The shortage of affordable malpractice insurance in West Virginia and elsewhere won't be easy to solve.

A Difficult Diagnosis

BY CHARLES GERENA

When malpractice insurance premiums started rising in West Virginia three years ago, doctors had few options. They could either find a way to lower their premiums or quit.

Medical professionals throughout West Virginia made some tough choices. City Hospital in Martinsburg closed its psychiatric unit, and hospitals in Putnam and Jackson counties shuttered their obstetrics units. Bluefield Regional Medical Center in southern West Virginia stopped performing angioplasties and open-heart surgeries.

"Obstetrics, orthopedics, neurosurgery, and general surgery are among the highest-risk medical fields," describes Tony Gregory, director of communications for the West Virginia Hospital Association. Since they are riskier, "they produce the most medical liability suits," and their practitioners pay the highest premiums. At the same time, reduced reimbursements from governmental payers have resulted in less revenue to offset premium increases.

Shortages of affordable malpractice insurance have occurred throughout the United States, with critical shortfalls in at least 12 states, including West Virginia, Pennsylvania, New Jersey, Nevada, and Mississippi. This problem is merely one symptom of larger issues facing insurers and a range of health care providers, from physicians to dentists to nursing homes.

Reports of doctors marching in front of government buildings and patients crossing state lines in search of care seem unprecedented. In fact, malpractice shortages occurred twice in the last 30 years.

An insurance company makes money in two ways, and both income sources are vulnerable to economic cycles. First, it achieves an underwriting profit, or loss, based on the difference between the premiums it collects and the expense of servicing policies, which includes claims paid and other administrative costs.

Second, the insurer can earn income to offset an underwriting loss by investing premiums in stocks, bonds, and other appreciable assets. "If an insurer knows that the payout is five or six years from now and it has certain administrative costs, it has to decide what to do with that money in the meantime," explains economist Frank Sloan of Duke University.

During the mid-1970s and mid-1980s, malpractice insurers faced poor investment returns. They also had more claims. According to economist Patricia Danzon of the University of Pennsylvania, the frequency of malpractice claims per 100 doctors jumped 10 percent annually between 1975 and 1985. During these "hard markets," insurers had to adjust other variables in their revenue-expense equation to maintain profitability. Premiums increased and requirements tightened for policyholders.

Many malpractice premiums dropped or increased modestly during the 1990s, until signs of a hard market emerged in the latter part of the decade. Underwriting losses started rising as claims outpaced premiums. Insurers say they were adrift in the choppy waters of tort law, which compensates injured patients and serves as a deterrent against future acts of malpractice.

"If an insurer has the perception that there is a lot of uncertainty with respect to judgments ... it doesn't know how to price the coverage," says Sloan. The firm could raise premiums or concentrate on other lines that are less volatile.

According to the West Virginia

WEST VIRGINIA STATE MEDICAL ASSOCIATION

Drs. Elizabeth Spangler, Kenneth Wright, and Michael Fidler speak with Senate Minority Leader Vic Sprouse (center) about West Virginia's malpractice insurance crisis.

Hospital Association, several insurers merged or left the state in the early to mid-1990s, and a major carrier declared insolvency in 1997.

The picture was just as cloudy nationwide, recalls Andrea Wood, spokesperson for The St. Paul Companies, formerly one of the nation's largest malpractice insurers. But firms like St. Paul believed they had enough reinsurance and good investment returns to carry them through to better days.

The new millennium brought two major shocks to the insurance market that quickly made matters worse for malpractice insurers. The Sept. 11 terrorist attacks caused many primary insurers to pay more for reinsurance and to increase their reserves for covering claims. Also, three straight years of stock market declines that began in 2000 evaporated insurers' investment returns.

Given the hardening of the malpractice insurance market, something had to change. Premiums jumped nationwide starting in 2000.

Not only did malpractice insurance become pricier, it also was hard to find. Many small insurers had such low reserves that they ceased operations, including PHICO Insurance Co. in Pennsylvania. A few large insurers stopped offering malpractice coverage, including The St. Paul Companies. "We determined that even with the double-digit rate increases that we're working on getting approved, we wouldn't be able to maintain profitability in that line of business," explains Wood.

In the Fifth District, some doctors in the Carolinas lost their malpractice coverage, but they had alternatives. A physician-owned mutual insurance company covers half of North Carolina's doctors in private practice, while a state-operated Patients' Compensation Fund provides excess coverage for more than three-quarters of South Carolina's private physicians. Still, malpractice insurance costs a lot more in both states and elsewhere in the region.

With an already limited supply of insurers, the Mountain State has been hit hard by the lack of affordable malpractice coverage. St. Paul's departure was devastating since the company insured about one-third of the state's doctors. Then the withdrawal of a smaller firm, OHIC Insurance, in 2002 added insult to injury. Only one major malpractice provider remains, Medical Assurance, and its policy standards are tighter.

Now, the malpractice market is narrower and more selective. Eugene Pawlowski, president of Bluefield Regional, says that just one lawsuit can cause a doctor to lose coverage, and then it's difficult to find another provider. "Smaller communities in West Virginia don't have the alternatives that bigger states like Virginia and North Carolina have."

Why are fewer insurers willing to do business in West Virginia? Some observers blame the state's reputation as a haven for litigation, due to its relatively lax tort system and sympathetic juries. While such a link is hard to prove, data from the National Practitioner Data Bank suggest that the state stands out. The number of malpractice payments in West Virginia rose from 8.1 to 11.5 per 100,000 people between 1995 and 2001, while the rest of the Fifth District had far fewer payments per capita (see graph at right).

