SB 601: Joint Subcommittee to Study Risk Management Plans for Physicians and Hospitals
September 7, 2004
Richmond

Senate Bill 601(2004) established a joint subcommittee to study matters relating to risk management plans, including the availability and affordability of medical malpractice liability insurance for physicians and hospitals in the Commonwealth. At the joint subcommittee's organizational meeting, Senator Newman was elected chair and Delegate Athey was elected vice chair. Members then heard from persons representing a variety of perspectives on issues relating to medical malpractice insurance.

Dr. Richard E. Anderson, chairman of the board of governors and CEO of The Doctor's Company, a California-based physician-owned medical malpractice carrier operating in Virginia, testified via videoconference on how premium rates are set for Virginia doctors and factors that are causing increases in medial liability premiums. His presentation also focused on the potential effects if Virginia enacts legislation containing elements of California's 1975 Medical Injury Compensation Reform Act (MICRA). He explained that rates in Virginia are based on claims experience specific to Virginia, calculating the loss cost and the frequency and severity of claims. Once the average annual loss amount is determined, the expense load is added. In the underwriting of individual physicians, the primary factors considered include the doctor's practice profile, loss history and the presence or absence of prior liability coverage.

The presence or absence of legal reform is critical in the ratemaking process because the method utilizes state-specific information to develop loss cost projections as a starting point for premium rates. Premiums have risen because severity has increased significantly in Virginia in recent years (167percent of the rate of California severity from 1998-2003). Dr. Anderson noted that Virginia caps total damages at $1.75 million with a $50,000 annual increase until the cap reaches $2 million. Although this reduces the likelihood of a very large verdict having an undue impact on overall rates, Virginia physicians generally carry coverage equal to the full cap, which means that almost every physician carries a $2/$6 million policy. Physicians in other states generally carry a $1/$3 million policy and this higher limit increases the average premium in Virginia by 25-30 percent.

Dr. Anderson stated that it would be advantageous for Virginia to adopt California's four major MICRA provisions: A $250,00 no-exceptions cap on noneconomic damages, periodic payment of future damages in excess of $50,000, allowing introduction of evidence that the plaintiff has already recovered damages from a third party (collateral source rule), and limitations on an attorney's contingency fee. He stated that if Virginia implemented MICRA reforms and reduced the prevailing policy limits to $1 million, physicians could anticipate savings of 40 percent or more. In response to a question, Dr. Anderson acknowledged that caps on attorneys' fees do not lower insurance premiums, but contended that they cause injured plaintiffs to receive more money.

Eric Lowe of the State Corporation Commission's Bureau of Insurance compared Virginia's current situation to the medical malpractice crisis in the late 1980's and discussed market trends as they relate to the availability of malpractice insurance in Virginia, trends in Virginia physician insurance rates, how insurers set rates for Virginia physicians and trends in the frequency and severity of malpractice settlements. The availability of medical malpractice insurance for the majority of physicians is significantly higher currently than in the late 1980's. Seven licensed companies are actively seeking new business in Virginia and more than a dozen are continuing to renew existing policies. Surplus lines insurers, risk retention groups and purchasing groups also write coverage for Virginia physicians. There is greater competition among insurers because there is less market concentration than in the 1980's. Affordability may be a greater problem than availability. In addition, the price of coverage for higher risk specialties, such as obstetrics and neurology, and for physicians with prior claim experience, can be very high. Issues with the availability and cost of medical malpractice insurance have been compounded by the demise of the Doctors Reciprocal Company and St. Paul Insurance's withdrawal from Virginia.

Premiums have risen rapidly since 2000, prior to which there was a nearly 10-year period of flat or slightly declining premiums. In December 2003, the Bureau of Insurance completed an actuarial analysis to determine whether or not the rates were excessive and concluded that the rates charged by the major licensed writers of physicians' and surgeons' professional liability coverage in Virginia appear to be adequate and not excessive. The Bureau also reported that Virginia physicians are not paying for poor past experience nor are they paying for losses in other states, based on additional analysis by its actuaries. Insurance companies invest heavily in bonds and have been impacted by the decline of interest rates. Lowe discussed a 2003 U.S. General Accounting Office report that found that the four main factors that have contributed to the recent increases in premium rates are: rapid increase in claim losses, decreases in investment income, reduced downward competitive pressure on premium rates that existed through the 1990's and increases in reinsurance rates.

