MICRA and Access to Healthcare

MICRA Helps Lower Healthcare Costs, Ensuring Patients Have Access to Healthcare

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November 2008

In November 2010, this report was updated to reflect 2010 U.S. Census Data on healthcare expenditures and its impact on the estimated cost of raising the MICRA cap on non-economic damages. In April 2011, this report was updated to include up to date average payments per claim.

BRG BERKELEY RESEARCH GROUP

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CALIFORNIA'S MICRA REFORMS: INCREASING THE CAP ON NON-ECONOMIC DAMAGES WOULD INCREASE THE COST OF, AND REDUCE ACCESS TO, HEALTHCARE

Overview

Background: California's Medical Injury Compensation Reform Act (MICRA) is an important protection to the state's healthcare system. The law ensures patients' access to compensation when they have been injured, while increasing access to healthcare by stabilizing medical liability costs.

MICRA allows injured patients to receive the following forms of compensation:

- Unlimited economic damages for any and all past and future medical costs.
- Unlimited economic damages for lost wages and lifetime earning potential.
- Unlimited punitive damages awarded in order to deter future malpractice and to punish the defendant for malicious or willful misconduct.
- Up to $250,000 for "non-economic" damages, often referred as pain and suffering. Unlike economic damages, non-economic damages are inherently subjective and often difficult to verify and measure.

Applying widely accepted principles of economics, and the results of scholarly empirical research, we find that:

- MICRA's $250,000 ceiling on non-economic damages has been effective in reducing and stabilizing medical liability insurance costs, thereby improving access to healthcare for all Californians.

- An increase in the cap on awards for non-economic damages would lead to more litigation, larger awards, and higher litigation-related expenses.

- We estimate that an increase in the MICRA cap on non-economic damages to $500,000 or more would raise healthcare costs in California by up to $9.5 billion per year.

- The increase in medical liability costs resulting from a higher cap on awards for non-economic damages would be passed along to Californians attempting to use the state's healthcare system, further limiting access to the system.

- These higher costs of healthcare ultimately would be borne by consumers who would pay more for their own healthcare costs and by federal, state and local taxpayers who would be responsible for the additional costs to cover public employee and retiree healthcare.

- A comparison of states with and without caps on non-economic damages demonstrates that in states with caps, medical liability premiums are lower.

- Even with the $250,000 cap on non-economic damages, the average size of all paid claims – large and small – has increased faster than the rise in inflation.

- There is no evidence that California's cap on non-economic damages has materially reduced access to the courts for those individuals with meritorious claims of medical liability.

- The MICRA cap discourages unnecessary medical procedures and treatments that inflate the cost of healthcare to the consumer without improving medical outcomes.

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William G. Hamm is an economics consultant with high-level experience in both government and business. An expert on public finance, financial institutions, and mortgage finance, 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 Departments of Labor and Housing and Urban Development, the Veterans Administration, and numerous other federal agencies. After leaving public service, Dr. Hamm was the executive vice-president/chief operating officer of an AAA-rated $50 billion bank. He has also run a $1.5 billion loan servicing business for an S&P 500 company.

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

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Dr. Wazzan is president and CEO of Wazzan & Co. Investment LLC, a venture capital firm providing seed level funding to firms specializing in semiconductor, optical networking, bio-mechanical, bio-medical, and related technologies. Dr. Wazzan has been an adjunct assistant professor of business and economics at California State University, Los Angeles and has taught at the University of Southern California, Marshall School of Business.

Dr. Wazzan's analyses have covered a wide range of industries, including basic manufacturing (*e.g.*, automotive, mining, oil and gas, steel, food processing and distribution); high-tech (*e.g.*, aircraft and avionics, semiconductors, digital signal processors, personal computers, computer peripherals); real estate (*e.g.*, diminution of value, appropriate interest rates in bankruptcy settings, lending discrimination); financial services (*e.g.*, banking, metals and other commodities trading, organized financial markets) and pharmaceuticals (*e.g.*, pricing of proteins, drugs and the modeling of expected sales).

Dr. Wazzan's research on predatory pricing, the economics patent licensing, the impact of socially motivated shareholder activism on securities prices, the effects of federal and state legislation on medical care costs and the use of statistics in labor law analyses has been published in economics journals and law reviews.

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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.

One of his books 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*.

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

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I. EXECUTIVE SUMMARY

A. Compensation Under the Medical Injury Compensation Reform Act (MICRA)

MICRA allows for the following types of payments to injured patients: (1) Economic damages; (2) Non-economic damages; and (3) Punitive damages.

Economic damages include past and future medical expenses, loss of past and future earnings, loss of property, costs of repair or replacement, and loss of employment or business opportunities. Economic damages are objective, verifiable and measurable. Under MICRA, there are no limits or caps on the amount an injured patient may receive for economic damages.

Non-economic damages include pain, suffering, inconvenience, emotional distress, loss of society and companionship, loss of consortium and loss of enjoyment of life. Non-economic damages are inherently subjective, and often difficult to verify and measure. Under MICRA, there is a $250,000 limit on the amount that may be awarded for non-economic damages.

Punitive damages are awarded to punish the defendant and deter future medical errors. Under MICRA, there is no limit or cap on punitive damages.

B. Response to a Crisis

In 1975, doctors and other healthcare providers were leaving California due to the rapidly rising cost of medical liability insurance. In response, the California Legislature, with bipartisan support, enacted MICRA. The purpose of MICRA was (and remains) to improve access to healthcare by stabilizing medical liability insurance premiums, thereby limiting the rate of growth in healthcare costs.

Newspaper headlines from 1975 demonstrate the extent of the crisis facing California's healthcare system:

> **Insurance Rates Peril Medical Care,** *San Jose Mercury News*, 2/23/75
>
> Premiums have reached the point that some physicians are leaving California or retiring from active practice and some other physicians in high-risk categories are unable to obtain liability insurance.
>
> **Doctors Face Insurance Crisis-May Affect 8,000 in Southland**, *Los Angeles Times*, 2/22/75
>
> Eight thousand physicians in seven Southern California counties face loss of their malpractice insurance coverage… The seven counties are Los Angeles, Orange, San Bernardino, Ventura, Santa Barbara, Kern and San Luis Obispo. The 8,000 doctors make up the bulk of medical practitioners in those counties.
>
> **New Bay Area Crisis in Medical Care: Doctors Might Halt Practice**, *San Francisco Chronicle*, 1/31/75
>
> A major health care crisis loomed yesterday with the cancellation of malpractice insurance, effective May 1, for most of the doctors in eight Northern California counties.

C. California State Supreme Court Upholds MICRA

The passage of MICRA was not sufficient to stabilize medical liability insurance premiums. There was great uncertainty whether the MICRA cap on non-economic damages would withstand court challenges. Until these challenges were resolved, insurers could not be certain that the cost of medical liability claims would go down, thereby allowing them to reduce insurance premiums. In 1985, the California Supreme Court removed this uncertainty by upholding the constitutionality of MICRA. The Court ruled that:

> [I]n enacting MICRA the Legislature was acting in a situation in which it had found that the rising cost of medical malpractice insurance was posing serious problems for the health care system in California, threatening to

> curtail the availability of medical care in some parts of the state and creating the very real possibility that many doctors would practice without insurance, leaving patients who might be injured by such doctors with the prospect of uncollectible judgments. In attempting to reduce the cost of medical malpractice insurance in MICRA, the Legislature enacted a variety of provisions affecting doctors, insurance companies and malpractice plaintiffs.
>
> [The limitation on recoverable non-economic damages] 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 noneconomic damages – is rationally related to the objective of reducing the costs of malpractice defendants and their insurers.[1]

D. States with Medical Liability Reforms See Increases in Health Access

In 2003 and in 2005, after a medical liability crisis similar to California's, Texas enacted medical liability reforms, including caps on non-economic damages ($250,000 for any and all doctors sued, with an additional cap of $250,000 for each of up to two medical care institutions). The resulting flood of doctors moving back to Texas underscores the direct connection between medical liability reforms, an increase in healthcare providers, and improved patient access to healthcare.

> **Texas' Tort Reform Gives Example For Other States,** *Tyler Morning Telegraph*, 5/27/08
>
> '[Prior to the reforms] doctors were caught between rising medical malpractice insurance costs and lower compensation from insurance-provided benefit contracts and low Medicare/Medicaid reimbursement levels,' [said former state Rep. Joseph] Nixon writing for the Texas Public Policy Center. 'Combined with increasing hassles and demands to appear in court or in depositions, doctors were choosing to retire or leave Texas. In doctor-per-citizen ratio, Texas ranked 49th out of 50 states. . . . Of the state's 254 counties, more than 150 had no obstetrician in 2003, and more than 120 had no pediatrician.'

[1] *Lawrence Fein, v. Permanente Medical Group*
S.F. No. 24336, Supreme Court of California, 38 Cal. 3d 137; 695 P.2d 665; 211 Cal. Rptr. 368; 1985. (Intervening footnotes omitted.)

> **More Doctors in Texas After Malpractice Caps**, *New York Times*, 10/5/07
>
> Four years after Texas voters approved a constitutional amendment limiting awards in medical malpractice lawsuits, doctors are responding as supporters predicted, arriving from all parts of the country to swell the ranks of specialists at Texas hospitals and bring professional health care to some long-underserved rural areas. The influx, raising the state's abysmally low ranking in physicians per capita, has flooded the medical board's offices in Austin with applications for licenses, close to 2,500 at last count. 'It was hard to believe at first; we thought it was a spike,' said Dr. Donald W. Patrick, executive director of the medical board and a neurosurgeon and lawyer. But Dr. Patrick said the trend — licenses up 18 percent since 2003, when the damage caps were enacted — has held, with an even sharper jump of 30 percent in the last fiscal year, compared with the year before.

E. Objectives of this Report

The purpose of this paper is to help policymakers, opinion leaders, and the public evaluate the effects that raising the MICRA cap would have on Californians and their healthcare system. The paper provides answers to questions such as: how does the MICRA cap affect medical liability insurance premiums and healthcare coverage?

F. Summary of Findings

The findings in this update are consistent with our findings in the original report in 2005. Our primary findings and conclusions in 2008 are as follows:

- Widely accepted economic principles, together with the results of empirical research, indicate that a cap on non-economic damages awards is effective in reducing medical liability insurance costs. It does so by reducing the incentive to litigate weak claims, by reducing the average size of liability awards (*i.e.*, severity), and by reducing total loss costs – all important determinants of medical costs. By reducing the cost of medical services, a cap makes healthcare more affordable and increases the public's access to physicians and hospitals.

- A comparison of states with and without caps on non-economic damages demonstrates that in states with caps, medical liability premiums are lower.

- The same economic principles and research findings indicate that an increase in the cap would lead to more litigation, larger awards, and significantly increased litigation-related expenses.

- There is no evidence that MICRA's cap on non-economic damages awards has materially reduced access to the courts for those individuals with meritorious claims of medical liability. In fact, tort claims for personal injury other than those involving medical liability have declined more rapidly than those subject to the MICRA cap.

- Even with the $250,000 cap on non economic damages, the average size of all paid claims – large and small – has increased faster than the rise in inflation.

- Based on the best data available, we estimate that an increase in the MICRA cap on non-economic damages from $250,000 to $500,000 would increase healthcare costs in California by up to $9.5 billion annually.

- These higher costs of healthcare ultimately would be borne by consumers who would pay more for their own healthcare costs' and by federal, state and local taxpayers who would be responsible for the additional costs to cover public employee and retiree healthcare.

- The increased cost of healthcare resulting from a higher cap would reduce Californian's access to quality care in two ways – by making health insurance more expensive and less affordable, and by reducing the number of healthcare providers, particularly in rural and low-income areas.

II. THE MICRA CAP REDUCES THE INCENTIVE TO LITIGATE WEAK OR NON-MERITORIOUS CLAIMS

Economic theory holds that individuals tend to act in their self-interest, given the costs and benefits associated with the alternative courses of action available to them. Empirical research has validated the theory's applicability to many types of behavior, including the propensity to file lawsuits. Other things being equal, a higher expected payoff from filing a lawsuit will lead to more claims of alleged medical liability being pursued.

A. Expected Return From Filing a Lawsuit

Three factors determine the size of the payoff expected from filing a lawsuit: (1) The probability of obtaining a favorable outcome, such as a verdict in the plaintiff's favor or a negotiated settlement (Pr); (2) The size of the expected award (A); and (3) The expected cost of litigating the claim (C). We can represent the interplay of these factors in determining the expected payoff from filing a lawsuit (E*) as follows:

$$E^* = (Pr \times A) - (C)$$

B. The Probability of Obtaining a Favorable Outcome

The likelihood that an individual plaintiff will prevail in litigation depends primarily on the strength of his or her case, although the likelihood that a plaintiff will prevail may be increased by the degree to which the jury views the plaintiff as sympathetic. A sympathetic plaintiff with a weak case may be as successful in obtaining a favorable award as a less-sympathetic plaintiff with a stronger case.

C. The Size of the Expected Award

The size of the expected award is a function of two factors: (1) the magnitude of the alleged damages suffered by the plaintiff; and (2) any limiting or enhancing factors on the award. A limiting factor would be a cap on non-economic damages awards. An enhancing factor would be the availability of punitive damages.

