

HealthTrek

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Medical malpractice claim trends in 2017

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Introduction

It is safe to say that never in history has the health care industry in the U.S. witnessed such dramatic change as it has since the enactment of the Affordable Care Act (ACA) in 2010. But in 2017, the Republican attempt to "repeal and replace" the ACA was not successful as of the end of April, leaving that landmark legislation in place, however imperfect.

While the ACA has influenced many health care industry trends, often accelerating them, certain major trends had begun even prior to its enactment. These major trends include hospital industry mergers and acquisitions, employment of physicians by hospitals, and changing reimbursement methodologies, especially the move from fee-for-service to value-based reimbursement and others.

The national environment for health care professional liability (HPL) in 2017 is stable; although, for the first time in a decade, the industry combined ratio may be at or over 100. As of this writing, A.M. Best had not released the industry results through year-end 2016. But the industry combined ratio has been rising in recent years indicating lower profitability.¹

This article reviews the recent national environment for HPL claims, including comments on the current national environment, hospital and physician claim trends, and prospective claim development potentially affected by the major health care industry trends set forth above.

The national environment

In 2017, the national environment for HPL continues to be mostly favorable for many reasons. The most notable one is continued low claim frequency.

The reasons for the significantly lower claim frequency are multifactorial:

- Effective tort reform passed in the last 15 years and mostly upheld as constitutional except in a few states
- Effective patient safety initiatives reducing patient injuries
- Careful screening of the intake of cases by the trial bar due to the high cost of funding such HPL litigation that often proves to be unsuccessful for the plaintiff
- An apparent change in the mind-set of the general public about malpractice litigation²

There are unfavorable factors. Consolidation in the health care industry has meant fewer hospital and physician buyers, thereby shrinking the overall HPL premium written. There have been many new entrants as companies have sought to enter a line of property/casualty insurance that has been profitable over the last decade. The fierce competition has affected the profitability of this line of insurance.³

Claim severity must continue to be carefully observed because the trend has been upward in recent years as evaluated by a number of carriers, such as Zurich, which reported a 4% trend from 2008 through 2013.⁴ But the upward trend to date is actuarially manageable unlike the last years of the 1990s, which drove the last malpractice crisis.



Certain states never enacted broader tort reform laws, especially caps on non-economic damages. Those states do have the most unfavorable malpractice environments. Claim professionals deem the states of New York, New Jersey, Pennsylvania, Florida and Illinois to be among the most difficult venues in which to litigate malpractice cases due to their lack of tort reform laws.

Another issue of concern is batch claims/systemic risk claims. Often these types of claims are driven by unnecessary procedures performed.⁵ There is no national claim database that tracks batch claims. Carriers anecdotally vary in their opinions on whether there have been an increasing number of them, with at least some carriers reporting fewer.

The number of large verdicts is concerning.⁶ These can and do consume a large portion of the total indemnity paid out for HPL claims even though the ultimate payout is often reduced to the policy limits of the insured when it is an individual provider.

While there are fewer malpractice cases filed, the ones that do are expensive to defend, thereby driving up legal and related expense for carriers and self-insured entities. Higher expense has contributed to the deteriorating profitability of this line of coverage in recent years.⁷

The Republican control of Congress and the majority of state legislatures after the 2016 election may offer some opportunity for federal and state malpractice reform laws to be enacted even despite the failure of the American Health Care Act to be enacted. President Trump called for medical liability reform in addressing Congress on February 28.⁸

The Accessible Care by Curbing Excessive lawSuits (ACCESS) Act (H.R. 1704) was introduced in Congress this year.⁹ Like previous federal malpractice reform legislation, it contains many traditional features, including caps on noneconomic damages, limitations on attorney contingency fees, and periodic payment of future damages. But it introduces new components by also including such elements as affidavits of merit, apology protections, cooling-off periods before litigation may be filed, and expert witness reform.¹⁰

Another tort reform bill was introduced this year in Congress. The Good Samaritan Health Professionals Act is intended to protect health care volunteers who serve without compensation after a federally declared disaster has occurred.¹¹

Lower claim frequency may blunt some of the argument for the need for tort reform. But the practice of defensive medicine drives up overall health care costs through the ordering of what can be viewed as unnecessary tests. The psychological toll of malpractice litigation on physicians is also incalculable.

