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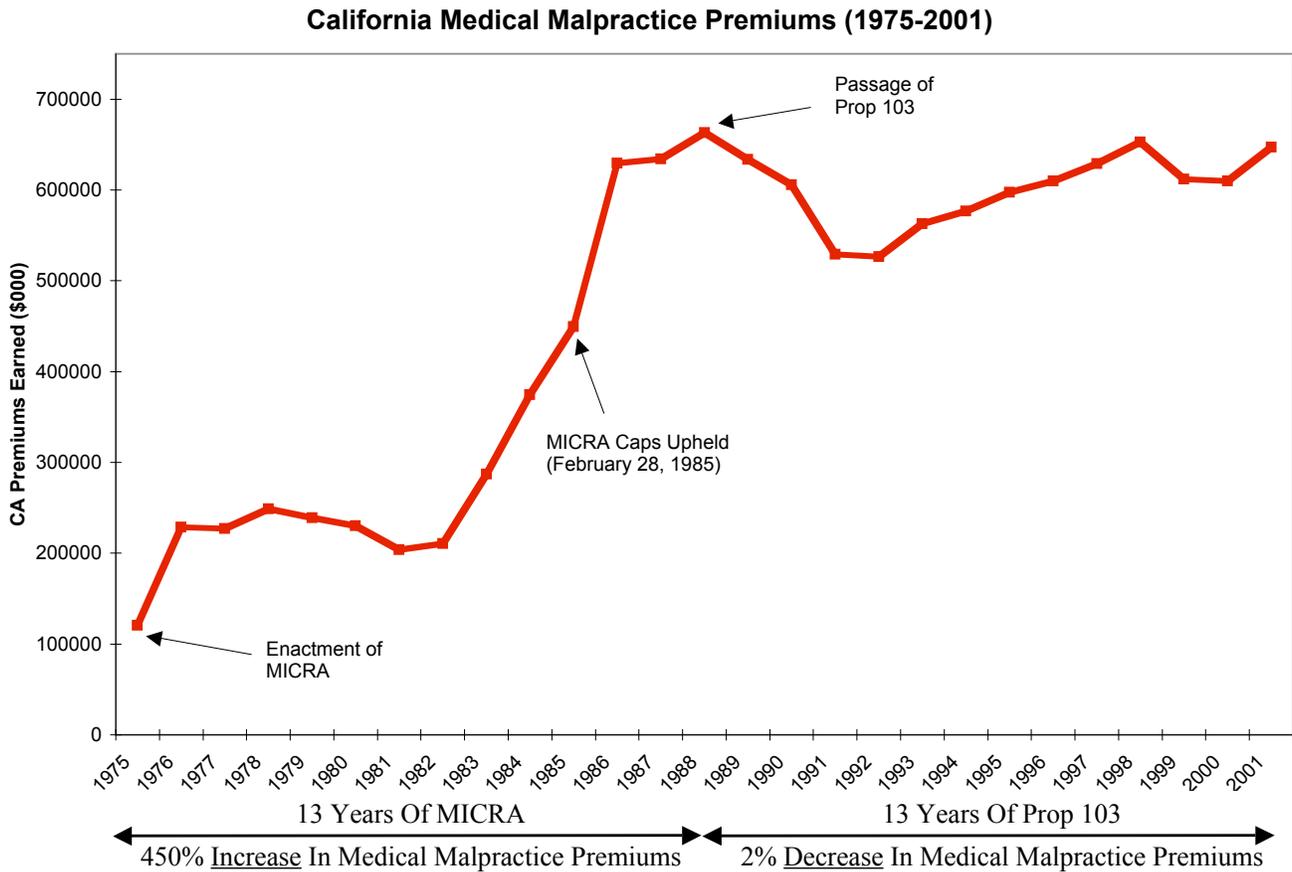
Testimony of
Douglas Heller, Executive Director
Foundation for Taxpayer and Consumer Rights

Before the Oklahoma Legislature
April 22, 2004

**Regulating Damages vs. Regulating Insurance Rates:
The California Experience**

The Foundation for Taxpayer and Consumer Rights is a non-profit, nonpartisan public interest organization based in California.

Regulating Damages vs. Regulating Insurance Rates: The California Experience¹



SOURCE: Foundation for Taxpayer and Consumer Rights, data from National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001, Direct Premium Earned 1975, A.M. Best, special data request

There is a California law that has lowered insurance premiums for doctors, hospitals and other health care providers. It is unique in the United States, and it is a model for the rest of the country. No, this is not referring to the infamous malpractice caps law known as MICRA, which was passed by the California legislature during the insurance crisis of the 1970s that, like the present crisis, threw our state's businesses and consumers into economic disarray.

¹ This report was prepared by Harvey Rosenfield, author of insurance reform Proposition 103 and founder of several non-profit citizen advocacy organizations, including the Foundation for Taxpayer and Consumer Rights, www.consumerwatchdog.org, where much of the information and sources noted in this briefing paper can be found. Contact info: 310-392-0522.

Rather, we refer to a law passed in 1988 when California voters, facing another insurance crisis of skyrocketing insurance premiums, and angry at the repeated failure of so-called “tort reform” to deliver promised savings, went to the ballot box and passed the nation’s most stringent reform of the insurance industry’s rates and practices – applicable to all lines of property-casualty insurance, including auto, homeowners, commercial as well as medical-malpractice insurance.

Proposition 103:

- **Mandated an immediate rollback of rates of at least 20%** -- rate relief to offset excessive rate increases by establishing a baseline for measuring appropriate rates. Prop. 103 required a roll back of at least 20% for all property and casualty insurance companies, *including* medical malpractice insurers.
- **Froze rates for one year.** Ultimately, in order to fully implement the law, rates remained frozen for four years pursuant to decisions by the state’s insurance commissioner.
- **Created a stringent disclosure and “prior approval” system of insurance regulation,** which requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Proposition 103 gives the California Insurance Commissioner the authority to place limits on an insurance company’s profits, expenses and projections of future losses (a critical area of abuse). Requiring insurers to open their books increases public confidence in the regulatory process, and gives consumers, regulators and lawmaker’s access to financial and claims data – data that is all but impossible to obtain in most states.
- Authorized consumers to **challenge insurance companies’** rates or practices in court or before the Department of Insurance.
- **Repealed anti-competitive laws** in order to stimulate competition and establish a free market for insurance. Proposition 103 repealed the industry’s exemption from state antitrust laws, and prohibited anti-competitive insurance industry “rating organizations” from sharing price and marketing data among companies, and from projecting “advisory,” or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents/brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. And it authorizes individuals, clubs and other associations to unite to negotiate lower cost group insurance policies.
- **Promoted full democratic accountability** to the public in the implementation of the initiative by making the Insurance Commissioner an elected position.

Insurers spent \$80 million in their unsuccessful effort to defeat Proposition 103, including the cost of sponsoring three competing ballot measures that would have enacted caps on damages and attorneys’ fees and various other restrictions on the right to go to court. Having seen how “tort reform” laws passed at the behest of the insurance industry in 1975 and 1986 had had no effect on premiums, the voters rejected the industry’s 1988 measures -- the damages cap

measures by enormous margins. California voters, having been burned before, were not about to be fooled again. Would that the same was true of policymakers in other states.

Proposition 103 worked. Insurance companies refunded over \$1.2 billion to policyholders, including \$135 million to doctors. In the closely studied area of auto insurance, California was the only state in the nation in which auto insurance premiums actually dropped between 1989 and 2001 – by a startling 22%, while rising 30% on average throughout the rest of the nation, according to NAIC data.² A 2001 study by the Consumer Federation of America concluded that the prior approval provision of Proposition 103 blocked over \$23 billion in rate increases for auto insurance alone through 2000. A copy of the text of Proposition 103 is attached as Appendix A. A detailed description of its provisions is available at the Foundation for Taxpayer and Consumer Rights web site, www.consumerwatchdog.org. A copy of a recent study by the Foundation for Taxpayer and Consumer Rights on the impact of Proposition 103 is attached as Appendix B. Copies of some California newspaper stories highlighting the savings generated by 103 are attached as Appendix C – take a look at them and think how happy your constituents would be to see similar savings on their auto and home insurance bills.

