runs” provided by a physician’s previous medical liability insurer. Loss runs document prior claims, damages, and defense costs. Surplus-lines carriers require applicants to produce loss runs for every company with which they have been insured.³⁴ Insurers reevaluate physicians annually.

Underwriters may even review the equipment a physician uses. A clinician may have had problems with claims in the past, but if he or she has adopted newer techniques or purchased safer equipment, that may allow the physician to secure a policy with a lower premium.³⁵ In Colorado and in Nebraska, the medical malpractice liability carrier COPIC performs a standardized review for significant safety and risk aspects of all the offices of the physicians it insures biannually (nearly 2,400 such reviews a year).³⁶

Underwriters occasionally have access to information that is not available publicly. For example, they might obtain information such as physician-specific utilization reports from a managed care company intent on negotiating a lower rate for its physicians.³⁷

Medical malpractice insurers require physicians to provide information that allows the insurance underwriter to assess liability risk.

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Experience Rating

Experience rating refers to the practice of charging physicians with a history of risky behaviors higher premiums than their same-specialty, same-location peers. As a first step in experience rating, a standard-lines carrier may impose premium surcharges on physicians whose claims histories do not meet the company's standards, or offer discounts to physicians with clean histories. A 1989 survey of insurance companies commissioned by the Institute of Medicine reported the use of experience rated surcharges at 6 carriers (of 10 that answered the question about use of experience rating and surcharges).³⁸

Insurance company rate filings in California show that admitted carriers routinely incorporate surcharges and credits in their rate manuals. Table A-1 lists surcharge provisions found in the most recent California rate filings. The last filing that made any changes to experience rating provisions is listed.³⁹ Florida filings are similar to those in California. A filing by Florida's second largest insurer includes surcharges between 50 and 500 percent of standard premiums based on a physician's seven-year claim history.⁴⁰ A survey of Vermont companies reported surcharges as high as 400 percent.⁴¹

Just as surcharges may be used to punish poor risk management, premium credits reward physicians who avoid lawsuits. As Table A-2 shows, almost all California filings include claims-free credits, where the size of the credit—from 5 to 25 percent of a physician's base premium—is often a function of how long a physician has been claims free. Similar credits showed up in Florida rate filings and were reported in the 2005 survey of Vermont companies.⁴²

Longevity credits also reward good claims experience, as continued eligibility for insurance indicates risk concerns have not changed substantially. One California insurance company offered a 5 percent credit to physicians insured for five or more consecutive years.⁴³

Rate filings may provide only weak evidence

of experience rating. Filing surcharges with the state gives insurance companies the flexibility to use them as they see fit, but filings do not indicate how often carriers actually apply those surcharges. Some carriers report that only a small percentage of insureds face surcharges at any point in time.⁴⁴ For example, an admitted carrier might decide to surcharge a physician with the intention that continuing education and enrollment in risk management seminars (see below) would move a physician to a position where the carrier is comfortable insuring him at standard rates.⁴⁵

One carrier reports that if the required surcharge would be much above 25 percent, the company is more likely to reject a physician's application, fail to renew a policy, or impose reductions in coverage upon renewal.⁴⁶ Some carriers' filings explicitly state that surcharges may substitute for nonrenewal or cancellation of a policy.⁴⁷

A 2008 study of malpractice premiums in Massachusetts offers a rare opportunity to see statistics on actual surcharges. A state-regulated mutual insurer in Massachusetts, ProMutual (with an estimated market share of the physician liability insurance market of between 40 and 50 percent in 2005), reports that it began underwriting within-practice specialties based on individual risk factors in 1990, offering discounts for lower-risk physicians. In 2000 the company began surcharging higher-risk physicians. By 2005, roughly 6 percent of ProMutual's policies carried surcharges. Four-and-a-half percent of physicians faced surcharges of less than 25 percent and 1.4 percent paid surcharges over 25 percent. At ProMutual, all physicians in a particular high-risk specialty paid identical premiums in 1990. By 2005, due to refined risk rating, the highest-risk physicians in these high-risk specialties paid premiums three times higher than their same-specialty, lower-risk, peers.⁴⁸

Experience Rating across Carriers

Though some experience rating takes place among physicians insured by a specific carrier, most experience rating takes place across carriers. Insurance carriers specialize in serving

physicians with similar risk profiles. Physicians who do not meet one carrier's risk profile must seek insurance elsewhere. This allows insurance carriers to specialize in underwriting certain risks.

Some companies who insure only the least-risky physicians do little underwriting. They pick physicians with spotless records. This keeps their costs and premiums low. In California, the Cooperative of American Physicians provides coverage through Mutual Protective Trust, a company whose underwriting guidelines are known to be particularly strict.⁴⁹ Preferred Physicians Medical Risk Retention Group advertises that, in more than 30 states, it insures only high-quality anesthesia practices.⁵⁰ General Star's Physicians Advantage Program insures only those physicians with a good loss history, specialty board certification, and no practice impairments.⁵¹ When such carriers reject an application because they are unwilling to assume that physician's liability risk, that itself is a clear example of experience rating.