D. The Cost of Medical Liability Litigation

It is costly to pursue damages claims, just as it is costly to defend against them. Annual legal defense costs in 2006, including benefits paid to third parties or their attorneys, claims handling, insurance company administrative costs, and other expenses related to medical liability, totaled approximately $30.3 billion nationwide.[2] This amount represents approximately $101 per year, per person in the U.S., or $404 for a family of four. In addition to the out-of-pocket costs associated with litigation, lawsuits require a heavy investment of the plaintiff's (and defendant's) time. The time spent on a lawsuit cannot be spent on other activities.[3]

The cost of pursuing litigation has both fixed (C_f) and variable (c_v) components. The variable component is a function of the amount potentially at stake. Other things being equal, a defendant will fight harder to avoid paying a larger award, and a plaintiff will make a greater effort to obtain such an award. The expected payoff formula can be refined to take account of the fixed and variable cost components, as follows:

$$E^* = (Pr \times A) - (C_f + c_v A)$$

This formula shows that the decision to pursue a malpractice claim is contingent on the probability of proving liability in court, and on the expected size of the settlement or

[2] Towers Perrin "2007 Update on U.S. Tort Cost Trends," 2007.

[3] In economic terms, the time and money spent bringing or defending a lawsuit can be thought of as the opportunity cost of litigation – the value of the time and resources that could be spent elsewhere. Opportunity costs can be measured and expressed in dollar terms, although we do not do so here.

award.[4] If the expected size of the settlement or award is sufficiently large, even plaintiffs with a relatively small probability of successfully proving liability will pursue awards.

E. The Propensity to Pursue Medical Liability Claims

A meaningful cap[5] on non-economic damages limits the reward that might have otherwise been expected from filing a medical liability lawsuit. Accordingly, a cap (as well as other limitations on the size of awards) will reduce the incidence and cost of malpractice claims by discouraging the weakest claims, and by encouraging out-of-court settlements. We model the effects of having no cap, as well as caps of $250,000, $500,000 and $900,000, on a claimant's incentive to file suit.[6]

Consider a claim of alleged medical liability consisting of $400,000 in economic damages and $600,000 in non-economic damages. Assume that meritorious claims have an 80 percent probability of success and non-meritorious claims have a 20 percent probability of success. Further assume that the fixed costs of litigating the claim (C_f) amount to $100,000, and the variable costs (c_v) amount to 5 percent of the maximum potential award. Table 1 shows the impact of various caps on meritorious and non-meritorious claimants.

[4] See, *e.g.*, Patricia M. Danzon and Lee A. Lillard, Settlement out of Court: the Disposition of Medical Malpractice Claims, *Journal of Legal Studies*, vol. XII (June 1983): p. 356; and Farber, Henry S. and White, Michelle J., "Medical Malpractice: An Empirical Examination of the Litigation Process," *RAND Journal of Economics* 22 (2) (Summer 1991), pp. 199-217. [Hereafter, Farber and White].

[5] Not all caps on non-economic damages awards are meaningful. A high cap, or a cap with significant exceptions, will not materially alter the plaintiff's and defendant's assessment of the expected award's size, and therefore will not be effective in altering the economic incentives to pursue or defend medical liability claims.

[6] We consider a $900,000 cap because some opponents of MICRA have argued that the original $250,000 cap should be set at this level in order to adjust for inflation. By analyzing the affect of a $900,000 cap, we are not suggesting that the cap on non-economic damages should be increased or inflation-adjusted.

Table 1: Impact of Caps on "Meritorious" and "Non-Meritorious" Claimants

Economic Damages	Non-Economic Damages	Cap	Prob. of win	Expected Gross Return	Fixed Cost of Litigating	Variable Cost of Litigating (as % of Award)	Variable Cost of Litigating ($)	Expected Value
a	b	c	d	e=d*{a+if(c>0,min(b,c), b)}	f	g	h=g*{a+if(c>0,min(b,c), b)}	i=e+ f+ h
PANEL A								
$400,000	$600,000	No cap	20%	$200,000	-$100,000	5%	-$50,000	$50,000
$400,000	$600,000	$250,000	20%	$130,000	-$100,000	5%	-$32,500	-$2,500
PANEL B								
$400,000	$600,000	No cap	80%	$800,000	-$100,000	5%	-$50,000	$650,000
$400,000	$600,000	$250,000	80%	$520,000	-$100,000	5%	-$32,500	$387,500
PANEL C								
$400,000	$600,000	No cap	20%	$200,000	-$100,000	5%	-$50,000	$50,000
$400,000	$600,000	$250,000	20%	$130,000	-$100,000	5%	-$32,500	-$2,500
$400,000	$600,000	$500,000	20%	$180,000	-$100,000	5%	-$45,000	$35,000
$400,000	$600,000	$900,000	20%	$200,000	-$100,000	5%	-$50,000	$50,000
PANEL D								
$400,000	$600,000	No cap	80%	$800,000	-$100,000	5%	-$50,000	$650,000
$400,000	$600,000	$250,000	80%	$520,000	-$100,000	5%	-$32,500	$387,500
$400,000	$600,000	$500,000	80%	$720,000	-$100,000	5%	-$45,000	$575,000
$400,000	$600,000	$900,000	80%	$800,000	-$100,000	5%	-$50,000	$650,000

1. The Effect of a $250,000 Cap

As Panel A indicates, a cap of $250,000 discourages the weak or non-meritorious claimant from filing a medical liability suit by changing the suit's expected payoff from positive ($50,000) to negative (-$2,500). The cap however would not discourage the strong claimant (see Panel B).

2. The Effect of Raising The Cap

Panel C indicates that while a cap of $250,000 discourages weak claimants from filing suits, the disincentive goes away when the cap is raised to either $500,000 or $900,000. Since a $250,000 cap does not discourage individuals from litigating meritorious claims,

it is not surprising that both a $500,000 cap and a $900,000 cap would leave such claimants with an economic incentive to litigate their claims, as Panel D indicates.

In sum, removing or increasing the cap on non-economic damages would increase the number of medical liability lawsuits filed – primarily by making it more economically attractive for individuals with the weakest claims to file suit. A larger number of suits would increase insurers' litigation expenses in two main ways. First, it would increase the cost of claims paid, both because some of the additional suits would be successful despite the weaknesses in the plaintiffs' claim, and because the plaintiffs would be less inclined to accept an out-of-court settlement. Second, by increasing the potential award, the higher cap will increase attorneys' expected payoff from litigating a claim. Caps on damage awards are an effective deterrent to claims of dubious merit because they increase the incentive for attorneys to settle a claim before trial.

III. THE MICRA CAP DOES NOT REDUCE ACCESS TO THE COURT SYSTEM

Some opponents of MICRA have argued that the cap on non-economic damages has reduced access to the court system by preventing injured plaintiffs with meritorious claims from hiring attorneys, thereby discouraging them from filing lawsuits. We can test this hypothesis by examining data on the number of medical liability lawsuits filed in California.[7]

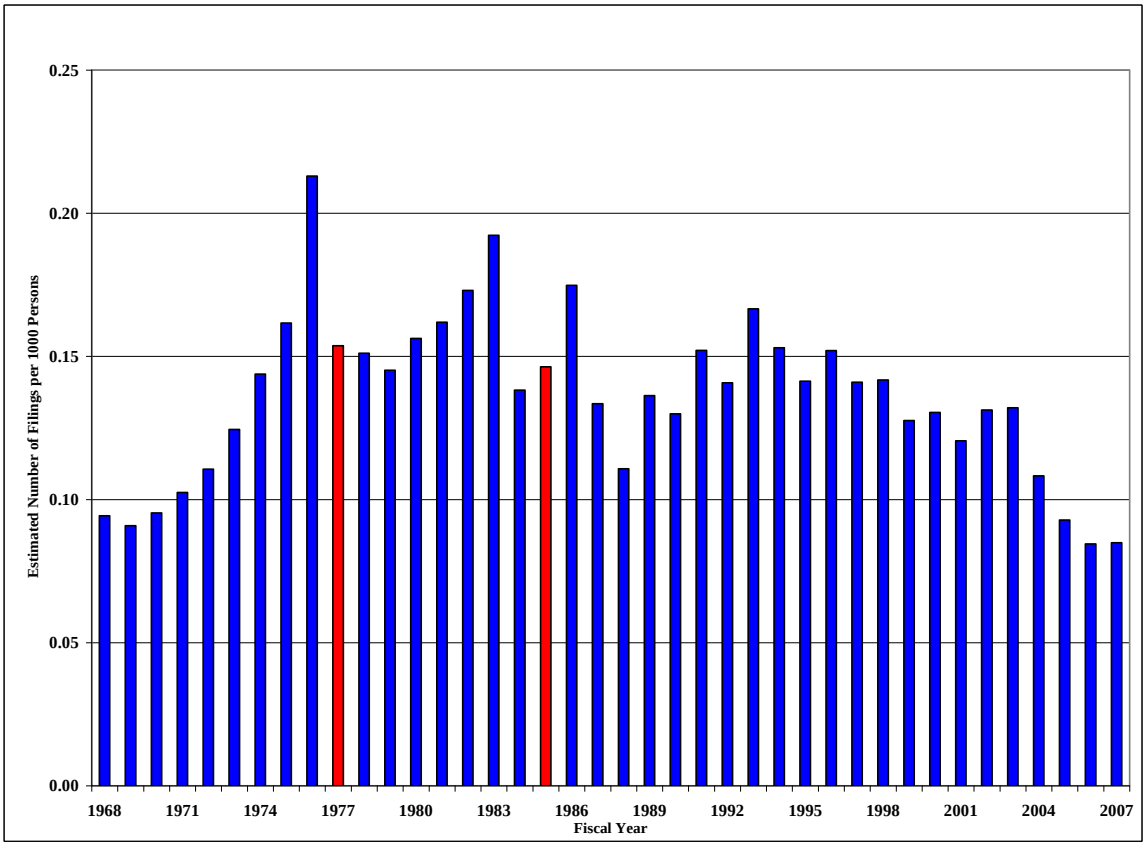
A. MICRA Has Not Significantly Reduced the Number of Lawsuits Filed in California

The empirical evidence provides no support for the hypothesis that MICRA (including the $250,000 cap) has reduced access to the court system. Figure 1 shows estimated medical liability filings in California on a per-capita basis, for the period 1968-2007. As

[7] The incidence of *lawsuits* is somewhat different from "frequency." The insurance industry uses the term "frequency" to refer to the rate of *claim* filings.

the figure makes clear, per-capita filings generally were higher during the 1986-2004 period, after MICRA's constitutionality was upheld, than they were in the late 1960s and early 1970s, before MICRA was enacted.

Figure 1: Estimated Per Capita Medical -Liability Filings in California, 1968 to 2007[8]



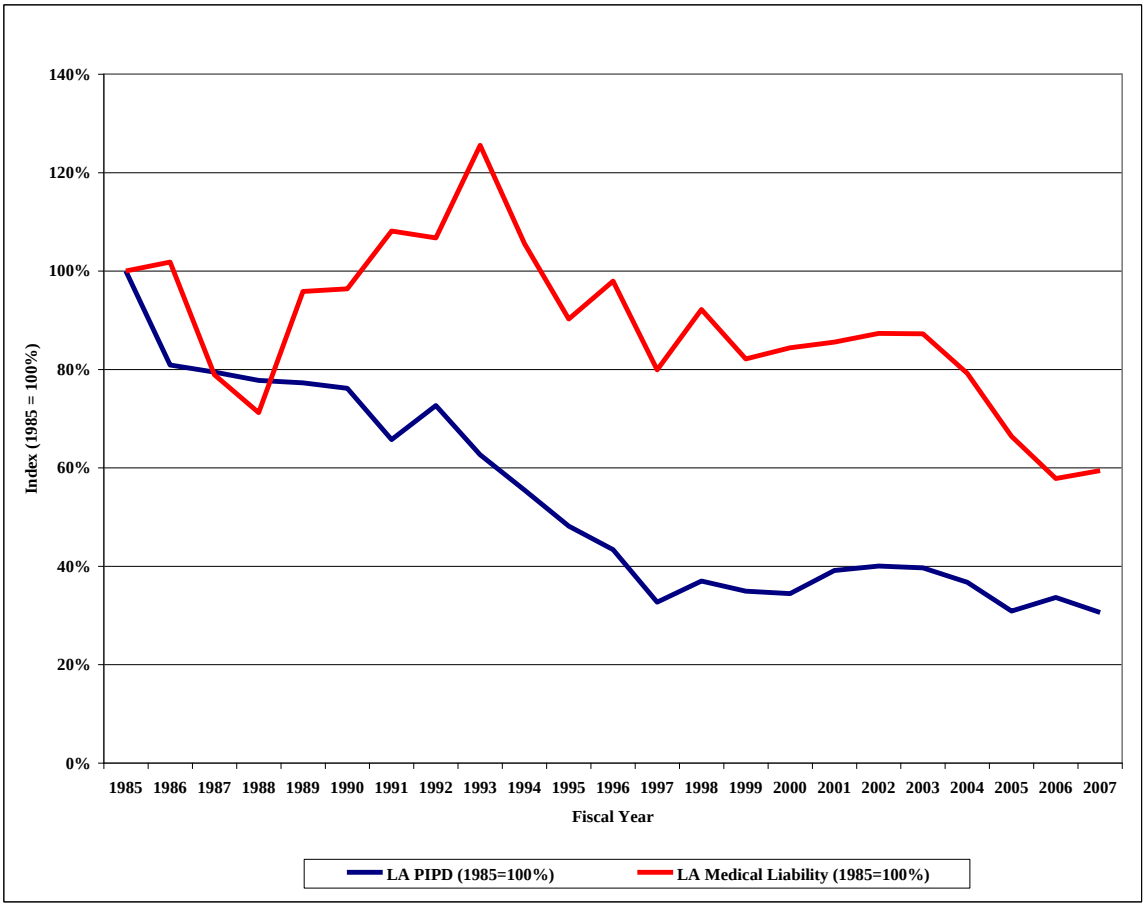
[8] California medical malpractice filings are estimated on 1968-2007 "Los Angeles Superior Court Filings and Disposition Comparison" prepared by Los Angeles Superior Court Statistics Section and 2008 Court Statistics Report, Statewide Caseload Trends, Judicial Council of California, Superior Courts, Table 4. Population data is obtained from California Department of Finance - Demographics Units, E-7. California Population Estimates, with Components of Change and Crude Rates, July 1, 1900-2007, updated December 2007 (http://www.dof.ca.gov/HTML/DEMOGRAP/ReportsPapers/ReportsPapers.php).

