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Medical Malpractice Insurance: An Economic Introduction and Review of Historical Experience

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Summary

Insurance is a critical piece of a modern economic system, but one often unnoticed until it becomes prohibitively expensive or its availability is curtailed. Such problems are reportedly occurring in the medical malpractice insurance market today. Many physicians have experienced substantial increases in insurance premiums and there are reports of increasing problems with availability of physician services due to doctors retiring or relocating from areas that have seen high premium increases. This is not the first time such a crisis has been proclaimed; similar events occurred in the latter half of both the 1970s and 1980s.

The fundamental purpose of insurance is to transfer an indefinite risk from one party to another for a definite premium. The pricing of this premium is critical but determining this price is uncertain because it depends on estimates of the chance of a future loss, as well as the estimated value of that loss. The premium will also depend on estimates of future investment gains or losses since an insurer also acts as a financial intermediary and invests the capital that is held in reserve against future losses.

Offering liability insurance for medical malpractice has proven a difficult market for insurance companies for a variety of reasons and the market has been unstable over the past three decades. The recurring market problems have provoked various policy reactions in both state legislatures and in Congress. Assessing the effectiveness of particular policy changes is, however, complex and strong conclusions have typically been equally strongly disputed.

In the 107th Congress, H.R. 4600, whose centerpiece was limitations on tort claims for medical malpractice, passed the House, but was not acted upon in the Senate. This bill was reintroduced as H.R. 5 in the 108th Congress and passed the House on March 13, 2003. The Senate began consideration of S. 11, a substantially similar bill, on July 7, 2003. After two days of debate, a cloture motion was rejected. In early February 2004, the majority leadership of the Senate indicated their conclusion that comprehensive medical malpractice reform could not pass the Senate in the 108th Congress, though narrower measures might be brought forward. Two such narrower bills, S. 2061 and S. 2207, which focus on specific medical specialties, were brought up in late February and April respectively. Both bills, however, failed to achieve cloture and no votes on the underlying bills were taken. Following the absence of progress in the Senate, on May 12, 2004, the House again passed a comprehensive bill, H.R. 4279, which was substantially similar to H.R. 5.

This report examines the economic issues and historical experience surrounding medical malpractice insurance. It includes an explanation of the fundamentals of insurance and how these fundamentals relate specifically to medical malpractice insurance. It also includes a discussion of the evolution of the medical malpractice insurance market since the 1970s and policy changes over this time, including an assessment of these changes It will be updated as major legislative events occur.

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Medical Malpractice Insurance: An Economic Introduction and Review of Historical Experience

Insurance is a critical piece of a modern economic system, but it often goes unnoticed until it becomes prohibitively expensive or its availability is curtailed. Such problems are reportedly occurring in the medical malpractice insurance market in early 2003. Many physicians have experienced substantial increases in insurance premiums. Rising premiums can affect more than simply the income of physicians; there are reports of increasing problems with availability of physician services due to doctors retiring or relocating from areas that have seen high premium increases. There have also been protests and job actions in some locations with hospitals finding it necessary to curtail services and send patients to more distant facilities.[1] This is not the first time such a crisis has been proclaimed, since similar events occurred in the latter half of both the 1970s and 1980s.

The recurring problems have provoked various reactions in the insurance marketplace and in legislatures both at the state level, where insurance and tort law is normally shaped, and in Congress. In the 107th Congress, H.R. 4600, whose centerpiece was limitations on tort claims for medical malpractice, passed the House, but was not acted upon in the Senate. This bill was reintroduced as H.R. 5 in the 108th Congress and passed the House on March 13, 2003.

The Senate began consideration of S. 11, a bill substantially similar to H.R. 5, on July 7, 2003. After two days of debate, a cloture motion was failed on a vote of 49-48, and the Senate turned to other business with no vote on the underlying bill. In early February 2004, the majority leadership of the Senate indicated their conclusion that comprehensive medical malpractice reform could not pass the Senate in the 108th Congress; though narrower measures might be brought forward.[2] A narrower bill, S. 2061, to reduce "the excessive burden the liability system places on the delivery of obstetrical and gynecological services" was debated on the Senate floor February 23-24, 2004. A cloture motion then failed by a vote of 48-45 with no vote taken on the underlying bill. A second such narrow bill, S. 2207, which is similar to S. 2061, but expanded to include emergency room services as well as obstetrics and gynecology was brought to the Senate floor in early April. The cloture motion on S. 2207 failed on April 7, 2004 by a vote of 49-48. Despite the apparent

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[1] See, for example, Joelle Babula, "Desert Springs Hospital: Emergency surgeons unavailable," *Las Vegas Review-Journal*, Mar. 26, 2003, sec. B, p. 1B.

