The Professional Liability Insurance Crisis and the Future Health of North Carolina's Hospitals

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"NO MARGIN, NO MISSION." North Carolina's hospitals have a mission of providing medical care to the community, including anyone in need, whether or not they are poor, without insurance, or unable to pay. Last year, North Carolina hospitals provided over $1 billion in charitable care.[1] In order to continue providing appropriate medical care to the community, each hospital must invest in new medical equipment and technologies, upgrade aging facilities, and maintain competitive salaries for scarce healthcare workers. Without a positive financial operating margin on its balance sheet, a hospital faces a difficult challenge in continuing to provide even basic healthcare services to the community. A negative margin jeopardizes a hospital's ability to continue fulfilling its mission over the long term.

The Financial Stability of North Carolina's Hospitals

Many of North Carolina's hospitals are struggling financially in the face of cuts in reimbursement from government and commercial payers, increases in the number of uninsured, and rising expenses. Over one third of all North Carolina hospitals have negative operating margins. Another third have operating margins below 5%, which is considered financially unhealthy. A study by Deloitte & Touche two years ago indicated that the number of hospitals with both negative operating margins and negative cash balances could soon grow to as many as a dozen if operating margins do not improve.[2]

It is against this backdrop of limited revenue sources and increasing expenses that hospitals find themselves approaching a crisis in the affordability of professional liability insurance. Most North Carolina hospitals have experienced threefold increases in their premiums over the past two years; several have seen increases of 300%-500% in one year alone.[3] What was once a manageable line item in the hospital budget has ballooned into an enormous annual expense that threatens to swallow the operating margins of smaller hospitals; erode community outreach, education, and screening programs; and force reductions in hospital staff.

Few, if any, hospitals in North Carolina have been spared these substantial premium increases, regardless of their size or location. A small, rural hospital in eastern North Carolina saw its professional liability insurance premium jump in one year from $87,956 to nearly $420,000. The premium for a large academic medical center increased from less than $3 million in 2001 to $8 million in 2002 to more than $11 million this year.[4]

The premium increases tell only part of the story. Most insured hospitals have seen their deductibles increase significantly. Many hospitals that previously had first-dollar insured coverage now carry significant deductibles, creating more out-of-pocket expense for the hospital. Larger self-insured hospitals that purchase reinsurance have also been hit by both premium increases and larger self-insured retentions. Two years ago, most of these hospitals could retain the first $1 million in liability on each claim and reinsure the excess liability above that amount with a reinsurance carrier. Today, many of those hospitals are required to absorb as much as $3 to $4 million on each claim before insurance kicks in. Those same hospitals have also sustained enormous reinsurance premium increases.[5]

These types of premium increases cannot be sustained in the future without adverse impact on hospitals' ability to provide essential services to the public. Revenue for hospitals is limited. Government reimbursement generally does not cover the cost of hospital services for patients covered by government programs, and commercial managed care companies are constantly pushing for more discounts from providers. As the State has struggled with its own budget recently, there have been no inflationary increases for hospitals or other providers in the state Medicaid program, even though caring for Medicaid patients costs providers more each year. Medicare rate increases have also lagged behind the increasing costs hospitals have faced.[6] The State Employees Health Plan, which covers more than 500,000 state employees, teachers, dependents, and retirees, has also drastically reduced reimbursement to hospitals and physicians over the past two years. With revenue limited and expenses—particularly professional liability insurance premiums—con-

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tinuing to rise, hospitals will be forced to trim services, personnel, or other items from their budgets in order to make ends meet.

Compounding the problem for hospitals is the professional liability insurance situation for physicians. With many obstetricians, neurosurgeons, and other specialists reporting substantial premium increases for their own malpractice insurance, hospitals are becoming increasingly concerned about their long-term ability to continue providing the level of emergency services, surgical services, and other high-risk services that their communities need. In addition to jeopardizing needed healthcare for the community, the loss or reduction of these services within a hospital can have a serious financial impact on the hospital. Recently, a news article noted that Onslow Memorial Hospital in Jacksonville, North Carolina, is losing over $1 million per month because of the loss of several physician specialists. Although the cost of malpractice insurance was not the only culprit, the increased insurance premiums and the concerns about liability for high risk services were noted as contributing factors in the loss of the specialists. [7]

Is the Insurance Market to Blame?

Some contend that the increased premiums are simply the result of a cyclical insurance market, losses by insurers in a depressed stock market, and the reluctance of reinsurers to underwrite more business after the 2001 terrorist attacks. Although each of these factors may play a role in increased premiums, it is the amount being paid out in medical malpractice judgments and settlements that is fueling the rapid escalation in premiums. North Carolina medical malpractice claims payouts have more than doubled between 1992 and 2001, increasing at more than three times the rate of general inflation and twice the rate of medical inflation.

