

# **Medical Malpractice Insurance Liability Update:**

## **A Brief Commentary on the Current State of Affairs**

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### **A. Market Trends**

#### **1. Increasing Number of Medical Malpractice Insurers No Longer Underwriting**

- a. Beginning in 2001, with a combined loss ratio in the 135% range in 2000 and investment income down, medical malpractice insurers began exiting the medical malpractice market entirely or withdrawing from writing medical malpractice in certain geographical areas. On December 12, 2001, The St. Paul Companies, the nation's second largest medical malpractice insurer, announced its intention to pull out of the medical malpractice insurance business over the next two years, forcing the 750 hospitals and 42,000 doctors its insures to find coverage elsewhere. Although medical malpractice premiums generated \$500 million for St. Paul in 2001, the company faced an underwriting loss of nearly \$1 billion. "We cannot subject our shareholders to those kinds of losses," commented company spokesman, Mark Hamel. SCPIE, a Los Angeles, based malpractice insurer, has also reportedly stopped writing coverage in Texas and Florida and other East Coast states citing the lack of damage caps in those states as a motivating factor.
- b. Pennsylvania and Florida have been especially hard hit as a number of its medical professional insurers have stopped writing. For example, there are just four insurers writing new medical malpractice in Florida down from 66 that provided coverage in 1999.

#### **2. Medical Malpractice Insurers Are Imposing Significant Rate Hikes and Implementing Tighter Underwriting Requirements**

- a. Medical malpractice insurers are imposing significant insurance rate hikes on hospitals, nursing homes, physician, and physician groups to

make up for years of inadequate pricing and reserving during the competitive soft market. The increases ranged from 30-300%. Practitioners in Florida, West Virginia, Mississippi, and Pennsylvania are experiencing sharp rate increases. Florida medical malpractice premiums were 55% higher than the national average last year, and the states average premium has increased 64% since 1996 compared with a 26% rise nationally. Insurance regulators are now stepping into the mix and ordering malpractice insurers to cap rate increases. For example, in February 2003, New Jersey's top insurance regulator ordered Zurich America to "cease and desist from billing a base rate increase of 108% for its physicians and surgeons professional liability programs. The carrier must implement an immediate rate roll back to no more than a 30% base rate increase and notify all affected policyholders; those that overpaid will receive refunds." Zurich had originally sought to non-renew its individual and small group medical malpractice business but was ordered to offer quotes by regulators. About half of New Jersey's practicing physicians staged a work stoppage in early February 2003 to protest average rate incases between 35% - 100%.

- b. Insurers are also implementing tighter underwriting requirements, which means physicians, especially those who have been sued before or who practice in risky areas like obstetrics, are finding that their malpractice is being non-renewed.

### **3. Hospitals and MCOs Are Maintaining Large Self-Insured Retentions Under Their Medical Malpractice Programs**

- a. Many hospital systems and Managed Care Organizations (MCOs) have opted to increase their self insured retentions in the face of significant premium rate hikes. For example, Advocate Healthcare, an Oak Brook, Illinois based hospital system, increased its self insured retention to \$15 million per occurrence from \$2 million. At those levels, most medical malpractice losses will be covered by the hospital system. Moreover, some large commercial managed care companies are maintaining self insured retentions ranging from \$25 - \$50 million.

### **4. Record Number of Captives Are Being Formed As Alternative Forum to Procure Medical Malpractice Insurance**

- a. For many healthcare entities, interest in captives is being driven by the larger retentions their insurers are forcing on them. Healthcare entities are looking to satisfy auditors by having a formal mechanism for funding retained losses. There has been a marked increase in the number of new captive formations and applications in the Cayman Islands, Bermuda and Vermont. However, prospective captive owners

are discovering that forming their own insurance company may not be the panacea for their risk management ills. Many captives, particularly those being formed by nursing homes, face the added challenge of funding reinsurance and fronting capacity in a steadily contracting market.

