October 7, 2013

Hon. Kamala D. Harris
Attorney General
1300 I Street, 17th Floor
Sacramento, California 95814

Attention: Ms. Ashley Johansson
Initiative Coordinator

Dear Attorney General Harris:

Pursuant to Elections Code Section 9005, we have reviewed the proposed statutory initiative (A.G. File No. 13-0016) relating to medical malpractice damage awards, physician substance abuse, and the prescribing and dispensing of drugs by physicians and pharmacists.

BACKGROUND

Medical Malpractice

Under current state law, patients injured while receiving health care may sue health care providers for medical malpractice. A successful malpractice claim typically requires that the injured party demonstrate that the provider caused the injury due to an action or inaction and that the provider was negligent. Damages awarded in medical malpractice cases include:

- ***Economic Damages*—**funds to compensate a plaintiff for the monetary costs of an injury, such as medical bills or loss of income.
- ***Noneconomic Damages*—**funds to compensate for items other than monetary losses, such as pain and suffering.

Medical Malpractice Insurance. Health care providers pay for the costs of medical malpractice claims in at least a couple of different ways. Many providers purchase medical malpractice insurance, whereby the provider makes monthly premium payments to a malpractice insurer and the malpractice insurer pays for the costs associated with any medical malpractice claims filed against the provider. In other instances, providers may be employed by, or affiliated with, an organization that "self-insures," meaning the organization directly pays for the costs associated with medical malpractice claims against the health care providers.

Medical Injury Compensation Reform Act (MICRA). In 1975, the Legislature enacted MICRA, which made several significant changes to the medical malpractice system in California. One MICRA provision established a $250,000 cap on noneconomic damages that may be awarded to an injured plaintiff. This cap was not made subject to annual inflationary

adjustments. There is no cap on economic damages. The MICRA also established a limit on attorney's fees in medical malpractice cases.

The Medical Board of California

The Medical Board of California (Board) is part of the California Department of Consumer Affairs. The Board licenses and regulates physicians, surgeons, and certain other health care professionals. The Board is also responsible for investigating complaints and disciplining physicians and certain other health professionals who violate the laws that apply to the practice of medicine. For example, the Board may suspend or revoke a license on the grounds that a licensee has been convicted of a crime if the crime is substantially related to the licensee's medical profession.

The Controlled Substance Utilization Review and Evaluation System (CURES)

The California State Department of Justice (DOJ) maintains CURES, which contains electronic information about the prescribing and dispensing of certain drugs. Using CURES, physicians, pharmacists, and other registered users (such as law enforcement officials) can review a patient's prescription drug history to potentially prevent the abuse of prescription drugs. For each prescription of certain types of drugs, the dispenser is required to provide specified information on a weekly basis to DOJ, including the name, address, and date of birth of the user of the drug. Prescribers and pharmacists are not currently required to register to use the system or consult the database prior to prescribing or dispensing controlled substances. In February of 2013, DOJ estimated that about 6 percent of all prescribers and pharmacists in California are registered to use the system. However, beginning January 1, 2016, prescribers and pharmacists will be required to apply to obtain access to CURES, but they will not be required to consult CURES prior to prescribing or dispensing controlled substances.

State and Local Governments Pay for a Substantial Amount of Health Care

The state and local governments pay for a substantial amount of health care services in California. Governments typically pay for health care services by either purchasing services from health care providers and health plans or operating government health care facilities. In this section, we describe some of the major state and local health programs and facilities that pay for health care services.

Medi-Cal. In California, the federal-state Medicaid Program is known as Medi-Cal. Medi-Cal purchases health care services mainly for low-income individuals. With an estimated average monthly enrollment of over eight million and annual General Fund budget of over $15 billion, Medi-Cal is by far the state's largest health program. (Medi-Cal enrollment will increase with the implementation of federal health care reform, effective January 1, 2014.) There are two main systems for the delivery of medical care to Medi-Cal enrollees: fee-for-service (FFS) and managed care. Under FFS, Medi-Cal enrollees may receive services from any provider accepting Medi-Cal patients and the state generally reimburses the health care provider a set rate for each medical service delivered to a beneficiary. Under managed care, the state pays health plans a predetermined amount per enrollee, per month. In turn, the health plan is responsible for

organizing the delivery of the health care to plan enrollees and reimbursing health care providers for services delivered to plan enrollees.

