DIRECT REGULATION OF MEDICAL MALPRACTICE PREMIUMS: THE LEAST DANGEROUS REFORM

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I. INTRODUCTION AND BACKGROUND

Medical malpractice is a wrong that society tries to prevent, in part, through its tort system. Like all tort awards, medical malpractice verdicts serve two societal goals: deterrence and victim compensation. Unlike other torts, however, medical malpractice operates in the arena of health care and is therefore the subject of tremendous scrutiny. In response to a perception that medical malpractice lawsuits have an adverse effect on both health care access and health care cost, lawmakers across the country have set their attention on reforming the medical malpractice system. Common reforms change the tort litigation landscape by affecting the ability of plaintiffs to (1) initiate litigation (e.g., reducing the statute of limitations or requiring plaintiffs to obtain certification from experts that their claims have merit); or, (2) litigate the issues (e.g., changing expert testimony requirements); or, most commonly, (3) be compensated upon a verdict or settlement in their favor (e.g. capping damages, limiting joint and several liability, capping attorneys' fees). Many of these reforms—most notably, damage caps—retard the traditional tort goals of victim compensation and deterrence and impose a substantial cost on the state. This note argues for an alternative reform: direct regulation of malpractice insurance companies and the premiums they charge.

Part II of this note puts medical malpractice in the context of the healthcare arena and examines whether the current system affects access to care or total health care expenditures. Part II concludes that even though there is only incomplete (and under-examined) evidence that the malpractice system negatively affects access to care or total health care expenditures, legislatures will continue to act in the face of crises—periods of exorbitantly rising premiums—and that it is therefore worth examining legislative options. Part III evaluates empirical and theoretical evidence to determine what causes the crisis periods and concludes that the malpractice insurance underwriting cycle, and not excessive litigation/jury awards, causes the crisis periods. It also assesses the risk of a crisis period in the near future.

Part IV assesses the social utility of the most dramatic response to the crises—damage caps—and concludes that costs outweigh benefits. Part V reviews and endorses direct insurance regulation as an alternative to damage caps and assesses its feasibility and legality. Part VI reviews some recent medical malpractice reforms. Part VII briefly concludes.

II. MEDICAL MALPRACTICE IN CONTEXT

A. Crisis Periods

There have been three distinct periods—during the mid-1970's, the mid-1980's, and early 2000's—during which the cost of malpractice insurance has risen at a dramatic and unsustainable rate.[1] During the most recent crisis, the American Medical Association designated about half of all states to either be in full crisis or in danger of crisis-level increases in malpractice premiums.[2] Depending on the specialty and the state, malpractice premiums increased between 15% and 30% per year.[3] In Pennsylvania, for example, from 1999 to 2002 premiums for practitioners of internal medicine increased by 73% and 130% in Philadelphia and Harrisburg, respectively.[4] In those two cities, general surgery practitioners saw similar premium

[1] *See generally* Christina O. Jackiw, *The Current Medical Liability Insurance Crisis: An Overview of the Problem, Its Catalysts and Solutions*, 13 ANNALS HEALTH L. 505, 513 (2004); AMERICAN MEDICAL ASSOCIATION, MEDICAL LIABILITY REFORM - NOW!: A COMPENDIUM OF FACTS SUPPORTING MEDICAL LIABILITY REFORM AND DEBUNKING ARGUMENTS AGAINST REFORM 1–2 (2008), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnow.pdf [hereinafter AMA CALL FOR REFORM].

[2] AMA CALL FOR REFORM, *supra* note 1, at 7.

[3] Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFFAIRS Web Exclusive, 1 (2004), http://healthaff.highwire.org/cgi/reprint/hlthaff.w4.20v1.pdf.

[4] UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES, GAO-03-702, 12 Figure 2 (2003), *available at* http://www.gao.gov/new.items/d03702.pdf [hereinafter GAO MULTIPLE FACTORS].

hikes while obstetrics/gynecology specialists saw their premiums rise by even more.[5] Texas, Mississippi, and Florida also saw rate increases well over 50% during that period, while other states, such as California and Minnesota, saw more moderate rate increases.[6] Each of the three crisis periods has resulted in a variety of legislative responses.

B. A Broader Context for Medical Malpractice: Access to Health Care and Health Care Spending

Congressional responses to these periods of crisis usually stem from fears that malpractice premiums reduce access to health care.[7] It is difficult to empirically test for the systematic effects of high premiums because it is difficult to control for all the factors that affect the quantity and location of health care supply. On an anecdotal level, however, stories of doctors leaving their practices under the weight of malpractice premiums are commonplace[8] and newspapers often run stories about a doctor leaving her practice for a state with lower premiums.[9] Probably most importantly, doctors and the American Medical Association (the "AMA") vociferously complain about premiums and their negative effect on access to care. During the crisis in the early 2000's, doctors in a few states went on strike in protest of high malpractice costs.[10] Not only does the AMA have a

[5] *Id.*

[6] *Id.*

[7] *See, e.g.*, Richard A. Epstein, *Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice*, 54 DEPAUL L. REV. 503, 503–04 (2005).

[8] *Id.*

[9] *See, e.g.*, Editorial, *Messing with Malpractice Reform: Tort Lawyers in Illinois Try an End Run Around the Voters*, WALL ST. J., Dec. 1, 2008, at A22 ("Due to the rising cost or unavailability of liability insurance, some doctors quit the state. An Illinois obstetrician could save $75,000 to $100,000 per year on liability insurance by moving to nearby Wisconsin, Indiana or Missouri. Physicians in neurosurgery, orthopedics and anesthesiology were no longer performing high-risk procedures.").

[10] Kevin J. Gfell, *The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions*, 37 IND. L. REV. 773, 778–79 (2004).

portion of its website devoted entirely to the problem of malpractice premiums,[11] but it also regularly issues reports on the subject, profiling doctors that leave their practices and the communities that allegedly lack care as a result.[12] The implication is that malpractice premiums reduce access to care generally and systematically.[13]

Large-scale empirical evidence of such an effect, however, is harder to come by. A study for the National Bureau of Economic Research found that while generally malpractice premiums did not seriously affect the physician workforce in a state, in a few specific areas, access may be affected.[14] For instance, doctors just beginning or just ending their careers might take malpractice premiums into account in deciding whether to retire or where to locate.[15] More broadly, the study also finds evidence that high malpractice premiums may reduce doctor levels in rural areas.[16] The study found that a 10% increase in malpractice premiums reduces the number of doctors in rural areas by 1%.[17] These results are typical of research in the area.[18] It is not clear, however, whether a reduction in the number of doctors

[11] AMA Medical Liability Reform, http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/practice-management/medical-liability-reform.shtml (last visited Feb. 6, 2010).

[12] AMA CALL FOR REFORM, *supra* note 1, at 9.

[13] *Id.*

[14] Katherine Baicker & Amitabh Chandra, *The Effect Of Malpractice On The Delivery Of Health Care*, FORUM FOR HEALTH ECON. & POL'Y, 2005, 17–18.

[15] *Id.*

[16] *Id.*

[17] *Id.* at 18.

[18] *See* MICHELLE M. MELLO, THE ROBERT WOOD JOHNSON FOUNDATION, RESEARCH SYNTHESIS REPORT NO. 10, MEDICAL MALPRACTICE: IMPACT OF THE CRISIS AND EFFECT OF STATE TORT REFORMS 10 (2006) ("Overall, a reasonable conclusion to draw from this group of studies is that caps appear to be associated with a small but statistically significant increase in physician supply."); UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE, GAO-03-836, 12 (2003), *available at* http://www.gao.gov/new.items/d03836.pdf [hereinafter GAO IMPLICATIONS] (finding "instances" of reduced access, but no widespread impairments to access).

negatively affects patient access to care. It is generally thought that patients may have to travel farther and wait longer when the number of physicians is reduced, but there is no definitive correlation.[19] In fact, there is some evidence that a high baseline supply of doctors provides a cushion and therefore, when some doctors leave a specialty, there is no resulting effect on access to care.[20]

Probably the toughest claim to assess is whether malpractice premiums increase health care expenditures by encouraging physicians to practice "defensive medicine"—running tests or taking actions not because they are medically necessary but to avoid potential litigation. As recently as 2003, a Government Accountability Office study found no reliable estimate of the "overall prevalence or costs of defensive medicine practices"[21] and a 2003 Congressional Budget Office (CBO) study reached a similar result, finding "no effect of tort controls on medical spending" and "no statistically significant difference in per capita health care spending between states with and without malpractice tort limits."[22] However, in 2009, the Director of the CBO, in a letter to Senator Hatch, wrote that certain changes, including a cap on non-economic damages, would reduce medical costs by .3% due to a reduction in overutilization.[23]

There are two primary ways of testing for the existence of defensive medicine: physician surveys and econometric models.