Other companies underwrite physicians with somewhat higher risk. When admitted carriers deny coverage to physicians who present too much risk, those physicians must turn to surplus-lines carriers, who typically charge more. Premiums in the surplus-lines market are generally between 150 to 500 percent of those in standard markets.⁵² A physician paying \$10,000–\$15,000 in the admitted market might pay \$25,000–\$50,000 in the surplus-lines market if he had been sued many times.⁵³ Tim Vlazny reports that premiums in the surplus-lines market average twice the level of those in admitted markets in the hard part of the medical malpractice cycle (a seller's market) and 1.25 times the admitted rate in a soft market (buyer's market).⁵⁴ In addition to higher premiums in the surplus-lines market, it is common to require deductibles between \$5,000 and \$25,000 per claim.⁵⁵ With deductibles, physicians bear the first dollar of damage costs, creating additional incentives for physicians to reduce their risk.⁵⁶

Physicians denied or dropped by admitted companies not only pay higher premiums and bear more financial risk, but when they

retire or are disabled, they pay substantially more than other physicians for Extended Reporting Period (tail) coverage. Tail coverage is important to retired physicians because, while practicing, physicians buy "claims-made" coverage. This type of coverage only protects them against claims made during the period the insurance is in effect. When a physician retires, liabilities for past adverse events are not covered unless the physician has tail coverage.⁵⁷ Physicians in the admitted market are offered tail coverage at no charge or at a significantly reduced premium.⁵⁸ In contrast, physicians who retire from the surplus-lines market find tail coverage expensive. Premiums may range from 500 percent of the physicians' previous year's premium for five years of tail coverage to 125 percent for one year of tail coverage. Physicians enrolled in "Tribute Plan," a medical malpractice policy offered by the carrier The Doctors Company, face an additional penalty if dropped—they lose access to their Tribute Plan retirement benefit, which includes a retirement payment.⁵⁹

There is stratification of risk within the surplus-lines market as well. For example, General Star has two programs in the surplus-lines market, its Physician Select Program and its Special Risk Program.⁶⁰ CNA's surplus-lines company targets only those physicians who have the potential to return to the admitted market.⁶¹ Darwin National Assurance Company specializes in writing so-called "grey docs," physicians who don't have bad claims records but are in the surplus-lines market because they need more underwriting than the standard market is willing to provide. They may have gaps in coverage, practice in two or more states (as with a radiologist involved in telemedicine), have a large claim that is relatively old, or be involved in clinical research.⁶² Some companies underwrite more extensively than others. Whereas Markel evaluates the validity of claims against physicians (appealing to doctors with invalid claims), RSUI treats every claim equally.⁶³ Only a very few companies have the expertise to underwrite physicians in the extreme risk category.⁶⁴

Once in the surplus-lines market, physi-

Most experience rating takes place across carriers.

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Physicians are motivated to reduce their perceived risk.⁶⁵ For many, being placed in the surplus-lines market is a “major wake-up call.”⁶⁶ Physicians know that if their insurance is not renewed they will not be allowed to practice in most hospitals or be affiliated with most health maintenance organizations.⁶⁷ In some states, they are not allowed to practice at all. Most doctors return to the admitted market after showing that their problems have been resolved. For some, the passage of time suffices to demonstrate to the admitted market that they bring with them no unusual risk.⁶⁸

Specialization across companies in the level of risk they choose to insure provides a second level—and stronger evidence—of experience rating. Outside observers may see little evidence of experience rating among physicians insured by a particular carrier, but that is because those physicians have already been selected for common risk characteristics. According to a leading health economics textbook, “markets produce ‘experience rating’ even when firms don’t”:

Even if individual insurance firms don’t use experience rating to price their insurance, the market may produce an equivalent result. That is, every firm might charge each of its customers the same price, yet each firm may accept different classes of risk. This can readily lead to high-risk customers paying higher rates and low-risk customers paying low rates, even if no single firm charges different rates to different risk classes.⁶⁹

Experience rating across carriers also occurs in other insurance markets, including automobile insurance.⁷⁰

Experience rating of this sort—where admitted carriers deny coverage to high-risk physicians who then must turn to surplus-lines carriers or the government—also appears in some of the very research that helped form the conventional wisdom about the infrequency of experience rating.⁷¹ In 2000 Danzon referred to this process as a “crude” form of experience rating.⁷²

When told that the common view is that medical malpractice is not experience rated, CNA’s Tim Vlazny replied:

I’m surprised that people have difficulty believing physicians’ malpractice premiums are impacted by the practitioner’s loss experience. Virtually every professional liability line has a premium modification formula for prior losses. Virtually every insurance coverage line discerns on the basis of price risks with and without claims. Large risks—with credible experience—are specifically loss rated by actuaries. Smaller risks or risks without enough credibility on a stand-alone basis are pooled with other like/kind risks and within that pool, risks with prior losses will pay more.⁷³

Reconsidering the Conventional Wisdom

If medical professional liability insurance is experience rated, how did the conventional wisdom arise? One explanation is that researchers looking for evidence of experience rating have focused on premium surcharges and discounted the experience rating that occurs as different firms specialize in different levels of risk.⁷⁴

Another explanation is that the conventional wisdom took hold before competitive forces began changing the industry. As Danzon notes, in the 1970s the market was dominated by medical society-sponsored insurance programs that guaranteed coverage to their members. By the 1980s, the entry of physician-owned mutual insurance companies, who used peer review to assess the validity of malpractice claims against physicians, had changed the market.⁷⁵ Competition from new entrants would tend to encourage underwriting.

Finally, the declining cost of data retrieval, data management, and record keeping have made it easier for underwriters to assess the claims history of individual physicians, and

thus a particular physician's level of risk. All else equal, declining data costs increase a carrier's return on investment in underwriting.

Direct Risk Management

Beyond the incentives experience rating creates for physicians to reduce the risk of harming patients, the medical malpractice liability insurance industry further protects patients by offering physicians direct guidance on how to reduce that risk. Reviews of malpractice claims and other peer-review efforts have enabled carriers to identify clinical practices that pose a risk to patient health.⁷⁶ The Physicians Insurers Association of America (PIAA) Data Sharing Project alerts insurance companies to areas and patterns of practice with a high incidence of claims or suits.⁷⁷ This helps hospitals and other health care providers identify patterns of practice where malpractice risk is substantial.⁷⁸ Another example is CNA's Physical Therapy Claims Study, which offers risk-management suggestions for physical therapists.⁷⁹ In Colorado, COPIC, which insures the majority of physicians and many of the hospitals in the state, engages in extensive risk management training. The company has a 22-employee patient safety and risk management department, delivers over 400 seminars a year, and over 80 percent of all resident physicians in training programs in Colorado rotate through a one-week COPIC-run patient safety and risk-management program prior to completing their residency.⁸⁰