Today, the nation is in the midst of the same public policy debate that occurred in California during the insurance crisis of the 1970s and again during the crisis of the 1980s. Insurance companies claim that the key to lowering insurance premiums is limiting the right of consumers and victims of medical mayhem to go to court. Many inside and outside the medical profession have accepted the insurance industry's promises based on unsubstantiated arguments and manipulated data. California has had damage caps for thirty years. It has had stringent regulation of insurance rates and practices for fifteen years.

What Proposition 103 has done for California doctors has not received much attention, because the results contradict the insurance-medical industry's claims and threaten its unregulated status in other states. But the results are indisputable, particularly when compared to MICRA. California has tried it both ways, and I'm here today to present the results.

I. Medical Malpractice Insurance Premiums in California Rose 450% During the Thirteen Years after the Passage of MICRA

MICRA was enacted in 1975 at the height of the so-called "insurance crisis" of the 1970s, when the national economy was weak and insurers' investment returns were low. Insurance companies increased malpractice premiums at an unprecedented rate. In fact, years later, doctors successfully sued Travelers Insurance for overcharging doctors by increasing prices by 327% in 1976.³ At the time, however, striking doctors joined with insurance companies – as

² "Proposition 103's Impact On Auto Insurance Premiums In California," The Foundation for Taxpayer and Consumer Rights, November 10, 2003, using data from National Association of Insurance Commissioner, "State Average Expenditures & Premiums for Personal Automotive Insurance." Study available at <http://www.consumerwatchdog.org/insurance/rp/rp003828.pdf> California auto insurers also prospered during the same period. A calculation of annual return on net worth from 1990 to 1999 reveals that these insurers received a 16.0 percent return compared to only 10.9 percent received by auto insurers nationally. Dr. Robert Hunter, Director of Insurance, "Why Not The Best? The Most Effective Auto Insurance Regulation In The Nation," Consumer Federation of America, June 2001.

³ "Doctors Will Get Refunds on Insurance," by S.J. Diamond and Harry Nelson, *Los Angeles Times*, February 6, 1981.

they have today all over the United States – to promote changes in the tort laws as a solution to soaring malpractice premiums. However, after a modest decline in both California and US premiums reflecting improved insurance company investment returns in the late 1970s, by 1982 malpractice premiums were rising higher than ever.

During the insurance crisis of the mid-1980s, insurers once again blamed their conduct on extraordinary increases in lawsuits and claims. During that same period, despite MICRA, California malpractice premiums increased by an average of more than 20% annually. By 1988, thirteen years after the passage of MICRA, California medical malpractice premiums had reached an all-time high – **450% higher** than in 1975, when MICRA was enacted.

Insurance companies and the medical lobby argue that premiums continued to increase after MICRA’s passage because of court challenges to the law. However, the California Supreme Court upheld MICRA’s periodic payments rule in July of 1984, the collateral source offset in November 1984 and the damage cap in February of 1985. Despite that ruling, malpractice premiums in California increased more dramatically in 1986 than in any year after the passage of MICRA. Between 1985, when the cap was upheld, and 1988, malpractice premiums soared 47%, to the highest levels in California history.

Premium Increases During the 1980s Insurance Crisis

Year	California Premiums Earned	Percentage Change
1983	\$287,256,000	36.37%
1984	\$374,661,000	30.43%
1985	\$449,727,000	20.04%
1986	\$629,448,000	39.96%

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

II. Proposition 103 Reduced Medical Malpractice Insurance Premiums

A. Proposition 103 Imposed A Moratorium on Rate Increases in California

Proposition 103 required that all insurance rates were to be frozen for one year at the rolled-back rate level (at least 20% lower than the rates in effect one year before election day, November 8, 1988). After the passage of the initiative, the insurance commissioner declared a moratorium on all rate increases by medical malpractice insurance companies, as well as other insurers, pending resolution of the insurers’ legal challenges to Proposition 103 and the promulgation of regulations governing the rollback process.

The initiative itself, including the rollback requirement, was upheld by a unanimous California Supreme Court in May 1989. The insurance commissioner at the time continued the freeze while developing rollback regulations. Litigation delays blocked the rollback regulations, and when California’s first elected insurance commissioner took office, he announced final rollback regulations and re-authorized the rate freeze pending payment of the rollbacks by each insurer. Largely because of lawsuits brought by the insurers against the rollback regulations, the rate freeze remained in effect for many insurers through 1994.

B. Premiums Dropped by 20% After Proposition 103

Unlike MICRA, Proposition 103 explicitly required a rate rollback of up to 20%. Unlike the so-called “tort reform” bills sponsored by insurers and the medical lobby, which contain rollback provisions riddled with loopholes and qualifications that have allowed insurers to evade paying refunds, Proposition 103 established a bullet-proof requirement. The relevant portion of California Insurance Code Section 1861.01 reads:

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

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

Malpractice Premiums Dropped After Prop. 103

Year	Cal. MedMal Premiums (total)	% Change	Cumulative % Change
1988	\$663,155,000	--	--
1989	\$633,424,000	-4.5%	-4.5%
1990	\$605,762,000	-4.4%	-8.7%
1991	\$529,056,000	-12.7%	-20.2%

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

After **adjusting for inflation** (using the Consumer Price Index - All Urban Consumers), the premium drop was actually **30.7%**.

C. Proposition 103 Required Medical Malpractice Insurers to Refund \$135 Million

Lobbyists for the insurance industry have told lawmakers in some states that Proposition 103's rollback did not apply to medical malpractice insurers, or that no malpractice insurers paid the rollbacks required by Proposition 103. For example, Mr. Lawrence Smarr, representing the Physician Insurers Association of America, in written testimony provided to the U.S. House of Representatives Energy and Commerce Subcommittee on Oversight and Investigations, stated that: “medical liability insurers were not the intended target of Prop. 103, but were covered by the resulting regulations.” Further, Mr. Smarr said, “no monies were returned to policyholders as a result of Prop. 103.”⁴

These statements, and similar ones made by various insurance and medial lobby officials in a number of states, are **false**. Medical malpractice insurers were among the first insurance companies in California to comply with Proposition 103's mandatory rate rollback. Three of the state's largest malpractice insurers – Norcal Mutual, SCPIE and The Doctors Company –

⁴ Testimony of Lawrence E. Smarr, President, Physician Insurers Association of America, Before the United States House of Representatives Committee on Energy and Commerce Subcommittee on Oversight and Investigations, regarding: The Medical Liability Insurance Crisis: A Review of the Situation in Pennsylvania. February 10, 2003, p. 28.

refunded \$69.1 million directly to doctors by 1992. By 1995, insurers providing medical malpractice coverage had issued more than \$135 million in refunds to policyholders. According to a February 18, 1992, California Department of Insurance news release:

The Doctors' Company follows two other medical malpractice insurance groups and the Automobile Club of Southern California in agreeing to voluntarily comply with the rollback provisions of Proposition 103. The agreement calls for the return of \$18.5 million to the company's 9,500 California physician members, a 19.24% rebate...

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

Proposition 103 Mandated Refunds Paid by Major Malpractice Insurers

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

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

It should be noted that under Proposition 103, each insurer was given the opportunity to demonstrate, in an administrative hearing, that its rates were not excessive and hence it could not afford to pay the 20% rollback.

That the voters could order insurance companies to pay a rate rollback -- and that an examination of these medical malpractice insurers' books evidenced so much waste, inefficiency and profiteering that they were ordered to make massive refunds -- is apparently such a *frightening precedent to the insurers and the medical lobby* that they are desperate to deny that the refunds ever took place.

Indeed, forced to admit that Proposition 103 applied to medical malpractice insurers and that these insurers did in fact issue \$135 million in refunds to doctors, Mr. Smarr and representatives of some of the other insurers that were forced to make the refunds subsequently insisted that these insurers were only paying "dividends" that they would have paid anyhow. These assertions are contradicted by the legal settlement orders signed by the insurers themselves, in which it is expressly stated that the refunds were made pursuant to the Prop. 103 rollback requirement; that the refunds were made for the year in which the rollbacks

were required, 1988-1989, and included interest until the date the orders were signed – several years later; and finally that the insurers were ordered to report the refunds as rollbacks required by 103, and for accounting purposes, were allowed by the Insurance Commissioner to treat the rollbacks as a “return of premium” or “dividends.” Attached as Appendix D are examples of the official rollback settlement documents.

