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WILLIAM T FUJIOKA
Chief Executive Officer

August 3, 2012

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To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
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From: William T Fujioka
Chief Executive Officer

**MOTION BY SUPERVISOR ANTONOVICH TO SUPPORT FEDERAL LEGISLATION
BASED ON CALIFORNIA'S MEDICAL INJURY COMPENSATION REFORM ACT
(ITEM NO. 6, AGENDA OF AUGUST 7, 2012)**

Item No. 6 on the August 7, 2012 Agenda is an item continued from the July 24, 2012 Board meeting, which is a motion by Supervisor Antonovich recommending that the Board support Federal legislation based on California's Medical Injury Compensation Reform Act (MICRA). This memorandum responds to Supervisor Yaroslavsky's request that the Director of Health Services and Chief Executive Officer report back to the Board with the principles for the Federal legislation that might be supported by the Board.

Recommended Principles for Federal Medical Malpractice Legislation

This office recommends, and the Department of Health Services concurs, that the following principles for Federal medical malpractice legislation that might be supported by the Board:

- **Federal legislation should not preempt state laws which govern medical malpractice and torts, such as MICRA, and also should not limit each state's authority to regulate medical practices and torts.**
- **Federal legislation should support reforms of how states handle medical malpractice disputes through Federal grants to states to help fund reforms and demonstrations, Federal-funded evaluations and studies, and the dissemination of information on state medical malpractice laws and potential reforms.**

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The Medical Injury Compensation Reform Act was enacted in California in 1975 to reform how medical liability claims are litigated and resolved in hope of reducing health care costs and keeping medical liability insurance affordable while preserving protections for patients. A basic principle intrinsic to MICRA and other states' medical malpractice laws is that each state can best determine how medical liability claims are to be handled and has the authority to regulate torts, including medical malpractice. States, not the Federal government, historically have regulated medical malpractice.

Federal enabling legislation, therefore, is not required for other states to enact and implement reforms modeled after MICRA, and many other states, in fact, have incorporated parts of MICRA into their laws. Key elements of MICRA include:

- Limitation on Damages for Non-Economic Losses, such as "pain and suffering," to \$250,000 in any medical malpractice case, including when more than one plaintiff is at fault;
- Limitation on the Plaintiff's Attorney Contingency Fees, which reduces the size of the fee as a percentage of the total award as the size of the award increases (note: MICRA's original attorney fee limits were changed under the Brown-Lockyer Civil Liability Reform Act of 1987);
- Binding Arbitration, which allows health providers to require binding arbitration of medical malpractice actions in advance of any dispute;
- Admission of Collateral Sources into Evidence, which allows a health care defendant to introduce into evidence various potential sources of payments, such as from insurance or workers compensation, which can help compensate the plaintiff for economic damages caused by the medical malpractice;
- Periodic Payment of Future Damages, which allows future damages over \$50,000 to be paid in installments instead of a lump sum.

Federal legislation modeled after MICRA also has been introduced, including H.R. 5, which the House passed, 223 to 181, on March 22, 2012. The House Judiciary Committee report on the bill explicitly states that its medical malpractice reforms are modeled after California's MICRA. H.R. 5, however, generally preempts states' medical malpractice laws, imposes uniform standards, and procedures on all states, and limits the authority of states to change such laws, just as California has done since MICRA was originally enacted in 1975. Moreover, while the bill is modeled after MICRA, it also differs from California's laws, as noted in the dissenting views on H.R. 5 in the House Judiciary Committee report, which were signed by all of California's five Democratic members on the Committee, including Representatives Howard Berman, Judy Chu, Linda Sanchez, and Maxine Waters from the County's delegation.

The principle that Federal medical malpractice legislation should not preempt state laws which govern medical malpractice and torts, such as MICRA, and also should not limit state authority is consistent with the overall policy in the County's Federal Legislative Agenda to oppose Federal preemption of State and local government authority.

Instead of usurping the authority of states to regulate medical malpractice and torts within their boundaries, it is more appropriate for the Federal government to encourage and help states to make reforms and to improve existing medical malpractice and tort laws. For example, the Federal government might provide grants to help states finance and evaluate the effectiveness of medical malpractice reforms and demonstrations. This could include providing grants to other states which may want to adopt or test one or more key elements of MICRA. Federal funding also could help finance demonstrations, evaluations, and studies of potential changes to MICRA in California, such as the impacts of increasing the \$250,000 limitation on non-economic damages, which has remained unchanged since 1975. This \$250,000 limitation is one of the most controversial features of MICRA and H.R. 5, which would impose the \$250,000 limitation nationwide.

In closing, the central issue with Federal medical malpractice legislation is whether the Federal government should preempt state authority over medical malpractice and torts. As indicated earlier, this office recommends that any Federal medical malpractice legislation should not preempt existing state laws, consistent with the policy in the County's Federal Legislative Agenda opposing Federal preemption of state and local government authority. The Department of Health Services has prepared the attached report on the impacts of MICRA. California should be allowed to retain all of its medical malpractice and tort laws, including MICRA, and to enact further reforms, as needed.

