Medical-adversity insurance: a modest proposal

Why not try the free-enterprise approach to professional liability coverage?

By Charles Bond

May 1, 1985, was the 10th anniversary of the professional liability crisis of 1975. This anniversary is marked by the resurgence of renewal of the symptoms of a decade ago: Premiums are rising, and malpractice insurers in all but two states are underwriting in the red. In 1983, the number of malpractice trials in California dropped, but verdicts doubled. Recognizing the potential impact of this problem, CMA has appointed its own task force on professional liability, which I understand is now meeting feverishly at a rate of almost once a week.

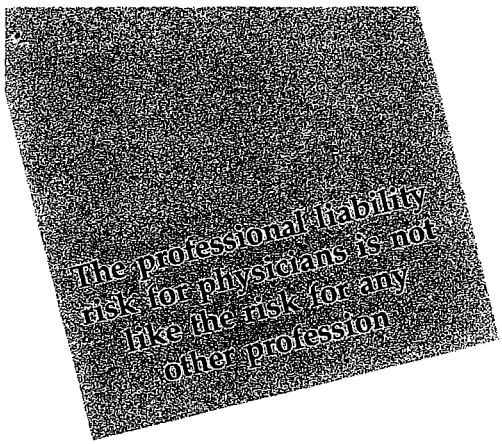
But how far have we really come in a decade? First, we changed the underwriting method from occurrence to claims-made in 1975. This change gave the doctor-owned companies several years to accumulate funds before they had to pick up the malpractice tail. Then, by the time they finally did start underwriting the tail, we were in the midst of the high-interest/high-yield era of the late '70s and early '80s. Now that investment returns have subsided to more normal rates, virtually the entire professional liability risk is being borne by the cost of premiums. Under a claims-made policy, the cost of insuring the risk is based directly on the claims made in the prior year. So for the first time since 1975, it can be said that the current premiums reflect the true cost of underwriting the malpractice risk. Those current premiums also reflect the slow but steady climb in frequency and severity of claims, and there seems to be little sign of abatement in those increases.

Thus there is a curve of increased severity and frequency of claims leading to higher and higher premiums. At the same time, though, the average physician's gross income is declining in real terms. Eventually, these curves are going to come to a point of critical intersection.

In some specialties, such as obstetrics, the crisis has already arrived. This cost crisis is going to get more and more acute as reimbursements decline. With the ever-escalating curve of severity in claims, we are entering a new professional liability crisis; but it will not be like the crisis of 1975. The new malpractice crisis is sneaking up on us: It will not be sudden, nor will it be universal, as it was in 1975. There will not be a crisis in the availability of primary insurance because the primary insurers in the present market are predominantly doctor-owned. But the underwriting of the malpractice risk has not been completely internalized and self-contained within the medical profession. There also is a "crisis of underinsurance." Companies in the future may be unwilling or unable to underwrite policy limits high enough to cover the large awards we now are selling. So physicians may have to put their own assets at risk to help cover the huge awards.

Is malpractice uninsurable?

The reemergence of this crisis leads one to ask the fundamental questions: Is the medical malpractice risk itself insurable? And in this regard, I wish to make a couple of basic observations about how the malpractice risk is



distributed in our present system. First, the premise underlying the concept of insurance is spreading the risk; but our malpractice insurance system does just the opposite—it concentrates the risk. Consider the raw numbers. In California, we are trying to provide insurance protection for the entire patient population of the state—24 million people—with premiums paid by an insurance base consisting of only 600 hospitals and roughly 44,000 physicians. Instead of broadly distributing the risk, that is funneling it.

Furthermore, the professional liability risk for physicians is not like the risk for any other profession. For example, only a fraction of the population even consults an architect or a lawyer, but everyone these days sees a physician. So the number of potential claimants against physicians' professional liability insurance is much larger than any other profession.