**5. Hospitals are Stepping Up to the Plate to Bridge the Gap in Physicians' Insurance Coverage**

- a. Physician difficulty in finding coverage is increasing the trend of hospitals employing physicians while in some cases, hospitals are providing liability coverages for non-employed physicians on their staffs.

**6. An Increasing Number of Medical Malpractice Insurers Are Placed in Rehabilitation or Liquidation**

- a. PHICO Insurance Co., formerly the 11<sup>th</sup> largest medical malpractice insurer, is in liquidation. Earlier this year, Virginia regulators seized Reciprocal of America (ROA), a Glen Allen, VA based malpractice insurer placed it into receivership due to concerns regarding the insurers' shrinking surplus. Similarly, Tennessee regulators seized three related Risk Retention Groups (RRGs) which had the same management as ROA and reinsured all of their business with ROA. The RRGs include: Doctors Insurance Reciprocal, formed in 1990 to write physician malpractice coverage; and The Reciprocal Alliance, formed in 1995 and specializing on malpractice coverage for hospitals, nursing homes and managed care organizations.
- b. To the extent the number of medical malpractice insurer insolvencies continue to increase, the statutorily created guaranty funds/ associations will play a role in medical malpractice claim handling and litigation. The guaranty fund pays expenses incurred in the claim process and the actual loss payments, up to a statutory maximum cap, ranging from a low of \$100,000 to a high of \$1,000,000, with \$300,000 as the average. It should be noted that RRGs and other captives are not subject to guaranty fund protection.

**B. Noteworthy Litigation Trends**

**1. Increase in Severity Of Medical Malpractice Awards and Settlements Against Physicians, Hospitals and other Health Care Entities**

- a. Jury awards in medical malpractice suits have skyrocketed in recent years. Last month, New York's highest court affirmed a lower court decision that a child was entitled to **\$140 million** in compensation for devastating brain injury resulting from malpractice at a New York hospital. *Desiderio v.*

*Ochs, et. al.*, 2003 WL 1818120 (2003). The New York Court of Appeals in *Desiderio* said it was bound to uphold the lower court's decision despite the fact the court had determined the appropriate level of compensation to be \$50 million, before structuring. The \$140 million damage figure resulted from application of a statutory formula that relates to situations where long-term care is required as a result of malpractice.<sup>1</sup> Similarly, in October 2002, a Suffolk County New York jury awarded **\$80 million** to a 12 year-old spastic diplegic due to the alleged negligence of her physicians in treating her mother for pre-term labor. *Brenner v. Spector, Klein*, Docket No. 1581/95 (October 2002). The defendant hospital settled out with the plaintiff prior to trial for \$2.9 million.

- b. The median medical malpractice award increased from \$500,725 in 1997 to \$800,000 in 1999, an increase of 60%. The number of medical malpractice insurance payouts exceeding \$1 million has risen to over 800 in 2002 from 200 in 1996. Settlements show a similar trend with median settlements climbing from \$400,000 in 1997 to \$650,000 in 1999—a growth of over 60%.<sup>2</sup> According to the experts, there are many factors driving up these awards including: publicity of medical errors, disgruntled healthcare staff, lottery type mentality of jury pool, nursing and other healthcare staffing shortages, the sophisticated plaintiffs' bar, anti-managed care sentiment. Not surprisingly, according to a study by Conning & Co., "Medical Malpractice Insurance, A Prescription for Chaos, 2001", the shift in health care delivery to cost-contained managed care has moved medical malpractice from a "world dominated by committed medical acts to one of omitted acts." Claims for alleged failure to diagnose are one of the leading causes of action alleged in medical malpractice suits today.