Physician claim trends

The favorable national medical malpractice environment continued to inure to the benefit of physicians in all but a handful of states. Claim frequency overall and for physicians remains at a historic low and shows no sign of a turn for the worse. Overall claim severity is trending upwards annually, but in an actuarially predictable manner. These conditions indicate general stability in the legal environment and in the market for medical professional liability insurance. These trends have favorably affected lower premiums for physicians for more than 10 years.

Few storm clouds are appearing on the horizon in this positive environment for physicians, though some carriers are addressing underpricing in a few markets. When the industry combined ratio is released, it may well exceed 100, thereby making this line of insurance unprofitable again. That could lead to at least some firming of rates in the years ahead if the trend is not reversed.

The PIAA was formerly known as the Physician Insurers Association of America. Their Data Sharing Project is the largest physician close claim database outside of the National Practitioner Data Bank with more than 300,000 closed claims over 30 years.

Highlighted below are a few graphs from the PIAA's most recent Specialty Specific Series issued in late 2016, which contain comprehensive reports on more than 20 major specialties for the 10-year time frame from 2006 through 2015. These graphs are a good snapshot of recent physician closed claim trends.

Exhibit 1

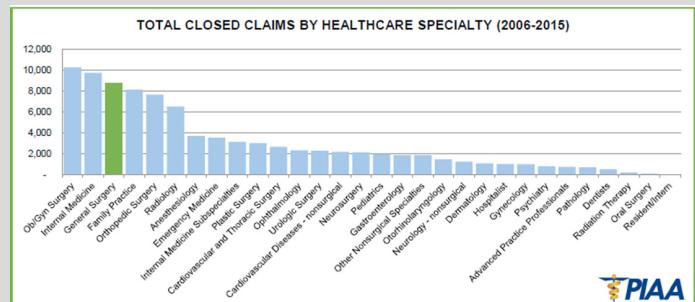


Exhibit 1 depicts total closed claims by health care specialty (dentists are included and these exhibits are all taken from the General Surgery report, thus the green highlighting). In that 10-year time frame, the specialties with the largest number of closed claims were:

- OB
- Internal medicine
- General surgery
- Family practice
- Orthopedic surgery

Exhibit 2 depicts average indemnity by specialty. The specialties with the highest average indemnity (and all these were above the norm for all specialties) were:

- Neurosurgery
- Neurology
- OB
- Pediatrics
- Anesthesiology
- Radiology
- Radiation therapy
- Internal medicine
- Pathology

Exhibit 3 depicts specialties by claim paid-to-closed ratios. Excluding oral surgery and dentists, the physician specialties with the highest paid-to-closed ratios (and above the norm for all specialties) were:

- ENT
- Pathology
- OB
- General surgery
- Neurosurgery
- Radiology
- Family practice
- Pediatrics
- Orthopedic surgery
- Gynecology