B. Medical liability Suits Have Not Declined As Much as Personal Injury Suits *Not* Subject to a Cap

Since 1993, there has been a decline in per-capita medical liability filings. This decline, however, is reflective of a decline in personal injury lawsuits generally. In fact, the incidence of *non*-medical liability personal injury lawsuits has gone down at a faster rate than the incidence of malpractice suits.

Figure 2 compares the medical liability filings in Los Angeles County between 1985 and 2007, with the number of all other personal injury filings. To facilitate a comparison between the two series, we have indexed both to 1985.

Figure 2: Trends in Medical Liability and Personal Injury-Other (Excluding MedMal) Cases Filed in Los Angeles County 1985-2007 (1985=100%)[9]



As the figure shows, other personal injury filings have declined more rapidly than medical liability filings, even though awards in these cases are not subject to a cap on non-economic damages. This comparison undercuts the claim that the MICRA cap is responsible for the decline in medical liability cases.

In sum, the available evidence indicates that the cap has not reduced access to the court system to any significant degree. Californians continue to have access to the court system, and attorneys continue to accept medical liability cases, notwithstanding the cap. To the extent the cap has discouraged individuals from filing medical liability suits, it is

[9] 1968-2007 "Los Angeles Superior Court Filings and Disposition Comparison" prepared by Los Angeles Superior Court Statistics Section.

reasonable to infer that these cases primarily involve the weakest claims – that is, the group of claims targeted by the California Legislature in enacting MICRA.[10]

C. MICRA Has not Significantly Reduced the Number of Claims Made Against Physicians in California

We have been provided with complete data by one medical liability insurer showing both the number of physicians it insures and the number of claims made by its insured during the period 1976 through 2006. We believe this data, which covers all 50 states, provides a fair representation of frequency rates in California and elsewhere.[11]

Table 2 shows the frequency rate for both California and the other 49 states during the period 1976 through 2006. It indicates that during the seven years prior to the California Supreme Court's action in upholding MICRA (1978-1985), claims frequency in California was approximately 23.4%.[12] For the next twenty years (1986-2006), the rate decreased slightly to 22.9%. This data supports our finding that MICRA has not had a significant impact on the rate at which medical liability lawsuits are filed.

[10] Figure 1 estimates medical liability claims in California *per capita*. Another important perspective on the incidence of such claims can be gained by comparing claims with the number of *physicians*. In 2003 an estimated 4,632 medical liability lawsuits were filed in California, which is home to 93,171 physicians. Thus, one suit was filed in this one year for every 20 doctors.

[11] Different insurers (and self-insured entities) define 'claim' and count 'claim' in different ways. They include differentiating between a notice of claim, or potential claim reported by a physician vs. an actual lawsuit filed and served upon the physician. Some companies count claims by plaintiff, others by defendant, in other words if a plaintiff sues 4 doctors and a hospital, depending on how one counts that could be one, four or five claims. No single uniform standard for counting frequency of claims exists and consequently we are unable to aggregate historical data from multiple insurance firms. We therefore present data from a single large firm which underwrites in all 50 states – The Doctors Company – as being representative.

[12] We do not include 1976-1977 in our sample as the number of insured doctors outside California is not sufficient to provide a representative sample.

Table 2: California vs. Non-California Frequency Rates[13]

	CALIFORNIA			NON-CALIFORNIA			
	[a]	[b]	[c]=[a]/[b]	[d]	[e]	[f] = [d]/[e]	[g] = [c]/[f]-1
Year	Claims	Insured Doctors	Claim Frequency	Claims	Insured Doctors	Claim Frequency	Frequency Difference
1976	40	678	5.9%	0	n/a	0.0%	n/a
1977	251	106	236.8%	0	n/a	0.0%	n/a
1978	506	2,691	18.8%	1	11	9.1%	106.8%
1979	640	3,575	17.9%	12	94	12.8%	40.2%
1980	783	4,399	17.8%	24	240	10.0%	78.0%
1981	1,075	5,000	21.5%	74	313	23.6%	-9.1%
1982	1,171	5,472	21.4%	114	378	30.2%	-29.0%
1983	1,465	5,880	24.9%	144	484	29.8%	-16.3%
1984	1,571	5,958	26.4%	170	653	26.0%	1.3%
1985	**1,872**	**5,783**	**32.4%**	**213**	**699**	**30.5%**	**6.2%**
1986	1,721	5,941	29.0%	268	865	31.0%	-6.5%
1987	1,779	6,388	27.8%	385	1,412	27.3%	2.1%
1988	1,821	6,798	26.8%	645	2,725	23.7%	13.2%
1989	1,511	6,981	21.6%	652	3,475	18.8%	15.4%
1990	1,542	7,179	21.5%	651	4,058	16.0%	33.9%
1991	1,610	7,232	22.3%	701	4,759	14.7%	51.1%
1992	1,877	6,855	27.4%	894	5,348	16.7%	63.8%
1993	1,774	7,203	24.6%	1,100	5,698	19.3%	27.6%
1994	1,857	7,221	25.7%	1,173	6,069	19.3%	33.1%
1995	1,730	7,034	24.6%	1,232	6,164	20.0%	23.1%
1996	1,781	6,864	25.9%	1,244	6,698	18.6%	39.7%
1997	1,934	6,711	28.8%	1,084	6,096	17.8%	62.1%
1998	1,860	6,449	28.8%	1,345	6,340	21.2%	36.0%
1999	1,574	6,184	25.5%	1,038	5,638	18.4%	38.2%
2000	1,456	6,162	23.6%	1,022	5,474	18.7%	26.6%
2001	1,420	6,448	22.0%	1,297	6,928	18.7%	17.6%
2002	1,469	6,843	21.5%	1,593	9,432	16.9%	27.1%
2003	1,511	7,074	21.4%	1,723	10,347	16.7%	28.3%
2004	1,216	7,897	15.4%	1,206	10,538	11.4%	34.5%
2005	1,152	8,951	12.9%	1,009	10,871	9.3%	38.7%
2006	1,231	9,229	13.3%	936	10,976	8.5%	56.4%
1994-2006	20,191	93,067	21.7%	15,902	101,571	15.7%	38.6%
1978-1985	9,083	38,758	23.4%	752	2,872	26.2%	-10.5%
1986-2006	33,826	147,644	22.9%	21,198	129,911	16.3%	40.4%

A comparison of claims frequency in California and in all other states further undermines the claim that the MICRA cap has reduced the rate at which medical liability lawsuits are filed. Although MICRA represents the strongest set of medical liability reforms enacted

[13] Underlying exposures have not been adjusted to a base classification. The data does not reflect the claims-made experience of large medical groups or medical schools. Claim counts have been updated for all years based on observed changes to allocated claim conversions. (Provided by The Doctors Company).

in the U.S. to date, the incidence of malpractice claims in California is significantly higher than in all other states, combined. In 2006, for example, the claims frequency rate was 13.3 percent in California – 56 percent higher than the average rate for the other states.

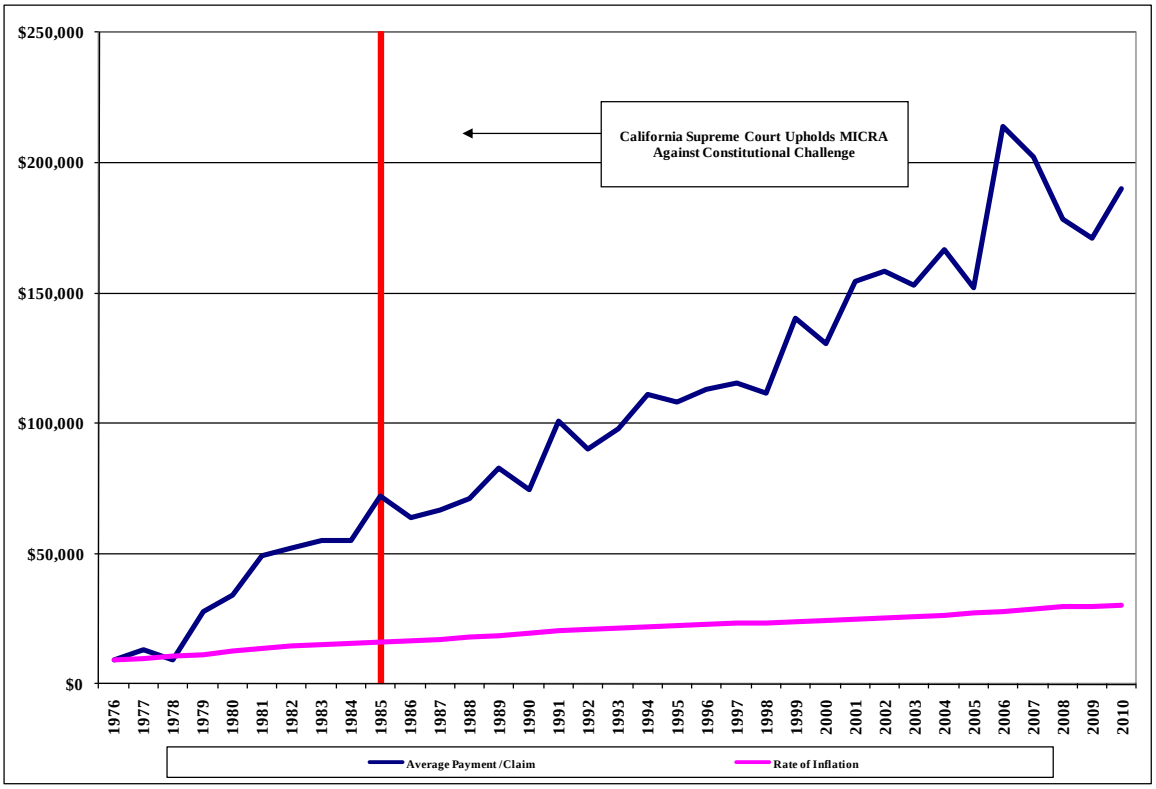
IV. EVEN WITH THE MICRA CAP, THE AVERAGE SIZE OF PAYMENTS HAS CONTINUED TO INCREASE

Using "paid losses" as a measure of malpractice insurance costs, the available data clearly shows the effectiveness of the $250,000 cap and other provisions of MICRA.

A. The Average Size of All Claims (Large and Small) Continues to Increase

The evidence shows that the average size of all claims – large and small – has increased at a rate greater than the rate of inflation. Figure 3 shows the actual average payment per claim, and compares it with what the average would have been if it had merely kept pace with inflation.

Figure 3: Inflation-Adjusted Mean Payment Per Paid Claim in California[14]



As the figure demonstrates, notwithstanding the $250,000 cap, the average size of paid medical liability claims has increased faster than the rise in inflation.

Taken together, Figures 1 through 3 demonstrate that the MICRA cap is achieving the purpose envisioned by the California Legislature when it adopted the cap. The cap is reducing the cost of the medical liability tort system without decreasing access to the courts by those who have experienced malpractice.

B. States With Caps Exhibit Smaller Average Per-Claim Malpractice Payments

More than half of the states have followed California's lead and enacted caps to limit non-meritorious claims, restrain the rate of growth in healthcare costs and to preserve access to affordable healthcare. Not all of these caps, however, are equally effective.

[14] Aggregate data for Cooperative of American Physicians, Medical Insurance Exchange of California, NORCAL Mutual Insurance Company, American Healthcare Indemnity Company, SCPIE Indemnity Company, and The Doctors Company; and U.S. Department of Commerce, Bureau of Economic Analysis, Table 1.1.9. Implicit Price Deflators for Gross Domestic Product, Personal Consumption Expenditures.

Some states, such as Hawaii, have adopted caps but provide for liberal exceptions that make it easy for plaintiffs to evade the cap. Other states have set caps on non-economic damages at a relatively high level, thereby weakening or eliminating the disincentive to pursue non-meritorious claims. Nevertheless, states with caps tend to report smaller average per-claim payments.

Table 3 shows average payments per malpractice claim, by state, for 2007.[15] As the table shows, California had the eighth lowest average liability payment per claim – $183,538 – despite being a relatively high-cost state. Several heavily populated, industrialized states without caps were much higher (*i.e.*, have higher per-claim payments). For example, New York was 12th highest at $374,060.

[15] National Practitioners Data Bank ("NPDB"). Data through June 2007. Note that the Data Bank's rules require the reporting only of doctors named in final malpractice settlements, so a payment doesn't have to be reported when a doctor's name is removed from the claim. Consequently, the Data Bank is missing information on some malpractice payments. It is not clear what effect the missing data might have. See *e.g.*, "Doctor Is Out: Attempt to Track Malpractice Cases Is Often Thwarted; Deleting a Physician's Name From a Suit Before Settling Keeps It Out of Data Bank; Dubbed the 'Corporate Shield'" Joseph T. Hallinan. Wall Street Journal (Eastern Edition). New York, N.Y., Aug 27, 2004, p. A.1.