In addition to the refunds, after the passage of Proposition 103 malpractice insurers also dramatically increased their dividend payments to doctor-policyholders. This reflects the imposition of 103’s stringent regulatory limits on insurer rates and expenses. In the six years prior to Proposition 103, California’s major medical malpractice insurers averaged dividend payments of 8.7% annually. For the six years following Prop 103 dividend payments averaged 25.1%. Dividend payments to doctors increased after regulation even as total premiums paid by doctors decreased, indicating that doctors actually saved more than the 20% mandated by Proposition 103.

Average Annual Dividends Paid By CA Medical Malpractice Insurers

	1983-1988	1989-1994
Norcal Mutual	12.9%	31.2%
Doctors Company	2.1%	12.6%
SCPIE	10.6%	14.3%
MIEC	9.4%	42.4%

Source: Best’s Insurance Reports, 1987-1994 Editions

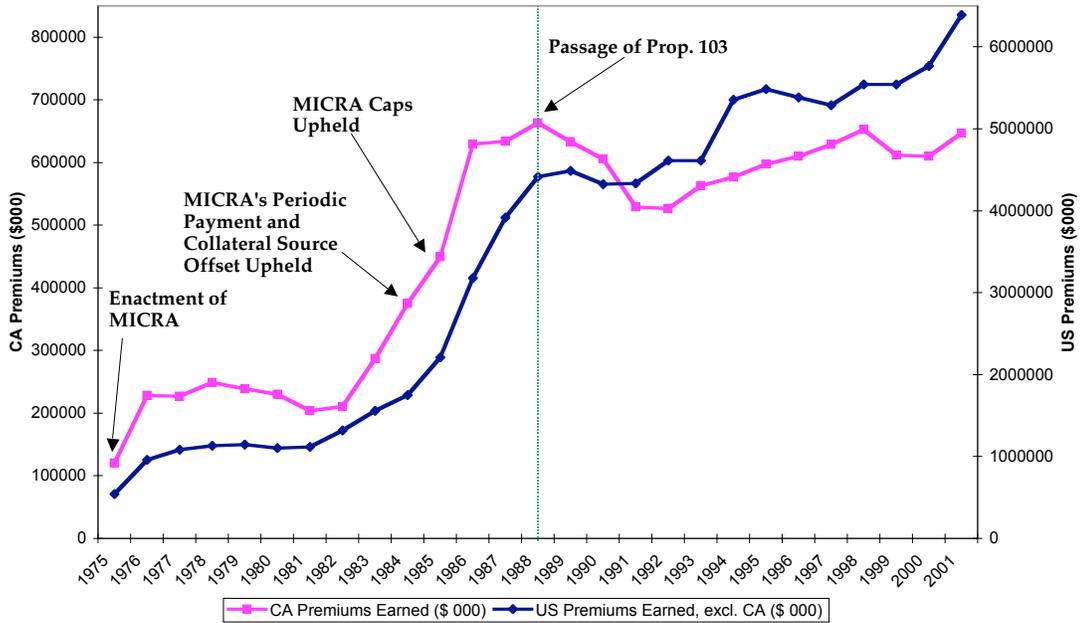
III. Comparing MICRA v. Proposition 103

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

California doctors’ premiums generally tracked premiums countrywide between 1975 and 1988, following the recognized boom-bust “insurance cycle” that has coincided with each insurance “crisis” in this country, including the present one.

But malpractice premiums fell sharply in California immediately after passage of Proposition 103, as the chart below illustrates by comparing premium growth in California and nationwide. Moreover, they continued to drop in ensuing years, bucking the national trends, before beginning to increase in 1993, rising in a stable manner while national rates continued to fluctuate.

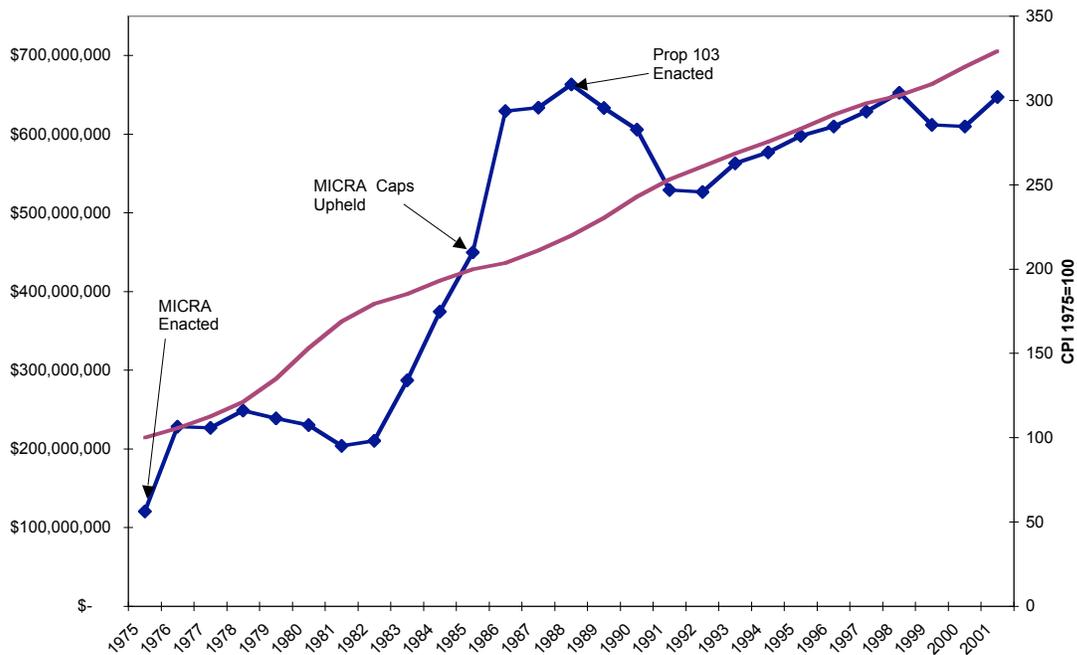
Medical Malpractice Premiums: CA v. US (1975-2001)



SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001, Direct Premium Earned 1975, A.M. Best, special data request

The chart below compares the growth rate in medical malpractice premiums to inflation. In the first thirteen years after the enactment of MICRA, California doctors' premiums rose by 450%, much faster, overall, than the national rate of inflation. After California voters enacted insurance reform Proposition 103 in 1988, medical malpractice rates first fell dramatically and then generally followed the rate of inflation or declined further.

California Medical Malpractice Insurance Premiums vs. Inflation



The data also demonstrate that Proposition 103's "prior approval" system, under which the commissioner may, at any time, invalidate an insurers' rate if it is too high *or too low*, has ameliorated some of the premium instability induced by the "insurance cycle." The price chaos of the 1970s and 1980s was replaced with a steady reduction of rates and then continued relative price stability for California health care providers in the 1990s, even through the current "insurance crisis" that has rampaged across the nation since 2001.

Annual Change in California Medical Malpractice Premiums

MICRA Period	Premium Chaos	Proposition 103 Period	Price Stability
1975-1976	+89.35%	1988-1989	- 4.48%
1976-1977	-0.60%	1989-1990	- 4.37%
1977-1978	+9.53%	1990-1991	-12.66%
1978-1979	-3.94%	1991-1992	- 0.48%
1979-1980	-3.64%	1992-1993	+6.93%
1980-1981	-11.47%	1993-1994	+2.45%
1981-1982	+3.35%	1994-1995	+3.62%
1982-1983	+36.37%	1995-1996	+2.07%
1983-1984	+30.43%	1996-1997	+3.09%
1984-1985	+20.04%	1997-1998	+3.78%
1985-1986	+39.96%	1998-1999	- 6.25%
1986-1987	+0.71%	1999-2000	- 0.34%
1987-1988	+4.61%	2000-2001	+6.15%

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

California's Strict Regulation of Malpractice Rates Has Blocked over \$35 Million in Rate Increases During the Last Year Alone

Like all property-casualty insurers doing business in California, medical malpractice insurers are subject to Proposition 103's "prior approval" regulatory system, which requires medical malpractice insurers to justify rate increases or decreases to the Department of Insurance. Such rate change applications may be subjected to intensive regulatory review and public hearings if the insurance commissioner so chooses, or upon a request by members of the public. The Commissioner must approve of any proposed rate changes before they take effect. Finally, as previously noted, the Commissioner may, at any time, invalidate an insurers' rate if it is too high *or too low*.

