



Agenda Item 6

September 16, 2014

ITEM NAME: Update on Proposition 46 – Drug and Alcohol Testing of Doctors and Medical Negligence Lawsuits

PROGRAM: Legislation – State Initiative Statute

ITEM TYPE: Information

EXECUTIVE SUMMARY

Among other things, Proposition 46 – The Troy and Alana Pack Patient Safety Act of 2014, applies an inflation adjustment to the existing \$250,000 statutory cap on non-economic damages in a medical malpractice lawsuit, effectively raising it to \$1.1 million in current dollars. It also provides for mandatory random drug and alcohol testing for physicians, with failure or refusal to submit to testing subject to discipline by the Medical Board of California (Medical Board). The Initiative also requires health care practitioners and pharmacists to consult an existing statewide prescription database prior to prescribing or dispensing certain drugs such as OxyContin or Vicodin.

STRATEGIC PLAN

This item relates to Goal A of the California Public Employees' Retirement System (CalPERS) Strategic Plan to improve long-term pension and health benefit sustainability, as the intent of the Initiative, in part, is to reduce the incidence of medical errors by imposing mandatory drug testing on doctors, which could contribute to reducing the number of medical malpractice cases and lowering health care costs. It may also impact benefit sustainability to the extent it increases ongoing medical costs.

BACKGROUND

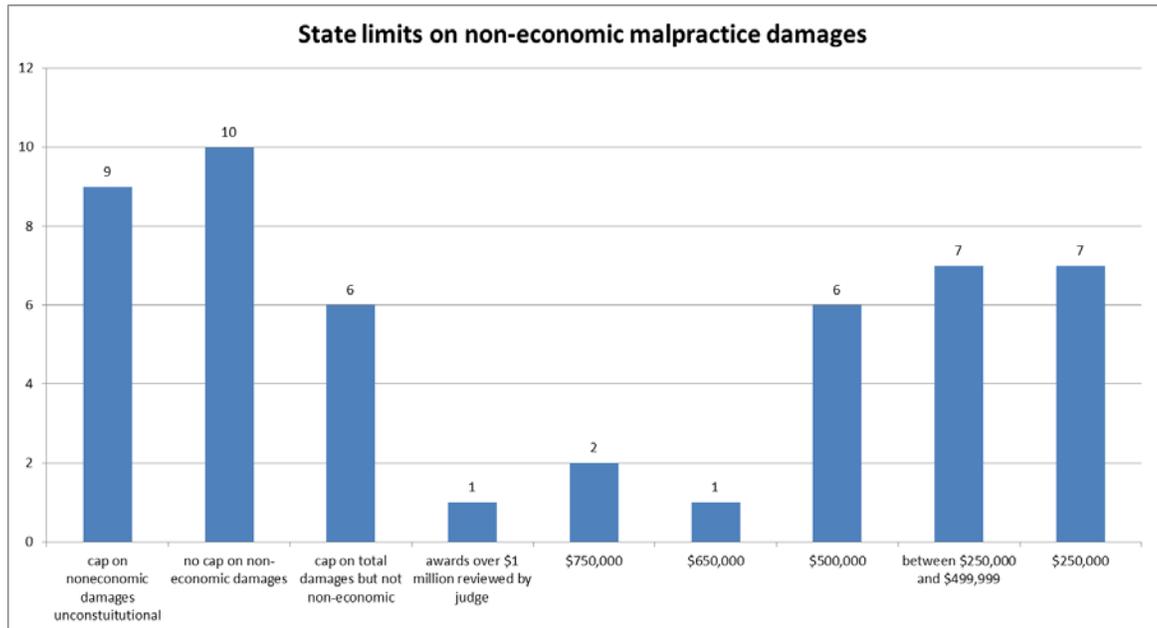
1. Existing Law

Medical Malpractice Awards

Injured patients are able to sue their health care providers for medical malpractice under state law for failure to follow an appropriate standard of care. If these plaintiffs are successful in medical malpractice cases, they can recover economic damages for medical bills, loss of income, etc. that result from the injury, and non-economic damages for pain and suffering. In 1975, the California Legislature passed and the Governor signed into law the Medical Injury Compensation Reform Act (MICRA) which, among other things, imposed a \$250,000 cap on non-economic damages that could be awarded to an injured plaintiff. The amount of the cap was not made subject to any annual inflation

adjustment, and California is currently one of seven states with the lowest limits on non-economic damage awards.