Physicians surveyed admit to practicing defensive medicine, but those surveys are not always reliable. For

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[19] MELLO, *supra* note 18, at 4.

[20] *Id.* at 4–5.

[21] GAO IMPLICATIONS, *supra* note 18, at 26.

[22] CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE: H.R. HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2003 5 (2003), *available at* http://www.cbo.gov/ftpdocs/40xx/doc4091/hr5.pdf.

[23] Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to Orrin G. Hatch, U.S. Senator (Oct. 9, 2009) (on file with author), *available at* http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf.

starters, they often suffer from low response rates.[24] Worse yet, there are varying ways of characterizing defensive medicine and it is difficult to truly know why a doctor took a certain action.[25] If litigation was in the back of a doctor's mind, does it matter that the doctor also thought there was some medical reason to run the test? Mindful of these limitations, it is still interesting that most surveys of this type find doctors admitting to, at least occasionally, running tests they consider medically unnecessary in order to protect themselves from potential liability.[26] How often this type of behavior occurs, and how much it costs the system, however, is more difficult to measure.[27]

Economic models prove only slightly more reliable. One direct method of assessing whether malpractice premiums result in defensive medicine is to measure the total health care spending in different states with different malpractice environments.[28] A study taking this approach found that states with damage caps had 3.4% lower per capita health care expenditures than states without such reforms.[29] This study did not, however, distinguish between states with different dollar amount caps.[30]

A second approach for assessing the prevalence of defensive medicine involves looking at the propensity of physicians to use different treatments in different malpractice environments.[31] Here too, the results are mixed.[32] Where an effect is found, it is often signified by increased screening procedures, which comports with survey results implying that fear of litigation leads to excessive

[24] GAO IMPLICATIONS, *supra* note 18, at 26.

[25] *Id.*

[26] *Id.* at 27.

[27] *Id.*

[28] *Id.* at 28–29.

[29] Fred J. Hellinger & William E. Encinosa, *The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures*, 96(8) AM. J. PUB. HEALTH 1375, 1379 (2006).

[30] *Id.* at 1379, 1380.

[31] GAO IMPLICATIONS, *supra* note 18, at 28–30.

[32] *Id.* at 28–30; MELLO, *supra* note 18, at 5.

testing.[33] There is also fairly strong evidence that procedures, tests, and referrals are more common during malpractice crises.[34] Unfortunately, it is difficult to know when a test's marginal utility is outweighed by its costs.[35] It is therefore possible that the increase in procedures, tests, and referrals seen during crises improves patient care and is therefore not wasteful defensive medicine.[36] Indeed, a 2009 study for the National Bureau of Economic Research concluded that while "[a] ten percent reduction in malpractice costs would reduce total health care expenditures by, at most 1.2 percent[,] . . . [a] 10 percent increase in malpractice costs reduce[s] mortality by . . . approximately 0.2%[.]"[37] The authors conclude that the reduction in mortality "more than likely outweighs the increase in medical costs."[38]

Taking this empirical evidence into account, it is virtually impossible to definitively conclude that medical malpractice reform is necessary to reduce health care spending or to ensure broad access to care.[39] Despite these challenges, the

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[33] *See, e.g.*, Baicker & Chandra, *supra* note 14, at 19–21.

[34] MELLO, *supra* note 18, at 6.

[35] *Id.* at 5.

[36] *See* Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 429–35 (2005).

[37] Darius Lakdawalla & Seth Seabury, *The Welfare Effects of Medical Malpractice Liability* 4 (Nat'l Bureau of Econ. Research, Working Paper No. 15383, 2009). *But see* Frank A. Sloan & John H. Shadle, *Is There Empirical Evidence for "Defensive Medicine"? A Reassessment*, 28 J. HEALTH ECON. 481, 490 (2009) (finding, with one exception, that "reducing the threat of tort has no effect on patient outcomes").

[38] Lakdawalla & Seabury, *supra* note 37, at 4.

[39] This discussion brings to mind an anecdote relayed by Atul Gawande in his thought-provoking *New Yorker* article about health care costs. Dr. Gawande describes a group of doctors' response to being told that they practiced in the most expensive (in terms of health care) city in the country:

> "Maybe the service is better here," the cardiologist suggested. "People can be seen faster and get their tests more readily," he said.
> Others were skeptical. "I don't think that explains the costs he's talking about," the general surgeon said.

issue remains in the public and legislative eye. In the face or aftermath of a crisis, where complaints by patients and doctors grow loudest, legislatures are still likely to act. Therefore, it is still worth understanding the crises and examining common legislative responses to them.

III. WHAT CAUSES THE CRISES?

There are two competing narratives attempting to explain the crisis periods. One explanation, endorsed by an assortment of recent scholarship, argues that the crises are caused by the cyclical nature of the malpractice insurance underwriting business.[40] The other, more traditional explanation argues that excessive litigation costs and damage awards cause the periods of crisis.[41]

> "It's malpractice," a family physician who had practiced here for thirty-three years said.
> "McAllen is legal hell," the cardiologist agreed. "Doctors order unnecessary tests just to protect themselves," he said. Everyone thought the lawyers here were worse than elsewhere.
> That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn't lawsuits go down?
> "Practically to zero," the cardiologist admitted.
> "Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures.

Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, NEW YORKER, June 1, 2009, at 36, *available at* http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande.

[40] *See, e.g.*, Baker, *supra* note 36 at 396; Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 PENN ST. L. REV. 1077, 1083 (2004); Carrie Lynn Vine, Comment, *Addressing the Medical Malpractice Insurance Crisis: Alternatives to Damage Caps*, 26 N. ILL. U. L. REV. 413, 422 (2006).

[41] *See, e.g.*, OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERV'S, CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND

A. A Review of the Empirical Evidence: No Evidence of Systematic Frivolous Litigation or Excessive Damage Awards

There is no perfect empirical test available to prove what actually drives the growth in premiums during the periods of crisis, but what data exists does not support the narrative that litigation costs and huge damage awards are the dominant drivers of premium growth. A study of medical malpractice in Texas, a "crisis" state according to the AMA, found that between the years 1988 and 2002, total payouts to patients were "roughly constant."[42] The number of claims filed per 100 physicians declined,[43] as did the number of claims paid per 100 physicians.[44] The authors of that study concluded: "[the] evidence suggests that no crisis involving malpractice claim outcomes occurred."[45] Another study using data from Florida reaches a similar conclusion, finding that the number of cases, per capita, was nearly identical in the early-90's as in the early-2000's.[46] While the authors find that payouts did increase during the most recent crisis, they attribute this to factors other than increasing jury awards because of the "831 million-dollar-plus payments, only sixty-three, just 7.5%, followed a jury trial[,]" and because only two of thirty-seven awards greater than five million dollars involved juries.[47] These findings are consistent with results in longer term studies. A 2002 study by Americans for

LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 8–11 (2002), *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.htm.

[42] Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988–2002*, 2 J. EMPIRICAL LEGAL STUD. 207, 209–10 (2005). Importantly, the authors controlled for changes in the population, healthcare spending, and the number of doctors practicing in the state. *Id.*

[43] *Id.* at 236.

[44] *Id.*

[45] *Id.* at 210.

[46] Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. 315, 353 (2005).

[47] *Id.* at 354–45.