Similarly, the nature of the personal injury risk insured by physicians is also much different than in any other field of insurance. Physicians are unlike any other defendants in personal-injury actions. The likelihood of physicians being sued for personal injury is much greater because of their profession. This becomes clear when comparing the malpractice risk to the automobile risk. The average driver will run into somebody and cause them personal injury on a random and infrequent basis. Physicians, by contrast, deal constantly with the bodies of their patients, and thus the chance of an accident or a mere bad result inflicting disability or personal injury is increased far beyond any other class of person. Statistically, it is inevitable that physicians per capita will be sued more frequently than any other type of defendant, simply because they are treating the bodies of other persons. That is why statistically one out of three or four physicians will be sued this year in California. No other class or group can claim such a grim statistic. Underwriting the malpractice risk, therefore, is a bit like underwriting automobile insurance for a demolition derby. The risk of being sued for malpractice is truly an occupational hazard.

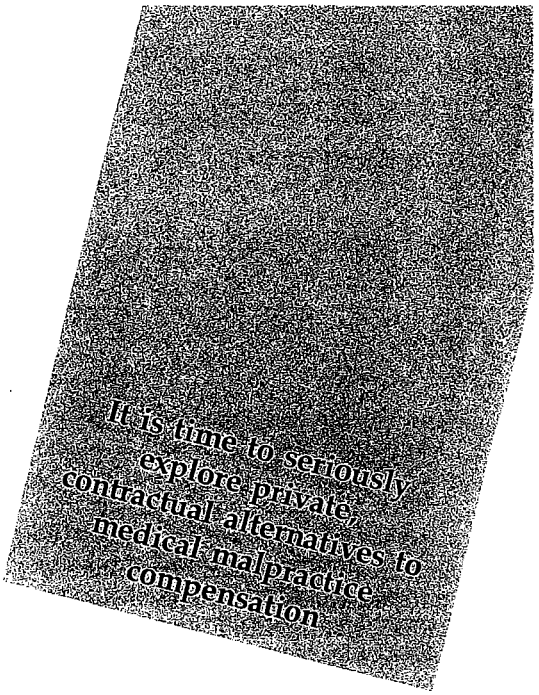
Because of these fundamental underwriting problems, which are inherent in the malpractice risk, further tort reform is not the answer to the impending crisis. Further tinkering with the tort system is like fiddling the fine-tuning knob on a television set that is not plugged in. It's not going to correct the problem.

The lack of efficacy of tort reform can be measured by the fact that it is now 10 years after the last tort reforms, and they have had no substantial impact on premiums. Furthermore, the most important reform has not yet been finally adjudicated as to its constitutionality. Furthermore, I do not think that there is a realistic chance of making headway against the CTLA in the present legislature.

The free-enterprise approach

Instead of legislated tort reform, CMA should concentrate on using free enterprise to bring about changes. With the rise of reimbursement contracting, it is time to seriously explore private, contractual alternatives to medical malpractice compensation.

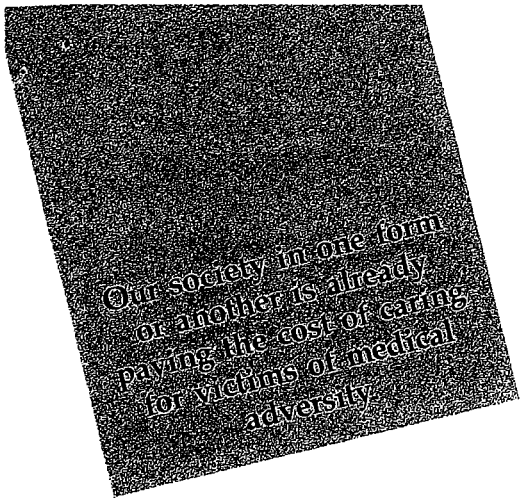
How would such a system work? Simply as follows: At the time the patient selects a health plan, the patient would have the right to choose one or more plans that would offer the patient medical adversity insurance in lieu of the right to sue for malpractice. In giving up the right to sue for malpractice, the patient would agree instead to be compensated by direct medical adversity insurance. The medical adversity insurance would be triggered by the happening of a designated compensable event. If a designated compensable event occurred during a course of treatment covered by the health plan, the plan would pay the patient directly pursuant to a basic schedule of benefits that would be spelled out in advance, agreed to by the patient, and paid for by the health plan. The insurance itself would, in effect, be like flight insurance. It would be nothing more than a package of direct life, accident, disability, and health insurance of the kind now routinely written that would pay in the event of medical accident or



adversity. If patients want a higher level of benefits, they could purchase additional adversity insurance at the time they sign up for the health plan. In essence, patients would have the opportunity to select their own level of benefits at the time they sign up for the plan.

