



MICRA and Access to Health Care

By Lowering Health Care Costs, MICRA Has Improved Californians' Access to Care

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This report is an update of the Hamm-Frech-Wazzan report published in 2008. The original report has been revised to incorporate the latest data on health care expenditures and medical liability claim payments, as well as the latest scholarly research on the relationship between non-economic damages caps and the incidence of defensive medicine.

EXECUTIVE SUMMARY

In 1975, the California Legislature enacted, and Governor Edmund G. Brown Jr. signed, the Medical Injury Compensation Reform Act, commonly known as “MICRA.”

A. Compensation Available Under MICRA

MICRA allows individuals who have experienced medical malpractice to receive the following types of compensation for their losses: (1) Economic damages; (2) Non-economic damages; and (3) Punitive damages.

Economic damages include compensation for 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 as compensation for economic damages.

Non-economic damages include compensation for 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 are difficult or impossible to verify and measure. Under MICRA, there is a \$250,000 limit, or cap, on the amount that may be awarded for non-economic damages.

Punitive damages may be awarded to punish the defendant and deter future medical errors. Under MICRA, there is no limit or cap on the amount of punitive damages that may be awarded in medical liability cases.

B. Response to a Health Care Crisis

The purpose of MICRA, as its author – Assemblyman Barry Keene – explained, was to address:

... a persistent problem of enormously escalating medical costs [that have] evolved, in my judgment, into a crisis . . . [that] threatens to degenerate further into a catastrophe of immense proportions to the health care consumer.¹ (Mr. Keene’s emphasis)

In 1975, doctors and other health care providers were leaving California due to the rapidly rising cost of medical liability insurance. In response, the California Legislature, with bipartisan support, enacted MICRA. In doing so, the Legislature sought to improve access to health care by stabilizing medical liability insurance premiums and limiting the rate of growth in health care costs.

C. Other States Have Followed California’s Lead

California was the first state to reform its medical liability tort system, and many other states have followed its lead. For example, in response to a medical liability crisis similar to the one California experienced

¹ Opening Remarks of Assemblyman Barry Keene to the Joint Health-Judiciary Committee Meeting on Medical Malpractice, June 5, 1975.

in the mid-1970s, Texas in 2003 enacted medical liability reforms that included caps on non-economic damages.² Currently, 28 states limit the size of non-economic damages awards.

D. Purpose of this Report

The purpose of this paper is to help policymakers, opinion leaders, and the public evaluate (1) the effects that the MICRA cap has had on California's health care system, and (2) how an increase in the cap would affect Californians' access to the care they need. Our conclusions reflect the findings of scholarly literature and the latest data on health care expenditures; the bases for these conclusions are cited throughout the report so that interested parties can confirm their validity.

E. Summary of Findings

Our primary findings and conclusions can be summarized as follows:

- 1. A cap lowers medical liability insurance premiums by reducing insurers' loss costs.** It does so by (a) reducing the incentive for individuals and their lawyers to litigate weak and invalid claims, and (b) limiting the average size of liability awards. A comparison of states with caps and without caps on non-economic damages clearly shows that in states with caps, medical liability insurance premiums are significantly lower.
- 2. A cap on non-economic damages reduces health care costs, making health care more affordable.** In addition to reducing doctors' and hospitals' costs of insuring against medical liability, non-economic damages caps reduce the incentive for health care providers to order costly and medically unnecessary tests and procedures that reduce their vulnerability to lawsuits but do nothing to improve patients' health and well-being. (Such unnecessary tests and procedures are commonly called "defensive medicine.") By reducing the costs of medical liability insurance and the incentive to practice defensive medicine, a cap makes health care more affordable and increases the public's access to physicians and hospitals when they require care.
- 3. The MICRA cap has not reduced access to the courts for individuals with meritorious claims.** There is no evidence that MICRA's cap on non-economic damages awards has materially reduced access to the courts for individuals with meritorious claims of medical liability. In fact, since 1985 (when the constitutionality of MICRA was upheld) tort claims for personal injury other than those involving medical liability have declined more rapidly than claims subject to the MICRA cap.
- 4. Notwithstanding the MICRA cap, the rate of increase in medical liability damages awards in California far exceeds the rate of inflation.** Even with the \$250,000 cap on non-economic

² The caps limit awards for non-economic damages to \$250,000 for any and all doctors sued, plus \$250,000 for up to two medical care institutions. Texas Civil Practice and Remedies Code Section 74.301.

damages, the average size of paid claims has increased since 1976 at a rate that is more than 2.5 times the rate of inflation.

5. **An increase in the cap on non-economic damages would significantly increase the cost of health care in California.** The real-world experience of states that have adopted or eliminated a cap on non-economic damages awards proves that an increase in the MICRA cap would lead to more lawsuits, larger awards, and significantly greater litigation-related expenses. Scholarly research indicates that an increase in the cap would also increase the cost of providing health care to Californians without improving medical outcomes.
6. **We estimate that an increase in the MICRA cap would raise the annual cost of California's health care system by \$9.9 billion, or \$1,000 per four-person household.** Based on the best data available, we estimate that raising the cap on non-economic damages from \$250,000 to \$1,000,000 or more would increase health care costs in California by approximately \$9.9 billion per year – an average of \$261 per resident, or more than \$1,000 for a family of four.
7. **The additional \$9.9 billion in health care costs resulting from a higher cap would be borne by three groups of Californians: consumers, employees, and taxpayers.** If the MICRA cap is raised:
 - a. **Consumers** will be forced to pay more for the health care they receive.
 - b. **Employees** who are covered by employer-subsidized health insurance will suffer a reduction in their disposable income because their employers will seek to recoup the higher cost of providing insurance by holding down wages and salaries and/or by increasing deductibles and copayments.
 - c. **Taxpayers** will have to pay as much as \$2 billion³ per year more because, when the cost of health care goes up, the State and local governments will have to pay more:
 - (1) To provide health care to individuals, such as patients in State and county hospitals; and
 - (2) To partially cover the cost of health care that doctors and hospitals provide to other Californians, such as government employees and children from low-income families.
8. **A higher cap on non-economic damages would reduce Californians' access to quality health care.** It would do so primarily in three ways:
 - a. By making health care and health insurance more expensive and less affordable for Californians of limited means;

³ For the details behind this estimate, please see "How Would Voter Approval of AG Ballot Measure 13-0016 Affect Health Care Costs in California and State and Local Expenditures and Revenues?" – an analysis prepared by William G. Hamm, Jeannie Kim, and Jenny Young.

- b. By reducing the number of health care providers – doctors and hospitals – in California, particularly in rural and low-income areas; and
- c. By discouraging doctors from delivering babies and performing high-risk, but potentially life-saving, surgeries, where the risk of a lawsuit is disproportionately high.

Acknowledgements

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I. Introduction

In 1975, the California Legislature enacted, and Governor Edmund G. Brown Jr. signed, the Medical Injury Compensation Reform Act, commonly known as “MICRA.” The purpose of the act, as its author – Assemblyman Barry Keene – explained, was to address:

. . . a persistent problem of enormously escalating medical costs [that have] evolved, in my judgment, into a crisis . . . [that] threatens to degenerate further into a catastrophe of immense proportions to the health care consumer.⁴ (Mr. Keene’s emphasis)

Newspaper headlines from 1975 highlight the severity of the crisis facing California’s health care 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.

A. California State Supreme Court Upholds MICRA

The mere passage of MICRA was not sufficient to stabilize medical liability insurance premiums, as the Legislature intended. After the measure became law, there was great uncertainty as to whether the cap on non-economic damages awards would withstand court challenges. Until these challenges were resolved, insurers could not be certain that the cost of medical liability claims would stabilize, 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

⁴ Opening Remarks of Assemblyman Barry Keene to the Joint Health-Judiciary Committee Meeting on Medical Malpractice, June 5, 1975.

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.⁵

B. Compensation Available Under MICRA to Individuals Who Have Experienced Medical Malpractice

MICRA allows successful plaintiffs in medical liability cases to receive the following forms of financial compensation:

- Unlimited monetary awards for any and all past and future medical costs;
- Unlimited monetary awards for lost wages and lifetime earning potential;
- Unlimited monetary awards that a court may grant as punitive damages to deter future malpractice and to punish the defendant for malicious or willful misconduct; and
- Monetary awards of up to \$250,000 for “non-economic” damages, often referred as pain and suffering damages.⁶

C. Objectives of this Report

The purpose of this report is to provide interested parties, including Members of the Legislature, government officials, the media, and the public, with an objective analysis of (1) various economic issues pertaining to California’s MICRA cap on non-economic damages, and (2) proposals to raise the cap. A companion report⁷ analyzes the likely fiscal impact of a specific proposal to raise the cap on the State, local governments, and school districts. The authors take no position on this or any other proposal to raise the cap, and we acknowledge that other considerations besides the cap’s effect on the cost of, and access to, health care in California may be relevant when deciding whether the cap should be raised.

The preparation of this report was commissioned and funded by Californians Allied for Patient Protection (“CAPP”), an organization that represents physicians, dentists, hospitals, community clinics, health centers, nurses, emergency providers, police officers, labor unions, women's health advocates, and other healthcare professionals in California.⁸ CAPP describes its purpose as “protect[ing] access to healthcare and patient safety

⁵ *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.)

⁶ By their very nature, non-economic damages are inherently subjective and difficult or impossible to verify and measure.

⁷ William G. Hamm, Jeannie Kim, & Jenny Young, “How Would Voter Approval of AG Ballot Measure 13-0016 Affect Health Care Costs in California and State and Local Expenditures and Revenues?” published in August 2013.

⁸ See CAPP website, “About CAPP” (<http://www.micra.org/about-capp/about-capp.html>) (accessed September 27, 2013)).

through California's Medical Injury Compensation Reform Act.”⁹ In agreeing to prepare the report, we insisted on, and were given, total control of our methodology, findings, and conclusions, as well as complete control over the editorial content of the report. Our findings and conclusions are the products of objective analysis, and do not necessarily reflect the sponsoring organization’s views.

D. Organization of the Report

The balance of this report is organized as follows:

- Part II draws on well-established economics principles and the findings of empirical research to show how caps on non-economic damages awards affect the incentives of individuals and their lawyers to file lawsuits against doctors and hospitals.
- Part III tests the hypothesis advanced by some of MICRA’s critics that the cap has reduced access to California’s court system.
- Part IV compares the trend in the average payment per medical liability claim since the MICRA cap took effect to the rate of inflation.
- Part V analyzes the MICRA cap’s impact on medical liability insurance premiums in California.
- Part VI tests the hypothesis, also advanced by some of MICRA’s critics, that medical liability insurance companies have used the cost-savings from MICRA to generate excess profits, rather than pass these savings along to the doctors and hospitals they insure.
- Part VII draws on the results of scholarly research and studies by highly regarded government agencies to estimate how an increase in the \$250,000 MICRA cap would affect the cost of health care to Californians.
- Part VIII shows who would be required to pay the increased health care costs resulting from an increase in the MICRA cap.
- Part IX analyzes how an increase in the MICRA cap would affect the number of uninsured persons in California.
- Part X draws upon well-established principles of economics and Texas’s real-world experience to show how an increase in the cap would affect Californians’ access to doctors and hospitals.
- Part XI analyzes how a higher MICRA cap would affect the willingness of doctors to treat high-risk patients when the probability of a successful outcome from even the best medical care is relatively low.

⁹ *Ibid.*

- Part XII analyzes how an increase in the MICRA cap would affect California's social safety net.
- Part XIII briefly summarizes our conclusions.

E. Summary of Findings

Our findings may be summarized as follows:

- The MICRA cap reduces the incentive for individuals and their lawyers to litigate weak or non-meritorious claims against doctors and hospitals.
- Data on claim filings indicates that the MICRA cap has not reduced access to the court system for individuals with meritorious claims.
- Data on claims paid by medical liability insurance companies shows that since the MICRA cap was imposed, the average monetary payment to successful claimants has risen at a rate that is more than two-and-one-half times the rate of inflation.
- The MICRA cap, by limiting awards for non-economic damages and reducing the number of lawsuits filed against doctors and hospitals, has reduced medical liability insurance premiums by as much as 38%.
- MICRA does not generate excess profits for California medical liability insurers because (1) most of these insurers are owned by premium-payers (doctors), (2) when losses are less than anticipated, excess premiums are returned to the policy holders, and (3) the companies earn relatively modest returns on their invested capital, given the risks they assume.
- Raising the MICRA cap would increase the cost of providing health care to Californians by nearly \$10 billion per year because a higher cap would (1) increase the size of awards and the number of lawsuits filed against doctors and hospitals, thereby increasing the medical liability insurance premiums that health care providers must pay, and (2) increase the incentive for care providers to order costly and medically unnecessary tests and procedures as a means to offset their increased vulnerability to lawsuits.
- The nearly \$10 billion per year increase in the cost of health care resulting from a higher cap would be borne by three groups of Californians: consumers, employees, and taxpayers. The increase would amount to \$261 per California resident or more than \$1,000 for a family of four annually.

- By increasing the cost of health care and making health insurance more expensive, an increase in the MICRA cap would cause the number of uninsured persons in California to increase.
- An increase in the MICRA cap would reduce the number of doctors practicing in California – especially in inner-city and rural areas, and would cause some poorly capitalized hospitals and community health centers to close, thereby impairing Californians’ access to high-quality and affordable health care.
- A higher MICRA cap would decrease the willingness of physicians to treat high-risk patients when the probability of a successful outcome from even flawlessly delivered medical care is relatively low.
- By adding to the financial problems of hospitals and clinics, an increase in the MICRA cap would reduce the health care services available to the poor, thereby negatively affecting California’s social safety net.

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

Economics principles 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 of individuals to file lawsuits. Other things being equal, a larger 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 jury verdict in the plaintiff's favor or a negotiated settlement with the defendant (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 claiming medical liability depends primarily on the strength of his or her case, although the probability may be increased if the jury views the plaintiff as especially sympathetic. A sympathetic plaintiff with a weak case may be as successful in obtaining a favorable award as a less-sympathetic plaintiff with a strong case.

C. The Size of the Expected Award

The size of the expected award is a function of two sets of factors: (1) the magnitude of the plaintiff's alleged damages; and (2) any limiting or enhancing considerations. 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 2010, including benefits paid to third parties and their attorneys, claims handling, insurance company administrative costs, and other expenses related to medical liability, totaled approximately \$29.8 billion nationwide.¹⁰ This amount represents approximately \$97 per year, per person in the U.S., or \$388 for a family of four. In addition to the out-of-pocket costs associated with litigation, lawsuits require a heavy investment of the

¹⁰ Towers Watson, "2011 Update on U.S. Tort Cost Trends," 2011.

plaintiff's and defendant's time. The time spent on a lawsuit cannot be spent on other activities.¹¹ For example, when a doctor is sued, he or she will have to take time away from seeing patients in order to prepare a defense, testify at a deposition, and attend the trial.

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, as well as on the expected size of the settlement or damages award.¹² If the expected size of the settlement or award is sufficiently large, even attorneys for plaintiffs with weak or non-meritorious claims and a relatively small probability of successfully proving liability will determine that it is in their economic interest to file a lawsuit.

E. The Propensity to Pursue Medical Liability Claims

A meaningful cap¹³ on non-economic damages limits the reward that might have otherwise been expected from filing a medical liability lawsuit. Accordingly, a cap 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 \$1,250,000, on a claimant's incentive to file suit.

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.

¹¹ 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 have been spent elsewhere. Opportunity costs can be measured and expressed in dollar terms, although we do not do so here.

¹² See, for example, 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 Henry S. Farber and Michelle J. White, "Medical Malpractice: An Empirical Examination of the Litigation Process," *RAND Journal of Economics* 22 (2) (Summer 1991), pp. 199-217.