Insurance Reform ("AIR") finds that the amounts paid out by insurance companies over the last thirty years have been stable, rising at a rate similar to medical inflation.[48]

Defenders of the litigation-based narrative also argue that damage caps have been successful at reducing insurer losses and/or reducing malpractice premiums and that this fact, in turn, confirms that excessive jury awards and frivolous litigation are the cause of the crises.[49] Proving that damage caps reduce insurer payouts and/or malpractice premiums does not prove that excessive litigation or jury awards cause the crises. Nevertheless, advocates of caps may argue they are justified simply because they reduce premiums, regardless of why they do so.[50]

Professor Mello analyzed the effect of damage caps on malpractice premiums in a meta-study for the Robert Wood Johnson Foundation.[51] Overall, she found that caps "moderately" constrain the growth of premiums.[52] In states with caps on non-economic damages, premiums continue to grow robustly; however, on average, the growth rate is slightly slower than in states without caps.[53] Specifically, she cites four reliable studies that together show a 6 to 13% reduction in the rate of premium growth in states with caps.[54] Consistent with these conclusions, a paper for the National Bureau of Economic Research treated malpractice premiums as a function of malpractice award payments and found, at marginal significance, that that for every 10%

[48] AMERICANS FOR INS. REFORM, MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES 1 (2002), *available at* http://www.centerjd.org/air/StableLosses.pdf.

[49] *See* AMA CALL FOR REFORM, *supra* note 1, at 10–15.

[50] *See, e.g., id.*; Richard A. Epstein, *Starting Over?: Redesigning the Medical Malpractice System*, 54 DEPAUL L. REV. 503, 504 (2005) ("Of the many different medical malpractice reforms, the only plan that seems to have some traction is a cap on non-economic damages, which, as used in California, reduced overall verdicts by about thirty percent according to a detailed Rand study, with a still steeper drop in attorneys' fees.").

[51] *See* MELLO, *supra* note 18, at 1.

[52] *Id.* at 15.

[53] *Id.* at 12.

[54] *Id.*

increase in malpractice payments, malpractice premiums would rise by approximately 1.6%.[55] The authors summarized: "past and present malpractice payments do not seem to be the driving force behind increases in premiums."[56] It is also widely accepted that damage caps reduce damage awards[57] and insurer losses.[58]

Texas provides a recent anecdotal example of the relationship between non-economic damage caps and malpractice premiums.[59] In 2003, a state constitutional amendment was passed to ensure that a recent statute imposing a non-economic damages cap of $250,000 would not be struck down by the courts (something that had happened previously to damage caps in Texas).[60] In the years following the cap, some large insurers did cut rates.[61] However, even though those rate cuts were sometimes substantial, they did not come close to reducing rates to levels seen before the crises began.[62] Causation and correlation are also difficult to distinguish because the caps were instituted around the time the third malpractice crisis ended on a national level. Texas did see its malpractice insurance market become more competitive following the imposition of caps, but that too is hard to attribute directly to the caps because more profitable insurance periods tend to coincide with increases in

[55] Baicker & Chandra, *supra* note 14, at 13.

[56] *Id.* at 21.

[57] *See infra* Part III.

[58] *See, e.g.*, AMA CALL FOR REFORM, *supra* note 1, at 11; Patricia H. Born & W. Kip Viscusi, *Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance*, 72 J. RISK & INS. 23, 32 (2005) ("The results suggest that [insurer] losses in states with non-economic damages reforms are reduced 16–17 percent compared to states without these measures.").

[59] *See generally* Giana Ortiz, *Medical Malpractice Damages Caps – Constitutional Per Se in Texas, but at What Price? A Look at Alternative Patient Compensation Schemes*, 43 HOUS. L. REV. 1281, 1290 (2006).

[60] *Id.* at 1294–95.

[61] *Id.* at 1296.

[62] *Id.* at 1296–97.

competition.[63] One thing is clear: the total number of malpractice lawsuits filed in Texas has dropped.[64]

To summarize the empirical evidence available, non-economic damage caps are associated with a small reduction in the growth rate of malpractice premiums. Caps reduce malpractice payouts and increase insurer profits, and it is therefore unsurprising that they reduce premiums. However, the reduction in premiums is minimal and since damage caps reduce malpractice payouts more dramatically than they reduce malpractice premiums, it is unlikely that excessive litigation and/or damage awards are the cause of the crises. This is consistent with empirical findings demonstrating a traditionally stable growth rate of insurer payouts on malpractice claims.

B. A Theoretical Explanation for the Empirical Evidence: The Insurance Underwriting Cycle

The empirical evidence is consistent with a theoretical explanation for the crises: the insurance underwriting cycle. Payouts on claims must affect malpractice premiums because an insurance company must charge enough to cover future costs. The periods of crisis, however, cannot be explained by increases in insurer payouts to successful litigants because those payouts have been relatively stable.[65] Therefore, another explanation is necessary and the best explanation for the crises is that they result from the unique nature of underwriting malpractice insurance.

There are two dominant costs associated with insurance: the general selling and administrative costs, and the cost of paying successful claims that may arise.[66] The latter cost must be predicted, and accounts for the lion's share of insurers' total costs (about five times selling and administrative costs).[67] Predicting future claims is difficult

[63] *See* Baker, *supra* note 36, at 413–14.

[64] Ortiz, *supra* note 59, at 1297.

[65] *See supra* Part II.A.

[66] Baker, *supra* note 36, at 396–97.

[67] *Id.* at 397.

because there are a variety of reasons that payouts differ from year to year. Despite this challenge, all insurance companies must make this essential prediction because an insurer must maintain enough assets to pay off those costs when they arise in the future.[68] To help ensure the ability to pay these future costs, most states require (and common business sense demands) a minimum percentage of the predicted expenses be held in reserve.[69] The reserved money is invested by the insurance company to earn income ("investment income"), and the reserves are adjusted upward when expected costs rise (and reduced when expected costs decrease).[70] Future investment income also must be predicted, which, again, requires assumptions.[71] The higher the returns expected on current reserve holdings, the less capital necessary to meet expected payout costs in the future.[72] The challenge unique to malpractice insurance is the length of time that transpires before it is clear what expenses will result from a policy.[73] "The length of the payout period is referred to as the 'tail' of the insurance policy" and malpractice insurance has a substantially longer tail than most other types of insurance.[74] The length of this tail, coupled with the uncertainty about future payouts and future investment income, helps explain why the malpractice premiums are so volatile.[75]

In addition to affecting the reserves necessary for this year's crop of policies, a change in assumptions regarding future investment income or claim payouts will affect the expected gains or losses on premiums written years before,

[68] *Id.* There are three central challenges to predicting future payouts on claims: (1) different years bring different doctors (with different specialties) as clients; (2) medical procedures and techniques can change year over year; and (3) the liability environment evolves. *Id.*

[69] *Id.*

[70] *Id.* at 397.

[71] *Id.*

[72] *Id.*

[73] *Id.* at 398.

[74] *Id.*

[75] *Id.* at 408.

which, in turn, requires a change in those reserve levels as well.[76] When the assumptions change for the worse, insurance companies find their reserves underfunded.[77] Since payouts have risen at stable rates, predictions regarding future investment income are more likely to be mistaken.[78] That is why changes in interest rates, a proxy for changes in investment profits, partially explain swings in malpractice premiums as insurers raise their premiums to ensure adequate reserves in the face of reduced investment income.[79] Of course, it is worth remembering that while interest rates (and economic activity), as proxies for investment returns, are important factors in explaining the crisis, they are not conclusive. Many factors affect premiums and there have been precipitous drops in interest rates that were not followed by malpractice crises, most notably in the early 1990's.

To summarize, the exceptionally long tail, coupled with difficulty in predicting (1) payout costs and (2) investment income, make premiums highly volatile. Payout costs are determined by a variety of factors, not the least of which are litigation defense expenses, settlement costs, and jury awards on successful claims. When those costs exceed expectations, premiums will rise if all else is equal. However, as discussed above, there is little evidence that payouts on claims rose at unstable (or unpredictable) rates in the past.[80] Therefore, investment income is probably the most powerful factor affecting premiums. This conclusion is supported by empirical studies that have found that malpractice crises follow weakened economic activity and falling interest rates[81] because weakened economic activity and falling interest rates are good estimates of investment income.

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[76] *Id.* at 399–400, 406–07.

[77] *Id.* at 406–09.

[78] *See supra* Part II.A.