[2] Susan Davis, "Senate GOP Leaders Pull Plug On Medical Malpractice," *CongressDailyAM*, Feb. 2, 2004.

absence of consensus or cloture, Majority Leader Frist has indicated that he plans to bring a malpractice bill to the floor every two months until the issue is resolved.[3]

Following the absence of progress in the Senate, on May 12, 2004, the House again passed a comprehensive medical malpractice liability bill, H.R. 4279, which was substantially similar to H.R. 5. Pursuant to a rule, two other bills, H.R. 4280 and H.R. 4281, which addressed other aspects of health care, were later added to H.R. 4279 before it was forwarded to the Senate.

Insurance Fundamentals

Risk Transfer and Financial Intermediation

The most obvious function of insurance is to allow a person or corporation facing some risk, such as the risk that a physician will be sued for medical malpractice, to transfer this risk to another economic entity. Typically the entity accepting the risk will be a company, resulting in this risk then being spread across the owners of the insurer, either the stock holders in a normal incorporated insurance company or other policy holders in the case of a mutual insurance company.[4] Risk is also spread from one insurer to others through reinsurance.

Transferring risk, however, is not the only role that insurance plays. In the course of receiving payment for accepting risk, large amounts of capital are generated. This capital is then invested, allowing for its productive use to generate jobs and economic growth in addition to providing a reserve against future losses. Although the risk transfer and sharing aspect of insurance is the most obvious, the financial intermediation aspect is an equally integral part of the modern operations of insurance companies. The gains from investment of capital typically allow an insurer to offer lower rates to the insured than would be the case if the insured was paying completely for the transfer of risk. This also means, however, that the insured face some of the volatility in premium amounts inherent in relying upon investment returns. This can be seen in the alternating market cycles that are discussed below.

Insurance Operations and Pricing

Insurance involves highly complex calculations regarding uncertain outcomes of future events, although the basic operations can be simply explained. A company begins with a certain amount of capital stock to allow it to credibly promise to provide insurance in the future, as well as enough to satisfy regulators that it will be able to fulfill this promise. It offers insurance policies against whichever risks it is willing to assume. Money flows into an insurer primarily from two sources, premiums from customers of insurance and investment income from the company's reserves. Money flows out of an insurer primarily to pay for claims made for events

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[3] "Senate Fails To Invoke Cloture On Med-Mal Bill," *CongressDaily*, Apr. 7, 2004.

[4] A mutual insurance company is a non-profit insurer owned by the policy holders with ownership shares in proportion to their premium volume..

for which the insurer has agreed to bear the risk, including costs such as defending against lawsuits in the case of medical liability insurance.[5]

The ability of insurance to fulfill its role as a financial intermediary, as well as the solvency of individual insurers, rests critically on keeping the inflows and outflows balanced over time. This means estimating the future return on investments as well as estimating future losses from claims. The accuracy of these estimates can vary widely and insurers have relatively little direct control over what either actual value will turn out to be. Insurers can affect their returns somewhat by varying the mix of their investments, but this mix is subject to state regulation. In the United States, most investments are relatively stable investments such as bonds, but even bonds are subject to the vagaries of the marketplace. Many insurers also try to minimize claims through sharing information with policy holders on reducing risks and offering incentives to policy holders who take action to minimize risks.

The one variable that an insurer does directly control, subject to the pressures of the marketplace and sometimes state insurance regulators,[6] is the price or premium that it charges for a certain amount of insurance. This price should cover the value in today's dollars (the "present value") of any future loss, multiplied by the expected probability of this loss. If a physician wants to insure against the risk of paying a $1 million malpractice claim today, and the insurance company believes that there is a 1% chance that this claim will occur today, then it will charge $10,000 for this insurance. If the insurance extends for a length of time further into the future, then the future amounts of money to be paid out would be adjusted based on the expected inflation rate, or the expected rate of return, that the insurer foresees over the period of time the insurance is in place.