To encourage risk management, most medical professional liability insurance companies offer premium discounts to physicians who engage in risk-management activities or comply with medical specialty-based risk-management requirements. Some firms offer credits for the use of electronic medical records.⁸¹ Several California carriers offer a 5-percent credit to physicians who attend a company-approved risk-management/loss-prevention workshop. PHICO has offered credits of up to 5 percent to physicians who

comply with federal guidelines regarding mammography testing, on-site laboratory testing, and employee exposure to blood-borne pathogens. The Doctors Company, one of the nation's largest malpractice insurers, offers moderate discounts for physicians who participate in risk-management activities or comply with specialty-based risk-management program requirements.⁸² A 1989 Institute of Medicine survey of 20 commercial and physician-owned carriers found four types of risk-management strategies to be prevalent: (1) data gathering and analysis, (2) development of clinical standards and protocols, (3) educational programs, and (4) premium discounts for risk-management activities. Many carriers employed all four.⁸³ When Congress enacted the Federally Supported Health Centers Assistance Act of 1992, extending malpractice insurance coverage to community and migrant health centers under the Federal Tort Claims Act, many of the health centers did not want to cancel their private insurance because they did not want to lose the tailored risk-management services the private carriers supplied.⁸⁴

Surplus-lines carriers often require physicians to take specific remedial actions.⁸⁵ These can include upgrading equipment, working under the supervision of another professional, limiting the scope of a physician's practice, and other safety measures. Some surplus-lines companies offer risk-management services on a case-by-case basis.⁸⁶ For example, MedPro/Frontier's program for high-risk physicians included "specialized risk management designed to 'rehabilitate' those physicians and return them to the standard market."⁸⁷ Conventus Inter-Insurance Exchange recently announced a program designed to get marginal physicians back in the admitted market:

We will provide a full suite of . . . risk-management services including a practice assessment . . . [providing] specific guidelines and steps the practice must take, and standards the practice must meet, in order to qualify for a transfer from this program into Conventus.⁸⁸

The medical malpractice liability insurance industry further protects patients by offering physicians direct guidance on how to reduce risk.

Practice Constraints

Unlike state licensure, which does not restrict a physician's practice to a particular specialty or area, malpractice insurers sometimes limit the scope of duties a physician may perform by excluding specified medical services from coverage. For example, California rate filings include forms to exclude performing surgery, administering anesthesia, treating pregnancy, and practicing over the Internet.⁸⁹

In some cases, insurance policies dictate evidence-based standards of care that must be met for coverage to apply. For example, the Utah Medical Insurance Association developed guidelines for underwriting and loss prevention for obstetrical practice, and its insured physicians are required to follow specific protocols.⁹⁰ Due to the much-celebrated advances in safety associated with delivering anesthesia, some medical professional liability insurers have adopted protocols for anesthesia developed by the profession. For example, the Medical Insurance Exchange of California includes an Anesthesia Restrictive Endorsement that dictates how many certified registered nurse anesthetists a physician may supervise and lays out mandatory standards for monitoring patients:

Blood pressure and heart rate should be recorded every five minutes; respiratory rate and oximeter reading every 15 minutes; carbon dioxide recordings every 15 minutes only if the endotracheal tube is placed.

The restrictive endorsement includes specific equipment that must be available, including

an audible device that detects disconnection of any component of the breathing system when an automatic ventilator is used [and] an oxygen analyzer that will detect the concentration of oxygen and has a low concentration of oxygen alarm.⁹¹

The Doctors Company has a similar endorsement form.⁹² Malpractice insurers impose

these constraints because they believe such practices reduce the risk of patient injury.

Practice constraints are often part of negotiated malpractice insurance policies in the surplus-lines market. Underwriters verify that physicians adhere to the restrictions in their policies when the policies are renewed each year and by looking at the doctor's website or advertisements aimed at consumers. Physicians who fail to comply are financially liable to pay any related malpractice claims.⁹³ To preclude risky practice patterns, a physician with a policy limit of a million dollars per claim for most services might be offered a policy with a lower, or even zero, limit for certain specified surgical services.⁹⁴

Evaluating Novel Treatments

Not all physicians in the surplus-lines market are there because they have gotten in trouble. Some are there because they offer fairly unique or risky services that companies in the admitted market do not have the expertise to underwrite. In 2002, for example, GE Medical Protective declined to cover general surgeons taking on gastric bypass surgeries on morbidly obese people or ear, nose, and throat (ENT) doctors offering tummy tucks.⁹⁵

The surplus-lines market plays a major role when doctors are accumulating experience with a novel procedure.⁹⁶ If there are numerous claims, policies issued through the admitted market impose exclusions for novel procedures and physicians performing those procedures must turn to the surplus-lines market. Examples include the introduction of laparoscopic gallbladder surgery (cholecystectomy), bariatric procedures (including gastric bypass and lap band), the da Vinci prostatectomy (a minimally invasive, robotic-assisted surgical procedure for prostate cancer), and the first LASIK eye surgeries to correct vision.⁹⁷ Surplus-lines carriers monitor claims stemming from new procedures and verify a physician's training to see if it is appropriate to the task.⁹⁸

Malpractice insurers sometimes limit the scope of duties a physician may perform.