[79] *See* Baker, *supra* note 36, at 406–08.

[80] *See supra* Part II.A.

[81] *See, e.g.*, Nathanson, *supra* note 40; AMERICANS FOR INS. REFORM, *supra* note 48.

In addition to the long tail, the malpractice insurance underwriting cycle is beset by problems of moral hazard and poor institutional incentives.[82] One important example concerns physician-controlled mutual insurance companies (major players in the malpractice insurance business).[83] These are typically nonprofit and "quasi-public" entities, which raises a host of potential issues. The "quasi-public" nature of these entities may give managers a sense that regulators will avoid declaring them insolvent.[84] More importantly, the lack of shareholders who demand profits creates a greater incentive to maximize market share.[85] This is dangerous because insurers in "soft" markets (where profits are strong) may, in an attempt to increase share, be more likely to issue policies at too low a rate.[86] The malpractice underwriting cycle also faces some dangerous institutional incentives. In soft markets, all insurers have an incentive to reduce prices (there is a lot of competition), but this may be exacerbated in the malpractice context because providers are very sensitive to premium changes.[87] These institutional incentives and moral hazards, coupled with the difficulties inherent in the insurance underwriting cycle, make insurance reform, discussed later, particularly attractive.

[82] Baker, *supra* note 36, at 427–29.

[83] *Id.* at 428.

[84] *Id.* New York's second-largest medical malpractice insurance provider faced losses that reduced its cash to a point where state regulations required the insurer be put into receivership, but after intense lobbying, the company was exempted from the rules and receivership was avoided. David Halbfinger & David Kocieniewski, *D'Amato Uses Clout to Assist Democrats*, N.Y. TIMES, Feb. 5, 2009, at A24 ("But the insurance company's lobbyists . . . persuaded lawmakers to exempt it from the reserve requirements, blocking a [receivership].").

[85] Baker, *supra* note 36, at 428.

[86] *Id.* at 495.

[87] *Id.* at 429.

C. Current Risks: Current Conditions Could Give Rise to a Crisis Period of Rising Malpractice Premiums

Accepting that the insurance cycle best explains the crises, the financial meltdown of 2008 has the potential to lead to another dramatic inflationary period for malpractice premiums. Insurance companies usually have some limitations placed on their investment portfolios by statute, often requiring a large percentage of investments be in safer debt securities. However, the typical state statute is not extremely restrictive.[88] Insurance companies in general have faced substantial difficulty in the equity markets during the recession, some even going so far as to buy thrifts to take advantage of one of Congress's bailouts for the financial system, the Troubled Asset Relief Program.[89] Some life insurers were forced to raise capital due to poor performances in their investment portfolios.[90] Pension funds, functionally similar to insurer reserves in that they are heavily regulated and risk-averse long-term investment vehicles, have seen losses of over 20%.[91] In general,

[88] *See, e.g.*, 40 PA. CONS. STAT. §§ 653c, 722.1 (2004). The Pennsylvania statutes regulating what insurance companies can do with their reserves permit a wide variety of investments, including more exotic securities and investment vehicles. §§ 653c(a)(4), 653c(a)(12).

[89] Marcy Gordon, *Four Insurers Seek to Buy Thrifts for Part of Bailout*, ASSOC. PRESS, Nov. 14, 2008, http://www.usatoday.com/money/economy/2008-11-14-2722836066_x.htm (last visited Feb. 28, 2010). *See also* Scott Patterson & Leslie Scism, *The Next Big Bailout Decision: Insurers* WALL ST. J., Mar. 12, 2009, at A1 ("Shares of Hartford Financial Services Group Inc., which already received a capital injection from German insurer Allianz, are down 93% as of Wednesday's close from their 52-week high. MetLife Inc. and Prudential Financial Inc. are both suffering as the value of their vast investment portfolios declines.").

[90] Mary Williams Walsh, *Life Insurers Facing Cuts in Ratings*, N.Y. TIMES, Nov. 12, 2008, at B1 ("Most life insurers need to strengthen their finances because their investment portfolios are sinking along with the stock market, and in some cases because of extensive holdings of mortgage-backed securities.").

[91] *See, e.g.*, Marc Lifsher, *CalPERS Wrestles Another Bear*, L.A. TIMES, Oct. 28, 2008, at C3 ("The California Public Employees Retirement

institutions that rely on investment income are showing signs of suffering.[92] Worse still, relatively low-risk bonds and other fixed income investments have been hit hard in the current crisis.[93] For example, the Fidelity Short-Term Bond fund has faced a far more severe drawdown during the current crisis than it did during the early 2000's.[94] Even the target federal funds rate points towards difficult market conditions for malpractice insurers. During the course of a malpractice crisis in the early 2000's, the federal funds rate dropped from 6% in 2000 to 1% in the latter part of 2003.[95] As of December 16, 2008, the effective federal funds rate was set at between 0.00 to 0.25%, down from 5.25% at the start of 2007.[96]

Some market conditions will act to soften the investment losses. For instance, malpractice suits may drop slightly if cash-strapped health care consumers forego treatment and therefore reduce the pool of potential injuries. Any mitigating effect would be minimal, however, as health care is a non-discretionary consumption choice and is considered somewhat recession-proof.[97] Going forward, the

System, known as CalPERS, had a total portfolio value of $185 billion on Friday, down 23% from $239 billion at the start of its fiscal year.").

[92] *See, e.g.*, Daniel Gross, *Harvard's Investment Errors*, SLATE, Nov. 17, 2008, http://www.slate.com/id/2204827/?from=rss.

[93] *See* Jeff Sommer, *Seeking Solace? You'll Find Little in the Bond Market*, N.Y. TIMES, Nov. 23, 2008, at BU6 ("Long-term corporate bonds, for example, declined in value by more than 18 percent, on average, through October . . . . That's worse than any full-year decline on its records going back to 1926.").

[94] Ticker Symbol: FSHBX. Data on file with author.

[95] FRB: Statistics and Historical Data. Data downloaded by author from the Federal Reserve website at http://www.federalreserve.gov/Releases/. For a chart of historical target federal funds rates, see the Federal Reserve Bank of New York's website at http://www.newyorkfed.org/markets/statistics/dlyrates/fedrate.html.

[96] *Id.*

[97] *See, e.g.*, Dan Macsai, *Health-Care MBAs See Brighter Future*, BUSINESSWEEK, Dec. 2, 2008 ("For business school students seeking job security, pursuing health-care management is 'one of the most stable' career options, because people will always need care[.]"), *available at* http://www.businessweek.com/bschools/content/dec2008/bs2008122_96910.htm.

availability of higher interest rates on corporate bonds might also prove beneficial for insurers' relying on investment income. Such yields, however, will not be immediately useful because all current reserve holdings will lose value as the yields on corporate bonds rise.

IV. THE STATUS QUO: A DISCUSSION OF CAPS ON DAMAGES AS THE DOMINANT RESPONSE TO MALPRACTICE CRISES

If the credit crisis and economic turmoil of 2008 cause another malpractice crisis, states will feel more pressure to act. Caps on non-economic damages are currently the most prevalent response to the malpractice crises and states that have not taken such measures often consider them. Unfortunately, these damage caps can be costly.

On top of their limited effectiveness in mitigating and preventing malpractice crises,[98] non-economic damage caps disproportionately affect the most severely injured patients.[99] One study examined the effect of California's $250,000 non-economic damage cap on malpractice cases that reached a jury.[100] In analyzing this issue, the first thing to consider is what types of malpractice cases reach juries. According to this study, "no claims [that reached a jury] involved emotional or insignificant injury exclusively, and only 3% involved temporary minor injury."[101] Of that pool of cases that did reach the jury, the damage cap resulted in a 73% reduction of non-economic damages awarded during the observed period.[102] The biggest reductions occurred in cases involving severe, but nonfatal injuries, and in general, the more severe the injury, the greater the effect of the cap.[103]

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[98] *See supra* Part II.

[99] David M. Studdert, Y. Tony Wang & Michelle M. Mello, *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFFAIRS 54, 63 (2004).

[100] *Id.* at 56.

[101] *Id.* at 57.

[102] *Id.* at 58.

