Medical Liability Insurance as a Barrier to the Provision of Abortion Services in Family Medicine

Christine E. Dehlendorf, MD, MAS, and Kevin Grumbach, MD

Family physicians who wish to provide abortions have been subject to both denial of coverage by medical liability insurers and the imposition of large premium increases. These policy decisions by insurance companies raise questions about the role of family physicians in abortion care and about the autonomy of medical specialties in defining their scope of practice.

We review the issues specific to abortion services in the primary care setting and examine the broader implications for the medical profession. Finally, we review how advocacy and improved regulation of the insurance industry could help to ensure that clinicians who are trained and willing to provide services to their patients are not limited by the decisions of medical liability insurers. (*Am J Public Health*. 2008;98:1770–1774. doi: 10.2105/AJPH.2008.136325)

IN 2004, A FAMILY PHYSICIAN in New York State decided that he would offer medication abortion with mifepristone and misoprostol to patients in his practice who desired early pregnancy termination. He received training in medication abortion and made arrangements for back-up surgical abortion coverage in the event of unsuccessful termination. He also wrote his medical liability carrier a letter to inform them of his plans. Although he was accustomed to prescribing medications with potential toxicity, such as sildenafil, warfarin, and oxycodone, without requesting clearance from his liability carrier, he decided that it would be prudent to notify the company of his plans to prescribe mifepristone. To his surprise, he received the following reply from the carrier:

> Our determination is that this procedure will be covered for OB/GYN physicians only. We do not believe this falls within the accepted scope of practice for a Family Physician, and therefore will not cover a family physician who provides Mifepristone in their [*sic*] practice. (R. Morrow, written communication, May 2006).

The treatment of this physician—and many others like him—by liability insurance carriers raises questions that are specific to abortion care, as well as more fundamental questions about the autonomy of the medical profession. Here we explore the issues regarding liability insurance for family physicians providing abortions: Is abortion within the scope of practice for family physicians? Are there in fact legitimate concerns about the liability risk associated with abortion care performed by members of this specialty that justify limitations on women's access to pregnancy termination? In addressing these issues, we also draw attention to the more far-reaching questions: Who has the authority to define the scope of practice of physician specialties? Is it appropriate for insurers to make medication-by-medication decisions about coverage of the liability risk associated with prescribing drugs approved by the Food and Drug Administration? How are decisions about coverage of specific medical services made? Finally, what actions can be taken to ensure that restrictions on malpractice coverage do not inappropriately limit physicians' ability to provide care to their patients?

BACKGROUND

More than 1 million abortions are performed in the United States every year,[1] and it is estimated that 44% of women will have an abortion in their lifetime.[2] Although there is therefore a large need for abortion services, women's ability to access them is increasingly limited. Nationally, 87% of counties have no practicing abortion provider,[1] and the number of sites providing abortions decreased by 11% between 1996 and 2000[3] and by 2% between 2000 and 2005.[1]

One strategy that has been suggested to reverse the shrinking pool of abortion providers is to increase the number of family physicians who provide these services.[4,5] Family physicians provide care to women of reproductive age and are trained to perform many office-based procedures. Further, first-trimester aspiration (also known as surgical) abortion and medication abortion are low-risk procedures that can be safely provided in an out-patient setting, with a serious complication rate of 0.2% or lower.[6,7] In addition, many family physicians provide care in areas with limited access to other health care providers,[8] such as rural communities, and therefore may increase access where it is needed most. Increasing integration of these services into primary care practice could lessen the inconvenience to women of traveling long distances to obtain abortions, the medical risks associated with delays in abortion, and the harassment women often suffer when entering large abortion clinics.