As elsewhere, malpractice insurers in California began boosting premiums in 2000. However, no California medical provider or organization has ever sought to avail itself of Proposition 103's regulatory protections – virtually all doctors are unaware of the opportunity, and the California Medical Association has never challenged a rate increase for its members. Last year, the Foundation for Taxpayer and Consumer Rights became aware that several of the largest malpractice insurers were planning enormous increases for malpractice coverage. The Foundation decided to investigate these increases, and subsequently filed administrative challenges to proposed increases requested by companies insuring over 40% of the state's doctors.

- In 2002, the state's second largest medical malpractice insurer, SCPIE Indemnity, requested permission to raise its 2003 rates by 15.6% -- an \$18 million increase for its 9,000 physician

policyholders on top of the 22.7% increase in the company's rates over the previous three years. The Foundation challenged the increase. Its actuary calculated that SCPIE should be ordered to *lower* physicians' rates by more than six percent, rather than raise rates as the company proposed. After a lengthy hearing process, the Insurance Commissioner ordered the increase be reduced by 36% to 9.9%, saving doctors \$23 million. SCPIE subsequently requested an 8.9% rate increase for 2004. However, when FTCCR challenged that request, the company withdrew it – another \$11 million in savings for SCPIE's policyholders.

- In 2003, the Foundation challenged Norcal Insurance Mutual Company's proposed 9.9% medical malpractice insurance rate hike. The ensuing scrutiny by California Department of Insurance regulators led the state's largest malpractice insurance company to slash its rate request by 70%, resulting in \$11.6 million in savings to Norcal-insured doctors.
- In 2004 Medical Protective Co. requested a 29.2% increase in the medical malpractice premiums the firm charges its doctors. FTCCR has recently challenged that proposal as excessive. The hearing is pending.

A key benefit of the regulatory system imposed by Proposition 103 is that it can provide the public and policymakers with data upon which to independently assess the often unsubstantiated arguments made by insurers and medical lobbying groups regarding claims payments, lawsuits and carriers' financial conditions. Indeed, during the SCPIE rate challenge, an Administrative Law Judge asked SCPIE to address "any impact the statutory provisions of the Medical Injury Compensation Reform Act of 1975 (MICRA) have on the magnitude of risk covered by medical malpractice insurance in California." In response, the company asserted that California's strict malpractice caps law did **not** hold down insurance rates. In written testimony, SCPIE's actuary and Assistant Vice President James Robertson stated:

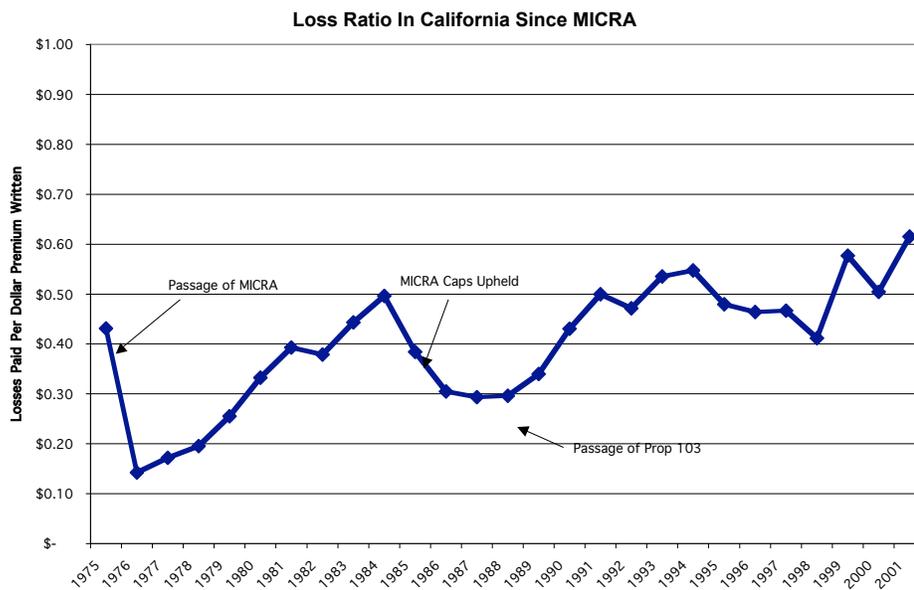
"While MICRA was the legislature's attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California."

But SCPIE was telling a different story publicly. Soon after the company filed that testimony with the California Department of Insurance, SCPIE's CEO told *Time Magazine* that the company had pulled out of states that lacked legal restrictions such as MICRA. (June 1, 2003 issue). Mr. Donald Zuk said: "I won't go into Texas, Florida or any of the states I pulled back from until there's some semblance of tort reform." Thus, SCPIE tells lawmakers that damage caps are necessary, while it tells regulators in California that its caps do not work to lower insurance premiums.

Insurance Company Expenses Soared Under MICRA

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

In fact, between the enactment of MICRA in 1975 and the 1988 passage of Proposition 103, which disallows excessive rates (and thereby forces loss ratios towards more appropriate levels), California insurers never paid out in claims more than half of the amount of premiums they wrote. Between 1976 and 1988, the average percentage of each premium dollar paid out in the form of compensation to malpractice victims – expressed as a “loss ratio” – was 31.4%. The balance – sixty-eight cents of every premium dollar – paid for other insurer costs, primarily profits, insurance company lawyers and overhead. That is, more than sixty-eight cents of every premium dollar paid by doctors was used for purposes other than compensating victims. Insurers had promised doctors lower premiums, but instead of reducing premiums commensurate with the lower claims payouts associated with malpractice caps, insurers simply captured higher profits and became more wasteful.

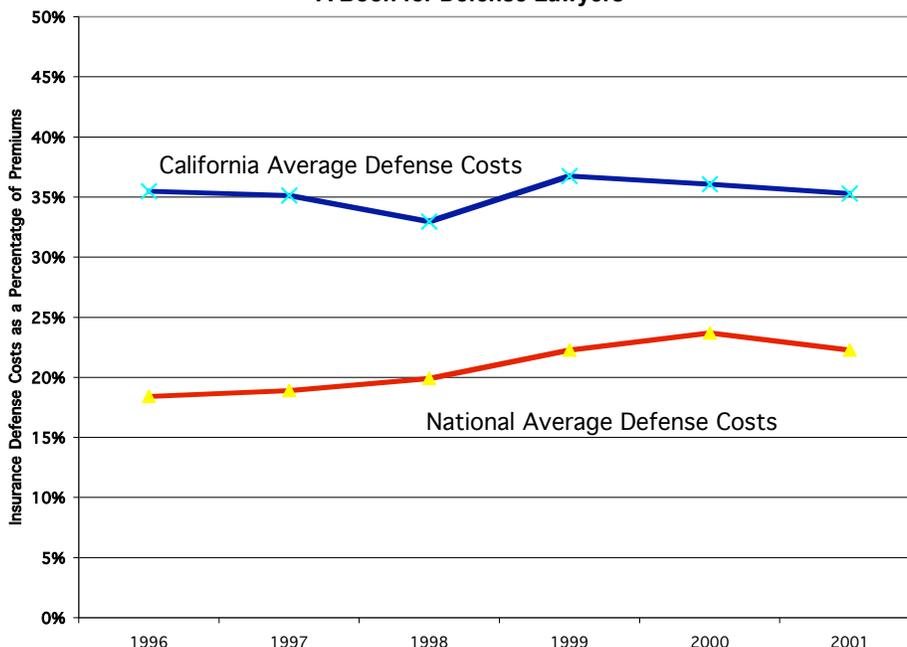


Source: A.M. Best and Co. special data compilation for Americans for Insurance Reform, reporting data for as many years as separately available.

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

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

**Malpractice Caps:
A Boon for Defense Lawyers**



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

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

Malpractice Defense Expenditures (1992-1995)

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

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

The insurance industry and the medical lobby often argue for limits on victims' attorneys' fees under the guise of returning more money to the victims of malpractice. However, in some years, insurers have spent a greater proportion of malpractice premiums on their own lawyers and defense costs in California, with liability limits in place, than on compensating patients. In other states, victims receive more of the premium dollar, while the insurers' own legal expenses are less.