¹³ Not all caps on non-economic damages awards are meaningful. A high cap, or a cap with significant exceptions, may not materially alter the plaintiff's and defendant's assessment of the expected award's size, and therefore may not be effective in altering the economic incentives to pursue or defend medical liability claims.

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
<i>a</i>	<i>b</i>	<i>c</i>	<i>d</i>	<i>e</i> ¹	<i>f</i>	<i>g</i>	<i>h</i> ²	<i>i</i> ³
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	\$1,250,000	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	\$1,250,000	80%	\$800,000	-\$100,000	5%	-\$50,000	\$650,000

¹ $e = d * \{a + \text{if}(c > 0, \min(b, c), b)\}$

² $h = g * \{a + \text{if}(c > 0, \min(b, c), b)\}$

³ $i = e + f + h$

1. The Effect of a \$250,000 Cap

As Panel A shows, a cap of \$250,000 on non-economic damages awards discourages weak or non-meritorious claimants 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) from pursuing a claim.

2. The Effect of Raising the Cap

Panel C shows 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 \$1,250,000. 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 \$1,250,000 cap would leave such claimants with an even stronger economic incentive to litigate their claims, as Panel D shows.

In sum, increasing the cap on non-economic damages would increase the number of medical liability lawsuits filed against doctors and hospitals – primarily by making it economically attractive for individuals with the weakest claims to file suit.

An increase in the number of lawsuits against doctors and hospitals would increase insurers' litigation expenses in two main ways. First, it would increase the cost of claims paid because some of the additional suits would be successful, despite the weaknesses in the plaintiffs' claim. Second, it would make plaintiffs less inclined to accept out-of-court settlements, thereby increasing the insurers' defense costs.

III. THE MICRA CAP DOES NOT REDUCE ACCESS TO THE COURTS

Some opponents of MICRA have argued that the cap on non-economic damages awards has reduced Californian's access to the court system by preventing injured plaintiffs with meritorious claims from finding attorneys willing to take their cases. We can test this hypothesis by examining data on the number of medical liability lawsuits filed in California since MICRA was enacted, and comparing the trend to the trend in the number of other personal injury lawsuits.¹⁴

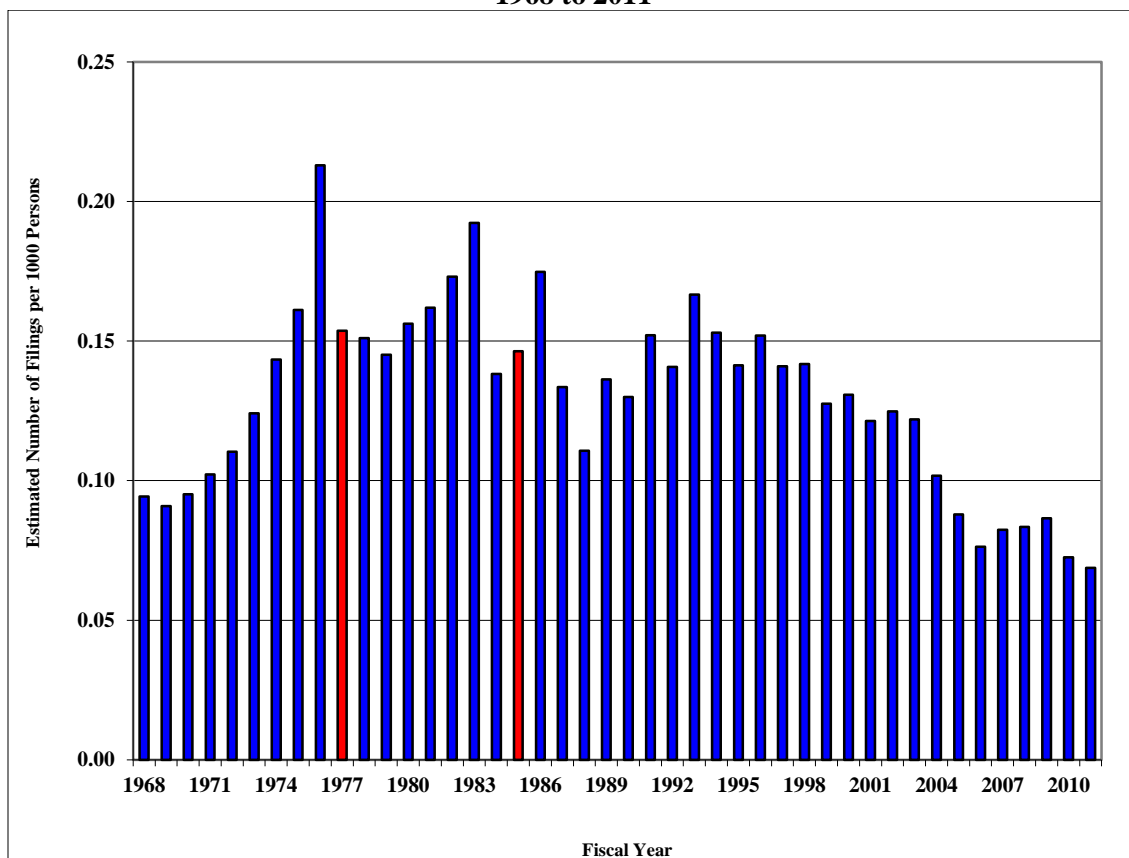
A. MICRA Has Not Significantly Reduced the Number of Lawsuits Filed in California

The empirical evidence provides no support for the hypothesis that MICRA's \$250,000 cap has reduced access to the court system for individuals with meritorious claims. Figure 1 shows estimated medical liability filings in California on a per-capita basis, for the period 1968-2011. As 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.

It is true that medical liability filings have declined since the constitutional issue was resolved. The same trend, however, is evident in the number of filings involving other types of personal injury claims. As the following section demonstrates, the drop in medical liability filings has been significantly less than the drop in personal injury lawsuits that are not subject to caps on damages awards.

¹⁴ The incidence of *lawsuits* is somewhat different from "frequency." The insurance industry uses the term "frequency" to refer to the rate of *claim* filings.

**Figure 1:
Estimated Per Capita Medical -Liability Filings in California,
1968 to 2011^a**



^a SOURCES: California medical liability filings are estimated based on the following sources: 1968-2011 "Los Angeles Superior Court Filings and Disposition Comparison," prepared by Los Angeles Superior Court Statistics Section; and 2012 Court Statistics Report, Statewide Caseload Trends, Judicial Council of California, Superior Courts, p. 96. Population data was obtained from California Department of Finance - Demographics Units, E-7, California Population Estimates, with Components of Change and Crude Rates, July 1, 1900-2012, updated December 2012 (<http://www.dof.ca.gov/research/demographic/reports/estimates/e-7/>).

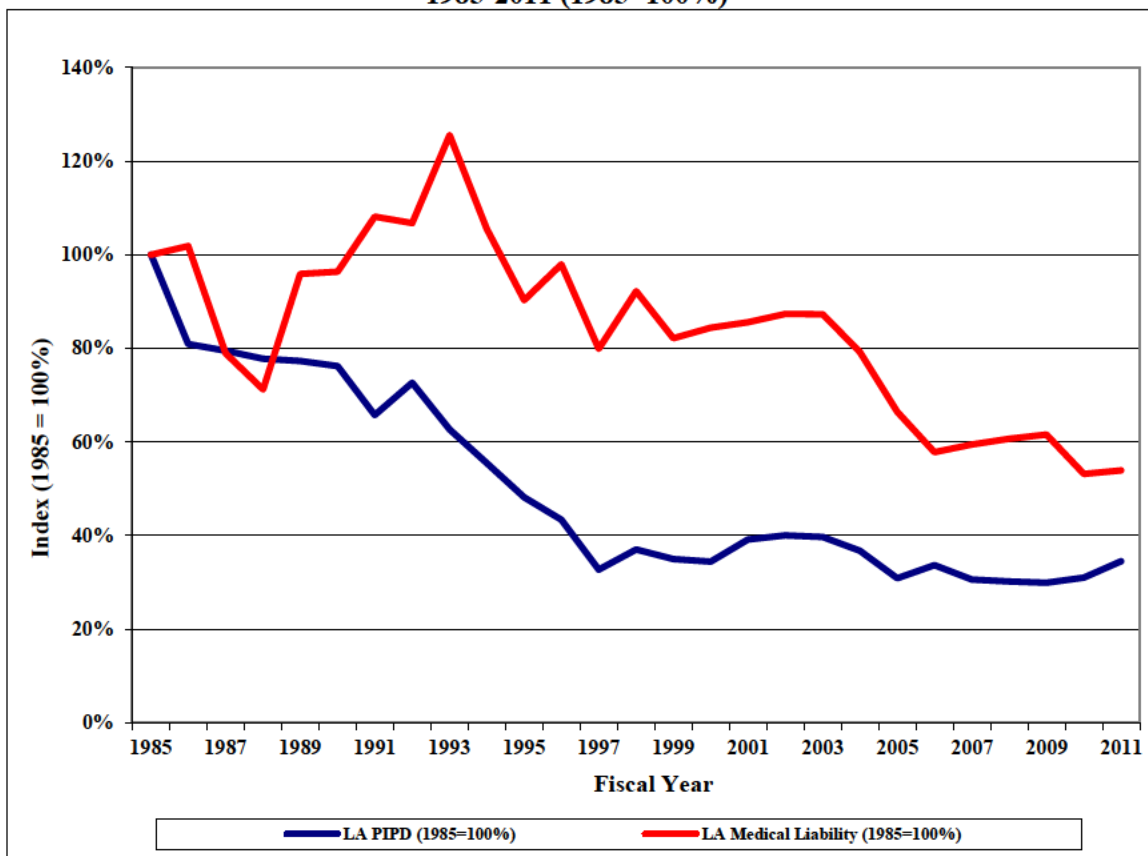
B. Medical Liability Suits Have Not Declined as Much as Personal Injury Suits That Are *Not* Subject to a Cap on Damages Awards

Since the mid-1980s, there has been a significant decline in the number of personal injury lawsuits. Despite the \$250,000 cap on non-economic damages awards, however, the number of medical liability lawsuits has not declined as much as the number of other personal injury lawsuits that are not subject to a cap.

Figure 2 shows the trend in medical liability filings for California's most-populous county – Los Angeles¹⁵ – during the 1985-2011 period, and compares it to the trend in all other personal injury filings. To facilitate a comparison between the two data series, we have indexed both to the number of filings in 1985.

¹⁵ Los Angeles County is home to more than one of every four residents in California. See, United States Census Bureau, State & County QuickFacts, Los Angeles County, California (<http://quickfacts.census.gov/qfd/states/06/06037.html>); and "U.S. Census Bureau Delivers California's 2010 Census Population Totals, Including First Look at Race and Hispanic Origin Data for Legislative Redistricting, United States Census Bureau, Newsroom, March 8, 2011 (http://www.census.gov/newsroom/releases/archives/2010_census/cb11-cn68.html).

Figure 2:
Trends in Medical Liability and Personal Injury-Other
(Excluding Medical Liability) Lawsuits Filed in Los Angeles County
1985-2011 (1985=100%)^a



^a SOURCE: "Los Angeles Superior Court Filings and Disposition Comparison" prepared by Los Angeles Superior Court Statistics Section.

As the figure shows, other personal injury filings in Los Angeles have declined more rapidly than medical liability filings, even though awards in these cases are not subject to caps on either economic or non-economic damages awards. 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 judicial system to any significant degree for individuals with meritorious claims. Notwithstanding the cap, Californians who believe they have experienced medical malpractice continue to find attorneys willing to take their cases, and for these claimants the door to the courthouse remains open. While there has been a drop in the number of medical liability cases on a per capita basis, the evidence strongly suggests that it is the weakest claims that have not been pursued.

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

Another important perspective on the incidence of medical liability claims can be gained by comparing the number of such claims with the number of physicians practicing in California. In 2011, an estimated 2,583 medical liability lawsuits were filed in the State, which is home to 95,041 physicians.¹⁶ Thus, in this one year, one suit was filed for every 37 doctors.

We have obtained complete data for one large medical liability insurer showing both the number of physicians it insures and the number of claims made against its policyholders. This data, which covers all 50 states during the period 1976-2012, allows us to compare claims frequency rates in California with the rates in other states.¹⁷

As Table 2 indicates, during the seven years prior to the California Supreme Court's decision upholding MICRA's constitutionality (1978-1985), claims frequency in California was approximately 23.4%.¹⁸ For the next twenty-seven years (1986-2012), the rate decreased to 19.0%.

¹⁶ California medical liability filings for 1968-2011 are estimated in "Los Angeles Superior Court Filings and Disposition Comparison," prepared by Los Angeles Superior Court Statistics Section, and 2012 Court Statistics Report, Statewide Caseload Trends, Judicial Council of California, Superior Courts, p. 96. The number of physicians is given by "Total Professionally Active Physicians," The Henry J. Kaiser Family Foundation, November 2012, (<http://kff.org/other/state-indicator/total-active-physicians/>).

¹⁷ Different insurers (and self-insured entities) define 'claim' and count 'claims' 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, when a plaintiff sues 4 doctors and a hospital, the suit could be counted as one, four or five claims, depending on how one defines a "claim." No single uniform standard for measuring claims frequency exists, and consequently we are unable to aggregate historical data from multiple insurance firms. We therefore present data from a single large firm (The Doctors Company) which, because it underwrites in all 50 states, is representative of the medical liability insurance industry.

¹⁸ We do not include 1976-1977 in our sample, as the number of insured doctors outside California in The Doctors Company's data is not sufficient to provide a representative sample.

Table 2:
California vs. Non-California Medical Liability Claims Frequency Rates ^a

CALIFORNIA				NON-CALIFORNIA			
Year	[a] Claims	[b] Insured Doctors	[c]=[a]/[b] Claim Frequency	[d] Claims	[e] Insured Doctors	[f] = [d]/[e] Claim Frequency	[g] = [c]/[f]-1 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%	107.2%
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	1,873	5,783	32.4%	213	699	30.5%	6.3%
1986	1,721	5,941	29.0%	268	865	31.0%	-6.5%
1987	1,780	6,388	27.9%	385	1,412	27.3%	2.2%
1988	1,823	6,798	26.8%	645	2,725	23.7%	13.3%
1989	1,512	6,981	21.7%	652	3,475	18.8%	15.4%
1990	1,545	7,179	21.5%	651	4,058	16.0%	34.2%
1991	1,614	7,232	22.3%	702	4,759	14.8%	51.3%
1992	1,877	6,855	27.4%	894	5,348	16.7%	63.8%
1993	1,776	7,203	24.7%	1,100	5,698	19.3%	27.7%
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%	1,085	6,096	17.8%	61.9%
1998	1,855	6,449	28.8%	1,342	6,340	21.2%	35.9%
1999	1,573	6,184	25.4%	1,038	5,638	18.4%	38.2%
2000	1,455	6,162	23.6%	1,021	5,474	18.7%	26.6%
2001	1,420	6,448	22.0%	1,297	6,928	18.7%	17.6%
2002	1,468	6,741	21.8%	1,592	9,608	16.6%	31.4%
2003	1,509	6,937	21.8%	1,721	11,006	15.6%	39.1%
2004	1,214	7,793	15.6%	1,210	11,487	10.5%	47.9%
2005	1,152	8,815	13.1%	1,018	12,259	8.3%	57.4%
2006	1,233	9,093	13.6%	986	12,826	7.7%	76.4%
2007	1,224	9,439	13.0%	1,153	14,610	7.9%	64.3%
2008	1,199	9,664	12.4%	1,453	15,775	9.2%	34.7%
2009	1,848	16,252	11.4%	1,609	17,075	9.4%	20.7%
2010	1,871	15,980	11.7%	1,539	18,658	8.2%	41.9%
2011	1,873	15,915	11.8%	1,649	20,177	8.2%	44.0%
2012	1,788	15,775	11.3%	1,824	24,211	7.5%	50.4%
1994-2012	29,984	175,477	17.1%	25,186	217,099	11.6%	47.3%
1978-1985	9,085	38,758	23.4%	752	2,872	26.2%	-10.5%
1986-2012	43,632	230,054	19.0%	30,483	245,439	12.4%	52.7%

^a 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. (SOURCE: The Doctors Company).