Table 3: 2007 Average Payments Per Malpractice Claim

(Listed From Highest to Lowest)[16]

State[17]	Average Payment	Cap	State	Average Payment	Cap
Illinois	$567,867	Yes	Tennessee	$251,362	
Alaska	$533,056	Yes	Utah	$247,209	Yes
Massachusetts	$468,808	Yes	Washington	$237,481	
Minnesota	$447,785		Indiana	$237,234	Yes
Georgia	$443,712	Yes	Kentucky	$236,535	
District of Columbia	$427,833		Rhode Island	$226,149	
Connecticut	$425,767		Idaho	$224,219	Yes
Nevada	$417,981	Yes	Iowa	$219,085	
New Jersey	$415,832		Florida	$217,822	Yes
Wisconsin	$415,541	Yes	Missouri	$216,824	Yes
New Hampshire	$399,020		Mississippi	$214,732	Yes
New York	$374,060		Colorado	$209,940	Yes
Wyoming	$372,071		Oregon	$205,860	
Pennsylvania	$370,169		North Dakota	$205,313	Yes
Delaware	$355,694		Alabama	$205,304	
Hawaii	$342,639	Yes	New Mexico	$204,063	Yes
Arizona	$328,921		South Carolina	$196,160	Yes
Ohio	$320,143	Yes	**California**	**$183,538**	**Yes**
Virginia	$318,325	Yes	Arkansas	$177,741	
Maryland	$315,055	Yes	South Dakota	$172,563	Yes
West Virginia	$296,991	Yes	Vermont	$171,889	
Nebraska	$272,803	Yes	Louisiana	$166,304	Yes
Maine	$268,971		Kansas	$144,757	Yes
Oklahoma	$261,162	Yes	Texas	$131,749	Yes
Montana	$260,143	Yes	Michigan	$127,955	Yes
North Carolina	$257,375	Yes			

Texas's experience illustrates the efficacy of caps on non-economic damages. In 2004, Texas was found to be 39th highest in terms of average payment per malpractice claim. By adopting a $250,000 cap on non-economic damages, Texas by 2007 had the second lowest average payment per claim.[18] The impact of the cap on healthcare costs is even more evident when we compare the per-claim average malpractice payment in 2004 – $214,939 —to the average in 2007 – $131,749.

[16] National Practitioners Data Bank ("NPDB"). Data through June 2007.

[17] Includes District of Columbia. Data for Federated States of Micronesia, Puerto Rico, Armed Forces – Europe, Armed Forces – Pacific, and Armed Forces – Americas not reported.

[18] The cap was ratified by the voters when they approved Proposition 12 in 2003.

V. THE MICRA CAP REDUCES MEDICAL LIABILITY INSURANCE PREMIUMS BY AS MUCH AS 43%

Medical liability insurance premiums, like all insurance premiums, are primarily determined by the insurer's cost of providing insurance and paying claims. Over time, increases in these costs must be passed along to policyholders, in the form of higher insurance premiums. The evidence shows that by reducing the cost of the medical liability tort system, the MICRA cap significantly reduces malpractice insurance premiums. Conversely, we find that if the MICRA cap were eliminated or raised, insurance premiums will increase.

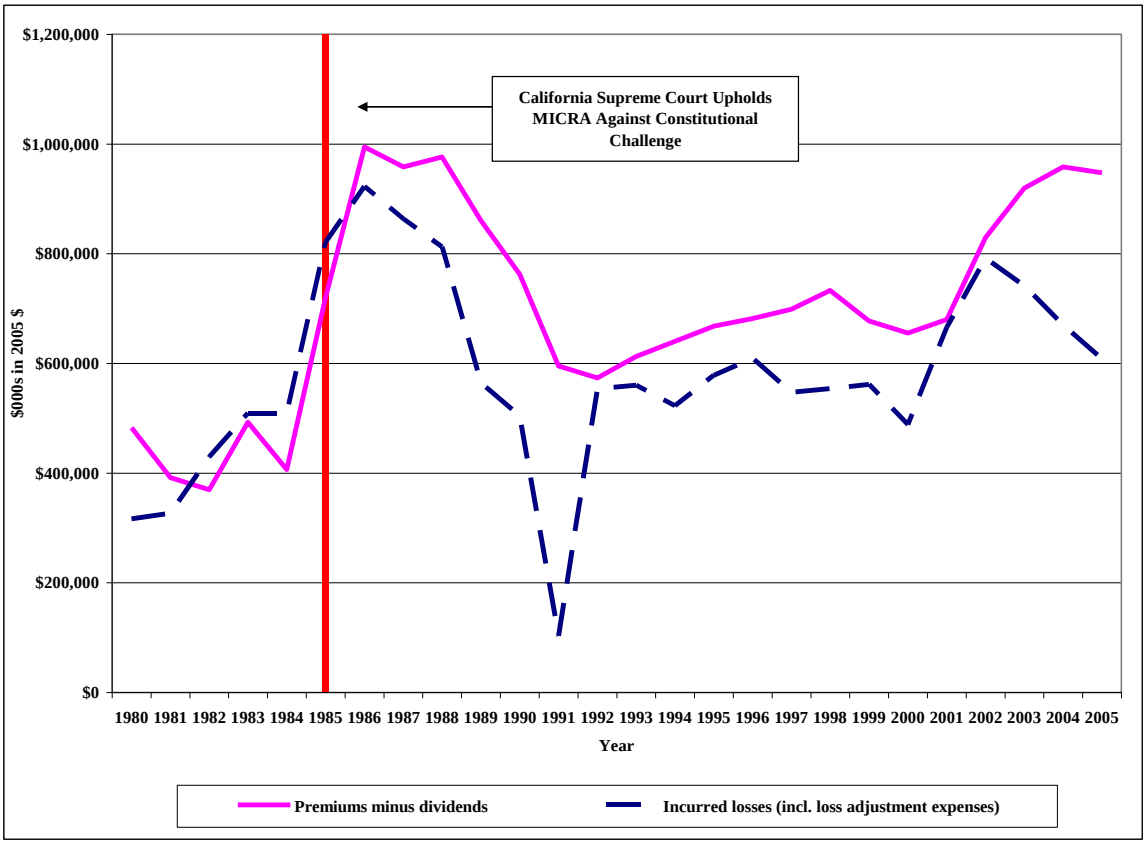
A. Incurred Losses Are Strongly Correlated With Medical Liability Premiums

The close connection between incurred losses (including paid losses and loss adjustment expenses) and medical liability premiums in California is well established by the empirical evidence. Figure 4 shows that incurred losses and medical liability premiums are highly correlated, indicating that any increases in incurred losses will be closely followed by increases in medical liability insurance premiums.[19] Consequently, an increase in the cap on non-economic damages awards, by increasing incurred losses, will cause an increase in medical liability insurance premiums.[20]

[19] A study by the American Academy of Actuaries also found that medial liability premiums declined as losses declined in California between 1975 and 1994. (See, Issue Brief. American Academy of Actuaries. Fall 1996).

[20] Note that losses and premiums immediately following the Supreme Court's decision in 1985 continue to trend upwards before eventually falling off a few years later. This is easily explained by the long lag between collecting premium income and paying claims. Premium rates for the next year must be high enough to cover claims that will be reported that year, the majority of which will be paid over the next 3 to 5 years. Due to the volatility of the ultimate payouts on medical liability claims, it is difficult for insurers to predict the amount of those payouts with great certainty. See, *e.g.*, United States General Accounting Office Report to Congressional Requesters, June 2003, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. GAO-03-702, p. 44.

Figure 4: Incurred Losses and Medical Liability Premiums are Strongly Correlated (In 2005 dollars)[21]



Both incurred losses and direct premiums earned fell after 1985 (the year MICRA was upheld as constitutional by the California Supreme Court) and have remained below the peak levels of 1986.[22]

Some have argued that MICRA does not deserve credit for reducing medical liability insurance premiums. Rather, they argue, credit should be given to the Insurance Rate Reduction and Reform Act (Proposition 103), which the voters approved on November 8, 1988. It is easy to prove, however, that this argument is completely without merit.

[21] 1980-2005 NAIC Medical Malpractice Insurance Profitability Reports; and U.S. Department of Commerce, Bureau of Economic Analysis, Table 1.1.9. Implicit Price Deflators for Gross Domestic Product, Personal Consumption Expenditures.

[22] It is reasonable to assume that several years passed before the full effect of MICRA was felt (*i.e.*, there is an observed lag).

Proposition 103 sought to control insurance *rates*, but did nothing to limit the determinants of insurance rates – insurance *costs*.

Furthermore, as the authors have demonstrated[23] medical liability insurance premiums declined sharply during the three years after Proposition 103 took effect (and shortly after the California Supreme Court upheld MICRA's constitutionality). During the same period, the average rates for other insurance lines subject to Proposition 103's controls increased. The obvious explanation for this discrepancy is that MICRA reduced medical liability claim costs, but had no effect on other personal injury claim costs.

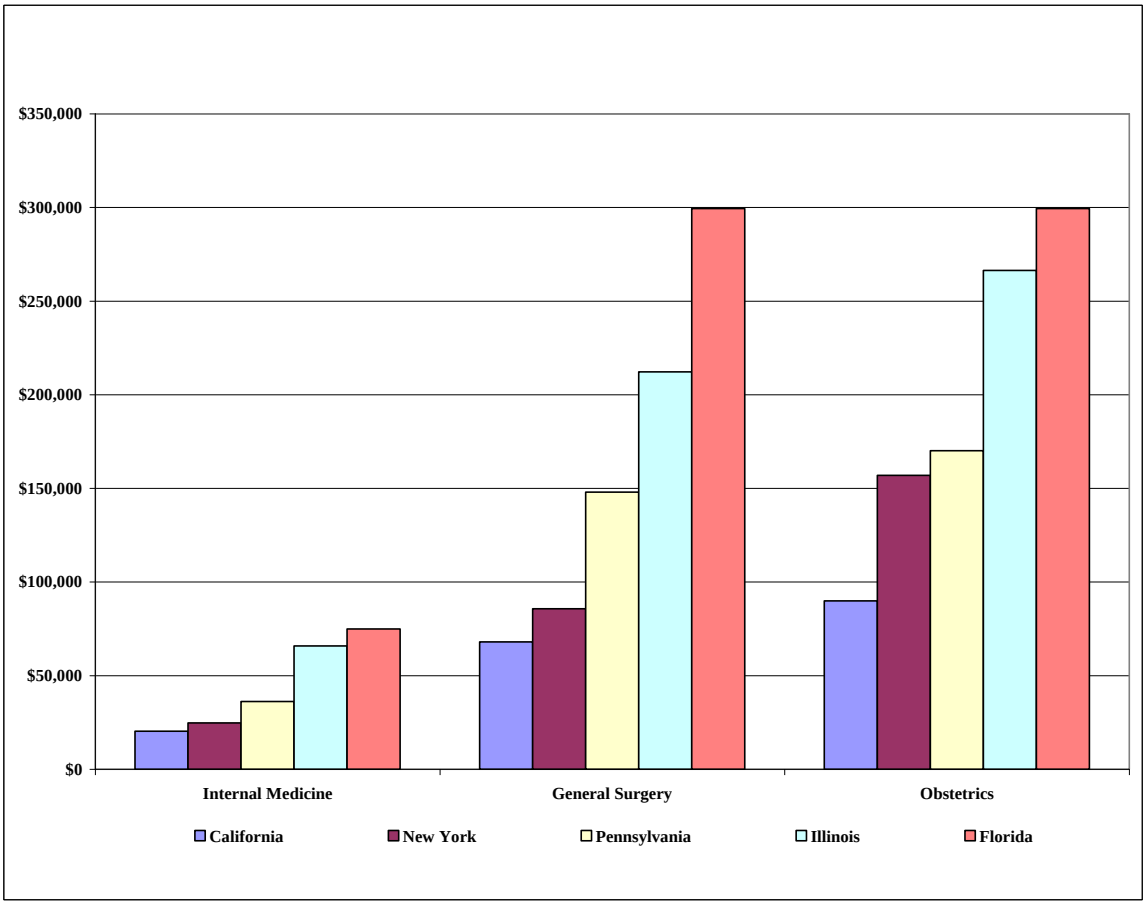
B. States With Caps Benefit From Lower Medical Liability Premiums

In addition to observing the correlation between loss costs and premiums, we compare medical liability insurance premiums in states with and without caps. Figure 5 shows medical liability insurance premiums for the five states with the largest share of the insurance market. It illustrates MICRA's effectiveness in holding down medical liability insurance premiums. [24]

[23] Frech III, H.E., William G. Hamm, and C. Paul Wazzan. "Controlling Medical Malpractice Insurance Costs – Congressional Act or Voter Proposition?" Indiana Health Law Review, Volume 3, Issue 1 (2006).

[24] Data represents manual rates for specific mature claims-made specialties with limits of $1 million/$3 million. Rates reported should not be interpreted as the actual premiums an individual physician pays for coverage. They do not reflect credits, debits, dividends or other factors that may reduce or increase premiums. These five states represent almost forty percent of the physician liability insurance market. Data shown represents the highest rate (by county and provider) in each state. For comparison, average rates for internal medicine (across all counties and providers) are $20,283 and $74,855 for California and Florida respectively; a difference of 269%.

