

MICRA, NOT PROPOSITION 103, ACCOUNTS
FOR THE RELATIVELY LOW GROWTH IN
MEDICAL MALPRACTICE INSURANCE COSTS
IN CALIFORNIA

ABSTRACT

In 1975, the California Legislature enacted the Medical Injury Compensation Reform Act ("MICRA"). Due to legal challenges, MICRA's status was in doubt until 1985, when the California Supreme Court upheld the Act's constitutionality. Three years later, in 1988, California voters passed Proposition 103, which sought to control insurance rates but not malpractice insurance costs. Our analysis shows that MICRA's \$250,000 ceiling cap on non-economic damages and not Proposition 103, accounts for the relatively low growth in medical malpractice insurance costs in California since 1988.

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I. INTRODUCTION

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 healthcare 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. 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 healthcare 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 [*159] 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, Barme 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 premiums. It appears obvious that this section—by placing a ceiling of \$250,000 on the recovery of non-economic damages—is rationally related to the objective of reducing the costs of malpractice defendants and their insurers.¹

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, such as pain and suffering, in medical malpractice lawsuits;² (2) it allowed defendants to

¹ *Lawrence Fein, Plaintiff and Appellant, v. Permanente Medical Group, Defendant and Appellant*, S.F. No. 24336, Supreme Court of California, 38 Cal. 3d 137; 695 P.2d 665; 211 Cal. Rptr. 368; 1985.

² The law defines non-economic losses as “pain, suffering, inconvenience, physical impairment, disfigurement and other non-pecuniary damage.” CA Civil Code, §3333.2(a)

introduce evidence showing that the plaintiff had already received compensation for a portion of his or her losses; (3) it authorized trial courts to require periodic payments for future damages, in lieu of lump-sum awards; and (4) it imposed limits on the contingency fees that lawyers can charge medical malpractice claimants.

MICRA imposes no limits on economic or punitive damages.³ 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 percent from the levels in effect on November 8, 1987. The measure also required any change in property and casualty insurance rates to be approved by the Insurance Commissioner, beginning November 8, 1989.

Among the insurance lines subject to Proposition 103's provisions are: 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 Longshoremen's & Harbor Workers' Compensation Act.

C. OBJECTIVES OF THIS REPORT

Several groups and individuals have posited that Proposition 103—not MICRA—is responsible for controlling the cost of medical malpractice insurance.⁴ The purpose of this paper is to assist policymakers, opinion leaders, and the public evaluate this argument.

D. SUMMARY OF FINDINGS

The evidence shows that Proposition 103 cannot explain the relatively modest growth in malpractice premiums in California since 1988. MICRA must be given credit for this favorable trend.

³ There is some evidence (post-cap) that non-economic awards represent approximately 42 percent of total awards. Pace, Nicholas M., Daniela Golinelli and Laura Zakaras, "Capping Non-Economic Awards in Medical Malpractice Trials. California Jury Verdicts Under MICRA," RAND Institute of Civil Justice (hereafter, "RAND report"), Table 3.1, p 20.

⁴ See for example, "How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California And How Malpractice Caps Failed," Foundation for Taxpayer and Consumer Rights, March 7, 2003.

II.

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

We test the critics' contention that Proposition 103, rather than MICRA, 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, rather than MICRA, 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

We would not expect Proposition 103 to 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 or dividends. In the insurance business, costs drive premiums—not the other way around.

Proposition 103 did not do anything to reduce insurance costs. As a result, 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 Insurance Commissioner has ruled that a demonstrable increase in the cost of providing insurance is sufficient to justify a rate increase. Consequently, to the extent that medical malpractice insurance costs were to increase because the MICRA cap on non-economic damages was raised or eliminated, Proposition 103 would not be able to hold premiums down.

It is our understanding that only two malpractice insurers have ever been denied the full premium increase sought. In both instances, reduced increases were

approved, and the companies indicated that they would subsequently refile to adjust rates to the full levels originally sought.

Could Proposition 103 hold down premiums by keeping medical malpractice insurance rates so low that insurers are forced to reduce their loss reserves? No. Neither Proposition 103 nor the Commissioner can 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 18th out of 30 states in terms of reserve adequacy, and their reserves are within two percent of the national mean.

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 of malpractice insurance in California is written by non-profit, mutual insurance companies that have no incentive to generate excess profits.⁵ 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).

⁵ By "excess profits," we mean revenues in excess of costs, including the market-determined cost of capital.

TABLE 1
2003 RANKINGS: NET INCOME; POLICYHOLDER'S SURPLUS;
LOSS RESERVES; UNDERWRITING INCOME⁶

State ⁷	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 ⁸	(\$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	16	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
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)	

⁶ AM Best Key Rating Guide, 2004 Edition. 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 30.