Exhibit 2

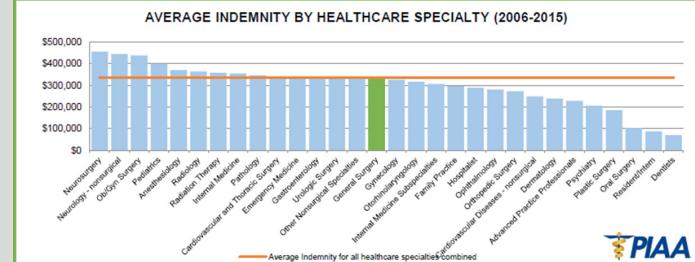


Exhibit 3

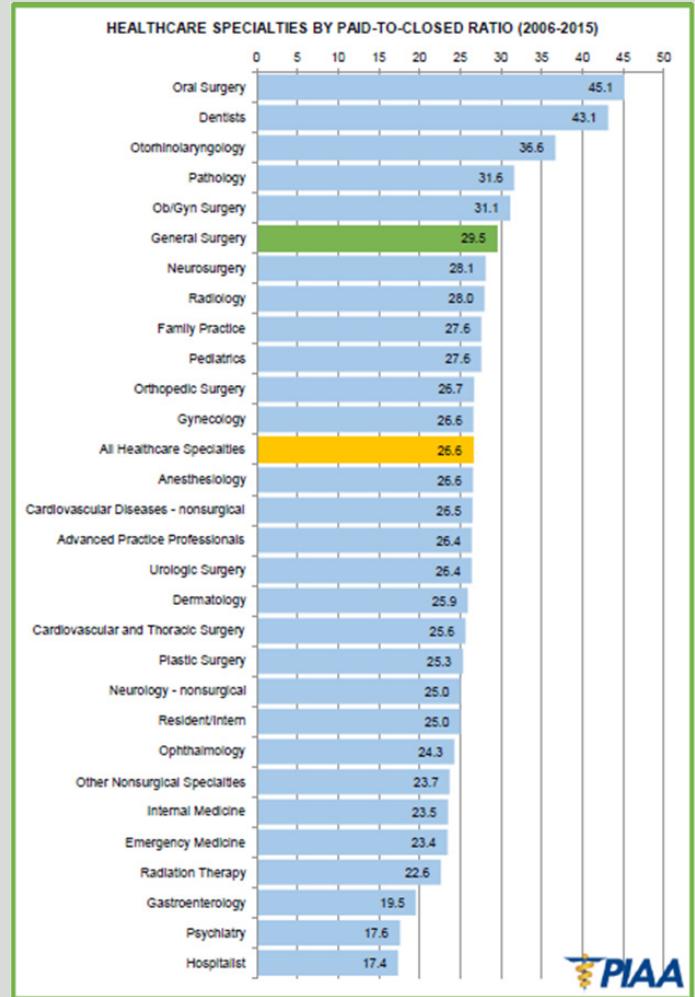


Exhibit 4

Exhibit 4 depicts the specialties with the highest average indemnity payments (above the norm for all specialties). They were:

- Neurosurgery
- Neurology
- OB
- Pediatrics
- Anesthesiology
- Radiology
- Radiation therapy
- Internal medicine
- Cardiovascular and thoracic surgery
- Emergency medicine
- Gastroenterology

Exhibit 5 depicts specialties by largest average indemnity payment. The top five were:

- OB
- Internal medicine
- ENT
- Neurosurgery
- Family practice

Hospital claim trends

Hospitals historically have been targeted by the trial bar as the "deep pocket" in malpractice litigation. The reason is that individual physician defendants carry low limits of malpractice insurance coverage in comparison to hospitals, which carry much higher limits of insurance coverage. It is always more difficult to defend an entity that has size and large assets (even though hospital profit margins run very lean) than individual providers (physicians, nurses) who as a group are usually viewed very favorably by the public.

Hospital claim trends mirror the previous observations about physician trends and the national medical malpractice environment. Frequency is low and stable per Zurich Healthcare's 2016 Benchmark Study of Healthcare Professional Liability Claims (**Exhibit 6**). CNA's closed hospital claim study released in 2015 also noted stability in claim frequency.

HEALTHCARE SPECIALTIES BY AVERAGE INDEMNITY (2006-2015)

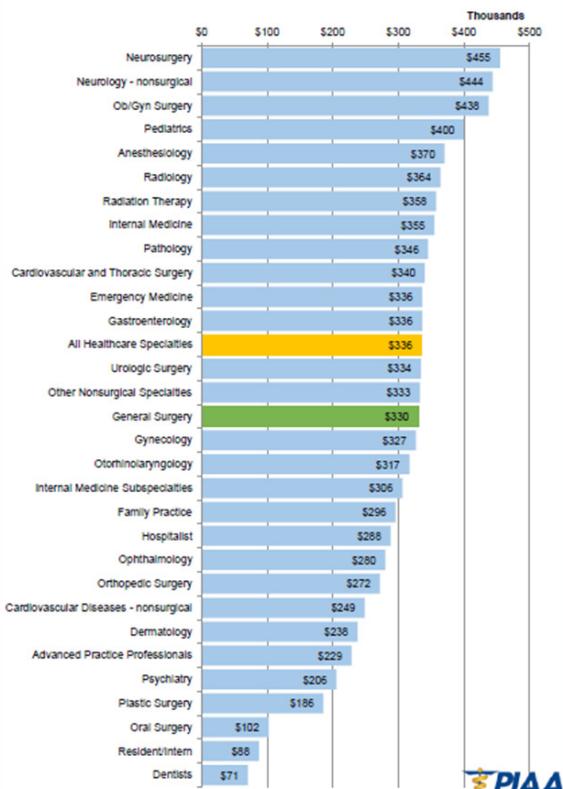


Exhibit 5

HEALTHCARE SPECIALTIES BY LARGEST INDEMNITY PAYMENT (2006-2015)