Since insurance pricing is theoretically based on the risk that is being transferred, this implies charging a different premium to people or companies with different inherent levels of risk. Without the ability to segment different risks into different categories, and charge these different categories different rates, the price charged to everyone will be relatively high reflecting the possibility that the purchaser is in a high risk category. A high price tends to lead those who believe their own risks are low not to buy insurance or to underinsure, while those with high risks do purchase insurance or even overinsure. This tendency is known as "adverse selection" and usually results from the insured having more information regarding their own risk than the insurer. Adverse selection results in a higher overall level of risk in the pool of those who buy insurance and thus results in higher than expected claims. Higher claims must ultimately be followed by higher prices, which is then

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[5] There are, of course, other substantial payments that an insurer makes, such as operational expenses and profits returned to stockholders, that are critical in differentiating among companies, but not as critical in discussing industry-wide issues.

[6] Laws in many states require preapproval by the state before an insurer can change the rates charged for insurance. The justification for this regulation is generally twofold: (1) to prevent insurance companies from charging too much and gouging their customers, and (2) to prevent insurance companies from charging too little and risking insolvency when their losses are greater then their reserves.

followed by lower risks not buying insurance and so on. The extreme result of this would be a situation where insurance essentially does not exist.

Market Cycles: Hard and Soft Markets

Insurance in general, and property and casualty insurance (of which medical malpractice is a part) in particular, has experienced alternating periods of "soft" markets and "hard" markets. This cycle is usually ascribed to changes in the investment climate, although it may be more accurate to think about it as due to changes in the comparison between insurers' financial inflows and outflows.

A soft market typically occurs when the investment climate is good and insurers make returns on the capital that they are holding in reserve that are high relative to expected insurance payouts. These high investment returns allow insurers to offer lower prices on insurance, sometimes selling insurance at a premium that they know will result in losses, and then offsetting these losses by the gains from investing the premium. Soft markets are usually marked by increases in the number of insurers and by the expansion in the geographic area or types of insurance offered by existing insurers.

A hard market typically occurs when the investment climate worsens and returns drop. Low investment returns imply that the premium paid for insurance must cover more of the actual loss that is expected from this insurance. This means higher premiums and can lead to withdrawals from poorly performing lines of insurance or from particular geographic areas that remain unprofitable. For an insurer offering only one type of coverage in a specific geographic area, such withdrawal is not an option. Such companies must either raise rates or eventually withdraw from the business of insurance if the investment returns do not increase or if costs are not somehow lowered. At the beginning of a hard market, especially when it is preceded by a long soft market, one might expect to see very large increases in premiums as the premium level comes closer to the value of the actual losses due to the risk that is being transferred.

Due to high capital mobility and interdependence in financial markets, hard markets would be expected to be a nationwide or even international phenomenon. The experience within the U.S., however, has been that periods of market hardening have a disparate impact among the various states. This suggests that when market problems develop, there may be more at work than simply a general hard market due to lower investment returns.

Medical Malpractice Insurance

Different insurance markets have very different characteristics. Life insurance, for example, tends to be very stable because the amounts that are to be paid out are clearly known and the estimates that are used for life expectancy are generally reliable. Insuring against hurricane damage is less stable; it is much harder to predict how many hurricanes might hit, where they might hit, and how much damage they might do. With enough historical and other data, insurance can operate effectively

even in such uncertain environments. Insuring against medical malpractice liability offers some particular difficulties as compared to other lines of insurance and it has proven challenging for companies to operate in this field over time. Among the difficulties are the longer time frames inherent in malpractice claims, high and uncertain claim amounts, and uncertainty in recognizing and segmenting high-risk from low-risk healthcare providers.

Medical Malpractice's Long "Tail"

Medical malpractice liability insurance has what is known in the insurance industry as a long "tail." Liability policies in general are often written to cover the claims arising from a certain period of time. In fire insurance, for example, this is relatively unproblematic; whether or not a fire has occurred is generally straightforward and uncomplicated. There may be disputes arising about the extent of damage that should be paid, but at a minimum, a company will know at the end of the insurance period or shortly thereafter whether a claim will be made. In contrast, injuries from medical malpractice, and thus the claims that arise from them, can take a longer time to manifest themselves, as many as several years in some cases. Even after injuries are noticed, the time before a full amount an insurer must pay is known and actually paid out is often measured in years because litigation can be complex and demand long discovery processes with various medical experts examining the case.