Other states place limits on non-economic damage awards as follows:



Data Courtesy of the National Conference of State Legislatures

Substance Abuse Testing

The Medical Board is responsible for licensing, investigating complaints, and disciplining specified health care professionals, including physicians, for such things as failure to follow an appropriate standard of care, illegally prescribing drugs, and drug abuse. The Medical Board follows uniform licensee monitoring and drug testing standards established by a Substance Abuse Coordination Committee within the Department of Consumer Affairs. In addition, it does not have a Diversion Program for substance abusers, and penalties are limited to licensee probation or revocation.

Statewide Prescription Database

The California Department of Justice (DOJ) currently maintains an electronic database known as the Controlled Substance Utilization Review and Evaluation System (CURES), which contains electronic information about the prescribing and dispensing of certain drugs. As of 2013, the DOJ estimated that about six percent of all prescribers and pharmacists were registered to use the system, but beginning on January 1, 2016, all prescribers and pharmacists will be required to apply for access (but not required to consult the database before prescribing or dispensing controlled substances).

ANALYSIS

1. Proposed changes

Specifically, Proposition 46 would:

Medical Malpractice Awards

- Effective January 1, 2015, adjust the \$250,000 cap on non-economic damages in a medical malpractice case to reflect increases in inflation as measured by the annual Consumer Price Index (CPI) since the cap was established.
- Require the January 1, 2015, revised cap on non-economic damages to be annually adjusted thereafter to reflect increases in inflation as measured by the CPI.
- Require the Department of Finance to calculate and publish on its Internet website the adjustments to the cap on non-economic damages.
- Apply the revised cap on non-economic damages to an award of non-economic damages in any action not resolved by final settlement, judgment, or arbitration award as of January 1, 2015.
- Apply the limitation of attorney's fees set forth in Section 6146 of the Business & Professions Code to actions for medical malpractice.
- Create a presumption of professional negligence in any malpractice action against a physician who tested positive for drugs or alcohol or who refused or failed to comply with drug and alcohol testing required by the Initiative following the alleged malpractice and in any action arising from the failure of a licensed health care practitioner to comply with the requirements in the Initiative relating to prescribing a Schedule II or Schedule III controlled substance.

Substance Abuse Testing

- Require all physicians, and permit anyone else, to report to the Medical Board any information which appears to show that any physician may be or has been impaired by drugs or alcohol while on duty, or failed to follow the appropriate standard of care during an adverse event.
- Upon adoption of regulations by the Medical Board, require hospitals to conduct drug and alcohol testing on physicians as follows: (1) on a random basis on physicians who are employees, contractors, or have admitting privileges, immediately upon the occurrence of an adverse event on physicians responsible for the care and treatment of a patient during the event or who treated or prescribed medication for the patient within 24 hours of the event, and (2) at the direction of the Medical Board upon receiving a referral pursuant to the aforementioned provisions.
- Mandate hospitals to bill physicians for the costs of these tests and prohibit physicians from passing on the costs of the tests to patients or their insurers.
- Require hospitals to report verified positive test results, or the refusal or willful failure to submit to testing by a physician, to the Medical Board.

- Require the Medical Board to refer the matter of the positive test result to the DOJ, temporarily suspend the physician's license pending a Medical Board investigation and hearing, and notify the physician and each health facility at which he or she practices of the suspension.
- Require the Medical Board, after an investigation and hearing, to take disciplinary action against a physician found to have been impaired by drugs or alcohol while on duty or during an adverse event or willfully refused or failed to comply with drug and alcohol testing.
- Upon a finding that a physician was impaired by drugs or alcohol during an adverse event, require the Medical Board to notify the patient involved, or, if the patient has died, the family of the patient.
- Require the Medical Board to impose a fee on all physicians that is sufficient to pay the reasonable costs of administering the physician drug and alcohol testing and enforcement provisions of the Initiative by the Medical Board and the DOJ.
- Make payment of the fee a condition of physician licensure or license renewal.

Statewide Prescription Database

- Require licensed health care practitioners and pharmacists to access and consult the electronic history in the CURES database prior to prescribing or dispensing a Schedule II or Schedule III controlled substance to a patient for the first time.
- Prohibit a licensed health care professional from prescribing any additional controlled substances if a patient has an existing prescription for a Schedule II or Schedule III controlled substance, unless the practitioner determines there is a legitimate need for the prescription.
- Subject a health care practitioner to disciplinary action for failure to consult with the CURES database.
- Require the licensing boards for all health care practitioners authorized to write or issue prescriptions to notify the practitioners of the requirements in the Initiative regarding the CURES database and prescriptions.