What explains this behavior in California? Because the rigid caps make it more difficult for victims to obtain representation and prosecute a case, and because such caps limit insurance companies' exposure, insurers have an incentive to withhold claims payments as a negotiating tactic, forcing plaintiffs and their attorneys to spend inordinate resources to recover losses. This "scorched earth" litigation conduct discourages cases and forces patients to accept reduced compensation. Additionally, insurance companies owned by physicians have an incentive to fight harder to protect physicians' from having to admit liability even if liability is clear.

Although, under the strictures of MICRA, insurers will continue to pay limited claim settlements in California, sustained and increasingly rigorous regulation will continue to improve insurers' loss ratio over time, as noted below.

IV. Tort "Reform" Does Not Lower Premiums

There should be little surprise concerning California's experience with MICRA. After the fusillade of restrictions on the rights of malpractice victims in the 1980s took effect, insurance companies did not cut their malpractice premiums accordingly, as numerous studies have since verified. Yet the lesson of the last insurance crisis has been ignored by lawmakers in state after state.

Legislation enacted in Florida in the spring of 1986 at the behest of a coalition of insurance companies, medical lobbies and corporations contained dramatic restrictions on victims' rights. But it also required insurers to reduce their insurance rates concomitantly, unless they could demonstrate to state insurance regulators that the limitations on consumers' rights would not reduce their costs. Six months after the law was enacted, two of the nation's largest insurance companies told the Florida Insurance Department that limiting compensation to injury victims would not reduce insurance rates. St. Paul Fire and Marine Insurance Company, then the nation's largest medical malpractice insurer, and Aetna Casualty & Surety Co., provided an extensive "actuarial analysis" of five specific limitations on victim's rights that the insurance industry had promised would reduce premiums. Overall, the Aetna report concluded that one provision of the law would reduce rates by a maximum of 4/10 of 1 percent, while all of the other tort restrictions would have "no impact" on rates.⁵ In fact, Aetna asked for a 17 percent rate *increase* based on its analysis of the impact of the law. The St. Paul study concluded that the restrictions "will produce little or no savings to the tort system as it pertains to medical malpractice."⁶ St. Paul stated:

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

⁵ Letter from Thomas L. Rudd, Superintendent of Insurance Department Affairs, Commercial Lines, Aetna Casualty and Surety Company, to Florida Insurance Commissioner Bill Gunter and Charlie Gray, Chief of Bureau of Policy and Contract Review for the Florida Department of Insurance, August 8, 1986, enclosing "Bodily Injury Claim Cost Impact of Florida Tort Law," Aetna Casualty and Surety Company.

⁶ Addendum of St. Paul Fire and Marine Insurance Company," undated 1986 filing before the Office of the Insurance Commissioner of Florida.

In April, 1987, the insurance industry's rate-making agency, the Insurance Services Office (ISO), released the results of a study intended to respond to repeated demands from policymakers and legislators across the country that the industry provide empirical data to support its claims that changes in the tort law system would alleviate the nation's insurance crisis. The study examined the responses of 1262 insurance adjusters from nine property-casualty insurance companies and two independent adjusting firms located in 24 states. The adjusters were asked to determine the impact of actual restrictions in the tort laws of 15 of the states on six hypothetical injury cases. In addition, they were asked to judge the impact of similar proposals that did not become law in the remaining nine states. Much to the chagrin of the insurance industry, the study failed to support years of insurance industry propaganda. Instead, it disclaimed any impact upon rates. One insurance industry official was quoted as saying, "Some state legislators are going to be shaking their heads after hearing us tell them for months how important tort reform is, and now we come out with a study that says the legislation they passed was meaningless."⁷

Indeed, in the midst of the "crisis," the federal government's watchdog agency, the U.S. General Accounting Office, published a study of six states that had enacted many different forms of tort law restrictions during the "crisis" of the mid-1970s, including caps on compensation. The GAO report showed that the price of medical malpractice liability insurance in California had increased dramatically since the passage of MICRA. In fact, "premiums for physicians increased from 16 to 337 percent in southern California ... between 1980 and 1986."⁸ The GAO study concluded:

While it is not possible to assess the extent to which the act [MICRA] has had an impact on the state's malpractice situation, our analysis of key indicators indicated that the problem is continuing to worsen in California.⁹

According to the GAO, four states (Arkansas, Florida, New York and North Carolina) reported that the restrictions had had "little effect" on insurance premiums.¹⁰ So-called "tort reform" does not lower insurance premiums.¹¹

When MICRA failed to deliver the promised premium reductions in California in the late 1970s, physicians participating in the Southern California Physicians Council (SOCAP) sought recourse by filing a lawsuit (on a contingency fee basis) against their malpractice carrier, Travelers Insurance Co., for what the physicians described as a "rip-off." Travelers ultimately agreed to pay over \$50 million, including refunding excessive projections of future losses -- roughly 18% of each physician's premiums for 1976-1978. As the President of the Los Angeles

⁷ Robert Finlayson, "Insurers Fear Reform Foes to Capitalize on ISO Study," *Business Insurance*, May 18, 1987, p. 2.

⁸ U.S. General Accounting Office, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms* (Washington, D.C.: U.S. Government Printing Office, 1986), p. 25.

⁹ *Ibid.*, p. 26

¹⁰ *Ibid.*, pp. 2-3.

¹¹ In 1999, FTCR studied auto insurance premium changes since 1989 among states that did not allow third party accident victims to sue insurers for bad faith, which insurers argue is key to lower auto insurance rates. Twenty-four of the 26 states with restrictions on such lawsuits faced 25% rate increases or more over the 7 year period studied. States with restrictions averaged larger rate increases than states with no legal restrictions on bad faith suits. Not only is California, which passed Proposition 103 in 1988, the only state, with tort limits that saw a reduction in that period, it is the only state to have had reduced premiums in the nation as a whole between 1989 and 1996.

County Medical Association put it: "This proves that we were right during the crisis; premium increases of 486% or even 327% were unjustified."¹²

No Rate Reductions from Recent Tort Law Changes in Other States

Two years into the latest insurance crisis, and after promising rate relief in exchange for tort law changes, once again insurers and the medical lobby are reneging on their promises. Now that state legislatures have passed caps and other restrictions on access to the courts and compensation of victims of torts, the industry is refusing to reduce premiums. A few examples:

Washington: "The cap [on non-economic damages of \$250,000) will not lower premiums." – Cliff Webster, Washington State Medical Association, Testimony to House Judiciary Committee, February 21, 2003.

Florida: "No responsible insurer can cut its rates after a [malpractice tort] bill passes." – Bob White, President, First Professional Insurance Company, quoted in Palm Beach, Florida, Post, January 29, 2003.

Texas: "Awards Cap Malpractice: Physicians may or may not see decrease in premiums," Amarillo Globe News, October 12, 2003. "Insurers won't say when rates will drop," Galveston Daily News, September 28, 2003. "Proposition 12 aftermath: doctors won't return yet," Corpus Christi Caller-Times, September 16, 2003.

Insurance Industry Profits Up 320%

While the insurers plead poverty, the industry's profits have skyrocketed. The property-casualty insurance industry registered a 320% increase in net income for the first nine months of 2003 as compared to 2002, according to a recent study by the Insurance Services Office (ISO) and the National Association of Independent Insurers. The industry recorded a 10.1% increase in premiums during the period, the second largest increase in premiums during any nine-month period **since the last insurance crisis in 1987.**

V. Proposition 103 Reduces Insurance Rates Because the "Crisis" Is the Creation of the Insurance Industry, Not Litigation

The present insurance "crisis" – apparent in homeowners, auto, commercial liability as well as medical and other malpractice lines -- constitutes the apogee of a financial cycle to which the insurance industry is subject:

Insurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely under price their policies and insure very poor risks just to get premium dollars to invest. This

¹² Edward Zalta, "Finally, Travelers Refunds SOCAP Policyholders More than \$18 Million in Premium Overpayments," LACMA Physician, February 23, 1981, pp.26-29. Article attached.

is known as the “soft” insurance market. But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a “hard” insurance market usually degenerating into a “liability insurance crisis.” A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. Again, in 2002, the country is experiencing a “hard market,” this time impacting property as well as liability coverages with some lines of insurance seeing rates going up 100% or more.¹³

Fitch, a Wall Street rating firm, recently began a discussion of the current “crisis” by harkening back to the last one:

We need to look back at the hard market of the mid-1980s.... The last major hard market turn was in the mid- 1980s, and was inspired greatly by a sharp drop in interest rates. In years prior to the mid-1980s, cash flow underwriting was prevalent in which a significant amount of naive capital was attracted to the property / casualty industry on the lure of making strong investment returns on the premium “float” between the time premiums were collected and claims were paid. Naturally, much of the naive capacity was directed at long-tail casualty and liability lines at both the primary and reinsurance levels in order to maximize the float. In the early 1980s, nominal interest rates were running in the mid-teens. When interest rates dropped off and significant reserve deficiencies were simultaneously detected, many insurers suffered large losses to both earnings and capital. The result was a sharp turn in the market, especially in long-tail lines, and the emergence a so-called “liability insurance crisis.” The liability insurance crisis included a sharp drop in availability of coverages, and huge price increases (in many cases several-fold).¹⁴

The country is presently suffering through the third insurance cycle in as many decades – this one caused by declining returns, particularly in the equity markets, and the collapse of interest rates to historical lows.