Putting Teeth in State Board Sanctions

It is common for a physician sanctioned by a state board to be denied coverage by admitted carriers. A substantial number of physicians in the surplus-lines markets are in this category. In response to a question posed by this author, Vlazny calculated that of all hard-to-place physicians reviewed by CNA between 2004 and 2009, 22.6 percent had been the subject of a state medical board action at least one time in their career.⁹⁹ Nancy Davies, an underwriter at RSUI, and John Dow, a broker at Tegner-Miller, estimated that about half the nonstandard physicians they dealt with had state board sanctions in effect.¹⁰⁰

It is general practice in the surplus-lines industry to write any state medical board stipulations that restrict the practice patterns of physicians into a physician's professional liability insurance contract.¹⁰¹ A number of physicians resolve drug or alcohol issues under state board stipulations requiring rehabilitation.¹⁰² When a state medical board sanctions a physician for drug or alcohol abuse, the physician's policy may include an endorsement form requiring notification if drug or alcohol use resumes. The physician may be monitored to ensure participation in a diversion program.¹⁰³

Supporting Other Private Quality-Improvement Efforts

Private privileging and credentialing organizations rely on medical malpractice insurance industry oversight. For example, a hospital credentialing board considering whether to grant admitting privileges to a physician might ask why she is insured in the surplus-lines market or why her policy has a fairly recent retroactive date, signaling lack of coverage for prior periods.¹⁰⁴

Even if a state board allows a physician to practice, insurers may decline to offer coverage.¹⁰⁵ Since many hospitals and health maintenance organizations require physicians to be insured, denying coverage to such physicians

can effectively bar them from practicing medicine.¹⁰⁶ Courts have ruled that hospitals and health maintenance organizations may require physicians to purchase medical malpractice insurance as long as the requirement is not arbitrary and capricious.¹⁰⁷ In such cases, patients, hospitals, and health maintenance organizations all benefit from the oversight provided by medical malpractice insurers, which is more comprehensive than that provided by direct government regulation.

Better Tort Results

As noted above, the efficiency of the medical malpractice liability system depends on the accuracy of court judgments and awards.¹⁰⁸ Efforts by medical professional liability insurance companies to evaluate the validity of claims contribute to the efficiency of the system as a whole.

Since the mid-1970s, the growth of physician-owned professional liability insurance companies has led to more extensive peer review of claims.¹⁰⁹ Companies advertise that they will defend physicians in cases where peer review indicates that adverse outcomes are not the result of physician negligence.¹¹⁰ Similarly, traditional commercial insurers have come to rely on expert witnesses and experienced malpractice attorneys to judge whether a claim involves physician negligence or substandard care.¹¹¹ For example, Darwin National Assurance Company relies on registered nurses (some of whom are also lawyers) to assess the validity of claims.¹¹² These efforts by medical professional liability insurance companies to investigate claims not only work to preserve the reputation of a physician falsely accused of negligence, but lead to more accurate penalties for negligence and substandard care.

Policy Implications

The evidence presented here suggests that actions of medical malpractice insurance companies transmit the risk of liability in a way

The oversight provided by medical malpractice is more comprehensive than that provided by direct government regulation.

In addition to shifting the costs of negligence, capping medical malpractice awards could increase the frequency of injuries due to negligence.

that encourages providers to take steps to reduce the risk of negligent harm. This conclusion has implications for policy at both the federal and state levels, including caps on malpractice awards, medical professional licensing requirements, malpractice immunity for government employees, and state subsidies to high-risk physicians through joint underwriting associations.

Capping Damages

Tort reform is a major topic in current discussions of health care reform. Lawmakers at both the federal and state levels have sought to limit malpractice awards by placing caps on damages, whether economic, noneconomic, or both. Every year since 2002 House Republicans have submitted a bill that would cap noneconomic damages in cases of malpractice. The 2011 version would put a \$250,000 cap on noneconomic damages.¹¹³ Many states already have caps on noneconomic damages and some states have caps on both economic and noneconomic damages.¹¹⁴ In many cases, the caps are not adjusted for inflation, so they become progressively more constraining. For example, in 1975 California's Medical Injury Compensation Reform Act set a \$250,000 cap on noneconomic damages. Since then, the average price level has risen more than 200 percent, causing the cap to decline in real terms and increasing the severity of the cap.

Supporters claim that reducing the size of medical malpractice awards reduces spending on defensive medicine—expensive tests and procedures motivated by the fear of malpractice suits—and with it the cost of health insurance. Researchers have confirmed the existence of defensive medicine in some situations, though its overall prevalence remains controversial.¹¹⁵ State-level award caps have reduced spending on heart disease and mammograms in the Medicare population, and reduced caesarean section rates.¹¹⁶ A Congressional Budget Office analysis of the House Republicans' Help Efficient, Accessible, Low-Cost Timely Healthcare (HEALTH) Act of 2011 predicted that, by eliminating defensive medicine, the bill would reduce federal spend-

ing on health care by \$34 billion and increase federal tax revenues (as firms respond to lower health insurance costs by increasing wages) by about \$6 million over a 10-year period.¹¹⁷

Some observers are skeptical that medical malpractice awards are the driving force behind excessive tests and procedures, claiming that physicians deliver these services because they are risk-averse, to please patients, or to generate additional income rather than to avoid liability.¹¹⁸

Furthermore, defensive medicine is not necessarily undesirable. A well-functioning malpractice system would not eliminate defensive medicine. Rather, it would discourage the use of *inefficient* defensive medicine, where the expected costs of a test or treatment exceed the expected benefits, and promote *efficient* defensive medicine, where expected benefits exceed expected costs.¹¹⁹

Opponents of damage caps rightly point out that caps shift the costs of malpractice injuries from negligent providers to their victims.¹²⁰ In 1989 an Indiana lobbyist, who had helped establish that state's \$500,000 cap on damages, found himself the victim of negligent care. He later wrote:

The cost of this cascading series of medical debacles is painful to tally: I am confined to a wheelchair and need a respirator to keep breathing. I have not been able to work. I have continuous physical pain in my legs and feet. . . . At the age of 49, I am told that I have less than two years to live. My medical expenses and lost wages, projected to retirement age if I should live that long, come to more than \$5 million. . . . The kicker, of course, is that I fought to enact the very law that limits my compensation. . . . Make no mistake, damage caps . . . remove the only effective deterrent to negligent medical care.¹²¹

The foregoing analysis suggests that in addition to shifting the costs of negligence, capping medical malpractice awards could increase the frequency of injuries due to negligence. When

damage caps shift part of the cost of provider negligence to patients, they reduce the incentives for malpractice insurers and health care providers to assess and reduce the risk of injuring patients. The smaller the potential liability, the fewer resources medical malpractice insurers will invest in monitoring and reducing risk.