To address the tail problem, many insurers have changed their policies from an "occurrence" policy, which covers claims resulting from an action that occurred during the period that the insurance was in effect, to a "claims made" policy, which covers only claims actually made during the insured period. Such a shift has an immediate impact in reducing the uncertainty for the insurer, but the effect is largely a one time phenomenon. As a claims made policy stays in effect for several years, the total risk to the insurer under this type of policy converges with that the insurer would bear under an occurrence policy.

Impact of Tort System

The claim amounts that medical malpractice insurers pay out are generally determined either through the tort system, or by threats to use the tort system. The details of tort law vary from state to state, but compensatory damages under tort law are often separated into two types: economic damages and non-economic damages. Economic damages are generally intended to redress direct economic loss, such as lost wages and costs for medical care. Non-economic damages are not tied to direct out-of-pocket expenses and include damages due to pain and suffering. Another primary type of damages is punitive damages. Punitive damages are noncompensatory damages that are intended to punish a defendant for egregious conduct.[7]

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[7] See CRS Report RL31692, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages*, by Henry Cohen for a more complete discussion of tort law as it relates to medical malpractice.

Economic damages generally have the greatest impact on medical malpractice claims through the medical cost component.[8] Unsurprisingly, the damage from medical malpractice usually requires additional medical treatment to repair, sometimes an entire lifetime of medical treatment. As a result, medical costs tend to be a higher component of medical malpractice claims than most other types of insurance claims. Coupled with this is the experience that medical costs have typically risen faster than the general rate of inflation,[9] sometimes much faster. All other things being equal, this implies that the rates for medical malpractice insurance are going to rise faster than most other types of insurance.

While the medical cost component of economic damages tends to drive medical malpractice insurance generally higher than other insurance, non-economic and punitive damages add another aspect to malpractice claims: unpredictability. By definition, non-economic and punitive damages are more subjective and difficult to quantify than economic damages. Different juries in the same town or city can and do come to different conclusions as to the monetary value of a plaintiff's pain and suffering or the amount of punitive damages warranted to punish willful misconduct, for example. Jury awards are even more variable when comparisons are made involving different parts of the country.[10] The conclusions reached on such damages can also be difficult to dispute in contrast to damages that are specifically related to concrete economic factors. This unpredictability can make it very difficult to form the accurate estimations of expected losses that are at the heart of insurance pricing.

Risk Segmentation

Risk segmentation and adverse selection in the health care field are particularly problematic because information to accurately judge the quality of a provider, and thus ostensibly to accurately estimate his or her risk of a malpractice claim, is sparse. Some of this is due to past public policy choices, which have resulted in few mechanisms to track the quality of health care, but some is also due to the inherent difficulties in doing this tracking. It can be very difficult to distinguish a physician with higher malpractice liability due to poor skills from one with high skills, but sicker patients and more difficult cases. Both may have poor patient outcomes but without a careful examination of the incoming patient population, which is rarely practicable to undertake, an insurer is likely to charge both physicians similar rates. Risk segmentation in medical malpractice insurance is generally based on geographic area and specialty type, but relatively little is based on some measure of provider quality or on malpractice claims history.

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[8] A study by Milliman USA suggests that medical costs make up approximately 75% of economic damage awards, although this appears to be slowly decreasing. This study was commissioned by the Florida Hospital Association and is unpublished. See [http://www.fha.org/acrobat/Millimanstudypressrelease.pdf],visited Apr. 26, 2004.

[9] According to the Bureau of Labor Statistics at the end of the 30-year period from 1973 to 2002, medical prices were nearly seven and a half (7.4) times greater than the beginning, while prices generally were slightly more than four (4.1) times greater.

[10] See, for example, "Malpractice crisis? Not here!," *Medical Economics*, July 12, 2002, pp. 86-96.

One of the particular aspects of the historical evolution of the medical malpractice insurance market, which is discussed in greater detail below, has been the growth in small insurers, particularly provider-owned companies. This success runs contrary to one of the theoretical fundamentals of insurance, namely spreading risk across as wide a base as possible. A small, provider-owned company transfers risk away from individual physicians or other health care providers, but still leaves the risk to the company itself more concentrated relative to a bigger, shareholder-owned company.