We will continue to keep you advised.

WTF:RA
MR:MT:ma

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Director of Health Services



Health Services
LOS ANGELES COUNTY

- Attachment

August 6, 2012

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TO: Each Supervisor

FROM: Mitchell H. Katz, M.D., Director *mm 1/5*

SUBJECT: **IMPACTS OF CALIFORNIA'S MEDICAL INJURY COMPENSATION REFORM ACT (MICRA) AND SIMILAR LAWS (Agenda Item #6, August 7, 2012)**

Research suggests that MICRA, and laws in other states which place limits on non-economic damages in malpractice awards, have affected malpractice cases and health care in several ways. Overall, we believe that MICRA is beneficial to patients and access to care.

Slower growth of malpractice premium rates – Although changes in malpractice premium rates occur due to a wide variety of factors, several studies indicate that caps on non-economic damages have a mitigating effect on rate increases. For example, a 2003 General Accounting Office (GAO) report found that in 2001-2002, average premium rates rose 10% in states with non-economic damage caps of \$250,000, compared with a 29% increase in states with limited reforms.¹ Another study found that between 1995 and 2001, malpractice premiums were 17% lower in states capping malpractice payments.²

Preserve availability of physicians – Because limitations on malpractice damages appear to limit malpractice premiums, it is believed that physicians, particularly those in high-risk specialties, are more likely to stay in practice in states with damage award caps. One study in the Journal of the American Medical Association found that states adopting “direct reforms,” such as non-economic damage caps, experienced increased physician supply of 3.3% three years after adoption, with greater gains occurring for some “high-risk” specialties, such as emergency medicine and anesthesiology.³ Another study of county-level data from 1985-2000 found that counties in states with a cap on non-economic damages had 2.2% more physicians per capita, and rural counties in states with a cap had 3.2% more physicians per capita. Rural counties in states with a \$250,000 cap had 5.4% more obstetrician-gynecologists and 5.5% more surgical specialists per capita than did rural counties in states with a cap above \$250,000.⁴

¹ *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*. Washington, DC: US General Accounting Office; 2003. Report GAO-03-836, p. 31

² Thorpe KE. *The medical malpractice 'crisis': recent trends and the impact of state tort reforms*. Health Affairs (Millwood). January-June (suppl Web exclusives), 2004;W4-20-30. Available at: <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1>.

³ Daniel P. Kessler, PhD, JD; William M. Sage, MD, JD; David J. Becker, BA, *Impact of Malpractice Reforms on the Supply of Physician Services*, Journal of the American Medical Association, June 1, 2005—Vol 293, No. 21, p. 2623

⁴ William E. Encinosa and Fred J. Hellinger, *Have State Caps On Malpractice Awards Increased The Supply Of Physicians?*, Health Affairs, no. (2005); doi: 10.1377/hlthaff.w5.250

Reduced cost of care – Laws limiting malpractice awards may also reduce the cost of “defensive medicine,” physicians ordering more tests than necessary, or avoiding high-risk patients/procedures, to protect against costly malpractice claims. Defensive medicine is difficult to evaluate because it is difficult to identify and measure. However, some studies have suggested a reduced cost of health care in states that cap damages. For example, one analysis of state health care expenditures indicated that spending per resident is 3-4% lower in states that cap non-economic damages, versus states that don't place limits on these damages.⁵ Another study found that health care expenditures for Medicare patients with acute myocardial infarction and ischemic heart disease were 5.3% lower and 9% lower, respectively, in states with laws directly limiting damage payments, without significant differences in outcomes for patients.⁶

Reduced attorney's fees – A study of medical malpractice verdicts from 1995 to 1999 by the Rand Corporation⁷ indicates that MICRA resulted in a 60% reduction overall of attorney fees in medical malpractice cases studied. This helps to ensure that more of the award goes to plaintiffs. Critics of MICRA assert that these reduced fees may have a negative impact on the ability of some plaintiffs with legitimate claims to get quality legal representation. However, at this time there does not appear to be evidence to support or refute this claim.

SUMMARY

We believe that MICRA, in particular its \$250,000 cap on non-economic damage awards, is beneficial in preserving access to care for patients.

Please contact me if you have questions or need any further assistance in this matter.

MHK:ws

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

⁵ Fred J. Hellinger, PhD, and William E. Encinosa, PhD, *The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures*, American Journal of Public Health, August 2006, Vol 96, No. 8, p. 1379

⁶ Kessler DP, McClellan MB. *Do doctors practice defensive medicine?* National Bureau of Economic Research Working Paper Series, pp. 24-27.

⁷ Nicholas M. Pace, Daniela Golinelli, Laura Zakaras, *Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA*, Rand Institute for Civil Justice, 2004, p.37