Figure 5: 2005 Liability Insurance Premiums, by State and Specialty[25]



As Figure 5 shows, medical liability premiums are significantly lower in California than in the other four states, each of which lacked strong MICRA-type reforms.[26] For example, in Florida which caps non-economic damages at $500,000 – double the limit in California, internists pay approximately $54,572 (269 percent) more per year than their counterparts in California; General Surgeons pay approximately $231,413 (340 percent) more per year; and Obstetricians pay approximately $209,467 (233 percent) more per year. This comparison provides strong evidence that the $250,000 cap has held down medical liability insurance premiums, and that an increase in the cap to the level in

[25] *Medical Liability Monitor*, October 2005 (Vol. 30, No. 10, p. 4).

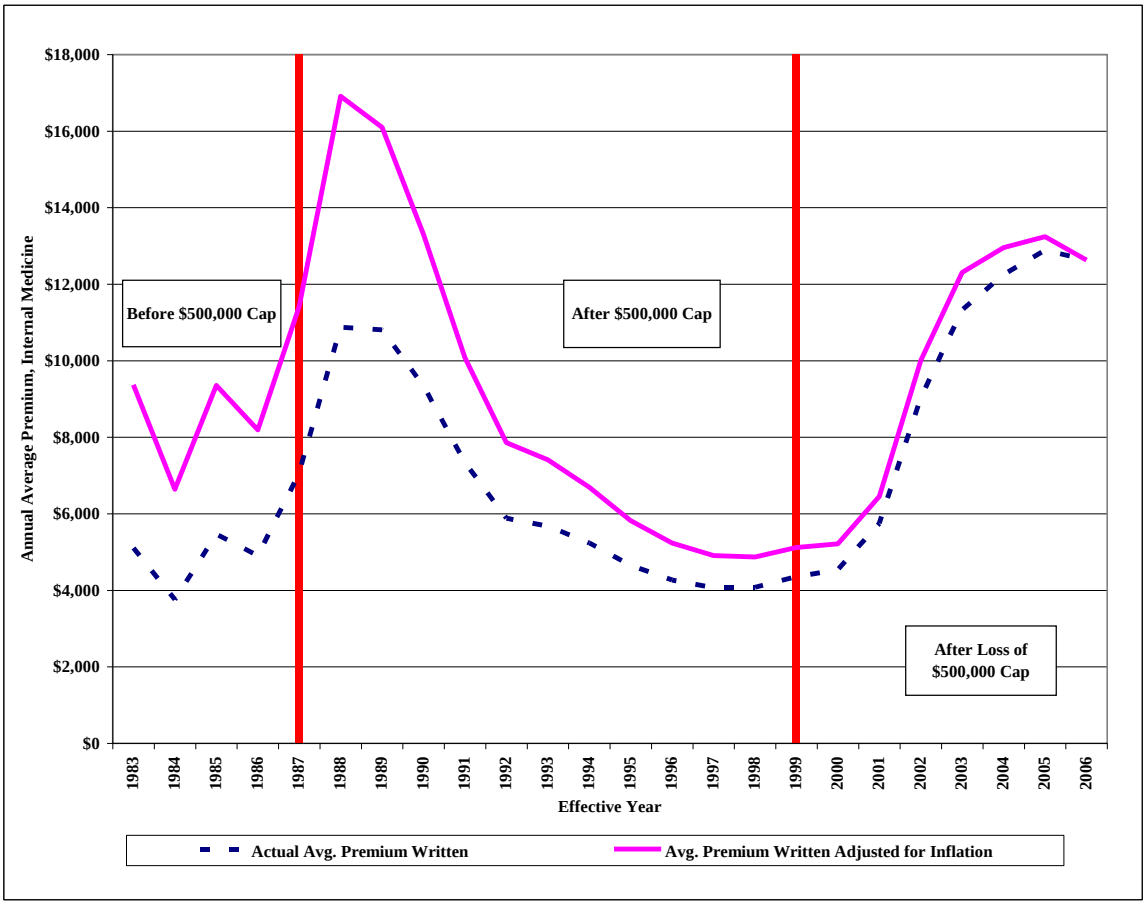
[26] New York and Pennsylvania have no non-economic damages cap. In 2005, Illinois passed a $500,000 non-economic damages cap effective for cases filed after 8/25/2005. Consequently, the premiums shown in Figure 5 would not have reflected the newly instituted cap. Florida had a $500,000 non-economic damages cap.

Florida ($500,000) would lead to significantly higher premiums for California providers, and significantly higher costs for Californians.

C. Emasculating the Cap Would Cause Significant Increases in Liability Premiums

Evidence from Oregon provides compelling evidence on the effects of both implementing and removing a cap on non-economic damages. In 1987, the Oregon legislature passed medical liability reforms that imposed a cap of $500,000 on non-economic damages. Twelve years later, in 1999, the Oregon Supreme Court removed the cap. Figure 6 shows the premiums paid by internal medicine specialists before, during, and after the cap was in effect.

Figure 6: Impact of Non-Economic Damages Caps on Medical Liability Insurance Premiums in Oregon[27]



In 1999, the inflation-adjusted average premium for internal medicine was $5,116. By 2006, the premium had risen to $12,628, an increase of 247%. It is unlikely that physicians in Oregon became 2.5 times more prone to commit malpractice. Rather, the difference in rates is more likely the result of increases in healthcare related costs.

[27] Northwest Physician Mutual Insurance Company; and U.S. Department of Commerce, Bureau of Economic Analysis, Table 1.1.9. Implicit Price Deflators for Gross Domestic Product, Personal Consumption Expenditures.

D. Removing the MICRA Cap Would Cause Medical Liability Premiums to Increase by 20-43 Percent

The results of empirical research on medical liability insurance premiums are consistent with our findings. Several studies have estimated the effect of removing or implementing a cap on non-economic damages. One study finds that premiums are approximately 17 percent lower in states that cap awards than they are in states that have no cap. These results suggest that removing the cap in California would cause an increase in medical liability premiums of 20.5 percent.[28] The CBO estimates that if caps (and other reforms) were imposed at the federal level, medical liability premiums ultimately would average 25 - 30 percent less than under current law.[29] These estimates indicate that removal of a cap from a state that already has one would bring about an *increase* in medical liability insurance premiums of 33 percent to 43 percent. Note that the upper end of this range is virtually identical to the percentage increase in paid losses that RAND finds would result from elimination of California's $250,000 cap.[30]

In short, it is clear that the higher loss costs resulting from an increase in the cap on non-economic damages awards would significantly increase medical liability insurance premiums.

[28] See, Thorpe, Kenneth E. "The Medical Malpractice 'Crisis': Recent Trends And the Impact of State Tort Reforms" *Health Affairs*, January 21, 2004, p. w4-w20. Because California has one of the strongest caps in the United States, eliminating the MICRA cap would almost certainly cause an increase greater than 20.5 percent.

[29] Congressional Budget Office, Cost Estimate March 10, 2003. H.R. 5 Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003. As ordered reported by the House Committee on the Judiciary on March 5, 2003, p. 4.

[30] See, 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, Figure 4.2, p. 38. The RAND study examined 257 plaintiff verdicts issued in malpractice trials between 1995 and 1999 and attempted to calculate the non-economic damage cap's impact on jury awards, attorneys' fees, and plaintiffs' recoveries. The study determined that MICRA reduced defendants' liabilities by 30 percent.

VI. MICRA DOES NOT GENERATE EXCESS PROFITS FOR CALIFORNIA INSURERS OR PHYSICIANS

Some opponents of the MICRA cap contend that the reduction in loss payments resulting from the cap has not produced savings for the consumer. Instead, they argue that the benefits have gone to medical liability insurance underwriters or physicians, enabling them to make supra-competitive profits.[31] We can find no reliable evidence to support this argument.

A. Medical Liability Insurance Companies Face Strong Market Competition

Economic theory holds that in competitive markets, prices must be high enough to enable firms to cover their costs and earn a competitive rate of return. If market conditions temporarily allow firms to earn returns exceeding their costs (including the cost of capital), new firms will enter the market or existing firms will expand and drive down prices, thereby eliminating any excess profits. Similarly, if competition pushes prices below the point where firms are able to earn a reasonable return on their capital, some firms will leave the market, causing prices to rise. Thus, the competitive process tends to force prices to the level where firms are able to cover their costs and earn a competitive return, but not an excessive return.

Medical liability insurance companies are not exempt from the competitive forces that keep prices and profits in check elsewhere in the economy. To the contrary, the evidence indicates that competition within the insurance industry is vigorous. As the GAO found, "competition among insurers can put downward pressure on premium rates, even to the point at which the rates may, in hindsight, become inadequate to keep an insurer solvent."[32]

[31] Supra-competitive profits are defined here as profits superior to those that would exist under a state of unregulated or unhindered competition.

[32] United States General Accounting Office Report to Congressional Requesters, June 2003, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. GAO-03-702, p. 40.

Insurance premiums are determined primarily by the insurers' cost of providing insurance (including the cost of capital). Therefore, the increase in costs that would result from an increase in the MICRA cap on non-economic awards ultimately would be reflected in the insurance premiums paid by healthcare providers.

B. Physician-Owned Medical Liability Insurance Companies Have No Incentive to Retain Excess Profits

Most physician medical liability insurance in California is provided by physician-owned, nonprofit mutual insurance companies. These companies include Medical Insurance Exchange of California, NORCAL Mutual Insurance Company, and The Doctors Company.[33] As a mutually-owned company, each of these insurers retains some of its earnings in order to increase the company's capital base and protect its long-term solvency from unforeseen future risks. When the firm enjoys strong profit years, it distributes dividends to its shareholders or premium rebates to its policyholders.

Because physicians are both the shareholders and the customers of these mutual insurance companies, the companies have a built-in incentive to return the savings resulting from MICRA to physicians.[34] Therefore, even if these companies had the market power to raise premiums above competitive levels, they would have no incentive to do so.

C. California Medical Liability Insurers Do Not Make Excessive Profits

One way to determine if California medical liability insurers are earning supra-competitive profits is to examine the companies' return on equity.

[33] Some carriers, such as Cooperative of American Physicians, are required by law to operate at a break even level. See California Insurance Code 1280.7.

[34] The competitive market ensures that the savings passed on to physicians are in turn passed on to consumers.

Table 4 shows that, as measured by return on equity, medical liability insurers in California are not earning excess profits. During the 1990-2006 period, annual nominal returns ranged from –13.6 percent to +17.7 percent, with an average return of 4.93 percent. By comparison, the rate of return on one-year U.S. Treasury Bonds averaged +4.52 percent during this same period. The rate on the U.S. Treasury is frequently used by economists as a measure of the risk-free time value of money. In other words, between 1990 and 2006, medical liability insurance companies earned slightly more than what they would have earned by investing their capital in a financial instrument that carries no risk of default. Insurance companies, in contrast, are exposed to significant risks. Thus, medical liability providers are not only failing to earn excess profits; in an economic sense they are not earning profits at all (*i.e.*, negative risk-adjusted returns).

Table 4: Return on Equity for California Medical Liability Insurance Providers[35]

Year	Total Shareholder Equity	Net Income After Rebates and Tax	Return on Equity	Return on Constant Maturity One Year U.S. T-Bond
1990	$ 258,675,160	$ 14,042,355	5.43%	7.89%
1991	$ 294,281,331	$ 22,453,900	7.63%	5.86%
1992	$ 329,931,078	$ 23,305,219	7.06%	3.89%
1993	$ 355,890,808	$ 19,715,366	5.54%	3.43%
1994	$ 388,624,908	$ 52,597,994	13.53%	5.32%
1995	$ 691,721,124	$ 59,676,466	8.63%	5.94%
1996	$ 744,214,302	$ 48,984,643	6.58%	5.52%
1997	$ 811,915,697	$ 69,822,289	8.60%	5.63%
1998	$ 851,552,288	$ 66,324,728	7.79%	5.05%
1999	$ 841,356,537	$ 55,348,931	6.58%	5.08%
2000	$ 839,121,338	$ 52,342,110	6.24%	6.11%
2001	$ 777,665,996	$ (74,585,008)	-9.59%	3.49%
2002	$ 742,336,385	$ (100,801,838)	-13.58%	2.00%
2003	$ 729,665,066	$ (87,656,969)	-12.01%	1.24%
2004	$ 826,086,543	$ 54,069,256	6.55%	1.89%
2005	$ 973,780,964	$ 109,362,047	11.23%	3.62%
2006	$ 1,189,044,548	$ 209,860,631	17.65%	4.94%
Average (1990-2006)			**4.93%**	**4.52%**

D. Physicians and Hospitals Are Under Significant Pressure to Hold Down Fees and Limit Profits

Healthcare plans face intense pressure from both employers and the state to hold down or reduce premiums. In response, the plans exert pressure on providers, such as physicians and hospitals, to limit fees. Furthermore, as managed care becomes more prevalent in California, the pressure on providers to hold down fees tends to increase. Managed care providers (*e.g.*, HMOs, PPOs) improve competition among physician organizations and

[35] Aggregate data for Cooperative of American Physicians, Medical Insurance Exchange of California, NORCAL Mutual Insurance Company, American Healthcare Indemnity Company, SCPIE Indemnity Company, and The Doctors Company; and Federal Reserve Statistical Release, H.15 Selected Interest Rates, Treasury Constant Maturities, 1-Year (http://www.federalreserve.gov/releases/h15/data.htm).

hospitals. HMOs, for example, can shift the patient pools by signing or refusing to sign provider contracts. Physicians who are operating in these increasingly competitive markets are, thus, under pressure to pass-on to health insurers the cost-savings from lower medical liability insurance premiums made possible by MICRA.