A comparison of medical liability claims frequency in California with claims frequency in the other 49 states further undermines the contention that the MICRA cap, rather than other factors, has reduced the rate at

which medical liability lawsuits are filed. Although MICRA represents the strongest set of medical liability reforms enacted in the U.S. to date, the incidence of medical liability claims in California remains significantly greater than it is outside California. In 2012, for example, the claims frequency rate was 11.3 percent in California – 50 percent higher than the average rate for the other 49 states.

Moreover, while the claims frequency rate in California has dropped by approximately 19% since the MICRA cap was found to be constitutional, the rate in the other states has, on average, gone down by 53%.

In sum, individuals and their lawyers are suing California doctors and hospitals at a much higher rate than their counterparts in other states, notwithstanding the fact that MICRA limits the recovery of non-economic damages.

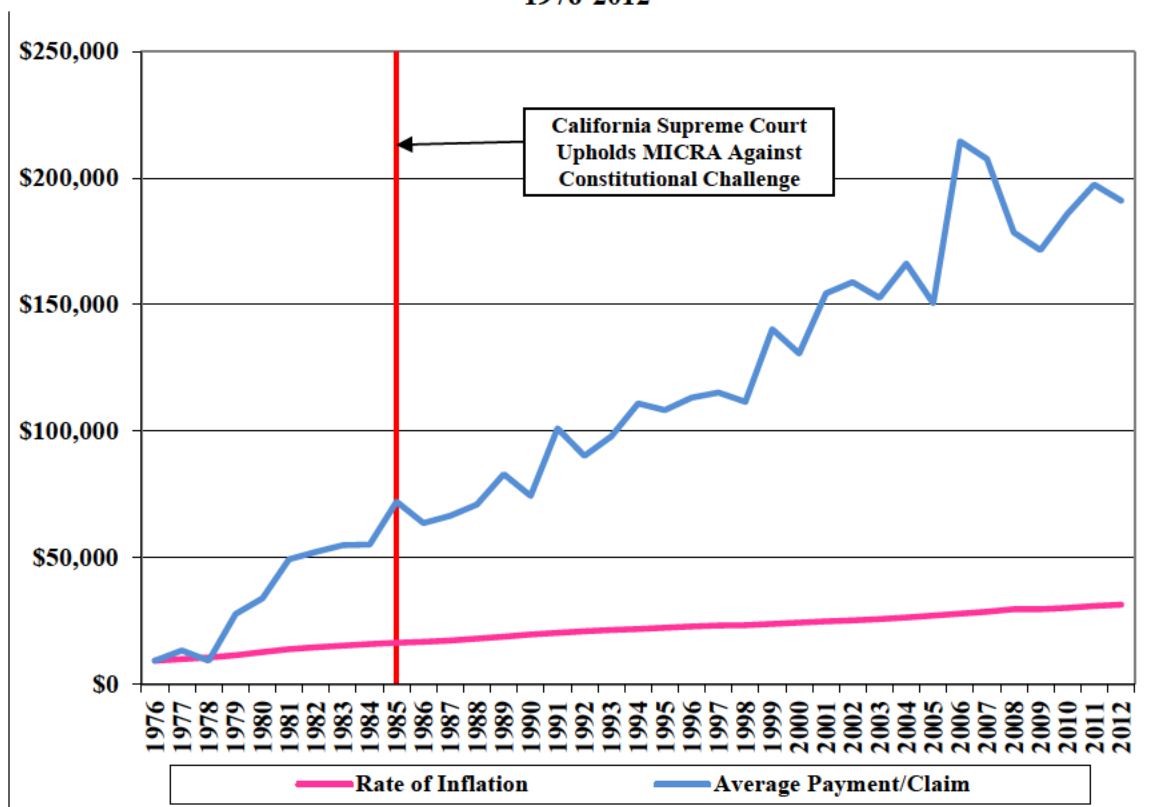
IV. THE RATE OF INCREASE IN THE AVERAGE PAYMENT TO MEDICAL LIABILITY CLAIMANTS HAS FAR EXCEEDED THE RATE OF INFLATION

While the MICRA cap has limited non-economic damages awards and discouraged the filing of weak and non-meritorious claims, it has not prevented the average payment to medical liability claimants from continuing to rise at a rate exceeding the rate of inflation.

A. The Average Size of All Paid Claims Has Continued to Increase

Figure 3 shows the average payment per claim for each year from 1976 through 2012, as well as what the average *would have been* if it had merely kept pace with inflation since the cap was imposed in 1975.

Figure 3:
Inflation-Adjusted Mean Payment per Paid Claim in California^a
1976-2012



^a SOURCES: Cooperative of American Physicians, Medical Insurance Exchange of California, NORCAL Mutual Insurance 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.

As the figure demonstrates, since 1976 the average size of paid medical liability claims in California has increased at a rate that is 2.54 times the rate of inflation, notwithstanding the \$250,000 MICRA cap. As a result,

the average payment per claim in 2012 (\$191,162) was more than six times what the average would have been if it had merely kept pace with the rate of inflation (\$31,404).

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

B. States with Caps Exhibit Smaller Average Per-Claim Medical Liability Payments

More than half of the states have followed California's lead and enacted caps on non-economic damages awards to discourage non-meritorious claims, restrain the rate of growth in health care costs, and preserve access to affordable health care. These caps, however, are not equally effective. Some states, such as Hawaii, have adopted caps but provide for liberal exceptions that make it easy for plaintiffs to evade the statutory limitation. Other states have set caps on non-economic damages at relatively high levels, thereby weakening or eliminating the disincentive for individuals and their attorneys to pursue non-meritorious claims. Nevertheless, states with caps, as a group, report smaller average per-claim payments than states without caps because caps tend to discourage large non-meritorious claims.

Table 3 shows average payments per medical liability claim, by state, for 2012.¹⁹ As the table indicates, California had the fourth lowest average payment – \$171,538 – despite being a relatively high-cost state. Several heavily populated, industrialized states without non-economic damages caps had average payments that were much higher. For example, New York's average payment per claim, at \$441,233, was 2.6 times the average for California. The explanation for this disparity is that California's cap discourages attorneys from filing weak or non-meritorious claims – the type of claim that is potentially viable in an uncapped state such as New York.

¹⁹ National Practitioners Data Bank ("NPDB"). Data through March 2013. Note that the Data Bank's rules require the reporting only of doctors named in final medical liability 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 medical liability payments. It is not clear what effect the missing data might have. See, for example, "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), Aug 27, 2004, p. A.1.

Table 3:
2012 Average Payments per Medical Liability Claim ^a

State (Listed From Highest to Lowest) ^b	Average Payment	Cap	State (Listed From Highest to Lowest) ^b	Average Payment	Cap
Minnesota	\$704,371		Kentucky	\$257,760	
Illinois	\$571,937		Delaware	\$255,956	
Massachusetts	\$529,436	Yes	Missouri	\$255,768	
Hawaii	\$512,674	Yes	New Mexico	\$254,584	Yes
Connecticut	\$500,773		Colorado	\$249,617	Yes
Oregon	\$450,464		Arkansas	\$248,627	
New York	\$441,233		South Dakota	\$244,000	Yes
New Hampshire	\$426,943		North Carolina	\$243,969	Yes
Wyoming	\$402,917		District of Columbia	\$232,524	
Maryland	\$383,945	Yes	Oklahoma	\$229,681	Yes
Pennsylvania	\$375,057		Florida	\$228,448	Yes
Rhode Island	\$372,282		North Dakota	\$220,313	Yes
Maine	\$370,417		Utah	\$210,563	Yes
New Jersey	\$365,758		Vermont	\$209,125	
Virginia	\$365,048	Yes	Nevada	\$204,698	Yes
Alaska	\$361,029	Yes	Tennessee	\$201,832	Yes
Georgia	\$352,775		Kansas	\$194,274	
Idaho	\$331,065	Yes	Michigan	\$193,896	Yes
Iowa	\$326,788		South Carolina	\$190,378	Yes
Alabama	\$317,813		West Virginia	\$183,221	Yes
Arizona	\$300,745		Louisiana	\$177,583	Yes
Wisconsin	\$293,384	Yes	California	\$171,538	Yes
Montana	\$286,667	Yes	Texas	\$138,429	Yes
Nebraska	\$286,197	Yes	Indiana	\$126,333	Yes
Washington	\$282,018		Mississippi	\$81,820	Yes
Ohio	\$259,909	Yes			

^a SOURCE: National Practitioners Data Bank (“NPDB”). Data through March 2013.

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

Texas’s experience illustrates the efficacy of caps on non-economic damages awards. In 2004, Texas’s average payment per medical liability claim was \$214,939. By adopting a \$250,000 cap on non-economic damages, Texas was able to reduce the average to \$138,429 in 2012 – the third lowest among states.

V. THE MICRA CAP REDUCES MEDICAL LIABILITY INSURANCE PREMIUMS BY AS MUCH AS 38%

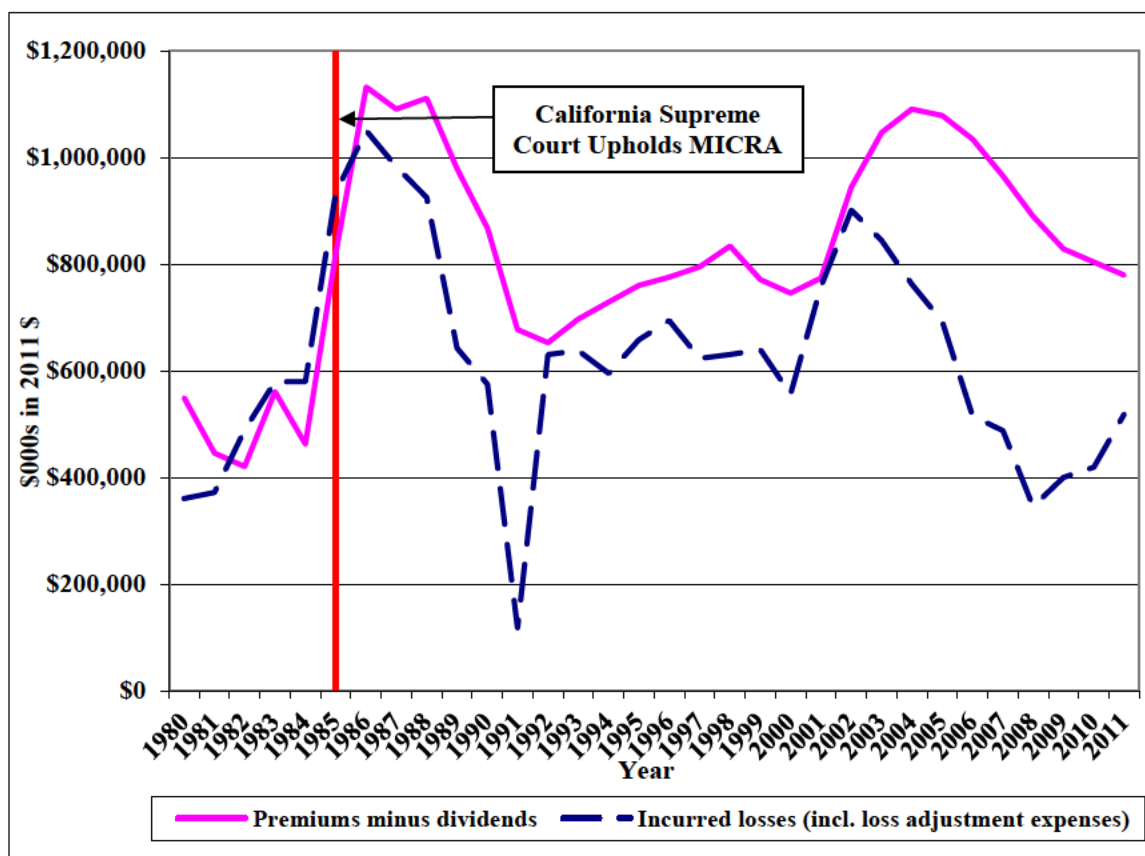
The evidence shows that by discouraging weak and non-meritorious claims, and thereby reducing the cost of the medical liability tort system, the MICRA cap has significantly reduced medical liability insurance premiums. Should the MICRA cap be eliminated or raised, these cost-savings will go away and insurance premiums will increase sharply.

A. Incurred Losses Are Strongly Correlated With Medical Liability Insurance Premiums

Figure 4 shows the close connection between incurred losses (including paid losses and loss adjustment expenses) and medical liability insurance premiums in California. It shows, for example, that both incurred losses and direct premiums earned fell after 1985 (the year in which the constitutionality of MICRA was upheld by the California Supreme Court), and that both have remained below the peak levels of 1986.²⁰

²⁰ It is reasonable to assume that several years passed before the full effect of MICRA was felt.

Figure 4:
Incurred Losses and Medical Liability Insurance Premiums
are Strongly Correlated (In 2011 dollars) ^a



^a SOURCES: 1980-2011 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.

The correlation between losses and premiums means that any future increases in incurred losses will be closely followed by increases in premiums.²¹ Consequently, an increase in the cap on non-economic damages awards, by significantly increasing incurred losses, will lead to an increase in the medical liability insurance premiums that doctors and hospitals must pay.²²

²¹ A study by the American Academy of Actuaries also found that medical liability premiums declined as losses declined in California between 1975 and 1994. (See, Issue Brief, American Academy of Actuaries, Fall 1996).

²² 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, for example, United States General Accounting Office, Report to Congressional Requesters, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," GAO-03-702, June 2003, p. 44.

B. Does MICRA or Proposition 103 Deserve the Credit for Lower Premiums?

Some have argued that MICRA does not deserve credit for reducing medical liability insurance premiums. Rather, they assert, credit should be given to the Insurance Rate Reduction and Reform Act (Proposition 103), which the voters approved on November 8, 1988.

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, or the insurance company will go out of business. Rate regulation cannot hold down rates when costs are going up.

Proposition 103 sought to control insurance *rates*, but did nothing to limit the determinants of insurance rates – insurance *costs*. Therefore, there is no reason to believe that the measure was effective in limiting rates.

More importantly, the factual evidence clearly shows that Proposition 103 cannot be credited with the reduction in medical liability insurance premiums. As the authors have demonstrated, premiums declined sharply during the three years after Proposition 103 took effect – a period that also followed the California Supreme Court's decision upholding MICRA's constitutionality. During the same three-year period, the average rates for other insurance lines subject to Proposition 103's rate controls *increased*.²³ The obvious explanation for this discrepancy is that MICRA reduced medical liability claim costs, but had no effect on claim costs for other lines of personal injury insurance.

