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He is North American Editor of the *International Journal of the Economics of Business*. He has published numerous articles and written or edited several books on many topics, including industrial organization, health economics, insurance, energy economics, land use controls, the Coase Theorem and the property rights theory of the firm.

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Professor Frech has given lectures at numerous conferences and institutions in North America and in Europe. H.E. Frech specializes in industrial organization, economic theory, health economics, and political economy and holds a Ph.D. in Economics from the University of California Los Angeles.



## **William G. Hamm**

**William G. Hamm is an economics consultant with high-level experience in both business and government. An expert in banking and financial institutions, he has been the executive vice-president/chief operating officer of an AAA-rated \$50 billion bank. He has also run a \$1.5 billion payment processing and customer service operation for an S&P 500 company. Prior to entering the private sector, Dr. Hamm headed the non-partisan Legislative Analyst's Office in California, where he earned a nationwide reputation for objectivity, expertise and credibility on public policy issues ranging from taxation to healthcare. He also spent 8 years in the Executive Office of the President in Washington, D.C., where he headed a division of OMB responsible for analyzing the programs and budgets of the Department of Labor, HUD, the Veterans Administration, and numerous other federal agencies.**

**As a consultant, Dr. Hamm specializes in helping courts, legislative bodies, and the public develop a better understanding of complex economic and public policy issues. He assists businesses and public agencies analyze existing and proposed government policies, develop sound policy alternatives, and communicate the results to decision-makers. He is also recognized as an effective expert witness who can clarify complex litigation issues.**

**Dr. Hamm has a B.A. from Dartmouth College and a Ph.D. in Economics from the University of Michigan. He is a member of the American Economics Association and the American Law and Economics Association. He is also a Fellow of the National Academy for Public Administration, a Founding Principal of the Council for Excellence in Government, a member of the California Institute for County Government's Governing Board, and a member of Freedom From Hunger's Board of Trustees.**



### **C. Paul Wazzan**

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Dr. Wazzan is President and CEO of Wazzan & Co. Investment LLC, a venture capital firm specializing in semiconductor, optical networking, bio-mechanical, bio-medical and related technologies.

Some of the areas in which Dr. Wazzan has conducted substantial economic and statistical analyses include: the competitive effects of mergers and joint ventures; monopolization; price discrimination; predatory pricing; market definition; securities fraud; option valuation; class certification; commodities price manipulation (e.g., non-ferrous metal price manipulation on the COMEX and LME exchanges); labor economics (e.g., class certification, wage & hour, employment discrimination); and intellectual property (e.g., patent and trademark infringement, theft of trade secrets). His analyses have covered a wide range of industries, including basic manufacturing (e.g., mining, oil and gas, steel, food processing and distribution); high-tech manufacturing (e.g., aircraft and avionics, semiconductors, personal computers, computer peripherals); and services (e.g., banking, metals trading, organized financial markets).

Dr. Wazzan has published on the impact of socially motivated shareholder activism, the influence of pension fund investment/divestment on securities prices, the effects of federal and state legislation on medical care costs and the use of statistics in labor law analyses. Dr. Wazzan is a member of the American Finance Association and the American Economic Association.



# CONTROLLING MEDICAL MALPRACTICE INSURANCE COSTS—CONGRESSIONAL ACT OR VOTER PROPOSITION?

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## I. INTRODUCTION

It has been generally established that reducing medical malpractice insurance costs enhances the public welfare by reducing consumer (i.e., purchasers of medical care) costs and increasing access to health services.<sup>1</sup> While many states, including: Alaska, California, Colorado, Florida, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin, have already implemented some form of malpractice insurance cost controls, federal lawmakers are currently seeking ways to control medical malpractice insurance costs on a national level.<sup>2</sup> For example, H.R. 4280, which was pending before the U.S. House of Representatives during the 108th Congress, provides for a \$250,000 cap on non-economic damages:

Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the

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1. See, e.g., Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice* (Jan. 8, 2004), available at <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf>; Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends And the Impact of State Tort Reforms*, HEALTH AFFAIRS (Jan. 21, 2004), available at <http://www.healthaffairs.org> (follow Quick Search author equals Thorpe) last visited Apr. 2, 2006; and U.S. GENERAL ACCOUNTING OFFICE, *MEDICAL MALPRACTICE, IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE*, GAO-03-836 (2003).