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<sup>1</sup> Through his mother, plaintiff Samuel Desiderio sued the defendants, New York Hospital and several of its doctors, for malpractice that resulted in severe brain damage. Samuel was born with hydrocephalus and, in October 1990, Dr. Snow performed surgery to revise a shunt used to treat the condition. The shunt failed, putting pressure on Samuel's brain. After nearly three years of inpatient care, Samuel now breathes at home through a permanent tracheostomy and must be fed through a gastrostomy tube. His injury also reactivated and exacerbated a seizure disorder resulting in frequent episodes—sometimes several per day—in which Samuel stops breathing and must be resuscitated. In 1999, the New York County, New York jury returned with a \$79 million verdict (including \$40 million for future nursing care over a 55 year period). The Hospital conceded liability (i.e., that its failure to properly monitor and detect the pressure on Samuel's brain caused him to suffer a brain herniation and brain damage) before trial. While the jury found Dr. Snow was negligent, it concluded his negligence was not the proximate cause of Samuel's injuries. The judgment was ultimately reduced to approximately \$50 million on June 4, 2001. Pursuant to New York statute, future damages over \$250,000 must be structured pursuant to an annuity. The defense argued that the ultimate annuity payout should not exceed the jury award while the plaintiffs successfully argued to the Court of Appeals that it must uphold the structured judgment statutory formula which it utilized in calculating future damages notwithstanding the fact the total payout may exceed the jury award. While the Court of Appeals ruled in favor of the plaintiffs, it urged the New York legislature to revisit the statute to determine whether it is achieving its intended purposes.

<sup>2</sup> See, 2000 Edition of Jury Verdict Research's *Current Award Trends in Personal Injury*.

## **2. Skyrocketing Medical Malpractice Awards May Further Increase Health Care Entities' Vicarious Liability Exposure**

Health care entities, including hospitals and MCOs, often employ and/or contract with healthcare providers to render healthcare services to their patients and/or subscribers. A health care entity's agency relationship with its providers exposes the entity to vicarious liability claims arising out of the providers' alleged negligent medical treatment of patients and subscribers of managed health care plans. *The increased frequency and severity of medical malpractice claims has and will continue to impact the vicarious liability exposures of health care entities.* Other factors which have also contributed to MCOs' increased vicarious medical malpractice liability exposures include judicial reluctance to find that ERISA bars vicarious liability claims against MCOs and persistent anti-managed care public sentiment.

## **3. More Medical Malpractice Liability May Shift to Health Care Entities As Deep Pocket Defendant: Enterprise Liability<sup>3</sup>**

- a. More and more health care entities, including MCOs, are being named as the sole defendants in medical malpractice actions. Aside from alleging vicarious liability for medical malpractice, the plaintiffs routinely allege that the healthcare entities are directly liable for the plaintiff's injury due to alleged improper case management/coordination of care and improper financial incentives which allegedly corrupted the provider's treatment decisions. Particularly since providers carry small limits, or in some instances no insurance, the plaintiffs' attorneys are increasingly targeting the "deep pocket" managed care and hospital defendants. Thus, some plaintiffs are electing not to name the individual provider as a defendant in exchange for the provider's damaging testimony placing blame on the healthcare entity defendant for the physician's treatment decision in an effort to "ring the bell" against the healthcare entity defendant. These phenomena may result in more medical malpractice liability essentially shifting to healthcare entities.

## **4. Pybas v. CIGNA Healthcare of Texas: A Case Study on Aggravating Circumstances which Foster Adverse Medical Malpractice Awards Against Health Care Entities In Non-Birth Injury Claims**

- a. Some of the aggravating circumstances leading to multi-million dollar verdicts against health care entities and providers due to their alleged malpractice include: (1) finger pointing between treating physician and health care entity; (2) evidence that financial incentives played a role in

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<sup>3</sup> Under the enterprise liability theory, responsibility and liability for medical malpractice shifts from individual physicians to the health care entity. Physicians are not named as individual defendants in a suit alleging malpractice but assume the limited role as fact witnesses.

defendants' treatment decisions; (3) allegations that the defendants destroyed critical medical records after suit has been filed; and (4) significant bodily injury or death to an elderly patient.<sup>4</sup>