Health Coverage for State and Local Government Employees and Retirees. The state, California's two public university systems, and many local governments in California pay for a large portion of health costs for their employees and related family members and for some of their retired workers. Together, state and local governments pay roughly $20 billion annually for employee and retiree health benefits. Employee and retiree health benefits are typically provided through private health plans.

State-Operated Facilities. The state administers institutions that provide health care services directly to the populations they serve. These institutions include:

- ***Mental Hospitals.*** The Department of State Hospitals administers the state mental health hospital system consisting of five hospitals that provide treatment to about 5,500 patients.
- ***Prisons.*** The California Department of Corrections and Rehabilitation administers the state prison system, which provides health care to about 124,000 inmates.
- ***Developmental Centers (DCs).*** The Department of Developmental Services administers the state DCs system consisting of four institutions that provide residential services and health care to about 1,300 individuals with developmental disabilities.

Generally, these state institutions employ physicians, pharmacists, and other medical professionals to provide health care services. For these state employees, the state generally self-insures against the financial risk associated with the costs of medical malpractice claims against its employees. In some cases, state institutions are not equipped to provide the level of medical care needed by a patient. For example, DCs are not equipped to perform major surgeries. In these cases, the patient is usually taken to a nearby medical facility that is equipped to provide the level of medical care required by the patient, and the state reimburses the provider for the services. The costs for operating state prisons and mental hospitals are paid for almost entirely with state funds, and the costs for operating DCs are shared roughly equally by the state and the federal government.

University of California (UC) Hospitals. The UC operates several hospitals. The operational costs of the hospitals are mainly funded by revenue generated from providing services to patients with health insurance coverage.

Local Government Health Programs. Local governments—primarily counties—provide a wide variety of health care services, mainly to low-income individuals. For example, some counties operate hospitals and clinics. Funding for county hospitals is complex, but it includes revenue from providing health services to individuals with health insurance coverage, such as Medi-Cal, as well as county contributions to provide services to low-income populations without health insurance. County-operated hospitals and clinics employ health care providers and the county generally self-insures against the risk associated with the costs of a medical malpractice claim against its employees.

PROPOSAL

This measure has several provisions that generally relate to health care provider conduct.

Raises Cap on Noneconomic Damages for Medical Malpractice. Beginning January 1, 2015, this measure adjusts the current $250,000 cap on noneconomic damages to reflect the increase in inflation (as measured by the Consumer Price Index) since the cap was established—effectively raising the cap to approximately $1.1 million. The cap on the amount of damages would be adjusted annually thereafter to reflect any increase in inflation.

Requires Reporting of Suspected Physician Drug or Alcohol Impairment or Failure to Follow Appropriate Standard of Care. The measure requires physicians to report to the Board any information known to them that appears to show a physician was impaired by drugs or alcohol while on duty, or that a physician who treated a patient during an adverse event (as defined in state law) failed to follow the appropriate standard of care. Persons who are not physicians may also report this information to the Board, but are not required to do so.

Requires Hospitals to Conduct Alcohol and Drug Testing on Physicians. This measure requires hospitals to conduct testing for drugs and alcohol on physicians as follows:

- Random testing on physicians who are hospital employees, contractors, or who have the authority to admit patients to the hospital.
- Following an adverse event, tests on physicians who were responsible for the care and treatment of a patient or prescribed medication to a patient within 24 hours prior to the adverse event. Physicians would be required to make themselves available for drug testing as soon as possible after the adverse event occurs. Failure to submit to drug testing within 12 hours after the physician learns of the adverse event can be cause for suspension of the physician's license.
- At the direction of the Board, tests on physicians who are the subject of a report of possible drug or alcohol use or failure to follow the appropriate standard of care (discussed above).

The hospital would be required to bill the physician for the cost of the test. The hospital would also be required to report any positive test results, or the willful failure or refusal of a physician to submit to the test, to the Board which must do the following:

- Refer the matter to the Attorney General's Health Quality Enforcement Section for investigation and enforcement.
- Temporarily suspend the physician's license pending the Board's investigation and hearing on the matter.
- Notify the physician and each of the health facilities at which the physician practices that the physician's license has been temporarily suspended.

