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

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October 2, 2009

Congressional Research Service
7-....
www.crs.gov
RL31886

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

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 occurred in the medical malpractice liability insurance market most recently in the early part of the 2000s. Many physicians experienced substantial increases in insurance premiums, and there were reports of problems with availability of physician services due to doctors retiring or relocating from areas that had seen high premium increases. This was not the first time such a crisis has been proclaimed; similar events occurred in the latter half of both the 1970s and 1980s. In the latter half of this decade, overall losses for medical malpractice insurance have dropped and premiums have moderated. Public discussion of medical malpractice has lessened as well.

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 because an insurer also acts as a financial intermediary and invests the capital that is held in reserve against future losses.

The market for medial malpractice liability insurance has been unstable during the past three decades for a variety of reasons. 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.

Congress has not directly addressed medical malpractice liability insurance since the 109th Congress, when the House passed a bill, H.R. 5, whose centerpiece was a limitation on tort claims for medical malpractice; similar bills passed the House in the previous two Congresses. The Senate, however, did not act on any of these House bills and failed to invoke cloture on the Senate bills addressing medical malpractice. Although the medical malpractice insurance market is not currently in the midst of a crisis, Congress has again focused on medical malpractice in the 111th Congress as a part of overall healthcare reform.

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. It will be updated as major legislative events occur.

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Introduction

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 occurred in the medical malpractice insurance market in the first half of this decade. Many physicians experienced substantial increases in insurance premiums, and there were reports of problems with the availability of physician services because of doctors retiring or relocating from areas that have seen high premium increases. There were also protests and job actions in some locations, with hospitals finding it necessary to curtail services and send patients to more distant facilities.[1] Crises have been proclaimed in the past as well; similar events occurred in the latter half of both the 1970s and 1980s. Since 2004 or so, overall losses experienced by medical malpractice insurers have dropped significantly and overall premiums have moderated as well, although not nearly to the same extent as losses.

The recurring problems have provoked various reactions in the insurance marketplace and in legislatures both at the state level, where insurance law and tort law are normally shaped, and in Congress. In the 107th (H.R. 4600), the 108th (H.R. 5 and H.R. 4279), and 109th (H.R. 5) Congresses, the House passed bills whose central thrust was to limit damages for medical malpractice tort claims. The Senate, however, did not act on any of these House bills and failed to invoke cloture on the Senate bills addressing medical malpractice (S. 11, S. 2061, and S. 2207 in the 108th Congress; S. 22 and S. 23 in the 109th Congress). The 110th Congress did not consider any bills on the floor to address directly medical malpractice insurance.

The medical liability insurance market is not currently exhibiting widespread crisis symptoms. That is not to say that the affordability and availability of malpractice insurance are no longer issues, but such problems are not as acute as compared with other time periods. According to the latest summary information published by the Medical Liability Monitor, 2008 premiums for malpractice insurance are part of a "downward trend of the past few years."[2] By extension, physicians and physician groups (primarily the American Medical Association) are not responding to current market conditions in the same manner as during crisis periods, when they engaged in more public displays of dissatisfaction (e.g., participating in "strikes"). However, even during a non-crisis period, the malpractice system is characterized by issues with equity, access, and other problems. For example, the current system performs poorly with respect to compensating patients who have been harmed by malpractice,[3] deterring substandard medical care,[4] and promoting patient safety,[5] among other issues.

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

[2] Chad Karls, "Medical Liability Monitor," Vol. 33, No. 10, October 2008, p. 1.

[3] E. Thomas, et al., "Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado," *Medical Care*, Vol. 38, No. 3, Mar. 2000, and T. Brennan, et al., "Incidence of Adverse Events and Negligence in Hospitalized Patients," *New England Journal of Medicine*, Vol. 324, No. 6, Feb. 7, 1991.

[4] M. Mello and T. Brennan, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," *Texas Law Review*, Vol. 80, 2002.

[5] L. Sato, et al., *Legal Liability and Protection of Patient Safety Data*, Harvard Risk Management Foundation, 2005.

Current Focus on Medical Malpractice and Health Reform

The current legislative interest in medical malpractice reform differs from the past in that it is largely driven by overall health reform, rather than an immediate crisis in medical malpractice insurance. As such, the focus is likely to be broadened. Beyond asking what can be done to stabilize premiums for medical malpractice, Congress may decide to ask what changes to the medical malpractice system might do for overall health reform? In terms of direct costs, medical malpractice insurance adds relatively little to the cost of health care. Medical malpractice premiums written in 2008 totaled approximately $11.2 billion,[6] whereas health expenditures are estimated by the Congressional Budget Office (CBO) to total $2.6 trillion.[7] Indirect costs, particularly increased utilization of tests and procedures by physicians to protect against future lawsuits or "defensive medicine," have been estimated to be much higher than direct premiums. These conclusions, however, are controversial, particularly in light of synthesis studies that have concluded that national estimates of defensive medicine are unreliable.[8]

