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Testimony of Harvey Rosenfield
The Foundation for Taxpayer and Consumer Rights[1]
Before the House Energy and Commerce Committee
Subcommittee on Oversight and Investigations
February 10, 2003
Langhorne, Pennsylvania

Insurance Regulation vs. Tort Reform

Mr. Chairman and Members of the Committee:

There is a law in California that has lowered insurance premiums for doctors, hospitals and other health care providers. It is unique in the United States, and it is a model for the rest of the country.

It is not the infamous malpractice caps law known as MICRA, however.

In 1988, California voters, facing skyrocketing insurance premiums and angry at the failure of tort reform to deliver its promised savings, went to the ballot box and passed the nation's most stringent reform of the insurance industry's rates and practices.

Proposition 103:

- **Mandated immediate rate relief** to offset excessive rate increases by establishing a baseline for measuring appropriate rates. Prop. 103 required a roll back of at least 20% for all property and casualty insurance companies, *including* medical malpractice insurers.

- **Froze rates for one year**. Ultimately, because of the delay caused by insurance company legal challenges to Proposition 103, rates remained frozen for four years pursuant to decisions by the state's insurance commissioner.

[1] The Foundation for Taxpayer and Consumer Rights is a California-based non-profit, non-partisan citizen education and advocacy organization. FTCR's main issues are insurance, health care, and energy deregulation. I am the author of California Proposition 103, and President of the organization. Web: www.consumerwatchdog.org.

- **Created a stringent disclosure and "prior approval" system of insurance regulation**, which requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Proposition 103 gives the California Insurance Commissioner the authority to place limits on an insurance company's profits, expenses and projections of future losses (a critical area of abuse).

- Authorized consumers to **challenge insurance companies'** rates or practices in court or before the Department of Insurance.

- **Repealed anti-competitive laws** in order to stimulate competition and establish a free market for insurance. Proposition 103 repealed the industry's exemption from state antitrust laws, and prohibited anti-competitive insurance industry "rating organizations" from sharing price and marketing data among companies, and from projecting "advisory," or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents / brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. **And it authorizes** individuals, clubs and other associations to unite to negotiate lower cost group insurance policies.

- **Promoted full democratic accountability** to the public in the implementation of the initiative by making the Insurance Commissioner an **elected position**.

Attached as Appendix A is a copy of the text and a detailed description of Proposition 103 and its provisions.

Insurers spent $80 million in their unsuccessful effort to defeat Proposition 103, including three competing ballot measures that would have enacted "tort reform." Having seen how "tort reform" laws passed at the behest of the insurance industry in 1975 and 1986 had had no effect on premiums, the voters rejected the industry's 1988 measures by enormous margins.

Proposition 103 worked. Insurance companies refunded over $1.2 billion to policyholders, including doctors. In the closely studied area of auto insurance, California was the only state in the nation in which auto insurance premiums actually dropped between 1989 and 1998 (4%), while rising 25% on average throughout the rest of the nation, according to a 2001 study by the Consumer Federation of America.[2] The report concluded that the prior approval provision of

[2] California auto insurers also prospered during the same period. A calculation of annual return on net worth from 1990 to 1999 reveals that these insurers received a 16.0 percent return compared to only 10.9 percent received by auto insurers nationally. "Why Not The Best? The Most Effective Auto Insurance Regulation In The Nation," by Robert Hunter, Director of Insurance, Consumer Federation of America. June 2001

Proposition 103 blocked over $23 billion in rate increases for auto insurance alone through 2000.

What Proposition 103 has done for doctors has not received as much attention. But the results are indisputable, particularly when compared to MICRA.

I. Impact of MICRA on Medical Malpractice Insurance Premiums

MICRA was enacted in 1975. However, premiums continued to rise. By 1988, twelve years after the passage of MICRA, California medical malpractice premiums had reached an all-time high – 190% higher than 1976, when MICRA was enacted.

During the mid 1980s, California malpractice premiums increased by more than 20% annually. Insurance companies argue that premiums continued to increase after MICRA's passage because of court challenges to the law; the California Supreme Court upheld the damage cap in 1985. Despite that ruling, however, malpractice premiums in California increased more dramatically in 1986 than any year since the passage of MICRA. Between 1985, when the cap was upheld, and 1988, malpractice premiums soared 47%, to the highest levels in California history.

Figure 1. Premium Increases During the Last Insurance Crisis

Year	California Premiums Earned	Percentage Change
1983	$287,256,000	36.37%
1984	$374,661,000	30.43%
1985	$449,727,000	20.04%
1986	$629,448,000	39.96%
1987	$633,903,000	0.71%
1988	$663,155,000	4.61%
SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001		

II. Impact of Proposition 103 on Malpractice Insurance Premiums

A. Premiums Drop by 20% After Proposition 103

Unlike MICRA, Proposition 103 explicitly required a rate rollback of up to 20%. The relevant portion of California Insurance Code Section 1861.01 reads:

> For any coverage for a policy . . . of insurance subject to this chapter . . . every insurer shall reduce its charges to levels which are at least 20% less than the charges for the same coverage which were in effect on November 8, 1987.

Medical malpractice rates in California began to fall immediately after the passage of Proposition 103, and, within three years of the passage of insurance reform, total medical malpractice premiums had dropped by 20.2% from the 1988 high.

Figure 2. Premiums dropped after Prop. 103

Year	Cal. MedMal Premiums (total)	% change	Cumulative % Change
1988	$663,155,000	--	--
1989	$633,424,000	-4.5%	-4.5%
1990	$605,762,000	-4.4%	-8.7%
1991	$529,056,000	-12.7%	**-20.2%**
SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001			

After adjusting for inflation, the premium drop is actually 30.7%.

B. Insurance Reform Requires Medical Malpractice Insurers to Refund Millions to Doctors.

Lobbyists for the insurance industry have told lawmakers in some states that Proposition 103's rollback did not apply to medical malpractice insurers. Their statements are false. Medical malpractice insurers were among the first insurance companies in California to comply with Proposition 103's mandatory rate rollback. Three of the state's largest malpractice insurers – Norcal Mutual, SCPIE and The Doctors Company – refunded $69.1 million to doctors by 1992. By 1995, insurers providing medical malpractice coverage issued more than $135 million in refunds to policyholders.