David Anderson representing the Virginia Trial Lawyers Association (VTLA) stated that additional tort reform legislation is not needed and that it is time for Virginia to move in a bold new direction such as the Commonwealth-backed risk management plan established by SB 601. Jack Harris, Executive Director of VTLA stated that Virginia health care providers and their insurers currently enjoy a stable, low-cost tort system with significant protections for all defendants, including: contributory negligence, a cap on punitive damages, conservative statutes of limitations, no discovery rule for accrual of actions, a restrictive rule on future economic damages for minors, a bar to recovery for emotional distress without physical injury and good Samaritan immunity for emergency assistance. Other elements of Virginia's restrictions on lawsuits against medical professionals include the $1.75 million cap on liability that applies regardless of the severity of the injury, the right to a malpractice review panel before trial, and a no-fault system for severe birth-related neurological injuries. Mr. Harris stated that there is no factual support for the often-touted claim that increasing litigation, larger verdicts, or both, are responsible for the rising increase in premiums. He asserted that recent increases in liability insurance premiums are the result of market conditions and insurance company practices. Mr. Harris pointed out that Virginia is one of only four states with a total cap on medical malpractice liability and averred that liability insurance premiums in California nearly doubled in the 12 years following enactment of MICRA, and that it was only after

insurance rate regulation was enacted in Proposition 103 that premiums stabilized. After 25 years of MICRA, average California premiums are eight percent higher than the average premiums in states without damage caps.

The sharp increases in premiums are caused by the cyclical nature of the industry and actions taken by insurers to secure market share or maximize returns. Damage caps take away relief from those who most clearly need and deserve it. Caps on noneconomic damages were criticized as having a disproportionate impact on children, homemakers and the elderly and it was contended that abrogating the collateral source rule would reward the wrongdoer and penalize the person who has paid for insurance or earned it through employment. Finally, persons of ordinary means would not be able to bring complicated and time-consuming medical malpractice cases unless their attorneys were able to charge fees on a contingency basis.

As part of the VTLA presentation, John Wilson, an economist, presented data which he stated show that Virginia's medical malpractice insurer profitability continues to achieve record levels as premium charges continue to increase by amounts that greatly exceed the insurance industry's loss payment experience. Charles Zauzig, an attorney in private practice who takes medical malpractice cases, said reputable attorneys are very selective about the cases they take. With litigation costs for the average case being $50,000, an attorney cannot afford to bring frivolous medical malpractice suits. He also reminded members that in order to prevail, the doctor's conduct must have fallen below the applicable standard of care no matter how grave the injury, and that § 8.01-581.20 of the Code of Virginia provides protections regarding an expert witness' qualifications to testify.

Dr. Daniel Carey, a cardiologist from Lynchburg, representing the Medical Society of Virginia (MSV) stated that harm is occurring to Virginia's medical and health care systems and that Virginia's citizens, particularly those most vulnerable, fragile and greatest in need, bear the brunt of decreased access to medical care caused by rising medical malpractice premiums and stagnant reimbursement rates. Several examples of physicians for whom it is no longer feasible to practice because of high premiums were cited, as well as the closing of an OB unit in Buchanan County. Although obstetrics is currently most at risk, other medical disciplines at risk are neurosurgery, trauma care, emergency medicine, orthopedics, general surgery and critical care medicine because there are occasional poor outcomes despite optimal care. The current environment jeopardizes patient safety; as a result of the current environment physicians are risk averse and transfer difficult cases, practice defensive medicine which results in increased costs, older physicians are driven from practice and physicians are distracted and inhibited from quality improvement efforts. The current litigation system does not benefit the injured patient. The MSV suggested both short-term potential solutions, many of which are based on MICRA, and longer-term structural changes to the medical litigation system.

Subcommittee members discussed the feasibility and legality of requiring that medical malpractice liability insurers doing business in Virginia operate through a subsidiary that only sells policies in the Commonwealth, in order to ensure that Virginia doctors do not pay for mistakes made in other states. In support of this approach, it was offered that The Reciprocal went bankrupt because of experiences in states other than Virginia. There was also discussion of the practice by hospitals of requiring that doctors carry med mal policies with $2 million limits as a condition on being granted privileges.

At its next meeting, the subcommittee will discuss reciprocals and mutuals, receive information on a Nebraska plan where doctors pay for the lower portion of their coverage and buy the difference from the state, and receive information on hospital premiums. Senator Newman asked subcommittee members to be thinking of possible solutions.

Complete copies of some of the presentations are available on the subcommittee's website.

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website:
http://dls.state.va.us/SB601.htm