Smaller companies, however, may do a better job at reducing the risk that they choose to bear, rather than just spreading it. This risk reduction could come, for example, if smaller insurers were more able to persuade physicians to adopt lower risk practices or if they could better identify doctors who are at greater risk for operating in a manner that might invite malpractice claims and either charge them a higher premium or choose not to insure such doctors. Another advantage of mutual insurers, particularly small ones, may be reduced moral hazard[11] since the insured are also the owners of the company. Smaller companies can also reduce the concentration of risk that they take on by purchasing reinsurance and this device is used often by such insurers.

Historical Experience in Medical Malpractice Insurance

Particular problems in medical malpractice insurance have been observed for many years. As far back as 1969, a report of a Senate subcommittee[12] concluded the following:

1. The number of malpractice suits and claims is rising sharply in certain regions of the country. The size of judgments and settlements is increasing rapidly.
2. Most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. The majority have proved justifiable. These suits are the indirect result of the deterioration of the traditional physician-patient relationship.
3. The publicity given to the higher malpractice judgments and settlements, based frequently on new legal precedents, is likely to trigger increased litigation in other States. The situation threatens to become a national crisis.
4. Already higher judgments and settlements are having the following direct results:
   (a) Companies providing malpractice insurance are increasing the cost of coverage.

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[11] Moral hazard is the term used for the increased chance of a loss actually due to the existence of insurance. For example, those insured against loss from fire may be more careless in fireproofing their property.

[12] U.S. Congress, Senate Committee on Government Operations, Subcommittee on Executive Reorganization, *Medical Malpractice: The Patient Versus The Physician*, 91st Cong., 1st sess. (Washington: GPO, 1969), pp. 1-2.

(b) These costs — in the form of higher charges — are being passed on to patients, their health care insurance companies, and Federal health care programs.

5. The rising number of malpractice suits is forcing physicians to practice what they call defensive medicine, viewing each patient as a potential malpractice claimant. Physicians often order excessive diagnostic procedures for patients, thereby increasing the cost of care. Moreover, they are declining to perform other procedures, which in themselves, may entail some risk of patient injury.
6. At present, it appears no one affected by the rise in malpractice suits and claims has been able to deal with this problem in a manner that promises to alleviate this situation.
7. The lion's share of the total cost to the insurance companies of malpractice suits and claims goes to the legal community.
8. There is a definite Federal role in the malpractice problem.

There is certainly continuing dispute over some of these conclusions, but such a list might very well have been prepared during the debate today rather than 34 years ago.

Evolution in the Insurance Market

Up until the middle of the 1970s, medical malpractice insurance coverage was dominated by traditional insurers who offered it as one of several different lines of insurance. A list of the top 10 companies in 1976 was composed of primarily diversified shareholder-owned insurers with 61% of the market among them. With the market hardening in the mid to late 1970s, many of these diversified insurers pulled back from offering medical malpractice insurance, leaving a void in the market. In response to this void, numerous new companies were created specifically focusing on insuring medical malpractice liability. Not only were these companies specialized, they also were largely owned by small groups of medical providers or by the entire group of their policy holders. These companies were also usually focused on a geographic area, often serving only one state. Some were, and still are, affiliated with a particular state's medical society.

With addition of capacity to the market, and the aforementioned shift to claims-made policies, the difficulties of the 1970s abated and was replaced by a soft market for the first half of the 1980s. The shift in market structure away from larger, diversified insurers, however, seems to have been permanent. By 1986, six of the top 10 medical malpractice insurers were provider-owned and market concentration was somewhat less, with the top 10 companies holding 56%. One exception to this shift was The St. Paul Companies, Inc. The St. Paul is a diversified shareholder-owned insurance company and grew from 11% of the nationwide market in 1976 to 21% in 1986[13]. Taking this company out of the situation gives a view of a more pronounced splintering of the market. The total market share of numbers two through 10 on the list of top insurers dropped from 51% of the market in 1976 to only 36% of the market in 1986.

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[13] Conning & Company, *Medical Malpractice Insurance: A Prescription for Chaos 2001,* pp. 82-85.