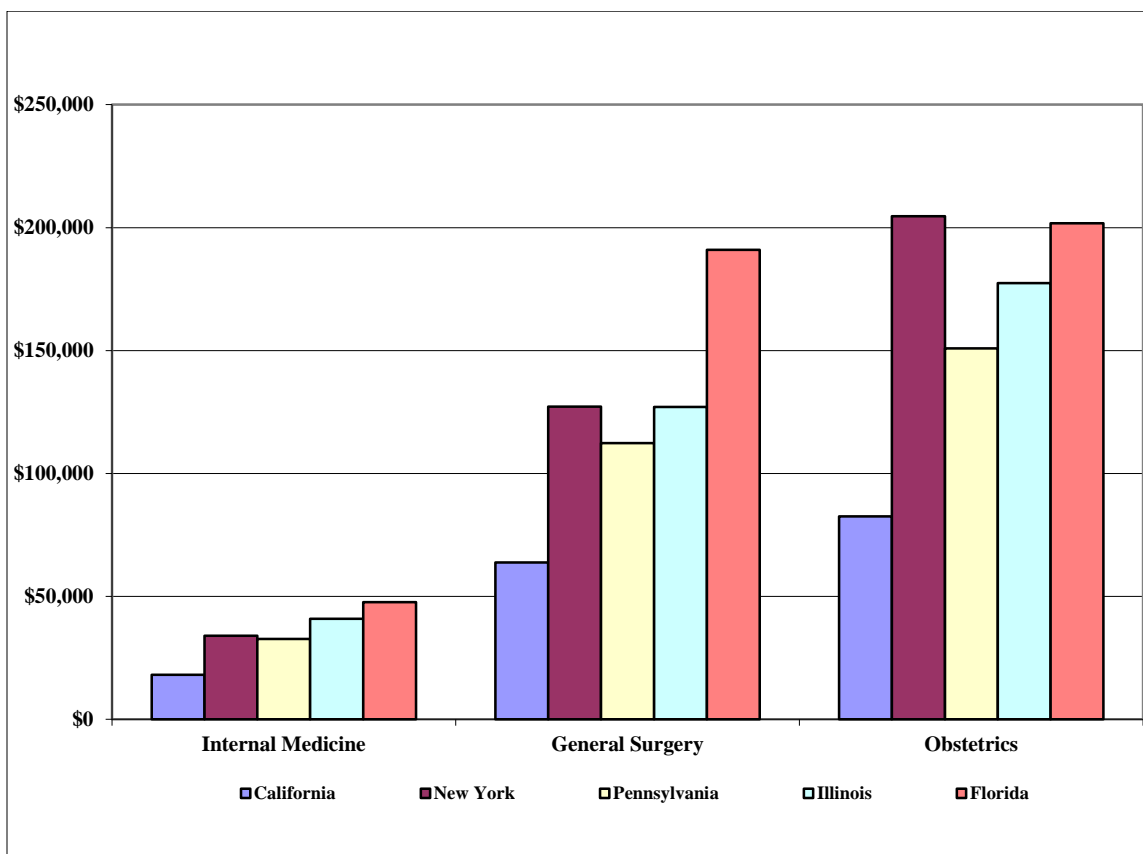
C. Doctors in States with Caps Benefit from Lower Medical Liability Insurance Premiums

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

²³ H. E. Frech III, 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 represent 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 represent the highest rate (by county and provider) in each state. For comparison, average rates for internal medicine (across all counties and providers) are \$18,093 and \$47,731 for California and Florida respectively; a difference of 164%.

Figure 5:
2012 Liability Insurance Premiums
By State and Specialty^a



^a SOURCE: Medical Liability Monitor, October 2012 (Vol. 37, No. 10).

As Figure 5 illustrates, medical liability insurance premiums are significantly lower in California than in the other four states, each of which lacked strong MICRA-type reforms.²⁵ For example, in Florida which caps non-economic damages at \$500,000 – double the limit in California, internists pay \$29,638 (164 percent) more per year than their counterparts in California; General Surgeons pay \$127,076 (199 percent) more; and Obstetricians pay \$119,182 (144 percent) more. This comparison provides strong evidence that MICRA’s \$250,000 cap has been very effective in holding down medical liability insurance premiums. It also indicates that an increase in the cap to or above \$500,000 – the limit in Florida – would lead to significantly higher premiums for California providers, and ultimately to higher costs for Californians.

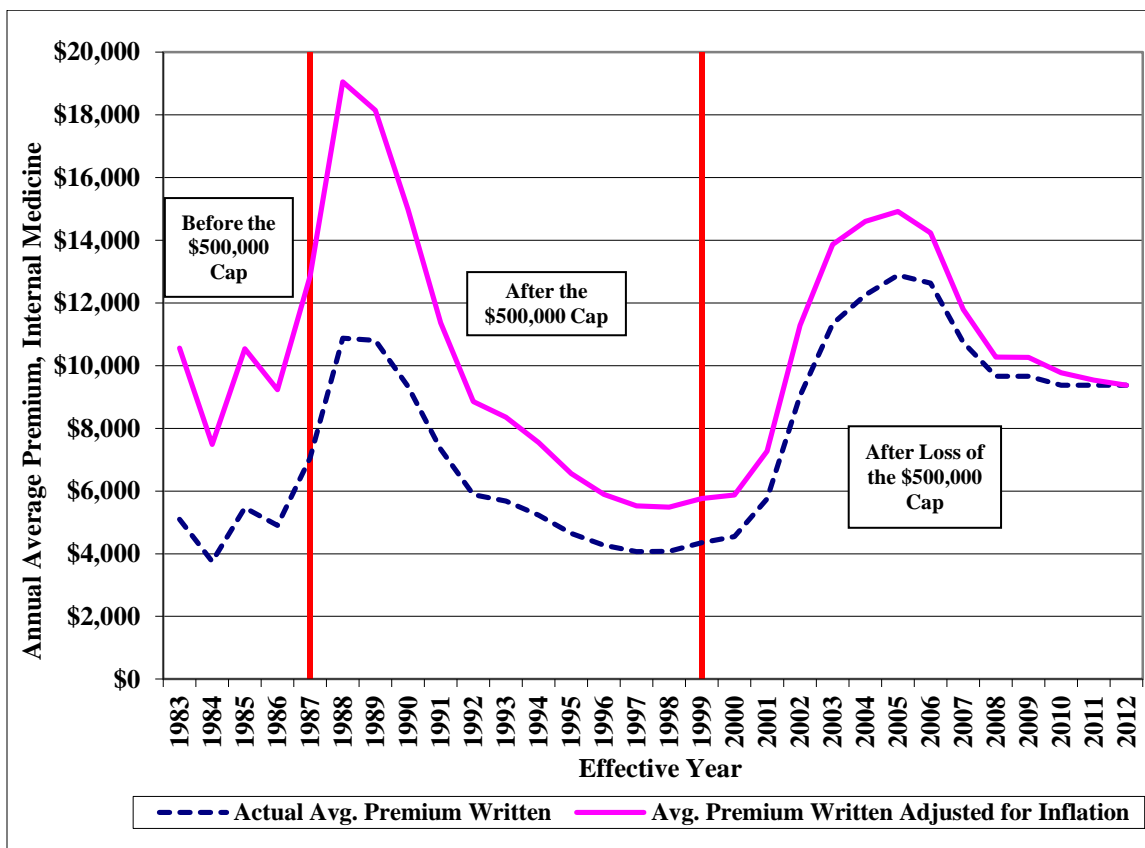
D. Emasculating the Cap Would Cause Significant Increases in Liability Premiums

Oregon provides compelling evidence regarding the effectiveness of caps in holding down medical liability insurance premiums. In 1987, the Oregon legislature passed medical liability reforms that included a cap

²⁵ Illinois, New York, and Pennsylvania have no non-economic damages cap. Florida has a \$500,000 non-economic damages 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, 1983-2012 ^a



^a SOURCES: 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.

In 1999, when the cap was still in effect, the average premium for internal medicine was \$5,764. By 2012, the inflation-adjusted premium had risen to \$9,373, an increase of 63%. It is most unlikely that physicians in Oregon became 1.6 times more prone to commit malpractice during this 13-year period. Rather, the difference in rates almost certainly reflects a 20 percent increase in the number of lawsuits brought against doctors and hospitals and a significant increase in non-economic damages awards that followed removal of the cap.

E. Increasing the MICRA Cap Would Cause Medical Liability Premiums Paid By California Providers to Increase by up to 38%

To what extent would an increase in the MICRA cap bring about an increase in the medical liability insurance premiums paid by California doctors and hospitals? In answering this question, we considered both nationwide data and the experience of two Western states that in recent years raised or lowered their caps on non-

economic damages. Based on our analysis of the data, we estimate that an increase in the MICRA cap to \$1 million or more would cause medical liability premiums to increase by 16 to 38 percent.

1. Estimates of the increase in premiums based on nationwide data

Several studies have analyzed the efficacy of caps on non-economic damages awards. One study finds that premiums in states that limit awards are approximately 17 percent lower than they are in states that have no cap. This finding suggests that removing the caps in these states would cause medical liability premiums to go up by 20.5 percent.²⁶ If the MICRA cap was removed or dramatically increased, however, premiums in California would almost certainly rise by more than 20.5 percent, since this percentage is an average for all states that limit non-economic damages awards, and the average cap in the other states is significantly higher than California's cap (\$250,000).

In 2003, the Congressional Budget Office ("CBO") estimated that if Congress imposed caps and other direct reforms on all states (including those that already cap non-economic damages awards), medical liability premiums ultimately would average 25 - 30 percent less than under current law.²⁷ This estimate suggests that removing or significantly increasing a nationwide cap would bring about an increase in medical liability insurance premiums of 33-43 percent.²⁸ Once again, we would expect the increase in California resulting from a higher cap to be greater than 33-43 percent because the MICRA cap is significantly lower than the average cap nationwide.

In 2009, the CBO lowered to 10 percent its estimate of the decline in premiums that a nationwide \$250,000 cap would yield.²⁹ The lower estimate reflects the fact that Texas, Nevada, Alaska, Idaho, Maryland, Nebraska, North Carolina, Oklahoma, South Carolina, Tennessee, Utah, Virginia, Florida, and Ohio imposed caps on non-economic damages awards after 2003,³⁰ thereby reducing the incremental savings from a nationwide cap. For this reason, we believe the CBO's 2003 estimate is likely to be more indicative of the impact that a higher MICRA cap would have on medical liability premiums in California.

²⁶ 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. The reason why the percentage increase in premiums when a cap is lifted is greater than the percentage reduction when a cap is imposed is that, in the former case, the premium is lower. For example, if the average premium is \$100 and a cap reduces it to \$97, the cost-savings will be 3.00% (\$3/\$100). If the cap is then removed and the average premium returns to \$100, the cost increase will be 3.09% (\$3/\$97).

²⁷ Congressional Budget Office, Cost Estimate for 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, estimate dated March 10, 2003, p. 4.

²⁸ See footnote 28 for an explanation of why the percentage change in premiums when a cap is increased is greater than the percentage change when a cap is imposed.

²⁹ Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to the Honorable Orrin G. Hatch, Senator from Utah, dated October 9, 2009, p. 2.

³⁰ State Enactments of Selected Health Care Liability Reforms, PIAA, as of June 11, 2013.

2. Estimates of the increase in premiums based on California and Oregon data

Rather than rely on estimates of medical liability insurance premium changes for the average state, we can estimate the impact that an increase in the MICRA cap would have on premiums charged California providers using data specific to two other Western states: Oregon, and Texas.

a. Impact of a higher cap, assuming no increase in the number of lawsuits

In 2004, the RAND Corporation analyzed 257 verdicts for the plaintiffs in medical liability cases adjudicated during the period 1995-1999.³¹ Its analysis found that if the MICRA cap during those five years had been approximately \$750,000, instead of \$250,000, the final judgments in these 257 cases would have been approximately 13 percent larger.³²

b. Impact of a higher cap on the number of lawsuits filed

Larger awards in cases filed while the \$250,000 cap was in effect, however, is only part of what needs to be taken into account in estimating the effect of increasing the MICRA cap. A higher cap would enable plaintiffs' lawyers to file more lawsuits against doctors and hospitals by increasing the potential award from weak claims, thereby increasing the fees that attorneys could expect to earn.³³ Thus, if the MICRA cap is increased, medical liability insurers will have to increase the premiums they charge doctors and hospitals not only to cover the higher cost of awards in cases that would have been filed even if the cap had remained at \$250,000; they will have to raise premiums sufficiently high to cover the cost of awards and settlements in the additional cases that the higher cap will make potentially viable.

To estimate the number of new cases likely to result from a higher cap, we looked at trends in the number of claims filed in two states that in recent years significantly altered the limits on non-economic damages awards in medical liability cases: Oregon and Texas.

- Oregon limited non-economic damages awards to no more than \$500,000 from 1987 until 1999, when the state's Supreme Court invalidated the cap. After the cap was taken away, the number of medical liability claims increased by 20 percent.³⁴
- Prior to 2003, Texas did not limit non-economic damages awards. After the Legislature imposed a \$250,000 cap, the number of medical liability claims declined by about 39 percent.³⁵

³¹ RAND Institute for Civil Justice, *Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA* (2004).

³² *Ibid.*, p. 44.

³³ Attorney fees typically are equal to a percentage of the medical liability award. Hence, if the maximum award goes up, the maximum attorney fee goes up.

³⁴ National Practitioners Data Bank. See Appendix A for details.

³⁵ National Practitioners Data Bank. See Appendix A for details.

Using Oregon's experience, we estimate that raising the MICRA cap to a level four times the current level (that is, to \$1 million) would increase medical liability awards by 33 percent, as shown in Table 4.

Table 4:
Likely Impact on Claim Payments if the Cap is Increased

Number of medical malpractice claims filed in CA (2012) ^a	1,188	[A]
Average payment per claim filed in CA (2012) ^a	\$171,538	[B]
Percent increase in medical malpractice claims filed in CA ^b	20%	[C]
Estimated increase in medical malpractice claims filed in CA	234	[D] = [A] x [C]
Additional medical malpractice claim costs	\$40,083,144	[E] = [B] * [D]
Estimated increase in "new" claim costs	20%	[F] = [E]/([A] x [B])
Estimated increase in "old" claim costs (per RAND) ^c	13%	[G]
Total increase in claim costs	33%	[H] = [F] + [G]
Claim costs as a percent of premiums ^d	49%	[I]
Estimated percentage increase in premiums	16%	[J] = [H] x [I]

^a SOURCE: National Practitioners Data Bank.

^b The average change in the number of claims filed in Oregon between 1994 and 1998, when Oregon had a \$500,000 non-economic cap, and 2000 to 2004, when Oregon no longer had a cap on non-economic damages. See Appendix A for details.

^c SOURCE: N. Pace, D. Golinelli, and L. Zakaras, "Capping Non-Economic Awards in Medical Malpractice Trials - California Jury Verdicts under MICRA," RAND Institute for Civil Justice, 2004, p. 44.

^d SOURCE: The Doctors Company Annual Reports for 2008 to 2011. See Appendix B for details.

If, instead, Texas's experience is more indicative, the increase in claim costs would be approximately 77 percent.³⁶

c. Relationship between increased claim costs and increased premiums

An increase in claim costs does not imply a corresponding percentage increase in medical liability insurance premiums, since part of the premium is intended to cover costs such as overhead and administration that are less sensitive to changes in the limit on damages awards. For purposes of estimating how an increase in claim costs would affect medical liability insurance premiums, we calculated the average ratio of indemnity payments to revenue from premiums for The Doctor's Company – a large medical liability insurance provider. We used this ratio – 49%³⁷ – to calculate the increase in premiums that would result from an increase in claim costs.

³⁶ See Appendix C for details.

³⁷ See Appendix B for details.

3. Conclusion

In sum, whether we use nationwide data or the experience of Oregon and Texas to estimate the impact on medical liability insurance premiums of an increase in the MICRA cap, the likely increase in premiums ranges from 16% to 38%. Assuming the increase in claims that Oregon experienced is indicative of what California's experience would be if the MICRA cap is increased to \$1 million or more, the higher cap would cause medical liability premiums to go up by 16 percent (see Table 4). If, instead, Texas's experience is more indicative, the increase in premiums would be 38 percent.