2. Determination of whether individual states have caps is based on direct review of each state's laws. For example, the Code of Virginia defines a cap on total damages. VA. CODE ANN. § 8.01-581.15 (Michie 2006). Other states are reviewed accordingly.

sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.<sup>3</sup>

California is often cited as a model for such reform as it was among the first to take a proactive role in addressing this issue through congressional acts and voter measure as described below.

#### A. *The Medical Injury Compensation Reform Act*

In 1975, the California Legislature enacted the Medical Injury Compensation Reform Act ("MICRA"). The Act sought to improve Californians' access to health care by stabilizing medical malpractice insurance premiums, thereby making care more affordable and encouraging doctors to continue practicing in California.

After MICRA became law, there was great uncertainty as to whether the measure's cost-savings provisions would withstand court challenges.<sup>4</sup> Until these challenges were resolved, insurers could not be certain that the cost of malpractice insurance would go down, so as to justify lower insurance premiums. In 1985, the California Supreme Court upheld the constitutionality of MICRA, stating:

[I]n enacting MICRA the Legislature was acting in a situation in which it had found that the rising cost of medical malpractice insurance was posing serious problems for the health care system in California, threatening to curtail the availability of medical care in some parts of the state and creating the very real possibility that many doctors would practice without insurance, leaving patients who might be injured by such doctors with the prospect of uncollectible judgments. In attempting to reduce the cost of medical malpractice insurance in MICRA, the Legislature enacted a variety of provisions affecting doctors, insurance companies and malpractice plaintiffs.

Section 3333.2, like the sections involved in *American Bank, Barne* and *Roa*, is, of course, one of the provisions which made changes in existing tort rules in an attempt to reduce the cost of medical malpractice litigation, and thereby restrain the increase in medical malpractice insurance

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3. Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2004, H.R. 4280, 108th Cong. § 2 (2004).

4. See, e.g., *Am. Bank & Trust Co. v. Cmty. Hosp. of Los Gatos-Saratoga, Inc.*, 683 P.2d 670 (Cal. 1984); *Barne v. Wood*, 689 P.2d 446 (Cal. 1984); *Roa v. Lodi Med. Group, Inc.*, 695 P.2d 164 (Cal. 1985).



premiums. It appears obvious that this section—by placing a ceiling of \$250,000 on the recovery of noneconomic damages—is rationally related to the objective of reducing the costs of malpractice defendants and their insurers.<sup>5</sup>

MICRA made four important changes to California's medical malpractice tort system: (1) it imposed a \$250,000 cap on awards for non-economic losses,<sup>6</sup> such as pain and suffering, in medical malpractice lawsuits; (2) it allowed defendants to introduce evidence showing that the plaintiff had already received compensation for a portion of his or her losses;<sup>7</sup> (3) it authorized trial courts to require periodic payments for future damages, in lieu of lump-sum awards;<sup>8</sup> and (4) it imposed limits on the contingency fees that lawyers can charge medical malpractice claimants.<sup>9</sup> MICRA imposes no limits on economic or punitive damages.<sup>10</sup> Nor does it limit the exposure of HMOs and pharmaceutical companies to awards for non-economic damages resulting from medical malpractice.

### *B. The Insurance Rate Reduction and Reform Act – Proposition 103*

The Insurance Rate Reduction and Reform Act, more popularly known as Proposition 103, was passed by California voters on November 8, 1988. Under the measure, insurers were required to reduce rates by at least 20% from the levels in effect on November 8, 1987.<sup>11</sup> The measure also required any change in property and casualty insurance rates to be approved by the Insurance Commissioner, beginning November 8, 1989.

The California Insurance Code indicates that insurance lines subject to Proposition 103's provisions include: medical malpractice, personal automobile, dwelling fire, earthquake, homeowners, inland marine, umbrella, commercial aircraft, boiler and machinery, burglary and theft, business owners, farm owners, some fidelity, fire, glass, miscellaneous, multi-peril, other liability, professional liability, special multi-peril, and coverage under the United States Longshore and Harbor Workers' Compensation Act.<sup>12</sup>

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5. *Fein v. Permanente Med. Group*, 695 P.2d 665, 680 (Cal 1985).

6. The law defines non-economic losses as "pain, suffering, inconvenience, physical impairment, disfigurement and other non-pecuniary damage." CAL. CIV. CODE § 3333.2(a) (2006).

