Rising Liability Insurance Premiums: Myth versus Reality

As the national debate about reforming the medical liability system has evolved, many myths and misunderstandings have arisen about the underlying causes of rising liability insurance premiums. The editor of the Review talked with David Bounk, president and CEO of the MMIC Group, and Elizabeth Lincoln, MMIC vice president of law and health policy, to straighten out some of the confusion for policyholders.

There's talk of a nationwide malpractice crisis. Are professional liability claims becoming more frequent?

Lincoln: Actually, we are fortunate in the Midwest that we have experienced record low numbers of claims in the last few years. Fewer than six claims per 100 insured physicians were reported to MMIC in 2003. Historically, this figure has been in the range of 9 – 10 claims per 100 physicians per year. However, claim frequency has been rising in some parts of the country and we’re watching the trends closely.

If the number of claims is down, why are physicians’ insurance costs increasing?

Bounk: The driving factor in recent rate increases is the dramatically increasing size of indemnity payments. Nationwide data from The Physician Insurers Association of America highlight the severity of the problem. The average indemnity payment by physicians jumped from just over $232,000 in 1998 to nearly $324,000 in 2002 – a 40 percent increase in just five years. The number of payments over $1 million has doubled in the past four years. Results from 2003 are not yet tallied, but indications are that the size of payments has continued to climb. And, shock verdicts are becoming more and more common. In some states, it’s no longer rare for juries to award tens, or even hundreds, of millions of dollars in medical malpractice cases. MMIC is benefiting from relatively moderate jury awards, but actuarial projections indicate that payments will continue to rise.

Lincoln: Figures from the National Practitioner Data Bank paint a similar picture. The average medical liability payment reported to the NPDB in 2003 was 32 percent higher than in 1998. Although settlements and awards tend to be lower in the Midwest, NPDB statistics from MMIC’s states also show significant increases over the same period.

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Bounk: The cost of defending claims is also a factor. The PIAA data show that legal expenses have risen almost 30 percent in the past five years. MMIC has been very successful in holding defense costs down compared to other carriers, but even our costs are increasing significantly.

Opponents of liability reform have alleged that attempts by insurance companies to make up for losses in the stock market are what are really driving premium increases. Is this true?

Lincoln: No, and the facts debunk this allegation. First, insurance is a highly regulated industry; all requests for rate increases are closely evaluated by state insurance departments. There is no component in the rating formula that allows for making up market losses in future rates. In fact, the only element of the formula that considers investments is the present value factor, which anticipates investment income on premiums earned. Application of this factor can only result in decreases to rates.

Bounk: Also, the medical liability insurance companies are not heavily invested in stocks. A study by Brown Brothers Harriman found that, in 2001, stock market investments comprised just nine percent of the portfolios of the entire medical liability insurance market. Approximately 85 percent of the assets of medical liability insurers are invested in bonds. And, at least for MMIC, losses have just not been an issue. We have had a 17 percent average annual rate of return on our stock portfolio through the end of 2003.

Reform opponents have also alleged that insurance carriers have been raising rates and gouging physicians simply to increase profits. How does MMIC respond to this?

Lincoln: This allegation simply doesn’t make sense when physician-owned and physician-governed companies like MMIC insure the majority of physicians in the country. The boards of directors of these companies have absolutely no incentive to raise rates unnecessarily; they are just as impacted personally by rate increases as are all other policyholders.

Bounk: You also have to remember that MMIC returns unanticipated profits from individual policy years to policyholders in the form of dividends. Rates are set each year to cover projected losses. If it turns out that our projections were too high, unneeded premiums are returned to the physicians, they are not simply accumulated to make the company more profitable.

The reality is that it’s increasing indemnity payments and expenses that are driving rate increases and causing medical liability crises around the country. Physicians are retiring early, restricting their practices or even moving out of states with the highest liability premiums. Access to health care has to suffer when this happens. Opponents of tort reform try to divert the debate and lay blame on the insurance carriers, but the data prove their arguments to be unfounded. There are legitimate policy disagreements about tort reform that deserve reasoned discussion; we can’t let ourselves be distracted by misinformation and uninformed assertions. The stakes are too high.
Chairman’s Letter to Iowa Policyholders

The 2004 Iowa Legislature passed a $250,000 cap on noneconomic damages in medical liability lawsuits to help avert a crisis in the availability and affordability of liability insurance. The Governor vetoed the bill. In response to that veto, MMIC’s board chair Richard Geier, M.D., sent the following letter to Iowa policyholders.