Claims over $1 million represent a growing percentage of malpractice awards. Malpractice insurance in North Carolina is more unprofitable for insurers than across the country generally, with combined losses and expenses reaching $1.66 being paid out for every $1.00 in premium collected. Few insurance companies are willing to write insurance in an unhealthy market. St. Paul, historically one of the larger underwriters of medical malpractice insurance in North Carolina, withdrew from the state last year. Several insurers, including PHICO and the Reciprocal of America, which provided insurance to a number of North Carolina hospitals, went insolvent within the past 24 months.

What About Medical or Professional Errors?

Our current legal system leaves hospitals, doctors, and other healthcare workers exposed to enormous claims liability. Healthcare is a complex system of care and treatment which is continuously evolving. Advancements in healthcare and medical technology have increased consumer expectations about medical care. Recently, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics released a report indicating that the majority of newborn brain injuries are not caused by lack of oxygen during labor and delivery, as previously believed, but are instead the result of problems that occurred before labor. Many obstetricians and other providers have reportedly been sued in the past on the assumption that they could have taken action during the labor and delivery to prevent the brain damage. [8]

Hospitals and other healthcare providers do make mistakes. There is no question that a patient who suffers an injury through the fault of a healthcare provider should be compensated for past and future medical care, lost wages, loss of future earnings, and other economic losses. These damages can be identified, measured, and justly compensated. But there is no yardstick for a jury to use to value and measure noneconomic losses, such as pain and suffering, nor is there a limit on how much the jury can award. Although it is not known how much of the average award in North Carolina is attributable to noneconomic damages, data from a couple of other states suggest that it may be substantial. A recent Texas report indicates that noneconomic damages represent 77% of the awards in Florida, 70% of the awards in Texas, and 50% or more of the awards in all states without caps on noneconomic damages. [9]

The Need for Reasonable Limits on Noneconomic Damages

The General Assembly has stepped in before to put limits on damages that are difficult to quantify. In 1995, the legislature placed a cap on punitive damages and adopted new criteria governing when these types of damages are appropriate.[10] Placing a reasonable cap on noneconomic damages would go a long way towards restoring a sense of fairness to our legal system and containing rising premium increases over the long run. Providers do not expect insurance premiums to plummet overnight if a noneconomic damages cap is enacted by the legislature. The effectiveness of the cap is in its long-term impact. California enacted a $250,000 cap on noneconomic damages in medical malpractice actions in 1975. Since that time, professional liability insurance premiums nationwide have increased three times more than rates in California.[11] In Oregon, malpractice payouts remained in check while a cap on noneconomic damages was in effect, but they began a steady rise upward when the cap was later struck down.[12] Studies by the United States Department of Health and Human Services also show lower premium increases in states with noneconomic damages caps than in states without them.[13]

Many states have enacted caps on noneconomic dam-

ages, including several states that took action this year. Within the past 12 months, several states have taken action to either put a cap in place or lower their existing caps on noneconomic damages. These states join at least 20 others that already place a cap on noneconomic damages.[14] States have taken different approaches with their caps, with some allowing inflationary increases in the cap and others making certain exceptions to the cap. A reasonable cap on noneconomic damages that leaves the patient fully compensated for all economic damages is a fair and balanced solution to addressing the increasing costs of medical malpractice payouts.

Other Reforms Needed As Well

Hospitals also support other meaningful reforms that will help contain costs and ensure future access to medical care. The North Carolina Hospital Association has joined with the North Carolina Medical Society and the North Carolina Healthcare Facilities Association to promote a package of reforms to address problems with the current litigation system. Among the other proposed reforms are contingency fee limits, periodic payment of damages, limits on double recoveries by plaintiffs, and improvements in the quality assurance privilege laws for healthcare institutions.[15] Reasonable limits on contingency fees will ensure that the most seriously injured patients keep more of the damages they are awarded. Reform of the collateral source rule will also help. Currently, some plaintiffs recover for the same injury twice – once from the healthcare provider and again from other available sources, such as government programs or insurance benefits.

Every healthcare facility and its medical staff want to ensure that quality healthcare is being provided to patients. Mistakes do occur in the delivery of healthcare. Learning from those mistakes and ensuring that they do not reoccur is a focus for all providers. For example, when a serious medical error occurs, a hospital performs a "root cause" analysis that examines what went wrong in the system that led to the error. This type of analysis looks beyond individual fault and searches for system improvements that can be made to prevent such errors in the future. It is critical that hospitals, nursing homes, physicians, and others involved in the evaluation of quality can conduct these analyses with complete candor and thoroughness in a confidential environment. Peer review, root cause analysis, and other patient quality activities are an ongoing and important part of patient healthcare today.