VI. MICRA DOES NOT GENERATE EXCESS PROFITS FOR CALIFORNIA INSURERS

Some opponents of MICRA contend that the reduction in incurred losses made possible by the \$250,000 cap has not resulted in savings for either providers (doctors and hospitals) or consumers. Instead, they argue that the savings have been retained by medical liability insurance companies, allowing them to make supra-competitive profits.³⁸ There is no reliable evidence to support this contention, which is not surprising given the structure of the medical liability insurance market.

A. Medical Liability Insurance Companies Face Strong Market Competition

Bedrock economics principles hold that in competitive markets, prices must be high enough to enable firms to cover their costs and earn a competitive after-tax return on their capital. 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 the 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 on their capital, 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 especially vigorous. In fact, U.S. General Accounting Office (“GAO”) found that “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.”³⁹

Real-world evidence of the medical liability insurance market’s competitiveness is provided by the recent experience of firms that competed in this market. Since 1998, six medical liability insurers have succumbed to competitive pressures and become insolvent.⁴⁰ In addition, the St. Paul Companies – the United States’ largest underwriter of medical liability insurance during the 1990s – pulled-out of the market in 2002. According to Jay Fishman, the company’s chairman and chief executive officer, staying in the medical liability insurance business “would threaten the solvency of the company.”⁴¹ The experience of these seven insurers cannot be reconciled

³⁸ Supra-competitive profits are defined here as profits superior to those that would exist in an unregulated, perfectly competitive market.

³⁹ 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. The GAO subsequently changed its name to the Government Accountability Office.

⁴⁰ Five of these firms have been liquidated due to insolvency: PIE Mutual (2009), Frontier Insurance (2012), MIXX-New Jersey (2008), PHICO Insurance Company (2002), and Reciprocal of America (2003). The sixth, PRI-New York, is technically insolvent per its 2012 financial statements, but has not been liquidated.

⁴¹ See Milt Freudenheim, “St. Paul Cos. Exits Medical Malpractice Insurance,” *New York Times*, December 13, 2001.

with the claims of MICRA's opponents that insurers are able to earn supra-competitive profits writing medical liability insurance.

Medical liability 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 damages awards ultimately would be reflected in the insurance premiums paid by health care providers. Competition ensures that there would be no "excess profits" available to absorb the increased costs.

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

A second reason why we would not expect insurers in California to earn excess profits is that most medical liability insurance in the state 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 which collectively in 2012 had about 71.5% of the market.⁴² As mutually-owned companies, were they to temporarily earn excess profits in any year, they would either distribute the excess as dividends to their physician-shareholders or as premium rebates to their physician-policyholders.

Because doctors are both the shareholders and the customers of mutual insurance companies, the companies have a built-in incentive to pass along to them the savings resulting from MICRA reforms. Thus, even if these companies had the market power to raise premiums above competitive levels (which they do not), they would have no incentive to do so. While non-mutual insurance companies lack this built-in incentive to distribute excess profits to their policyholders, they must compete with these mutual companies for business, meaning that they must resist any temptation to raise rates above competitive levels (assuming, counterfactually, they had the power to do so).

⁴² 2012 California P&C Market Share Report, Line of Business: Medical Professional Liability, California Department of Insurance (<http://www.insurance.ca.gov/0400-news/0200-studies-reports/0100-market-share/2012/upload/IndMktShr2012WP.pdf>). 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.

C. California Medical Liability Insurers Do Not Earn Excessive Profits

One way to determine if California medical liability insurers are earning supra-competitive profits is to examine the companies' average return on equity and compare it to the average returns earned by firms in other industries.⁴³

Table 5 shows that, as measured by return on equity, medical liability insurers that operate in California have earned relatively modest profits. During the 1990-2012 period, annual returns for these firms ranged from – 13.6 percent to +20.2 percent, with an average return of 7.13 percent.⁴⁴ During this same period, the rate of return on one-year U.S. Treasury bonds averaged +3.67 percent per year.⁴⁵

⁴³ We use return on equity (ROE) as the measure of an insurer's profitability because it is the accepted measure of profitability among economists and financial analysts. The "return" in ROE is the revenue earned by the insurer that is not needed to pay claims, loss adjustment expenses, operating expenses, overhead expenses, premium taxes, and income taxes. The "equity" in ROE is the capital that the shareholders have committed to the business, instead of investing it elsewhere in the economy.

Some authors have attempted to show that California medical liability insurers earn excess profits by calling attention to their *loss ratios*. (See, for example, Jay Angoff, "Less than zero: The effect on clinics of raising MICRA's \$250,000 cap" at <http://www.38istoolate.com/assets/Angoff-Raising-MICRAs-250000-cap-wont-hit-clinics-7-31-2013.pdf>). Loss ratios, however, tell us nothing about an insurer's profitability, either on an absolute or relative basis, because they make no allowance for the insurer's operating expenses and taxes. Nor do they reflect the amount of capital the insurer has committed to the business. An insurer could have a relatively low loss ratio and still lose money if factors beyond its control saddled it with high expenses or its investments performed poorly due to a downturn in the stock market.

Furthermore, an insurer that settles claims relatively quickly, as is true for California medical liability insurers (thanks to MICRA), will not have its reserves invested in income-producing instruments for as long as insurers in other states, and it will need to have a lower loss ratio in order to achieve the same degree of profitability as these other insurers.

In sum, a comparison of loss ratios reported by medical liability insurers in different states cannot shed any light on whether California insurers are realizing excess profits. Nor can such a comparison indicate whether California insurers could incur the additional costs that an increase in the MICRA cap would impose on them without having to raise the premiums they charge doctors and hospitals.

⁴⁴ Calculated by the authors from data provided by Cooperative of American Physicians, Medical Insurance Exchange of California, NORCAL Mutual Insurance Company, and The Doctors Company.

⁴⁵ Federal Reserve Statistical Release, H.15 Selected Interest Rates, Treasury Constant Maturities, 1-Year (available at <http://www.federalreserve.gov/releases/h15/data.htm>).

Table 5:
Return on Equity for California Medical Liability
Insurance Providers ^a

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%
2007	\$ 1,420,189,558	\$ 241,650,424	17.02%	4.53%
2008	\$ 1,406,468,049	\$ 77,712,131	5.53%	1.83%
2009	\$ 1,753,780,091	\$ 256,866,395	14.65%	0.47%
2010	\$ 2,023,785,593	\$ 407,963,717	20.16%	0.32%
2011	\$ 1,834,380,399	\$ 259,396,071	14.14%	0.18%
2012	\$ 1,988,203,127	\$ 170,764,473	8.59%	0.17%
Average (1990-2012)			7.13%	3.67%

^a SOURCES: Cooperative of American Physicians, Medical Insurance Exchange of California, NORCAL Mutual Insurance 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>).

The yield on Treasury bonds is used by economists as a measure of the risk-free time value of money – that is, the minimum return that investors should expect to receive when they forego the use of their funds so that another entity can put the money to work. When we subtract the average return on U.S. Treasury bonds from the medical liability insurers’ average return on equity during the 1990-2012 period, we find that the insurers earned 3.46 percentage points more than they would have earned if, instead of investing their capital in the volatile insurance business, they had invested it in financial instruments that carry no risk of default. In effect, 3.46 percent is what these insurance companies were paid annually for assuming medical liability risk from doctors and hospitals.

Is 3.46 percent an excessive return for bearing medical liability risks? Based on the risk premiums earned by firms in similar industries, the answer clearly is “no.”

Ibbotson and Associates has calculated the equity risk premium earned by the average large company during the period 1990-2011 to be 4.2 percent.⁴⁶ The average is 21 percent greater than the 3.46 percent risk premium earned by medical liability insurers. As Appendix D shows, the insurers’ risk premium also compares unfavorably with the risk premiums earned by the average firm in other financial services industries, such as Property/Casualty Insurance (3.57%), Securities Brokerage (4.48%), Investment Management (5.33%), Diversified Financial Services (5.62%), and Life Insurance (6.05%). Based on this comparison, one might question whether the medical liability insurers are being paid enough to take-on medical liability risk.

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

While the evidence that medical liability insurers are not using the savings from tort reform to produce excessive profits is compelling, one might ask if these savings ever make it to the consumers, employees, and taxpayers that pay for health care in California. As is true for medical liability insurers, the competitive market makes it highly likely that doctors and hospitals benefiting from the lower insurance premiums made possible by the MICRA cap pass-along the savings to consumers and other payers.

Health care plans face intense pressure from both employers and the state to hold down or reduce insurance premiums. In response, the plans exert pressure on providers, such as physicians and hospitals, to limit the fees they charge patients. Furthermore, with managed care accounting for approximately 80 percent⁴⁷ of California’s health care market, the pressure on providers to hold down fees is even greater than it is in other states. Managed care providers, such as Health Maintenance Organizations (“HMOs”) and certain Preferred Provider Organizations (“PPOs”), encourage competition among physicians and hospitals because they can shift their entire patient pools from higher-cost to lower-cost providers simply by signing or refusing to sign service contracts. Physicians who operate in these increasingly competitive markets are under pressure to pass-on to health insurers the cost-savings from lower medical liability insurance premiums made possible by MICRA.

In sum, it is clear that the ultimate beneficiaries of the cost-savings produced by MICRA are the consumers, employees, and taxpayers who pay for health care provided to Californians.

⁴⁶ “2012 Ibbotson SBBI Risk Premia Over Time Report, Estimates for 1926-2011,” Morningstar, p. 13. The equity risk premium is calculated as the difference between the total return on equity less the average total return on long-term government bonds (*i.e.*, the risk-free rate).

⁴⁷ See, e.g., “Managed Care Has Slowed Growth in Medical Spending,” National Bureau of Economic Research (<http://www.nber.org/digest/may98/w6140.html>).

VII. AN INCREASE IN THE MICRA CAP WOULD INCREASE THE COST OF HEALTH CARE TO CALIFORNIANS

Raising the current \$250,000 cap on non-economic damages awards would impose significant additional costs on the state's health care system, both directly and indirectly. Initially, the additional costs would be borne by health care providers, in the form of higher medical liability insurance premiums and higher claims cost for self-insured providers. Because the health care system is interconnected and highly competitive, however, higher costs imposed on one segment of the system eventually affect the remaining segments. Thus, when health care providers are forced to pay more for medical liability insurance, the higher costs ultimately are passed along to the ultimate payers – consumers, employees, and taxpayers.⁴⁸

In addition, a higher cap would cause doctors to order more costly and unnecessary tests and procedures, in order to reduce their exposure to the greater risk of being sued. Their defensive behavior would further increase health care costs in California.

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

Empirical evidence shows that an increase in medical liability insurance 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 raised doctors' total annual fees by an average of \$0.16 for office visits, and \$0.09-\$0.17 for hospital visits.⁴⁹ The Danzon analysis indicates that if the average premium for California obstetricians (\$82,626 in 2012) increased to the level prevailing in Florida (\$201,808), the increase (\$119,182) would raise the annual cost of physician visits (per physician) by \$19,069, and would raise the annual cost of hospital visits by \$10,726 - \$20,261.⁵⁰

B. Raising the MICRA Cap Would Lead to More Costly and Unnecessary Tests and Procedures ("Defensive Medicine")

Health care providers seek to reduce their exposure to medical liability suits by adopting sub-optimal behaviors that increase the cost of health care provided to patients without improving the quality or effectiveness of care. The term used to describe this exposure-reducing behavior is "defensive medicine." Economic principles hold that an increase in a provider's exposure to lawsuits will lead to an increase in the amount of defensive

⁴⁸ 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 medical liability 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.

⁴⁹ Patricia M. Danzon, Mark V. Pauly, 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 managed care became the dominant form of health insurance.

⁵⁰ See Figure 5 for comparison of premium rates.

medicine, while a reduction in exposure – such as results from medical liability tort reform – will cause the amount of defensive medicine to decrease.

The most widely cited study of the relationship between medical liability tort reform and the practice of defensive medicine was published in 2000 by two prominent Stanford University scholars: Daniel Kessler and Mark McClellan. This study found that, on average, direct reforms of the medical liability tort system – primarily caps on non-economic damages – were associated with a 5.44 percent reduction in health care expenditures on elderly patients who had suffered heart attacks or had ischemic heart disease. Despite the reduction in expenditures, however, the study found no increase in adverse medical outcomes.

Kessler and McClellan also found that not all of the cost-savings in states with non-economic damages caps were properly attributable to the caps. In some of these states, managed care dominated the health care market, and it was responsible for part of the cost-savings. When the authors made adjustments for the effect of managed care, they found that the average reduction in health care expenditures associated with direct tort reform was 3.04 percent, rather than 5.44 percent.

It is important to note that the 5.44 percent reflects the average reduction in health care costs for all states that had enacted direct reforms of their medical liability tort system. Since none of these states had a lower cap on non-economic damages than California, and many states had significantly higher caps, it stands to reason that (1) the percent reduction in California's health care expenditures associated with the MICRA cap was significantly greater than 5.44 percent, and (2) when allowance is made for the effects of managed care, the reduction properly attributable to the \$250,000 MICRA cap is significantly greater than 3.04 percent.

Kessler and McClellan's findings are consistent with the findings of other scholars. For example, Fred J. Hellinger and William Encinosa found that states with caps on non-economic damages have 3-to-4 percent lower overall health care spending than states without caps.⁵¹ Frank A. Sloan and John H. Shadle found that the average cost of treating an illness requiring hospitalization declined by 3.6 percent after the enactment of direct reforms.⁵² Although the Sloan-Shadle finding is not statistically significant, it is of approximately the same magnitude as the impacts found by Kessler and McClellan and by Hellinger and Encinosa.

In a 2011 article for the prestigious *Journal of Economic Perspectives*, Kessler cites approximately 90 articles that comprise the scholarly literature on the relationship between tort reform and the practice of defensive medicine. While not all of these articles support Kessler and McClellan's findings, we find that, taken together the weight of empirical research clearly supports the conclusion that caps on non-economic damages reduce the

⁵¹ F. Hellinger and W. Encinosa, "The impact of state laws limiting malpractice damage awards on health care expenditures," *Government, Politics, and Law*, 96 (2006) 1375 – 1381.

⁵² F. Sloan and J. Shadle, "Is there empirical evidence for "Defensive Medicine"? A reassessment," *Journal of Health Economics*, 28 (2009) 481-491.

practice of defensive medicine without having an adverse impact on outcomes. The non-partisan CBO reached the same conclusion in 2009, when it stated:

Because of mixed evidence about whether tort reform affects the utilization of health care services, past analyses by the Congressional Budget Office (CBO) have focused on the impact of tort reform on premiums for malpractice insurance. However, more recent research has provided additional evidence to suggest that lowering the cost of medical malpractice tends to reduce the use of health care services. CBO has updated its estimate of the budgetary effects of proposals for tort reform to reflect that new information.⁵³

C. The Annual Direct and Indirect Costs Resulting From a Higher Cap on Non-Economic Damages Would Be Approximately \$9.9 Billion

Table 6 summarizes the available empirical evidence on the quantifiable costs to California's health care system in 2015 from raising the \$250,000 cap on non-economic damages.⁵⁴ As the table shows, raising the cap would increase the cost of providing health care to Californians by \$9.9 billion. The increased cost amounts to \$261 per California resident,⁵⁵ or \$1,045 for a family of four. As discussed in the next part of this report, the additional costs will be borne by Californians in their capacity as health care consumers, employees, and taxpayers.

⁵³ See Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to the Honorable Orrin G. Hatch, Senator from Utah, dated October 9, 2009, pp. 1 and 3.

⁵⁴ We chose 2015 for the calculation because several initiative statutes were recently proposed that would raise the MICRA cap to approximately \$1.1 million, effective 2015.