According to a California Department of Insurance news release of February 18, 1992:

> The Doctors' Company follows two other medical malpractice insurance groups and the Automobile Club of Southern California in agreeing to voluntarily comply with the

rollback provisions of Proposition 103. The agreement calls for the return of $18.5 million to the company's 9,500 California physician members, a 19.24% rebate…

The company joins two other medical malpractice insurers, Norcal Mutual and the Southern California Physicians Insurance Exchange (SCPIE) that have already agreed to pay Proposition 103 rebates to their policyholders. Norcal Mutual agreed to pay 9,000 policyholders $19.9 million, while SCPIE's agreement calls for $30.7 million to be paid to its 13,800 members.

News releases and articles about the malpractice rollbacks are attached as Appendix B

Figure 3. Proposition 103 Mandated Refunds Paid by Major Medical Malpractice Insurers

Malpractice Insurer	Total Refund**	Date Paid
Norcal Mutual Insurance Co.	$19,875,172	10/6/91
SCPIE	$30,730,384	10/15/91
Doctors Insurance Co.	$18,519,217	2/20/92
Medical Insurance Exchange of CA Gp.	$4,725,452	10/8/93
St. Paul Cos.*	$10,000,000	6/28/94
Dentists Insurance Co.	$1,886,342	5/26/95
Zurich-American Insurance Gp.*	$13,495,977	10/25/95
Farmers Insurance Gp.*	$35,978,041	12/14/95
Total Paid by Major Malpractice Insurers	**$135,210,585**	

Source: California Department of Insurance
*Insurer carried several property-casualty lines, which were subject to Prop 103 Rollback. Refund amount was paid to policyholders in all lines, including physicians. Other insurers carried medical malpractice exclusively at the time of the rollback.
**Refund amount includes interest.

C. Insurance Reform Imposed Moratorium on Rate Increases in California

According to Proposition 103, all insurance rates were to be frozen for one year at the rolled-back rate level. After the passage of the initiative, a moratorium was declared on all rate increases by medical malpractice insurance companies, as well as other insurers, pending resolution of the insurers' legal challenges and the promulgation of regulations governing the rollback process.

The initiative itself, including the rollback requirement, was upheld by a unanimous California Supreme Court in May, 1989. The insurance commissioner at the time imposed a freeze while developing rollback regulations. Litigation delays blocked the regulations, and when California's first elected insurance commissioner took office, he announced rollback regulations and ordered a rate freeze pending payment of the rollbacks by each insurer.

Largely because of lawsuits brought by the insurers against the rollback regulations, the rate freeze remained in effect for many insurers for four years.

D. Strict Regulation of Rate Increases Followed Rate Freeze, Rollbacks

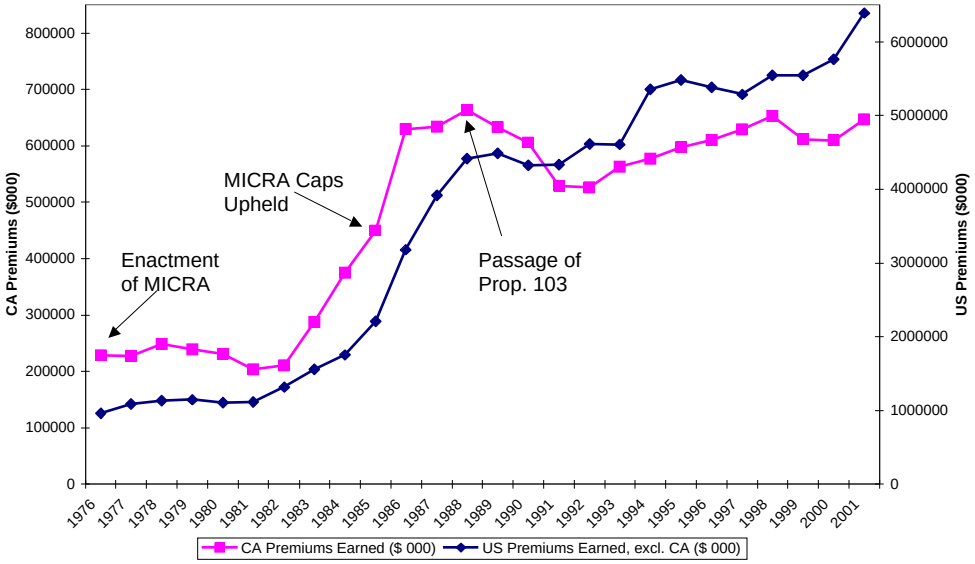
Upon payment of the rate rollback refunds, insurers were then subject to Proposition 103's "prior approval" regulatory system, which requires medical malpractice insurers to justify rate increases or decreases to the Department of Insurance, and the commissioner may, at any time, invalidate an insurers' rate if it is too high *or too low*.

III. Comparing MICRA v. Proposition 103

The following tables graphically illustrate that Proposition 103, not MICRA, reduced malpractice premiums in California.

California doctors' premiums generally tracked premiums countrywide between 1976 and 1988, following the recognized boom-bust "insurance cycle" that has coincided with each insurance "crisis" in this country, including the present one.[3]

Figure 4. Medical Malpractice Aggregate Premiums CA v. US (1976-2001)