BUDGET AND FISCAL IMPACTS

1. Benefit Costs

Review of Cost Estimates for Adjusting Non-Economic Damage Awards

As part of its mandate to analyze and report the potential costs of state ballot measures, the non-partisan Legislative Analysts' Office (LAO) has published estimates of the costs associated with adjusting for inflation the existing \$250,000 statutory cap on non-economic damages in medical practice lawsuits pursuant to the provisions of Proposition 46. In addition, the federal Congressional Budget Office (CBO) was asked by Senator Orrin Hatch in 2009 to estimate the cost savings of imposing tort reform nationwide that included a \$250,000 cap on non-economic damages. The estimated savings that the CBO

projected apply equally well as increased cost estimates if the \$250,000 cap were increased significantly.

Both the LAO and CBO separated costs into two components: direct costs either from the increase in malpractice award amounts and the number of suits being filed, or the resulting increase in malpractice insurance premiums; and indirect costs from doctors ordering more tests and procedures in order to reduce the chance of a lawsuit being filed. One of the major opponents of Proposition 46, the California Medical Association (CMA), previously commissioned an economic study on the subject conducted by researchers that included a former Legislative Analyst (with findings updated in January 2014), reported cost estimates in a similar manner as displayed below.

This table summarizes the various cost estimates (using total CalPERS 2013 expenditures of \$7.51 billion).

Projected cost impacts of Proposition 46 on CalPERS				
	LAO low	LAO high	CBO	CMA
direct	0.10%	0.50%	0.20%	0.03%
indirect	0.10%	1.00%	0.31%	3.13%
total	0.20%	1.50%	0.51%	3.16%
CalPERS impact	\$15,020,000	\$112,650,000	\$38,301,000	\$237,335,915

The supporters of Proposition 46 have not offered any cost estimates of their own, instead focusing on cost savings if the ballot measure were to pass. They have previously disputed the methodologies used by the LAO and CBO, claiming that both focus on the costs of relaxing tort reform but ignore the benefits. They also note that the CBO estimates that medical negligence claims constitute only 0.3 percent of all health care spending, and so they argue that even a substantial increase in malpractice costs would have a negligible impact on overall medical costs.

Comparison of Direct Cost Estimates of Adjusting MICRA for Inflation

The LAO estimated direct costs to range from 0.1 percent of health care spending to 0.5 percent. The LAO derived these estimates from reviewing studies from other states that indicated increasing the cap on non-economic damages would increase malpractice costs by 5 percent to 25 percent, and applying those increases to the estimate that malpractice costs comprise 2 percent of all medical costs.

The CBO estimated that the change in direct spending on malpractice would be 0.2 percent of all health care spending. The CMA projects medical malpractice liability premium increases of \$92.5 million, which would be approximately 0.3 percent of their estimate for all health care spending.

It should also be noted that medical malpractice insurance rates are regulated by the Insurance Commissioner under the power vested in that Office by Proposition 103. Therefore, any increase in insurance rates will reflect the increase in costs to insurers in larger malpractice awards due to the adjusted cap, but insurers will not be able to increase rates by more than that other than a reasonable profit. Therefore, it is likely that premiums will increase by about the same amount as insurers make increased payouts.

Comparison of Indirect Cost Estimates of Adjusting MICRA for Inflation

The LAO estimated that the indirect cost of adjusting the non-economic damages cap would be between 0.1 percent of all health care spending to 1 percent, again based on the experiences in other states. Combining the two estimates arrives at a total impact between 0.2 percent of health care spending to 1.5 percent.

The CBO estimated that the change in indirect spending as a result of lifting a \$250,000 cap would be 0.3 percent of total health care spending.

The CMA predicts that defensive medicine costs would rise by 3.13 percent, which is more than triple the high bound of the LAO estimate, and more than ten times the CBO estimate. It arrives at that estimate on page 36 of its 2014 report by using a multiplier established by a Kessler and McClellan paper from the year 2000 that examined indirect cost reductions due to the imposition of tort reform on expenditures for cardiologists treating heart disease patients. The CMA report assumes that this relationship holds for all medical services provided to California residents, and then uses the derived multiplier to extrapolate the cost savings of MICRA. However, a 2011 Rand study showed that cardiologists were more likely to have a malpractice claim made against them than the average physician, and their average payout for a malpractice claim was higher than the average for all doctors.