⁵⁵ The per capita calculation uses the California Department of Finance's state population estimate for January 1, 2013 (37,966,471). See <http://www.dof.ca.gov/research/demographic/reports/estimates/e-1/view.php>.

Table 6:
Measurable Costs of Increasing the Cap on
Non-Economic Damages

Cost of Increased Defensive Medicine Expenditures		
California Projected Health Care Expenditures (2015 projected) ^a	[A]	\$305,423,357,619
Estimated increase in personal health care expenditures due to more defensive medicine ^b	[B]	3.13%
Estimated increase in personal health care expenditures in California (2015)	[C] = [A] x [B]	\$9,559,736,919
Direct Cost to Medicare and Other Federal Health Care Program		
Increase in Medicare and related expenditures (2015 projected) ^c	[D]	\$2,160,000,000
California portion of national Medicare and related expenditures ^d	[E]	10.86%
Estimated increase in California Medicare and related expenditures (2015)	[F] = [D] x [E]	\$234,630,450
Medical Liability Premium Increase		
2011 premiums written for California ^e	[G]	\$813,264,000
Estimated percentage increase in premiums ^f	[H]	16.01%
Estimated increase in premiums for California	[I] = [G] x [H]	\$130,212,824
Estimated percentage of insurance coverage excluding Medi-Cal/Medicare ^g	[J]	71%
Estimated increase in premiums for California excluding Medi-Cal/Medicare (2011)	[K] = [I] x [J]	\$92,451,105
Cost of Increased Claim Costs for Self-Insured California Hospitals		
2012 estimated loss rate for self-insured California hospitals ^h	[L]	\$140,140,000
Estimated increase in claim costs ⁱ	[M]	33%
Estimated increase in claims cost for self-insured California hospitals	[N] = [L] x [M]	\$45,782,501
Estimated percentage of insurance coverage excluding Medi-Cal/Medicare ^g	[O]	71%
Estimated increase in claim costs for California hospitals excluding Medi-Cal/Medicare	[P] = [N] x [O]	\$32,505,576
Estimated Annual Cost of Increasing the Cap	[Q] = [C]+[F]+[K]+[P]	\$9,919,324,051

^a SOURCES: Based on data provided by the National Health Expenditure Projections 2011-2021, Center for Medicare & Medicaid Services, Table 1 (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf>); and Total All Payers State Estimates by State of Residence - Personal Health Care, Center for Medicare & Medicaid Services (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.pdf>). Personal Health Care expenditures for California assume the state's share of national expenditures remains the same as it was in 2009.

^b SOURCE: Percentage increase is equal to 3.035/(1-3.035). The 3.035 represents the reduction in health care expenditures for heart attack and ischemic heart disease patients attributed to tort reforms in Daniel Kessler and Mark McClellan, "Medical liability, managed care and defensive medicine", NBER working paper 7537, February 2000, Table 6.

^c SOURCE: Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Senator Orrin G. Hatch, dated October 9, 2009, pp. 3-4. CBO estimates that 40% of its estimated reduction in direct costs resulting from tort reform is due to lower medical liability premiums. By applying the 40% to CBO's most recent estimate of expected savings in Medicare and related expenditures, we have a basis for estimating the increase in direct costs that would result from higher premiums.

^d SOURCE: Center for Medicare and Medicaid Services - 2011 Data Compendium, Section VII, State Data, Table VII.1 (2010 Expenditure).

^e SOURCE: NAIC Profitability Report, 2011.

^f and ⁱ SOURCE: Table 4.

^g SOURCE: "California Health Plans and Insurers: A Shifting Landscape," California Health Care Almanac, March 2013, p. 3.

^h SOURCE: "2012 Hospital and Physician Professional Liability Benchmark Analysis," October 2012, p. 43. Based on total Occupied Bed Equivalents of 57,200 and Loss Rate per OBE of \$2,450 for California.

The estimates in Table 6 assume that the cap on non-economic damages is increased to \$1.0 million 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 health care. We believe our estimates are reasonable, given the empirical evidence that caps above \$500,000 have no significant effect on reducing premium growth rates.⁵⁶

It is possible that the cost to California's health care system resulting from an increase in the \$250,000 cap on non-economic damages awards could be higher or lower than the estimates shown in Table 6. The cost of defensive medicine in connection with the treatment of coronary disease may or may not be representative of the defensive medicine costs associated with other diagnoses.⁵⁷ Indeed, the increase in health care costs associated with a higher cap could be larger than 3 percent for some diagnoses and smaller for others. The available evidence, however, provides no basis for assuming that the average increase for all diagnoses is less than 3 percent, nor does it provide a basis for assuming that it is greater than 3 percent.

It should also be kept in mind that the Kessler and McClellan's findings are based on the experience of the average tort reform state. Since no state has a lower cap on non-economic damages than California, and many tort reform states have higher caps, the cost-savings resulting from the MICRA cap are likely to have been greater than 3.04 percent, and the increase in health care costs that would result from a major increase in the cap is likely to be greater than 3.13 percent. Also, we note that the increase in medical liability insurance premiums (16.01%) assumed in Table 6 is far lower than the increases reported for Oregon physicians (*e.g.*, 215% for internists) after the state's Supreme Court removed the cap on non-economic damages.⁵⁸

⁵⁶ 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.

⁵⁷ 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. See, for example, United States General Accounting Office, Report to Congressional Requesters, "Medical Malpractice Implications of Rising Premiums on Access to Health Care," GAO-03-836, August 2003, pp. 53-54.

⁵⁸ 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 \$9,373 by 2012, an increase of 215%.

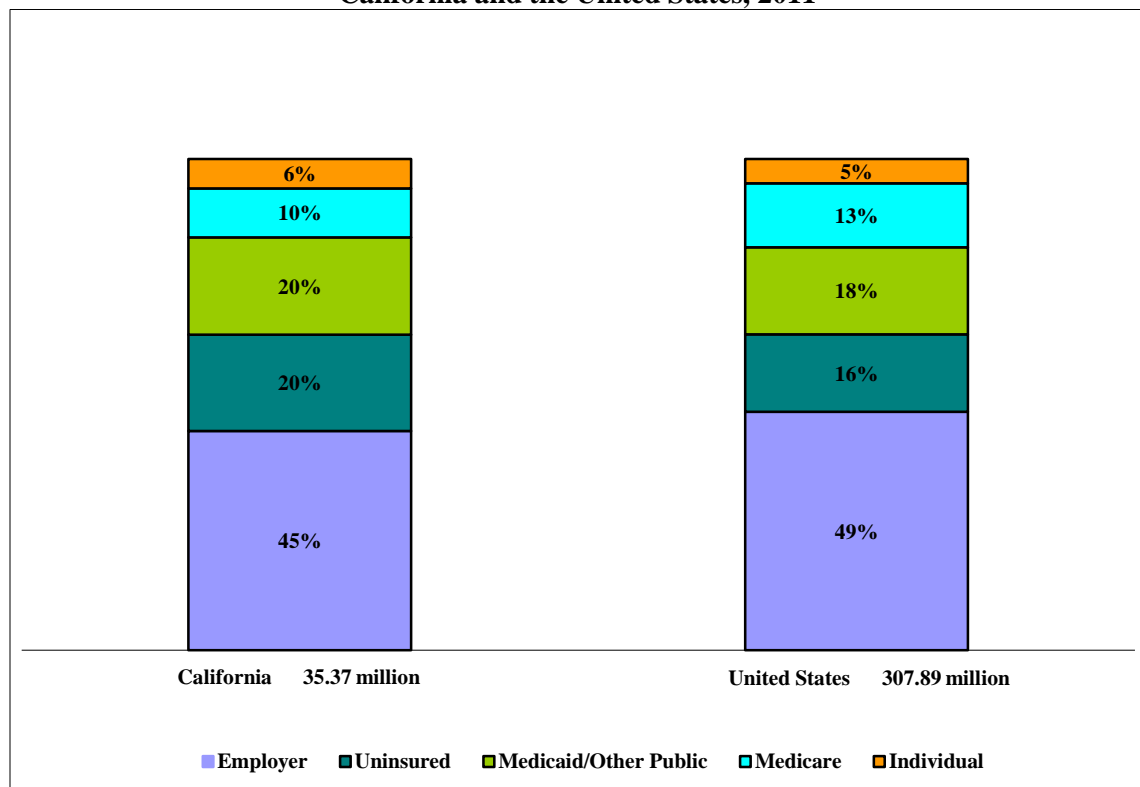
VIII. THE INCREASED COSTS OF HEALTH CARE RESULTING FROM A HIGHER CAP WOULD BE BORNE BY CALIFORNIA CONSUMERS, EMPLOYEES, AND TAXPAYERS

Participants in California's health care system – physicians, employers, government and consumers – would not share equally in the increased costs of health care resulting from a higher cap on non-economic damages awards. While physicians and hospitals initially would bear the costs resulting from the higher cap, most or all of these costs eventually would be passed along to other participants, in the form of increased fees and charges.⁵⁹

A. Employers Would Shift Most of the Increase in the Cost of Employee Health Insurance to Their Employees

As Figure 7 indicates, 45 percent of California's population receives health insurance through their employers.

Figure 7:
Distribution of the Total Population, by Health Insurance Status,
California and the United States, 2011^a



^a SOURCE: The Henry J. Kaiser Family Foundation, California: Health Insurance Coverage of the Total Population, states (2010-2011), U.S. (2011).

⁵⁹ 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.

If the MICRA cap is raised, the cost of employer-sponsored health insurance will go up for two reasons. First, the increased cost of medical liability insurance will be reflected in the fees charged by physicians, hospitals, and other affiliated professionals. Second, the significant increase in defensive medicine resulting from the higher cap will increase the costs that health insurers have to pay.

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

- Some employers that continued to offer health insurance to their employees would reduce coverage. The reductions are most likely to occur in areas such as vision care, mental health, and counseling. Employees would either have to begin paying the cost of these services from their own pockets or do without them.
- Other employers that continued to offer health insurance would 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.
- A third group of 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.
- A fourth group of employers would decide to terminate health insurance coverage for their employees, or choose not to offer it for reasons of cost.⁶⁰

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 their employees.⁶¹ 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."⁶² On the supply side, the CBO argues, employees are willing to pay for health care, "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."⁶³ Thus, employees "end up bearing the costs of that insurance because supplies of labor are not elastic."⁶⁴

B. The Taxpayers Would Bear a Large Portion of the Increased Health Care Costs That Result from a Higher Cap

In one way or another, every unit of government in California is in the health care business. Thus, when the cost of health care goes up, the cost of government goes up and the burden on the taxpayers increases.

⁶⁰ See, for example, Mark V. Pauly, Health Benefits at Work: An economic and political analysis of employment based health insurance, University of Michigan Press. 1997.

⁶¹ CBO, "Economic Implications of Rising Health Care Costs," October 1992.

⁶² *Ibid.*, at p. 35.

⁶³ *Ibid.*

⁶⁴ *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.*

Government's role in the health care business typically takes one of two forms:

- **Provider.** Government provides health care to individuals, such as patients in State and county hospitals, and often is not fully compensated for the costs it incurs in providing this care.
- **Payor.** Government pays for all or part of the health care that doctors and hospitals provide to other individuals, such as government employees and children from low-income families.

The CBO estimates that the savings from enacting MICRA-like reforms for all states would reduce federal direct spending for Medicare, Medicaid, Federal Employees Health Benefits (FEHB), and other federal health benefits programs by \$41.3 billion over the 2012-2022 period.⁶⁵

If California were to raise the MICRA cap, the State and its local governments would lose a portion of the cost-savings they currently enjoy as a result of the cap, and government expenditures on health care would increase. We estimate that the increase would total \$1.95 billion annually, as follows:⁶⁶

State Government	\$1,086 million
Higher education (UC and CSU).....	\$86 million
K-12 schools.....	\$170 million
Community colleges.....	\$25 million
Counties.....	\$297 million
Cities (including San Francisco)	\$173 million
Special districts.....	<u>\$111 million</u>
Total, California State and local government	\$1,948 million

In addition to these higher costs, the State will experience a loss of General Fund revenue, as employers offset the increased cost of employee health insurance premiums by holding down salaries and wages or by increasing the employees' share of the costs. Because salaries and wages are taxable but employer-paid health insurance benefits are not, the offset will reduce the amount of income subject to the State's personal income tax. Moreover, the increased cost of health care that the initiative would impose on Californians would cause some employees to cut-back on taxable purchases, thereby reducing State and local government revenues from the State's sales and use tax.

⁶⁵ Congressional Budget Office, Cost Estimate for Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2011, as approved by the House Committee on the Judiciary on April 25, 2012, dated April 26, 2012. The estimated \$41.3 billion in savings would be in addition to the cost-savings that states with MICRA-like reforms (*e.g.*, California) are already realizing. Thus, the total financial benefit from capping non-economic damages and other direct medical liability tort reforms is considerably larger than \$41.3 billion.

⁶⁶ The bases for our estimate are set forth in William G. Hamm, Jeannie Kim, & Jenny Young, "How Would Voter Approval of AG Ballot Measure 13-0016 Affect Health Care Costs in California and State and Local Expenditures and Revenues?"

Our estimate of the proposed fiscal effect is incomplete because it makes no allowance for the increased costs that will occur as the number of doctors and hospitals in California goes down and health care markets become less competitive. While we know that the law of supply and demand will, over time, cause the cost of health care to go up in California as the number of providers goes down, we do not have sufficient data to estimate how large the increase in costs would be.

C. Consumers Would Bear a Large Portion of the Increased Health Care Costs Resulting from a Higher Cap

A portion of the increases in physician and hospital fees resulting from a higher cap on non-economic damages eventually would be shifted to consumers who purchase health insurance in the individual market. Uninsured consumers also would have to pay more for their health care. As the next part of this report demonstrates, more Californians will fall into the uninsured category if the cap is raised, as some employers drop coverage for their employees and some participants decide that health insurance has become too costly.

D. Conclusion: Who Would Bear the Additional 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?**

Text in blue – further cost-shifting will occur
Text in red – who ultimately bears the cost

Row	Cost	Initially Imposed On	Shifted To
A	Increased loss costs	Medical liability insurers	Insured providers
		Self-insured providers	Uninsured consumers Health care insurers Government programs
B	Higher medical liability insurance premiums	Insured providers	Uninsured consumers Health care insurers Government programs
C	Increased cost of defensive medicine	Uninsured consumers	
		Health care insurers	Employers Insured consumers
		Government programs	Taxpayers
D	Increased cost of providing health insurance	Employers	Employees
		Insured consumers	
E	Increased cost of government programs	Federal, state & county agencies	Taxpayers

As the table illustrates, all of the increased costs that would result from raising the MICRA cap will be paid by California consumers, employees, and taxpayers. Although part of the increased loss costs incurred by medical liability insurance companies as a result of the higher cap (Row A) will be shifted to “Government programs,” these costs ultimately will be paid by taxpayers (Row E). Similarly, while part of the increased cost of medical liability insurance premiums will be shifted to health care insurers (Row B), these costs ultimately will be paid by consumers and employees (Row D).

IX. AN INCREASE IN THE CAP WOULD INCREASE THE NUMBER OF UNINSURED PERSONS IN CALIFORNIA

The percentage of uninsured persons in California in 2011 exceeded the United States average by approximately 25 percent (20% vs. 16%).⁶⁷ California also has a lower rate of employer-based health insurance coverage than the United States as a whole (45% vs. 49%).⁶⁸

By increasing the cost of health care in California, a higher cap on non-economic damages would reduce both the willingness and ability of Californians to obtain health insurance, making it more difficult for them to secure the medical care they need. It would also reduce the willingness and ability of the state's health care system to provide care – particularly to under-served groups and residents of under-served areas.