7. CAL. CIV. CODE § 3333.1 (West 2006).

8. CAL. CIV. CODE § 667.7 (West 2006).

9. CAL. BUS. & PROF. CODE § 6146 (West 2006).

10. Nicholas M. Pace, Daniela Golinelli & Laura Zakaras, *Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA*, RAND INSTITUTE OF CIVIL JUSTICE (Rand Corp. 2004). There is some evidence (post-cap) that non-economic awards represent approximately 42% of total awards.

11. Proposition 103, CAL. INS. CODE § 1861.01 (a) (West 2006).

12. Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 (2006).

### *C. Summary of Findings*

As a result of the relatively simultaneous implementation of Proposition 103 and MICRA, there is some confusion as to which of these legal reforms is responsible for controlling the cost of medical malpractice insurance, and which would best serve as a model for Federal reform.<sup>13</sup> In an effort to assist policymakers, opinion leaders, and the public in evaluating this argument, we examine the economic effect of each of these laws.

Economic theory and empirical evidence show that Proposition 103 cannot explain the relatively modest growth in malpractice premiums in California since 1988 and that MICRA must be given credit for controlling these costs.

## II. PROPOSITION 103'S IMPACT ON THE COSTS OF MEDICAL MALPRACTICE INSURANCE

We first test the hypothesis that Proposition 103 is responsible for the relative stability of medical malpractice insurance rates by comparing the trends in premiums for all lines of insurance subject to the proposition's provisions. If Proposition 103 is primarily responsible for holding down malpractice insurance premiums, we should observe the same favorable trend in premiums for homeowners insurance, automobile insurance, and other casualty insurance lines.

### *A. Proposition 103's Potential Impact on Medical Malpractice Insurance Premiums is Limited*

Ex-ante, it is theoretically unlikely that Proposition 103 could be effective in limiting the growth in medical malpractice insurance premiums for four reasons.

#### *1. Insurance costs determine insurance premiums, and Proposition 103 does not affect medical malpractice insurance costs.*

Insurance premiums must cover the expected cost of providing coverage (including the cost of capital required by insurers to conduct business). Competition ensures that premiums do not rise to levels where unneeded surpluses are generated. If unneeded surpluses are generated by a firm's rate structure, the excess often is returned to policyholders in the form of rebates

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13. See, e.g., *How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California And How Malpractice Caps Failed*, FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS (Mar. 7, 2003), available at <http://www.consumerwatchdog.org> (follow "Medical Malpractice" hyperlink) (last visited Apr. 2, 2006).

or dividends. In the insurance business, costs drive premiums—not the other way around. Proposition 103 does not impact insurance costs; consequently, it cannot be expected to hold down premiums.

*2. Proposition 103 permits rate increases whenever they are justified.*

Proposition 103 does not prohibit increases in insurance rates; it simply requires that the increases be justified. The California Insurance Commissioner has ruled that a demonstrable increase in the cost of providing insurance is sufficient to justify a rate increase.

It should be noted that, as a matter of law, Proposition 103 cannot force insurers to operate at a loss by keeping reserves below expected claims. Moreover, the evidence shows that loss reserves maintained by California medical malpractice insurers are not significantly different from the reserves held by insurers in other states. As Table 1 illustrates, California insurers rank eighteenth out of thirty states in terms of reserve adequacy, and their reserves are within two percent of the national mean.

