Trends in Malpractice Premiums for Dermatologists

Results of a National Survey

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Objective: To analyze professional liability premiums in dermatology and factors associated with premium variation.

Design: This study examines data from a survey of dermatologists conducted in 2004.

Results: Survey respondents (n=1095) reported mean medical liability premiums of $10,898 in 2004 (95% confidence interval, $10,295-$11,501). Premiums increased by 24.4% in 2003 and 16.7% in 2004. There was substantial variation by state, and mean premiums were higher in American Medical Association (AMA)-declared “crisis states” than in those states listed as “currently OK” ($11,669 vs $9,527; P=.03). Premium growth from 2002 through 2004 was higher in AMA crisis states and in states without $250,000 caps in place for noneconomic damages. Even when excluding payment for cosmetic riders, premium levels were higher for dermatologists spending more than 10% of their time in cosmetic practice ($13,816 vs $10,185; P<.001) or more than 30% of their time in noncosmetic surgery ($12,551 vs $10,453; P=.01).

Conclusions: While premiums paid by dermatologists for professional liability insurance in 2004 were well below those experienced by higher-risk specialties, geographic factors and state tort law variation seem to be affecting dermatology premiums in much the same way they affect the field of medicine as a whole.

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In the last decade, the increasing cost of the medical malpractice system has received a great deal of attention. While the causes of and proposed solutions for cost increases remain highly controversial, their existence is well established. In 2001, median awards in malpractice trials exceeded $1 million, an increase of 176% from 1994. Out-of-court settlements (which account for 96% of payouts) averaged $299,000 per individual defendant in 2001. Total payments for malpractice claims increased at an annual rate of 26.3% over the period 1998 through 2002. As these payouts increased, carriers collectively paid out $1.42 for every dollar of premium revenue they collected in 2002. The largest national medical malpractice carrier and some large multistate physician-backed liability firms have completely left the market.

During the same period, physicians have experienced growing professional liability insurance premiums, which totaled more than $21 billion in 2001. In the 10 years preceding 2001, premiums increased 3 times faster than overall inflation and twice as fast as medical inflation. Certain specialties and geographic areas have been affected more than others—premiums for obstetricians in Florida averaged $201,376 in 2002. In addition to avoidance of high-risk activities, specialties with high litigation and high premiums are reporting increasing difficulty in recruiting trainees to their fields.

While many have argued that increasing jury awards and settlements have been the primary driver of premium growth, others have suggested alternative hypotheses. Two factors cited include declining investment returns on premiums invested by insurance companies and increasing costs of reinsurance.

The law governing medical liability varies greatly among the states, and the American Medical Association (AMA) has identified “crisis states” in which the liability situation has led to declines in patient access to care. A few states have enacted a variety of tort reforms. Perhaps the best known longstanding reform is California’s Medical Injury Compensation Reform Act (MICRA), enacted in 1976. That law included a $250,000 cap on noneconomic damage awards, as well as contingency fee limits and a collateral source rule that allows juries to hear about other benefits available to an injured patient. From 1976 through 2001, while premiums increased by 569% in the rest of the United States, they increased by 85% in California.
States, California’s medical liability premiums only rose by 18.2%. By the year 2000, those states with damage caps had 12% more physicians per capita than other states, and in 2002, premiums in states with caps were 17.1% lower than in states without caps. Some other states have taken different approaches, including pretrial screening panels, limits on joint and several liability, and compensation funds to cover high-end losses.

Medical liability premiums also vary tremendously by specialty. Dermatology has been considered a relatively low-risk specialty, but almost no data are available on patterns of dermatology premiums. A study published in 1981 found that dermatologists accounted for only 0.7% of total paid claims between 1975 and 1978 and that payments from these claims represented 0.6% of dollars paid (at a time when dermatologists were 1.4% of all practicing physicians). Failure to diagnose malignant neoplasms is the most common reason for suits against dermatologists, with cases of melanoma generating the highest payouts. The present study examines data from a survey of dermatologists conducted in 2004 to analyze professional liability premiums for dermatologists and factors associated with premium variation.