CBO has noted that there is no "consistent evidence that changes in the medical malpractice environment would have a measurable impact on health care spending."[9] CBO conducted its own analysis, as well as synthesized and analyzed previous studies on the relationship between medical malpractice and health care costs.[10] These studies differed somewhat in their findings. For example, the studies' estimates for the reduction of health care spending attributable to state tort reforms varied, though they all found relatively little impact (4%-6%). Other studies not analyzed by CBO have found even less of an impact.[11]

To date, of the health reform proposals that have been reported out of the three committees of jurisdiction in the House (Ways and Means, Energy and Commerce, and Education and Labor) and the Senate Health, Education, Labor and Pensions Committee, only the one reported out of House Energy and Commerce includes language addressing issues with the medical malpractice system.[12] The Energy and Commerce version would allow states to receive incentive payments to enact and implement a medical liability law. The state law would be required to provide for an

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[6] NAIC, "Countrywide Summary of Medical Malpractice Insurance, Calendar Years 1991-2008," September 1, 2009.

[7] Douglas Elmendorf, "Expanding Health Insurance Coverage and Controlling Costs for Health Care," testimony provided to the Senate Budget Committee, February 10, 2009.

[8] For example, see Michelle Mello, "Understanding medical malpractice insurance: A primer," Robert Wood Johnson Foundation, Research Synthesis Report No. 8, Jan. 2006, and Office of Technology Assessment, "Defensive Medicine and Medical Malpractice," 1994.

[9] U.S. Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, December 2008, p. 154 available at http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

[10] CBO, "Budget Options, Volume 1: Health Care, December, 2008; D. Kessler and M. McClellan: "Malpractice Law and Health Reform: Optimal Liability Policy in an Era of Managed Care," *Journal of Public Economics*, Vol. 84, No. 2, May 2002; "How Liability Law Affects Medical Productivity," Working Paper No. 7533, National Bureau of Economic Research, Feb. 2000); and "Do Doctors Practice Defensive Medicine?," *Quarterly Journal of Economics*, Vol. 111, No. 2, May 1996.

[11] See P. Danzon, "Liability for Medical Malpractice," *Handbook of Health Economics*, Culyer and Newhouse, eds., 2000.

[12] The Senate Finance Committee is currently marking up its health reform proposal, "America's Healthy Future Act." The Chairman's mark includes a Sense of Senate statement regarding the opportunity that health reform presents to address concerns with medical malpractice and malpractice insurance.

"early offer" system, a "certificate of merit" program, or a combination of both.[13] The Secretary of Health and Human Services would determine that a state law was compliant if she were satisfied that the state had enacted and was currently implementing the law, and if she found the law to be "effective." To determine the effectiveness of a law, the Secretary would consider whether it (1) made the medical liability system more reliable through the prevention of, or prompt and fair resolution of, disputes; (2) encouraged the disclosure of health care errors; and (3) maintained access to affordable liability insurance.

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.[14] 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 complex calculations regarding uncertain outcomes of future events, although the basic operations can be explained in simple terms. A company begins with a certain amount of capital, or "policyholders surplus," to allow it to promise credibly 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

[13] In general, an early offer system permits a defendant to offer to a claimant within 180 days after a claim is filed, periodic payment of the claimant's economic losses. If an early offer is not made, the injured party can proceed with a normal tort claim for both economic and noneconomic damages. However, if an early offer is made and the claimant declines the offer, both the standard of misconduct and standard of proof are raised. A certificate of merit program requires claimants, when a medical malpractice suit is first filed, to include testimony from a qualified medical expert that establishes that there is merit to the claim.

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

the company's reserves. Money flows out of an insurer primarily to pay for claims made for events for which the insurer has agreed to bear the risk, including costs such as defending against lawsuits in the case of medical liability insurance.[15]

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,[16] 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 approximately $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.

Because 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 would tend to lead those who believe their own risks are low not to buy insurance or to underinsure, whereas those who believe their risks are high would tend to continue to buy insurance or even to overinsure. This tendency is known as "adverse selection" and usually results from the insured having more information than the insurer regarding their own risk. 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 are eventually followed by higher prices, which are then followed by lower risk clients not buying insurance and so on. The extreme result of this would be a situation where an insurance market essentially ceases to exist.

[15] 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.

[16] 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.

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, very large increases in premiums occur as the premium level comes closer to the value of the actual losses due to the risk that is being transferred.

Because of high capital mobility and interdependence in financial markets, hard markets might be expected to be a nationwide or even international phenomenon. The experience in the United States, 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. If different insurers offer insurance in the various states, it also may be that particular insurers' investment portfolios perform differently.