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

A fundamental tenet of economics is that, for the vast majority of goods and services, an increase in price causes a reduction in demand. Thus, an increase in health insurance premiums resulting from a higher cap on non-economic damages would lead to an increase in the number of individuals without insurance 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 or go without coverage because they believe the higher monthly premiums make health insurance too expensive. The extent to which an increase in health insurance premiums leads to reduced coverage depends on the price elasticity of the demand for insurance.⁶⁹

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.⁷⁰ In California, a full 72 percent of 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.⁷¹

Rather than discontinue coverage, some employers faced with increases in the cost of health insurance will choose to shift the increased costs to employees by (1) requiring a larger employee co-payment, (2) raising

⁶⁷ See Figure 7.

⁶⁸ See Figure 7.

⁶⁹ The price elasticity of demand refers to the sensitivity of demand for a product or service to a change in the price of that service.

⁷⁰ Arleen Leibowitz and Michael Chernew, "The Firm's Demand for Health Insurance," U.S. Department of Labor, July 17, 1992.

⁷¹ Employer Health Benefits, 2007 Annual Survey, Kaiser Family Foundation, Exhibit 2.8, p. 41.

the deductible, (3) increasing the employee's share of insurance premium costs, or (4) reducing the range of health care coverage offered.

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

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 changes in health insurance costs. Studies have shown that the price elasticity of demand for health insurance 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.⁷² Thus, given California's population of approximately 37 million 2011, a 10% increase in the price of health insurance could be expected to reduce the number of Californians who chose to purchase insurance by between 370,000 and 1.48 million.

⁷² See, for example, Susan M. Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-group Market," *Journal of Health Economics*, 1995; J. Sheils et al., *Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy*-Technical Appendix, National Coalition on Health Care, October 1999; Jeanne S. Ringel, 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.

X. AN INCREASE IN THE CAP WOULD REDUCE THE SUPPLY OF HEALTH CARE IN CALIFORNIA

By holding down the cost of medical liability insurance, the MICRA cap has had a favorable effect on both the supply of, and access to, health care supplied by California health care providers, clinics, and hospitals. Just as a lower price causes consumers to buy more, an increase in expected compensation causes providers to supply more. The reverse is also true: an increase in medical liability insurance costs, by initially reducing the financial rewards from providing health care, would have an adverse impact on the supply of care. We have identified five ways in which this predictable consequence of a higher cap on non-economic damages awards would reduce the supply of health care in California.

A. A Higher Cap Would Discourage Physicians from Setting-up Their Practices in California

Physician supply in any location (as well as in any medical specialty) depends, in part, on the doctors' expected income. It also depends on the doctors' perceptions of their vulnerability to professional liability lawsuits. As noted earlier, when a doctor is sued, her expected income is reduced not just because she must pay higher insurance premiums; she must also reduce the amount of time she devotes to seeing patients so that she can work with her counsel to mount an effective defense. There is also a psychological and emotional cost to being sued that we are not able to quantify, but that also affects physicians' location decisions.

If one state has significantly higher medical liability insurance costs and causes doctors to perceive that they are more vulnerable to being sued than they would be in other states, the doctors' expected incomes 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 medical liability costs and greater litigation risk.⁷³ Texas provides a compelling example of this phenomenon.

Prior to 2003, Texas experienced a medical liability insurance crisis similar to the one California endured in the mid-1970s. The crisis resulted in a severe shortage of health care providers within the state, as newspapers reported at the time:

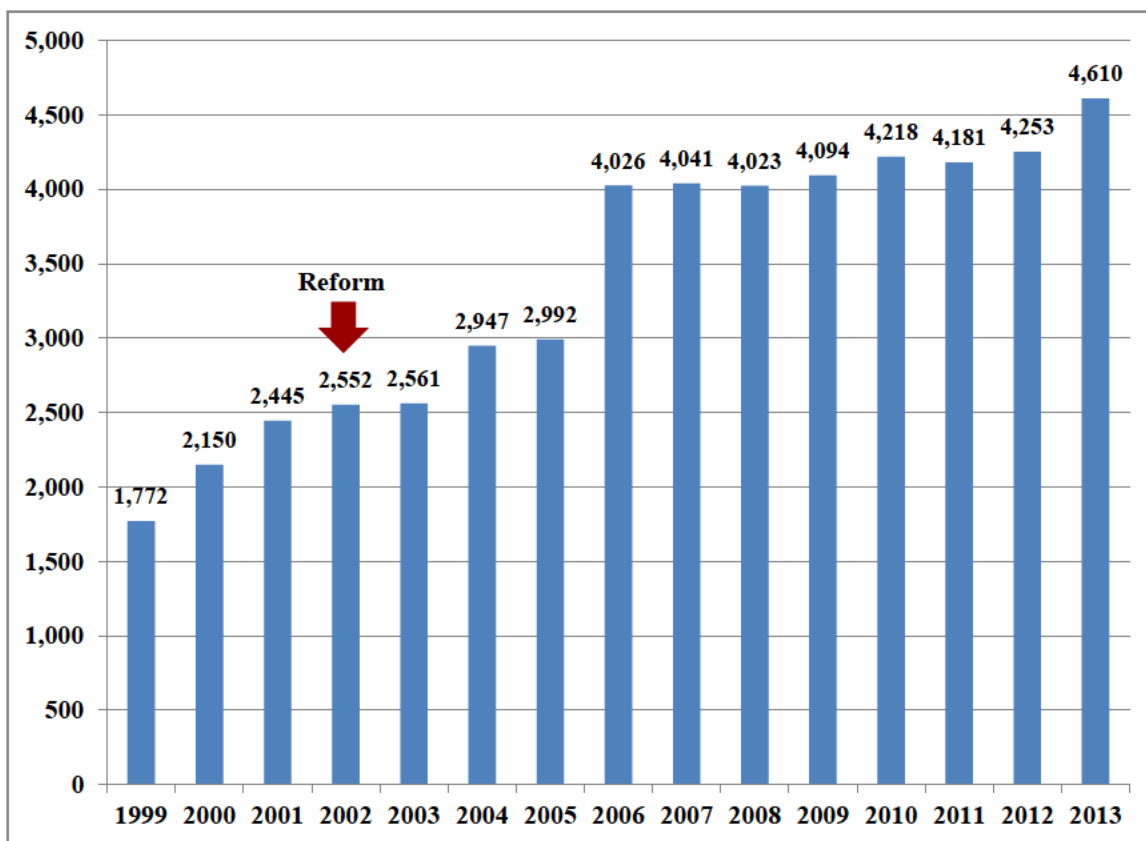
Texas' Tort Reform Gives Example For Other States, *Tyler Morning Telegraph*, 5/27/08

[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.

⁷³ See, for example, Mark A. Satterthwaite, "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.

In response to the crisis, the Texas Legislature in 2003 passed House Bill 4 and the voters' approved Proposition 12, capping non-economic damages awards.⁷⁴ Since then, both insurance premiums in Texas and physicians' perceived exposure to non-meritorious lawsuits have decreased dramatically. As a consequence, the Texas Medical Board reports that the number of doctors seeking to establish their practice in Texas has increased sharply, as Figure 9 illustrates.

**Figure 9:
New Physician Applications Received
(1999-2013)^a**



^a SOURCE: Texas Medical Board, Fiscal Year-End Reports.

As the figure shows, during the four years prior to tort reform (1999-2002), new application for physician licenses averaged 2,230 per year. During the eight years after the caps stabilized insurance premiums and reduced physicians' vulnerability to lawsuits (2006-2013), applications averaged 4,181 per year – an increase of 87 percent.

⁷⁴ The cap was set 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.

B. A Higher Cap Would Cause Some California Physicians to Move Their Practices to Other States

Just as an increase in the MICRA cap would discourage some doctors from setting-up their practices in California, it would also cause some doctors who are already licensed in the state to move their practices elsewhere. 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 medical liability insurance costs.⁷⁵

C. A Higher Cap Would Encourage Early Retirements by Physicians

Retirement decisions are also influenced by one's future earnings potential. If a physician nearing retirement sees his or her medical liability costs (including vulnerability to non-meritorious lawsuits) increase significantly as a result of a higher cap on non-economic damages, the physician will be more likely to accelerate his or her retirement date, thereby reducing the supply of doctors available to serve Californians.

D. A Higher Cap Would Discourage Physicians from Continuing to Practice in High-Risk Specialties

Medical specialties that deliver babies (*e.g.*, obstetrics),⁷⁶ along with surgery and anesthesiology, are especially vulnerable to medical liability lawsuits because these specialties carry an above-average risk of sub-optimal outcomes, even when the doctor performs flawlessly. Bad outcomes often prompt unhappy patients to file lawsuits. The increased vulnerability to lawsuits is reflected in the medical liability insurance premiums that specialists must pay. For example, Table 7 shows the premiums paid by various specialists in Los Angeles, Miami, Long Island, Detroit, and Chicago.

⁷⁵ Medical Liability Reform – NOW! June 14, 2004. American Medical Association, p. 3.

⁷⁶ See, for example, Stephen A. Norton, "The Malpractice Premium Costs of Obstetrics," *Inquiry*, Spring 1997, p. 62.

Table 7:
Medical Liability Premiums, by Specialty ^a
Los Angeles, Miami, Long Island, Detroit, & Chicago
2012

Specialty	Los Angeles, CA ^b	Miami, FL ^b	Long Island, NY ^c	Detroit, MI ^{b,d}	Chicago, IL ^e
Allergy	\$5,603	\$19,751	\$9,022	\$15,984	\$16,256
Psychiatry (Non-Shock)	\$6,741	\$23,043	\$9,022	\$17,764	\$21,720
Pathology	\$10,343	\$42,794	\$22,917	\$19,427	\$21,720
Anesthesiology	\$12,128	\$46,086	\$34,839	\$39,416	\$39,932
Family Practice (Non-Surgical)	\$9,158	\$42,794	\$24,813	\$27,620	\$32,648
Internal Medicine (Non-Invasive)	\$8,274	\$47,731	\$34,032	\$31,103	\$38,112
Radiology (Non-Invasive)	\$16,227	\$90,525	\$62,786	\$41,012	\$41,752
Cardiology (Invasive)	\$15,458	\$90,525	\$44,048	\$63,060	\$56,320
Pediatrics (Non-Surgical)	\$12,245	\$29,626	\$22,917	\$24,611	\$21,720
Ophthalmology	\$15,187	\$32,918	\$32,702	\$37,766	\$32,648
Urology	\$19,075	\$57,607	\$66,053	\$47,625	\$54,500
Dermatology	\$25,075	\$19,751	\$10,291	\$22,021	\$21,720
Emergency Medicine	\$23,742	\$90,525	\$60,601	\$73,685	\$56,320
Otolaryngology	\$24,891	\$32,918	\$53,570	\$81,150	\$56,320
Proctology	\$27,154	\$65,836	\$66,053	\$53,484	\$59,964
General Surgery	\$41,775	\$190,926	\$127,233	\$121,321	\$100,028
Thoracic Surgery	\$39,571	\$164,591	\$127,233	\$141,056	\$129,164
Cardiovascular Surgery	\$39,571	\$164,591	\$115,111	\$165,346	\$129,164
Orthopedics	\$34,483	\$115,214	\$131,106	\$105,226	\$100,028
Plastic Surgery	\$29,738	\$90,525	\$90,094	\$77,443	\$96,384
OB/GYN	\$49,804	\$190,926	\$176,005	\$95,865	\$140,092
Neurosurgery	\$68,380	\$237,011	\$297,664	\$176,448	\$231,144
Average - All Specialties	\$24,301	\$85,737	\$73,551	\$67,202	\$68,075

^a 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.

^b SOURCE: The Doctors Company

^c SOURCE: Medical Liability Mutual Insurance Company. Rates effective between July 1, 2012 and June 30, 2013.

^d Comparison reflects mature annual premium costs for \$1 million maximum per case/\$4 million maximum for all cases in a given year.

^e SOURCE: ISMIE. Rates effective on or after October 1, 2012, up to and including September 30, 2013.

The large premiums and increased vulnerability to non-meritorious lawsuits encourage physicians to switch from high-risk specialties such as obstetrics to less-impacted specialties, as the following news reports illustrate.

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.

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, *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).

Malpractice Costs Up 150% Since 1999, Hospitals Say, *New York Times*, January 6, 2005

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.⁷⁷

The loss of obstetricians is especially unfortunate. Obstetrical services, such as prenatal care, are among the most cost-effective forms of preventive medical care available. Any improvement in infant health outcomes is likely to provide benefits during the individual's entire lifetime.

Obstetricians, however, have a significant exposure to medical liability lawsuits. Parents whose infants have imperfect birth outcomes are likely to file a malpractice lawsuit, and juries are highly sympathetic to claims involving infants. High medical liability 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.

Texas has shown that a shortage of practitioners in high-risk specialties can be overcome by capping non-economic damages awards. As Table 8 shows, after the state imposed a cap and medical liability insurance premiums stabilized, the number of high-risk specialists in Texas grew by 26.8 percent in six years (May 2006-May 2012) – more than twice as fast as the state's population.⁷⁸

⁷⁷ Thomas J. Lueck, “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.

⁷⁸ Texas Medical Board, Physicians Demographics by County/Specialty <http://www.tmb.state.tx.us/agency/statistics/demo/docs/d2011/0511/county.php>.

Table 8:
Texas Physicians in High-Risk Specialties
(May 2006 & May 2012)^a

Specialty	May 2006	May 2012	Change	% Change
Pediatric Sub-specialists	318	1,044	726	228.00%
Vascular Surgeons	94	153	59	62.80%
Emergency Care Doctors	1,689	2,560	871	51.60%
Neurosurgeons	303	370	67	22.10%
Anesthesiologists	2,770	3,338	568	20.50%
Orthopedic Surgeons	1,439	1,609	170	11.80%
OB/GYN	2,329	2,569	240	10.30%
Cardiologists	1,232	1,358	126	10.20%
Cardiovascular and Thoracic Surgeons	348	341	-7	-2%
High Risk Combined	10,522	13,342	2,820	26.80%
Texas Population	23,464,827	26,403,743	2,938,916	12.50%
High Risk Specialists per 100,000 Population	44.84	50.53		12.69%

^a SOURCES: Physician Data: Texas Medical Board, Physicians Demographics by County/Specialty (<http://www.tmb.state.tx.us/agency/statistics/demo/docs/d2011/0511/county.php>); and Texas Population Data: Texas Department of State Health Services (<http://www.dshs.state.tx.us/chs/popdat/ST2005.shtm>).

Texas's experience with caps on non-economic damages awards demonstrates that by holding down premiums for high-risk specialists, MICRA improves access to health care in California – especially for women and infants.

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

Medical students are keenly aware of the costs of liability insurance and factor these costs into their selection of specialties and location of practice. According to survey data, 50 percent of medical students cite liability insurance costs as an important factor in choosing a specialty, and 39 percent cite liability insurance costs as an important factor in choosing where to locate their practice.⁷⁹ Consequently, those areas and specialties with relatively higher liability costs and relatively greater vulnerability to lawsuits will be underserved as students elect to pursue other less-risky or less-costly options.

⁷⁹ AMA survey: Medical students' opinions of the current medical liability environment. American Medical Association Division of Market Research and Analysis, November 2003.

F. A Higher Cap Would Have a Disproportionate Impact on the Supply of Physicians in Low-Income Rural and Inner City Areas

While higher medical liability premiums would affect health care providers throughout California, physicians in rural and inner-city areas would be the ones most adversely affected by the increase because, relative to their suburban counterparts, it is more difficult for them to pass along the increased costs to patients. According to the GAO:

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.⁸⁰

Many rural and inner city areas are medically under-served because the amounts that residents of these communities can pay toward their health care are more limited, and the cost of serving these residents is often higher. To the extent physicians are unable to pass along the higher cost of medical liability premiums to lower-income families, a higher cap would discourage more providers from serving these rural and inner city communities, thereby exacerbating the doctor shortage in these areas.