- b. *Pybas v. CIGNA Healthcare of Texas* is a case study on how the presence of these aggravating factors can lead to significant compensatory and punitive awards against health care entities. On June 28, 2002, a Dallas county jury awarded \$13 million in damages to the family of an 83-year-old nursing home patient who died after his HMO allegedly forced him out of a skilled nursing home facility to cut costs. *Pybas v. CIGNA Healthcare*, Tex. Dist. Ct. No. 01-02980J.<sup>5</sup> The jury ordered CIGNA to pay \$3 million in actual damages, plus \$10 million in punitive damages. Since the jurors found CIGNA caused serious bodily injury to Pybas, a violation of the state's criminal law against abuse of the elderly, the state cap on punitive damages did not apply. (ERISA did not apply as Pybas' HMO policy was not offered by an employer but as an alternative to a federal Medicaid healthcare benefits plan).
- c. The plaintiffs in *Pybas* alleged that the HMO, through its medical director, utilization review nurse, and other utilization management personnel "influenced and pressured" Pybas' treating physician to discharge the patient by using "length of stay" guidelines. Plaintiffs asserted that the HMO questioned the medical necessity of care and treatment prescribed by the treating physician. Significantly, during the trial, the treating physician testified that he wanted to keep the patient in the nursing home longer. Further exacerbating CIGNA's liability was (1) evidence introduced at trial that CIGNA Healthcare paid one of its utilization review nurses \$500 bonuses in three successive calendar quarters, plus an annual raise, for controlling bed days at the facility; and (2) evidence that CIGNA shredded documents related to Pybas' case after the lawsuit had been filed. Prior to trial, CIGNA repeatedly only offered \$150,000 to settle the case.

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<sup>4</sup> Elder abuse allegations by plaintiffs attorneys represent the beginning of a trend that will likely trouble hospitals and other healthcare entities for years to come. The upsurge in elder abuse claims, which first surfaced in Florida, represents creative attempts by the plaintiffs' bar to circumvent state laws that cap medical malpractice awards and, in some cases, punitive damages. Rather than characterizing their claims as a medical malpractice action (e.g. alleged negligence against the facility's for the failure of it and its staff to adequately treat decubitus ulcers), plaintiffs' counsel are filing suit under their state's elder abuse laws or unfair business practices statutes, among others, and attacking the entity's financial decision making with respect to staffing in an effort to avoid medical liability damage caps.

<sup>5</sup> According to the lawsuit, Pybas had been hospitalized on numerous occasions between October 6, 1998 until his admission to a skilled nursing facility in Sherman, Texas on December 31, 1998. He suffered from anemia, congestive heart failure and progressive renal failure. At the facility, Pybas received physical and speech therapy and continuous oxygen to improve his medical condition. He was forced out of the facility by CIGNA 22 days later, and discharged to receive home healthcare, according to the complaint. However, required oxygen and prescribed at-home healthcare services were not ready as promised. The following day Pybas' physical condition deteriorated and he was transported by ambulance to the hospital where he died six days later.

**C. Increased Premiums and Escalating Verdicts Are Having an Adverse Impact on Quality of Care**

1. According to some insurance buyers, the crisis in the medical professional liability market is affecting the delivery of care and threatening the country's existing health care system. Some examples include:
  - ◆ The more money spent by hospitals on medical malpractice premiums means less money is available for new services or equipment to treat patients.
  - ◆ Physicians, especially obstetricians, are relocating practices to less litigious areas where malpractice coverage is more affordable leaving many patients without access to prenatal care especially in rural parts of the U.S. Moreover:
    - 1) Various hospitals, including, six HCA hospitals, have reportedly closed obstetrics units in recent months due to the inability to find obstetricians to take calls; and
    - 2) Obstetricians are relinquishing privileges at select hospitals to reduce the number of mandatory emergency shifts they must work taking care of high-risk patients.
  - ◆ Physician walk-outs are becoming commonplace as a ploy to prompt state legislators to pass effective tort reform. However, these walks-outs are jeopardizing patient access to timely medical care.

**D. Medical Malpractice Crisis is Spurring Tort Reform**

1. The increase in severity of medical malpractice awards and higher malpractice premiums have resulted in passage of proposed federal and state legislation limiting liability for medical malpractice suits. Approximately 19 states already have damage caps in place. These include: California, Colorado, Indiana, Maryland, Massachusetts, Michigan and Nevada.

