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## Remodeling Federal Medical Malpractice Act: A Possible Improvement to the Affordable Care Act

Nancy Kubasek

Tiffany Durham

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# REMODELING FEDERAL MEDICAL MALPRACTICE: A POSSIBLE IMPROVEMENT TO THE AFFORDABLE CARE ACT

*Nancy Kubasek\* & Tiffany Durham\*\**

*During the debates about healthcare reform, the Congressional Budget Office found that federal medical liability reform could drastically reduce federal budget deficits, yet political and legal scholars could not reach agreement about the best way for the Patient Protection and Affordable Care Act (PPACA) to provide such reform. Instead, provisions were made to fund state level demonstration projects. The law that is considered one of the most successful models to date of conventional tort reform is the Medical Injury Compensation Reform Act of California. This Article exams that legislation and discusses how we might use what can be learned from that legislation to improve the PPACA.*

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\* Professor Kubasek received her J.D. from the University of Toledo College of Law in 1981, and has been a professor of legal studies at Bowling Green State University since 1984. She has also been a visiting professor of public health law and medical ethics at St. Matthews School of Medicine. She has published over ninety-five articles and twelve books.

\*\* Tiffany Durham received her paralegal certification from the University of Toledo in 2015, and a B.S. in Business Administration from Bowling Green State University in 2014.

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## I. FEDERAL TORT REFORM UNDER THE AFFORDABLE CARE ACT

During the many years that medical liability laws have provided redress for victims of malpractice, there has been ever-present controversy about the most effective way to handle these malpractice cases in court.<sup>1</sup> Much of this controversy is fueled by the fact that medical liability laws are managed at the state level. With various states creating laws differently, there is currently a messy patchwork of tort law addressing malpractice.<sup>2</sup> As will be explained throughout this Article, this patchwork of legislation has resulted in increased malpractice insurance premiums, an increased practice of defensive medicine,<sup>3</sup> and increased health care costs in the United States.<sup>4</sup>

In reaction to the legal and financial problems resulting from our current system of tort laws, tort reform via the Patient Protection and Affordable Care Act (PPACA)<sup>5</sup> was suggested as part of the solution.<sup>6</sup> During the 2009 debates about healthcare reform, the

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1. See Alan G. Williams, *The Cure for What Ails: A Realistic Remedy for the Medical Malpractice "Crisis"*, 23 STAN. L. & POL'Y REV. 477, 489 (2012) (describing the opposing perspectives of conservatives versus liberals on medical malpractice and effective tort reform). For a history of past suggestions for tort reform by legal scholars and policy makers, see generally Chapter II of TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* (2005).

2. Williams, *supra* note 1, at 492 ("[T]he federal government could pass national medical malpractice reform . . . to replace the states' patchwork of varied and disparate medical malpractice statutes and rules.").

3. *Id.* at 486–87 ("Estimates of how much, dollar-wise, defensive medicine costs the healthcare system are quite disparate, with the American Medical Association quoting figures as high as \$126 billion annually . . .").

4. *Id.* at 482–83 (highlighting Republicans' association of increased health care costs with frivolous medical malpractice lawsuits). However, Williams later explains that:

In general, most patients harmed by medical negligence do not file medical malpractice claims. Various studies have examined the problem, reaching consistent conclusions. In a California study, 1% of patients were injured by medical negligence, but statewide only 10% of injured patients sued. A Harvard Medical Practice Study found that, in fifty-one New York hospitals, 1% of patients were injured by negligent treatment yet the number of negligent injuries was 6.7 times greater than the number of malpractice claims filed statewide . . . . Based on the volume of studies regarding medical malpractice claim filings, it would appear that *any suggestion that the current medical malpractice system is overrun with frivolous litigation is patently false.*

*Id.* at 485 (emphasis added).

5. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

6. See Thomas L. Hafemeister & Joshua Hinckley Porter, *The Health Care Reform Act of 2010 and Medical Malpractice Liability: Worlds in Collision or Ships Passing in the Night?*, 64 SMU L. REV. 735, 737 (2011) ("In the log-rolling that led up to the passage of the PPACA, there was some speculation that this partisan split might be bridged. For example, when President Barack Obama gave an invited presentation to the members of the

Congressional Budget Office (CBO) found that federal medical liability reform would drastically reduce federal budget deficits by \$54 billion over the course of ten years.<sup>7</sup> Political and legal scholars disagreed about the best way for the PPACA to provide adequate tort reform; many pushed for federalization of medical malpractice laws.<sup>8</sup> Some focused specifically on mandating caps on non-economic damages in medical malpractice cases, while others suggested “conditioning states’ receipt of federal health funds . . . on their willingness to adopt changes to their tort systems.”<sup>9</sup>

In the end, the PPACA did not federalize medical malpractice laws, nor did it include any proposals for tort reform.<sup>10</sup> Instead, the PPACA included a provision to allocate funds for “state-level demonstration projects” that would allow for states to study the problem of medical malpractice within their borders and to test “malpractice reform alternatives.”<sup>11</sup> Such alternatives could include offer and disclosure programs and health courts, among others.<sup>12</sup>

With the passing of the PPACA, and its being upheld as constitutional, many states have planned and implemented these

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American Medical Association, some construed his remarks as indicating a willingness to address medical malpractice reform in the PPACA.”).

7. See Leonard J. Nelson III et al., *Medical Liability and Health Care Reform*, 21 HEALTH MATRIX 443, 445 (2011).

8. Williams, *supra* note 1, at 491.

9. *Id.* at 492 (quotation marks omitted) (explaining the suggestions made by medical malpractice scholars and professors, Michelle M. Mello and Troyen A. Brennan, during the 2009 debate regarding national healthcare reform).

10. *Id.* at 489 (“Although some commentators predicted medical liability reform would be included in the PPACA, the final bill paid lip service to the issue . . . by not incorporating any proposed tort reforms but instead merely allocating funds to study the problem on a state level.”); see also Nelson, *supra* note 7, at 444 (“There was a chance that alternative medical liability reforms . . . would be bundled with the health care reform as part of a bipartisan compromise, but it was not included in the final legislation.”) (footnote omitted).

11. Nelson, *supra* note 7, at 444; see also Williams, *supra* note 1, at 498. Williams explains that “Alternative Legal Systems” generally consist of four categories:

The first is alternative dispute resolution, consisting of the creation of health/medical courts, the use of private contracts to control any disputes, early offer programs to encourage prompt settlement prior to the filing of a claim, and compensating claims through a fault-based administrative system. The second category is alternatives to the negligence standard, which include compensating claims through a no-fault administrative system and implementation of pre-designated compensable events. The third category is relocation of legal responsibility . . . while the fourth category frequently discussed is the creation of enterprise insurance.

Williams, *supra* note 1, at 498.