[103] *Id.*

This is true in absolute terms (more dollars capped off) and in relative terms (greater percentage of the award capped off).[104] The caps resulted in the biggest reductions in awards for severe injuries that did not result in major economic loss (e.g., deafness, numbness, disfigurement, chronic pain),[105] presumably because those injuries hindered quality of life but did not result in high medical expenses or an inability for the claimant to work.[106]

A recent study of malpractice suits in Texas reaches generally similar results.[107] For instance, looking at the effect of non-economic damages caps on unemployed plaintiffs, the authors found that in cases of death, the average percentage reduction in aggregate payout for an unemployed claimant was 53%, compared to 17% for an employed claimant.[108] In addition, elderly plaintiffs were more likely to see their non-economic awards capped.[109] Perhaps most importantly, this study found that caps reduce payouts in settlements, a particularly important point because most successful plaintiffs settle.[110] Generally, a settlement was more likely to be capped under the same circumstances where jury verdicts were more likely to be capped (i.e., unemployed, elderly, quality of life affecting

[104] *Id.* at 60.

[105] *Id.* at 61.

[106] *Id.* at 63. A study commissioned by RAND Institute for Civil Justice reached a slightly different result about what type of injury results in an award most likely to be capped, finding that the cap was utilized more often in cases involving death. NICHOLAS M. PACE ET AL., RAND INSTITUTE FOR CIVIL JUSTICE, CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS: CALIFORNIA JURY VERDICTS UNDER MICRA (2004), http://www.rand.org/pubs/monographs/2004/RAND_MG234.pdf. Despite that variation, that study comports with these conclusions, finding that more severe injuries resulted in awards more likely to be capped than less severe injuries and that plaintiffs who lost the largest percentages of their awards had relatively modest economic damages but severe injury the quality of life. *Id.* at xxii, xxvii.

[107] David A. Hyman et al., *Estimating the Effect of Damage Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. L. ANALYSIS 355.

[108] *Id.* at 383.

[109] *Id.* at 382.

[110] *Id.* at 384.

injury, etc.), although the caps were slightly less severe in the settlement context.[111]

If evidence showed that the most severely injured were being excessively compensated, it would be of little concern that their damage awards were being reduced, but "[i]n fact, available evidence suggests that the reverse is true: Plaintiffs with the most severe injuries appear to be at highest risk for inadequate compensation."[112]

It is also essential to view these results in the context of the substantial medical error in this country, and the few effective deterrents for such mistakes. One older study found that only 1.53% of malpractice victims sue.[113] Experts in general consider the tort system vastly underutilized in the malpractice setting,[114] and this is particularly troubling considering the fact that medical error kills tens of thousands each year.[115] A study of hospitalized patients in New York found a "7.5 to 1 ratio between negligence-induced adverse events and the total number of medical malpractice

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[111] *Id.* at 387.

[112] Studdert, *supra* note 99, at 63.

[113] OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, *supra* note 41 (citing A.R. Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245 (1991)).

[114] *See, e.g.*, David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 976 (2005) ("The basic reason for the failure of the tort system is that injured patients rarely sue . . . . The oft-heard charge that patients sue whenever bad outcomes occur is simply wrong."); Douglas A. Kysar et al., *Medical Malpractice Myths and Realities: Why An Insurance Crisis Is Not a Lawsuit Crisis*, 39 LOY. L.A. L. REV. 785, 791 (2006) ("Using a conservative methodology for identifying negligent medical care, the Harvard researchers found that of the 27,179 cases of medical negligence identified in New York State hospitals in 1984, only 1.5 percent of victims filed medical malpractice claims. Several more recent studies support the conclusion that there is too little litigation brought against negligent care providers.").

[115] INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (1999), http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf.

claims."[116] Of this truncated group that sues, the vast majority are legitimate complaints.[117] Worse yet, there is no adequate institutional alternative to malpractice suits to provide the deterrence of substandard medical care that the country desperately needs.[118] Despite oaths and good intentions, doctors acting as their own checks have merely proved the old adage that a fox should not guard the henhouse.[119]

Caps, coupled with other statutes restricting payments to victims of malpractice and their attorneys, further isolate doctors as their own regulators because lawyers refuse to take malpractice cases. An empirical study of California—a state with a non-economic damage cap and a cap on attorney contingency fees[120]—by the RAND Institute for Civil Justice found that damage caps, without caps on attorneys' contingency fees, reduce attorneys' fees (by reducing awards) by 30%.[121] They further estimate that a cap on contingency fees, without caps on non-economic damages, would reduce fees by 46%.[122] Non-economic damage caps and contingency fee caps together reduce attorneys' fees by 60%.[123] These fee reductions coupled with a low success rate for malpractice plaintiffs at trial (about 22%[124]) and the high costs of experts,

[116] Hyman & Silver, *supra* note 114, at 791–92.

[117] *Id.*

[118] Kysar et al., *supra* note 114, at 791–92.

[119] *Id.* at 793.

[120] Pace, *supra* note 106, at xvii.

[121] *Id.* at xxiv.

[122] *Id.*

[123] *Id.* "To put it another way, defendants would have paid out $420.6 million without MICRA but with the award cap, aggregate liabilities were $295.5 million, a $125.1 million savings. Without MICRA, we estimate that plaintiffs would have received $280.4 million in net recoveries after fees were deducted but with the award cap and the fee limits, aggregate net recoveries were $239.5 million, a $40.9 million drop. The difference between the defendants' savings and the reduction in plaintiffs' net recoveries, approximately $84 million, would come in the form of reduced attorneys fees." *Id.* at xxvii–xxviii n.5.

[124] *Id.* at xx.

make it likely that attorneys will be very selective about whom they represent.

Finally, an additional problem with caps as a legislative response is that they may face substantial legal obstacles. In Texas, caps were unconstitutional[125] until an amendment to the state constitution was passed in 2003.[126] In Illinois, the state legislature battled to institute some form of a damage cap only to have it struck down as unconstitutional three times over a forty-year period.[127] The most recent challenge involved a 2005 statute that, among other things, placed a cap on non-economic damages.[128] In 2007, a trial court struck down that cap;[129] in 2010, the Illinois Supreme Court affirmed, holding that the cap on non-economic damages violated the separation of powers clause of the state's constitution.[130]

While a handful of other state supreme courts have struck down caps on non-economic damages, they are upheld more often than not[131] and some form of a damage cap

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[125] Lucas v. United States, 757 S.W.2d 687, 690 (Tex. 1988).

[126] Ortiz, *supra* note 59, at 1293.

[127] Chris Rizo, *Illinois Justices Consider Constitutionality of Medical Malpractice Caps,* LEGAL NEWSLINE.COM, Nov. 19, 2008, http://www.legalnewsline.com/news/217448-illinois-justices-consider-constitutionality-of-medical-malpractice-caps.

[128] *Id.*

[129] Lebron v. Gottlieb Mem'l Hosp., 2007 WL 3390918 (Ill. Cir. Ct. Nov. 13, 2007) (Trial Order).

[130] Lebron v. Gottlieb Mem'l Hosp., Nos. 105741, 2010 WL 375190, at *25 (Ill. Feb. 4, 2010).

[131] Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation,* 33 J.L. MED. & ETHICS 515, 516, 517 tbl.1 (2005) ("[W]e analyze the five most common constitutional challenges that caps legislation has faced: claims based on access to courts provisions, right to jury-trial provisions, equal protection guarantees, due process protections, and separation of powers principles. We conclude that damages caps passed as a response to documented strains in the liability insurance market are generally upheld against constitutional challenges, except in a small minority of states in which they are judged to implicate interests important enough to trigger heightened judicial scrutiny. We note that most state courts have been

presently exists in the majority of states.[132] The Bush administration repeatedly called for a national cap on non-economic damages,[133] although the Obama administration appears disinclined to pursue a cap.[134] Still, as problems in the malpractice area continue, and legislatures continue to grapple with these issues, the sometimes-questionable constitutionality of non-economic damage caps is worth noting, especially in the context of a cap's effects on the most vulnerable patients and on deterrence of medical error.