Medical Malpractice Insurance

Different insurance markets have very different characteristics. Life insurance, for example, tends to be stable because the amounts that are to be paid out are 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, however, 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 a fire has occurred is generally straightforward and uncomplicated. There may be disputes arising about the extent of damage that should be paid or whether there was some sort of malfeasance involved, 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. If a claims made policy stays in effect for several years, the total risk to the insurer under this type of policy converges with the risk 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 noneconomic damages. Economic damages are generally intended to redress direct economic loss, such as lost wages and costs for medical care. Noneconomic 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.[17]

Economic damages generally have the greatest impact on medical malpractice claims through the medical cost component. 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. All other things being equal, this implies that the rates for medical malpractice insurance will rise faster than most other types of insurance.

Although the medical cost component of economic damages tends to drive medical malpractice insurance generally higher than other insurance, noneconomic and punitive damages add another aspect to malpractice claims: unpredictability. By definition, noneconomic and punitive damages

[17] See CRS Report RL31692, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages*, by (name redacted); and CRS Report RL31722, *Punitive Damages in Medical Malpractice Actions: Burden of Proof and Standards for Awards in the 50 States*, by (name redacted), for additional discussion of tort law as it relates to medical malpractice.

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.[18] 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 reduces the accuracy of the 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 judge accurately the quality of a provider, and thus ostensibly to estimate accurately 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 between a physician with poor skills and one with high skills who takes on 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.

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 proliferation of 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. One advantage of mutual insurers, particularly small ones, may be reduced moral hazard[19] because 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 insurers.[20]

[18] See, e.g., "Malpractice crisis? Not here!," *Medical Economics*, July 12, 2002, pp. 86-96.

[19] 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.

[20] The Reinsurance Association of America reports that in 2005, approximately 14% of medical malpractice occurrence policy premiums and 23% of the claims made policy premiums were reinsured. This compares to an average for all P/C lines of approximately 21%, available at http://www.reinsurance.org/i4a/pages/Index.cfm?pageID=3324.

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[21] 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.

   (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 recent debate rather than 40 years ago.

Evolution in the Insurance Market

Until the mid-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%

[21] 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.

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 additional capacity in the market, and the aforementioned shift to claims-made policies, the difficulties of the 1970s abated and were 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% of the market. 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.[22] 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.

The market cycle turned again in 1985-1986 and problems arose that bear many of the hallmarks of the situation in the early 2000s, 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. These new companies, however, were not just more traditional mutual insurance companies, but also a large number of captive insurers.[23] 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 ascertain reliably the size and scope of this market, but overall growth has been significant. One of the captives that was not offshore, Health Care Indemnity, a captive of the HCA hospital chain, grew over seven-fold from 1993 to 1994 to become the fourth largest medical malpractice insurer at the time.[24]

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 whereas some captives and mutuals converted to stock companies 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).[25] 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.[26]

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

[23] 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.

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

[25] The NAIC is the national organization collectively representing the insurance commissioners from the 50 states plus (continued...)

This soft market began to harden in the late 1990s, a trend exacerbated by the unexpected losses from the September 11, 2001 attacks. Starting in 1999, the malpractice insurance market saw increasing premiums along with both general withdrawals from the market and contractions in the geographical areas covered by companies. The insurance rating firm A.M. Best reports that aggregate medical malpractice premiums increased 15.6 % in 2001,[27] 22.5% in 2002,[28] and 13.5% in 2003.[29] Perhaps the most striking occurrence in this time period was the decision in December 2001 by The St. Paul to withdraw completely from writing medical malpractice insurance as part of an "effort to improve profitability."[30] Withdrawal typically occurs gradually through non-renewal of policies, but because The St. Paul's market share approached 50% in some states, the impact of even gradual withdrawal was significant.

The hard market in medical malpractice insurance seems to have peaked between 2002 and 2004. Statistics from A.M. Best show a 5.5% increase in aggregate premiums in 2004 and only 0.5% in 2005.[31] In 2007, A.M. Best's statistics show aggregate premiums dropping by 6.5%, followed by a drop of 5.3% in 2008.[32] The individual premiums reported in surveys done by *Medical Liability Monitor* (MLM) lag to some degree the aggregate statistics from A.M. Best. In 2003 and 2004, the MLM surveys showed increases of 20.4% and 20.5% respectively, with a 9.5% increase in 2005. Rates increased only 0.7% and 0.4% according to the 2006 and 2007 surveys, with individual rates falling by 4.3% in 2008.[33]

Policy Responses

When problems of availability or affordability of insurance 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, whereas 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.

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the District of Columbia.

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

[27] "Medical Malpractice, Top Writers—2001," *A.M. Best Statistical Study*, August 5, 2002, p. 1.

[28] "Medical Malpractice, Top Writers—2002," *A.M. Best Statistical Study*, November 17, 2003, p. 1.

