



# Independent Insurance Agents of Virginia

Incorporated

8600 Mayland Drive, Richmond, VA 23294  
804-747-9300 [www.iiav.com](http://www.iiav.com)

## IIAV Position Paper on Tort Reform Related to Medical Malpractice 2005 Follow up to 2004 Recommendations

Thomas P. Cox, ARM  
Vice President  
PhillipsCox Insurance and Financial Services

Robert N. Bradshaw, Jr., MAM  
Executive Vice President  
Independent Insurance Agents of Virginia

*Summary: Access to health care continues to be threatened in the Commonwealth due to a combination of the high costs associated with running a medical practice and low reimbursement. As presented last year, it is the position of the IIAV that the introduction of a state-run medical malpractice insurance program, operated by the Commonwealth to compete with the private market, does not address any of the challenges confronting the delivery of health care in the Commonwealth as it promises to do nothing to lower costs or increase reimbursement. To decrease the possibility of access to care challenges occurring, it remains our opinion that the General Assembly should strive to either reduce costs to the malpractice insurance companies (with a resulting decrease in premiums to physicians), find other ways to decrease costs to physicians, or increase physician reimbursement.*

To date the mass exodus of physicians from private practice in Virginia has not occurred. It is the opinion of the IIAV that this is not an indication that circumstances have greatly improved, but more an indication that many physicians either do not want to quit practicing, out of a love for the practice of medicine, or are financially unable to quit. But physicians **are** leaving early and it is not solely the "bad" physicians, as portrayed by the plaintiff's bar. While the malpractice insurance marketplace continues to soften, with rate increases flattening and underwriting loosening up a little bit, the issue of stagnant or declining physician reimbursement remains and this is the real challenge facing physicians in the Commonwealth. As the study by the Bureau of Insurance indicated to this panel last year, there is plenty of medical malpractice insurance available in Virginia; the challenge is that the physicians are struggling to afford the higher premiums in conjunction with other increased costs.

We do agree with the trial lawyers that the changes emerging out of the efforts of this committee in 2004, that took effect July 1, 2005, should be given time to work and the impact of these changes assessed. We hope that these changes do have the impact of reducing the number of claims filed and reducing the cost of defending those claims that are filed. However, we believe these changes are only a start and feel that additional changes can enhance the delivery of care in the Commonwealth.

For example, according to the ongoing claims study by the Physicians Insurance Association of America, medication errors became the single largest source of malpractice claims in 2003, the last year for which information is available. Medication errors are system errors and there is a decreased chance of system-wide changes occurring when the current tort climate:

1. Punishes physician – patient communication after an adverse outcome, as well as punishing any attempt by the physician to mitigate harm, such efforts being viewed as an admission of guilt and used against the physician in any subsequent claim;

2. Rewards injured parties, rather than making them whole again, with verdicts disproportionate to the loss incurred;
3. Does little to discourage careless use of the legal system;
4. Prevents or hinders the sharing of information between medical providers and others on how to make the delivery of health care better and safer.

The IIAV fostered five proposals last year that we believed would have the ultimate result of enhancing access to care in the Commonwealth. Some of those proposals were accepted, some were not. Of those that were not a part of the omnibus legislation enacted July 1, 2005, we believe the following still have merit and propose one additional new proposal. We believe these changes have the potential to have a greater positive impact on access to care than a malpractice insurance program operated by the Commonwealth:

#### **Proposal 1**

Pass legislation which mandates that health care providers in the Commonwealth carry malpractice insurance with minimum limits of \$1 million/\$3 million, but prohibit any entity from mandating that physicians carry limits equal to or greater than the current malpractice cap.

*COMMENT: By allowing physicians to carry lower limits if they feel comfortable doing so, premium savings of up to 15% can be realized. In states where there is no cap on damages, hard or soft, the majority of physicians carry limits of \$1 million/\$3 million. Virginia physicians do receive protection from the cap, but are also penalized by having to pay for higher limits. Additionally, the excess over \$1 million would not necessarily have to go unfunded as there would be multiple ways to fund this using some form of alternative risk transfer.*

*As noted in 2004, this is not a panacea nor is it actual tort reform, but does give doctors the opportunity to reduce premium in return for taking on some risk.*

#### **Proposal 2**

Change the dynamic of the current tort system by spreading the risk incurred by each entity involved in a claim. This can be accomplished by:

- A. Mandating that all malpractice cases be heard by a Malpractice Review Panel, as presently defined in the Virginia Code, prior to litigation being filed or prior to litigation proceeding;
- B. If the panel finds in favor of the defense and the plaintiff proceeds with the suit regardless, and the plaintiff loses at trial, the plaintiff's attorney (*not the plaintiff*) must pay all defense costs.

