MICRA

A manufactured crisis and a solution that keeps on giving – to insurers

By Chuck Cordes

There is perhaps no piece of legislation more regularly lamented in the pages of any plaintiffs' bar magazine than the Medical Injury Compensation Reform Act (MICRA). With its $250,000 cap on non-economic damages, and its diminishing contingent fee scheme, both set in place in 1975 and never adjusted for inflation, it seems the medical malpractice attorney may, compliments of MICRA, eventually go the way of the Dodo. And yet any suggestion that MICRA be modified, even modestly, is met with howls of complaint and the inevitable prediction that the entire state will be flung into crisis just as it was in the dark days before MICRA, when — as the defender's of MICRA like to characterize it — the legislature, acting boldly to save medicine itself, brought to heel the looming menace of rising medical malpractice costs.

The history – because it matters

What about MICRA? How much hyperbole do you suppose occasioned its birth? And why do the events leading up to MICRA matter? Because its proponents falsely present MICRA as a thoroughly vetted and thought-out piece of legislation representing a legislative determination that malpractice plaintiffs were receiving unfair awards and their counsel, by extension, unfair fees. In reality, MICRA was a hasty gambit aimed at appeasing a sector of private industry that suddenly had the legislature by the short hairs. The so-called crisis and the legislature's purported realization of tort unfairness have entered the language of political mythology right alongside other cartoon narratives, e.g., "unfair government regulations," impinging on a "free market" that would otherwise work perfectly. MICRA is, however, simply another government regulation.

According to "Californians Allied For Patient Protection," an insurance-medical industry lobbying group dedicated to preventing MICRA reform, "prior to MICRA, out-of-control medical liability costs were forcing community clinics, health centers, doctors, and other health-care providers out of practice. MICRA stabilized liability costs." As evidence of the problem which prompted MICRA, CAPP lobbyists cite four newspaper articles from early 1975 describing rising malpractice insurance costs. Likewise, the California Medical Association cites the same quartet of newspaper excerpts, noting in its "history" of MICRA that "[i]n the mid-1970s, California physicians were embroiled in a malpractice insurance crisis. Driven by frivolous lawsuits and excessive jury awards, medical liability insurers levied massive insurance premium increases and canceled insurance policies for many physicians across the state."

MICRA might have been more accurately named the Malpractice Insurance Cost Reduction Act because it was enacted for the purpose of lowering malpractice insurance costs. At its heart was the assumption that suddenly spiking insurance costs were a legitimate and commensurate result of escalating malpractice jury awards. The crisis, as described in contemporaneous records, seems to have come on like a bolt out of the blue. One day malpractice insurance costs were reasonable and predictable and then suddenly, in the space of a few short weeks, insurers discovered they were going broke and needed to quadruple rates just to keep the lights on. The legislature, acting swiftly, saved the day. All very theatrical — and dubious.

In reality, years before MICRA's hasty enactment in 1975, the subject of medical malpractice was already well established as an issue of concern at the federal level. In January of 1973 the Department of Health Education and Welfare issued "The Report of the Secretary's Commission on Medical Malpractice." There were 21 commission members, nearly all of them drawn from medicine, insurance or the defense bar.

What did the commission say?

The commission's report was far from alarmist, offering little to excite today's opponents of tort recovery. The commission focused on various means to address medical malpractice, including ways to improve patient care to avoid claims in the first place; a fair amount of attention was given to the concept of arbitration and how it might be used to streamline the claims process. Significantly, the commission expressly affirmed the necessity of plaintiff access to court actions: "With rare exceptions, the legal system provides the only mechanism by which patients who have suffered injury as a result of medical treatment can obtain redress." The commission disputed the widely-held belief on the part of doctors that contingent fees encouraged the filing of meritless claims, finding instead that the cost and difficulty of succeeding with malpractice claims meant that meritless claims were few.