Dear Doctor:

The professional liability insurance market is changing – dramatically and rapidly. Driven by spiraling claim losses, insurance rates are increasing, underwriting standards are tightening and physicians are finding it more and more difficult to locate affordable coverage. As a practicing surgeon, Chair of the Minnesota Medical Association Board of Trustees and Board Chair of MMIC, I share your frustrations about this situation.

The Iowa General Assembly took bold action this year to avert a liability crisis in the state. Both the House and Senate passed a bill that would cap non-economic damages in malpractice claims at $250,000 and return much-needed predictability to awards and settlements. Governor Vilsack, however, vetoed the bill, opting instead to further study the situation.

MMIC commends the Iowa Medical Society on its extensive legislative efforts on liability reform. MMIC staff spent many hours working hand-in-hand with the IMS to provide reliable information to legislators and the Governor’s staff about the realities of liability insurance and how the worsening liability climate impacts physicians. Our staff is also actively involved in liability reform at the federal level through leadership roles in the Health Coalition on Liability and Access (HCLA) and the Physician Insurers Association of America (PIAA).

Please be assured that the board and staff of MMIC will continue to do everything in our power to rein in the high cost of liability insurance. The company is owned by you, our physician policyholders. It is governed by elected physicians who follow your mandate to price our coverage as affordably as possible, while responding appropriately to the harsh business realities that could threaten our strength and stability. With this foundation, you can be confident that all company decisions are based on the best interests of our policyholders.

MMIC will remain actively involved on your behalf as the liability debate evolves. We are hopeful that, with coordinated efforts by all interested parties, we can soon be confident again that liability insurance will be available and affordable for Iowa physicians.

Sincerely;

G. Richard Geier, M.D.
Board Chair, Midwest Medical Insurance Company
Dave Bounk receives PIAA’s Highest Honor

MMIC Group President and CEO David P. Bounk received the Peter Sweetland Award of Excellence at the Physician Insurers Association of America’s annual meeting in Boston this spring. Each year the PIAA gives the award to an individual who has made an extraordinary contribution to the medical malpractice insurance industry.

PIAA President Larry Smarr wrote: “The members of the Peter Sweetland Committee and our board are most appreciative of Mr. Bounk’s many contributions to the PIAA and our industry, to include lengthy and valuable service on the PIAA board and our section committee. Dave’s many attributes that qualify him for this award include commitment of time and expertise as a board member and treasurer of the PIAA, willingness to contribute significant corporate staff and resources to support PIAA activities, service as a board member of the Health Care Liability Alliance to support PIAA’s position on tort reform and eagerness to support the success of physician-owned companies by freely sharing ideas, materials and MMIC successes and failures.”

Peter Sweetland was a founder of the PIAA and one of its chief architects and ongoing supporters. He was president of the Medical Inter-Insurance Exchange of New Jersey from its inception in 1977 until his death in 1990.

HIPAA Online Resources

The Department of Health and Human Services has published informational materials on its Web site (http://www.hhs.gov/ocr/hipaa/) to help hospitals and other covered entities implement the HIPAA Privacy Rule protections. The site also includes a Frequently Asked Questions (FAQs) section that includes answers to common questions relating to HIPAA. The FAQs and materials cover the following topics:

- Sharing patient information for treatment purposes. HIPAA does not require patients to sign consent forms before doctors, hospital or ambulance staff can share information for treatment purposes. Available materials about this topic include the fact sheet, Uses and Disclosures for Treatment, Payment, and Health Care Operations (http://www.hhs.gov/ocr/hipaa/guidelines/sharingfortpo.pdf) and the Summary of the HIPAA Privacy Rule (http://www.hhs.gov/ocr/privacysummary.pdf).

- Incidental disclosures. HIPAA does not require providers to eliminate all incidental disclosures when they have policies that reasonably safeguard and appropriately limit how protected health information is used and disclosed. Materials available include the fact sheet Incidental Uses and Disclosures (http://www.hhs.gov/ocr/hipaa/guidelines/incidentalandud.pdf).