If the quantity of tests and procedures are a concern, reforms that make patients more cost-conscious or that increase managed care enrollment could improve the situation without triggering a reduction in the patient protections created by the medical malpractice system. If advocates of damage caps believe the courts do not compensate individuals appropriately, an alternative would be to improve the legal process that determines awards, perhaps through nonbinding arbitration or better instructions to jurors.¹²² Michael Cannon argues consumers should be allowed to contract with providers for the level of malpractice protection they prefer. In other words, doctors would compete on the basis of liability protection and consumers could choose a level of protection along with other provider characteristics.¹²³

An Alternative to Licensing

Elsewhere, I have advocated eliminating government licensing of medical professionals on the grounds that state licensing is ineffective and adds little if any protection to the quality safeguards that would continue to exist in its absence, including the tort system, the malpractice insurance market, private specialty boards, and hospital credentialing.¹²⁴ This paper elaborates on the medical professional liability insurance industry's role in protecting patients.

State board sanctions do not appear to be a crucial tool for identifying negligent or incompetent physicians. Medical malpractice underwriters know substantially more about physicians at any point in time than do state medical boards. As noted above, Tim Vlazny reports that only 22.6 percent of physicians that CNA reviewed for surplus-lines coverage between 2004 and 2009 had a state board action filed against them at least one time in their career. This suggests the medical malpractice system, including carriers evaluating prior claims, identifies more

high-risk physicians than state licensing boards do. Vlazny further reports that only about one third of the state-sanctioned physicians had no malpractice claim on record. Claims histories alone therefore identified two-thirds of state-sanctioned physicians, and state medical boards were instrumental in identifying at most 8 percent of physicians applying for surplus-lines coverage from this carrier. Even that figure may overstate the benefits of licensing. It is possible that carriers would identify such physicians for some other reason, including loss of hospital privileges, actions taken against them by another provider (e.g., being dismissed from a physician group), gaps in coverage, or the nature of their practice (e.g., employing untested procedures). Carriers may also identify those physicians due to the very behaviors that led to state board sanctions, including illegal drug use or sexual abuse. Malpractice insurers already deny coverage to troubled physicians overlooked by state licensing boards, precluding them from practicing in some states and affiliating with many hospitals and health care providers. Moreover, Vlazny reports that “many standard markets will also insure a physician with a prior board action, but [who] is loss-free,” which calls into question whether state board actions are even a useful indicator of physician quality.¹²⁵

State medical boards do a poor job of informing the public about high-risk physicians, often to the point of protecting those physicians from public scrutiny.¹²⁶ Another mark against the state system is that the regulatory apparatus can be manipulated by special interest groups to limit competition through scope-of-practice restrictions. Physician groups have been the most successful using licensing to protect themselves from competition by limiting the scope of services that state-licensed nonphysician clinicians may perform, despite no evidence that consumers benefit from more restrictive scopes of practice.¹²⁷ This is not trivial; it makes medical care more expensive and reduces access, particularly for the poor. Absent state licensing, decisions about clinicians' scopes of practice would rest with hospitals, other providers, and malpractice carriers—parties less susceptible to pressure from special-interest groups.¹²⁸

Medical malpractice underwriters know substantially more about physicians at any point in time than do state medical boards.

States could save money and improve consumer protection by eliminating state licensing and instead requiring physicians to secure malpractice insurance.

Requiring Medical Malpractice Insurance

Seven states already require physicians to purchase professional liability insurance. Another seven states require it as a condition to qualify for caps on damages or to participate in a state compensation fund.¹²⁹ Table A-3 lists the states with requirements and describes the relevant state laws. Florida is not included because a doctor may practice without the required insurance if he posts a sign advising patients of the fact.¹³⁰

At present, these requirements exist in addition to these states' licensing requirements. Given the resources of the medical malpractice insurance industry, its detailed efforts to identify physicians at risk of hurting consumers, and the financial incentives embedded in the structure of malpractice premiums—and given the success of physician groups in keeping many state board sanctions hidden from the public¹³¹—states could save money and improve consumer protection by eliminating state boards and instead requiring physicians to secure malpractice insurance.

In May of 2011 Georgia became the first state to pass a law to require physicians to disclose whether they have medical malpractice insurance. Physicians must let the Georgia Composite Medical Board know if they are insured and the board must publish the information on its website. A similar law passed the Illinois Assembly in 2011.¹³²

Malpractice Immunity for Government Employees

The 1946 Federal Tort Claims Act (FTCA) shields government-employed physicians from medical malpractice claims.¹³³ This includes medical professionals who work for the Department of Veterans Affairs, the Indian Health Service, the Department of Defense, and other federal agencies.¹³⁴ The FTCA makes the federal government responsible for defending federal employees when malpractice claims arise, and makes taxpayers liable for harm due to negligence. The Federally Supported Health Centers Assistance Act of 1992 extended FTCA medical malpractice insurance coverage to community and migrant health centers. The goal was to allow health centers to shift money from medical malpractice insurance

to expanding patient treatment.¹³⁵

Shifting liability for malpractice from physicians to taxpayers shields government physicians from underwriting and oversight by private insurers. Federal agencies, such as the Department of Defense and the Indian Health Service, do often create risk-management programs. Yet government agencies have less of an incentive to reduce the risk of negligent injuries than private malpractice insurers do, because the money at risk in a malpractice suit is a common resource (federal revenues), rather than a privately owned one. Because private malpractice insurers have more at stake in a malpractice suit than government agencies do, the government's risk-management efforts are likely to be less rigorous. Indeed, federal investigators have found that in some cases, such as community and migrant health centers, the government is ill-equipped to provide risk management.¹³⁶ In most cases, consumers would be better off were government agencies not to shield their physicians from malpractice immunity.