### METHODS

In November 2004, the American Academy of Dermatology Association (AADAs) mailed a 2-page liability survey to its members. The survey included a number of questions about professional liability policies and premiums over the preceding 3-year period, as well as some questions about practice patterns. Of 8417 dermatologists surveyed, 1355 (16.1%) responded. Of these, 1095 were in active practice in the United States and supplied usable data about their premiums. Further analysis for this study (using DataDesk 6.1; Data Description Inc, Ithaca, NY) was performed under exempt status approved by the institutional review board of the University of California, San Francisco. Tests were used to compare mean values between subsets of respondents (2-sample) or between years (paired), and $P<.05$ was considered significant.

States were defined according to their AMA crisis level based on the AMA crisis map in circulation at the time of the study. Those states that had caps on noneconomic damages for at least 2 of the 3 years asked about in the study were considered to have caps for the purpose of the analysis.

### RESULTS

The survey respondents reported mean medical liability premiums of $10 898 in 2004 (95% confidence interval, $10 295-$11 501; median, $8 500). This was significantly higher (Table 1) than the mean premiums for each of the previous 2 years ($9 341 in 2003 and $7 506 in 2002; $P<.001$). Most respondents (59.6%) reported per occurrence coverage limits of $1 million, and only 14.8% had limits of $500 000 or less. There was no significant change in the distribution of coverage limits from 2002 through 2004.

Premiums varied significantly by state (Table 2), and state location was the most strongly predictive factor of premium levels in a series of regression analyses. The states with the highest mean premiums included Alabama, Arizona, Florida, Nevada, Ohio, Washington, and West Virginia. When respondents were grouped by their state’s liability crisis level (as defined by the AMA), there were significant differences in mean premiums for dermatologists (from $11 669 in “crisis” states to $9 527 in “currently OK” states; $P=.03$). The mean increase in indi-

### Table 1. Annual Dermatology Medical Liability Premiums by Year, 2002-2004*

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median, $</td>
<td>6000</td>
<td>7267</td>
<td>8500</td>
</tr>
<tr>
<td>Mean, $</td>
<td>7506</td>
<td>9341</td>
<td>10 898†</td>
</tr>
</tbody>
</table>

*Excluding cosmetic riders and state liability fund costs.
†Mean premiums in 2004 were significantly higher than those in 2002 and 2003 ($P<.001$).

### Table 2. Dermatology Medical Liability Premiums by Subgroups, 2004*

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>No. of Respondents</th>
<th>Median, $</th>
<th>Mean, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice pattern</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;10% Cosmetic practice</td>
<td>215</td>
<td>10 200</td>
<td>13 816†</td>
</tr>
<tr>
<td>≤10% Cosmetic practice</td>
<td>880</td>
<td>8215</td>
<td>10 185</td>
</tr>
<tr>
<td>&gt;30% Noncosmetic surgery</td>
<td>232</td>
<td>9584</td>
<td>12 551†</td>
</tr>
<tr>
<td>≤30% Noncosmetic surgery</td>
<td>863</td>
<td>8233</td>
<td>10 453</td>
</tr>
<tr>
<td>State AMA-defined crisis level</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>States in crisis</td>
<td>648</td>
<td>9051</td>
<td>11 699§</td>
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<tr>
<td>States showing problem signs</td>
<td>272</td>
<td>8500</td>
<td>9941</td>
</tr>
<tr>
<td>States “currently OK”</td>
<td>175</td>
<td>7046</td>
<td>9027</td>
</tr>
<tr>
<td>Presence of state liability reform</td>
<td>563</td>
<td>8472</td>
<td>10 748</td>
</tr>
<tr>
<td>No caps on noneconomic damages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caps in place (&gt;=$250 000)</td>
<td>417</td>
<td>8500</td>
<td>11 261</td>
</tr>
<tr>
<td>$250 000 Caps in place</td>
<td>114</td>
<td>8598</td>
<td>10 339</td>
</tr>
</tbody>
</table>

