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Proposition 46: Drug and Alcohol Testing of Doctors. Medical Negligence Lawsuits.

LEGISLATIVE ANALYST'S OFFICE

Presented to:
Assembly Health Committee
Hon. Richard Pan, Chair

Assembly Judiciary Committee
Hon. Bob Wieckowski, Chair

Assembly Business, Professions and Consumer Protection Committee
Hon. Susan A. Bonilla, Chair

Senate Health Committee
Hon. Ed Hernandez, Chair

Senate Judiciary Committee
Hon. Hannah-Beth Jackson, Chair

Senate Business, Professions and Economic Development Committee
Hon. Ted W. Lieu, Chair

Summary

☑ This measure has several provisions that relate to health care provider conduct and patient safety. Specifically, the measure's primary provisions relate to medical malpractice, prescription drug monitoring, and alcohol and drug testing for physicians. We estimate increased state and local government costs from raising the cap on medical malpractice damages ranging from tens of millions to several hundred million dollars annually, offset to some extent by savings from prescription drug monitoring and alcohol and drug testing requirements.

Background: Governments Pay for a Substantial Amount of Health Care

Government Spending on Health Care. The state and local governments in California spend tens of billions of dollars annually on health care services. The major types of public health care spending are:

- ***Health Coverage for Government Employees and Retirees.*** The state, public universities, cities, counties, school districts, and other local governments in California pay for a significant portion of health costs for their employees and their families and for some retirees.
- ***Medi-Cal.*** In California, the federal-state Medicaid program is known as Medi-Cal. Medi-Cal provides health care to over 10 million low-income persons.
- ***State-Operated Mental Hospitals and Prisons.*** The state operates facilities, such as mental hospitals and prisons, that provide direct health care services.
- ***Local Government Health Programs.*** Local governments—primarily counties—pay for many health care services, mainly for low-income individuals.

Background: Medical Malpractice

☑ ***Persons Injured While Receiving Health Care May Sue for Medical Malpractice.*** Persons injured while receiving health care may sue health care providers for medical malpractice. Damages awarded in medical malpractice cases include:

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

☑ ***How Health Care Providers Cover Malpractice Costs.*** Health care providers usually pay the costs of medical malpractice claims—including damages and legal costs—in one of two ways:

- ***Purchasing Medical Malpractice Insurance.*** The provider pays a monthly premium to an insurance company and, in turn, the company pays the costs of malpractice claims.
- ***Self-Insurance.*** Sometimes the organization a provider works for or with—such as a hospital or physician group—directly pays the costs of malpractice claims. This is often referred to as self-insurance.

These malpractice costs are roughly 2 percent of total annual health care spending in California.

☑ ***Medical Injury Compensation Reform Act (MICRA).*** In 1975, the Legislature enacted MICRA. The act made several changes intended to limit malpractice liability, including limiting the size of medical malpractice claims. For example, it established a $250,000 cap on noneconomic damages that may be awarded to an injured person. (There is no cap on economic damages.)

Background: Prescription Drug Abuse and Monitoring

- ***California's Prescription Drug Monitoring Program.*** The state Department of Justice administers California's prescription drug monitoring program, which is known as the Controlled Substance Utilization Review and Evaluation System (CURES). The CURES is an electronic database that gathers information about the prescribing and dispensing of certain drugs. This information is used to reduce prescription drug abuse, among other things. For example, it is used to identify potential "doctor shoppers"—persons obtaining prescriptions from many different physicians over a short period of time with the intent to abuse or resell the drugs for profit.

- ***Health Care Providers Required to Register for, but Not Check, CURES Beginning in 2016.*** Certain health care providers—such as physicians and pharmacists—are allowed to review a patient's prescription drug history in CURES. In order to review a patient's drug history in CURES, a user must first register to use the system. Providers, however, are not currently required to register. Beginning January 1, 2016, providers will be required to register. Even then, as currently, providers will not be required to check the database prior to prescribing or dispensing drugs.

- ***CURES Upgrades Scheduled to Be Complete in Summer 2015.*** Currently, CURES does not have sufficient capacity to handle the higher level of use that is expected to occur when providers are required to register beginning in 2016. The state is currently in the process of upgrading CURES. These upgrades are scheduled to be complete in the summer of 2015.

Proposal

☑ ***Raises Cap on Noneconomic Damages for Medical Malpractice.*** Beginning January 1, 2015, this measure adjusts the current $250,000 cap on noneconomic damages in medical malpractice cases to reflect the increase in inflation since the cap was established—effectively raising the cap to $1.1 million. The cap on the amount of damages would be adjusted annually thereafter to reflect any increase in inflation.

☑ ***Requires Health Care Providers to Check CURES.*** This measure requires health care providers, including physicians and pharmacists, to check CURES prior to prescribing or dispensing certain drugs to a patient for the first time. Providers would be required to check the database for drugs that have a higher potential for abuse, including such drugs as OxyContin, Vicodin, and Adderall. If the check of CURES finds that the patient already has an existing prescription for one of these drugs, the health care provider must determine if there is a legitimate need for another one.

☑ ***Requires Hospitals to Conduct Alcohol and Drug Testing on Physicians.*** This measure requires hospitals to conduct testing for drugs and alcohol on physicians who are affiliated with the hospital. There are currently no requirements for hospitals to test physicians for alcohol and drugs. The measure requires that testing be done randomly and in two specific instances:

- When a physician was responsible for the care and treatment of a patient within 24 hours prior to an adverse event.
- When a physician is the subject of a report of possible drug or alcohol use while on duty or failure to follow the appropriate standard of care (discussed below).