LIABILITY INSURANCE AS A BARRIER

A growing number of family medicine residency programs now offer training in medication and first-trimester aspiration abortion, and an expanding cadre of family physicians are prepared to provide these services. The cost and

availability of liability insurance have emerged as a prominent barrier for these physicians in published reports[9,10]; this was confirmed in our communications with practicing providers. In the most extreme cases, insurance carriers have refused altogether to provide coverage for family physicians providing abortion. Even when insurers agree to cover family physicians, the premiums may not be affordable. Abortion is often covered as part of existing comprehensive liability policies for the minority of family physicians who perform obstetrics, but for other family physicians, abortion riders cost as much as $10 000 to $15 000 per year. This cost is comparable to the average annual cost of basic coverage for family physicians, reported at $12 300 in 2002.[11]

In many cases, physicians who wish to prescribe medications—mifepristone and misoprostol—to induce abortion have been subjected to the same limitations that are imposed on physicians performing first-trimester aspiration abortion, a surgical procedure. Some medical liability insurance carriers refuse to provide coverage altogether or charge the same premiums for liability coverage for medication abortion as for aspiration procedures.

These coverage decisions do not affect only family physicians. Other primary care providers, including internists[12] and advanced-practice clinicians,[13] are increasingly receiving training in early pregnancy termination with the goal of incorporating this service into their primary care practices. Limitations on coverage will likely affect these providers as well.

ASSESSING THE MERITS OF THE COST OF AND LIMITATIONS ON LIABILITY COVERAGE

What evidence justifies the determination by some carriers that abortion should not be performed by family physicians? In fact, there is considerable precedence for the place of abortion within the scope of practice for the specialty of family medicine. Aspiration abortion for pregnancy terminations up to 10 weeks' gestation is listed as an advanced skill by the American Academy of Family Physicians,[14] and a 1997 survey of members of the National Abortion Federation found that 18% were family physicians.[15] Many family physicians participated in the original trials of mifepristone that led to approval by the Food and Drug Administration.[16,17] Finally, the safe and effective provision of medication and aspiration abortion by family physicians has been extensively described in the literature.[18–21] Further, it is the position of the American Academy of Family Physicians, the specialty society for family medicine, that

> clinical privileges should be based on the individual physician's documented training and/or experience, demonstrated abilities and current competence, and not on the physician's specialty.[22]

Therefore, the unilateral determination by some liability carriers to deny coverage for abortion services by family physicians appears to be an inappropriate intrusion on medical practice.

What about the rationale for the large premiums for abortion riders? This might be justified if abortions provided by family physicians were associated with a large liability risk. However, the evidence suggests that the charges are out of proportion to the true risk involved. Although liability risk is not exactly equivalent to medical risk, the low complication rate associated with first-trimester termination indicates that the increase in liability is also likely to be low. Our research identified no available public data on liability risk for abortions. Therefore, to better quantify this risk, we obtained information about all abortion-related payments in 1996 to 2005 from the National Practitioner Databank, a federally administered database that lists all malpractice payments.

During this period, 756 payments were made for cases involving abortions (including those performed after the first trimester; Table 1). These payments totaled $157 million, and only 1, for $585 500, was identified as being related to a medication abortion. Assuming all other payments were related to surgical abortions, and with a total of 14.1 million surgical abortions performed in the United States over this period,[1] the average liability payout for abortion was approximately $11 per procedure. Therefore, a primary care physician performing 10 procedures per month would have an average cumulative liability of approximately $1320 per year.

Although this estimate is an oversimplification of the actuarial process used for premium rate setting and does not include administrative costs, it is the best estimate possible given the data available; more-accurate calculations would require liability carriers to make information about their actuarial models public. Our calculation most likely overestimates the costs involved for family physicians, because family physicians generally provide only first-trimester abortions, which are associated with fewer adverse outcomes than are second-trimester procedures.[23] The recent approval of mifepristone limits conclusions about the liability

TABLE 1—Abortion-Related Medical Liability Payments, 1996–2005

	No.
Payments, no.	756
Total abortions in United States[a]	14.1 million
No. payments per million abortions	53.62
Median payment,[b] $ (25%, 75%)	88 037 (27 225, 235 950)
Amount of liability payment per abortion performed, $	11.11

[a]Figure is for 1991 to 2000 because of the time lag between the incident leading to a liability claim and the liability payment.
[b]In 2006 dollars.

risk involved with medication abortion. Overall, the premiums charged to family physicians providing abortions seem to be out of proportion to the financial risk.