V. INSURANCE REGULATION AS AN ALTERNATIVE TO DAMAGE CAPS

A. Insurance Regulation as a Viable Response to Malpractice Crises

An alternative to damage caps is to directly regulate the setting of malpractice insurance premiums. California's Proposition 3 is a well-known and comprehensive example of a direct regulation of malpractice premiums.[135] Passed by ballot initiative, Proposition 3 fixed insurance rates for a

hesitant to overturn damages caps, even in the face of judicial doubt about their efficacy.").

[132] For a chart containing a description of the type of cap in each state, as well as the author's estimation of the effect of that cap on malpractice insurance payments in the state (based on a simulation derived from Texas data), see Black et al., *Estimating the Effect of Damages Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. LEGAL ANALYSIS 355, 393 tbl.11 (2009).

[133] *See, e.g.*, Gfell, *supra* note 10, at 776 ("The Help Efficient, Accessible, Low-Cost Timely Healthcare Act of 2003, which would have capped non-economic damage awards in medical malpractice actions at $250,000, was passed by the United States House of Representatives in March of 2003, but in July, a similar measure was blocked by a filibuster in the Senate. The vote on these measures has generally come down along party lines, with the most recent pieces of legislation being backed by President George W. Bush.").

[134] BARACK OBAMA AND JOE BIDEN'S PLAN TO LOWER HEALTH CARE COSTS AND ENSURE AFFORDABLE, ACCESSIBLE HEALTH COVERAGE FOR ALL 3–4, http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf.

[135] CAL. INS. CODE §§ 1861.01–.16 (2009).

year (at a 20% reduction) and required that the California Department of Insurance approve any future rate increases.[136] Notably, California did not suffer dramatic rate increases during the early-2000's crisis.[137] While, it is not clear what role the required rate approval played because the vast majority of requests for rate increases were granted by the California Department of Insurance,[138] there are reasons to believe it has played an important part in California's success in avoiding the most recent malpractice crisis. First, there is a correlation between Proposition 3's passing and the stabilization of rates in California[139] because California's malpractice premiums did not stabilize after damage caps were instituted, but did stabilize twelve years later in the wake of Proposition 3's passage. Furthermore, while Proposition 3 allows for reasonable rate increases, the process of requiring approval itself may reduce premiums as it forces companies to provide a reason for increases, ensuring there is no gouging. More importantly, it also may help moderate the underwriting cycle by mitigating certain behavioral and institutional considerations that contribute to the volatility in rate premiums. If insurers know that rate growth will be limited, they have a better incentive not to overly expand coverage during profitable "soft" markets, an important incentive when considering that over-expansion during soft markets has contributed to the crises.[140]

A Proposition 3-like reform could also have ancillary benefits. It puts the administrator in charge of approving

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[136] *Id.*; Vine, *supra* note 40, at 418.

[137] GAO MULTIPLE FACTORS, *supra* note 4, at 12 F.2.

[138] MELLO, *supra* note 18, at 26 ("Data from the California Department of Insurance on closed rate filings show that in 2000–2003, the Department received 59 medical malpractice insurer requests for rate increases (not including requests from insurers that handled only dentists or podiatrists). Excluding five cases in which the insurer withdrew the request, the Department approved the full increase or close to the full increase requested 89 percent of the time. The median premium increase approved was 11 percent and the largest was 80 percent.").

[139] Vine, *supra* note 40, at 418–19.

[140] *See supra* Part II; *see also*, GAO MULTIPLE FACTORS, *supra* note 4, at 35.

rate increases in a position to collect an assortment of data about medical malpractice insurance. For example, the (unconstitutional)[141] Illinois statute discussed above experiments with direct premium regulation (in addition to caps) and creates a Secretary of Financial and Professional Regulation to approve reasonable and justified rate increases.[142] The administrator is empowered to set up a website with information about the different insurance companies and to collect information about the lawsuits affecting those insurers.[143] Profit and loss information might also be available for researchers because insurers are required to report their profits per county for the last ten years.[144] Collecting this type of information will enable researchers and the legislature to gauge the effectiveness of reforms and gain insight into whether payouts are actually growing at an alarming rate.

There is an important difference between empowering an administrative agency to approve rate increases and empowering an administrative agency to set rates; the former is considerably more attractive. In New York, the State Insurance Superintendent has the power to set medical malpractice rates.[145] Because of legislative interference, it is not clear how successful such regulation has been, but New York's experience is still instructional. New York's market has little commercial competition in the malpractice area and those malpractice insurers that do exist are typically

[141] Lebron v. Gottlieb Mem'l Hosp., Nos. 105741, 105745 cons, 2010 WL 375190, at *18 (Ill. Feb. 4, 2010) ("Because the Act contains an inseverability provision . . . we hold the Act invalid and void in its entirety."). Even though no longer good law, the statute remains instructive for purposes of this paper by demonstrating the type of information that could be collected by an executive agency.

[142] 215 ILL. COMP. STAT. 5/155.18 (amended 2005). *See also* Edward J. Kionka, *Things to do (or Not) to Address the Medical Malpractice Insurance Problem*, 26 N. ILL. U. L. REV. 469, 505 (2006).

[143] 215 ILL. COMP. STAT. 5/155.18a. *See also* Kionka, *supra* note 142, at 505.

[144] 215 ILL. COMP. STAT. 5/155.19. *See also* Kionka, *supra* note 142, at 505.

[145] N.Y. INS. LAW § 2343 (2008).

owned by their insured.[146] The regulatory framework is such that insurers are selective in who they will cover and providers who cannot get coverage directly can get it through a state created fund.[147] From 1975 until 2000 this fund was called the Medical Malpractice Insurance Association ("MMIA").[148] During the 1990's, about one billion dollars worth of MMIA's medical malpractice liability reserves were appropriated by the legislature for other uses.[149] In 2000, the MMIA was dissolved and the Medical Liability Mutual Insurance Co. took its place.[150] Without the investment income from large reserves, however, this replacement is running into trouble.[151] While this legislative interference makes it difficult to assess the success of New York's rate-setting policy, it does illuminate some reasons to avoid governmental setting of rates. First, directly setting rates is bound to discourage entrants into the markets because generally rates will be set as low as possible. New York devolved from a fairly competitive landscape to a state where virtually all medical malpractice insurers were owned by their insureds.[152] Competition is good for the malpractice environment, so this is an unfavorable result. Of course, requiring administrative approval of rate increases (rather than setting the rates directly) will also deter entrants, but the impact should be less severe because it puts insurers in a better position. In a rate-approval system, insurers have to convince a regulator that an increase is justified, which is generally not difficult. In a rate-setting system, insurers

[146] Michael A. Haskel, *New York State's Medical Malpractice Plan: Unfunded, Unworkable, and Unconstitutional,* N.Y. ST. BAR J., Feb. 2006, at 30.

[147] *Id.*

[148] *Id.*

[149] *Id.*

[150] *Id.*

[151] New York State Insurance Department, *Rate Increase Staves Off Looming Insurance Industry Crisis as New Task Force Confronts Medical Malpractice Reform*, July 2, 2007, *available at* http://www.ins.state.ny.us/press/2007/p0707021.htm.

[152] Haskel, *supra* note 146, at 30.

must demonstrate to a court that the rate schedule promulgated by the executive agent is unreasonable, which is very difficult. The difference can be seen anecdotally. In California, most rate increases requested by insurers are approved.[153] In New York, the rate schedule is almost invariably upheld[154] and it has resulted in rates below those the insurance companies request.[155] Another reason why it is better to approve rates than to set them is that it makes the process less political. It is politically easier for a politician (or a civil servant) to approve unpopular rate increases than to set them.[156]

B. The Constitutionality of Insurance Regulation is Clear

An added benefit of direct insurance regulation is that it is almost certainly constitutional on the federal and state level. This is important because other measures, including damage caps, do not always withstand constitutional scrutiny, and legal challenges delay the effectiveness of any reform as the market will not respond until it is certain what

[153] *See* MELLO, *supra* note 18, at 26 ("Excluding five cases in which the insurer withdrew the request, the Department [of Insurance] approved the full increase or close to the full increase requested 89 percent of the time.").

[154] Medical Malpractice Ins. Ass'n v. Superintendent of Ins. of State of New York, 533 N.E.2d 1030 (N.Y. 1988).