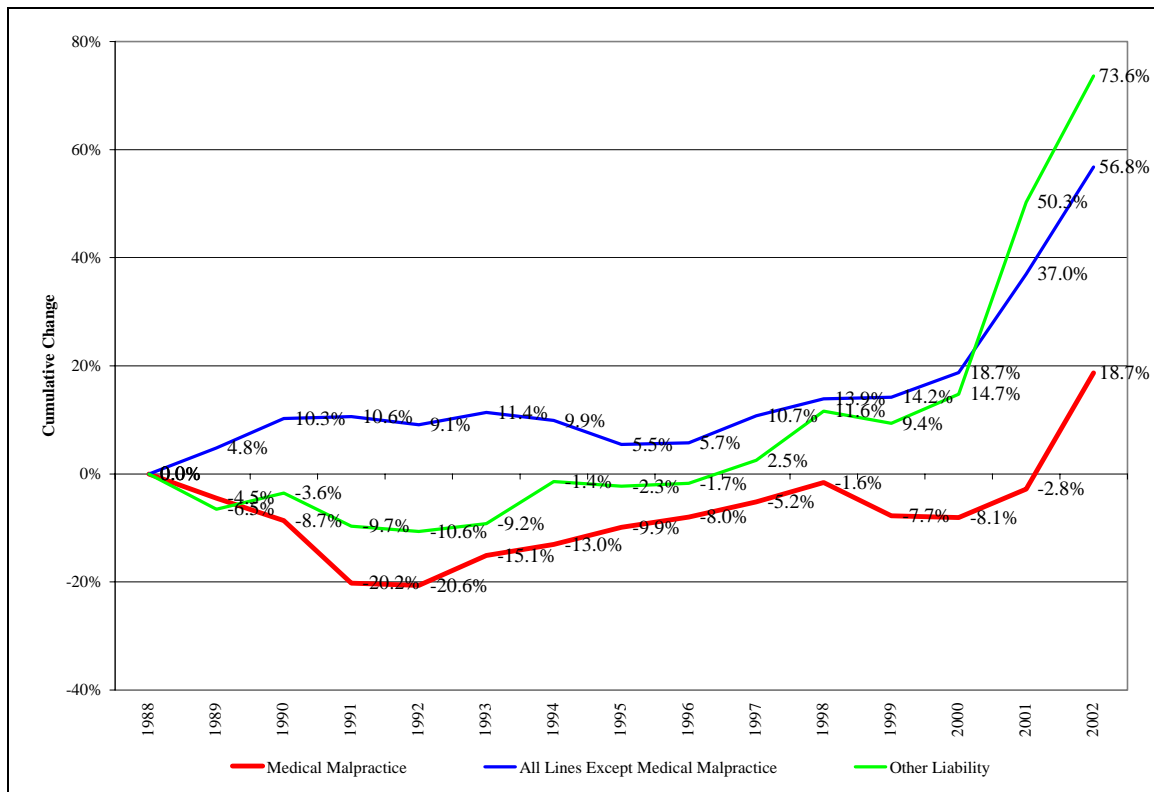
⁷ State indicates first state of business (*i.e.*, majority of revenue generated in indicated state).

⁸ Includes: 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.

B. CALIFORNIA MEDICAL MALPRACTICE PREMIUM RATES HAVE GROWN MORE SLOWLY THAN RATES FOR OTHER PROPOSITION 103-REGULATED LINES

If Proposition 103 (rather than MICRA) is responsible for holding down 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. We have tested this hypothesis by comparing the trend in premiums for medical malpractice insurance with the trend for these other insurance lines. Figure 1 provides this comparison.

FIGURE 1
CUMULATIVE PREMIUM CHANGE (BY LINE) SINCE THE ADOPTION OF PROPOSITION 103⁹



As Figure 1 clearly 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 percent.

What accounts for the opposing trends? The obvious explanation is the difference in claim costs. Medical malpractice insurance rates went down because claim costs went down. Premiums for “all lines except medical malpractice” went up because

⁹ Source: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976 – 2002; California data.

claim costs went up. (If costs had not gone up, the Insurance Commissioner would have refused to approve the higher rates.)

Proposition 103 had no effect on the cost of providing medical malpractice insurance, but MICRA clearly did. Because 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 a different direction.

When we extend the period of analysis to 1998, we observe the same disparate trends in premiums: medical malpractice premiums remained below the 1988 level (-1.6%), while—notwithstanding Proposition 103—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).

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 percent, while premiums for “all lines except medical malpractice” grew by 57 percent, and premiums for “other liability” grew by 74 percent.

III. CONCLUSION

In sum, the data demonstrates that MICRA, rather than Proposition 103, deserves the credit for the drop in medical malpractice insurance rates and the resulting moderation in healthcare costs. This finding is not surprising, given the fact that Proposition 103, unlike MICRA, did nothing to limit the cost of providing medical malpractice insurance.

APPENDIX

BIOGRAPHIES

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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 eight 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.

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Dr. Wazzan is the CEO of Wazzan & Co. Investment LLC, a venture capital company providing seed financing to startups in the fields of semiconductors, optical networking, bio-mechanical, bio-medical and related technologies.

Dr. Wazzan has published on the impact of socially motivated shareholder activism and the influence of pension fund investment/divestment on securities prices and is a member of the American Finance Association.

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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.

His most recent book is Competition and Monopoly in Medical Care, published by the American Enterprise Institute. The journals in which he has published include the *American Economic Review*, *Journal of Political Economy*, *Journal of Law and Economics*, *Quarterly Journal of Economics*, *Journal of Institutional and Theoretical Economics*, *De Economist* and *Review d'Economie Politique*.

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