As to medical malpractice insurance rates, the commission noted a dramatic increase in the previous five years, but it did not correlate rate increases with malpractice injury awards. It merely opined

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that rate setting was difficult because of the "long-tail problem," the lengthy period of time between some acts of medical negligence and the resulting discovery of injury. The commission recommended that insurance companies set up an information clearing house to collect cost data to assist states in regulating rate increases. The commission also found that medical insurance was available to individual and group practitioners at a competitive price, but that insurance companies frequently provided insufficient notice of impending cancellation.

The commission made a number of findings and recommendations regarding plaintiff counsel fees. First, it found that hour for hour on a matter, plaintiff and defense counsel earned roughly the same amount; but the commission noted that plaintiff counsel often invest significant time into zero-recovery cases — on average 441 hours — making the choice of which cases to take especially important, and, by implication, leaving even meritorious claims unprosecuted. The commission recommended that contingent fees be sliding scale, along the lines of a rule adopted by the New Jersey Supreme Court. But the rationale for imposing the sliding scale was the opposite of what today's tort opponents would claim. The commission was concerned that the injured party be adequately compensated: "A patient who is permanently and severely injured requires a substantial financial return if he is to sustain himself adequately for the rest of his life." The commission found that a straight one-third recovery by counsel did not always leave the amount of funds needed. The sliding scale was not intended to deter plaintiff counsel, but instead to ensure the plaintiff's financial independence.

Notably absent from the commission's report and recommendations is any assertion that damage awards, whether for economic or non-economic damages, be capped. Indeed, such a limit would be counter to the commission's stated goal of just compensation and maximizing the funds available to an injured plaintiff.

At about the same time, the California legislature also turned its gaze to medical malpractice matters. The assembly's "Select Committee on Medical Malpractice" convened in May 1971, chaired by Henry Waxman. It took testimony from many of the same players involved in the HEW Commission Report. Its report, characterized as a "Preliminary Report," issued in June 1974. Citing the HEW Commission Report, the Select Committee also recommended adoption of a graduated contingent fee schedule; and like its federal predecessor, the Assembly Report contained no recommendation of a cap on damages.

The report did, however, focus more on malpractice insurance costs. The committee took considerable testimony from doctors, insurers, and counsel, both defense and plaintiff, pertaining to malpractice insurance costs. The report noted that group insurance rates had increased by 400% from 1968 to 1970. But it essentially threw up its hands regarding whether the increases were justified, stating that, "it is difficult to evaluate the reasonableness of malpractice insurance premiums. It would certainly involve an investigation now beyond the present resources of this Committee." The report failed to account for the ratio of dollars paid to close out malpractice claims and the amount of malpractice insurance premiums collected. Instead, it assumed that rates must be fair because of the supposed bargaining power of county medical societies and other doctor group representatives and of competition among insurance carriers. The Select Committee noted that the malpractice insurance market (as of June 1974) was "very competitive in California" but that "instability" might lead to coverage problems in the future.

In short, neither the 1973 HEW Report, nor the 1974 Select Committee Report, found "frivolous" malpractice litigation to be pervasive or even commonplace; neither report expressed a felt need to cap plaintiff recoveries or characterized awards as excessive or plaintiffs as undeserving; and the graduated contingent fee recommendation was aimed at getting more money into the pockets of injured parties, not deterring counsel from being able to prosecute an action in the first place. All in all, these government reports were hardly a mandate leading to MICRA.

But then "instability" arrived — probably even faster than Select Committee imagined possible. Within a few short months insurers rolled out their winter surprise, some mailing rate increase announcements of three to four hundred percent, and others notifying doctors (and the press) they would stop writing malpractice insurance policies altogether.