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 Medical Board.

Proposal *(Continued)*

- ☑ ***Requires Medical Board to Discipline Physicians Found to Be Impaired.*** If the Medical Board finds that a physician was impaired by drugs or alcohol while on duty or during an adverse event, or that a physician refused or failed to comply with drug and alcohol testing, the Medical Board must take specified disciplinary action against the physician.

- ☑ ***Requires Reporting of Suspected Physician Misconduct to the Medical Board.*** The measure requires physicians to report to the Medical Board any information known to them that appears to show another physician was impaired by drugs or alcohol while on duty, or that a physician who treated a patient during an adverse event failed to follow the appropriate standard of care. In most cases, individual physicians are not currently required to report this information.

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.

I. Effects of Raising Cap on Noneconomic Damages in Medical Malpractice Cases

Increase in Overall Health Care Spending. Raising the cap on noneconomic damages would likely increase overall health care spending in California (both governmental and nongovernmental) by: (1) increasing direct medical malpractice costs and (2) changing the amount and types of health care services provided.

Higher Direct Medical Malpractice Costs. Raising the cap on noneconomic damages would likely affect direct medical malpractice costs in the following ways:

- ***Higher Damages.*** A higher cap would increase the amount of damages in many malpractice claims.
- ***Change in the Number of Malpractice Claims.*** Raising the cap would also change the total number of malpractice claims, although it is unclear whether the total number of claims would increase or decrease.

On net, we estimate these changes would likely result in an *increase* in medical malpractice costs ranging from 5 percent to 25 percent. Since medical malpractice costs are currently about 2 percent of total health care spending, raising the cap would likely increase total health care spending by 0.1 percent to 0.5 percent.

Costs Due to Changes in Health Care Services Provided. Raising the cap on noneconomic damages would likely encourage health care providers to change how they practice medicine in an effort to avoid medical malpractice claims. Such changes in behavior would increase health care costs in some instances and decrease health care costs in other instances.

Fiscal Effects *(Continued)*

For example, a physician may order a test or procedure for a patient that he or she would not have otherwise ordered. This could affect health care costs in different ways:

- The additional test or procedure could reduce future health care costs by preventing a future illness.
- The additional test or procedure could simply increase the total costs of health care services, with little or no future offsetting savings.

Based on studies looking at other states' experience, we estimate that this would result in a net *increase* in total health care spending of 0.1 percent to 1 percent.

Increase in Governmental Health Care Spending. Given the above-noted effects on health care spending overall from raising the cap on noneconomic damages, the measure would likely have the following effects specifically on state and local governmental health care spending.

Annual Government Costs Likely Ranging From Tens of Millions to Several Hundred Million Dollars. As noted earlier, state and local governments pay for tens of billions of dollars of health care services annually. There would likely be a very small percentage increase in health care costs as a result of raising the cap. However, even a small percentage change in health care costs could have a significant effect on government health care spending. For example, a 0.5 percent increase in state and local government health care costs in California as a result of raising the cap would increase government costs by roughly a couple hundred million dollars annually. Given the range of potential effects on health care spending, we estimate that state and local government health care costs associated with raising the cap would likely range from the tens of millions of dollars to several hundred million dollars annually.

II. Effects of Requirement to Check CURES and Physician Alcohol and Drug Testing

Effects of Requirement to Check CURES. Once the CURES upgrades are complete, this measure would result in health care providers checking CURES more often because of the measure's requirement that they do so. Checking CURES more often could have many fiscal effects, including:

- ***Lower Prescription Drug Costs.*** Providers checking CURES would be more likely to identify potential doctor shoppers and, in turn, reduce the number of prescription drugs dispensed. Fewer prescriptions being dispensed would result in lower prescription drug costs.
- ***Lower Costs Related to Prescription Drug Abuse.*** Fewer prescriptions being dispensed would likely reduce the amount of prescription drug abuse. This, in turn, would result in lower governmental costs associated with prescription drug abuse, such as law enforcement, social services, and other health care costs.
- ***Additional Costs Related to Checking CURES.*** Certain health care providers would be required to take additional time to check CURES. As a result, they would have less time for other patient care activities. This could result in additional costs for hospitals or pharmacies needing to hire additional staff to provide care to the same number of patients.

Effects of Physician Alcohol and Drug Testing. The requirement to test physicians for alcohol and drugs could have several different fiscal effects, including:

- ***Savings From Fewer Medical Errors.*** Physician testing would likely prevent some medical errors. Fewer medical errors would decrease overall health care spending.

Fiscal Effects *(Continued)*

- ***Costs of Performing Tests.*** The measure requires hospitals to bill physicians for the cost of alcohol or drug testing. This would increase costs for providers and some of these costs would be passed along to state and local governments in the form of higher prices for health care services provided by physicians.

- ***State Administrative Costs.*** The measure's alcohol and drug test requirements would create state administrative costs, including costs for the Medical Board to enforce the measure. These administrative costs would likely be less than a million dollars annually, to be paid for by a fee assessed on physicians.

☑ ***Uncertain, but Potentially Significant, Net Savings to State and Local Governments.*** On net, the requirements to check CURES and test physicians for alcohol and drugs would likely result in annual savings to state and local governments. The amount of annual savings is highly uncertain, but potentially significant. These savings would offset to some extent the increased governmental costs from raising the cap on noneconomic damages (discussed above).