[29] "Medical Malpractice, Top Writers—2003," *A.M. Best Statistical Study*, November 15, 2004, p. 1.

[30] See The St. Paul Companies, Inc. press release "The St. Paul Announces Fourth-Quarter Actions to Improve Profitability and Business Positioning," December 12, 2001, at http://www.prnewswire.co.uk/cgi/news/release?id=78106.

[31] "Continued Improvement in 2005 Results as Medical Malpractice Premium Growth Subsides," *A.M. Best Statistical Study*, August 28, 2006, p. 1.

[32] A.M. Best, "U.S. Medical Professional Liability 2008 Market Review," *Best's Special Report*, April 27, 2009, p. 1.

[33] "Overall Average Rate Change by Year," *Medical Liability Monitor*, vol. 33, no. 10, October 2006, p. 4.

Expanding Market Supply

The basic legal structures for the mutual insurers that arose in response to the market difficulties of the 1970s have been in place for some time. Mutual insurers existed essentially as long as insurance has existed. Captives are a newer concept, dating from the 1950s and 1960s, but they also serve many areas outside of medical malpractice. In some cases, however, states went beyond the existing mutual or captive framework to allow for medical malpractice insurance. For example, in Florida, statutes were passed in the 1970s specifically allowing for medical malpractice self-insurance trusts.[34] This statute was amended in 1992 to disallow its future use, but a governor's task force recommended rescinding this action given the difficulties in Florida's medical malpractice market.[35] States also created nonstandard 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[36] 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 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 in the most recent crisis. For example, at the beginning of 2003, 10 risk retention groups formed in the previous year were offering medical malpractice insurance in Pennsylvania,[37] one of the states then experiencing market difficulties.

Reducing Insurers' 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 in detail issues surrounding tort changes,[38] but it

[34] Section 627.357, F.S.

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

[36] Formerly the Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 *et seq*).

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

[38] 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 (name redacted), for a more complete discussion.

should be noted that a cap on noneconomic damages for medical malpractice claims is not the only change that has been implemented at the state level. There have also been limits on other damages, lawyers' fees, and joint and several liability. Some states allow or encourage arbitration in place of litigation to resolve medical malpractice disputes or have implemented patient compensation funds, which limit insurer liability. Some states, such as Florida and Virginia, have implemented very limited "no-fault" systems, bypassing the question of liability altogether.

A frequently cited example of tort reform, as well as the expressed model for the previous bills considered by Congress, such as H.R. 5 in the 109th Congress, 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.[39]

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 medical malpractice crises are the result of improper market manipulation rather than a confluence of market forces. This concern has been raised at the federal level where the McCarran-Ferguson Act[40] gives a limited antitrust exemption to the insurance industry. 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, possibly leading to lower premiums.[41]

In response to difficulties in the medical malpractice insurance market, Senator Patrick Leahy's Medical Malpractice Insurance Antitrust Act of 2003 and of 2005 (108th Congress' S. 352 and 109th Congress' S. 1525) were aimed at the antitrust exemption as it relates to medical malpractice insurance. Broader concerns over the insurance industry prompted bills by Senator Leahy and Representative Peter DeFazio (110th Congress' S. 618/H.R. 1081) to repeal the antitrust exemption for all insurance. Representative DeFazio also introduced this bill, H.R. 1583, in the 111th Congress.

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

[39] *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).

[40] 15 U.S.C. Sec. 1011 *et seq*.

[41] See CRS Report RS22639, *Impact of the Abolition of McCarran-Ferguson Antitrust Exemption for the "Business of Insurance"*, by (name redacted) and (name redacted).

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 have often equally been 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.[42] In contrast, the NAIC saw no improvement from the formation these groups, indicating that the market cycle would inevitably have turned and that these insureds would have been able to find insurance in the commercial market.[43] As noted before, risk retention groups were still being formed to deal with the medical malpractice market situation at the time, 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 other 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 California's experience. California has experienced significantly lower medical malpractice premium growth over the years since the passage of MICRA in 1975. This is cited by some as evidence that tort reforms work and should be more widely adopted.[44] Countering this, others have argued that most of the slow growth, or even declines, in California premiums have come since Proposition 103 in 1988, suggesting the effectiveness of strengthened regulation.[45] A difficulty in economic analysis of the two arguments stems from the relative closeness of the two policy changes, particularly because MICRA was not finally upheld in court until 1985. As was discussed earlier, the pricing of insurance is a long-term economic enterprise fraught with many uncertainties. In such an endeavor, underwriters may wait to see what definite effect a policy change has on their losses before making dramatic changes to 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 arguably have temporarily overwhelmed the effect of other policy changes.[46]

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

[43] Ibid., Appendix E-4.

[44] 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.

[45] 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.

[46] 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 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.

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