The market cycle turned again in 1985-86 and problems arose that bear many of the hallmarks of the current situation, including reports of physician work stoppages and problems with access to care. This situation was broader than just physicians or healthcare liability insurance and included difficulties in access to many other forms of liability insurance. In healthcare, larger providers, such as hospitals and nursing homes, were more severely affected than individual physicians. The market response was again the formation of new smaller insurance companies to serve the market. These new companies, however, were not just more traditional mutual insurance companies, but also a large number of captive insurers.[14] Many of these captive insurers were located offshore in such locales as the Cayman Islands and thus operated outside of the U.S. tax and regulatory system. The offshore nature of these entities makes it difficult to develop exact information about the size and scope of this market, but overall growth has been significant. One of the captives that is not offshore, Health Care Indemnity, a captive of the HCA hospital chain, grew over seven-fold from 1993-1994 to become the fourth largest medical malpractice insurer at the time.[15]

The 1990s saw predominantly a soft market with high investment returns fueling low rates and strong competition across various insurance lines. Medical malpractice insurance followed this trend with an increase in competition in many forms. Some traditional shareholder-owned insurers entered or reentered the market while some captives and mutuals converted to stock companies and/or expanded their geographic base into areas beyond their initial ones. This increased competition can be seen in the total number of companies directly underwriting medical malpractice premiums as reported by the National Association of Insurance Commissioners (NAIC).[16] There were 398 of such companies in 1991, but by 1995, the number had jumped to 623 and it reached a high of 666 in 1997.[17]

This soft market hardened in the latter part of the 1990s and subsequently the market has seen increasing premiums and both general withdrawals from the market and contractions in the geographical areas covered by companies. Total numbers of insurers declined by 50 from 1999 to 2000, although the number is still high compared to the beginning of the 1990s. Perhaps the most striking occurrence in this latest hard market was the decision in December 2001 by The St. Paul to completely withdraw from writing medical malpractice insurance as part of an "effort to improve profitability."[18] Withdrawal typically occurs gradually through non-renewal of

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[14] A captive insurer is an insurer owned by a parent company for the purpose of insuring this parent company. Such a captive may insure other parties as well.

[15] Conning & Company, *Medical Malpractice Insurance: A Prescription for Chaos 2001,* p. 88.

[16] The NAIC is the national organization collectively representing the insurance commissioners from the 50 states plus the District of Columbia.

[17] Davin Cermak, "Medical Malpractice: The New Health Care Crisis or History Repeated?," *NAIC Research Quarterly*, Fall, 2002

[18] For more information, see The St. Paul Companies, Inc. press release "The St. Paul Announces Fourth-Quarter Actions to Improve Profitability and Business Positioning," Dec.

(continued...)

policies, but since there are states where The St. Paul's market share approached 50%, the impact of even gradual withdrawal is very significant.

Policy Responses

Given the importance of insurance, when problems of availability or affordability have arisen, the situations have been met with more than just marketplace evolution; various policy changes have been made as well. Some of these changes have been intended to facilitate market supply, such as the creation of alternative sources of insurance, while others have addressed the problem from the cost side through various changes in the tort system. In addition, there have been attempts to address the problem through direct regulation of insurance, with California's Proposition 103 being the primary example as discussed below.

Expanding Market Supply. The basic legal structures for the mutual insurers that arose in response to the market difficulties in the 1970s have been in place for some time. Mutual insurers have a long history going back essentially as long as insurance has existed. In some cases, however, states went beyond the existing mutual framework to allow for medical malpractice insurance. For example, in Florida, particular statutes were passed in the 1970s specifically allowing for medical malpractice self-insurance trusts.[19] This statute was amended in 1992 to disallow its future use, but a recent Governor's task force has recommended rescinding this action given the current difficulties in Florida's medical malpractice market.[20] States also created non-standard entities, such as joint underwriting associations (JUA). JUAs are nonprofit pooling arrangements intended to provide an "insurer of last resort" for healthcare providers who are unable to find insurance elsewhere.

The federal government, although not the primary regulator in the insurance markets, has also taken an interest in the market supply of liability insurance. The Liability Risk Retention Act of 1986[21] allows for the establishment of risk retention groups and risk purchasing groups. Risk retention groups operate much like a mutual insurer. They are made up of groups of entities involved in a similar business who wish to spread the risk among group participants. Such groups can be formed under state law, but the federal law allowed for reduced regulation because under federal law these groups are regulated only in the state where they are chartered rather than in every state where they write insurance. Risk purchasing groups essentially allow

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[18] (...continued)
12, 2001, at [http://www.prnewswire.co.uk/cgi/news/release?id=78106], visited Apr. 26, 2004.

[19] Section 627.357, F.S.