Joint Underwriting Associations

It is rare that private markets deny a physician insurance coverage for malpractice.¹³⁷ When this does occur, however, physicians in some states can turn to the state's Joint Underwriting Association (JUA). JUAs are state-sponsored risk-sharing pools that act as insurers of last resort.¹³⁸ The structure varies by state, but generally all insurers authorized to sell malpractice insurance must participate by underwriting the highest-risk physicians. Though JUAs set premiums with the objective of covering their costs, participating carriers are liable for losses based on their share of premiums written in the state.¹³⁹ In effect, this means high-quality physicians pay higher premiums to cover the costs of negligent injuries inflicted by low-quality physicians. In 2007 JUAs were operational in 13 states.¹⁴⁰ In some states, such as South Carolina, the JUA insures the majority of physicians in the state.¹⁴¹ Many states have the statutory authority to activate a medical malpractice JUA, but have chosen not to or have shuttered their JUAs.¹⁴²

In some cases, JUAs protect physicians who should only practice with restrictions or who

should not be practicing medicine at all. In the 1980s the New York Department of Insurance wrote of its JUA, “A merit rating plan is not intended to be used to remove poor doctors by pricing them out of business.”¹⁴³ That raises the question: why not? Why should physicians with good claims histories pay higher malpractice premiums to subsidize physicians with bad claims histories, especially when this practice puts patients at greater risk? In the mid-1990s, amid talk of shutting down New York’s JUA, the New York Department of Insurance offered further proof that its program exists largely to protect low-quality physicians. The agency concluded that were its JUA to fold, “there is a possibility that some physicians with truly disastrous loss histories would be uninsurable.”¹⁴⁴ Where JUAs protect “disastrous” physicians at the expense of patients and good physicians, states should eliminate them.

Conclusion

When asked how consumers benefit from medical malpractice insurance, industry executives typically mention only patient compensation. Yet much more is at work.

Competition in the market for medical malpractice insurance, and each insurer’s interest in reducing its exposure to malpractice awards, leads insurers to provide oversight that protects consumers from physician negligence. Malpractice underwriters review physicians annually. They evaluate claims histories and investigate loss of hospital privileges, substance abuse, and loss of specialty board certification. They alert the medical community to situations that result in bad outcomes and offer advice on how to reduce such outcomes. The evidence presented here shows that physicians pay a price for putting patients at risk. Carriers reward claims-free physicians and physicians who take part in risk-management activities. The industry provides oversight of risky practitioners, dictates patterns of practice, monitors the introduction of new procedures, imposes policy exclusions for specific

activities, and denies coverage in the most egregious cases, precluding affiliations that require insurance.

More broadly, patients derive protection from an interdependent system of physician evaluation, penalties, and oversight that includes hospital and health maintenance organization credentialing and privileging activities, specialty boards, and the medical malpractice insurance industry.¹⁴⁵ Underlying nearly all of these activities is the threat of legal liability for negligent injuries. Reducing physician liability for negligent care by capping court awards, all else equal, will reduce the resources allocated to medical professional liability underwriting and oversight and make many patients worse off. Legislators who see mandatory liability caps as a cost-containment tool should look elsewhere.

As noted above, state licensing of medical professionals is ineffective. A cheaper, more effective approach to consumer protection would be for states to require public reporting of malpractice coverage. Medical professional liability insurance companies know considerably more about physicians than do state medical licensing boards, and the level of oversight dwarfs what state medical boards have had the resources, the incentive, or even the capability to accomplish. Hospitals and health maintenance organizations already inquire about physicians’ medical professional liability insurance coverage. Requiring public reporting of malpractice coverage would encourage consumers to inquire about it when searching for independent physicians.

Finally, government agencies should not assume malpractice liability risk for physicians they employ. Profit-maximizing insurers have stronger incentives to promote effective risk-management efforts. State legislatures should shut down state joint underwriting associations. If medical malpractice insurers are unwilling to bet their own money on a particular physician, legislatures should not force taxpayers or other physicians to take the same bad wager, particularly since doing so exposes patients to a higher risk of adverse medical events.

Capping court awards, all else equal, will reduce the resources allocated to medical professional liability underwriting and oversight and make many patients worse off.

Appendix

**Table A-1
Experience Rating Provisions in California Rate Filings**

Rate filing reference	Credit or Debit/Surcharge to Base Premium	Note
Allianz (2000)	Debit to 94.5 percent, credit to 30 percent	Based on number of years since claim(s) made and total amount paid in indemnity and expense. Physicians with more than five claims or total payments and/or reserve(s) exceeding \$150,000 are set aside for special underwriting review.
AIG (1999)	± 25 percent	Applicable to those insured who, in the opinion of the company, uniquely qualify due to factors not contemplated in the filed rate structure of the company. A debit or credit of up to 15 percent may apply based on the claims experience. Additional debit or credit for loss history.
Chubb Group (1999)	Credit to 25 percent, surcharge to 75 percent	Compares actual to expected loss ratio to determine credit or surcharge.
CNA Insurance Companies Companies (1996)	None	
First Professionals Insurance Company (2001)	Maximum credit of 50 percent of premium, maximum debit of 200 percent	Only applies to risks with five full-time physician exposures and an annual basic limits manual (2006) manual premium of \$100,000 or more.
GE Global/MedPro (2007)	± 25 percent to maximum debt of 200 percent	Under the schedule rating plan, ± 25 percent maximum modification to recognize risk characteristics that are not reflected in the otherwise applicable premium. Considerations include unusual frequency or severity of claims, cumulative years of patient experience, and other measures not related to experience rating. In addition, there is a nondiscretionary debit-rating rule which assigns debits based on history of loss payments on claims and the number of claims pending against the physician. The highest debit rating, 200 percent, would apply to a physician who, in the past five years, had at least one loss payment in the \$100,000–\$250,000 range and another in the \$250,000–\$500,000 range.