Finally, the supporters of Proposition 46 argue that any costs generated by indexing the MICRA cap to inflation should be offset by several factors, including a decrease in the number of injuries and deaths due to malpractice as doctors behave more cautiously in order to avoid greater liability exposure. Their argument is based on a 2009 Lakwadalla and Seabury study entitled *The Social Cost of Adverse Medical Events* which concludes that doubling malpractice costs lowers the total death rate by 2 percent. Using this study in combination with others the proponents of Proposition 46 would equate the value of lives saved at approximately \$79 million and the cost savings of avoided injuries at \$65 million, for a total of \$144 million annual savings to California's health care system.

Substance Abuse Testing

The supporters of Proposition 46 cite a 2000 California Medical Board study that estimates that 18 percent of physicians have a drug or alcohol abuse problem at some time in their careers. A more recent study from 2007, not specific to California, estimates that approximately 6 percent to 8 percent of doctors have a substance abuse disorder and up to 14 percent have an alcohol use disorder (which mirrors the addiction levels in the general population). A 2011 California Medical Board newsletter cited the above estimates, as well as other estimates, that 13 percent of doctors suffered from alcohol abuse, 5 percent from alcohol dependence, 8 percent from drug abuse, and 3 percent from drug dependence.

Proposition 46 requires hospitals to bill physicians for the costs of substance abuse testing and prohibits physicians from passing on the costs of the tests to patients or their insurers. It also requires the Medical Board to impose a fee on all physicians sufficient to pay the costs of administering the associated enforcement provisions of the Initiative. However, there is a potential that physicians and hospitals will imbed these unknown costs in their contracts with health plans and insurers, including the contracts of CalPERS' health plan partners.

Statewide Prescription Database

An analysis of Proposition 46 by the LAO notes that the requirement of providers to check the CURES system before prescribing drugs could have a number of fiscal effects that are difficult to quantify. Prescription costs could be lower, as fewer drugs would be dispensed to patients who engaged in "doctor shopping" in order to illicitly obtain the drugs. Consequently, fewer prescriptions would mean fewer instances of prescription drug abuse, which would lower the costs of enforcing laws related to drug abuse. However, the requirement to use CURES might involve more time in filling prescriptions, which would reduce the time available for other patient-related activities. This could result in increased costs that would be passed along to health care purchasers. Overall, the fiscal effects of the increased use of the CURES system are difficult to quantify.

Supporters claim there will be cost savings for Medi-Cal and law enforcement by requiring the usage of the CURES database, which would discourage illicit drug-seeking activity. They cite a Wisconsin program similar to CURES that produced Medicaid cost savings of \$15.1 million in that state, plus increases in pharmacy efficiency and law enforcement savings. Supporters indicate that when translated to the larger California population, this requirement would provide savings of between \$126.5 million and \$268.6 million annually.

Access to Quality Health Care

Opponents of Proposition 46 claim there may be an additional negative impact on lower-income Californians and those living in rural areas if fewer doctors

chose to work with such patients due to rising malpractice costs. The potential impact of Proposition 46 on health care access for the poor may be minimized because doctors working at Federally Qualified Health Centers (FQHCs), which served over 2.3 million Californians at nearly 1,000 delivery sites in 2009, have their malpractice liability covered under the Federal Tort Claims Act (FTCA). Doctors at FQHCs are treated as federal employees, and any negligence on their part is subject to a claim against the federal government under the FTCA. While there is limited data available to support any conclusions, the potential impact of Proposition 46 on health care access for rural Californians may be limited because physicians in specialist fields that would likely experience the highest increases in medical malpractice liability insurance premiums tend not to locate their practices in such areas. However, the loss of even a single specialist, such as an obstetrician, serving a rural area could have a significant impact on health outcomes for the affected population.

2. Administrative Costs

There are no anticipated administrative costs for CalPERS.

ATTACHMENTS

Attachment 1 – CalPERS Board of Administration’s State Ballot Initiative Policy
Standard

Attachment 2 – Support and Opposition

DANNY BROWN, Chief
Office of Governmental Affairs

ANN BOYNTON
Deputy Executive Officer
Benefit Programs Policy and Planning