[155] *See* New York State Insurance Department, *supra* note 151 (showing the approved rate to be below the requested rate every year from 2002 through 2008).

[156] At least some commentators have argued that New York's rates were kept artificially low (even if still high as compared to the national average) for political reasons. As an executive of the Medical Liability Mutual Insurance Company said, "the rates for the past five or six years have been politically held down." Elizabeth Solomont, *'Worst of Both Worlds' Hits Insurance*, N.Y. SUN, July 3, 2007, at 1. In contrast, in California, insurance companies submit rates, which are usually upheld, *see supra* text accompanying note 153, and insurance companies are facing different political pressures than a gubernatorial appointee.

the regulatory and legal environment will be.[157] While there would probably be challenges to any law, in most states direct insurance regulation will pass constitutional scrutiny.

In 1914, the Supreme Court addressed whether a Kansas statute regulating fire insurance premiums offended the due process clause of the Fourteenth Amendment.[158] The insurance company argued that such a regulation was a taking and an impermissible intrusion in private business.[159] Rejecting this argument, the Court frames the question as whether "the business of insurance [is] so far affected with a public interest as to justify legislative regulation of its rates?"[160] Finding that the police power of the state was being exercised for the public interest—specifically, protecting a large part of the nation's wealth that is vulnerable to fire—the Court upheld the statute.[161] As a general principle, judicial deference for state regulation of insurers has not abated.[162] This type of statute would also likely be upheld under rent-control doctrine as long as the regulation had a rational relationship to a legitimate state interest,[163] a standard easily met under these circumstances.

California's Proposition 103 survived legal challenges, but not unscathed and not without some important judicial instruction. Proposition 103 required a 20% reduction in premiums, and precluded insurers from raising rates from

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[157] *See* Kelly & Mello, *supra* note 131, at 515–16 ("However, the experience of California and other early adopters of caps demonstrates that although caps are typically passed as an emergency response to a malpractice crisis that has reached critical levels, if there is uncertainty as to whether they will be upheld in the courts, liability insurers may not move immediately to reduce premiums. Rather, the relief doctors and hospitals expect may be delayed until constitutionality questions are settled.").

[158] German Alliance Ins. Co. v. Lewis, 233 U.S. 389, 404 (1914).

[159] *Id.*

[160] *Id.* at 406.

[161] *Id.* at 412–13.

[162] *See* 11–75 APPLEMAN ON INSURANCE § 75.1 ("From the cradle to the grave, insurers and their agents are under official surveillance.").

[163] *See, e.g.*, Pennell v. San Jose, 485 U.S. 1 (1988); Calfarm Ins. Co. v. Deukmejian, 771 P.2d 1247, 1251 (Cal. 1989).

that reduced level for a period of one year.[164] There was, however, a small escape hatch: the act allowed an insurer to raise rates during that first year if they were substantially threatened with insolvency.[165] The California Supreme Court, however, found this provision unconstitutional.[166] That court held that "[o]ver the long term the state must permit insurers a fair return."[167] Avoiding insolvency is not a fair return.[168] While the "avoiding insolvency" standard only applied for a single year, even in the short term insurers are entitled to a fair return unless there is an emergency situation.[169] Since malpractice premiums present a long term challenge, not a short term emergency, this part of the statute was unconstitutional.[170] Despite the court's disapproval of "avoiding insolvency" as an indicator of a reasonable return, they upheld the rate cut by construing Proposition 3 to require that insurers receive fair and reasonable rates even during that first year.[171] The upshot is that any regulation of premiums must allow for insurance company profits. There also has to be a mechanism for insurers to avoid facing confiscatory rates (rates of return that are not fair and reasonable).[172] Therefore, at least in California, a statute cannot set a maximum rate increase because under some circumstances, that might not provide for a fair and reasonable rate.[173] The court also makes clear that insurers cannot be punished for past profits.[174] These constitutional limitations arise out of the Fourteenth Amendment[175] and provide a typical analysis of the question.

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[164] CAL. INS. CODE § 1861.01(a) (2009).

[165] § 1861.01(b).

[166] *Calfarm*, 771 P.2d at 1255.

[167] *Id.*

[168] *Id.*

[169] *Id.*

[170] *Id.*

[171] *Id.* at 1256–57.

[172] *Id.* at 1252–53.

[173] *Id.* at 1253 n.7.

[174] *Id.* at 1247.

[175] *Id.* at 1254.

This is an important limitation on insurance regulation because it should help maintain a competitive private market for malpractice insurance.

C. Potential Problems with Insurance Regulation

One risk of insurance regulation is that it will push malpractice insurers out of the market. A reduction in the number of malpractice insurers has negative consequences for the malpractice insurance market and can exacerbate periods of crisis.[176] Therefore, direct insurance regulation cannot be effective if it severely reduces competition. It is here that the constitutional limitations play a crucial role by guaranteeing that direct regulation of the premiums allows for a reasonable rate of return. At least in California, insurance commissioners generally permit rate increases,[177] so there is little risk that such regulation will push insurers towards insolvency. This will encourage private malpractice insurers to enter, or remain in, the marketplace.

Professor Baker, who attributes the cause of the crises to the insurance underwriting cycle, does not support regulation of insurance markets to manage the crises because he believes that the crises might lead to better patient care by enhancing the deterrent effect of the tort system.[178] Relying on behavioral psychology and a little bit of common sense, Professor Baker argues that the attention these crises bring to the threat of litigation keeps doctors on their best behavior.[179] This may very well be true in theory. In practice, however, a recommendation not to regulate malpractice premiums ignores the fact that legislatures will continue to take action, and that that action may be worse for victim compensation and patient care than direct insurance regulation.[180] Furthermore, Professor Baker's

[176] Baker, *supra* note 36, at 416; Nathanson, *supra* note 40, at 1078–79.

[177] *See* MELLO, *supra* note 18, at 26.

[178] Baker, *supra* note 36, at 430–43.

[179] Baker, *supra* note 36, at 431.

[180] *See supra* Part III.

conclusions rest on the increased publicity medical malpractice gets during the crises. This ignores the fact that there is also increased coverage and attention to malpractice after large jury awards, something more and more states have restricted as a response to the crisis.

There is also an argument that the very existence of high malpractice premiums improves patient care.[181] Professors Hyman and Silver tell the story of anesthesiologists who, beset by malpractice premiums, innovated better methods of care that not only resulted in fewer lawsuits, but also reduced morbidity rates.[182] Fewer injuries and lawsuits, in turn, resulted in lower malpractice premiums.[183] If direct insurance regulation reduced premiums, the argument goes, the incentive to innovate would disappear. There is no reason, however, to conclude that direct insurance regulation would remove an incentive for doctors to innovate. In addition to any moral, ethical, or professional incentives, insurance regulation must allow for malpractice rates to rise in order to be effective and constitutional; as such, malpractice premiums will always be somewhat costly, and there will remain an incentive for doctors to innovate benefits for patient care. Furthermore, this argument, like Professor Baker's, ignores the fact that legislatures will continue to respond to the crisis by attempting to reduce premiums, often with the imposition of stricter caps on damages.[184]

It is a legitimate criticism of direct insurance regulation to point out that it may not be terrifically effective. Insurance regulation will not affect certain factors, including investment income and payout expenses, which play a central role in determining the cost of malpractice insurance. On the other hand, implemented properly, direct insurance

[181] Hyman & Silver, *supra* note 114, at 984.

[182] *Id.*

[183] *Id.* at 984–85.

[184] Professors Hyman and Silver may not mind this result as they support the use of caps as a carrot offered to insurance companies to get them to agree to better error reporting policies, which they believe will more effectively reduce medical injuries. *Id.* at 985.

regulation should moderate poor institutional incentives and curb certain moral hazards. The result should be a less aggressive malpractice insurance market during plush times and a less disastrous inflation during hard markets. Furthermore, direct insurance regulation only results in a small social and economic loss. It will not reduce payments to victims or bankrupt insurance companies. Therefore, even if the benefits are limited, they far outweighs the costs.

VI. A REVIEW OF RECENT MEDICAL MALPRACTICE REFORMS: THE GOOD AND THE BAD

Medical malpractice is under perpetual discussion in legislatures around the country. While proposals tend to fall into the usual categories, states continue to experiment, and some reforms are more reasonable than others.