12. Nelson, *supra* note 7, at 444.

suggested demonstration projects.<sup>13</sup> However, as was made clear during the ongoing healthcare reform debates, “malpractice reform alternatives” are not the only route for addressing the problems surrounding cases of medical malpractice. Instead, many states have focused on what has been considered “conventional tort reform” at the state-level.<sup>14</sup> Conventional tort reform may include limitation on access to courts, modification of liability rules, or focusing on caps on certain damages.<sup>15</sup> What has been considered one of the most successful models to date of conventional tort reform, specifically, of capping damages, is the Medical Injury Compensation Reform Act (MICRA) of California.<sup>16</sup> Since its enactment in 1975, MICRA has been dubbed the “gold standard” of malpractice reform.<sup>17</sup>

## II. HISTORY OF MICRA

Prior to California’s MICRA in 1975, the state was experiencing a significant healthcare crisis. Medical liability costs were getting out of control and were forcing community clinics, health centers, physicians, and other health care providers out of practice.<sup>18</sup> The crisis resulted from juries who were awarding excessive financial compensation, which caused the medical premiums to rise steeply by more than 300 percent.<sup>19</sup> Physicians were faced with five or more

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13. See *Master, Demonstration, Evaluation and Research Studies for ORDI System of Record 09-70-0591*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/medicare/demonstration-projects/demoprojectsevalrpts/downloads/mastersorlist.pdf> (last visited Nov. 12, 2014) (providing a list of current ongoing demonstration projects).

14. Williams, *supra* note 1, at 492–93. Williams explains that “Conventional Tort Reform” generally consists of three categories:

The first is limitation on access to courts, which includes shortening statutes of limitations, enacting statutes of repose, and establishing screening panels. The second category is modification of liability rules, which includes eliminating joint and several liability rules, imposing higher standards for proving breaches of informed consent, and eliminating *res ipsa loquitur*. The third category is damages reform, consisting of caps on economic, punitive and/or non-economic damages, limiting attorney’s fees, mandating collateral source offsets, and requiring periodic payments instead of allowing lump sum payouts.

*Id.*

15. *Id.*

16. Nelson, *supra* note 7, at 456.

17. *Id.*

18. *History of MICRA*, CALIFORNIANS ALLIED FOR PATIENT PROT., <http://micra.org/micra/history-of-micra.html> (last visited Mar. 4, 2014) [hereinafter CAPP *History*].

19. *California’s Medical Malpractice Insurance History*, ARTHUR J. GALLAGER & CO., <http://www.gallaghermalpractice.com/state-resources/California-Medical-Malpractice-Insurance/> (last visited Mar. 3, 2014) [hereinafter GALLAGER].

choices, and none of the options were beneficial to them or society. Their options were to raise medical costs, make medical care unaffordable for numerous patients, discontinue their professional liability insurance coverage, leave the state, or stop practicing medicine altogether.<sup>20</sup> Many physicians were trying to confront this steep rise in malpractice premiums, specifically those physicians in rural areas or in high-risk specialties who were being coerced to end their practice due to not being qualified for or not being able to afford medical liability insurance.<sup>21</sup>

Due to the closing of medical practices, payments for inflated premiums were subsequently falling to consumers in the manner of increase healthcare costs, thus causing patients to suffer. With the increase in healthcare costs, patients were being denied care because they could not afford it. At the request of Governor Jerry Brown, the California State Legislature called a session to resolve this healthcare crisis.<sup>22</sup> In that session, MICRA was passed with bipartisan support.<sup>23</sup>

The MICRA law is comprised of seven separate statutes, which are all aimed to work together cohesively with the collective objective of maintaining malpractice premiums at an equitable level, while justly rewarding patients who have been injured from medical malpractice. The central provisions of MICRA are: (1) a cap of \$250,000 on non-economic damages<sup>24</sup> of recovery against physicians; (2) limited allowance of attorney fees, so that more of the monetary awards are received by the plaintiff; (3) unlimited compensation for economic<sup>25</sup> and punitive<sup>26</sup> damages; (4) mandating

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20. *MICRA: A Brief History*, CAL. MED. ASS'N, <https://www.cmanet.org/issues-and-advocacy/cmas-top-issues/micra/micra-a-brief-history/> (last visited Mar. 4, 2014) [hereinafter *CMA History*].

21. *CAPP History*, *supra* note 18.

22. Kenneth R. Zuetel, Jr., *The Medical Injury Compensation Reform Act of 1975: Then and Now*, 5 INT'L J. COSMETIC SURGERY & AESTHETIC DERMATOLOGY 201, 201 (2003).

23. Nelson, *supra* note 7, at 457.

24. *CMA History*, *supra* note 20. Under MICRA, there is a cap on the award for non-economic damages of \$250,000. Compensation for non-economic damages is subjective and arduous to prove and assess. Non-economic damages include: pain, suffering, emotional distress, inconvenience, loss of society and companionship, loss of consortium, and harm to satisfaction of life.

25. *Id.* Under MICRA, there is no cap for economic damages on the amount the injured patient can receive as compensation. Economic damages are objective, can be measured, and can be validated. Economic damages include compensation for past and future medical expenses, harm of lost earnings past and future, loss of property, costs of repair or replacement, and the harm of employment or business prospects.

an advance notice of a claim and a statute of limitations on claims; (5) use of binding arbitration; (6) the admittance of evidence of collateral source payments to be deliberated; and (7) the allowance of periodic payments of monetary awards.<sup>27</sup> Through the California State Legislature's enactment of MICRA, the legislature expected to resolve the healthcare crisis in California, so that medical care could become more affordable for both patient and physician. In the end, this statute led to a decrease in malpractice insurance rates and more affordable care for the state of California.<sup>28</sup> Since the establishment of MICRA, the state of California has "become one of the most stable medical malpractice markets in the country."<sup>29</sup>

### III. MICRA PROVISIONS

#### A. Cap on Non-Economic Damages

MICRA, found in California Civil Code section 3333.2,<sup>30</sup> places a limit on the amount that a plaintiff can recover for non-economic losses at trial due to medical negligence at \$250,000. Since 1975, the cap has remained fixed at \$250,000, and the award cap affects nearly every claim against licensed health care providers for negligent acts or lack of providing adequate services, including claims against doctors, nurses, hospitals, psychotherapists, chiropractors, emergency medical technicians, blood banks, sperm banks, dentists,

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26. *Id.* Under MICRA, there is no cap for punitive damages on the amount that may be rendered in medical liability cases. Punitive damages may be rendered to reprimand the defendant and to prevent future medical errors.

27. CAPP *History*, *supra* note 18.

28. William G. Hamm et al., *MICRA and Access to Health Care*, CALIFORNIANS ALLIED FOR PATIENT PROT., <http://www.micra.org/studies-research/FINAL2014MICRAReport01.21.14.pdf> (last visited Nov. 15, 2014) ("California was the first state to reform its medical liability tort system, and many other states have followed its lead . . . in response to a medical liability crisis similar to the one California experienced in the mid-1970s, Texas in 2003 enacted medical liability reforms that included caps on non-economic damages.").

29. GALLAGER, *supra* note 19.

30. CAL. CIV. CODE § 3333.2 (West 2014). The California Civil Code states:

(a) In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.

(b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars (\$250,000).