The denial of coverage and increased premiums charged by liability insurers to physicians who provide medication but not aspiration abortions is especially troubling. To our knowledge, no other medication prescribed in the primary care setting is singled out in this manner by liability carriers, despite the fact that many other medications have toxicities equal to or greater than the combination of mifepristone and misoprostol. For example, a recent review of out-patient anticoagulation with warfarin found that 2.3% of patients using this medication were hospitalized in a year for warfarin-related complications,[24] fluoroquinolone antibiotics have been associated with an incidence of tendon rupture as high as 4 in 1000,[25] and the incidence of anaphylaxis with angiotensin-converting enzyme inhibitors is approximately 0.5%.[26] Because these medicines, and many others with known toxicities that are prescribed daily by family physicians, are not associated with increased premiums, mifepristone appears to have been singled out in an unprecedented manner.

THE DISCONNECT BETWEEN INSURER POLICY AND DATA

First-trimester abortion appears to be well defined within the scope of family medicine, and the premiums charged for liability coverage for abortion services seem to be unreasonable in comparison with the liability risk involved. Is this incongruence between liability insurer practices and the evidence the result of standard business practices, or is there more to the story? Two aspects of normal business operations by malpractice insurers offer potential explanations: the grouping of services under physician classifications and the cautious approach to insuring unknown risks.

The determination of malpractice rates is partially based on physician scope of practice. When insurers group procedures together to define the insured scope of practice, decisions about how procedures are categorized affect the cost of insurance. Lower-risk procedures may be classified with higher-risk procedures for simplicity and convenience[27] or simply because the relative liability risks are not understood. The categorization of first-trimester abortion with other procedures with higher medical risks, such as obstetrics, could explain the high premiums.

An additional factor that insurance companies consider in determining the cost of a premium is uncertainty about the liability exposure associated with a specific service. Insurers may charge higher premiums for services when only incomplete actuarial data are available, because they want to limit their liability associated with insuring an unknown risk.[28] The recent increase in family physicians who provide abortions may have introduced this type of uncertainty into insurers' rate-setting deliberations and resulted in higher premiums.

These underwriting practices may partly explain the high premiums for coverage of abortion services by family physicians. The routine nature of these practices is itself cause for concern, because other services important to public health may incur high premiums through arbitrary application of these principles. In addition, in the case of abortion, it is unlikely that these routine underwriting practices are the only contributing factors. It is difficult to justify the outright denial of coverage to family physicians who wish to provide abortions by evoking standard business practices. Further, the increased premiums associated with provision of medication abortion alone and the magnitude of premium surcharges for coverage of medication or aspiration abortion also suggest that family physicians providing abortions have been singled out for prejudicial treatment. Although we can only speculate about the reasons for this treatment, it is plausible that some decisionmakers at liability insurance companies are apprehensive about potential political fallout from decisions to cover abortions or have personal ethical objections to abortion that influence their business practices.

The probable role of these personal and political influences on liability coverage for abortion has parallels in other areas of female reproductive health, in which governmental and corporate decisionmakers appear to apply different standards than those governing other health care issues. Examples include the willingness of many health insurance companies to include medications for erectile dysfunction but not contraceptives for women as a covered benefit[29] and the prolonged and inordinately complicated process by which over-the-counter status for emergency contraception was approved by the Food and Drug Administration.[30] It has also been suggested that the pharmaceutical industry's relative neglect of development of new contraceptives is at least partly attributable to a desire to avoid controversy associated with these products.[31]

POLICY IMPLICATIONS AND RECOMMENDATIONS

Decisions made by medical liability insurers clearly affect both women who seek access to abortion services and family physicians who wish to provide these services. Further, these actions have implications for health professionals as a whole, raising the specter of medical liability insurers overriding the authority of the medical profession to determine scope of practice for medical specialties, determining premiums on a medication-by-medication basis, and charging inappropriately high premiums for specific services. Health professionals and the public both have a stake in increasing the transparency and fairness of liability insurance rate setting and the determination of scope-of-specialty practice, both for this procedure and for medical practice as a whole.