Abbreviation: AMA, American Medical Association.
*Excluding cosmetic riders and state liability fund costs.
†The mean premium was significantly higher for >10% cosmetic practice ($P<.001$).
‡The mean premium was significantly higher for >30% noncosmetic surgery ($P=.01$).
§The mean premium for dermatologists in crisis states was significantly higher than the mean in “some problem sign” states ($P=.004$) and the mean in “currently OK” states ($P=.03$).
idual premiums for dermatologists from 2002 through 2004 (Table 3) also varied by AMA crisis level ($4190 in “crisis” states and $2639 in “currently OK” states).

Premium growth also differed depending on the presence or absence of legal caps on malpractice awards for noneconomic damages in the dermatologist’s state. In states with caps of $250 000 in place, mean premium growth from 2002 through 2004 was only $2089 (vs $3556 in states without caps and $4551 in states with caps exceeding $250 000). Actual premium levels in 2004, however, were not associated with the presence or absence of caps. Dermatologists in a few states also reported significant annual payments to state patient compensation funds in addition to their regular liability premiums. These payments were prevalent among respondents in Indiana, Kansas, Louisiana, Nebraska, Pennsylvania, South Carolina, and Wisconsin.

Even when excluding cosmetic riders, premium levels varied depending on the amount of cosmetic and surgical practice. Dermatologists who reported spending more than 10% of their time in cosmetic practice had a mean annual premium of $13 816 (vs $10 185 for those with less cosmetic involvement; P < .001). Dermatologists who reported spending more than 30% of their time in noncosmetic surgery also had higher premiums compared with those who reported spending 30% of their time or less ($12 551 vs $10 453; P = .01). In a multivariate model, the effects of both surgical and cosmetic time were independently significant.

Only 23 respondents (2.1%) reported purchasing cosmetic riders on top of their basic dermatology liability coverage. The mean cost of a cosmetic rider was $17 548. Thirteen (56.5%) of those with cosmetic riders reported currently performing liposuction procedures. Most of those with cosmetic riders reported that more than 10% of their time was spent on cosmetic dermatology (one reported 100% cosmetics and another reported 80% cosmetics). Only 35 respondents (3.2%) reported having had a malpractice lawsuit filed against them in 2004 (almost unchanged from the 34 suits the same respondents reported in 2002). Of these, 5 (14.3%) reported multiple suits filed in 2004. Those with lawsuits filed in 2002 had a mean premium increase over the 2 following years of $6211 (vs $3705 for all others; P = .40).

Table 3. Dermatology Medical Liability Premium Increases by Subgroups, 2002-2004*

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>No. of Respondents†</th>
<th>Median Increase, $</th>
<th>Mean Increase, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>State AMA-defined crisis level</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>States in crisis</td>
<td>557</td>
<td>2700</td>
<td>4190‡</td>
</tr>
<tr>
<td>States showing problem signs</td>
<td>223</td>
<td>2514</td>
<td>3463</td>
</tr>
<tr>
<td>States “currently OK”</td>
<td>139</td>
<td>1173</td>
<td>2639</td>
</tr>
<tr>
<td>Presence of state liability reform</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No caps on noneconomic damages</td>
<td>482</td>
<td>2384</td>
<td>3556</td>
</tr>
<tr>
<td>Some caps in place (&gt;$250 000)</td>
<td>344</td>
<td>2544</td>
<td>4551</td>
</tr>
<tr>
<td>$250 000 Caps in place</td>
<td>92</td>
<td>1000</td>
<td>2089§</td>
</tr>
</tbody>
</table>

Abbreviation: AMA, American Medical Association
*Excluding cosmetic riders and state liability fund costs.
†The number analyzed was lower for this table because of missing data for 2002 premiums for some respondents.
‡The mean increase for dermatologists in crisis states was significantly higher than the mean for all other dermatologists (P = .03) but was not significantly higher than individual means for states showing problem signs (P = .12) or states “currently OK” (P = .054).
§Mean increase for dermatologists in states with $250 000 caps was significantly lower than the means for no caps (P = .03) and some caps (P = .201).