Would such a plan be legal? Although there is no certain answer, it is a propitious time for a test case. Physicians' interest now can be well-represented in front of the California Supreme Court, as evidenced by the recent victories in the AB 1xx cases. Accordingly, CMA should seriously consider an approach to the coming malpractice crisis that does not involve legislative action but would test the central reforms judicially. A well-structured pilot program giving rise to a carefully selected and handled test case has a chance of success.

Will medical adversity insurance stand up in court? The chances are good because it is a private contractual arrangement, with which the courts are generally reluctant to interfere. More importantly, upon a specific analysis of relevant cases, the structure of the program could well pass judicial muster. Although courts in the past have not looked with favor on contracts in which people give up their right to sue for negligence, such exculpatory clauses have been upheld where the contract is freely negotiated and its terms selected in advance (as in the health insurance setting), and particularly where the party giving up something gets something in return—a *quid pro quo*. In other words, if the patient were not simply granting providers immunity, but were



getting a demonstrable benefit in return, the courts could ratify this approach, particularly if accompanied by stringent peer review to ensure that physicians who create losses under the program are held accountable for their acts. Given such a system, I would be perfectly comfortable arguing in favor of medical adversity insurance in front of the California Supreme Court.

An affordable choice

Perhaps the most frequently asked question about medical adversity insurance is, "Can we afford such a system?" In response, it should be noted that our society in one form or another is already paying the cost of caring for victims of medical adversity. So the question is whether or not our tort-based system is the most efficient form of compensation. In California, more than a quarter of a billion dollars is spent each year on medical malpractice premiums. That's about $11 for every man, woman, and child in this state. On a national scale, one out of every $10 in the gross national product is spent on health care, and, of that amount, it is conservatively estimated that from 15-20 percent goes to the cost of malpractice premiums and to defensive medicine. If these resources were diverted into a medical adversity system, the potential underwriting pool for medical adversity insurance would be as much as 1-2 percent of the GNP.

Interestingly, the literature frequently describes the "no fault" approach as "too expensive." There then follows a footnote citing Don Harper Mills' study in 1977.* It is time to refine the Mills study. To the extent that I understand that study, it appears to have measured the entire universe of all possible malpractice claims. It did not attempt to apply either actuarial or legal definition to the term "compensable event." Underwriters do not underwrite the whole universe of potential claims, only a defined subset of that universe. For example, an automobile policy does not cover the entire universe of possible auto claims. It has a deductible, policy limits, and specifically defined conditions and exclusions, all of which make the risk insurable. The first step, therefore, should be to engage in a serious attempt to construct an acceptable underwriting model for medical adversity insurance.

This task was begun by the American Bar Association's Commission on Medical, Professional Liability, which undertook a study on the designated compensable event system. Significantly, it concluded that such a system was feasible, but it suggested further study. Some medical specialties have undertaken that further study and have developed lists of designated compensable events. To my knowledge, however, they have not engaged in the actuarial work to figure out the cost of insuring these events. The rise of medical contracting has created an unusual opportunity for the pursuit of the contractual approach. Now PPOs and other reimbursement contracting systems are providing the necessary contractual bonds. Accordingly, now is the time to undertake the necessary comprehensive actuarial and legal studies to find out if medical adversity insurance is an affordable alternative to the present tort system. CP

Mr. Bond is a San Francisco attorney.

*Mills, Don Harper, M.D. Report on the Medical Insurance Feasibility Study. *San Francisco: California Medical Association, 1977.*