**Table 1: 2003 Rankings: Net Income; Policyholder's Surplus; Loss Reserves; Underwriting Income<sup>14</sup>**

State <sup>1</sup>	Average of Net Income (\$000)	Rank Max=30	Average of Policyholders' Surplus (\$000)	Rank Max=30	Average of Loss Reserves (%)	Rank Max=30	Average of Net Underwriting Income (\$000)	Rank Max=30
AZ	\$1,739	9	\$127,250	8	69%	13	(\$13,067)	18
CA <sup>2</sup>	(\$5,170)	27	\$119,572	9	64%	18	(\$18,561)	22
CO	(\$274)	22	\$84,608	14	44%	28	(\$4,564)	7
CT	\$345	19	\$67,689	17	87%	2	(\$14,993)	20
DC	(\$4,900)	26	\$70,372	8	64%	16	(\$13,899)	19
FL	\$1,021	15	\$75,532	15	62%	22	(\$7,685)	12
GA	\$52	20	\$177,177	4	64%	17	(\$25,744)	25
IA	(\$332)	23	\$14,286	27	12%	30	(\$860)	4
IL	\$2,537	8	\$172,211	5	76%	9	(\$58,746)	28
LA	\$2,588	6	\$62,120	18	75%	10	(\$4,896)	10
MA	\$13,229	2	\$230,000	3	78%	6	(\$63,658)	29
MD	\$1,258	14	\$113,427	11	68%	14	(\$25,478)	24
ME	(\$6,364)	29	\$48,407	21	63%	20	(\$9,094)	14
MI	\$9,615	3	\$170,915	6	76%	7	(\$12,077)	17
MN	\$4,273	4	\$118,158	10	80%	4	(\$8,206)	13
MO	(\$2,159)	25	\$29,145	26	61%	25	(\$2,805)	6
MS	\$999	16	\$60,244	19	83%	3	(\$10,617)	16
NC	\$2,553	7	\$35,084	24	63%	21	\$462	1
NJ	(\$2,051)	24	\$45,952	22	48%	27	(\$15,767)	21
NY	(\$89,150)	30	\$266,391	2	80%	5	(\$153,829)	30
OH	(\$6,208)	28	\$145,653	7	72%	12	(\$25,833)	26
OR	\$834	17	\$9,756	30	61%	24	\$133	2
PA	\$1,738	10	\$106,716	12	88%	1	(\$19,290)	23

14. AM BEST Key Rating Guide (2004). Data represents all insurance companies where medical malpractice was listed as the first line of business (i.e., majority of business generated from medical malpractice insurance). Total states represented equals thirty. "State" indicates first state of business (i.e., majority of revenue generated in indicated state).

The insurance companies in California include: Everest Indemnity Insurance Co.; Claremont Liability Ins. Co.; American Healthcare Indemnity Co.; SCPIE Companies; SCPIE Indemnity Company; Doctors Company Ins. Group; Dentists Insurance Company; MIEC Group; Medical Insurance Exchange of Ca.; Doctors Company Interinsurance Exchange; California Healthcare Ins., RRG; NORCAL Group; NORCAL Mutual Insurance Co.; Professional Undrw. Liab.; Health Providers Ins. Recip. RRG; Podiatry Ins. Co., America Mut. Co.; MedAmerica Mutual RRG Inc.; Underwriter for Professions; NCMIC Group; and NCMIC Insurance Company.

TN	\$1,738	10	\$85,442	13	60%	26	(\$9,461)	15
TX	\$19,154	1	\$357,760	1	74%	11	(\$26,660)	27
UT	\$1,457	13	\$36,428	23	76%	8	(\$4,715)	9
VA	\$665	18	\$10,284	28	61%	23	(\$983)	5
WA	\$2,909	5	\$30,442	25	63%	19	(\$4,675)	8
WI	\$1,587	12	\$54,048	20	67%	15	(\$5,819)	11
WV	(\$42)	21	\$10,202	29	34%	29	(\$71)	3
Mean	(\$1,545)		\$97,842		66%		(\$18,715)	
Max	\$19,154		\$357,760		88%		\$462	
Min	(\$89,150)		\$9,756		12%		(\$153,829)	

*3. Most malpractice insurance in California is exempt from Proposition 103.*

Proposition 103 only applies to *regulated* medical malpractice insurance companies. It does not apply to risk retention groups or to institutions that self-insure against claims. Many physicians in California are covered by a combination of risk retention groups and self-insured institutions, both public and private (*e.g.*, MedAmerica Insurance Co.). Consequently, Proposition 103 can have no effect on premiums charged by these groups.

*4. Malpractice insurance is provided by non-profit and provider-owned firms that have no incentive to generate excess profits.*

Given the characteristics of California's medical malpractice insurance market, one would not expect Proposition 103 to have a material impact on insurance premiums. Most malpractice insurance in California is written by non-profit, mutual insurance companies that have no incentive to generate excess profits.<sup>15</sup> This type of insurer simply charges premiums that are sufficient to cover its expected losses and maintain a small surplus. To the extent that surpluses become too large, the firm can be expected to pay dividends to its customers (who are also the "owners" in the case of mutual insurance companies).