- Communications between providers and patients’ families and friends. Doctors and other providers can share information, including the patient’s location or general condition, with family, friends, or anyone else a patient identifies as involved in his or her care, as long as the patient does not object. Even when the patient is incapacitated, a provider can share appropriate information if he believes that doing so is in the best interest of the patient.

- Patient information listed in the hospital directory. Unless the patient objects, basic information about the patient, such as room and phone number, can appear in the hospital directory. Also, clergy can access religious affiliation information so they don’t have to ask for patients by name.

- Child abuse reporting. Doctors may continue to report child abuse or neglect to appropriate government authorities. Review the fact sheet Disclosure for Public Health Activities (http://www.hhs.gov/ocr/hipaa/guidelines/publichealth.pdf) for more information about this topic.

- Electronic communications. Doctors can continue to use e-mail, the telephone or fax machines to communicate with patients, providers and others using appropriate safeguards to protect patient privacy.
Liability Reform: Legislative Wrap Up 2004

Once again, medical liability reforms were front and center in legislatures around the country in 2004. Although in MMIC’s states, the most significant reform proposals introduced ultimately failed, they garnered more attention than in recent legislative sessions and reminded legislators that the Midwest is not immune to the liability trends that are threatening healthcare nationwide.

**Minnesota**

Representative Fran Bradley (R-Rochester) introduced a broad package of medical liability reforms including a $250,000 cap on non-economic damages, limits on attorney contingency fees, limits on punitive damages and defense protection for physicians who follow best practice guidelines. Although the bill did not progress out of the House, Rep. Bradley again proved himself to be a strong supporter of reasonable system reforms to help Minnesota avert the malpractice crisis many other states are facing.

**Iowa**

House File 2440 called for placing a limit of $250,000 on non-economic damages in medical liability lawsuits. The Iowa Medical Society, with support from MMIC, worked hard to demonstrate the problem physicians face in finding affordable liability insurance and the impact a limit on non-economic damages could have on stabilizing insurance rates. The bill passed both the House and Senate, but was vetoed by the Governor. IMS is continuing to work with the Governor to keep liability reform a priority issue.

**Nebraska**

Reforms to the Nebraska Patient Compensation Fund (PCF) were passed by the Unicameral to help stabilize the financial viability of the Fund. The threshold at which the PCF becomes responsible for indemnity payments was raised from $200,000 to $500,000; physicians will, therefore, need to raise their primary insurance limits as their policies renew on or after January 1, 2005. In addition, provisions passed in 2003 requiring insurance carriers to collect and submit physician PCF surcharges were repealed. MMIC is working with the Nebraska Insurance Department to promote smooth transitions to the new PCF threshold and increased primary limits.

If you have questions about MMIC’s legislative activities, contact Libby Lincoln, vice president, law and health policy, at 800-328-5532, 952-838-6752 or libby.lincoln@mmihc.com.
MMIC’s Online Business Partner Esurg offers Policyholders Access to Amerinet

For more than three years, Esurg, MMIC’s online business partner, has provided MMIC physicians and clinics with online access to a complete line of medical and surgical supplies, pharmaceuticals, capital equipment and office supplies via the MMIC Group Web site (www.mmicgroup.com).

Recently, Esurg partnered with Amerinet, a nationwide healthcare group purchasing organization. As a result, Esurg can provide MMIC Group customers with access to Amerinet’s competitive supply pricing contracts with no membership fee.

This free Amerinet membership increases a clinic’s purchasing power and provides instant savings on purchased products. A recent cost savings analysis by Esurg of 30 commonly used items for a family practice office yielded an approximate 12.5 percent savings from current vendor prices. Interested clinics may request a complimentary, personalized cost analysis for their own organization.

Esurg continues to offer numerous services, including personalized ordering templates, online product information (with pricing, descriptions, pictures and availability), complete usage and cost reports, and a single, unified invoice for all purchases made. Esurg also offers new clinic customers a $100 credit on their first Esurg order.

For more information or to request a cost savings analysis, visit the MMIC Group Web site (www.mmicgroup.com) and click “Business Services.” Or contact the MMIC Technology Solutions Sales team at 800-328-5532 or e-mail TechnologySales@mmihc.com.