*COMMENT: In a malpractice action the physician stands to lose his/her reputation, loss of business opportunity, and even loss of insurance, which would end the physician's career. The insurance company stands to lose money, while the defense attorney may lose future business if the case is considered to have not been defended well.*

*However, it can be argued that under the current system the only person involved in a malpractice case with nothing to lose and everything to gain is the plaintiff's attorney. At the very least it can be argued that the plaintiff's attorney has the least to lose. If this dynamic is changed slightly, so that the plaintiff's attorney takes on some risk or some more risk, it should reduce the cost of defending claims in Virginia by reducing the frequency of claims filed, while increasing the merit of claims filed.*

*As the plaintiff relies on advice from his/her attorney, a Medical Malpractice Review Panel finding for the defense gives the plaintiff's attorney an excellent opportunity to drop the case at this juncture. This reduces costs to the insurance company and the plaintiff, reduces the number of court cases, gives the doctor a better opportunity to maintain insurance coverage, and decreases potential legal malpractice claims against the plaintiff's attorney should a case be tried and lost.*

***The trial attorneys argued in 2004 that this would increase costs as each claim would have to be defended twice. This appeared to be an admission by the plaintiff's bar that it would still pursue claims under these circumstances, even in the face of a Panel finding in favor of the***

***defense. This misses the point. If the Panel has found unanimously in favor of either side it will foster a stronger motivation to settle, if the finding is for the plaintiff, and should foster a strong motivation to drop the suit, if the finding is for the defense. The end result is each case being tried only once, unless the finding of the Panel is inconclusive. Currently the insurance company pays whether it wins or loses; the plaintiff's attorney arguably never pays, win or lose.***

### **Proposal 3**

In order to assist physicians with paying for medical malpractice insurance, pass legislation that prevents any third party from prohibiting providers charging any additional fees above that which they will be reimbursed by a health insurance company.

*COMMENT: If a way cannot be found to decrease the cost of malpractice insurance, what can be done to increase the ability of a physician to pay for malpractice insurance? This remains elusive. For the last several years physician reimbursement has been declining, while health insurance premiums have been rising and covered services declining. Both Anthem and United Healthcare reported record profits in 2003 and 2004, and are reporting record profits again in 2005.*

*Despite this declining reimbursement, most people today believe that the cost of higher malpractice insurance premiums is passed along to them in the form of higher costs for their health insurance, imposed on either the patient or the health insurance company by the physician. As was illustrated last year, physicians are largely prohibited from passing any costs along to a patient under the contracts they must sign in order to become a provider for a given health plan. In other words, it would be great if physicians could pass along some of the increased cost of malpractice insurance, but usually they are prohibited from doing so. Allowing physicians to pass along increased costs, as all other businesses are allowed to do in the Commonwealth, can assist physicians with the challenge of increased costs and stagnant or declining reimbursement.*

*In order to assist patients with these fees, take this concept a step further. As patients are paying for this with after-tax dollars (unless the patient uses a flexible spending account (125 plan) or participates in a high-deductible health plan and the deductible is used to satisfy this fee), allow these fees as a deduction when the patient files his/her Virginia income tax each year.*

### **Proposal 4**

Related to proposal #3 above, we believe another step can be taken to assist medical practices in functioning as any other business in this country and enhance the financial condition of these practices.

Most people are familiar now with Health Savings Accounts (HSA) and a little less familiar with Health Reimbursement Arrangements (HRA). The foundation of each of these programs is that there is a high deductible. In some cases the deductible is the responsibility of the patient alone; in many cases the employer through which the patient has obtained the health insurance provides for part of the deductible. In most cases the patient has either a debit card or check book that draws from the deductible account.

Because of processing delays it has been reported to us that it often takes between 60 days and 90 days for a medical practice to obtain reimbursement from a health insurance company after rendering care. The extra work involved in obtaining this money results in the accounts receivable overhead for many medical groups running as high as 35%. When a person receives care and has either a HSA or HRA, that person is prepared to pay for the visit before leaving the doctor's office. This will greatly reduce the accounts receivable overhead and enhance the cash flow for the group.

Yet, medical practices are frequently **prohibited** from collecting any money from a patient with a HSA or HRA because of stipulations in the contracts they have with health insurance companies. If the General Assembly can find a way to allow medical practices to collect money at the time of the visit from those people with HSA and HRA plans it will be a small step towards allowing medical practices to operate more like all other businesses in this country.

### **Conclusion**

While the medical malpractice insurance market in the Commonwealth continues to improve, the higher costs of medical malpractice insurance, in combination with other increased costs of doing business and stagnant or declining physician reimbursement, has continued the stress on the delivery of health care in the Commonwealth. The position of IIAV remains that any steps the General Assembly can take to either reduce costs to medical groups or increase reimbursement to medical groups will help guarantee access to care in Virginia. We fail to see however, how the introduction of a state-run medical malpractice insurance program, operated by the Commonwealth to compete with the private market, will address any of the challenges confronting the delivery of health care in the Commonwealth or how it would address the concern over increased medical malpractice premiums.

**The Independent Insurance Agents of Virginia, Inc.**

Founded in 1898, IIAV is part of the nation's oldest and largest associations of independent insurance agents, representing a network of more than 300,000 agents and agency employees nationwide and over 5,500 in the Commonwealth. Its members are insurance businesses that offer customers a choice of policies from a variety of insurance companies. Independent agents offer all lines of insurance – property, casualty, life, health, employee benefit plans and retirement products. Web address: [www.iiav.com](http://www.iiav.com) and nationally [www.independentagent.com](http://www.independentagent.com).

September 20, 2005