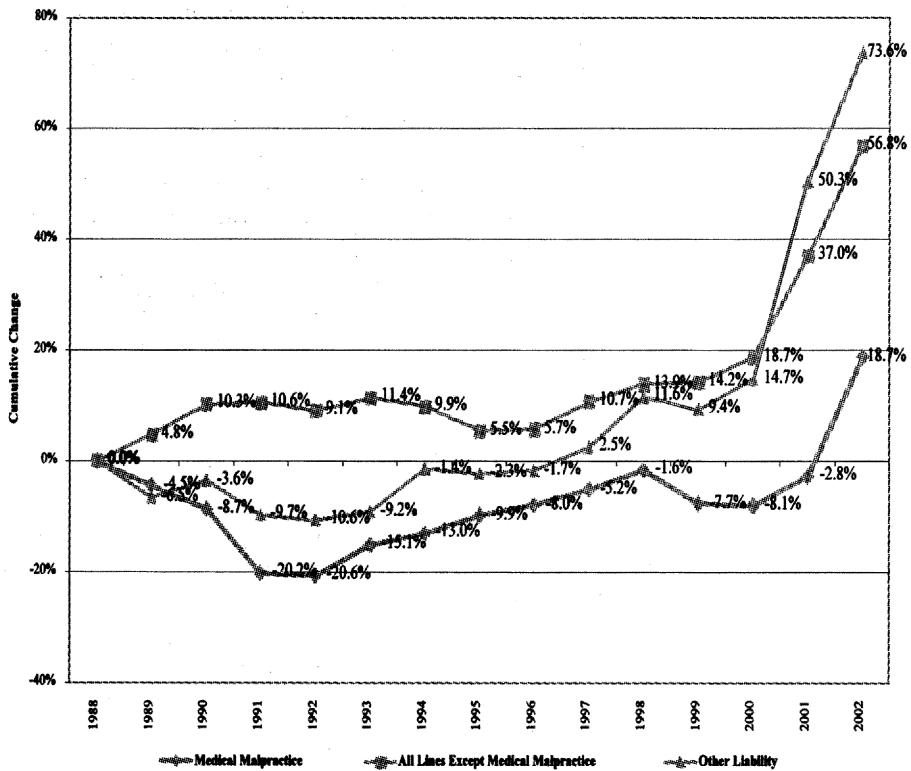
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15. "Excess profits" means revenues in excess of costs, including the market-determined cost of capital.

*B. California Medical Malpractice Premium Rates Have Grown More Slowly than Rates for Other Proposition 103-Regulated Lines.*

If Proposition 103 is effective in controlling medical malpractice premiums, it should be equally successful in limiting the premiums charged for other lines of insurance that are subject to the measure’s provisions. This hypothesis is tested by comparing the trend in premiums for medical malpractice insurance with the trend for these other insurance lines. See Figure 1.

Figure 1: Cumulative Premium Change (By Line) Since the Adoption of Proposition 103<sup>16</sup>



16. Data provided by National Association of Insurance Commissioners, NAIC Reports on Profitability By Line By State, 1976 – 2002; California data (on file with author).

As Figure 1 demonstrates, following Proposition 103's effective date, medical malpractice premiums declined, while the average premium for "all lines except medical malpractice" increased. Within the first three years, the decline in medical malpractice premiums amounted to more than 20%.

The obvious explanation for the opposing trends shown in Figure 1 is the relative changes in claim costs. Medical malpractice insurance rates went down because claim costs went down. Premiums for "all lines except medical malpractice" increased because claim costs increased. This inference is economically sound because if costs had not gone up, the California Insurance Commissioner would have refused to approve the higher rates.

Since Proposition 103 had no effect on the cost of providing medical malpractice insurance, while MICRA reduced medical malpractice insurance costs—but not auto insurance or homeowners insurance costs—the premiums charged for these and other forms of coverage moved in different directions. When the period of analysis is extended to 1998, the same disparate trends in premiums are observed: medical malpractice premiums remained below the 1988 level (-1.6%), while the rates for both "all lines except medical malpractice" and "other liability" were significantly higher than the 1988 rates (13.9% and 11.6%, respectively) notwithstanding Proposition 103.

Since 1988, the trend in medical malpractice insurance rates has been significantly more favorable than the trend in rates for other Proposition 103-regulated lines. From 1988 to 2002, medical malpractice premiums increased by 19% while premiums for "all lines except medical malpractice" grew by 57% and premiums for "other liability" grew by 74%.

### III. CONCLUSION

In sum, the data demonstrates that MICRA, rather than Proposition 103, is responsible for controlling medical malpractice insurance rates and the resulting moderation in health care costs. This finding is not surprising given the fact that Proposition 103, unlike MICRA, does nothing to limit the actual cost of providing medical malpractice insurance.