Exacerbating the insurers’ financial problems are their misguided investments in corrupt and failed companies during the boom years of the 1990s. Attached as Appendix F is a study published by the Foundation for Taxpayer and Consumer Rights that shows that when the stock market bandwagon came to a screeching halt during the corporate crime wave of 2001-2002, the insurers’ foray into the market caught up with them. Many of those insurance companies that were highly exposed to the “new economy” side of the market faced severe fraud related setbacks. The ten property and casualty insurance companies reviewed by the study lost a combined \$274.1 million in 2001-2002 as a result of investments in *The Big Five*

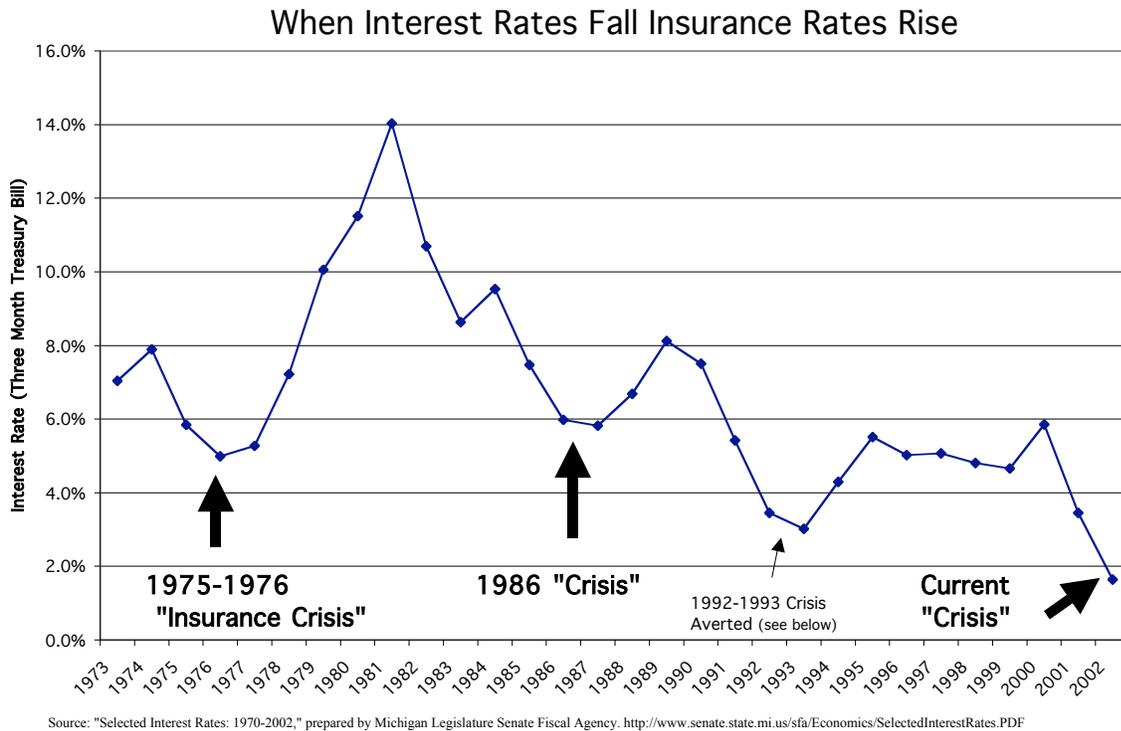
¹³ “Medical Malpractice Insurance: Stable Losses/Unstable Rates,” Americans for Insurance Reform, October 10, 2002.

¹⁴ Fitch Ratings, Inc., Insurance Special Report Review & Outlook: 2001/2002: U.S. Property/Casualty Insurance, January 17, 2002, p. 19-20.

Frauds – WorldCom, Enron, Adelphia, Global Crossing and Tyco.¹⁵ State Farm lost more than \$74 million as a result of that company’s investments in Enron and WorldCom alone.

The losses sustained by insurers when the fraudulent behavior at these corporations came to light flows very quickly into the premiums charged by insurers. In other words, insurance rates are rising because of Enron and WorldCom.

The combination of the bear market, the economic downturn, mismanaged investments in collapsed companies and low interest rates has dealt insurance companies’ investment income a quadruple whammy. Absent stringent regulation, insurers are free to recoup their investment losses through premium increases.



The Reserve Scam

To justify their sudden and enormous premium increases, insurers insist that their rates are simply reflecting similar enormous increases in the number and amount of claims they must pay. Typical is this statement: “malpractice insurers will pay out approximately \$1.40 for every premium dollar collected in 2001 and 2002.”¹⁶ By suggesting that individual insurers are

¹⁵ The companies reviewed include: Allstate Insurance Company, Auto Club of Northern California, Auto Club of Southern California, Farmers Insurance Exchange, Fireman’s Fund, Liberty Mutual Insurance Company, Mercury Casualty Company, Nationwide Mutual Insurance Company, State Farm Mutual Auto, United Services Automobile Association.

¹⁶ Statement Of The Physician Insurers Association Of America, Testimony of Richard E. Anderson, M.D., Chairman, The Doctors’ Company, before the Subcommittee on Health Committee on Energy and Commerce

“losing money” and are about to become insolvent because of excessive claims and litigation, insurers attempt to make their case for changes in tort laws that will ostensibly reduce claims.

However, the loss data insurers offer in support of their argument reflect a deeply flawed accounting practice unique to insurers that authorizes what amounts to accounting fraud. Insurers calculate their rates for a given year based on their “incurred losses” for that year. When insurers say they have an “incurred loss” of a certain amount in a given year, however, they do not mean that they have actually paid out that amount in that year. Rather, they mean that they estimate that they will ultimately pay out that amount on claims they predict they will receive that are covered by policies in effect in that year. In other words “incurred losses” represent projected losses. Thus, if an insurer reports in 2003 that its “incurred losses” for 2002 were \$100, the insurer has not paid out \$100 for 2002 claims. Rather, the insurer estimates that it will ultimately pay out – over a period of several years – \$100 for claims covered by policies in effect in 2002.

An insurer's “incurred losses” are, therefore, by definition, a guess. Statistical and mathematical methodologies have been developed which, using standard actuarial techniques, can be applied to make that guess an educated one. However, absent a regulatory formula that both mandates the use of such techniques and reviews insurers’ compliance (presently, only California law under Proposition 103 contains such a mandate), insurers have enormous discretion in determining incurred losses.

The independent Weiss ratings organization found that malpractice insurers reported a staggering 106.8% increase in the amount of malpractice claims between 2000 and 2001, an extraordinary single year leap in the amount insurers say they will have to pay out.¹⁷ Insurers claim these “losses” reflect a malpractice litigation crisis. In fact, they reflect only the projections made by self-serving insurance companies seeking to excuse their skyrocketing premiums. While booked as losses for tax and regulatory purposes, however, these losses never fully materialize, and the money held in reserve for them is later quietly moved into profits, or used to subsidize premium reductions during the trough of the insurance cycle. Here is how Dr. Robert Hunter, a former insurance commissioner described it:

“Paid losses” are a far more accurate reflection of actual insurer payouts than what insurance companies call “incurred losses.” Incurred losses are not actual payouts. They include payouts but also reserves for possible future claims – e.g., insurers’ estimates of claims that they do not even know about yet. While incurred losses do exhibit more of a cyclical pattern, observers know that this is because in hard markets, as we are currently experiencing, insurers will increase reserves as a way to justify price increases. In fact, the current insurance “crisis” rests significantly on a jump in loss reserves in 2001.