VII. AN INCREASE IN THE MICRA CAP WOULD INCREASE THE COST OF HEALTHCARE

The increase in medical liability costs resulting from a higher cap on non-economic damages would impose additional costs on the state's healthcare system, both directly and indirectly. Initially, the additional costs would be borne by healthcare providers. Because the healthcare system is both interconnected and highly competitive, however, higher costs imposed on one segment of the system eventually affect the remaining segments. Thus, when healthcare providers are forced to pay more for malpractice insurance, these costs ultimately are passed along to the payers – employers providing health insurance, workers, consumers and taxpayers.[36]

A. An Increase in the MICRA Cap Would Result in Increased Doctors' Fees

Empirical evidence shows that an increase in medical liability premiums, results in higher doctor's fees. Danzon, *et al*., modeled the effects of premium increases on doctors' fees and found that every $1.00 increase in premiums increased doctors' total annual fees by an average of $0.16 for physician visits, and $0.09-$0.17 for hospital visits.[37] To illustrate, if California premiums for obstetricians ($89,953 in 2005) increased to rates similar to Florida ($299,420 in 2005) this increase of $209,467 in premiums would lead

[36] The GAO found that "hospitals and physicians incur and pass on to consumers additional expenses that directly or indirectly relate to medical liability. Therefore, estimates of higher malpractice premiums – taken by themselves – understate the full effect of medical liability costs on national health expenditures." GAO, "Medical Liability: Impact on Hospital and Physician Cost Extends Beyond Insurance, September 1995.

[37] Danzon, Patricia M., Pauly, Mark V., and Raynard S. Kington, "The Effects of Malpractice Litigation on Physicians' Fees and Incomes," AEA Papers and Proceedings, May 1990. The authors caution that the ability of doctors and hospitals to pass on such fee increases to consumers will be determined by the competitiveness of the market. Note also that this study analyzed data from 1976, 1978 and 1982 -- before competitive changes in the healthcare market, such as an increased use of managed care.

to an increase of $33,515 in the annual cost of physician visits (per physician) and an increase of between $18,852 - $35,609 in the annual cost of hospital visits.[38]

B. Raising the MICRA Cap Would Result in Significant Increases In Costs For the Healthcare System and Patients

Healthcare providers reduce their exposure to liability suits by adopting sub-optimal behaviors that increase the cost of healthcare without improving the quality or effectiveness of care. The term used to describe this exposure-reducing behavior is "defensive medicine."

Kessler and McClellan (2000) found that medical liability tort reforms, particularly "direct" reforms such as caps on non-economic damages, lead to significant reductions in medical expenditures on cardiac disease, without having substantial effects on mortality or medical complications.[39] The reductions ranged from 2.93 to 3.14 percent, with an average of 3.04 percent. Assuming this relationship holds for all medical services provided to California residents, the share of the benefits from medical liability tort reform going to the state's consumers and taxpayers is approximately $9.0 billion in 2010.[40]

C. Annual Direct and Indirect Costs Resulting From a Higher Cap on Non-Economic Damages Would Exceed $9.5 Billion

Table 5 summarizes the available empirical evidence on the quantifiable costs to California's healthcare system of relaxing medical liability reforms such as the $250,000 cap on non-economic damages.

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[38] See Figure 5 for comparison of premium rates.

[39] Kessler, Daniel and McClellan, Mark, "Medical liability, managed care and defensive medicine" NBER working paper 7537, February 2000. See Table 5.

[40] (3.04%) ($295.94 billion) = $8.98 billion. 2010 California projected health expenditures are computed as a pro-rata share of projected 2010 U.S. health expenditures. (See, U.S. Census Bureau, Statistical Abstract of the United States: 2010. p. 97; U.S. Census Bureau, Statistical Abstract of the United States 2003, p. 107).

Table 5: Measurable Costs of Increasing the Cap on Non-Economic Damages

Indirect Cost of Increased Defensive Medicine Saving		
2010 California Projected Healthcare Expenditures[41]	A	$ 295,939,702,009
Estimated defensive medicine saving[42]	B	3.04%
Annual saving forfeited by lifting the cap	C = A x B	$ 8,981,769,956
Direct Cost to Medicare		
CBO-estimated increase to Medicare expenditures per year[43]	D	$ 1,490,000,000
2008 CA portion of national Medicare spending[44]	E	11.55%
Annual increased Medicare expenditures due to lifting the cap	F = D x E	$ 172,030,173
Projected Medical liability Premium Increase		
Projected 2005 Premium written for CA[45]	G	$ 963,059,000
Estimated percentage increase in premium[46]	H	31.75%
Projected annual premium increase after lifting the cap	I = G x H	$ 305,771,233
Estimated Annual Cost of Lifting the Cap	J = C+F+I	**$ 9,459,571,362**
Estimated CA Population (2010)[47]	K	**38,648,090**
Estimated Savings for a Family of Four	L = J / K * 4	**$979**

The estimates in Table 5 assume that the cap on non-economic damages is increased to $500,000 or more, and that Kessler and McClellan's estimates of defensive medicine costs in connection with the treatment of coronary disease can be extended to all types of healthcare. We believe these estimates are valid for an increase in the MICRA cap to $500,000 or more, given the empirical evidence that caps above $500,000 have no significant effect on reducing premium growth rates.[48]

It is possible that the cost to California's healthcare system resulting from an increase in the $250,000 cap on non-economic damages awards could be higher or lower than the

[41] U.S. Census Bureau, Statistical Abstract of the United States: 2010, p. 97.

[42] Mean of the "heart attack" and "ischemic heart disease" estimates provided by Kessler, Daniel and McClellan, Mark, "Medical liability, managed care and defensive medicine" NBER working paper 7537, February 2000. See Table 6 of that report.

[43] CBO Cost Estimation of H.R. 5, "Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2003," dated March 10, 2003.

[44] Center for Medicare and Medicaid Services - 2009 Data Compendium, Section VII, State Data, Table VII.1 (2008 Expenditure).

[45] Projection based on NAIC 2005 profitability data.

[46] (20.5+43)/2=31.75. See Section V.D.

[47] State of California, Department of Finance, E-5 Population and Housing Estimates for Cities, Counties and the State, 2001-2010, with 2000 Benchmark. Sacramento, California, May 2010.

[48] See, for example, Danzon, Patricia M., Andrew J. Epstein and Scott Johnson, The "Crisis" in Medical Malpractice Insurance, The Wharton School, University of Pennsylvania, December 2003, Prepared for the Brookings-Wharton Conference on Public Policy Issues Confronting the Insurance Industry, January 8/9, 2004.

estimates shown in Table 5. On the one hand, the cost of defensive medicine in connection with the treatment of coronary disease may not be representative of defensive medicine costs associated with other diagnoses. The GAO, for example, has questioned whether the results from specific studies, such as Kessler and McClelland's, can be applied to all patients and procedures.[49] Indeed, defensive medicine costs could be higher for some diagnoses and lower for others.

Moreover, Table 5 does not reflect all of the increased costs that would be expected to result from a higher cap. For example, it makes no allowance for the higher costs that self-insured providers, such as the University of California and public hospitals, would be forced to bear. Furthermore, the increase in medical liability insurance premiums (31.75%) assumed in Table 5 is far lower than the increases reported for Oregon physicians (*e.g.*, 290% for internists) after the state's Supreme Court removed the cap on non-economic damages.[50]

While the increased costs resulting from a higher MICRA cap could be higher or lower than the $9.5 billion shown in Table 5, we believe this is the best estimate given the results of empirical research.

[49] See, for example, Medical Malpractice Implications of Rising Premiums on Access to Health Care. United States General Accounting Office, Report to Congressional Requesters, GAO-03-836. August 2003, pp. 53-54.

[50] Data provided by NORCAL Mutual Insurance Company, and reported in Figure 6. Average premium written in 1999 for internists was $4,353. This amount rose to $12,628 by 2006, an increase of 290%.

VIII. THE INCREASED COSTS OF HEALTHCARE RESULTING FROM A HIGHER CAP WOULD BE BORNE BY CALIFORNIA CONSUMERS, EMPLOYERS AND FEDERAL, STATE AND LOCAL TAXPAYERS

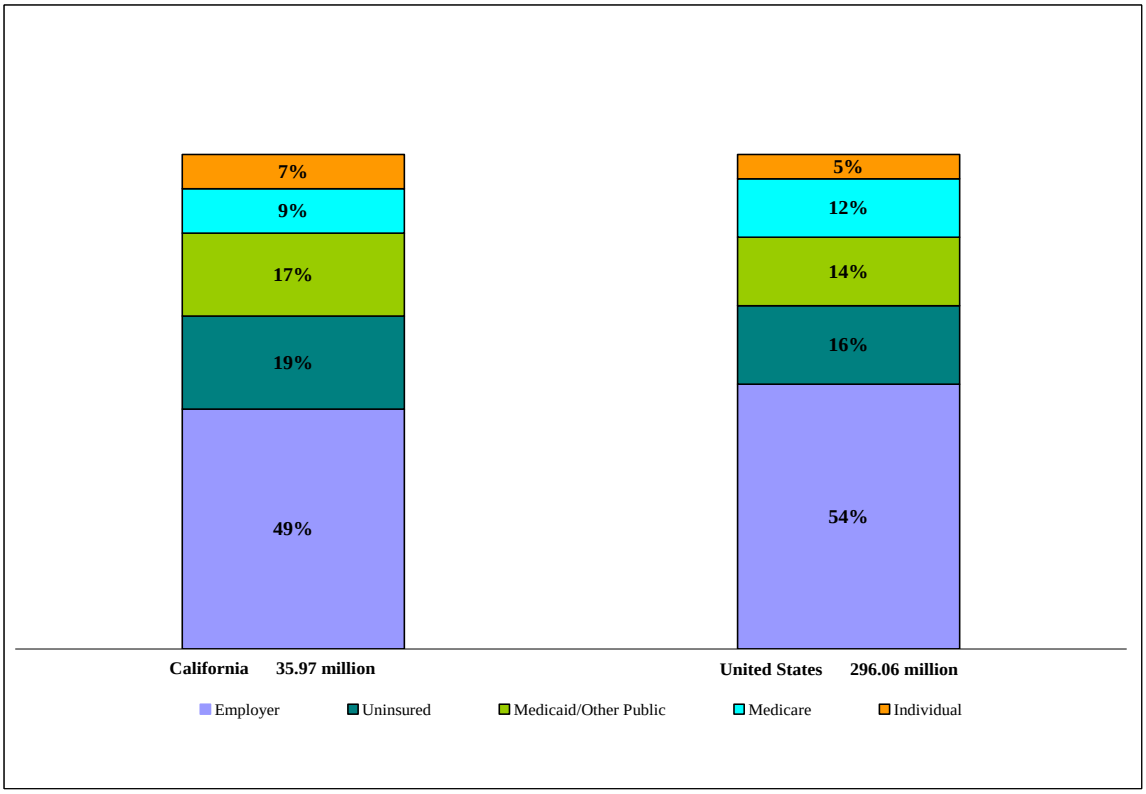
Participants in California's healthcare system – physicians, employers, government and consumers – would not share equally in the increased costs of healthcare resulting from a higher cap on non-economic damages. While physicians and hospitals initially would bear the costs resulting from the higher cap, most or all of these costs eventually will be passed along to other participants, in the form of increased fees and charges.[51]

A. Employers Would Respond to Increases in the Cost of Healthcare by Shifting Most of the Costs to Their Employees

Because insurance costs are a factor in physician, hospital and other affiliated professional reimbursement rates, the cost of employer-sponsored health insurance would go up if the MICRA cap is relaxed or removed. As Figure 7 indicates, 49 percent of California's population is insured through their employer.

[51] Danzon, Patricia M., Pauly, Mark V., and Raynard S. Kington, "The Effects of Malpractice Litigation on Physicians' Fees and Incomes," *AEA Papers and Proceedings*, May 1990.

Figure 7: Distribution of the Total Population, by Health Insurance Status, California and the United States, 2006[52]



An increase in the cost of employer-sponsored health insurance programs would affect employees in one of four ways.

First, some employers that continued to offer health insurance to their employees would be likely to reduce coverage. The reductions would be most likely to occur in areas such as vision care, mental health, and counseling.

Second, other employers that continued to offer health insurance would be likely to raise the employees' required contribution toward the cost of their insurance by requiring larger coinsurance payments, higher deductibles, or increases in the employee's share of premiums.

[52] The Henry J. Kaiser Family Foundation, statehealthfacts.org, California: Health Insurance Coverage of the Total Population, states (2005-2006), U.S. (2006).

Third, other employers that continued to offer health insurance would leave the benefit package intact, but hold down wages and salaries, in order to prevent the employees' total compensation costs from rising by more than the increase in employee productivity.