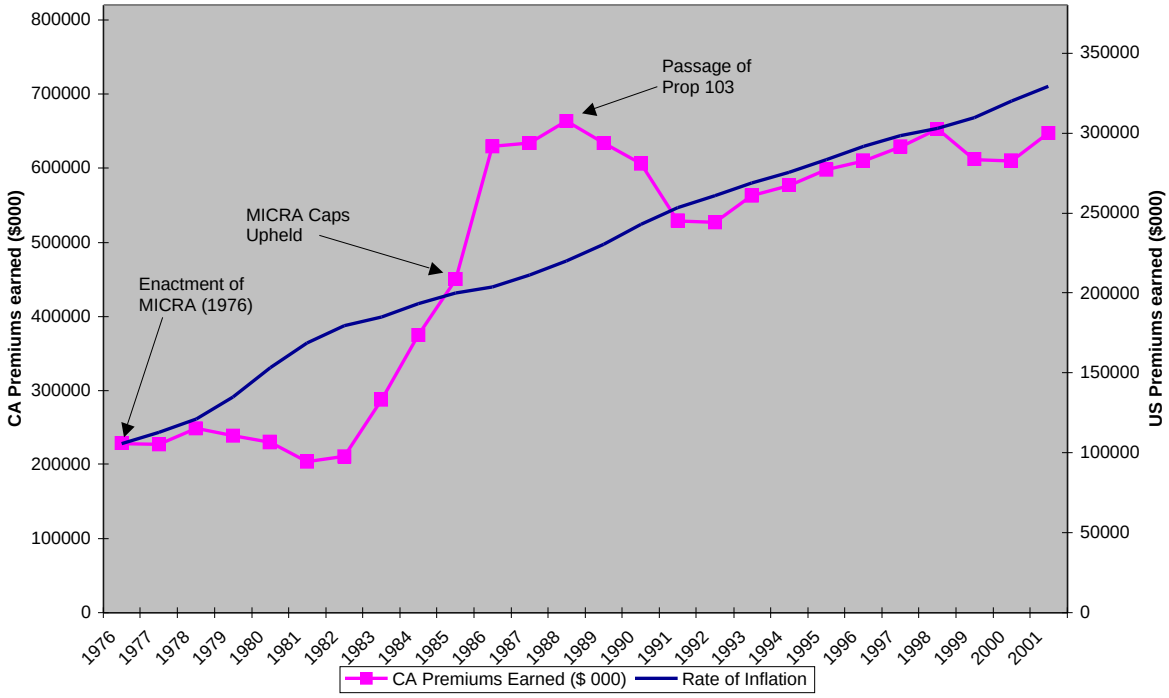
SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001

[3] "Medical Malpractice Insurance: Stable Losses / Unstable Rates," Americans for Insurance Reform, October 10, 2002.

But malpractice premiums fell sharply in California immediately after passage of Proposition 103. Moreover, they continued to drop in ensuing years, bucking the national trends, and then stabilized while national rates continued to fluctuate.

In the twelve years after the enactment of MICRA, California doctors' premiums rose much faster, overall, than the national rate of inflation. After California voters enacted insurance reform Proposition 103 in 1988, medical malpractice rates first fell dramatically and then generally followed the rate of inflation or declined still.

Figure 5. Total Premiums Earned
California v. Rate of Inflation (1976-2001)



SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001 and Consumer Price Index, All Urban Consumers (Bureau of Labor Statistics)

The data also show that Proposition 103's "prior approval" system, under which the commissioner may, at any time, invalidate an insurers' rate if it is too high *or too low*, has ameliorated some of the premium instability induced by the cycle. The price chaos of the 1970s and 1980s was replaced with a steady reduction of rates and then continued price stability for California doctors in the 1990s and through the current "insurance crisis."

Figure 6. Annual Change in California Medical Malpractice Premiums

MICRA years	Premium Chaos	**Proposition 103**	Price Stability
1976-1977	-0.60%	1988-1989	- 4.48%
1977-1978	+9.53%	1989-1990	- 4.37%
1978-1979	-3.94%	1990-1991	-12.66%
1979-1980	-3.64%	1991-1992	- 0.48%
1980-1981	-11.47%	1992-1993	+6.93%
1981-1982	+3.35%	1993-1994	+2.45%
1982-1983	+36.37%	1994-1995	+3.62%
1983-1984	+30.43%	1995-1996	+2.07%
1984-1985	+20.04%	1996-1997	+3.09%
1985-1986	+39.96%	1997-1998	+3.78%
1986-1987	+0.71%	1998-1999	- 6.25%
1987-1988	+4.61%	1999-2000	- 0.34%
		2000-2001	+6.15%

SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001

A. Tort Restrictions Enacted During the Previous Crisis Did Not Lower Premiums

There should be little surprise concerning these results. After the fusillade of restrictions on the rights of malpractice victims in the 1980s took effect, insurance companies did not cut their malpractice premiums accordingly, as numerous studies have since verified.

Legislation enacted in Florida in the spring of 1986 at the behest of a coalition of insurance companies, medical lobbies and corporations contained dramatic restrictions on victims' rights. But it also required insurers to reduce their insurance rates concomitantly, unless they could demonstrate to state insurance regulators that the limitations on consumers' rights would not reduce their costs. Six months after the law was enacted, two of the nation's largest insurance companies told the Florida Insurance Department that limiting compensation to injury victims would not reduce insurance rates. St. Paul Fire and Marine Insurance Company, then the nation's largest medical malpractice insurer, and Aetna Casualty & Surety Co., provided an extensive "actuarial analysis" of five specific limitations on victim's rights that the insurance industry had promised would reduce premiums. Overall, the Aetna report concluded that one provision of the law would reduce rates by a maximum of 4/10 of 1 percent, while all the other tort restrictions would have "no impact" on rates.[4] In fact, Aetna asked for a 17 percent rate *increase* based on its analysis of the impact of the law. The St. Paul

[4] Letter from Thomas L. Rudd, Superintendent of Insurance Department Affairs, Commercial Lines, Aetna Casualty and Surety Company, to Florida Insurance Commissioner Bill Gunter and Charlie Gray, Chief of Bureau of Policy and Contract Review for the Florida Department of Insurance, August 8, 1986, enclosing "Bodily Injury Claim Cost Impact of Florida Tort Law," Aetna Casualty and Surety Company.

study concluded that the restrictions "will produce little or no savings to the tort system as it pertains to medical malpractice." [5] St. Paul stated:

> The conclusion of the study is that the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice."