A manufactured crisis in California

In short order the "crisis" that CAPP and CMA lobbyists are now fond of citing to ensued. Physicians protested in the capital. Newspaper and television journalists across the state sounded in with panicked predictions of a looming medical crisis as doctors struggled to find insurance coverage vital to their business. The Assembly Select Committee convened on February 18, 1975, in Sacramento, and then again three days later in Los Angeles, to take public testimony. New committee chairman Howard Berman stated that, "We called these hearings in response to widespread public concern over the recent announcements by three insurers that they were no longer going to write medical malpractice insurance for doctors. Two insurers have already quit, leaving about 2,000 Southern California physicians scurrying for new coverage. In Northern California, almost 4,000 physicians will be without malpractice insurance as of May 1, unless they reportedly agree to a 384 percent increase in premiums. Even then, we are told that the Northern California insurer will not extend coverage beyond 1975."

Physician protests continued. The insurance companies now assured everyone that nothing short of an immediate legislative solution to "frivolous" litigation

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and "massive" jury awards could secure the future of medicine. Governor Jerry Brown convened an extraordinary session of the legislature on May 19, 1975 to deal expressly with the "crisis."

Legislative histories in California do not include records of floor debate where, in MICRA's case, the bulk of the action was. The law blogger and medical malpractice attorney Gerald Sterns was present for the debate. He has written that insurance industry lobbyists introduced the cap on non-economic, "pain and suffering" damages as the surest way to halt spiraling medical malpractice costs. But the legislature seems to have ignored the key question: Whether the sudden quadrupling of medical malpractice premiums was commensurate with increases in medical malpractice-related payouts. Figures cited on the record at the February 21, 1975, meeting of the Assembly Select Committee on Medical Malpractice suggest otherwise.

Several physicians testified to having received insurance bills in excess of $20,000 for 1975 coverage, and yet California Medical Association counsel Howard Hassard, also on the record, cited numbers amounting to an average of $1500 of malpractice claim payouts per physician. That's a delta large enough to lead the cynical mind to question whether the sudden spike in fees was not, at least in part, designed to manufacture the sort of crisis in which big legislative concessions might be obtained with minimal scrutiny of devilish details.

The insurance companies' actions created a political juggernaut. State Assemblyman Alister McAlister, a co-sponsor of the final MICRA legislation, later said, "It takes some monumental, catastrophic thing that's just looming up and about to devour us whole before the legislature will do anything on tort reform." According to McAlister, "the only reason the legislature passed [MICRA] is, at that time, we had a terrible crisis in our malpractice insurance system. Most insurance companies pulled out or increased their rates 300 or 400 percent, and the doctors nearly went crazy. They and their wives and their nurses spent a year lobbying the legislature, and when the doctors are united and 100 percent committed to accomplishing something, they're a very powerful group."

How real was the "crisis"? Having secured significant future protection from costs in the form of malpractice insurance payouts, you would expect insurers to begin lowering rates, perhaps not immediately, but soon — as MICRA worked its way through court challenges and ultimately started delivering more money into insurance company bank accounts. But rates went up, not down. Premiums rose an average of 191 percent in the thirteen years from 1976, when MICRA took effect, through 1988. In this time frame, the cost of malpractice premiums as a percentage of total health care costs was higher in California than in the rest of the country. And in most years following MICRA, average malpractice insurance premiums outpaced those levied on doctors in other states.

In 1988 rates finally leveled off, and began to drop, but only with the passage of Proposition 103, a piece of direct citizen legislation prompted by consumer disgruntlement over inexplicably rising property and casualty insurance rates. Proposition 103 expanded the powers of California's Department of Insurance, charging the CDI with assessing and preapproving property and casualty insurance company rates before going into effect and converting the Insurance Commissioner's job from an appointed to an elected position.

Even with the Insurance Commissioner's scrutiny, malpractice insurers are — and have been for decades — quite handsomely rewarded. The CDI collects and posts data by category of insurance, detailing the total amount of policy payouts that insurance companies make in a year. An annual payout of 65% is considered (at least by insurance regulators) to be a reasonable target. This means that if an insurer retains 35% of the premiums collected, it will have ample funds to pay its executive and staff salaries, outside counsel fees, general overhead, and still register a profit. From 1991 through 2011 the average annual medical malpractice payout has been 40% of premiums collected, leaving 60% in the insurers' pockets.