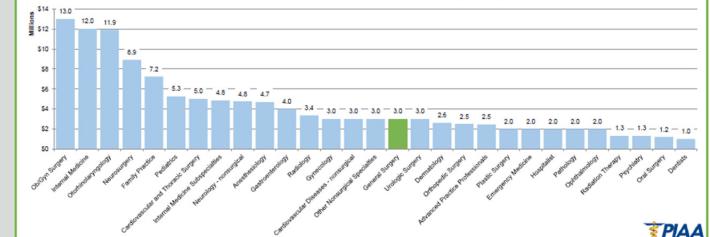
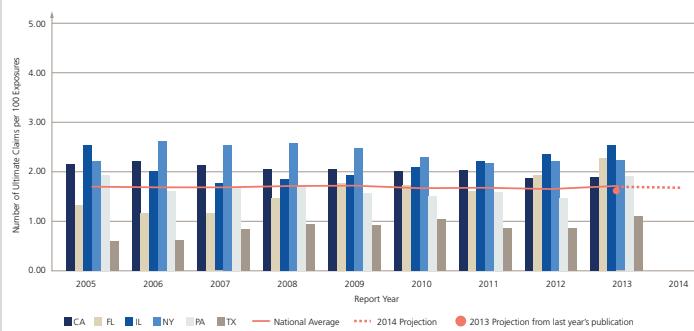


Exhibit 6

Ultimate frequency by state



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Hospital claim severity has been rising in recent years although Zurich Healthcare's data for 2013 show a slight decrease (**Exhibit 7**). The highest hospital claim severity is seen in the trends for children's hospitals and teaching hospitals, according to Zurich's 2016 report (**Exhibit 8**).

CNA's 2015 Hospital Professional Liability Claim Report noted an upward trend in severity for the 10-year time frame of 2005 through 2014.¹² For frequency of claims the leading locations for hospital claims were the inpatient medical unit, the emergency department, perioperative areas, inpatient surgical units and the perinatal unit (**Exhibit 9**). For the severity of hospital claims by average total amounts paid by location, the perinatal unit (perinatal units had both the highest indemnity and expense payments), critical care units, inpatient behavioral health, inpatient surgical unit and the emergency department were the leading locations (**Exhibit 10**).

Consolidation in the hospital industry via mergers and acquisitions has created larger regional health care systems comprising multiple facilities, usually employing physicians in multiple specialties. The larger the system, the greater the ability for a hospital to self-insure. Employment of physicians by hospitals increases the possibility for all co-defendants to be represented by one defense firm, a de facto joint defense. This reduces or eliminates potential conflict between co-defendants when they are separately insured and thus represented by separate defense counsel.

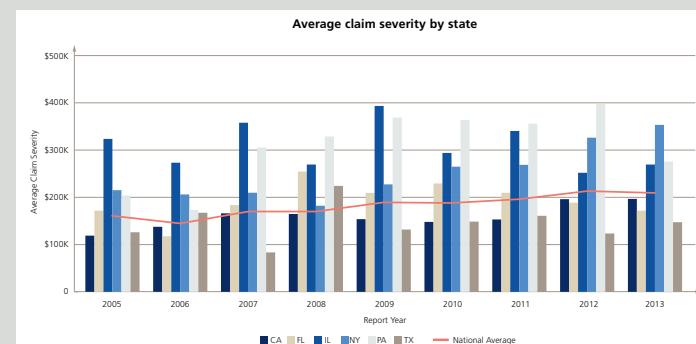
But hospitals are now more exposed than in the past to the traditional types of claims arising from physician actions, such as diagnostic error.¹³ This is especially true in physician employment models on a theory of vicarious liability and through the creation of accountable care organizations (ACOs) and other entities, such as clinically integrated organizations/networks (CIOs/CINs) on a theory of ostensible agency.

Emerging trends: Health care reform

Health care professional liability claims to date have seen little impact from the influence of health care reform. Whether or not the Affordable Care Act will be repealed and replaced is unknown as of this writing. But what will change significantly over the next five years are health care reimbursement methodologies. This will have a profound impact on provider behavior thereby affecting malpractice claims in time.