In April, 1987, the insurance industry's rate-making agency, the Insurance Services Office (ISO), released the results of a study intended to respond to repeated demands from policymakers and legislators across the country that the industry provide empirical data to support its claims that changes in the tort law system would alleviate the nation's insurance crisis. The study examined the responses of 1262 insurance adjusters from nine property-casualty insurance companies and two independent adjusting firms located in 24 states. The adjusters were asked to determine the impact of actual restrictions in the tort laws of 15 of the states on six hypothetical injury cases. In addition, they were asked to judge the impact of similar proposals which did not become law in the remaining nine states. Much to the chagrin of the insurance industry, the study failed to support years of insurance industry propaganda. Instead, it disclaimed any impact upon rates. One insurance industry official was quoted as saying, "Some state legislators are going to be shaking their heads after hearing us tell them for months how important tort reform is, and now we come out with a study that says the legislation they passed was meaningless." [6]

The Florida filings and excerpts from the ISO study are attached as Appendix C.

Indeed, in the midst of the "crisis," the federal government's watchdog agency, the U.S. General Accounting Office, published a study of six states that had enacted many different forms of tort law restrictions during the "crisis" of the mid-1970s, including caps on compensation. The GAO report showed that the price of medical malpractice liability insurance in California had increased dramatically since the passage of MICRA. In fact, "premiums for physicians increased from 16 to 337 percent in southern California ... between

[5] Addendum of St. Paul Fire and Marine Insurance Company," undated 1986 filing before the Office of the Insurance Commissioner of Florida.
[6] Robert Finlayson, "Insurers Fear Reform Foes to Capitalize on ISO Study," *Business Insurance*, May 18, 1987, p. 2.

1980 and 1986."[7] The GAO study concluded:

> While it is not possible to assess the extent to which the act [MICRA] has had an impact on the state's malpractice situation, our analysis of key indicators indicated that the problem is continuing to worsen in California. [8]

According to the GAO, four states (Arkansas, Florida, New York and North Carolina) reported that the restrictions had had "little effect" on insurance premiums. [9]

So-called "tort reform" does not lower insurance premiums.[10]

B. Malpractice Caps Resulted in Less for Injured Patients, More for Insurance Companies and Insurance Defense Lawyers

As a result of the severe malpractice caps in MICRA, insurance companies in California have consistently retained more of the premium dollar and paid a lower percentage of each premium dollar to victims than the national average. As would be expected under the onerous provisions of MICRA, the losses paid by insurers dropped in California immediately after the passage of MICRA, and for the next three years malpractice insurers paid less than twenty cents toward victims' compensation for every dollar worth of premium paid to insurers by doctors.

In fact, between the enactment of MICRA in 1975 and the 1988 passage of Proposition 103, which disallowed excessive rates (and thereby forced loss ratios towards more appropriate levels), California insurers never paid out in claims more than half of premiums written. Between 1976 and 1988, the average percentage of each premium dollar paid out in the form of compensation to malpractice victims – expressed as a "loss ratio" – was 31.4%. The balance – sixty-eight cents of every premium dollar – paid for other insurer costs, primarily profits, insurance company lawyers and overhead. That is, more than sixty-eight cents of every

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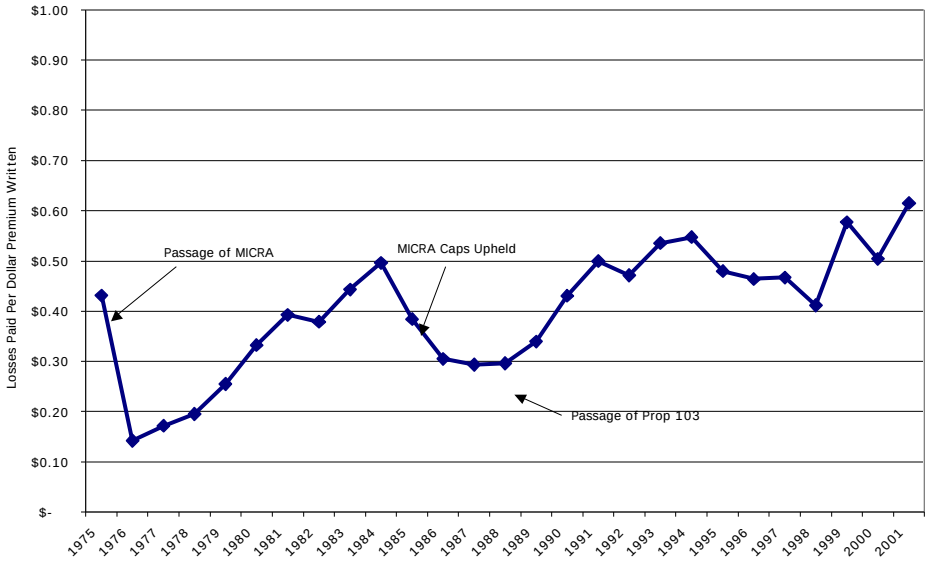
[7] U.S. General Accounting Office, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms* (Washington, D.C.: U.S. Government Printing Office, 1986), p. 25.
[8] *Ibid*., p. 26
[9] *Ibid*., pp. 2-3.
[10] In 1999, FTCR studied auto insurance premium changes since 1989 among states that did not allow third party accident victims to sue insurers for bad faith, which insurers argue is key to lower auto insurance rates. Twenty-four of the 26 states with restrictions on such lawsuits faced 25% rate increases or more over the 7 year period studied. States with restrictions averaged larger rate increases than states with no legal restrictions on bad faith suits. Not only is California, which passed Proposition 103 in 1988, the only state, with tort limits that saw a reduction in that period, it is the only state to have had reduced premiums in the nation as a whole between 1989 and 1996.

premium dollar paid by doctors was used for purposes other than compensating victims. Insurers had promised doctors lower premiums, but instead of reducing premiums commensurate with the lower claims payouts associated with malpractice caps, insurers simply captured higher profits in California.