For the last 10 years it has averaged 33%, meaning that the insurance companies have kept, on average, 67% of premiums collected, nearly double what is considered ample. That is a lot of money. For example, in 2009 California medical malpractice insurers collected $420 million in premiums, but paid only 23% of that, or approximately $97 million to claimants. If insurers had paid out 65%, then payouts would have totaled approximately $273 million. This means insurers kept $176 million more than they would have needed to operate at a tidy profit.

The 2004 Rand Report

In response to the national-level debate about medical malpractice recoveries the non-profit (and non-partisan) Rand Foundation issued a report in 2004 entitled "Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA." The Rand Report examined data from 257 plaintiff verdicts in medical malpractice trials from 1995 to 1999, assessing the effects of MICRA on plaintiffs' recoveries, the fees plaintiff attorneys receive, and the liabilities of defendants following trial. The Rand Report data revealed that MICRA was quite effective in doing three things: (1) limiting plaintiffs' recoveries, especially recovery by the most vulnerable plaintiffs; (2) dramatically reducing plaintiffs' counsel fees, making many meritorious claims uneconomical, and (3) transferring jury-awarded funds into the hands of insurance companies.

Rand also noted that MICRA has resulted in a "sea change" in the economics of asserting malpractice claims. The knock-out combination of award caps and limits on maximum contingency percentages resulted in plaintiffs' counsel losing

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60% of the fees they would have made but for MICRA. According to the report, the legislation's provisions regarding awards and fees could be characterized as "shifting some of the costs for compensating medical malpractice from defendants to not only plaintiffs but also to plaintiffs' counsel."

In sum, Rand reported, "defendants would have paid out $420.6 million without MICRA but with the award cap, aggregate liabilities were $295.5 million, a $125.1 million savings. Without MICRA, plaintiffs would have received $280.4 million in net recoveries after fees were deducted, but with the award cap and the fee limits, aggregate net recoveries were $239.5 million, a $40.9 million drop. The difference between the defendants' savings and the reduction in plaintiffs' net recoveries, approximately $84 million, came in the form of reduced attorneys fees."

It is arguable that MICRA was the first shot in the ongoing battle of so-called Tort Reform. Its $250,000 cap on non-economic damages and diminishing contingent-fee scheme form the centerpiece of legislation currently pending in Congress. Approved by the Republican-controlled House of Representatives in March of this year, H.R. 5 would eventually impose MICRA on every state in the union via invocation of the U.S. Constitution's commerce clause. The legislation has yet to be taken up by the Democratic-controlled senate, but a national drift toward the right in November's elections would certainly see a quick roll-out of this legislation in 2013.

Should the injured seek redress?

The fundamental moral question in medical malpractice is whether a person harmed by avoidable medical negligence should recover monetarily. Should the thing taken away from the person, which may be the power to take care of him- or herself at all, be "compensated"? Even tort opponents would answer yes. The question then is how to decide who gets compensated and at what level. The United States could adopt a no-fault system as New Zealand has. But insurance companies do not like that mode. In the hearings leading up to MICRA, an insurance company executive was asked whether a government-run, no fault system of compensation was preferable. The answer was "no," that a system of advocacy was the best mode for handling claims. Insurance companies do not want to eliminate tort actions — that would in effect kill the host — they simply want to shift a large part of the burden of malpractice injury onto the victims.

As a nation, we have chosen a private enterprise, you're-on-your-own system, to redress negligent medical injury. If I am harmed, it is up to me to get compensation. No government agency is going to come in and coddle me — to use the language of tort opponents. But to get compensation, I have to sue, and to sue, I need a lawyer. By its grinding logic of diminishing return, MICRA sweeps more and more injured parties from asserting any claim of recovery at all. I do not think that most people know that and I doubt they would believe it is fair.

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