Historically, reserves have been later “released” to profits during the “softer” market years. For example, according to a June 24, 2002, *Wall Street Journal* front page

U.S. House of Representatives, regarding: “Harming Patient Access to Care: Implications of Excessive Litigation,” Wednesday July 17, 2002, p. 9.

¹⁷ Insurers also projected a nonsensical 76% increase in auto accident payouts during this period. “Property and Casualty Insurers Suffer \$9 Billion Loss in 2001; Terrorist Attacks and Corporate Bankruptcies Contribute To Record Claims of \$381 Billion,” Weiss Ratings, July 8, 2002, p. 1.
http://weissratings.com/News/Ins_General/20020708pc.htm.

investigative article, St. Paul, which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the 1980s, so it “released” \$1.1 billion in reserves, which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states. Christopher Oster and Rachel Zimmerman, “Insurers’ Missteps Helped Provoke Malpractice ‘Crisis,’” *Wall Street Journal*, June 24, 2002.¹⁸

A review of incurred loss data from the past fifteen years, since the beginning of the last insurance crisis in 1986, shows that the “incurred losses” that medical malpractice insurance companies initially report for policies in effect in each of the years examined were, on average, 33% higher than the amount they actually paid out on those policies. Moreover, the insurers’ reported losses were particularly inflated during the last “insurance crisis” in the late 1980’s. In 1989, for example, medical malpractice insurers’ loss estimates were overstated by 40%.

Why Proposition 103 Works

No sudden increase in claims or awards is responsible for the insurance crisis. Thus, so-called “tort reforms” are irrelevant. Proposition 103 has controlled premiums and stabilized the insurance marketplace in California because:

- Its controls on insurers’ rate of return, expenses and loss reserves – coupled with the possibility of a challenge to rates by the insurance commissioner or the public – restrain insurers from the imprudent gyrations that characterize the highs and lows of the insurance cycle.
- Regulation has ended the cost-plus pass-through mentality pervasive in the insurance industry. In a poorly regulated environment, the more insurers charge, the more they can invest. There is no incentive to control expenses, especially since the insurers’ exemption from the antitrust laws enables them to circulate expense data. Under Proposition 103, insurers have tightened their belts as predicted: cutting agent commissions, reducing expenses, fighting fraud, and promoting loss prevention.¹⁹

Indeed, the insurance industry’s fear of provoking more Proposition 103-style reforms may have protected the nation from a modest “crisis” in the early 1990s. As the U.S. economy entered a recession—accompanied by a drop in investment income to which the industry would normally respond with premium increases—industry officials warned each other to

¹⁸ “Medical Malpractice Insurance: Stable Losses/Unstable Rates,” Americans for Insurance Reform, October 10, 2002.

¹⁹ Two years after Proposition 103 passed, the Los Angeles District Attorney noted that, “until coming under pressure to lower rates under Proposition 103, [insurance] carriers simply settled claims and passed the cost to consumers in the form of higher premiums. ‘That has begun to change,’ he said. ‘Insurance companies are getting serious about fraud.’” Lois Timnick, *51 to Face Charges in Auto Insurance Fraud Roundup*, L.A. TIMES, Oct. 18, 1990, at B4. Heightened scrutiny of claims by insurers is at least partly responsible for the 48% reduction between 1989 and 1994 in lawsuits for personal injury auto accidents filed in California Superior Courts. See JUDICIAL COUNCIL OF CAL., 1996 ANNUAL REPORT 109.

avoid the destabilizing premium gyrations of the mid-1980s. As one insurance executive explained, “The last soft market was driven purely by the need for cash to invest. . . . We all know we can’t do the dumb things we did last time. . . . We will not see a repeat of 1985-86.”²⁰ Another executive has observed: “I don’t think you’ll see a 1985-1986 repeat. There are too many regulatory restraints put in place to preclude it. A lot of regulations addressed our own stupidity. We made the bed and now we have to lie in it.”²¹ And a senior official with the Insurance Services Office, an industry trade group, warned:

As an industry, nothing will disrupt our relations with customers faster—not to mention regulators and public-policy makers—than an abrupt recovery from our current underwriting down cycle. . . . Remember the fallout from the last recovery: California’s Proposition 103 and other price-suppression laws, threats to the industry on the antitrust front, and virulent consumer hostility.²²

Today, insurers have once again become emboldened. Medical malpractice insurers around the country are raising rates to compensate for the downturn in the economy. These increases are happening in many states regardless of whether or not a particular state limits the rights of victims to be fully compensated. Both Michigan and Missouri are known as medical malpractice “crisis states,” despite both having caps in statute.

Even California, the birthplace of malpractice caps, is facing steep rate hike proposals. The difference in California is that Proposition 103 allows the public to challenge insurance company increases. With the law, the public can, and the insurance commissioner must, determine whether a rate proposal is too high or too low, if the basis for the rate hike is authentic or manufactured. The regulator can determine if the crisis is real or imagined.

VI. The Medical Lobby and the Campaign for MICRA

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

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

Last February 10, at a Congressional hearing in Langhorne on the medical malpractice insurance crisis, I asked American Medical Association President Donald Palmisano, an advocate of MICRA-style legislation, if he had ever looked into Proposition 103 or its results. Before being hustled away by an aide, Mr. Palmisano muttered that someone at the AMA had investigated “California” and had concluded that 103 wasn’t relevant to the debate. Organized medicine’s role in the insurance industry’s campaign against negligent victims deserves far more scrutiny than it has received.

²⁰ Mark A. Hofmann & Christine Woolsey, *Marketplace Not What It Used To Be: Insurers*, BUS. INS., July 13, 1992, at 55.

²¹ *Id.*, at 1, 14.

²² *Not Like 1985’s: ISO Official Predicts Next Upturn in Cycle to be Gradual*, INS. WK., Oct. 19, 1992, at 15.

The physicians promoting MICRA complain that they cannot afford the increasing cost of malpractice coverage. This is hard to fathom, since, according to *Medical Economics* magazine, medical malpractice insurance premiums account for between 1.2% of a doctor's gross receipts and 5.5% of receipts, depending upon the specialty. General surgeons, for example, have a relatively high average malpractice premium of \$21,641 annually, but that is only a small fraction of a surgeon's \$497,633 average collections for 2001. That same surgeon has, on average, a net income of more than \$257,000 per year, *after* accounting for expenses, such as rent, staff salaries and medical malpractice insurance. In other words, that doctor will make more in a year than many brutally injured patients will have access to for a lifetime of suffering under the proposed non-economic caps.²³

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

Doctors Are Leaving...California

Physicians around the country are angry about high rates, as were the Southern California physicians who in the 1970s eventually had to sue to get refunds. The highly visible threat that physicians will close their practices and move elsewhere absent passage of MICRA legislation has proved a potent political tool in state after state over the last two years. Apart from the practical difficulties of such a move, there remains the question of where they might go.

For, in California, where MICRA was pioneered nearly thirty years ago, physicians are apparently just as unhappy and are just as intent upon closing up shop and/or leaving the state, according to a study published by the California Medical Association (CMA) in 2001 -- before the current crisis -- which I found buried on CMA's website.

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

- 43% of surveyed physicians plan to leave medical practice in the next 3 years. Another 12% will reduce their time spent in patient care.
- Seventy-five percent of physicians have become less satisfied with medical practice in the past five years.
- More than 1/4 of physicians would no longer choose medicine as a career if starting over today, and more than 1/3 of those who would still choose medicine would not choose to practice in California.
- Low reimbursement, managed care hassles and government regulation are the greatest sources of dissatisfaction.
- The time physicians spend in patient care has declined by 7% in the last 5 years; 44% of

²³ "More Hours, More Patients, No Raise?" *Medical Economics*, November 22, 2002; "Expense Survey: What it costs to practice today," *Medical Economics*, December 9, 2002.

- physicians spend less time with patients than 5 years ago.
- 58% of physicians have experienced difficulty attracting other physicians to join a practice.
- More than 25% of physicians had difficulty in recruiting doctors in Los Angeles, Orange, Riverside, San Diego, Ventura, Marin, Del Norte, San Luis Obispo, Tehama and Shasta-Trinity counties.
- Primary care, neurology, orthopedic surgery and neurosurgery lead in specialty shortages.
- 2/3 of physicians are not advising their children to practice medicine.