**a. State Legislation**

Many state legislatures, including Florida, Kentucky, Idaho and Ohio, are embroiled in a heated debate over how to solve the medical malpractice crisis. Some features among the proposed legislation include:

- Cap on non-economic damages
- Removal of joint and several liability
- Require mediation if malpractice suit is to be filed to determine that a case warranted hearing by a court
- Strengthen requirements for medical experts

- Elevated standard to clear and convincing evidence in medical malpractice case
- Court appointed expert witnesses
- Known and disclosed potential complications should be no actionable unless the complication was as a result of reckless disregard

**b. Federal Legislation: Medical Malpractice Liability Act**

On March 13, 2003, the House of Representatives passed legislation (H.R. 5) which, among other things, places a federal limit of \$250,000 on non-economic (pain and suffering) damages in health care lawsuits and caps punitive damages at the greater of twice the amount of non-economic damages or \$250,000. Health care lawsuits are defined to include a demand by any person against a health care provider or health care organization which are based upon the provision of, use of, or payment for (or the failure to provide, use or pay for) health services, regardless of the theory of liability on which the claim is based and whether it is brought in state or federal court. The proposed legislation would apply to managed care organizations and administrators of health benefits plans since these entities would arguably qualify as Health Care Organizations under the Act<sup>6</sup>. However, H.R. 5 would not preempt any state law enacted before or after it that sets higher or lower damage caps for health care lawsuits; it only applies in states with no caps on damages. Moreover, H.R. 5 would not supersede any state or federal law “that imposes greater procedural or substantive protections for health care providers or organizations from liability, loss, or damages than those provided by this Act or create a cause of action.”

President Bush has endorsed the bill and urged Senate action on it, but commentators believe that it will be tough to navigate the bill through the Senate. Republicans in the Senate are reportedly preparing similar legislation but Senator Judd Gregg (R-N.H.), Chairman of the Senate Health, Education, Labor and Pensions Committee advises that the range of lawsuits covered in the Senate GOP bill would not be as broad as in the House measure which extends to health care liability suits filed against pharmaceutical makers. Moreover, commentators anticipate pressure in the Senate to increase the House bill’s \$250,000 cap on non-economic damages and to provide for exceptions from the cap in cases where medical malpractice results in death or dismemberment.

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<sup>6</sup> The Act defines Health Care Organization as “any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under contract or arrangement with a health care organization to provide or administer any health benefit.”

**Comments:** Under the proposed Medical Malpractice Act, MCOs would not be precluded from raising ERISA preemption to claims challenging its administration of healthcare benefits. However, to the extent ERISA does not preempt a claimant's state law claim asserting wrongful denial of benefits against an MCO based upon its mixed eligibility and treatment decision, the MCO would arguably obtain the benefit of the \$250,000 cap on non-economic and punitive damages in the absence of any applicable state medical malpractice liability caps.

**c. Commentary on Proposed State and Federal Tort Reform**

Some believe that comprehensive tort reform at both the state and federal level are too narrowly drafted and will do little to resolve the problem of excessive jury awards. Many of the current proposals have at their core a cap on non-economic damages in medical malpractice suits, but plaintiffs can circumvent caps in some states, rendering them ineffective by arguing that the defendants' acts were egregious. *However, a recent study by Milliman USA concludes that physicians in states with caps on non-economic damages consistently have lower average medical malpractice losses.* The Seattle based actuarial consultant examined medical malpractice loss costs in the 15 largest states from 1990 to 2001. The results clearly show that tort reform efforts that include caps on damages can reduce medical malpractice costs. For example, the lowest-cost large state, California, which has a \$250,000 cap on non-economic damages, reported a \$2,884 annual loss per doctor for medical malpractice losses, whereas Pennsylvania, which does not have a cap, reported the highest average loss at \$9,386 per doctor. Other states which have some form of cap on damages including: Colorado, which reported losses of \$3,817 per doctor; Indiana, \$4,734 per doctor; Maryland, \$3,503 per doctor; Massachusetts, \$3,802 per doctor; and Michigan, \$4,347 per doctor.