What steps can be taken to protect medical autonomy and to ensure that insurance companies are held accountable for the

reasonableness of their premiums for liability coverage for abortion services? Medical specialty organizations, legislators, regulators, and malpractice insurers should all be engaged in addressing these issues. Indeed, the American Academy of Family Physicians has an existing policy stating its intent

> to be an advocate for family physicians regarding any mechanism for . . . equitable premium differentials for family physicians . . . based on sound actuarial evidence and standards of care.[32]

To our knowledge, the academy has not actively pursued this policy as it pertains to premium differentials for abortion services. Further action, such as the lobbying of state and federal lawmakers and direct pressure on liability carriers, is clearly warranted, and support from other physician specialty societies and health professional organizations is essential to effectively resist unwarranted incursions by liability insurers on the ability of licensed health professionals to provide services to their patients.

Oversight of the medical liability insurance industry is relatively weak, with differing state regulations and differing enforcement of those regulations.[33] State legislatures and regulators should increase their oversight of the rate-setting process for medical liability insurance to ensure that premiums are actuarially fair and consistent with public health goals. Regulations prohibiting undue discrimination and unfair trade practices that negatively affect consumers and policyholders could enable greater oversight, and increased funding of regulatory agencies could lead to better enforcement of existing regulations.

Liability insurers should also voluntarily remedy their inequitable approach to covering abortion by using actuarial data specific to early pregnancy termination in determining premiums and by acknowledging that first-trimester abortion is within the scope of practice for family physicians, as indicated by extensive and easily available documentation. Clearly there are limitations on the degree to which liability insurers can tailor their coverage for individual services, but increased attention to the public health implications of physician classifications and scope-of-practice determinations could limit the negative consequences of insurance coverage decisions.

Disproportionate premiums and denial of coverage for abortion provision by family physicians limits access to abortion and presents a challenge to the medical profession as a whole. Advocacy by medical specialty organizations, improved regulation of the insurance industry, and increased attention by liability insurers to the effect of their decisions would help to ensure that primary care clinicians who are trained and willing to provide services to their patients are not limited by the decisions of medical liability insurers. ■

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Both authors originated the essay. C.E. Dehlendorf led the writing and performed data analysis. K. Grumbach revised the essay.

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When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals

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As Catholic-owned hospitals merge with or take over other facilities, they impose restrictions on reproductive health services, including abortion and contraceptive services. Our interviews with US obstetrician–gynecologists working in Catholic-owned hospitals revealed that they are also restricted in managing miscarriages.

Catholic-owned hospital ethics committees denied approval of uterine evacuation while fetal heart tones were still present, forcing physicians to delay care or transport miscarrying patients to non–Catholic-owned facilities. Some physicians intentionally violated protocol because they felt patient safety was compromised.

Although Catholic doctrine officially deems abortion permissible to preserve the life of the woman, Catholic-owned hospital ethics committees differ in their interpretation of how much health risk constitutes a threat to a woman's life and therefore how much risk must be present before they approve the intervention. (*Am J Public Health.* 2008;98: 1774–1778. doi:10.2105/AJPH.2007.126730)

OVER THE PAST DECADE, AS Catholic hospitals have merged with and purchased nonsectarian hospitals around the United States, the lay press and legal journals have featured discussion about the impact of these mergers on patient care, particularly with regard to reproductive health.[1–5] The literature has focused on policies prohibiting tubal ligation, contraceptive services, emergency contraception, and abortion. Although other religiously owned and nonsectarian hospitals may also prohibit or limit some of these services, Catholic-owned hospitals are the largest group of religiously owned nonprofit hospitals, operating 15.2% of the nation's hospital beds,[6] and increasingly they are the only hospitals in certain regions within the United States.[7] The result is that Catholic and non-Catholic patients alike come to depend on these facilities for emergencies, childbirth, and routine procedures without knowing how some of their options are potentially curtailed.

The findings reported here were not the original focus of our research. In the process of conducting a qualitative study about abortion provision in the clinical practice of obstetrician–gynecologists, we interviewed 30 obstetrician–gynecologists around the United States. During the interviews, which were conducted in 2006, 6 physicians working with or within Catholic-owned hospitals revealed that they were constrained by hospital policies in their ability to undertake urgent uterine evacuation. They reported that Catholic doctrine, as interpreted by their hospital administrations, interfered with their medical judgment. For example, some of them were denied permission to perform an abortion when uterine evacuation was medically indicated and fetal heart tones were still present.

Catholic-owned institutions and their employees must adhere