*Id.*



and other licensed health care professionals in a disagreement.<sup>31</sup> Regardless of the significance of the injuries claimed by the plaintiff, the cap on non-economic damages is applied to all cases, including cases unfortunately ensuing from the death of a patient. The award for non-economic damages is reduced after the jury has rendered its decision to abide by the MICRA limitations on awards for non-economic losses: “The jurors can award whatever amount they believe is appropriate for non-economic losses, but upon a post-verdict motion by the defendant, the judge will reduce the award to comply with MICRA’s limits before entering the final judgment in the case.”<sup>32</sup>

### B. Limitations on Plaintiff Attorney Fees

The Business and Professions Code section 6146<sup>33</sup> regulates the sum of attorney’s fees that can be given to the plaintiff’s attorneys in medical malpractice trials. Previously, plaintiff’s attorneys’ fees resulted in medical malpractice plaintiff’s receiving less of the awarded amount than plaintiffs in other types of cases.<sup>34</sup> MICRA has established a fee plan that results in a balanced reduction in fees as the award of the resolution sum increases. For the first \$50,000 recovered, the plaintiff’s attorney will receive 40 percent of the

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31. NICHOLAS M. PACE ET AL., CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS, RAND CORP. 8 (2004), available at [http://www.rand.org/content/dam/rand/pubs/monographs/2004/RAND\\_MG234.pdf](http://www.rand.org/content/dam/rand/pubs/monographs/2004/RAND_MG234.pdf).

32. *Id.*

33. CAL. BUS. & PROF. CODE § 6146 (West 2014). The Code provides:

(a) An attorney shall not contract for or collect a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon such person’s alleged professional negligence in excess of the following limits:

(1) 40 percent of the first fifty thousand dollars (\$50,000) recovered.  
(2) 33 and 1/3 percent of the next fifty thousand dollars (\$50,000) recovered.  
(3) 25 percent of the next five hundred thousand dollars (\$500,000) recovered.  
(4) 15 percent of any amount on which the recovery exceeds six hundred thousand dollars (\$600,000).

(b) If periodic payments are awarded to the plaintiff pursuant to Section 667.7 of the Code of Civil Procedure, the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and include this amount in computing the total award from which attorney’s fees are calculated under this section. 25 percent of the next five hundred thousand dollars (\$500,000) recovered.

*Id.*

34. Zuetel, *supra* note 22, at 202 (“Most standard attorney contingency fee contracts allow for recovery of fees representing 33⅓% of the settlement or 40% of the recovery.”).

award.<sup>35</sup> However, for the next \$50,000 the attorney will receive 33 $\frac{1}{3}$  percent of the damages.<sup>36</sup> For the next \$500,000, attorney fees will be recoverable up to 25 percent. And for amounts over \$600,000, attorney fees will be recoverable in an amount of 15 percent.<sup>37</sup> Due to section 6146, less money is going into the hands of the plaintiff's lawyers and more is being received by the injured plaintiffs.

### C. Evidence of Collateral Sources

California Civil Code section 3333.1<sup>38</sup> permits a healthcare defendant to enter into evidence various possible sources of payments that can assist in compensating the plaintiff for the economic damages that were created by the malpractice of the physician, and thus decrease the outcome or settlement award of the case.<sup>39</sup> The objective of this section of the Code is to remove the so-called "double recovery" acquired by plaintiffs who have had their medical fees paid by their own health insurances, and yet acquire damages for such expenses from the defendant.<sup>40</sup> Therefore, the jury is provided the opportunity to "set plaintiff's damages at a lower level because of its awareness of plaintiff's 'net' collateral source benefits."<sup>41</sup> Another objective is to protect the plaintiff from the "double reduction" that would take place if the jury decreased the

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35. CAL. BUS. & PROF. CODE § 6146(a)(1) (West 2003).

36. *Id.* § 6146(a)(2).

37. *Id.* §§ 6146(a)(3)–(4).

38. CAL. CIV. CODE § 3333.1 (West 2014). The Code provides:

(a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, [FNI] any state or federal income disability or worker's compensation act, any health sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.

(b) No source of collateral benefits introduced pursuant to subdivision (a) shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

*Id.*

39. Zuetel, *supra* note 22, at 203 ("Normally, such payments, called 'collateral sources,' are not admissible into evidence at trial.")

40. *See* Barne v. Wood, 689 P.2d 446, 449 (Cal. 1984).

41. *See* Fein v. Permanente Med. Grp., 38 Cal.3d 137, 164–65 (1985).

award due to collateral source benefits.<sup>42</sup> However, the collateral source could gain compensation of those benefits from the plaintiff's tort recovery.<sup>43</sup> Also, this section of the Code exists to ensure that any reduction in malpractice awards that could result from the jury's consideration of the plaintiff's collateral source benefits will inure to the defendant's benefit, instead of benefitting the collateral source.<sup>44</sup>

#### *D. Periodic Payments*

California Code of Civil Procedure section 667.7<sup>45</sup> requires that if the defendant healthcare provider makes an appropriate request of

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42. *MICRA Manual: 2012 Edition*, HORVITZ & LEVY, LLP 2 (2012), available at [http://horvitzlevy.com/images/ps\\_attachment/attachment740.pdf](http://horvitzlevy.com/images/ps_attachment/attachment740.pdf).

43. *Id.*

44. *Id.* at 2–3.

45. CAL. CIV. PROC. CODE § 667.7 (West 2009). The Code provides:

(a) In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars (\$50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

(b) (1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor. (2) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

(c) However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

(d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further

the court that has rendered a decision against him or her in future damages of \$50,000 or more, compensation in the case may be paid by periodic payments as opposed to one lump sum. Section 667.7 requires that after the jury or arbitrator makes a binding decision distinguishing the total amount of the future damages owed by the defendant, the defendant then moves the court or arbitrator for a request permitting periodic payments. Both the plaintiff and the defendant present propositions of annuities or additional payment plans to the court for deliberation.<sup>46</sup> Being contingent on such variables as the life-expectancy rate of the plaintiff, the assessment of the annuity provider, and the current rates, a substantial quantity of money can be protected by the insurer who proceeds meticulously in planning the annuity package.<sup>47</sup> Then, the court establishes the dollar amount of the periodic payments that will sufficiently compensate the plaintiff for his or her injuries.<sup>48</sup> Subsequently, the judgment is fulfilled upon the final payment, or as contrarily ordered by the court.<sup>49</sup> However, as an option, the defendant may choose to pay the total sum of the future payments, decreased to its present rate, thus satisfying the judgment upon that payment.<sup>50</sup>

#### *E. Arbitration*

California Code of Civil Procedure section 1295<sup>51</sup> permits healthcare providers in potential medical malpractice actions to

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payments shall cease and any security given, pursuant to subdivision (a) shall revert to the judgment debtor.

*Id.*

46. Zuetel, *supra* note 22, at 203.

47. *Id.* at 203–04.

48. *Id.* at 204.

49. *Id.*

50. *Id.*

51. CAL. CIV. PROC. CODE § 1295 (West 2007). The Code provides:

(a) Any contract for medical services which contains a provision for arbitration of any dispute as to professional negligence of a health care provider shall have such provision as the first article of the contract and shall be expressed in the following language: “It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.”

require binding arbitration of medical malpractice actions in advance of a possible lawsuit. The binding arbitration is allowed if the agreement follows the specified language that is defined in subdivisions (a) and (b) and is signed by the patient.<sup>52</sup> Upon signing the agreement, the patient is bound by the arbitration clause, and his or her heirs, spouse, and children have to abide by arbitration in any cases against the healthcare provider for medical malpractice.<sup>53</sup> According to subdivision (e), the patient's endeavors to evade arbitration on the basis that it is unfair or biased are automatically dismissed as long as the statutory language is appropriately applied.<sup>54</sup>

#### *F. Intent to Sue*

California Code of Civil Procedure section 364<sup>55</sup> requires an individual to give a healthcare provider a minimum of a ninety-day

(b) Immediately before the signature line provided for the individual contracting for the medical services must appear the following in at least 10-point bold red type:

“NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.”