[20] "Report and Recommendations," *Governor's Select Task Force on Healthcare Professional Liability Insurance*, Tallahassee, FL, Jan. 2003, p. xv. Available online at [http://www.doh.state.fl.us/myflorida/DOH-Large-Final%20Book.pdf], visited Apr. 26, 2004.

[21] formerly the Product Liability Risk Retention Act of 1981, (15 U.S.C. 3901 et seq).

for group purchasing of insurance with the expectation that such purchase will be lower cost than individual purchase.

The initial 1981 Act was limited to manufacturers, and was not widely used because of the soft market that prevailed at its time of passage. The 1986 law, however, amended the availability to include nearly all types of liability insurance, including medical malpractice. Companies offering medical malpractice liability insurance under the act began as early as 1987, with the Ophthalmic Mutual Insurance Company. The act's usage has continued to the current day. For example, at the beginning of 2003, 10 risk retention groups that had been formed in the previous year were offering insurance in Pennsylvania,[22] one of the states currently experiencing serious market difficulties.

Reducing Insurer's Costs. As detailed above, the primary outflow of money from a medical malpractice insurer is driven by the tort system. The tort system has thus been a primary focus of attempts to reduce insurer costs. It is beyond the scope of this report to discuss proposed tort changes in detail,[23] but it should be noted that a cap on non-economic damages for medical malpractice claims, which has been the center of attention during the recent debate in Congress, is not the only change that has been implemented at the state level. There have also been limits on other damages, on lawyers fees, and on joint and several liability. Some states have implemented patient compensation funds, which limit insurer liability to a certain amount, or allow or encourage arbitration in place of litigation to resolve medical malpractice disputes. There have even been states, such as Florida and Virginia, where a very limited "no-fault" system has been installed, bypassing the question of liability altogether.

The most cited example of tort reform, as well as the expressed model for the current H.R. 5 and S. 11, was passed by California in 1975: the Medical Injury Compensation Reform Act (MICRA). MICRA placed a $250,000 limit on noneconomic damages, such as pain and suffering, forced disclosure of other sources of payment to injured parties, limited lawyer fees, and strengthened the system that disciplines doctors. After passage in 1975, MICRA was challenged in the courts over several years before finally being upheld in 1984 and 1985.[24]

Strengthening Regulation. The first two policy responses implicitly treat an insurance "crisis" as the result of what might be described as normal market forces. An alternative explanation, however, is that the increasing prices and reduced availability that have marked the medical malpractice crises are the result of improper

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[22] "Risk Retention Act Responds to Pennsylvania's Health Care Crisis," *The Risk Retention Reporter,* vol. 17 no. 1, Jan. 2003.

[23] See the aforementioned CRS Report RL31692, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages,* by Henry Cohen, for a more complete discussion.

[24] *Fein v. Permanente Medical Group*, 38 Cal.3d 137 (1985), *appeal dismissed*, 474 U.S. 892 (1985); *Roa v. Lodi Medical Group, Inc.*, 37 Cal.3d 920 (1985), *appeal dismissed*, 474 U.S. 990 (1985); *Barme v. Wood*, 37 Cal.3d 174 (1984); *American Bank & Trust Co. v. Community Hospital*, 36 Cal.3d 359 (1984).

market manipulation rather than a confluence of market forces. This concern has been raised at the federal level where the McCarran-Ferguson Act gives a limited antitrust exemption to the insurance industry. At least one current bill, S. 352, would remove this exemption from medical malpractice insurance.[25] It is not clear what the impact of removing this exemption might be since some observers believe the information sharing facilitated by the exemption helps the industry operate more efficiently and leads to lower rates.

Such federal action would be relatively indirect compared to what individual states have done or might do. The insurance industry is highly regulated at the state level, with many states, for example, requiring prior approval before a company can adjust rates, change policy forms, or even withdraw from writing certain lines of insurance. The most dramatic action taken on the insurance regulatory front since the recurring market problems began was Proposition 103, a ballot initiative approved by California voters in 1988. Proposition 103 was a broad change that was not specifically aimed at medical malpractice insurance but affected all property-casualty insurers in California. It created an elected, not appointed, insurance commissioner, forced insurers to justify their rate increases to the insurance commissioner, required insurance companies to open their books so regulators could determine if they needed rate increases, and allowed citizens to challenge proposed rate increases.