The CMA study says:

Indicators of significant physician dissatisfaction with medical practice and physician flight from California are dramatic. There appear to be widespread problems recruiting new physicians. Low reimbursement and managed care hassles are taking their toll. Only a third of physicians would still choose to practice in California if they had to do it over today. (p.iii).

Hundreds of physicians throughout the state report their plans to quit practice in California. (p.ii).

These findings foretell a dark and startling picture concerning physician supply in California. They predict a future with many fewer physicians. Negative career, professional and economic pressures in the California health care system are having the ultimate impact causing physicians to leave medicine and creating barriers for others to practice in the state. (p.18).

Physicians in California overwhelmingly report dissatisfaction with the current practice of medicine, and a majority say they will express this dramatically in the next three years by quitting practice or otherwise cutting hours spent treating patients. The result will be fewer physicians, longer waits for care, less preventive medicine and higher costs to the health care system. Of the 55% of physicians who will reduce time spent treating patients: 78% will change professions, leave the state or retire early... Only a third of physicians (35%) would still choose to practice in California. (p.18).

The CMA study is a decisive refutation of the rosy picture painted by the AMA – and the CMA – of California under MICRA. Indeed, far from heaven on earth for physicians, California is apparently one of the less lucrative states in which to practice medicine in the nation. *Medical Economics* reports that doctors in the West, many of whom are in California, earn the lowest annual salary in almost every specialty and overall, with an average of \$212,810.²⁴

Placed in the current context, the CMA study raises the question of whether the dissatisfactions driving doctors to promote MICRA are based on personal financial considerations that have nothing to do with the legal system, tort law or damage claims. Perhaps sensitive to the perception that their campaign for tort “reform” is self-serving, the doctors organizing a series of strikes by New Jersey physicians last year issued an email to the strikers containing the following warning:

²⁴ “More Hours, More Patients, No Raise?” *Medical Economics*, November 22, 2002

"Do not talk about your falling income, rotten HMO's, your busy life, the cost of vacations and cars, your malpractice history. These are irrelevant!"²⁵

VII. MICRA: The Impact on Patients

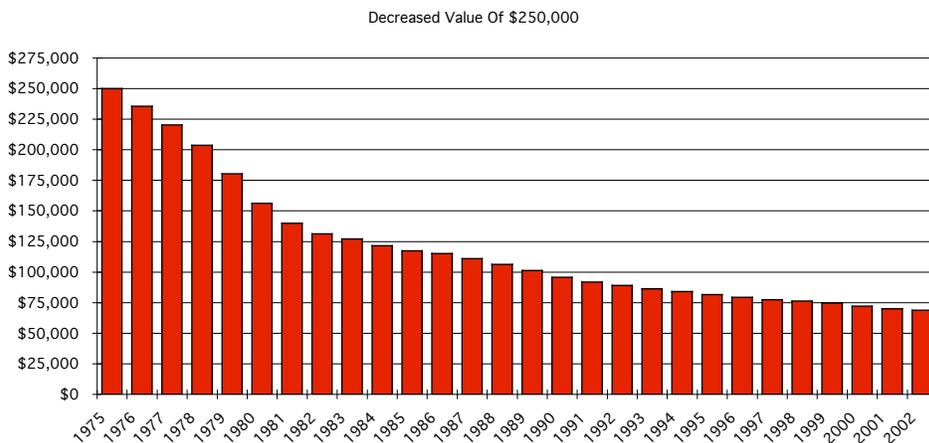
Ignored in the debate over how to lower insurance premiums for disgruntled doctors is the human impact of MICRA-style changes in state laws. In recent years, Californians have been confronted with MICRA's devastating effects upon patients as well as its failure to achieve its goal of lowering premiums. The California legislature has tried twice in the last four years to repeal MICRA's damage cap. Unfortunately, the legislative grip of the insurance industry has proven too strong.

MICRA's main provisions:

- Place a \$250,000 cap on the amount of compensation paid to malpractice victims for their "non-economic" injuries.
- Permit those found liable for malpractice to pay the compensation they owe victims on an installment plan basis.
- Establish a sliding scale for attorneys fees that discourages lawyers from accepting serious or complicated malpractice cases.
- Eliminate the "collateral source rule" that forces those found liable for malpractice to pay all the expenses incurred by the victim.

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

The MICRA cap on non-economic damages has no flexibility, either with respect to the egregiousness of the negligence or to account for inflation. As a result of the latter rigidity, the real value of non-economic compensation capped by MICRA has declined substantially over



time. In order to provide the same level of compensation in today's dollars, the \$250,000 cap would have to be approximately \$800,000. Put another way, the MICRA cap has decreased in

²⁵ The e-mails are available online at <http://www.consumerwatchdog.org/healthcare/rp/rp003150.pdf> and <http://www.consumerwatchdog.org/healthcare/rp/rp003151.pdf>.

value since 1975, when compared to the Consumer Price Index, to approximately \$70,000. Though health care costs – hospital charges, medical fees, *etc.* – have skyrocketed since 1975, compensation for non-economic damages has been frozen by the statute. It goes without saying that neither doctors nor insurers would accept a flat cap on their rates or fees – much less a twenty-nine year rollback in the value of their services. Yet that is exactly what has been imposed upon California patients.

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

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

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

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

California's cap system has reduced liability for egregious error to an acceptable cost of doing business, permitting systemic medical negligence to continue undeterred. There is no incentive to address systemic problems that maim and kill. Deterrence to wrongdoing is especially important for HMO patients. Arbitrarily applying the one-size-fits-all caps to systemic wrongdoing lets HMOs know there is a financial limit to how much they will pay no matter how egregious and irresponsible their conduct.

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

B. Periodic Payments Reward Convicted Wrongdoers At The Expense Of Malpractice Victims They Injure

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

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

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

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

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

Periodic payments put the burden on the victim to meet their basic needs. The periodic payment arrangement, once approved, is extraordinarily difficult to modify. If costs of the victim's medical care increases beyond their means, or a special expensive medical technology is made available which the victims requires, the injured patient must retain a lawyer to have the schedule modified.

Secret settlements that result from the periodic payment provision let dangerous doctors off cheap and shield their name from public record. In California, the periodic payment provision results in the settling of cases through secret agreements -- even after a verdict for the victim. The California Medical Board -- as a result of a lawsuit by the California Medical Association -- reports no information about negligent doctors who have settled cases to the public, denying consumers vital information to deter future incidents of medical malpractice.

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

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

As a result, only the most seriously injured victims with clear-cut cases to prove and substantial economic damages can ever find legal representation in California. In states with caps on attorney contingency fees for medical malpractice cases (and particularly in states such as California where a victim's pain and suffering compensation is also capped), victims of medical malpractice simply cannot find legal representation. It is not cost effective for attorneys to take the vast majority of cases. Says the President of Safe Medicine For Consumers, a California-based medical malpractice survivors group, "The vast majority of individuals who contact us are women, parents of children or senior citizens. Ninety percent of these individuals are unable to pursue meritorious medical malpractice cases because they can not find legal representation on a contingency basis and their savings have been wiped out."

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

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

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

Recognizing the harmful effects of MICRA, Robert C. Baker, the leading defense attorney for insurance companies and doctors in California and an expert on MICRA, told a congressional committee that, "As a result of caps on damages, as well as limitations on attorneys' fees, most of the exceedingly competent plaintiff's lawyers in California will simply not handle a medical malpractice case." Mr. Baker's testimony is attached as Appendix E.

D. MICRA's Collateral Source Offset Forces Taxpayers And Policy Holders To Pay For Wrongdoers Errors

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

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

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

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

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

CONCLUSION

Malpractice litigation is not responsible for the present “crisis,” and malpractice caps did not solve the California crisis of the 1970’s. Thirty years of experience in California shows that regulating insurance rates, not patients’ right to go to court, is the only way to lower insurance premiums.

By contrast, caps on damages and other onerous restrictions reflected upon the civil law rights of negligence victims do not lower premiums; they only enrich insurance companies, whose profits have soared during the current recent crisis.

Lost in the insurance and medical lobby’s greed-driven campaign for caps on damages and other pernicious proposals are the victims of medical negligence. The real crisis today is not the price of malpractice insurance, but the epidemic of medical mistakes and negligence, so the best way to reduce malpractice claims is to reduce the amount of medical malpractice in our country.