(c) Once signed, such a contract governs all subsequent open-book account transactions for medical services for which the contract was signed until or unless rescinded by written notice within 30 days of signature. Written notice of such rescission may be given by a guardian or conservator of the patient if the patient is incapacitated or a minor.

(d) Where the contract is one for medical services to a minor, it shall not be subject to disaffirmance if signed by the minor's parent or legal guardian.

(e) Such a contract is not a contract of adhesion, nor unconscionable nor otherwise improper, where it complies with subdivisions (a), (b) and (c) of this section.

(f) Subdivisions (a), (b) and (c) shall not apply to any health care service plan contract offered by an organization registered pursuant to Article 2.5 (commencing with Section 12530) of Division 3 of Title 2 of the Government Code, or licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, which contains an arbitration agreement if the plan complies with paragraph (10) of subdivision (a) of Section 1363 of the Health and Safety Code, or otherwise has a procedure for notifying prospective subscribers of the fact that the plan has an arbitration provision, and the plan contracts conform to subdivision (h) of Section 1373 of the Health and Safety Code.

*Id.*

52. Zuetel, *supra* note 22, at 204.

53. *Id.*

54. *Id.*

55. CAL. CIV. PROC. CODE § 364 (West 2006). The Code provides, in part:

(a) No action based upon the health care provider's professional negligence may be commenced unless the defendant has been given at least 90 days' prior notice of the intention to commence the action.

notice of an intent to sue prior to filing a lawsuit for professional negligence.<sup>56</sup> No specific form of notice is demanded, but it must inform the defendant of the legal basis of the claim and the type of loss sustained, including the specific nature of the injury suffered.<sup>57</sup>

### G. Statute of Limitations

California Code of Civil Procedure section 340.5<sup>58</sup> allows for medical malpractice cases to have their own specific time limitations. Under MICRA, a case must be brought to commencement within three years after the date of the injury or one year after the plaintiff discovers, or through the use of rational attentiveness should have discovered the injury, whichever circumstance happens first. This time period could be extended, however, if the plaintiff can prove fraud, intentional concealment, or the presence of a foreign body with no therapeutic purpose in the person of the injured party.

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(b) No particular form of notice is required, but it shall notify the defendant of the legal basis of the claim and the type of loss sustained, including with specificity the nature of the injuries suffered.

(c) The notice may be served in the manner prescribed in Chapter 5 (commencing with Section 1010) of Title 14 of Part 2.

(d) If the notice is served within 90 days of the expiration of the applicable statute of limitations, the time for the commencement of the action shall be extended 90 days from the service of the notice.

(e) The provisions of this section shall not be applicable with respect to any defendant whose name is unknown to the plaintiff at the time of filing the complaint and who is identified therein by a fictitious name, as provided in Section 474.

*Id.*

56. *Id.* § 364(a) (West 2006).

57. *Id.* § 364(b).

58. *Id.* § 340.5. The Code provides:

In an action for injury or death against a health care provider based upon such person's alleged professional negligence, the time for the commencement of action shall be three years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of legal action exceed three years unless tolled for any of the following: (1) upon proof of fraud, (2) intentional concealment, or (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person. Actions by a minor shall be commenced within three years from the date of the alleged wrongful act except that actions by a minor under the full age of six years shall be commenced within three years or prior to his eighth birthday whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which parent or guardian and defendant's insurer or health care provider have committed fraud or collusion in the failure to bring an action on behalf of the injured minor for professional negligence.

*Id.*

#### IV. THE EFFECTS AND BENEFITS OF MICRA

Since 1975, MICRA has been advertised by many as successful in protecting access to healthcare services, and fighting against rising healthcare costs.<sup>59</sup> The MICRA has been supported by a large and diverse association of patient advocates and healthcare providers across California.<sup>60</sup>

##### A. *Stabilizing Premiums and Healthcare Costs*

Before the enactment of MICRA, medical liability costs were out of control and were forcing health centers, physicians, community clinics, and other healthcare providers out of practice.<sup>61</sup> Since its passing, MICRA has been successful in stabilizing liability costs. According to the California Medical Association, research in 2011 shows how MICRA has regulated medical premiums. Below, Figure 1 demonstrates the specific premium costs for physicians based upon various counties in the United States, which are then compared to Monterey County Medical Society. Based on this chart from 2011, MICRA had saved physicians in Monterey County, California an average of \$67,861:

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59. Nelson, *supra* note 7, at 467–68 (“The AMA touts the relative stability of the California insurance market since the enactment of MICRA in 1975 as proof of the efficacy of caps.”); see Michael S. Hull et al., *House Bill 4 and Proposition 12: An Analysis with Legislative History*, 36 TEX. TECH. L. REV. 1, 32 (2005) (“Patients in California have access to health care because insurance premiums are more affordable and stable. Injured parties have access to the courts and receive fair compensation for quantifiable damages, settlements are expedited, gross abuses of excessive contingency fees have been eliminated, and competition among insurance carriers thrives.”); see *Reasons to Support MICRA*, CAL. MED. ASS’N, <http://www.cmanet.org/issues-and-advocacy/cmas-top-issues/micra/reasons-to-support-micra/> (last visited Nov. 13, 2014) (“While eliminating or increasing the Medical Injury Compensation and Reform Act (MICRA) cap on non-economic damages will impact physician medical liability rates, it will also lead to higher costs and reduced access for patients.”).

60. For an explanation of the American Medical Association’s support of MICRA, see Nelson, *supra* note 7, at 462.

61. *Medical Injury Compensation Reform Act (MICRA)*, SAN DIEGO CNTY. MED. SOC’Y 22 (2013), <http://www.sdcms.org/Portals/18/Assets/pdf/MICRA.pdf> [hereinafter SAN DIEGO CNTY. MED. SOC’Y].