Fourth, some employers might decide to terminate health insurance coverage for their employees, or firms on the verge of adding health insurance to their benefit package might decide not to do so for reasons of cost.[53]

Reflecting the consensus of economists, the CBO has determined that over the long run, employers pass along increases in the cost of health insurance to employees.[54] The CBO explains that the cost shift may affect either the demand for, or supply of labor, or both. On the demand side, employers seek to keep employees' "total compensation (wages plus benefits) in line with labor productivity. If the real cost of insurance for employers goes up by a dollar and the added costs are not accompanied by increased productivity, employers face strong pressures to cut a dollar from some other component of labor compensation, such as real wages."[55] On the supply side, the CBO argues, employees are willing to pay for healthcare, "which means that they would be willing to give up some of their income to get it, just as they give up income to buy other goods and services."[56] Thus, workers "end up bearing the costs of that insurance because supplies of labor are not elastic."[57]

B. The Taxpayers Would Bear a Large Portion of the Costs Imposed on Healthcare Providers

Federal, State and local governments, as major purchasers of healthcare, also would bear a significant portion of the increased costs resulting from a higher cap on non-economic

[53] See, *e.g.*, Pauly, Mark V., Health Benefits at Work: An economic and political analysis of employment based health insurance. University of Michigan Press. 1997.
[54] CBO, "Economic Implications of Rising Health Care Costs," October 1992.
[55] *Ibid*, at p. 35.
[56] *Ibid*.
[57] *Ibid*. This outcome will depend on the shape of the labor supply curve. It is likely that the employers would bear some, probably small, part of the costs and their employees would bear most of the costs. See Danzon, Pauly, *op cit*.

damages. The CBO estimated that the savings from enacting MICRA-like reforms would reduce federal direct spending for Medicare, Medicaid, Federal Employees Health Benefits (FEHB), and other federal health benefits programs by $14.9 billion over the 2004-2013 period.[58]

The CBO's estimate should be considered a lower bound, as it does not take into account the heavy costs of defensive medicine.[59] In addition, the estimate does not reflect the nationwide cost-savings from a cap, because California and other states already limit non-economic damages awards. If California were to raise the MICRA cap, Federal and State governments would lose a portion of the savings they are currently getting from the cap, and government expenditures on healthcare would increase.

C. An Increase in Healthcare Costs Resulting from an Increase in the Cap Ultimately Would Be Borne by Patients as Consumers

Increases in physician and hospital fees resulting from a higher cap on non-economic damages eventually would be shifted to consumers. Employers would pass along the added costs to consumers by requiring employees to contribute more toward their health insurance coverage. Some employers might find the increased cost of health insurance unaffordable, and drop coverage for their employees, forcing them to purchase more-costly individual policies or go uninsured. Participants in government-financed health insurance programs would experience the same outcomes – higher co-payments or reduced coverage.

Individual consumers of healthcare and the taxpayers would end up paying for increases in healthcare costs due to a higher cap on non-economic damages.

[58] Congressional Budget Office, Cost Estimate March 10, 2003. H.R. 5 Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003. As ordered reported by the House Committee on the Judiciary on March 5, 2003.

[59] See, *e.g.*, Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care. March 3, 2003. Prepared by U.S. Department of Health and Human Services; Office of the Assistant Secretary for Planning and Evaluation.

D. Conclusion: Who Would Bear the Costs Resulting From an Increase in the MICRA Cap?

Figure 8 summarizes the incidence of the higher costs that would result from an increase in the $250,000 cap on non-economic damages under MICRA.

Figure 8: Who Bears the Costs of a Higher Cap?

COST	IMPOSED ON	SHIFTED TO
Increased loss costs	Medical liability insurers	Insured providers
	Self-insured providers	Government programs Healthcare insurers Uninsured consumers
Higher medical liability insurance premiums	Insured providers	Healthcare insurers Uninsured consumers Government programs
Increased cost of defensive medicine	Healthcare insurers	Employers Insured consumers
	Uninsured consumers	
	Government programs	Taxpayers
Increased health insurance premiums	Employers	Workers
	Insured consumers	
Increased cost of government programs	Federal, state & county agencies	Taxpayers

IX. THE INCREASED COSTS OF HEALTHCARE RESULTING FROM A HIGHER CAP WOULD INCREASE THE NUMBER OF UNINSURED PERSONS IN CALIFORNIA

Currently, there are a higher percentage of uninsured persons in California than in the United States as a whole (19% vs. 16% in 2006). Possible factors contributing to this difference include California's larger immigrant population (16% vs. 8%).[60] California also has slightly lower rates of employer-based health insurance coverage than the United States (49% vs. 54%), as Figure 7 shows.

By increasing the cost of healthcare in California, a higher cap on non-economic damages would reduce the willingness and ability of Californians to obtain health insurance and seek needed medical care. It would also reduce the willingness of healthcare providers to offer care – particularly to under-served groups or individuals in under-served areas.

A. An Increase in the Cost of Healthcare Would Reduce Healthcare Insurance Coverage

A fundamental tenet of economics is that, for most goods and services, an increase in price causes a reduction in demand. Consequently, we can be certain that increases in health insurance premiums resulting from a higher cap would lead to an increase in the number of individuals electing to go without coverage.

In some cases, the reduction in coverage would reflect decisions by employers to drop health insurance as an employee benefit. In other cases, employees themselves would make the decision to drop coverage because the higher premiums make it too expensive. The extent to which an increase in health insurance premiums leads to reduced coverage depends on the price elasticity of demand for insurance.

[60] The Henry J. Kaiser Family Foundation, statehealthfacts.org, California: Population Distribution by Citizenship Status, states (2005-2006), U.S. (2006).

B. Some Businesses Would Respond to Increased Health Insurance Premiums by Decreasing Coverage

Empirical evidence shows that employers continually evaluate whether to offer health insurance coverage to their employees, even when the economy is robust. Research published by the U.S. Department of Labor has shown that an increase in the cost of premiums decreases the likelihood that a firm will offer health insurance.[61]

Rather than discontinue coverage, an employer faced with increases in the cost of health insurance might choose to shift the increases to employees by requiring a larger employee co-payment, or by reducing the range of healthcare coverage offered.

C. An Increase in Health Insurance Costs Would Decrease Participation in Health Insurance Programs, Particularly by Low-Income Workers

If employees are required to pay more for health insurance, some will choose not to buy coverage. A growing body of research tests the sensitivity of employee behavior to health insurance costs. Studies have shown that health insurance price elasticity ranges from minus 0.1 to minus 0.4. These findings can be interpreted to mean that a 10% increase in the price of health insurance will lead to a 1-4% decrease in the number of people who choose to purchase health insurance.[62] Given California's population of approximately 35 million, a 10% increase in the price of health insurance would therefore reduce the number of Californians who chose to purchase insurance by 350,000 to 1.4 million.

[61] Leibowitz, Arleen and Michael Chernew, "The Firm's Demand for Health Insurance," U.S. Department of Labor, July 17, 1992.

[62] See, *e.g.*, Marquis, Susan M., and Long, Stephen H., "Worker Demand for health Insurance in the Non-group Market," Journal of Health Economics, 1995; Sheils, J., et al, Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy-Technical Appendix. National Coalition on Health Care, October 1999; Ringel, Jeanne S., Susan D. Hosek, Ben A. Vollaard and Sergej Mahnovski, The Elasticity of Demand for Health Care A Review of the Literature and Its Application to the Military Health System, Prepared for the Office of the Secretary of Defense, RAND National Defense Research Institute, undated.

Not only would fewer persons choose to purchase insurance; employers would be likely to reduce the availability of employer-offered insurance plans as insurance premiums rise. A full 72 percent of California employers who do not offer health insurance benefits to their employees cite high premium costs as a very important reason for not doing so. An additional seven percent cite costs as somewhat important.[63]

X. THE INCREASED COSTS OF HEALTHCARE RESULTING FROM AN INCREASE IN THE CAP WOULD REDUCE THE SUPPLY OF HEALTHCARE IN CALIFORNIA

Over time, the MICRA cap has had a favorable effect on both the supply of, and access to, healthcare provided by California physicians and hospitals. Just as an increase in price causes consumers to buy less, a reduction in price causes providers to supply less. To the extent an increase in medical liability costs initially would reduce the financial rewards from providing healthcare; a higher cap on non-economic damages would have an adverse impact on the supply of care in at least five ways.

A. A Higher Cap Would Discourage Physicians from Setting Up their Practices in California

Physician supply in any location and in any specialty depends, in part, on expected income. If one state has higher medical liability insurance costs than other states, and providers are temporarily unsuccessful in passing along the additional costs to consumers, the expected incomes of providers in that state will fall. Over time, the income disparity will reduce the number of physicians that choose to work in the state with higher malpractice costs.[64] New York provides a compelling example of this problem:

[63] Employer Health Benefits, 2007 Annual Survey, Kaiser Family Foundation, Exhibit 2.8, p. 41.

[64] See, *e.g.*, Satterthwaite, Mark A., "Competition and Equilibrium as a Driving Force in the Health Services Sector," In Managing the Service Sector, ed. by Robert P. Inman, Cambridge, pp. 239-67, Cambridge: Cambridge University Press, 1985.

> The cost of medical malpractice insurance in New York City, Westchester County and on Long Island has risen by nearly 150 percent since 1999, creating severe financial strains that have limited patients' access to such specialties as obstetrics and gynecology and made New York a ''crisis state'' for doctors, according to a report released yesterday by a hospital trade group.[65]

Texas's recent experience with its cap on non-economic damages provides equally compelling evidence on the increased access to healthcare resulting from medical liability tort reform. In 2003, the Texas Legislature passed House Bill 4 and the voters' approved Proposition 12, capping non-economic damages awards at $250,000 for any and all doctors sued, with an additional cap of $250,000 for each of up to two medical care institutions. Since then, insurance premiums in Texas have decreased dramatically and access to medical care has increased.

> **Doctors laud 5 years of malpractice relief. Tort reform: Keeping physicians in Texas**, *El Paso Times*, September 14, 2008
>
> Dr. Luis Linan, an East Side obstetrician-gynecologist, said Texas tort reform has allowed him to see high-risk patients again and has reduced his malpractice insurance costs from $32,000 a year to $18,000 a year. The savings have allowed him to expand medical procedures in his practice, he said. Dollar limits on malpractice lawsuits have lessened doctors' fears, bolstered their numbers and allowed them to increase services to patients.

B. A Higher Cap Would Discourage Physicians from Setting Up Their Practice in Low-Income Rural or Inner City Areas

While higher medical liability premiums would affect healthcare providers throughout the state, physicians in rural and inner city would be most affected by the increase because their ability to absorb the increased costs is more limited than their suburban counterparts. According to the GAO:

[65] Lueck, Thomas J. "Malpractice Costs Up 150% Since 1999, Hospitals Say," The New York Times, January 6, 2005 Thursday, Late Edition – Final, Section B; Column 1; Metropolitan Desk; p. 2.

> Actions taken by health care providers in response to rising malpractice premiums have contributed to reduced access to specific services on a localized basis in the five states reviewed with reported problems. We confirmed instances where physician actions in response to malpractice pressures have resulted in decreased access to services affecting emergency surgery and newborn deliveries in scattered, often rural areas.[66]

Many rural and inner city areas are medically under-served because these communities have higher costs in relation to revenues than do other communities. To the extent that physicians are unable to pass along the higher cost of malpractice premiums to lower-income families, a higher cap would exacerbate the provider shortage in rural and inner city areas.

C. A Higher Cap Would Discourage Physicians From Entering High-Risk Specialties

Higher malpractice premiums translate into higher costs for physicians, especially for those specializing in obstetrics and other high-risk specialties. Medical liability premiums are disproportionately high among obstetricians and family practitioners who deliver babies.[67] These high premiums and correspondingly higher costs discourage physicians and medical students from specializing in obstetrics or other high-risk specialties:

> **Malpractice Costs Leading To Closings of Maternity Wards**, *Philadelphia Bulletin*, May 23, 2008
>
> Since 1995, 36 of the state's hospital obstetrical units have closed, 14 of them in the southeast. But as these wards dwindle in number, demand for care for Pennsylvania's 147,000 annual births doesn't seem likely to subside. At Riddle Memorial Hospital, where the committee held the hearing, doctors, administrators and patients have felt the pressure of tort liability.

[66] The five states examined are: Florida, Nevada, Pennsylvania, Mississippi, and West Virginia. (See, Medical Malpractice, Implications of Rising Premiums on Access to Health Care, United States General Accounting Office. GAO-03-836. August 2003, p. 12).

[67] Stephen A. Norton, "The Malpractice Premium Costs of Obstetrics," *Inquiry*, Spring 1997, p. 62.

> Three years ago, the hospital had 12 obstetricians on staff. Today, seven still practice obstetrics, while the other five work only as gynecologists. Demand for obstetrical care, meanwhile, has grown. Births in the hospital have increased from 800 to 1,200 per year in the past decade. … "The crisis in malpractice insurance and the need for tort reform is exacerbating the problem and making it very difficult to recruit obstetricians," [Dan Kennedy, president of Riddle] said.

A Baby-Free New York, Editorial, *New York Post,* August 1, 2008

> New Yorkers may soon have to cross state lines just to have a baby - or maybe even just to see a doctor when they get sick. Raising that frightening prospect is this week's news that Long Island College Hospital plans to close its obstetrics ward in the face of skyrocketing medical-malpractice costs. Malpractice-insurance premiums have gone through the roof - thanks in large measure to state laws (and judges) that favor plaintiffs (and their lawyers).

Obstetrical services, such as prenatal care, are among the most cost-effective forms of preventive medical care available. Any improvement in infant health outcomes provides benefits during the individual's entire lifetime. Obstetricians, however, have a significant exposure to malpractice lawsuits, as is indicated by the relatively high level of their malpractice insurance premiums. Table 6 shows the premiums paid by practitioners in Los Angeles, Miami Long Island, Detroit, and Chicago.