Rate filing reference	Credit or Debit/Surcharge to Base Premium	Note
Medical Insurance Exchange of California (2006)	Surcharge up to 100 percent	In those individual situations where the risk of loss is materially higher than contemplated by the standard classification and rate because of unusually high loss frequency or severity, unusually hazardous practice pattern, or failure to comply with risk-management/loss-prevention recommendations.
Northwest Physicians Mutual Insurance Company (2002)	Surcharge of 10 to 25 percent	Allows NPM to recognize, through the use of a surcharge, a physician whose claims experience is below the norm of the company and allows NPM to charge a lower premium to those physicians with a superior claims history. Looks at 36-month history of claims. Surcharge kicks in with three claims (open or closed without payment) or paid claims totaling \$100,000. With paid claims totaling over \$750,000, the surcharge is 25 percent.
PHICO (1995)	± 15 percent	Based on history of incurred losses.
The Doctors Company (2008)	Surcharge up to 400 percent; beyond that "Nonrenew"	In lieu of declining or not renewing a risk. Considers frequency and severity of claims, drug or alcohol impairment, government agency actions (public reprimand, fine, citations, failure to report investigation, criminal and civil indictments/convictions, Medicare/Medicaid investigation, loss of Medicaid/Medicare privileges, inappropriate patient contact, privileges, gaps in practice, payment history and other characteristics). Some points go to characteristics that are not experience rating, such as not being board certified. The Florida rate filing (07-07147) in 2007 looks the same.
Zurich (2000)	Surcharge up to 60 percent	Factors that may be used in determining the surcharge include adverse claims frequency and severity, loss of hospital privileges, performance of a procedure outside of standards, and weak or nonimplemented credential procedures.

Sources: Allianz of America, Chicago Insurance Company (2000), *State of California Department of Insurance Application for Approval of Insurance Rates*, File 00-15362, California Department of Insurance, RateFilings.com File CAC10327 and CAC11265; AIG, National Union Fire Insurance Company of Pittsburgh (1999), *State of California Department of Insurance Application for Approval of Insurance Rates, New Program*, File 99-13489, California Department of Insurance, RateFilings.com, File CAC05592; Chubb Group of Insurance Companies, Executive Risk Indemnity Inc. (1999), *State of California Department of Insurance Application for Approval of Insurance Rates*, File 99-3293, California Department of Insurance, RateFilings.com, File CAC02796; CNA Insurance Companies, National Fire Insurance Company of Hartford (1996), *File 96-5126, California Department of Insurance, Ratefilings.com File CAC37767*; First Professional Insurance Company (2001), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #01-14462, California Department of Insurance, Ratefilings.com File CAC13409; GE Global, Medical Protective Company (MedPro) (2007), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #07-2132, California Department of Insurance, Ratefilings.com, File CAC34889; Medical Insurance Exchange of California (2006), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #06-4652, California Department of Insurance, RateFilings.com, Files CAC32341 and CAC32789; Northwest Physicians Mutual Insurance Company (2002), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #02-38372, *California Department of Insurance, RateFilings.com, File CAC18439*; PHICO (1995), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #95-10432, California Department of Insurance, RateFilings.com, File CAC3782918439; The Doctors Company (2008); *Physicians, Surgeons and Ancillary Healthcare Providers, Countrywide Rules and Rates Manual in California Rate and Rule Revision-Introduction of New Endorsements*, File 08-11851, California Department of Insurance, RateFilings.com, File CAC40789; Zurich Insurance Group, *Truck Insurance Exchange and Mid-Century Insurance Company (2000), State of California Department of Insurance Application for Approval of Insurance Rates Medical Malpractice Physicians and Surgeons New Program Filing*, File #00-15368, California Department of Insurance, RateFilings.com, File CAC10328.

Table A-2
Claim-Free Credits in California Rate Filings

Rate filing reference	Claim-free credit (%)	Note
CNA (1996)	5	Applies when physicians have had no claims with an incurred indemnity amount greater than \$5,000 in the past three years.
First Professionals Insurance Company (2001)	10 to 20	Offers a claim-free discount of 10 percent with five to nine loss-free years; 20 percent with 15 or more loss-free years.
GE Global/Med Pro (2007)	5 to 20	Offers a claim-free credit of 5 percent at three years, 10 percent at five years and 20 percent at 10 years. In a 2008 Florida rate filing, Med Pro revised its claim-free credit, bringing the maximum to 25 percent for 10 years (The Medical Protective Company, 2008).
Northwest Physicians Mutual Insurance Company (2002)	5	For physicians with three years of claim-free history.
The Doctors Company (2008)	12.5; 17.5	TDC offers a claims-free discount of 12.5 percent for policyholders who have been with the company for at least three years, whose cumulative outstanding claim reserves fall below \$20,000 and whose three-year cumulative claim payments are less than \$10,000. Surgical specialties qualify for a 17.5 percent claim-free discount.
Zurich (2000)	10	For physicians with five years claim-free, no incurred indemnity or expense amount greater than \$5,000, and an aggregate incurred indemnity for all claims reported less than \$5000.