Figure 1. 2011 Monterey County Medical Society MICRA Premium Savings Chart<sup>62</sup>

2011 Monterey County Medical Society MICRA Premium Savings Chart

<i>Specialty</i>	<i>Monterey County</i>	<i>Dade County, FL</i>	<i>Long Island New York</i>	<i>Wayne County, MI</i>	<i>FL-NY-MI Average</i>	<i>MICRA Savings</i>
Allergy	\$3,283	\$24,183	\$10,826	\$16,909	\$17,306	\$14,023
Anesthesiology	\$8,641	\$48,367	\$37,657	\$41,697	\$42,574	\$33,933
Cardiology (Invasive)	\$9,857	\$95,007	\$40,738	\$66,711	\$67,485	\$57,628
Cardiovascular Surgery	\$24,899	\$172,739	\$121,665	\$174,918	\$156,441	\$131,542
Dermatology (Lipo/Cosmetic)	\$23,031	\$54,413	\$36,779	\$23,797	\$38,330	\$15,299
Emergency Medicine	\$14,163	\$95,007	\$58,971	\$87,121	\$80,366	\$66,203
Family Practice (Non-Surgical)	\$8,284	\$44,912	\$26,817	\$33,893	\$35,207	\$26,923
General Surgery	\$23,031	\$200,377	\$121,665	\$143,445	\$155,162	\$132,131
Internal Medicine (Non-Invasive)	\$6,869	\$50,094	\$36,779	\$34,350	\$40,408	\$33,539
Neurosurgery	\$42,902	\$248,744	\$321,713	\$201,512	\$257,323	\$214,421
OB/GYN	\$30,463	\$200,377	\$196,111	\$135,935	\$177,474	\$147,011
Ophthalmology (LASIK/Cosmetic)	\$6,869	\$50,094	\$36,437	\$37,955	\$41,495	\$34,626
Orthopaedics	\$23,031	\$146,828	\$146,084	\$144,667	\$145,860	\$122,829
Otolaryngology (Cosmetic)	\$23,031	\$60,459	\$108,110	\$81,556	\$83,375	\$60,344
Pathology	\$4,781	\$44,912	\$24,769	\$19,524	\$29,735	\$24,954
Pediatrics (Non-Surgical)	\$6,869	\$31,093	\$26,817	\$28,928	\$28,946	\$22,077
Plastic Surgery	\$23,031	\$95,007	\$108,110	\$91,565	\$98,227	\$75,196
Proctology	\$23,031	\$69,096	\$64,281	\$53,751	\$62,376	\$39,345
Psychiatry (Non-Shock)	\$4,781	\$24,183	\$10,826	\$17,853	\$17,621	\$12,840
Radiology (Non-Invasive)	\$6,869	\$95,007	\$61,100	\$45,293	\$67,133	\$60,264
Thoracic Surgery	\$24,899	\$172,739	\$100,500	\$154,089	\$142,443	\$117,544
Urology	\$9,857	\$60,459	\$64,281	\$55,655	\$60,132	\$50,275
<b>Average - All Specialties</b>	<b>\$16,021</b>	<b>\$94,732</b>	<b>\$80,047</b>	<b>\$76,869</b>	<b>\$83,883</b>	<b>\$67,861</b>

62. California Medical Association, *2011 MICRA Savings Charts*, CMA (May 9, 2011), <http://www.cmanet.org/resource-library/detail?item=2011-micra-savings-charts>.



As displayed in this chart, the MICRA has been successful in regulating liability costs and healthcare costs. But the Act is especially important for protecting specialty and high-risk services, such as: women's healthcare, community clinics, health centers, and rural physicians can at minimum manage to afford skyrocketing costs. This is because "states without medical liability reform suffer from shortages of providers leading to the closing of hospitals, clinics, and trauma centers, and leaving patients with no doctors in their immediate vicinity."<sup>63</sup> Supporting this notion, the American Medical Association (AMA) conducted a study that revealed when premiums rise, 45 percent of hospitals lose physicians and experience emergency room cutbacks.<sup>64</sup>

The \$250,000 cap on non-economic damages required by MICRA makes healthcare more affordable by reducing the doctors' and hospitals' cost of covering themselves against medical liability, thus reducing the incentive for physicians to practice defensive medicine.<sup>65</sup> Defensive medicine can be defined as physicians requiring costly and medically unwarranted tests and procedures that decrease their liability to lawsuits, but have no medical benefit toward improving the patient's health and well-being.<sup>66</sup> By decreasing the costs of medical liability insurance and reducing the incentive to practice defensive medicine, a cap causes healthcare to become more affordable and increases access to physicians and hospitals for the public when they need care.<sup>67</sup>

According to California's former nonpartisan legislative analyst, if the state were to increase the cap from \$250,000 to \$500,000 that would raise healthcare costs in California by a minimum of \$9.5 billion annually.<sup>68</sup> This would translate to an estimate of \$1,000

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63. *Id.*

64. MICRA: CALIFORNIA'S LANDMARK HEALTHCARE LIABILITY LAW—A NATIONAL MODEL FOR ASSURING ACCESS TO AFFORDABLE HEALTHCARE, CAL. ALLIED FOR PATIENT PROT. 4 (2005), available at [http://www.sdcms.org/Portals/18/Assets/pdf/micra\\_handbook.pdf](http://www.sdcms.org/Portals/18/Assets/pdf/micra_handbook.pdf).

65. For a discussion on the practice of defensive medicine and its effects on health care costs, see Williams, *supra* note 1, at 486–87 ("Estimates of how much, dollar-wise, defensive medicine costs the healthcare system are quite disparate, with the American Medical Association quoting figures as high as \$126 billion annually but a team of Harvard researchers concluding that hospitals expend \$38.8 billion each year on defensive medicine costs and individual physicians \$6.8 billion.").

66. Hamm, *supra* note 28, *Executive Summary*.

67. *Id.*

68. SAN DIEGO CNTY. MED. SOC'Y, *supra* note 61, at 22.

annually for a family of four. Thus any legislation endeavoring to thwart MICRA's purpose and protections will result in an increase in healthcare costs, no improvement in quality, and a decrease in access to healthcare services.<sup>69</sup>

### B. Patient Safety Record

In addition, MICRA protects California's strong patient safety record. According to the Agency for Healthcare Research and Quality, between 2003 and 2009, the state had significantly fewer adverse patient safety incidents per 100,000 people than the average of all other states.<sup>70</sup>

"[P]olicy options that promote better patient safety may offer a new avenue for reducing malpractice pressure on physicians, at the same time that they improve clinical outcomes."<sup>71</sup> Greenberg, Haviland, Ashwood, and Main conducted research to investigate California's patient safety and medical liability data from 2001 to 2005 with the goal of investigating California's patient safety and medical liability data.<sup>72</sup> The study implied that California county-level safety performance, as revealed by variations in annual counts of patient safety indicators, is notably correlated with shifts in the amount of malpractice claims ensuing in the same counties in the same year. The counties that achieved improvement in the regularity of patient safety indicators during the year generally corresponded to an improvement in *the* amount of malpractice claims.<sup>73</sup> The authors of the study state:

It suggests that safety interventions that improve patient outcomes have the potential to reduce malpractice claiming, and in turn, malpractice pressure on providers. It also suggests that the traditional legal doctrine of malpractice, which focuses on deterring negligence and related injuries, is at best incomplete in addressing the underlying problem of patient safety in U.S. health care facilities.<sup>74</sup>

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69. *Id.* at 25.

70. *Id.* at 24.

71. Michael D. Greenberg et al., *Is Better Patient Safety Associated with Less Malpractice Activity?*, RAND CORP. 1, 2 (2010), [http://www.rand.org/content/dam/rand/pubs/technical\\_reports/2010/RAND\\_TR824.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR824.pdf).

72. *Id.*

73. *Id.* at 15.