Figure 7. Loss Ratio In California Since MICRA

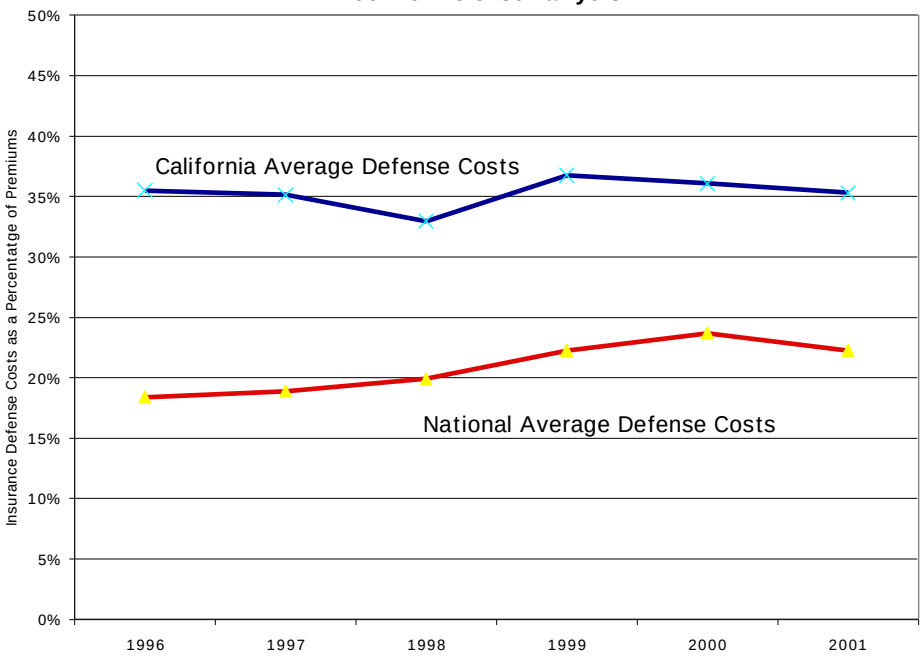


Source: A.M. Best and Co. special data compilation for Americans for Insurance Reform, reporting data for as many years as separately available.

While the malpractice loss ratio has improved in California under Proposition 103, it continues to oscillate around 50%, indicating that an astonishing fifty cents of every malpractice premium dollar that physicians pay remains with insurers. What are insurers doing with this money?

The NAIC data expose another product of MICRA: medical malpractice insurers in California are spending far more money fighting the claims of injured patients than the national average . That is, California malpractice insurers spend a disproportionate amount of a premium dollar on direct defense costs, which includes insurance company lawyers, expert witnesses and other claim adjustment expenses. Between 1996 and 2001, California medical malpractice insurers spent an average of 35% of premiums on defense costs compared to the 21% national average.

Figure 8. Malpractice Caps:
A Boon for Defense Lawyers



Source: Special data collection for FTCR. National Association of Insurance Commissioners, by permission. The NAIC does not endorse any analysis or conclusion based upon the use of its data.

Indeed, NAIC data show that California medical malpractice insurers incurred more costs fighting claims than actually paying claims in 1992 and 1993, and in 1994 and 1995, defense costs continued to be exceptionally high as compared to the losses incurred in California.

Figure 9. Malpractice Defense Expenditures (1992-1995)

Year	Total California Losses Incurred / (As Percentage of Premium Earned)	California Defense Costs Incurred / (As Percentage of Premium Earned)	Countrywide Losses Incurred / (As Percentage of Premium Earned)	Countrywide Defense Costs Incurred / (As Percentage of Premium Earned)
1992	**$209,545,400 (39.8%)**	***$216,389,850 (41.1%)***	$3,571,184,500 (69.5%)	$1,644,286,400 (32.0%)
1993	**$214,504,520 (38.1%)**	***$226,327,600 (40.2%)***	$3,342,439,500 (64.6%)	$1,554,157,200 (27.9%)
1994	$216,289,120 (37.5%)	$203,600,160 (35.3%)	$3,514,615,500 (59.3%)	$1,554,157,200 (26.2%)
1995	$248,028,900 (41.5%)	$226,513,140 (37.9%)`	$3,571,184,500 (59.3%)	$1,830,272,300 (30.1%)
SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001				

The insurance industry and doctors argue for limits on attorneys' fees under the guise of returning more money to the victims of malpractice. However, in some years, insurers have spent a greater proportion of doctors' premiums on their own lawyers and defense costs in California, with liability limits in place, than on compensating patients, contradicting a

premise of "liability reform." In other states, victims receive more of the premium dollar, while the insurers' own legal expenses are less.

What explains this behavior? Because the rigid caps make it more difficult for victims to obtain representation and prosecute a case, and because such caps limit companies' exposure, insurers have an incentive to withhold claims payment as a negotiating tactic, which will force plaintiffs and their attorneys to spend inordinate resources to recover losses, thereby discouraging cases and forcing lower recoveries.

Although, under the strictures of MICRA, insurers will continue to pay limited claim settlements in California, sustained and increasingly rigorous regulation will continue to improve insurers' loss ratio over time. Under Proposition 103, our organization has challenged a recent rate increase proposed by the state's second largest medical malpractice insurer. Using the consumer intervention aspect of the law, we are investigating the company's loss ratio and the company's defense costs. Due to our regulatory challenge, that company's policyholders have been shielded from 15% rate hikes.

IV. MICRA: Benefits to the Public – Or to Physicians?

It is clear that MICRA did not lower insurance premiums in California, and that the principle beneficiaries of MICRA have been insurance companies.

But what of the American Medical Association and its counterparts in states across the nation, whose member doctors can be found in recent weeks angrily on strike, refusing to see patients and threatening to "leave the state" unless MICRA legislation is enacted?

The physicians promoting MICRA complain that they cannot afford the increasing cost of malpractice coverage. This is hard to fathom, since, according to *Medical Economics* magazine, medical malpractice insurance premiums account for between 1.2% of a doctor's gross receipts and 5.5% of receipts, depending upon the specialty. General surgeons, for example, have a relatively high average malpractice premium of $21,641 annually, but that is only a small fraction of a surgeon's $497,633 average collections for 2001. That same surgeon has, on average, a net income of more than $257,000 per year, *after* accounting for expenses, such as

rent, staff salaries and medical malpractice insurance. In other words, that doctor will make more in a year than many brutally injured patients will have access to for a lifetime of suffering under the proposed non-economic caps.[11]

Pediatricians spend a mere 1.4% of their office's gross receipts on malpractice insurance -- about $6,628 per year according to the most recent data, according to the *Medical Economics* surveys. Even obstetricians, who pay some of the highest premiums, only spend about 5.5% of their annual receipts on insurance. They still, on average, earn $231,000 per year after expenses. Other than baseball players, not too many workers would strike if their annual take-home pay approached a quarter of a million dollars.