While premiums paid by dermatologists for professional liability insurance in 2004 were well below those for many other specialties, a number of patterns established in this study are consistent with findings across the practice of medicine. The premium growth seen for dermatologists (24.4% in 2003 and 16.7% in 2004) was similar to the 15% to 30% average premium increases seen in most other specialties.6

The high premiums for dermatologists seen in Arizona, Florida, Nevada, Washington, and West Virginia were not surprising given the events taking place in those states. Florida has seen a decline in the number of insurers offering coverage, shortages of neurosurgeons, and declining availability of obstetricians. Nevada has lost physicians to other states, and its only level 1 trauma center closed for a period in 2002. West Virginia saw 5% of its physicians retire early or leave the state because of rising malpractice rates. Washington’s largest provider of malpractice coverage to rural hospitals was forced into receivership, and 19% of the state’s obstetricians stopped delivering babies.1

The very low premiums in Indiana and Wisconsin may be associated with the presence of medical tort reform in those states. The relatively low premiums in New York, however, are somewhat surprising given the moderate to high prices paid by other physicians in that state.13

Mean premiums for dermatologists, as well as the rate of growth of premiums, was consistent with predictions that might be made based on the AMA’s list of crisis states. Dermatologists in AMA crisis states paid significantly more and saw significantly higher premium increases compared with their colleagues in other states.

When grouping respondents by the presence of caps on noneconomic damage awards in their states, however, the picture was slightly more complex. There was no significant difference in actual premium levels in 2004, but the rate of increase was significantly less in those states that had caps of $250 000. One possible explanation for the lack of difference in current premiums is that some of these caps were initiated in response to recent liability crises, so those states with caps might be more likely to have had higher rates that precipitated recent tort reforms. The lower rate of increase in the states with those caps suggests that they may be effective in slowing the growth of premiums. It is notable that caps set at levels over $250 000 did not seem to affect the growth of dermatology premiums.

Very few dermatologist respondents were carrying cosmetic riders on top of their basic professional liability poli-
cies. Those with cosmetic riders were likely to perform liposuction or donate a large amount of their time to cosmetic procedures. Even among those without cosmetic riders, however, a high rate of cosmetic or surgical activity was associated with higher premiums. It is not clear whether professional liability carriers are assessing practice patterns and responding with premium adjustments or whether dermatologists with highly cosmetic or surgical practices are seeking more expensive policies that might have additional benefits.

While the number of respondents with recent lawsuits filed was too low to allow for robust analyses, those with suits in 2002 tended to have higher premium increases in the subsequent 2-year period. This suggests that premiums might be sensitive to a history of suits filed, but the small number of suits reported precluded an analysis that controlled for geographic location. It is also possible that those with lawsuits filed lived in more litigious states and that their premiums instead rose for that reason.

The use of the AADA study to analyze liability premiums has some limitations. The study had a relatively low response rate, but there is no clear reason to believe that the respondents would have different premium levels than those paid by nonrespondents. The study also relied on self-report and physician recall of premiums paid over a 3-year period. The survey, however, was brief and focused, and respondents probably had easy access to the data required to report premiums paid.

Medical malpractice premium instability and its effects on physician practice and patient access have received a great deal of attention in recent years. Some states have passed limits on noneconomic damages (pain and suffering and punitive damages) while preserving patients' abilities to recover full economic losses and medical expenses. Active debate over reform action at the federal level continues. Dermatology premiums are far below those experienced by higher-risk specialties, but geographic factors and state tort law variation seem to be impacting dermatology premiums in much the same way they affect the field of medicine as a whole.

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Disclaimer: Dr Resneck serves in the House of Delegates of the American Medical Association as a representative of the American Academy of Dermatology.

REFERENCES