74. Greenberg, *supra* note 71.

*C. Patient Advocates and Healthcare Providers*

Across California, a large and diverse association of patient advocates and healthcare providers supports MICRA. Support for MICRA is comprised of more than 700 groups such as: healthcare providers, local governments, public safety and labor groups, community clinics, community health centers, organizations committed to disease prevention, hospitals, medical and dental societies, medical groups, healthcare-provider-owned professional liability carriers, among others. In the latest poll, it was found that, overall, voters supported MICRA by more than a 2-1 margin, with 56 percent of voters in support and 25 percent against.<sup>75</sup>

## V. ATTEMPT TO ALTER MICRA: PROPOSITION 46

Despite the assumed benefits of MICRA, it remains controversial among many. According to Bob Pack, the main author of the Troy and Alana Pack Patient Safety Act, or Proposition 46, MICRA has never been adjusted for inflation in thirty-eight years, which he and his supporters believe to be a problem.<sup>76</sup> Proposition 46, which was rejected by California voters during voting in November 2014,<sup>77</sup> proposed adjusting the \$250,000 cap to account for thirty-eight years of inflation. Pack claimed that, by raising the cap, “the ballot measure would also help reduce medical errors by requiring mandatory random drug and alcohol testing for physicians, as a high-risk profession as airline pilots or other jobs where intoxication-induced mistakes can cause deaths.”<sup>78</sup> He also argued that updating the MICRA cap would not increase healthcare costs and that there would be no other discernable effect.<sup>79</sup> He pointed out that medical malpractice payments have decreased by 29 percent over the past decade, as opposed to national healthcare spending which increased by almost 60 percent.<sup>80</sup> Pack believes that these

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75. SAN DIEGO CNTY. MED. SOC’Y, *supra* note 52, at 25.

76. See Bob Pack, *Want to Reduce Healthcare Costs? Start by Reducing Medical Errors*, BUDGET WATCHDOGS (2013), <http://www.budgetwatchdogs.org/increase-the-micra-cap/>.

77. See Tracy Seipel & Jessica Calefati, *California Voters Reject Propositions 45, 46, 48 Pass 47*, SAN JOSE MERCURY NEWS (Nov. 4, 2014, 11:11 PM), [http://www.mercurynews.com/breaking-news/ci\\_26866635/propositions-45-and-46-losing-early-returns](http://www.mercurynews.com/breaking-news/ci_26866635/propositions-45-and-46-losing-early-returns).

78. Pack, *supra* note 76.

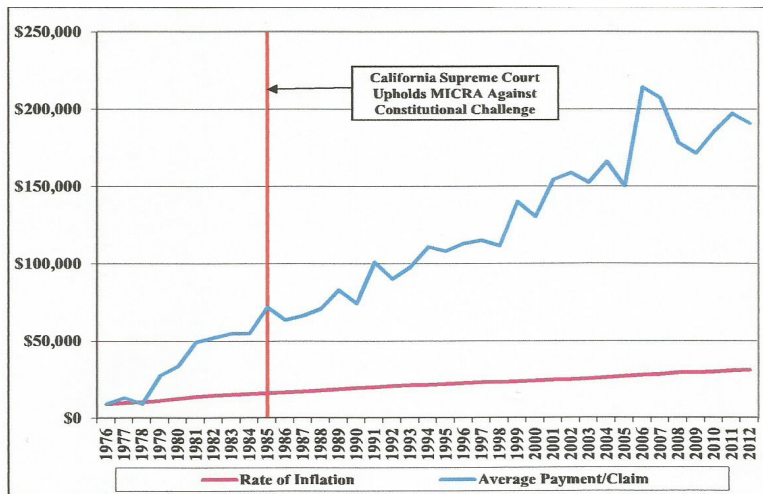
79. *Id.*

80. *Id.*

“divergent trajectories lay waste in claims that litigation is responsible for rising healthcare costs.”<sup>81</sup> He concluded that the outdated MICRA law is a “one-size-fits-all solution” that doesn’t function within the intricacy of medical malpractice; and many times, victims cannot find an attorney willing to take their case due to the limitations placed on attorney fees.<sup>82</sup>

However, according to Hamm, Frech III, and Wazzan, California consultants and professors of economics, the increase in the rate in the average payment to medical liability claimants has surpassed the rate of inflation.<sup>83</sup> While the cap has limited non-economic damages awards and deterred the filing of weak and non-meritorious claims, it has not prohibited the average payment of awards to medical liability claimants from continuing to rise at a rate surpassing the rate of inflation.<sup>84</sup> Figure 2, pictured below, displays the standard payment per claim for each year from 1976 through 2012. In addition, it displays what the average would have been if damage awards had simply kept with the rate of inflation since the cap was enacted in 1975.<sup>85</sup>

*Figure 2. Inflation-Adjusted Mean Payment per Paid Claim in California (1976–2012)*<sup>86</sup>



81. *Id.*

82. *Id.*

83. Hamm, *supra* note 28, at 16.

84. *Id.*

85. *Id.*

86. *Id.*

As Figure 2 exhibits, the average size of paid medical liability claims since 1976 in California has increased at a degree that is 2.54 times the rate of inflation, despite the \$250,000 MICRA cap. “As a result, the average payment per claim in 2012 (\$191,162) was more than six times what the average would have been if it had merely kept pace with the rate of inflation (\$31,404).”<sup>87</sup>

An opponent of the Troy and Alana Pack Patient Safety Act, Paul R. Phinney, the President of the California Medical Association, stated that “California trial lawyers and their allies are seeking to change a California law to make it easier to sue doctors, hospitals, nurses, community clinics and all other health care providers so they can make more in legal fees, costing taxpayers.”<sup>88</sup> The Troy and Alana Pack Patient Safety Act’s central requirement is to change MICRA by quadrupling the projective, non-economic damages cap of \$250,000 to \$1.1 million. The four-fold increase to MICRA’s non-economic damages cap propositioned in the ballot measure gives trial lawyers incentive to choose to take on non-meritorious cases, which will cause an increase in health care costs for everyone. The new limit on the cap of non-economic damages would allow trial lawyers to obtain three times more in legal fees than what they currently receive under the \$250,000 limit. Currently, trial lawyers receive \$74,166.67 per case, versus a potential \$235,666.67 per case under the new limit.<sup>89</sup> Phinney further disagrees with the positions of trial lawyers and advocates of Proposition 46, stating, “Meritless lawsuits waste precious health care resources. The end result is increased health care costs for everyone, plain and simple. . . . More lawyers filing meritless lawsuits is a bad idea. MICRA works well. We don’t need to change it just to benefit lawyers.”<sup>90</sup>

Based on the best data available, raising the cap on non-economic damages from \$250,000 to \$1,000,000 or more would cause health care costs to rise significantly in California by approximately \$9.9 billion per year. This is an average of \$261 per

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87. *Id.* at 16–17.

88. Paul R. Phinney, *Don’t Let Trial Lawyers Increase Health Care Costs and Reduce Access to Care*, BUDGET WATCHDOGS (2013), <http://www.budgetwatchdogs.org/increase-the-micra-cap/>.