The highly visible threat that physicians will close their practices and move elsewhere absent passage of MICRA legislation has proved a potent political tool. Apart from the practical difficulties of such a move, their remains the question of where they might go.

For, in California, where MICRA was pioneered nearly thirty years ago, physicians are apparently just as unhappy and are just as intent upon closing up shop and/or leave the state, according to a remarkable study done by the California Medical Association (CMA) in 2001 – before the current crisis.

In an extensive survey of its own physician members, in February, 2001, "And Then There Were None: The Coming Physisican Supply Proplem," the CMA found that:

- 43% of surveyed physicians plan to leave medical practice in the next 3 years. Another 12% will reduce their time spent in patient care.
- Seventy-five percent of physicians have become less satisfied with medical practice in the past five years.
- More than 1/4 of physicians would no longer choose medicine as a career if starting over today, and more than 1/3 of those who would still choose medicine would not choose to practice in California.
- Low reimbursement, managed care hassles and government regulation are the greatest sources of dissatisfaction.
- The time physicians spend in patient care has declined by 7% in the last 5 years; 44% of physicians spend less time with patients than 5 years ago.
- 58% of physicians have experienced difficulty attracting other physicians to join a practice.
- More than 25% of physicians had difficulty in recruiting doctors in Los Angeles, Orange, Riverside, San Diego, Ventura, Marin, Del Norte, San Luis Obispo, Tehama and Shasta-

[11] "More Hours, More Patients, No Raise?" Medical Economics, November 22, 2002; "Expense Survey: What it costs to practice today," Medical Economics, December 9, 2002.

Trinity counties.
- Primary care, neurology, orthopedic surgery and neurosurgery lead in specialty shortages.
- 2/3 of physicians are not advising their children to practice medicine. (p.ii)

The CMA says:

> Indicators of significant physician dissatisfaction with medical practice and physician flight from California are dramatic. There appear to be widespread problems recruiting new physicians. Low reimbursement and managed care hassles are taking their toll. Only a third of physicians would still choose to practice in California if they had to do it over today. (p.iii).
>
> Hundreds of physicians throughout the state report their plans to quit practice in California. (p.ii).
>
> **These findings foretell a dark and startling picture concerning physician supply in California. They predict a future with many fewer physicians.** Negative career, professional and economic pressures in the California health care system are having the ultimate impact causing physicians to leave medicine and creating barriers for others to practice in the state.(p.18).
>
> Physicians in California overwhelmingly report dissatisfaction with the current practice of medicine, and a majority say they will express this dramatically in the next three years by quitting practice or otherwise cutting hours spent treating patients. The result will be fewer physicians, longer waits for care, less preventive medicine and higher costs to the health care system. Of the 55% of physicians who will reduce time spent treating patients: 78% will change professions, leave the state or retire early… Only a third of physicians (35%) would still choose to practice in California. (p.18).

The CMA study is a decisive refutation of the rosy picture painted by the AMA – and the CMA – of California under MICRA. Indeed, far from heaven on earth for physicians, California is apparently one of the less lucrative states in which to practice medicine in the nation. *Medical Economics* reports that doctors in the West, the many of whom are in California earn the lowest annual salary in almost every specialty and overall, with an average of $212,810.[12]

Placed in the current context, the CMA study raises the question of whether the dissatisfactions driving doctors to promote MICRA are based on financial considerations that have nothing to do with the legal system.

Contrary to the claims made by proponents of MICRA, restricting malpractice payouts would do nothing to benefit the economy. MICRA has been portrayed by physicians and, most

[12] "More Hours, More Patients, No Raise?" Medical Economics, November 22, 2002

recently, President Bush, as a way to lower health care costs for the nation. This is incorrect. Medical malpractice premiums are 0.55% of the national health care expenditures, an all time low.[13] Malpractice payments to victims by insurers averaged $3 billion per year between 1991 and 1999 – roughly 0.3% of national health care expenditures, according to industry data. By contrast, the total cost of malpractice deaths and injuries to the national economy has been estimated at ten times the amount of payouts.[14]

Trading on their credibility – already diminished in recent years as profit-driven HMO medicine has wreaked havoc upon patients – the physicians promoting MICRA insist that it has provided other benefits to Californians, and thus deserves to be considered as a model for legislation in other states and for legislation which would federalize the malpractice tort system by imposing MICRA nationally. However, there is no independent evidence that MICRA has been of value to anyone other than the insurance companies – and perhaps the fraction of physicians, estimated at 5%, who commit 54% of the malpractice in the U.S.[15]

Ignored by the supporters of MICRA is the impact it has had upon patients.

V. MICRA: The Impact on Patients

In recent years, Californians have been confronted with MICRA's devastating human impact and its failure to achieve its financial goals. The California legislature has tried twice in the last four years to remove MICRA's limits. Unfortunately, the legislative grip of the insurance industry has proven too strong.

MICRA main provisions:

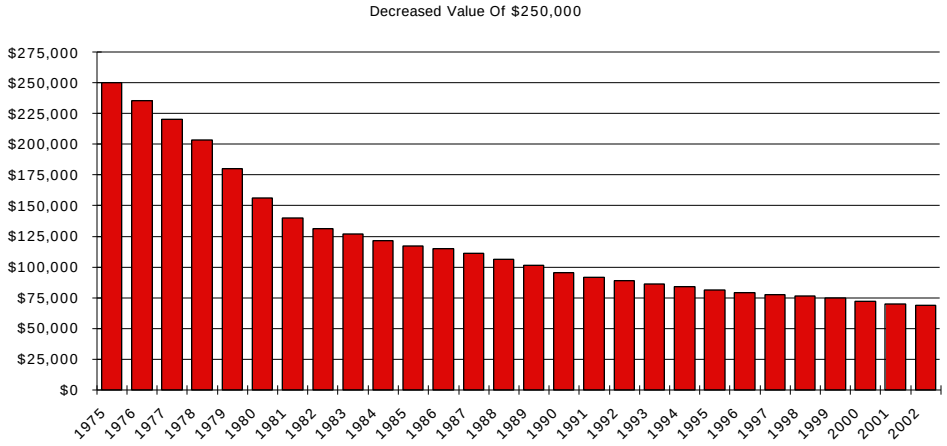
- Place a $250,000 cap on the amount of compensation paid to malpractice victims for their "non-economic" injuries.
- Permit those found liable for malpractice to pay the compensation they owe victims on an installment plan basis.
- Establish a sliding scale for attorneys fees which discourages lawyers from accepting serious or complicated malpractice cases.