Perhaps West Virginia's relatively unhealthy population makes it an expensive market to serve. The state's mortality rate for heart disease was 22 percent higher than the national average in 2000, the cancer rate was 14 percent higher, and the rate for chronic lower respiratory disease was 44 percent higher.

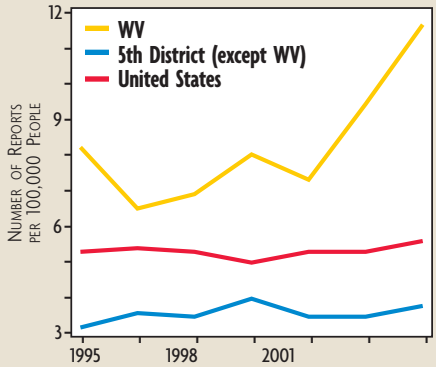
To make sure that West Virginians have access to health care, state lawmakers approved a temporary malpractice insurance plan during a special session in December 2001. Physicians can be insured for up to $1 million by the state's Board of Risk and Insurance Management (BRIM), which provides general liability coverage for state agencies, county and municipal governments, and nonprofit organizations.

Nearly 1,100 doctors and 12 hospitals have purchased malpractice insurance from BRIM so far. While BRIM's base rate was 5 percent lower than the commercial rate in West Virginia in late January, premiums still were higher for certain specialties like neurosurgery.

More Malpractice in the Mountain State?

The number of malpractice payments in West Virginia rose modestly from 147 in 1995 to 207 in 2001. But these numbers tell another story when taking the state's population into account. Compared to the rest of the Fifth District and the United States, West Virginia's payment experience per 100,000 people is quite high.

Number of Medical Malpractice Payment Reports, Per 100,000



NOTE: Per capita figures calculated using population estimates, except for actual Census count for 2000.

SOURCES: National Practitioner Data Bank, U.S. Department of Health and Human Services; U.S. Census Bureau

Fixing the Tort System

In January, West Virginia Gov. Bob Wise and President Bush proposed tort reform plans. Here's how they stack up.

Reform	Explanation	Proposed by Gov. Wise?	Proposed by Pres. Bush?	Adopted in 5th District
Limit non-economic damages	Awards for pain and suffering are capped; exceptions for cases of wrongful death and gross negligence are often made	YES[a,d]	YES	YES (MD, VA, WV)
Limit punitive damages	Awards to compensate plaintiffs in excess of actual damages are capped; commonly used to punish defendants for reckless misconduct and deter others	NO	YES	YES (NC, VA)
Eliminate joint-and-several liability	Defendant is not liable for paying the entire judgment, but only for his/her share of responsibility for an injury	YES[b,d]	YES	YES (DC)[c]
Change collateral source rule	Damages can be reduced by all or part of the value of lost wages or medical bills paid by third parties, including workers' compensation and health insurers	YES[d]	YES	NO
Permit periodic payment of damages	Instead of a lump sum, damages can be disbursed over time; this is typically done through an annuity that pays out periodically	NO	YES	YES (DC, MD, VA)

[a] Gov. Wise proposed lower noneconomic damages from a cap of $1 million to a base cap of $250,000, with a sliding scale based on severity of injury.
[b] Joint-and-several liability rules were relaxed somewhat in West Virginia in 1986. Doctors are liable for the entire judgment only when their share of responsibility exceeds 25 percent.
[c] In the District of Columbia, liability for punitive damages is apportioned by relative fault.
[d] Proposal included in legislation passed by General Assembly in March 2003.

SOURCES: "State Laws Chart: Liability Reforms," American Medical Association, April 2002; "Summary of Medical Malpractice Law," McCullough, Campbell & Lane, 1998; "State Laws on Medical Liability," American Tort Reform Association Web site, 1994

Costs for malpractice coverage are still high, argue tort reform advocates, because not enough has been done to reduce the frequency and size of tort claims. In his State of the State speech in January, Gov. Bob Wise proposed several reforms to address this concern. His recommendations included a base cap of $250,000 for pain and suffering and other noneconomic damages and a limit of $500,000 for damages against trauma care providers. Wise also proposed creating a three-year, $20 million fund to offset premiums paid by doctors in the BRIM program. (See sidebar above for a summary of Wise's proposals and similar reforms proposed by President Bush.)

In response to malpractice insurance shortages during the 1970s and 1980s, some states modified their tort law. Did these changes lead to more affordable coverage? According to a report by the U.S. Congress' Office of Technology Assessment, only caps on damage awards were consistently effective.

Tort reform hasn't been the cure-all some had imagined. That's because damage awards account for just part of a malpractice insurer's expenses. When setting premiums, an insurer must factor in the price of reinsurance, the administrative costs of investigating claims, and lawyers' fees for defending claims in court.

Therefore, buyers and sellers in the malpractice insurance market also must find solutions to the current shortage. Some hospitals have started self-insuring. Bluefield Regional uses its own money to cover the first $5 million in claims, and reinsurance from AP Capital to pay for claims above that amount.

So far, the hospital has succeeded in providing insurance at cheaper rates than BRIM. "I have better risks," notes Pawlowski. "The state takes the bad doctors with the good doctors. I'm just taking the good doctors."

But not all hospitals will be able to afford to do this. Some medical professionals will probably have to face the choice of paying more for malpractice insurance, retiring early, or moving out of the state.

If history is any guide, though, the overall ranks of the medical profession will continue to swell. Despite past spikes in malpractice premiums, America's supply of doctors has steadily grown from 366,000 in 1975 to 750,000 in 2001. So far, a sense of purpose and the promise of profits seem to have outweighed the increasing cost of doing business. **RF**

Readings

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