89. *Id.*

90. *Id.*

resident or approximately \$1,000 for a family<sup>91</sup> of four.<sup>92</sup> This weight of increased health care costs would be carried by three groups of Californians—consumers, employees, and taxpayers. If the MICRA cap is increased, consumers will be strained to pay more for their health care, and employees who are covered by employer-subsidized health insurance will experience a decrease in their disposable income because their employers will seek to recover the higher costs of providing insurance by retaining wages and salaries and by raising deductibles and copayments.<sup>93</sup> Taxpayers will be required to pay as much as \$2 billion<sup>94</sup> extra per year because when health care costs increase the state and local government will be required to pay more to offer health care to consumers.<sup>95</sup>

Many scholars and advocates against caps on damages have been concerned about lack of redress for non-economic damages, in turn arguing for raising the cap. However, after the passage of the PPACA, proponents of caps on damages have also pointed out that with the recent wide availability of health insurance “at adjusted community rates . . . there is less reason to be concerned that the imposition of a cap reduc[ing] the availability of funds to cover future economic losses such as health care costs.”<sup>96</sup>

#### VI. CONSIDERING MICRA, HOW DOES CALIFORNIA COMPARE TO OTHER STATES?

Overall, MICRA has benefited the state of California by protecting the patient and the physician, while in other states, there is a struggle to keep healthcare affordable for patients, and physicians struggle to afford medical liability premiums; as a result, physicians regularly avoid providing “services in emergency rooms and trauma and maternity centres because the fee hikes mean they can’t afford to

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91. CALIFORNIANS ALLIED FOR PATIENT PROT., MICRA THE MEDICAL INJURY COMPENSATION REFORM ACT 3 (Feb. 2005), [https://www.sdcm.org/Portals/18/Assets/pdf/micra\\_handbook.pdf](https://www.sdcm.org/Portals/18/Assets/pdf/micra_handbook.pdf). Currently, the medical liability costs are \$280 each year for a family of four. *Id.*

92. Hamm, *supra* note 28, at 4.

93. *Id.* at executive summary 7.

94. *Id.*

95. *Id.*

96. Nelson, *supra* note 7, at 451. Nelson points out that a system of caps on damages is similar to that of Canada, “a common law jurisdiction with a fault-based medical malpractice regime and universal access to health care.” *Id.* According to Nelson, in 1978, “the Supreme Court of Canada . . . limited non-economic damages in personal injury cases to \$100,000 (CAD).” *Id.*

work.”<sup>97</sup> The AMA has placed liability reform at the top of the national agenda, arguing that there are at least twelve states that have a “full-blown” liability insurance crisis.<sup>98</sup> Many, including the AMA, have argued that, through tort reform based upon California’s Medical Injury Compensation Reform Act of 1975, the crisis can be mended.

For example, when malpractice insurance premiums increased rapidly in Nevada, the state’s only Level 1 trauma center in Las Vegas shut down for ten days in July 2002.<sup>99</sup> The ten-day shutdown alarmed legislators and they met in a special session to find a solution. In reaction to the trauma center’s shutdown, Bill Welch, the President and CEO of the Nevada Hospital Association in Reno, stated that he and legislators “developed a draft bill that was modeled 100 percent on California’s liability law.”<sup>100</sup> On August 7, 2002, Nevada signed into law a measure similar to those of MICRA—a cap on non-economic damages of \$350,000, and a \$50,000 limit on damages for hospitals and physicians who care for trauma patients.<sup>101</sup>

Similar to the crisis in Nevada, in 2003, surgeons in West Virginia walked off the job to protest skyrocketing malpractice insurance fees, joining a growing succession across the county.<sup>102</sup> This strike caused patients to be transferred to neighboring states such as Ohio or Pennsylvania.<sup>103</sup> However, Pennsylvania was trying to manage a similar crisis of its own, with its hospitals beginning to limit services because of the expected work strikes by physicians—mainly obstetricians and surgeons.<sup>104</sup> In Scranton, Pennsylvania, one trauma center had closed, and another in a suburb of Philadelphia indicated that it could be closing its doors as well unless the liability insurance decreased.<sup>105</sup> And in rural Arizona, the Copper Queen Community Hospital in Bisbee ceased delivering

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97. See Milan Korcok, *Malpractice Fee Hikes Mean Some US MDs Can't Afford to Work*, 4 CAN. MED. ASS'N J. 472, 472 (2003).

98. *Id.*

99. See Richard Haugh, *California, Here We Come*, 10 HOSP. & HEALTH NETWORKS 16, 16 (2002).

100. *Id.*

101. *Id.*

102. Korcok, *supra* note 97, at 472.

103. *Id.*

104. *Id.*

105. *Id.*

babies after family physicians saw their estimated insurance rates increase from \$15,000 to \$57,000.<sup>106</sup>

These examples of physicians on strike and the shutting down of health services can all be explained by nationwide increases in medical liability insurance premiums. According to the National Association of Insurance Commissioners, a 2000 study analyzing data from the years 1976 to 1999 found that medical liability insurance premiums grew 420 percent nationally, whereas in California they rose only 168 percent.<sup>107</sup> The solution to the nationwide crisis, according to the AMA, is tort reform based on California's Medical Injury Compensation Reform Act of 1975, because the act "covers medical expenses and other economic damages following a medical misadventure, but discourages frivolous lawsuits by limiting incentives to pursue them."<sup>108</sup> Considering this national crisis and the effects and benefits of MICRA in California, how feasible would federal tort reform efforts based on MICRA really be?

#### VII. THE POTENTIAL FOR MICRA TO BE USED AS A MODEL FOR FEDERAL MALPRACTICE REFORM

Today, MICRA might be considered "conventional reform" in that it caps non-economic damages in malpractice cases at \$250,000.<sup>109</sup> While reform efforts that incorporate caps on damages are presently framed as "conservative" or "Republican" in nature, MICRA was supported primarily by Democrat Governor Jerry Brown, and received bi-partisan support.<sup>110</sup> During its enactment in 1975, the Act was relatively "uncontroversial."<sup>111</sup>

Since its enactment, many have suggested that the MICRA is a model reform for medical malpractice.<sup>112</sup> Specifically, AMA and efforts by former president George W. Bush have been the most aggressive in the push for MICRA-style reform. In the early 2000s, President Bush, alongside Republicans in Congress and the AMA, encouraged the Help Efficient, Accessible, Low-Cost, Timely

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106. *Id.*

107. Haugh, *supra* note 99.

108. Korcok, *supra* note 97, at 472.

109. *Id.*

110. Nelson, *supra* note 7, at 456–57.

111. *Id.*

112. *Id.* at 456.



Healthcare Act (HEALTH Act), which was proposed legislation modeled after MICRA.<sup>113</sup> Specifically, the HEALTH Act proposed a \$250,000 cap on non-economic damages in medical liability cases.<sup>114</sup> The HEALTH Act did not survive the Senate.<sup>115</sup>

Later, in 2003, the President of the AMA, Donald Palmisano, argued for federal MICRA-style reforms, asserting that MICRA was responsible for “keeping premium increases on medical liability insurance in California at moderate levels.”<sup>116</sup> He argued that MICRA-style reform at the federal level was necessary as “physicians could either no longer find or were unable to afford liability insurance and thus were closing their practices, retiring or reducing services.”<sup>117</sup> The AMA released additional support for MICRA-style reform in 2007.<sup>118</sup>

But despite the benefits and praise discussed in this Article, a large amount of controversy still exists about the success and effects of MICRA-style legislation.<sup>119</sup> While a number of states are enacting MICRA-like caps on damages, several high courts in states have deemed these caps unconstitutional.<sup>120</sup> Further, when MICRA-style reform was suggested by Republican speakers during the 2010 health care summit, specifically, when caps on damages were suggested, President Barack Obama instead noted his interest in “federal incentives for states to experiment much more vigorously with ways to reduce frivolous lawsuits, to pursue settlements, [and] to reduce defensive medicine.”<sup>121</sup> When the CBO found that “federal enactment of medical liability reform—including a cap on non-economic damages of \$250,000—would reduce federal budget

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113. *Id.* at 460.