[13] Letter to President Bush, Consumer Federation of America, July 30, 2002.
[14] Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).
[15] "Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors' Lobby," Congress Watch, January 2003, p. 21

• Eliminate the "collateral source rule" that forces those found liable for malpractice to pay all the expenses incurred by the victim.

A. Capping Medical Malpractice Victims' Compensation Causes Innocent Patients More Pain And Suffering

The MICRA cap has no flexibility, with respect to egregiousness of the negligence or to account for inflation. As a result of the latter rigidity, the real value of the caps has declined



substantially over time. In order to provide the same level of compensation in today's dollars, the cap would have to be approximately $800,000. Put another way, the $250,000 MICRA cap has decreased in value since 1975, when compared to the Consumer Price Index, to approximately $70,000. Though health care costs – hospital charges, medical fees, *etc.* – have risen dramatically since 1975, compensation for non-economic damages has been frozen by the statute.

Non-economic injuries include pain, physical and emotional distress and other intangible "human damages." Such damages compensate for severe pain; the loss of a loved one; loss of the enjoyment of life that an injury has caused, including sterility, loss of sexual organs, blindness or hearing loss, physical impairment, and disfigurement.

Applying a one-size-fits-all limit to non-economic damages objectifies and erases the person, considering them as a fixed “thing” for the purposes of law, so that there is no recognition of the uniqueness of their suffering. There is no quicker way to strip an individual of their humanity than to fail to recognize their suffering.

Caps on "non-economic" compensation devalue the lives and health of low-income patients. Caps on pain and suffering discriminate against the suffering of low-income people whose "economic" basis -- wages -- are limited. A strictly "economic" evaluation based on wages devalues what victims will create or produce in the future, their quality of life, as well as an injury's impact on their ability to nurture others. For instance, a laborer may lose his arms due to the exact same act of medical negligence as a corporate CEO, but the CEO would be able to collect millions and the laborer would be closely limited to the $250,000 cap. A housewife similarly would be limited to the cap no matter the physical or emotional depths of her injury. Caps assign greater value to the limbs and lives of some people than the limbs and lives of others.

Caps make taxpayers foot the bill for dangerous doctors' mistakes. Malpractice victims receive full compensation only for medical bills and lost wages. But those who are not wage earners – such as seniors, women, and the poor – have no other resource from which to pay for unforeseen medical expenses and basic needs. A cap forces malpractice victims to seek public assistance from state or federal programs funded by taxpayers

In many cases, California 's cap system has limited the liability for egregious systemic error to an acceptable cost of doing business, permitting systemic medical negligence to continue undeterred. There is no incentive to address systemic problems. Deterrence to wrongdoing is especially important at HMOs. Arbitrarily applying one-size-fits-all caps to systemic wrongdoing lets HMOs know there is a financial limit to how much they will pay no matter how egregious and irresponsible their conduct. This is carte blanche in many cases to throw caution to the wind.

Ironically, proponents of MICRA claim it limits "defensive medicine" procedures. The Congressional Office of Technology Assessment reported in July 1994 that "defensive medicine," procedures purported to be driven by physicians' fears of lawsuits, account for only 8% of medical procedures and may in fact constitute merely preventative, high quality health care. As the OTA stated, fear of lawsuits can often simply make those with the least incentive to be cautious more with the patient. This is precisely the incentive HMOs and their doctors and hospitals now need.

B. Periodic Payments Reward Convicted Wrong-Doers At The Expense Of Malpractice Victims They Injure

MICRA permits defendants found liable for malpractice to pay jury awards on a periodic, rather than a lump sum, basis, if the award equals or exceeds $50,000 and the defendant requests it. Jury-designated malpractice awards can be restricted by the judge as to the dollar amount paid each period and the schedule of payments. The periodic payment arrangement, once approved by a judge, cannot typically be modified -- unless the victim dies earlier than expected, in which case the defendants, rather than the family of the deceased, retain the balance of what they owe.

This provision of MICRA allows the negligent provider or its insurance carrier to control, invest and earn interest upon the victim's compensation year after year. No adjustment is made in the payments to reflect unexpected trends in the inflation rate or changes in the cost of medical care.

If the defendant enters bankruptcy or simply ceases to pay, the victims are forced to return to court and engage in another lengthy legal proceeding. Another problem is that an inflexible payment schedule leaves the victim without sufficient resources in the event that unanticipated medical or other expenses arise. This is most likely to occur in the years immediately following the injury, when the periodic payments are unlikely to cover the aggregate costs.

Periodic payments allow insurers to invest and earn interest on the money owed injured victims. Periodic payment schedules permit convicted perpetrators to control the money owed victims and profit from its use year after year. If the insurance company happens to fall into bankruptcy due to bad investments, the victim is denied the agreed upon compensation.

If a patient dies, all payments stop and the victim's family receives nothing. Wrong-doers are rewarded for causing the most severe, life threatening injuries. If a patient dies, periodic payments immediately cease and the guilty physician is allowed to keep the remainder of their money. Awards do not revert to the next of kin.

Periodic payments reduce the already limited compensation received by victims, as the value of the verdict diminishes over time due to inflation. No adjustment is ever made in

the payments to reflect the inflation rate or changes in the costs for medical care -- which have risen sharply and well above the inflation rate for many years.