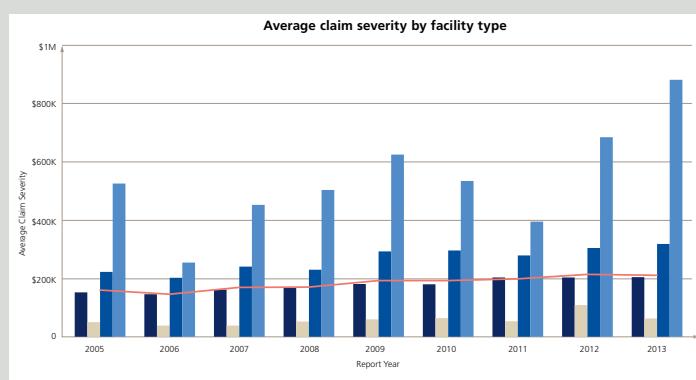
The shift to value-based payment is occurring slowly but will accelerate in the near term. The traditional reimbursement model in the U.S. has been patient volume-based and is titled fee-for-service. CMS and other payers will move to value-based payment reimbursement. The reimbursement methodologies of the future, such as value-based payment, bundled payments and population health/global payments will be based on quality and outcomes rather than just simply payment for treatment rendered.¹⁴

Exhibit 7



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Exhibit 8



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Exhibit 9

FREQUENCY OF CLOSED CLAIMS BY LOCATION

* "All other" includes subacute care hospital units, internal hallways, patient rooms, nurseries and pediatric units, as well as claims with no distinguishing location.

Location	Percentage of closed claims
Inpatient medical unit	18.8%
Emergency department	18.1%
Perioperative areas	15.7%
Inpatient surgical unit	10.0%
Perinatal unit	7.6%
All other*	6.8%
Ambulatory care - nonsurgical	4.6%
Radiology/laboratory/therapy	4.4%
Inpatient behavioral health hospital/unit	4.2%
Outdoor space	3.5%
Rehabilitation hospital/unit	3.4%
Critical care units	2.9%
Total	100.0%

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Exhibit 10

AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY LOCATION
* "All other" includes subacute care hospital units, internal hallways, patient rooms, nurseries and pediatric units, as well as claims with no distinguishing location.

Location	Average paid expense	Average paid indemnity	Average total paid
Perinatal unit	\$101,708	\$338,097	\$439,805
Critical care units	\$59,818	\$290,222	\$350,039
Inpatient behavioral health hospital/unit	\$71,091	\$242,987	\$314,077
Inpatient surgical unit	\$49,851	\$233,959	\$283,810
Emergency department	\$75,310	\$201,569	\$276,879
Ambulatory care - nonsurgical	\$41,347	\$225,907	\$267,254
Inpatient medical unit	\$55,106	\$202,513	\$257,619
Perioperative areas	\$30,521	\$162,361	\$192,882
All other*	\$35,630	\$147,793	\$183,423
Radiology/laboratory/therapy	\$21,657	\$123,415	\$145,071
Rehabilitation hospital/unit	\$20,045	\$92,450	\$112,495
Outdoor space	\$11,136	\$48,417	\$59,553
Overall	\$52,563	\$198,407	\$250,970

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Sources

- 1 A.M. Best. "Strong but Declining Profitability in 2015 for Medical Professional Liability Sector." Best's Special Report, Segment Review. May 9, 2016, p.4.
- 2 Greve, Paul and Milford, Allison. "Do Still Waters Still Run Deep? MPL in 2016." Medical Liability Monitor. Vol. 41, No.10. October, 2016, p1
- 3 Ibid.
- 4 Zurich Insurance. "2016 Benchmark Study of Healthcare Professional Liability Claims," p.4.
- 5 Ibid., p. 8.
- 6 Greve and Milford, p.3.
- 7 A.M. Best, MPL 2016, p.5.
- 8 Roy, Avrik. "In Address to Congress, Trump Backs Away from Universal Care." Forbes, The Apothecary. <https://www.forbes.com/sites/theapothecary/2017/02>
- 9 Pear, Robert. "G.O.P. Bill Would Make Medical Malpractice Suits Harder to Win." New York Times. April 16, 2016, p14.
- 10 PIAA Newsbriefs. <https://www.piaa.us/wcm/Adocacy/wcm/Advoc.3/31/17>.
- 11 Ibid.
- 12 CNA. Hospital Professional Liability Claims Report 2015,p.5.
- 13 Greve, Paul and Parikh, Divya. "Diagnostic Error: Pervasive and Persistent," PLUS Journal, April 2015. Vol.XXVIII, No.4. pp.1-2.
- 14 McKesson. Population Health Management. "Value-based Reimbursement vs. Volume-based Care." <http://www.mckesson.com/population-health-management/population-health/know-the-challenges/>

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