Texas's recent experience shows how caps on non-economic damages awards can improve access to needed medical resources in rural areas. Since the caps were imposed in 2003:

- 19 Texas counties gained their first cardiologist; 15 of these 19 counties are rural.
- 50 counties (40 rural) gained their first emergency medicine physician.
- 7 counties (5 rural) gained their first orthopedic surgeon.
- 14 counties (13 rural) gained their first obstetrician.⁸¹

⁸⁰ 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).

⁸¹ Texas Medical Board, "Physician Demographics, May 2013".

XI. A HIGHER CAP WOULD DECREASE THE WILLINGNESS OF PHYSICIANS TO TREAT VERY HIGH-RISK PATIENTS

Not all medical conditions can be treated successfully, even with state-of-the-art medications and the most advanced surgical procedures performed by the most highly trained and competent doctors. When all other treatments have failed to correct a medical problem, the only option available to a gravely ill patient may be a course of treatment that carries a high risk of a bad outcome. If a provider agrees to perform a procedure with a high risk of a bad outcome, his or her exposure to a medical liability lawsuit will increase sharply. If the provider wishes to avoid this exposure, he or she need only refuse to perform the needed procedure. In some cases, however, the high-risk procedure 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 health care procedures.⁸² 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.⁸³

Following Texas's adoption of caps on non-economic damages awards, physicians within the state were more willing to perform high-risk procedures, as the following newspaper report illustrates.

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.

Tort reform equals more medical care, Texas think tank reports, *LegalNewsline.com*, September 23, 2011

According to the study, doctors left Texas in droves prior to reform of the legal system passed by the state legislature in 2003. After the system was reformed doctors returned to the state in such great numbers that Texas now has more physicians per capita than ever before - even formerly underserved areas have access to physicians, the study claims.

⁸² The threat of medical liability suits can also discourage innovation and experimental medicine in the state. See, for example, Dorothy Nelkin and Laurence Tancredi, "Medical Malpractice and Its Effect on Innovation," in *The Liability Maze*, Ed. Peter W. Huber and Robert E. Litan, Brookings Institution Press, 1991, pp. 251-273.

⁸³ General Accounting Office, "Medical Malpractice: Case Study on California," December 1986. GAO/HRD-87-21S-2, p. 8.

“The number of obstetricians practicing in rural Texas has grown by 27 percent,” the study claims. “Twenty-two rural Texas counties have added at least one obstetrician since 2003, including ten counties that previously had none. Post-reform, Texas has licensed 212 orthopedic surgeons, representing a 15 percent increase in the number of Texas orthopedists in the past six years.”

Study Shows Increase in Texas Doctors Due to Liability Reforms, *Southeast Texas Record*, October 9, 2012

The study also indicated that the number of high-risk specialists in Texas grew 18 percent faster than the state’s population from 2005 to 2011 and the ranks of pediatric sub-specialists, emergency care physicians, cardiologists, vascular surgeons and anesthesiologists also outpaced the state’s population growth.

More High-Risk Doctors are Flocking to Texas, *Houston Business Journal*, March 23, 2012

Since the passage of the reforms, there are 966 more high-risk specialists practicing in Harris County, and the ranks of those specialists are growing at twice the rate of population growth, said Jon Opelt, director of the Texas Alliance For Patient Access. This allows for more than 2 million more physician visits per year than were available before the medical liability reform, he said.

As common sense and Texas’s experience make clear, the MICRA cap has improved access to needed care for patients requiring higher-risk procedures. Were the cap to be raised, such patients would have much greater difficulty obtaining the care they need.

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

California's social safety net includes medical care that doctors and hospitals provide to individuals with little expectation that they will be paid for these services. An increase in the cap would have a negative effect on health care providers because they will find it difficult – and sometimes impossible – to shift the higher costs resulting from the increase to others. As a result, a higher cap would reduce services for those dependent on the state's social safety net.⁸⁴

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

Most hospitals choose to self-insure against medical liability claims, rather than purchase liability coverage from an insurance company.⁸⁵ Such hospitals often pay into a self-insurance trust that provides a source of payments for losses (claims) as they accrue. The hospitals' contributions are based on actuarial determinations of future payment requirements, which are based on historical and expected losses.

In California today, the levels of hospital reserves assume continuation of a \$250,000 cap on non-economic damages awards. If the cap is increased, hospitals that self-insure will find it necessary to set aside a larger percentage of their revenues as reserves for medical liability costs. For example, the University of California, which maintains reserve balances for its teaching hospitals estimates that raising the MICRA cap would cost between \$7.2 million (+14%) and \$10.8 million annually in increased payments and defense costs.⁸⁶

Both public and private hospitals provide uncompensated care to the uninsured. An increase in expenditures on medical liability awards would require these hospitals to cut back on other expenditures. This cut-back would reduce their ability to provide needed health care services to those Californians who are unable to pay for them.

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

The uninsured rely heavily on safety net providers for health care. In California, these providers include a network of clinics and public hospitals. County health facilities often fill the gaps in health care available to the uninsured. An increase in the MICRA cap would require counties to increase their budgets for defense costs, as

⁸⁴ See, for example, Lisel Blash, Carol Lee, and Elissa Maas, "Quality Improvement in Solo and Small Group Practice, Strengthening the Private Practice Safety-Net," CMA Foundation, September 24, 2008.

⁸⁵ GAO, "Medical Liability: Impact on Hospital and Physician Costs Extends Beyond Insurance," GAO/AIMD-95-169, September 1995. Many hospitals purchase stop-loss insurance policies that provide coverage for awards exceeding \$2 million.

⁸⁶ The University's response to an August 1, 2013 request from the Legislative Analyst's Office.

well as their reserves for medical liability claims.⁸⁷ As a result, their ability to provide health care to the near poor would be impaired.

⁸⁷ 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.

XIII. CONCLUSION

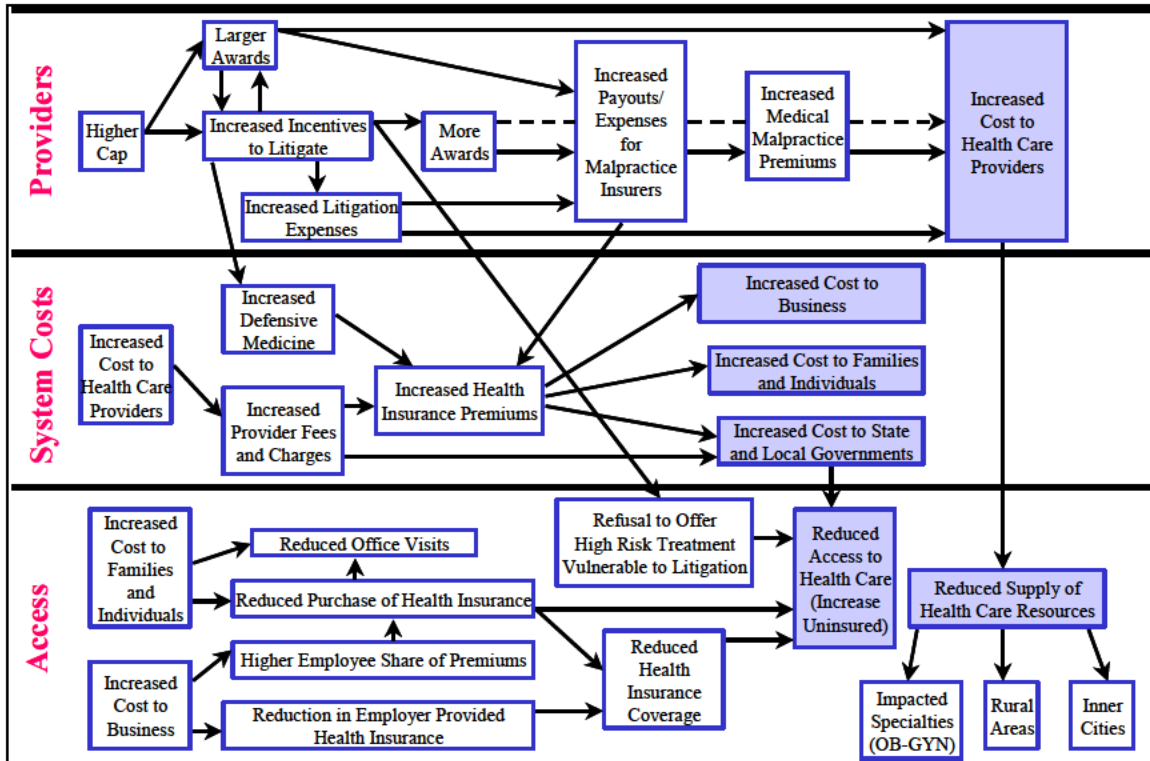
Well-established economic principles and a large body of empirical evidence indicate that increasing the cap on non-economic damages in medical liability cases would impose significant costs on California's health care system – costs that would be borne by California employees, consumers and taxpayers. We estimate that if the cap is raised to \$1 million or higher, these costs would total approximately \$9.9 billion annually, an amount equivalent to more than \$1,000 for a family of four.

Our analysis indicates that the likely effects of a higher cap would include: (1) an increase in the volume of medical liability-related litigation, since a higher cap would encourage more individuals with weak or 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; (3) an increase in loss payments and claim costs; and (4) an increase in costly and unnecessary medical procedures.

The resulting costs would flow through the health care system and eventually result in: (1) higher health care costs for Californians; (2) a reduction in available health care services; and (3) a reduction in the number of insured persons in California, increasing the financial burden on taxpayer-funded services. These consequences would be felt disproportionately by low-income and rural Californians.

Figure 10 summarizes the effects described in sections III-XII of this report. It illustrates how the different elements of the health care system are interrelated and interdependent. One can easily see how increased costs resulting from a higher MICRA cap will lead to increased costs throughout the system.

Figure 10:
Effects of Increasing the Cap on Non-Economic Damages



How a Change in the Cap on Non-Economic Damages Affected the Number of Claims Filed: Oregon's Experience

Year	Claims ^a
1991	150
1992	167
1993	141
1994	128
1995	105
1996	105
1997	114
1998	92
1999	99
2000	132
2001	116
2002	137
2003	142
2004	124
2005	106
2006	103
2007	119
2008	121
2009	102
2010	138
2011	109
2012	91
Average With Cap (1994 to 1998)	108.8
Average With No Cap (2000 to 2004)	130.2
Percentage Change ^b	20%

^a SOURCE: National Practitioners Data Bank.

^b In 1987, the Oregon legislature passed medical liability reforms that imposed a cap of \$500,000 on non-economic damages. In 1999, the Oregon Supreme Court removed the cap.

How a Change in the Cap on Non-Economic Damages Affected the Number of Claims Filed: Texas's Experience

Year	Claims ^a
1990	265
1991	1205
1992	1292
1993	1201
1994	1289
1995	1269
1996	1385
1997	1055
1998	1251
1999	1148
2000	1251
2001	1314
2002	1235
2003	1226
2004	1255
2005	1173
2006	758
2007	683
2008	579
2009	564
2010	564
2011	490
2012	464
2013	92
Average With No Cap (1999 to 2003)	1,235
Average With Cap (2005 to 2009)	751
Percentage Change ^b	39%

^a SOURCE: National Practitioners Data Bank.

^b In 2003, the Texas Legislature passed a bill enacting a \$250,000 cap on non-economic damages.

Average Claim Costs as a Percent of Medical Liability Insurance Premiums ^a
The Doctors Company

	2007	2008	2009	2010	2011	Total
Net Premiums Earned	\$519,234	\$578,988	\$573,699	\$834,580	\$812,982	\$3,319,483
Loss and Loss Adjustment Expenses	\$287,061	\$267,875	\$321,264	\$245,754	\$504,925	\$1,626,879
Average claim costs as a percent of premiums						49%

^a SOURCE: The Doctors Company Annual Reports for 2008 to 2011.

**Likely Impact on Claim Payments if the Cap is Increased
Based Upon Claims Experience in Texas**

Number of medical malpractice claims filed in CA (2012) ^a	1,188	[A]
Average payment per claim filed in CA (2012) ^a	\$171,538	[B]
Percent increase in medical malpractice claims filed in CA ^b	64%	[C]
Estimated increase in medical malpractice claims filed in CA	234	[D] = [A] x [C]
Additional medical malpractice claim costs	\$40,083,144	[E] = [B] * [D]
Estimated increase in "new" claim costs	64%	[F] = [E]/([A] x [B])
Estimated increase in "old" claim costs (per RAND) ^c	13%	[G]
Total increase in claim costs	77%	[H] = [F] + [G]
Claim costs as a percent of premiums ^d	49%	[I]
Estimated percentage increase in premiums	38%	[J] = [H] x [I]

^a SOURCE: National Practitioners Data Bank.

^b The average change in the number of claims filed in Texas between 1999 and 2003, when Texas did not have a non-economic damages cap, and 2005 to 2009, after Texas instituted a \$250,000 cap on non-economic damages. See Appendix A for details, which represent the percentage decrease as opposed to the percentage increase, which is shown in the table above (i.e., 39/61 = 64%)

^c SOURCE: Pace, N., Golinelli, D., and L. Zakaras, "Capping Non-Economic Awards in Medical Malpractice Trials - California Jury Verdicts under MICRA," RAND Institute for Civil Justice, 2004, p. 44.

^d SOURCE: The Doctors Company Annual Reports for 2008 to 2011. See Appendix B for details.

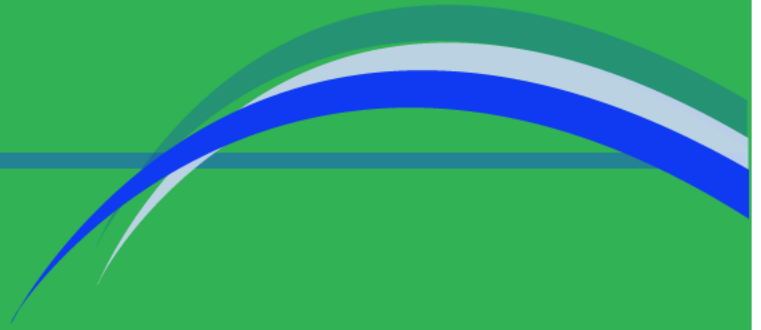
Risk Premiums Earned By Investors in Various Sectors of the Economy

Average Long-Horizon Equity Risk Premium, 1990 to 2011 ^a 4.20% [A]

Industry	[B] Beta ^b	[C] = [A] x [B] Risk Premium
Electric Utility (West)	0.58	2.44%
Bank	0.77	3.24%
Medical Liability Insurers		3.46%
Medical Services	0.84	3.52%
Insurance (Property/Casualty)	0.85	3.57%
Telecommunications Utility	0.92	3.85%
Securities Brokerage	1.07	4.48%
Information Services	1.25	5.24%
Investment Companies	1.27	5.33%
Railroads	1.32	5.53%
Financial Services (Diversified)	1.34	5.62%
Cable TV	1.40	5.89%
Insurance (Life)	1.44	6.05%
Total Market	1.17	4.90%

^a SOURCE: "2012 Ibbotson SBBI Risk Premia Over Time Report, Estimates for 1926-2011," Morningstar, p. 13.

^b SOURCE: Cost of Capital by Sector, as of January 2013, provided by Aswath Damodaran, Professor of Finance at the Stern School of Business at New York University (http://people.stern.nyu.edu/adamodar/New_Home_Page/datafile/wacc.htm).



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