Hospitals have also taken matters into their own hands in an effort to address the problems in the professional liability insurance market. Approximately 30 North Carolina hospitals, mostly smaller hospitals, have joined together to self-insure their professional liability exposure through an insurance consortium. The Consortium is designed to help leverage the purchasing power of this group of hospitals, save on some administrative expenses, and give the hospitals more control and direction over the settlement of their own claims. However, even the Consortium has been unable to spare participating hospitals from the same 300%-400% increases that other hospitals have seen. In fact, Consortium hospitals may see even higher costs in the beginning because of the combination of higher premiums and a required capital contribution for participation in the Consortium. The same legal environment that drives costs in the commercial insurance market also affects the Consortium and its rates.

Hospitals and the Communities They Serve

The financial health of hospitals is critical for their survival. Many people do not realize that the financial health of a community and its hospital are often tied together. Hospitals are one of the largest employers in the State, providing jobs to more than 135,000 persons. In many areas, the hospital is the largest employer, or among the largest employers, in the county. The economic impact of hospitals in many of our communities is enormous. Businesses considering relocation to North Carolina look at the availability of hospitals and healthcare services for their employees and their families. Hospitals are truly part of the economic engine in this State.

Spiraling professional liability insurance premium increases and other expenses must be reigned in if hospitals, especially small rural hospitals, are to survive and continue providing healthcare to our communities and jobs for our workers. Many of these hospitals have seen professional liability insurance premium increases in one year alone that threaten to wipe out their small operating margins or push negative operating margins even deeper. The vast majority of the hospitals in North Carolina are nonprofit, and their operating margin inures directly to the benefit of the community in terms of increased services, upgraded facilities, and other improvements in the delivery of healthcare. As one financial analyst noted, "If a nonprofit organization plans for only a financial break-even, it will be gradually starved of necessary capital investment. This slow process can eventually render it impossible for the organization to continue providing services."[16]

Hospitals and other healthcare providers need reasonable reforms to address the professional liability insurance situation. Hospitals and other healthcare providers also need adequate funding from Medicaid, Medicare, and other payers to ensure that we are keeping up with the cost of treating patients. Together, these efforts will help ensure that hospitals can continue delivering healthcare services, providing jobs, and serving as the healthcare safety net in our communities.

NOTES AND REFERENCES

1 NCHA Future of Reimbursement Study. Deloitte & Touche, 2001;35. In addition to treating the uninsured, hospitals also do not recover their costs in treating Medicare and Medicaid patients. The reimbursement "gap" for hospitals, which measures both the cost of treating the uninsured and the unreimbursed costs of treating Medicare and Medicaid patients, is approaching $2 billion per year for North Carolina's hospitals.

2 NCHA Future of Reimbursement Study, pp. 57-59.

3 NCHA Premium Survey, April, December 2002; May, 2003.

4 NCHA Premium Survey.

5 NCHA Premium Survey.

6 This is based on a comparison of rate increases in Medicare to the national hospital market base inflation rate.

7 Papandrea R. Hospital: $1 million a month lost with the departure of physicians. Jacksonville, NC: *Jacksonville Daily News*, June 30, 2003.

8 Gordon S. Newborn brain injury unlikely to occur during delivery; obstetricians and periatricians cite underlying causes. Healthscout News, January 31, 2003. The article quotes Gary Hankins, chairman of the ACOG task force that developed the report, on the issue of litigation, noting the following: "Hankins says the assumption that labor and delivery caused these conditions has been a huge litigation problem for obstetricians, and he hopes this report will help to educate obstetricians, the public, and judges and juries. Of the 6%-10% of cases attributable to labor and delivery problems, Hankins concedes that some of those cases are due to inadequate medical care, but says many also stem from highly challenging delivery problems, such as uterine rupture."

9 Critical condition: how lawsuit abuse is hurting healthcare and what Texans can do about it. Texas Public Policy Foundation, April 2003.

10 North Carolina General Statutes, Chapter 1D.

11 Health Coalition on Liability and Access, Medical Liability Reform. The answer to soaring insurance premiums. Available at: www.hcla.org

12 Hurley JD. Medical malpractice insurance dimate in North Carolina. Tillinghast-Towers Perrin, May 2003.

13 Confronting the new healthcare crisis: improving healthcare quality and lowering costs by fixing our medical liability system. US Department of Health and Human Services, July 25, 2002.

14 American Medical Association. American Tort Reform Association. The states that have taken recent action on caps are Idaho, Mississippi, Nevada, Ohio, Texas, and West Virginia.

15 House Bill 809. North Carolina General Assembly, 2003 session.

16 Fallon RP. Healthcare Management Review. Deloitte & Touche, 1991.