In 2005, Anthony Williams, the then mayor of Washington, D.C., responded to a perceived medical malpractice crisis with a plan to limit attorneys' fees and cap non-economic damages.[185] Rejecting caps, the D.C. Council opted for a plan that seems reasonable in light of the foregoing discussion. In D.C., malpractice premiums must be submitted to the Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner"), and those rates cannot be excessive.[186] When seeking to raise premiums, an insurer must ask the Commissioner for approval and is required to submit "all information, including all actuarial data, projections, and assumptions, that the medical malpractice insurer has relied on in calculating its proposed rates."[187] If the requested change is less than a 10% increase, then sixty days after the Commissioner makes the request public it is deemed granted

[185] Lori Montgomery, *Mayor Moves to Curb Medical Malpractice Costs; Proposal Would also Strengthen Roles of D.C. Health, Insurance Officials*, WASH. POST, May 5, 2005, at B03.

[186] *See* D.C. CODE § 31-2703(f-1)(1)(A) (2009); *see also* § 31-2701(2) (providing the definition of Commissioner, as used in § 31-2703).

[187] § 31-2703(f-1)(2).

without any explicit approval from the Commissioner.[188] If the requested increase is more than 10%, then the Commissioner must hold a hearing and explicitly approve or deny the rate change.[189] Finally, the statute provides a list of factors for the Commissioner to consider in her determination of whether a rate is "excessive":[190]

> (i) Past and prospective loss experience within the District;
> (ii) A reasonable margin for underwriting profit and contingencies;
> (iii) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;
> (iv) Past and prospective expenses in the District;
> (v) All investment income reasonably attributable to medical malpractice insurance in the District.[191]

And:

> (B) If District experience is not credible, the Commissioner may consider experience outside the District. The Commissioner shall promulgate rules setting forth the extent to which and the circumstances under which an insurer may rely on experience outside the District.[192]

This is a superb legislative response. Not only does D.C. not have a damage cap, but its medical malpractice policy is well thought out. The plan strikes a nice middle ground between the California and New York regimes. Whereas in California the default rule seems to be regulatory approval of the requested premiums, and in New York the regulator sets the rate (often below that requested by the insurers),[193] in D.C., the default rule is that smaller rate increases are automatically approved and larger rate increases must be

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[188] § 31-2703(f-1)(3).

[189] *Id.*

[190] § 31-2703(f-1)(1)(A)(i)–(v).

[191] *Id.*

[192] § 31-2703(f-1)(1)(A)–(B).

[193] *See supra* Part IV.A.

explicitly approved or denied by the regulator.[194] This is an intelligent compromise because it avoids the political pressures inherent in having the regulator set the rate (as can be seen in New York),[195] while creating a default rule ensuring that large rate increases are never hastily or quietly approved without a public hearing and an explicit ruling.[196] The statute is also careful to define "excessive" such that it allows for a reasonable profit to the insurers, avoiding a crippling of competition.[197] In determining whether a rate is excessive, the Commissioner can consider changes in investment income[198] and is therefore, possibly, better able to determine when larger rate increases are truly necessary. These components make the statute a careful form of direct insurance regulation that is likely to mitigate undesirable institutional incentives while resulting in little harm to society, making it an excellent statutory response to the perception of a malpractice crisis.

There are a variety of explanations for why the D.C. Council would eschew damage caps, not the least of which is that it is a liberal city,[199] and Democrats are generally less receptive to caps.[200] The other explanation is that D.C. was simply not facing a rapid growth in lawsuits or payouts on lawsuits. On a national level, payouts on malpractice claims have tended to rise at a rate comparable to medical spending in general.[201] In contrast, when controlling for medical

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[194] § 31-2703(f-1)(3).

[195] *See supra* Part IV.A.

[196] *See supra* Part IV.A.

[197] § 31-2703(f-1)(1)(A)(iii).

[198] § 31-2703(f-1)(1)(A)(v).

[199] *See* DISTRICT OF COLUMBIA BOARD OF ELECTIONS AND ETHICS, MONTHLY AND ETHICS, MONTHLY REPORT OF VOTER REGISTRATION STATISTICS FOR THE PERIOD ENDING DECEMBER 31, 2007 at 2 (2007), *available at* http://dcboee.org/pdf_files/Statistics_Report_December2007.pdf (stating that 277,050 of 374,008 registered voters were Democrats).

[200] *See, e.g.*, Janice Francis-Smith, *Tort Reform Takes Center Stage in Oklahoma Political Battle*, J. REC., Feb. 19, 2009 (describing a legislature's split on tort reform as more of a political fault-line than a disagreement over what is better for constituents.).

[201] *See supra* Part II.A.

inflation, malpractice payments in D.C. declined 52.5% from 1991 to 2004.[202] Similarly, over that same period, the median payout (adjusted for inflation) of malpractice claims declined, as did the number of payouts per doctor.[203] Thus, as compared to the nation, D.C.'s malpractice payout climate is not in crisis, and the absence of a real crisis undoubtedly made it easier for the Council to respond carefully to a call for reform.

Not all states' responses have been as measured. For example, New Jersey opted to place a tax of seventy-five dollars on all lawyers and doctors in the state for a period of three years.[204] The statute directed the bulk of the proceeds of this tax be used to subsidize malpractice costs for certain doctors and hospitals.[205] Probably the best thing that can be said about the tax is that it is constitutional.[206] It does nothing to address the causes of rising malpractice premiums, and it affects all lawyers and doctors indiscriminately, rather than imposing costs specifically on problem doctors or lawyers. One study in the District of Columbia estimated that fewer than 5% of doctors are responsible for nearly half of all malpractice payouts.[207] While there is no similar study estimating whether a small group of lawyers bring the majority of frivolous suits, it would not be surprising. New Jersey's tax, targeting all doctors and lawyers, does nothing to address these problem groups, and by subsidizing premiums without addressing the factors that determine those premiums, namely investment income and payout costs, it will add nothing to the long-term health of the malpractice market. Meanwhile, the American

[202] PUBLIC CITIZEN: CONGRESS WATCH, DISTRICT OF COLUMBIA MEDICAL MALPRACTICE PAYOUT TRENDS 1991–2004: EVIDENCE SHOWS LAWSUITS HAVEN'T CAUSED DOCTOR'S INSURANCE WOES 5 (2005), *available at* http://www.citizen.org/documents/WDC2005malpracticeanalysis.pdf.

[203] *Id.*

[204] N.J. STAT. ANN. § 17:30D-29(b), (f) (West 2004).

[205] § 17:30D-29(e).

[206] New Jersey State Bar Ass'n v. State, 387 N.J. Super. 24, 44 (App. Div. 2006) (holding the statute constitutional).

[207] PUBLIC CITIZEN, *supra* note 202, at 14.

Medical Association considered New Jersey a "crisis" state during the early part of this decade,[208] and according to the National Conference of State Legislatures, there were seventeen proposals for medical malpractice reform being considered by the New Jersey legislature in 2007.[209] New Jersey would do well to follow the District of Columbia's lead.

VII. CONCLUSION

There have been three periods of crisis where malpractice premiums rose at outrageous rates. In response to these periods, state legislatures have taken steps—most notably the imposition of damage caps—that are often more harmful to society than beneficial. Not only do damage caps potentially harm severely injured individuals and their families, but they are a response to a perception—that there is too much frivolous litigation and that jury awards are often excessive—that has little empirical support in recent research. An alternative response to these periods of crisis involves direct state regulation of malpractice insurance premiums. While not a panacea, this alternative has few social costs and can be implemented fairly and easily, as demonstrated by the District of Columbia. Because direct regulation of premiums would result in positive incentives for malpractice insurers and reduce the growth rate of premiums, it should be considered before more harmful alternatives.

[208] AMA CALL FOR REFORM, *supra* note 1, at 8.

[209] *See* NATIONAL CONFERENCE OF STATE LEGISLATURES, MEDICAL MALPRACTICE TORT REFORM, 2007 STATE INTRODUCED LEGISLATION, http://beta.ncsl.org/Default.aspx?TabId=16214 (last visited Feb. 7, 2010).