Table 6: 2007 Malpractice Premiums by Specialty[68]

Specialty	Los Angeles, CA[69]	Miami, FL[70]	Long Island, NY[71]	Detroit, MI[72]	Chicago, IL[73]
Allergy	$8,136	$33,247	$9,264	$19,169	$16,088
Psychiatry (Non-Shock)	$8,136	$33,247	$9,264	$20,240	$21,488
Pathology	$12,780	$75,994	$22,311	$22,134	$21,488
Anesthesiology	$14,716	$66,495	$32,223	$47,272	$41,288
Family Practice (Non-Surgical)	$14,716	$61,745	$22,948	$39,577	$32,288
Internal Medicine (Non-Invasive)	$14,716	$68,869	$31,472	$38,942	$37,688
Radiology (Non-Invasive)	$16,724	$130,614	$50,496	$51,348	$41,288
Cardiology (Invasive)	$18,756	$130,614	$40,738	$77,899	$59,288
Pediatrics (Non-Surgical)	$18,756	$42,747	$22,948	$32,796	$25,088
Ophthalmology	$23,304	$47,496	$31,179	$43,029	$32,288
Urology	$23,304	$83,118	$55,005	$63,096	$53,888
Dermatology	$25,844	$29,923	$9,264	$26,979	$21,488
Emergency Medicine	$35,952	$130,614	$48,737	$98,768	$59,288
Otolaryngology	$35,952	$47,496	$55,005	$92,459	$59,288
Proctology	$35,952	$94,992	$55,005	$60,937	$59,288
General Surgery	$43,056	$275,478	$100,550	$162,623	$98,888
Thoracic Surgery	$43,056	$237,481	$100,550	$174,690	$131,284
Cardiovascular Surgery	$49,116	$237,481	$100,550	$204,253	$131,284
Orthopedics	$49,116	$178,111	$125,004	$191,964	$131,284
Plastic Surgery	$62,272	$130,614	$97,378	$103,806	$102,488
OB/GYN	**$70,372**	**$275,478**	**$167,812**	**$158,732**	**$138,484**
Neurosurgery	$79,484	$341,972	$275,289	$228,453	$228,484
Average - All Specialties	$32,010	$125,174	$66,500	$89,053	$70,169

Parents whose infants have imperfect birth outcomes are relatively likely to file a malpractice lawsuit, and juries are highly sympathetic to claims involving infants. High malpractice insurance premiums can serve as a powerful deterrent to obstetrical practice, particularly in areas where reimbursement rates are low. These areas typically include rural areas with lower patient density, as well as low-income areas where many patients do not have health insurance and births are more likely to have medical complications.

[68] Note: Comparison reflects mature annual premium costs for $1 million maximum per case/$3 million maximum for all cases in a given year unless otherwise noted.

[69] Provided by SCPIE Indemnity Company. Rates effective in 2007.

[70] Provided by Florida Physicians Insurance Company. Rates effective between December 1, 2006 and December 1, 2007.

[71] Provided by Medical Liability Mutual Insurance Company. Rates effective between July 1, 2007 and June 30, 2008.

[72] Provided by American Physicians Assurance. Rates effective starting January 1, 2007. Comparison reflects mature annual premium costs for $1 million maximum per case/$4 million maximum for all cases in a given year.

[73] Provided by ISMIE. Rates effective on or after July 1, 2006 up to and including September 30, 2008.

By holding down premiums for high-risk and general practitioners, MICRA promotes access to healthcare in California.

D. A Higher Cap Would Encourage Early Retirement By Physicians

Retirement decisions are influenced by future earnings potential. If a physician nearing retirement sees his or her medical liability costs increase a significant amount, the physician will be more likely to retire sooner rather than later. In one survey, 45 percent of responding hospitals indicated that they lost physicians and/or suffered reduced coverage in emergency departments as a result of malpractice insurance costs.[74]

E. A Higher Cap Would Discourage Medical Students from Entering Certain Fields of Specialty or Geographic Regions

Likewise, medical students are keenly aware of the costs of liability insurance and factor these costs into their selection of specialties (50 percent of medical students cited liability insurance as an important factor) and location of practice (39 percent of medical students cited liability insurance as related to geography as an important factor).[75] Consequently, those areas and specialties with relatively higher liability costs will be underserved as students elect to pursue other less-risky or less-costly options.

[74] Medical Liability Reform – NOW! June 14, 2004. American Medical Association, p. 3.

[75] AMA survey: Medical students' opinions of the current medical liability environment. American Medical Association Division of Market Research and Analysis. November 2003.

XI. A HIGHER CAP WOULD DECREASE THE WILLINGNESS OF PHYSICIANS TO PROVIDE TREATMENTS THAT CARRY A RELATIVELY HIGH RISK

When a provider agrees to perform a high-risk procedure on a patient, the provider's exposure to a medical liability lawsuit increases sharply. High-risk procedures, by definition, often result in poor outcomes. Consequently, a provider can minimize his or her exposure to litigation by refusing to perform such procedures. In some cases, however, high-risk procedures may be the patient's best – or only – hope.

The presence or absence of medical liability reform can affect the willingness of physicians to perform high-risk healthcare procedures.[76] According to a GAO study, during the California medical liability insurance crisis of the 1970's:

> Officials of the California Hospital Association [noted]…that some doctors in California decided to discontinue providing medical care involving high risk procedures, some moved their practices to other states, and some opted to 'go bare' (practice without malpractice insurance). Further, medical care was not available in all parts of California, and patients treated by uninsured doctors faced the probability of unenforceable judgments if they suffered serious injury as a result of malpractice.[77]

An increase in the MICRA cap would decrease access to healthcare, particularly for low-income people and those seeking physician care in high-risk specialties such as obstetrics and gynecology.

[76] The threat of medical malpractice suits can also discourage innovation and experimental medicine in the state. See, e.g., Nelkin, Dorothy, and Laurence Tancredi. "Medical Malpractice and Its Effect on Innovation." The Liability Maze. Ed. Peter W. Huber and Robert E. Litan. Brookings Institution Press, 1991, pp. 251-273.

[77] General Accounting Office, "Medical Malpractice: Case Study on California," December 1986. GAO/HRD-87-21S-2, p. 8.

XII. AN INCREASE IN THE MICRA CAP WOULD NEGATIVELY AFFECT THE SOCIAL SAFETY NET

The social safety net is composed of health services that are provided to individuals with little expectation of reimbursement. An increase in the cap would likely have a negative effect on providers of these services, because they will find it most difficult to shift these costs to others. As a result, the increases in costs that would result from a higher cap are almost certain to cause a decrease in services for those dependent on the social safety net.[78]

A. Higher Medical Liability Premiums Would Decrease Hospitals' Ability to Provide Uncompensated Care

Most hospitals self-insure against medical liability claims, rather than purchase liability insurance from an insurance company.[79] Such hospitals pay into a self insurance trust, which provides a source of payments for losses (claims) as they accrue. The hospitals' contributions are based on actuarial determinations of future payments, which are based on historical and expected losses.

In California today, hospital reserves are premised on the continuation of a $250,000 cap on non-economic damages. If the cap is increased, hospitals that self-insure will be forced to set aside a larger percentage of their budgets as reserves for medical liability costs. For example, the University of California maintains reserve balances for its teaching hospitals. In 1997, UC advised the Legislature that raising the MICRA cap would cost an estimated $5.2 million-to-$7.9 million annually in increased payments and defense costs.[80] Adjusting for inflation since 1997, this amount translates to $6.3 million - $9.5 million in 2006.

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[78] See, e.g., Blash, Lisel, Carol Lee, and Elissa Maas. "Quality Improvement in Solo and Small Group Practice, Strengthening the Private Practice Safety-Net", CMA Foundation, September 24, 2008.

[79] GAO, Medical Liability: Impact on Hospital and Physician Costs Extends Beyond Insurance," GAO/AIMD-95-169, September 1995.

[80] Letter to Assembly Pro Tem Kuehl from Stephen A. Arditti of UC State Government Relations, May 1, 1997.

Hospitals currently provide uncompensated care to the uninsured. An increase in expenditures on the direct and indirect costs of medical malpractice liability would require hospitals, such as those in the UC system, to cut back on other expenditures, including such care. This cut-back would reduce the ability of these institutions to provide needed services to those Californians unable to pay for them.

B. Higher Medical Liability Premium Costs Would Diminish the Viability of Community Hospitals and Place a Greater Financial Burden on Local Governments

The uninsured rely on safety net providers for healthcare. In California, these providers include a network of clinics and public hospitals. County health facilities often fill the gaps in healthcare available to the uninsured. An increase in the MICRA cap would require counties to increase their budgets for defense costs, as well as increase the size of their reserves.[81] As a result, their ability to provide healthcare to the near poor would suffer. An increase in the cap would also increase the cost of defensive medicine.

Currently, many public hospitals in California are finding it necessary to reduce their budgets, due to changes in Federal and State funding for healthcare. Cuts in MediCal hospital funding[82] and funding for welfare recipients put pressure on funding for the County health system. Increases in costs borne by these safety net providers due to an increase in the MICRA cap would reduce the amount of funding and services available for the uninsured.

[81] Los Angeles County, for example, planned to spend $37.8 million in FY 1997-98 on its medical liability and hospital liability budget. Letter to Los Angeles County Supervisors from Chief Administrative Officer David Janssen, May 30, 1997.

[82] The Balanced Budget Act of 1997 reduced payments to the disproportionate share hospital (DSH) program.

XIII. CONCLUSION

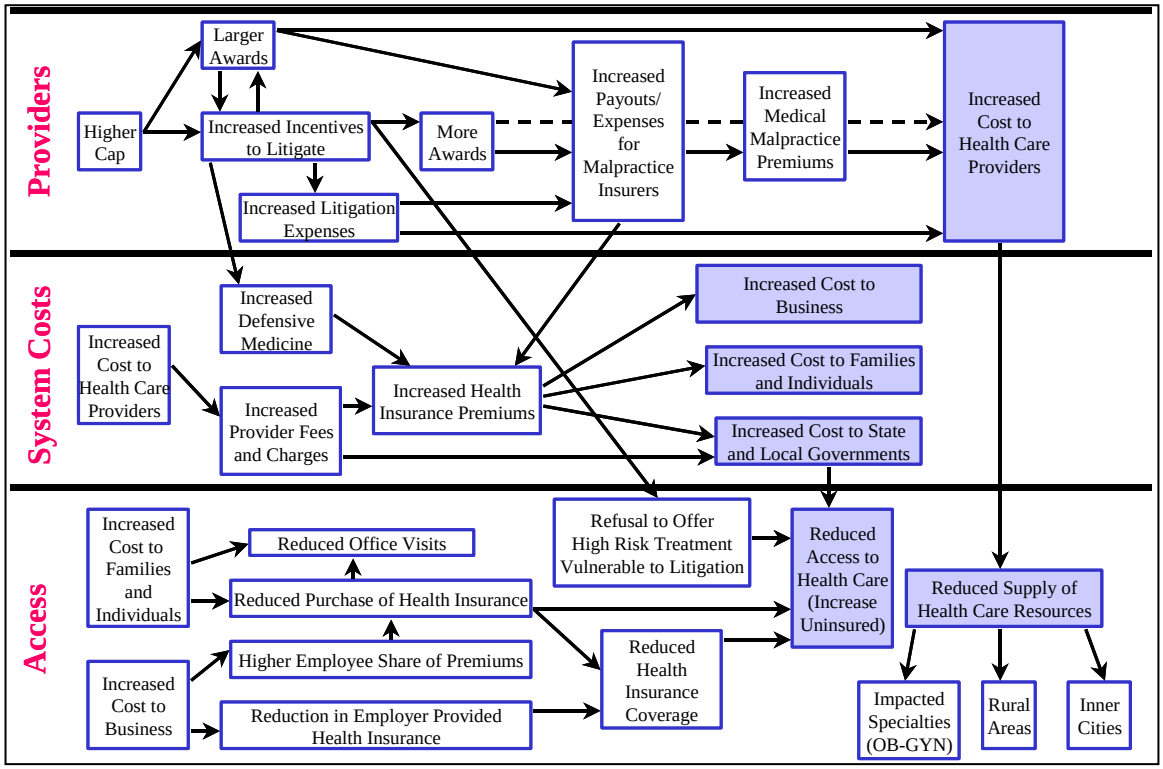
We have analyzed the effects of MICRA's $250,000 cap on medical liability insurance premiums, healthcare costs, and access to healthcare. We have also analyzed the likely consequences of increasing the cap. Economic theory and empirical evidence indicate that significantly increasing the cap would impose heavy costs on the healthcare system – costs that would primarily be borne by workers, consumers and taxpayers. In the event the cap was raised above $500,000, these costs would exceed $9.5 billion annually.

Our analysis indicates that the likely effects of a higher cap would include: (1) an increase in the volume of malpractice-related litigation, since a higher cap would encourage more individuals with non-meritorious claims to file suit; (2) an increase in the size of the average claim paid, since a higher cap would enable a relatively small number of plaintiffs to secure very large awards; and (3) an increase in loss payments and claim costs.

Together, the immediate results of the higher cap would be increased medical liability insurance premiums and an increase in defensive medicine. The resulting costs would flow through the healthcare system and eventually result in: (1) higher healthcare costs for Californians; (2) a reduction in available healthcare services; and (3) a reduction in the number of insured persons in California, increasing the financial burden on state-funded services. These consequences would be felt disproportionably by low-income and rural Californians.

Figure 9 summarizes the effects described in sections III-XII of this report. It illustrates how the different elements of the healthcare system are interrelated and interdependent. One can easily see how increased costs at one end, as a result of an increase in the MICRA cap, will result in increased costs throughout the system.

Figure 9: Effects of Increasing the Cap on Non-Economic Damages



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