How Effective Have Policy Changes Been?

Assessing the effectiveness of any of the various policy changes over the past three decades is empirically difficult and strong conclusions are often equally strongly disputed. For example, after the Liability Risk Retention Act of 1986, the U.S. Department of Commerce issued a report concluding that the 1981 and 1986 Acts were effective in reducing problems with the availability of liability insurance, citing among other things the numbers of insured then covered by risk retention groups.[26] In contrast, the NAIC saw no improvement from the formation these groups, indicating that the market cycle would have inevitably turned and that these insureds would have been able to find insurance in the commercial market.[27] As noted before, risk retention groups are still being formed to deal with the current medical malpractice market situation, but this alone does not prove conclusively that either of the previous Department of Commerce or NAIC positions were correct. Coming to this, or any, conclusion requires assessing both what has happened and what would have happened in the absence of the law .

The most voluminous debate has been over the effect of California's experience. California has experienced significantly lower medical malpractice premium growth over the 28 years since the passage of MICRA in 1975. This is cited by some as

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[25] For a more complete discussion, see CRS Report RS21461, *Medical Malpractice Liability Insurance and the McCarran-Ferguson Act*, by Rawle King.

[26] U.S. Department of Commerce, *Liability Risk Retention Act of 1986: Operations Report, 1989*, NTIS PB 90-123134, pp. 9-14.

[27] Ibid, Appendix E-4.

proof that tort reforms work and should be more widely adopted.[28] Countering this, others have argued that most of the slow growth, or even declines, in California premiums have come since Proposition 103 in 1988, indicating that the answer should be strengthened regulation.[29]

A major difficulty in economic analysis of the two arguments stems largely from the relative closeness of the two policy changes, particularly since MICRA was not finally upheld in court until 1985. As was discussed before, the pricing of insurance is a long-term economic enterprise fraught with many uncertainties. In such an endeavor, it would not be surprising that underwriters may wait to see what definite effect a policy change has on their losses before making dramatic moves in insurance pricing. Another difficulty in judging the California experience is the fact that liability insurance in general was experiencing a hard market in the mid-1980s and these market conditions may very well have temporarily overwhelmed the effect of other policy changes.[30]

Conclusions

The current difficulties in medical malpractice insurance are due in part to a cyclical hard market that is being experienced generally in the property/casualty insurance industry. However, since significant differences in experiences are observed among the various states, other factors, such as tort laws and insurance regulations, seem also to be playing a significant role. The responsibility for these two areas has traditionally been left to the individual states. During previous experiences with insurance market difficulties, Congress enacted laws encroaching to a minor degree on state insurance regulation. The current congressional focus is largely on intervening in the tort system, although proposals have been made to alter the insurance exemption from federal antitrust laws as well. Given the large amount of federal spending dedicated to Medicare and Medicaid, as well as the public

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[28] See, for example, *California's MICRA Should Go National*, an opinion piece written by a past president of the California Medical Association available at [http://www.calphys.org/html/bb193.asp], visited Apr. 26, 2004.

[29] See, for example, *Insurance Regulation, Not Malpractice Caps, Stabilize Doctors' Premiums*, a fact sheet by The Foundation for Taxpayer & Consumer Rights available at [http://www.consumerwatchdog.org/healthcare/fs/fs003013.php3], visited Apr. 26, 2004.

[30] Although the general economic analysis regarding California's experience seems inconclusive, there is at least one specific case where the stronger regulatory structure introduced by Proposition 103 directly resulted in lower medical malpractice premiums. In 2002, an insurer, the SCPIE Companies, filed for a 15.6% rate increase for 2003 that was then approved by the California Department of Insurance. Following the procedures set forth in Proposition 103, this increase was challenged by The Foundation for Taxpayer & Consumer Rights. On July 24, 2003, an administrative law judge reduced the increase to 9.9% in response to this challenge. See [http://www.insurance.ca.gov/ADM/DandR/SCPIE_Decision_for_Internet.pdf] for the text of the decision. Arguments from the two sides can be found at [http://www.scpie.com/publications/medigram/2003_special.pdf] and [http://www.consumerwatchdog.org/insurance/pr/pr002904.php3]. Websites visited on Apr. 26, 2004.

sensitivities raised when health care services are curtailed, strong congressional interest in this issue seems likely to continue as long as the current hard market prevails.