Sources: CNA Insurance Companies, National Fire Insurance Company of Hartford (1996), *File 96-5126*, California Department of Insurance, Ratefilings.com, File CAC37767; First Professional Insurance Company (2001), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #01-14462, California Department of Insurance, Ratefilings.com, File CAC13409; GE Global, Medical Protective Company (MedPro) (2007), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #07-2133, California Department of Insurance, Ratefilings.com File CAC34889; Northwest Physicians Mutual Insurance Company (2002), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #02-38372, California Department of Insurance, Ratefilings.com File, CAC18439; The Doctors Company (2008), *Physicians, Surgeons and Ancillary Healthcare Providers, Countrywide Rules and Rates Manual* in California Rate and Rule Revision-Introduction of New Endorsements, File 08-11851, California Department of Insurance, Ratefilings.com, File CAC40789; Zurich Insurance Group, Truck Insurance Exchange and Mid-Century Insurance Company (2000), *State of California Department of Insurance Application for Approval of Insurance Rates Medical Malpractice Physicians and Surgeons New Program Filing*, File #00-15368, California Department of Insurance, Ratefilings.com, File CAC10328.

**Table A-3
States that Mandate Minimum Levels of Professional Liability Insurance for Physicians**

State	Rule (The first number is required coverage per incident or claim, the second number is required coverage for all claims in a year)
Required in these states:	
Colorado	\$500,000/\$1,500,000 or equivalent bond
Connecticut	\$500,000/\$1,500,000
Kansas	\$200,000/\$600,000
Massachusetts	\$100,000/\$300,000 or equivalent bond
New Jersey	\$1,000,000/\$3,000,000; if you don't have extended reporting endorsement coverage (tail coverage) a \$500,000 letter of credit is required
Pennsylvania	\$1,000,000/\$3,000,000
Wisconsin	\$1,000,000/\$3,000,000
Not mandatory:	
Indiana	To participate in the state Patient Compensation Fund (a system of excess insurance): 250,000/\$750,000 in coverage.
Louisiana	To qualify for caps on damages: \$100,000 coverage per claim or equivalent bond.
Missouri	Physicians on the medical staff of a hospital in a county with a population over 75,000 and not employed by the hospital: \$500,000 in coverage.
Nebraska	To qualify for cap on damages: \$500,000/\$1,000,000.
New Mexico	To qualify for cap on damages: \$200,000 per occurrence or \$600,000 bond; must buy "occurrence-made" rather than "claims-made" policy.
New York	To participate in the excess liability pool: \$1.3 million/\$3.9 million.
Wyoming	To participate in the state Medical Malpractice Compensation Fund (a system of excess insurance): \$50,000 per occurrence.

Source: American Medical Association, Advocacy Resource Center, "Summary of Select State Laws Mandating Minimum Levels of Professional Liability Insurance," February 2008, <http://www.ama-assn.org/ama/pub/upload/mm/378/mlprliains.pdf>.

**Table A-4
2008 California Market Shares for Medical Malpractice Insurers, Top Ten by Written Premium**

Group/Company Name	Notes	Written Premium (\$)	Market Share (%)	Cumulative Market Share (%)
Norcal Mutual Insurance Company		163,317,374	26.8	26.8
The Doctors Company		151,261,024	24.8	51.5
SCPIE Indemnity Company	SCPIE was purchased by The Doctors Company in 2007	87,751,988	14.4	65.9
Medical Insurance Exchange of California		37,864,332	6.2	72.1
Dentists Insurance Company*	Dentists	28,532,495	4.7	76.8
Medical Protective Company		28,123,839	4.6	81.4
American Healthcare Indemnity Company (SCPIE Group)	Acquired by SCPIE in 1996; insurance for non-California physician physicians	25,983,208	4.3	85.6
National Union Fire Insurance Company of Pittsburgh (AIG Group)		16,378,872	2.7	88.3
American Casualty Company of Reading PA (CNA Group)		14,923,219	2.4	90.8
Professional Underwriters Liability Insurance Company	Surplus-lines insurance only; wholly owned subsidiary of The Doctors Company	10,799,148	1.6	92.5

Source: California Department of Insurance, Rate Specialist Bureau, April 30, 2009, <http://www.insurance.ca.gov/0400-news/0200-studies-reports/0100-market-share/Marketshare2008/upload/IndMktShr2008Alpha.pdf>.

* Rate filings for this company were not reviewed for this paper as only dentists are insured.

Notes

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1. These include captives and risk-retention groups. A risk-retention group comprises similar businesses that join together to create an insurance company to self-insure. Captives also self-insure the risk of their owners but are not restricted to insure similar risks. For example, they are not restricted to insure only against medical malpractice liability. Most commonly, captives insure the risks of a parent company or a group of companies. Richard J. Hillman and Lawrence Cluff, *Risk Retention Groups, Common Regulatory Standards and Greater Member Protections Are Needed*, U.S. Government Accountability Office, GAO-05-536, August 2005, <http://www.gao.gov/new.items/d05536.pdf>.

2. Dennis H. Pillsbury, "Where Do You Turn If One of Your Physician Insureds Has Claims Problems?" *Rough Notes*, March 1995, p. 50.

3. There are exceptions. PULIC is a surplus-lines carrier admitted in California. In New Jersey, surplus-lines policies are covered by the New Jersey Surplus-Lines Guaranty Fund offering protection should insurance companies become insolvent. Many of the surplus-lines companies doing business as nonadmitted carriers in one state are admitted and regulated in another.

4. Elisabeth Boone, "Rx for Doctors: Hard-to-Place Malpractice Risks May Find a Home with Professional Underwriters Liability and Bernard Warschaw Insurance Sales," *Rough Notes*, April 2002; Brian S. Martin, "Legal Beat: A Short Walk through Surplus Lines," *Insurance Journal*, July 22, 2002, www.insurancejournal.com/magazines/south-central/2002/07/22/legalbeat/21759.htm; Timothy Morse, senior vice president—health care professional liability at CNA HealthPro, conversation with author, August 26, 2009 (Morse is on the board of directors of the National Patient Safety

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6. Tim Vlazny, underwriting director, CNA HealthPro, conversation with author, September 2, 2009. Vlazny has more than 10 years experience in the hard-to-place physician market.

7. Perry Beider and Stuart Hagen, *Limiting Tort Liability for Medical Malpractice*, Congressional Budget Office Economic and Budget Issue Brief, 2004, <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf>.

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