If the Board finds that a physician was impaired by drugs or alcohol while on duty or during an adverse event, or that a physician has refused or failed to comply with drug and alcohol testing, the Board must take specified disciplinary action against the physician, which may

include suspension of the physician's license. The measure also specifies that there will be a presumption of professional negligence in any civil action taken against any physician who tested positive for drugs or alcohol or failed to comply with the drug testing requirements of this measure.

The measure requires the Board to assess an annual fee on physicians sufficient to pay the costs of (1) the Board to administer this measure and (2) the Attorney General to conduct investigations and take enforcement actions as required by the measure.

Requires Health Care Practitioners and Pharmacists to Consult CURES. This measure requires health care practitioners and pharmacists to consult CURES prior to prescribing or dispensing certain drugs, such as OxyContin or Vicodin, to a patient for the first time. If the patient has an existing prescription for the drug, the health care practitioner must determine there is a legitimate need. Failure to consult a patient's electronic history would be cause for disciplinary action by the health care practitioner's licensing board.

FISCAL EFFECTS

This measure would likely have a wide variety of fiscal effects on state and local governments—many of which are subject to substantial uncertainty. We describe the major potential fiscal effects below.

Increase in Government Costs Due to an Increase in Medical Malpractice Costs

Raising the cap on noneconomic damages would result in higher medical malpractice costs due to an increase in the amount of awards and settlements in medical malpractice cases and could result in higher medical malpractice costs due to a potential increase in the number of medical malpractice claims filed. These higher costs would likely be partially offset by a decrease in medical malpractice costs stemming from a change in health care providers' behavior in an effort to avert medical malpractice lawsuits. On net, these factors would likely increase the costs associated with resolving medical malpractice claims relative to what they would be absent the measure. The higher medical malpractice costs would, in turn, increase costs for health care providers.

Increased Costs for State and Local Government Purchasers and Providers of Health Care Services. As noted earlier, state and local governments purchase and directly provide tens of billions of dollars of health care services annually. The degree to which increased malpractice costs resulting from the measure would have fiscal effects on state and local governments depends, in large part, on the degree to which additional malpractice costs are passed on to state and local governments as purchasers of health care services in the form of higher prices for health coverage and health care services. Our analysis assumes additional medical malpractice costs are generally passed along to purchasers of health care coverage and health care services. According to one federal analysis, medical malpractice costs are about 2 percent of total health care spending (both governmental and nongovernmental) nationally. This federal analysis also found that a package of several federal medical malpractice reforms that serve to *limit* medical malpractice litigation—including caps on noneconomic damages—would reduce national medical malpractice costs by about 10 percent, on average. Assuming malpractice costs are

about 2 percent of state and local government health care spending in California and *raising* the cap on noneconomic damages would, on net, increase medical malpractice costs for state and local government health care purchasers and providers by an average of 10 percent, state and local government health care spending would increase by about 0.2 percent—or by the high tens of millions of dollars annually. However, given the uncertainty surrounding these assumptions—including the degree to which the assumptions in the federal analysis noted above can be applied to changes associated with raising the cap on noneconomic damages in California—actual costs associated with raising the cap could range from the low tens of millions of dollars to over one hundred million dollars annually.

Potential Increased Government Health Care Costs Due to Changes in the Amount and Types of Health Care Services Provided

Changes in the Amount and Types of Health Care Services Provided. In addition to its effect on medical malpractice costs, raising the cap on noneconomic damage awards may also affect the amount and types of health care services provided in California. As discussed earlier, the higher cap on noneconomic damages could increase the number of medical malpractice lawsuits filed against health care providers. In response, some health care providers, such as physicians, may change their behavior in an effort to avoid having a lawsuit filed against them. Such changes in behavior may increase or decrease health care costs. For example, a physician may order a test or procedure for a patient that he or she would not have otherwise ordered. In some instances, the additional test or procedure may reduce future health care costs by preventing further deterioration of a person's health that would have otherwise resulted in additional costs. In other instances, however, the additional test or procedure may simply increase the total costs of health care services, with little or no future offsetting reductions in costs.