114. *Id.*

115. *Id.*

116. *Id.* at 461.

117. *Id.*

118. *Id.* at 462 (“A 2007 position paper issued by the AMA noted that ‘MICRA’s \$250,000 cap on non-economic damages has been the cornerstone of organized medicine’s attempts to ensure a litigation system that does not hinder patient access to care.’”).

119. *See* Williams, *supra* note 1, at 479 (“Plaintiffs’ lawyers and patient advocacy groups complain that states are unconstitutionally restricting access to the courts by enacting legal hurdles to commencing medical malpractice claims and by capping damages, both economic and non-economic.”). Williams highlights that currently “28 states impose a cap on non-economic damages and six states impose a cap on total damages . . . [S]ix state supreme courts have ruled damages caps unconstitutional under their states’ constitutions.” *Id.* at 494–96 (footnote omitted).

120. Nelson, *supra* note 7, at 453.

121. *Id.* at 445–47 (internal quotation marks omitted).

deficits by \$54 billion over the period of 2009–2019,”<sup>122</sup> President Obama noted that “this savings was a relatively insignificant amount in a system that spends \$2 trillion annually.”<sup>123</sup> Overall, Democrats are largely opposed to caps on damages and view them as “unfairly penalizing the most severely injured victims of malpractice, and unlikely to reduce health care costs significantly.”<sup>124</sup>

Interestingly, the individual who primarily suggested MICRA for tort reform in California, Democrat Henry Waxman, has since argued that “while the California malpractice reforms ha[ve] been in place in California since 1975, they had not solved the problem of health care cost increases.”<sup>125</sup> Further, those who are opposed to caps on damages have asserted that reduced insurance premiums in California are a result of the passage of Proposition 103 in 1988, not the enactment of MICRA.<sup>126</sup> Finally, using 2010 data from California malpractice claims, a study by the Rand Institute for Civil Justice<sup>127</sup> “found a correlation between a reduction in potential adverse patient safety incidents and fewer malpractice claims,” but also found that “the decline in claims could not be explained by the ‘impact of tort reform within the state.’”<sup>128</sup> Overall, the positive effects of MICRA in the state of California seem to have been questioned and criticized as much as they have been praised.

MICRA has been described by some legal scholars as a “double edged sword,” unfortunately leading to a “propensity for significant inequality.”<sup>129</sup> Specifically, cases of catastrophic medical error may not receive the same appropriate redress as less extreme cases of

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122. *Id.* at 445.

123. *Id.* at 447.

124. *Id.* at 445.

125. Nelson, *supra* note 7, at 447. At the time of MICRA’s introduction, the reforms were “recommended by a committee chaired by Democrat Henry Waxman, then a member of the California Assembly.” *Id.* at 456–57.

126. *Id.* at 468. Proposition 103 was a measure that “included a rollback on premiums, and a mechanism for consumers to challenge rate increases.” *Id.*

127. Greenberg et al., *supra* note 71.

128. Nelson, *supra* note 7, at 468.

129. See Grant Wood Geckeler, *The Clinton-Obama Approach to Medical Malpractice Reform: Reviving the Most Meaningful Features of Alternative Dispute Resolution*, 8 PEPP. DISP. RESOL. L.J. 171, 185 (2007) (“[I]n cases of catastrophic medical error, the application of . . . damages caps may isolate the effect of the jury award at the policymaking level. Second, the capping of non-economic damages has shifted the perception of risks and rewards for medical malpractice plaintiffs’ attorneys by reallocating the costs . . . from defendants to plaintiffs and their counsel.”).

malpractice.<sup>130</sup> Does this propensity for inequality destroy MICRA's ability to effectively address the issues of malpractice insurance premiums and patient safety, or can MICRA be modified as a model for federal tort reform to prevent these legal pitfalls?

Some advocates for reform have suggested creating "carve-out provisions" to address the inequalities resulting from the caps provision of MICRA.<sup>131</sup> One legislative change could be creating a tort system that uses "horizontal equity," or "treating like cases alike."<sup>132</sup> This sort of change could include "standardized awards based on age and severity of injury, a distribution of the amounts awarded in comparable cases, and scenarios of prototypical injuries and their corresponding awards."<sup>133</sup> With careful analysis and modification, MICRA may yet have potential to serve as a model for federal tort reform.

### VIII. CONCLUSION

At the very least, scholars agree that reform for malpractice liability has traditionally followed crises in the insurance market "characterized by sudden spikes in rates and the withdrawal of insurers from the market."<sup>134</sup> Since the national spikes in insurance rates in 1974, California's MICRA has been one of the sole models for tort reform. This Article has sought to make clear that, despite MICRA's praise among many political and legal scholars, MICRA continues to remain controversial, and must be carefully analyzed before being implemented as a model for federal tort reform. As has been previously stated, "any remedy to the medical malpractice 'crisis' must also incorporate the political realities of our society."<sup>135</sup>

If MICRA is ever to be utilized as a model for federal tort reform, there must be compromise on its tenets, such as carve-out provisions that remedy the MICRA's propensity for unfair treatment of malpractice cases, which vary in severity of injuries.<sup>136</sup> Additionally, reform of any sort must include "physician buy-in," so

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130. *See id.*

131. *Id.*

132. *See* Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 93 (2011).

133. *Id.* at 93–94.

134. Nelson, *supra* note 7, at 453.

135. Williams, *supra* note 1, at 489.

136. Geckeler, *supra* note 129, at 185.

that there can be a decrease in the practice of defensive medicine; this in turn would result in a decrease in health care costs and unnecessary medical procedures performed, which often ignore patient safety.<sup>137</sup> MICRA has been deemed by many as successful because it includes this “physician buy-in,” as physicians typically desire “stable, affordable malpractice insurance premiums,” and “tort reform that caps non-economic damages to prevent what [physicians] consider . . . jury awards that exceed their malpractice insurance policy limits.”<sup>138</sup> If legislators and legal scholars can work toward further evaluating and modifying reform models like MICRA to more effectively address malpractice cases, medical liability laws may help physicians return to making “cost-effective investments in patient safety,”<sup>139</sup> which in turn benefit not only providers, but provides patients with adequate redress from medical error.

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137. See Williams, *supra* note 1, at 490–91; see also Nelson, *supra* note 7, at 482 (explaining how defensive medicine, in reaction to increased medical liability insurance premiums, resulted in physicians performing more cesarean sections, and that “this effect was greater for women of lower socioeconomic groups.”).

138. Williams, *supra* note 1, at 490.

139. See Jennifer Arlen, *Contracting Over Liability: Medical Malpractice and the Cost of Choice*, 158 U. PA. L. REV. 957, 959 (2010).