Periodic payments puts the burden on the victim to meet their basic needs. The periodic payment arrangement, once approved, is extraordinarily difficult to modify. If costs of the victim's medical care increases beyond their means, or a special expensive medical technology is made available which the victims requires, the injured patient must retain a lawyer to have the schedule modified – and may very well not succeed.

Closed-door settlements that result from the periodic payment provision let dangerous doctors off cheap and shield their name from public record. In California, the periodic payment provision results in the settling of cases through closed door agreements – even after a verdict for the victim. Because periodic payments reduce the value of awards over time due to inflationary factors, plaintiffs are encouraged to enter a settlement for a greatly reduced amount. Not only insurers of convicted doctors pay significantly lowered penalties for wrong-doing in California, but the state Medical Board – as a result of a lawsuit by the California Medical Association – reports no information about negligent doctors who have settled cases to the public, denying consumers vital information to deter future incidents of medical malpractice.

C. Capping Plaintiff Attorney Contingency Fees, But Not Defense Attorney Fees, Denies Victims Representation

MICRA sets a sliding contingency fee schedule for plaintiffs' attorneys representing victims of medical malpractice. The MICRA fees are limited to 40% of the first $50,000 recovered; 33 1/3% of the next $50,000; 25% of the following $100,000, and 15% of any amount exceeding $200,000. MICRA does not limit the fees of the defendant's lawyers.

Only the most seriously injured victims with clear-cut cases to prove can ever find legal representation. In states with caps on attorney contingency fees for medical malpractice cases (and particularly in states such as California where a victim's pain and suffering compensation is also capped), victims of medical malpractice simply cannot find legal representation. It is not cost effective for attorneys to take the vast majority of cases. Says the President of Safe Medicine For Consumers, a California-based medical malpractice survivors group, "The vast

majority of individuals who contact us are women, parents of children or senior citizens. 90% of these individuals are unable to pursue meritorious medical malpractice cases because they can not find legal representation on a contingency basis and their savings have been wiped out."

Limiting plaintiff attorney contingency fees, but not defense attorney fees creates an uneven playing field for victims. Defendants can typically afford very high priced attorneys who fly special expert witnesses in from around the country. A contingency fee practice demands that a plaintiff's attorney must front the cost of expert witnesses to refute the testimony of experts flown in by the defendant. With caps on fees, such costs become prohibitive for the victim's legal counsel.

Undermining the contingency fee mechanism contributes to a deteriorating quality of health care and passes costs onto taxpayers. Left without legal representation in California, victims go uncompensated, and dangerous doctors go undeterred. Taxpayers pay the cost of low-income victims' medical care and basic needs through public assistance programs if the physicians responsible for the injuries are not held accountable.

Undermining the viability of contingency fee mechanism discriminates against low-income patients who are most of risk of medical malpractice. A contingency fee system is a poor patient's only hope of affording an attorney to challenge a negligent physician. Undermining such a system through caps on fees, that reduce incentives for attorneys to take malpractice cases, gives dangerous doctors, hospitals and HMOs a license to be negligent in poor neighborhoods.

D. Imposing A Collateral Source Offset Forces Taxpayers And Policy Holders To Pay For Wrongdoers Errors

The collateral source rule prohibits defendants charged with negligence from informing the jury that the plaintiff has other sources of compensation, such as health insurance or government benefits, including social security and disability. The purpose of this long-established doctrine is to ensure that the jury holds the defendant responsible for the full cost of the harm the defendant caused by requiring the defendant to pay all the victim's expenses -- even if a collateral source has already paid them.

Application of another legal doctrine, known as subrogation, ensures that the collateral source rule does not result in "double recoveries" for injured victims. Under subrogation rights -- which are applicable to virtually all health insurance policies, government programs, and workers' compensation systems -- the third-party payor of a health or job loss benefit has the legal right to take funds from a malpractice award to reimburse itself for payments it has already made to the malpractice victim. The collateral source rule, in conjunction with subrogation rights, ensures that wrongdoers pay for the full amount of the harm they cause, and that victims do not receive double payments for their injuries.

For example, an injured individual's health care coverage usually pays the victim's medical bills. Under the traditional collateral source rule, if the victim sues the wrongdoer for compensation, including payment of medical bills, the defendant cannot tell the jury that the bills have already been paid by another source. However, once the jury makes an award to the victim, including damages for medical care, the health insurer can exercise its subrogation rights, and recover from the defendant (or the victim, if the award has been paid) the amount of money already paid for the victim's medical bills.

MICRA repealed these rules in California. Consequently, in a trial, defendants may introduce evidence of insurance or other compensation obtained by the plaintiff. The jury is further permitted to reduce its award against the defendant by the amount of alternative compensation the victim received or is entitled to. As with the cap on non-economic damages, abolition of the collateral source rule reduces the amount of money the wrongdoer must pay. In effect, responsibility for the harm is transferred to the victim, who purchased the insurance coverage, to the victim's insurer, and/or to taxpayers. Moreover, once the defendant tells the jury about payments made by collateral sources, MICRA prohibits the collateral source from using the subrogation process to obtain reimbursement from the wrongdoer.

Collateral source offsets will shift billions of dollars per year in malpractice injury costs caused by the negligent onto taxpayers and the health insurance system. The cost of injuries incurred as a result of medical malpractice total $60 billion each year, according to the Harvard School of Public Health. Instead of wrong-doers bearing the full cost of these injuries, tax-payer funded programs, such as social security, and policy-holder funded health plans, will be forced to pick up the tab.

A collateral offset forces poor patients onto welfare, while wrong-doers' fortunes will be protected. Low income victims "entitled" to public assistance payments from taxpayer-funded supplemental social security, social security disability and aid to families with dependent children become government assistance recipients while the insurers earn interest at the victim's expense.

VI. CONCLUSION

Malpractice litigation is not responsible for the present “crisis.” In fact, the real crisis today is not the price of malpractice insurance, but the epidemic of medical mistakes. The solution is not limiting the rights of victims of malpractice to have their day in court. The way to lower and stabilize medical malpractice premiums is to adopt insurance reforms. And the best way to reduce malpractice claims is to reduce the amount of medical malpractice in our country. Appendix D contains a series of proposals to address the insurance and malpractice crises facing the nation today.