Numerous studies have attempted to quantify the degree to which certain medical malpractice reforms affect the amount and types of health care services provided and the net effect such changes have on health care costs. The results from these studies vary, but, on balance, they suggest that certain medical malpractice reforms that *reduce* the likelihood of a provider being sued for medical malpractice, such as caps on noneconomic damages, are generally associated with the provision of different amounts and types of health care services that, on net, decrease health care costs. Accordingly, policies that *increase* the likelihood of a provider being sued for malpractice, such as raising the cap on noneconomic damages, would likely encourage the provision of different amounts and types of services that, on net, increase health care costs.

Potential Increased Costs for Government Providers and Purchasers of Health Care Services. The degree to which raising the cap on noneconomic damages from $250,000 to about $1.1 million would increase the use of certain health care services and, thereby, increase health care costs for state and local governments in California is highly uncertain. National estimates of the net effect of malpractice reforms—including caps on noneconomic damages—on spending associated with changes in the amount and types of health care services provided generally range from minor to an increase of more than 3 percent. Several factors likely affect the degree to

which such estimates could be applied to state and local government health care costs in California, including the degree to which services are provided through managed care.

In California, the range of potential net effects on state and local government costs would likely be toward the lower end of the range of national estimates, in large part due to the high prevalence of managed care—which is generally associated with fewer changes in the amount and types of health care services provided in response to malpractice reforms. However, even a small percentage change in health care costs could have a significant effect on government health care spending. For example, a 0.3 percent increase in state and local government health care costs in California would increase costs by over one hundred million dollars annually. Given the substantial uncertainty surrounding the potential changes in the amount and types of health care services purchased and provided by state and local governments, potential net costs could range from minor to the hundreds of millions of dollars annually.

Effect on State and Local Government Revenues

Change in State and Local Revenues Likely Not Significant. Health care is a significant segment of the California economy. As such, this measure could affect the economy and state and local government revenues. For example, to the extent that employer-provided health insurance premiums (a category of employee compensation that generally is not taxable) increase, taxable employee salaries may decrease as a result. Lower "take home" pay to workers could contribute to lower taxable retail sales, thereby reducing state and local sales tax revenues. Higher health insurance costs may reduce profits of businesses somewhat, thereby reducing state income tax revenues. Offsetting these revenue reductions to some degree would be increases in state taxes levied on certain insurance premiums, as well as increased taxable purchases by consumers that benefit from the higher awards allowed under this measure. A net reduction in state and local revenues is possible as a result of this measure, but it is not likely to be significant.

Other Fiscal Effects

This measure would likely have a wide variety of additional fiscal effects.

- ***State Costs to Administer New Alcohol and Drug Testing Requirements.*** The measure's alcohol and drug test requirements would create administrative costs for the Board and the Attorney General. These administrative costs would likely be less than a million dollars annually, to be paid for by a fee assessed on licensed physicians.
- ***Physician Alcohol and Drug Testing Effects.*** The measure requires hospitals to bill physicians for the cost of alcohol or drug testing. This would increase costs for physicians and some of these costs would eventually be borne by state and local governments. On the other hand, physician testing could prevent some medical errors and reduce the costs associated with such errors.
- ***Potential Savings Associated With Reduced Prescription Drug Use.*** To the extent the requirement that health care providers and pharmacists consult CURES reduces the number of unnecessary and/or illicit prescription drugs being dispensed, this

measure would likely reduce prescription drug costs for state and local governments relative to what they would have been absent the measure. In addition, this requirement could reduce other state and local government costs associated with unnecessary and/or illicit drug use, such as law enforcement, social services, and other health care costs.

- ***Medi-Cal Recovery of Malpractice Awards.*** Under current law, when Medi-Cal has paid for health benefits provided to a beneficiary injured by medical malpractice, it may recover a portion of medical malpractice damages awarded to the beneficiary to cover the state costs of these benefits. Increasing the number of medical malpractice awards would potentially increase the amount that could be recovered by the state.
- ***State Trial Court Costs.*** This measure could increase the number of medical malpractice cases and, thereby, potentially increase costs for state trial courts.

Summary of Fiscal Effects

This measure would have the following significant fiscal effects:

- State and local government costs associated with higher net medical malpractice costs, likely at least in the low tens of millions of dollars annually, potentially ranging to over one hundred million dollars annually.
- Potential net state and local government costs associated with changes in the amount and types of health care services that, while highly uncertain, potentially range from minor to hundreds of millions of dollars annually.

Sincerely,

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Mac Taylor
Legislative Analyst

_____

Michael Cohen
Director of Finance