A series of bad investments by an insurance company nearly 40 years ago led to what has been a nightmare ever since for Californians who were harmed or whose loved ones were killed by medical negligence. Those bad investments resulted in the Medical Injury Compensation Reform Act of 1975, commonly referred to as MICRA, which caps compensation for non-economic (“pain and suffering”) damages in medical malpractice cases at $250,000.

With no provision to adjust the cap for inflation, and with no changes made in the law in the nearly 38 years since it was signed by Gov. Jerry Brown (then a 37-year-old first-year governor), the cap squeezes victims ever harder, as the cost of living has increased more than 330% since MICRA took effect.

What’s puzzling is how a cap on compensation for Californians harmed through no fault of their own came to be part of the law in the first place, because it was not part of the initial discussions.

The rising cost of medical malpractice insurance for physicians had been an issue in the years leading up to MICRA. (Malpractice insurance rates were not regulated at that time the way they are now in California.) The U.S. Department of Health, Education and Welfare (now known as Health and Human Services) issued a report on malpractice insurance in January 1973, and the California Assembly’s Select Committee on Medical Malpractice came out with a report in June 1974, but neither suggested a cap on compensation awarded by juries. Both reports did recommend consideration of a sliding scale for plaintiffs’ lawyers’ contingent fees, a provision that became part of MICRA. But neither report found a prevalence of so-called “frivolous” malpractice litigation. In fact, no news stories or other reports, either at that time or looking back on that time in later years, point to any specific verdicts alleged to be unjust or outrageous.

The malpractice issue came to a head in California (and other states) in early 1975, when malpractice insurers were imposing dramatic rate hikes and some were getting out of the business altogether. The company that set off a panic in the medical industry was Argonaut Insurance of Menlo Park, which announced in January 1975 it would cancel its group coverage of 4,000 doctors in Northern California and Nevada on May 1 and would raise premiums by up to 384% for individual doctors it chose to cover. (At the time Argonaut provided malpractice insurance for more than 25% of the nation’s hospitals, making it the national leader.) Soon after, Travelers Insurance threatened to double its rates for 8,000 doctors in Southern California.

Even then it was obvious that other factors beyond damage awards were behind the “crisis.” Associated Press reporter Steve Lawrence wrote in February 1975, “Experts say the malpractice squeeze was caused by three problems: a sharp increase in the number of claims filed [more than double what it had been in 1968 on a per-policy basis], an upturn in the size of malpractice judgments [which the California Medical Association claimed to be, at that time, an average of $12,000] and the poor economic situation.”

What did “the poor economic situation” have to do with insurance rates? Insurance companies depend on investing the premium dollars they receive to generate much
or all of their profits, taking advantage of the time lag between when premiums are paid and claims are paid out. The two-year period 1973-74 was one of the worst ever for the stock market; on Dec. 6, 1974 the Dow Jones Industrial Average fell to a 12-year low, some 45% below where it had been less than two years earlier. “The insurance industry has been clobbered by the decline in the stock market,” CMA spokesman Jack Curley told Lawrence.

Argonaut was particularly hard hit by the bear market. An article by Robert Lindsey in The New York Times on June 8, 1975 reported the value of Argonaut’s bond and stock portfolio had dropped by almost $90 million in 1974 alone, and the company also lost $21 million on its investments that year.

James Ludlam, the longtime legal counsel for the California Hospital Association, put it this way in his 1998 book “Health Policy – the Hard Way”: “As a part of its aggressive [national] expansion, [Argonaut] engaged in some speculative investments, which produced substantial losses and contributed to its lack of adequate capital for reserves.”

Argonaut, a subsidiary of a Los Angeles-based industrial conglomerate, Teledyne, had little experience in the malpractice business but had grown rapidly since it entered the field in 1971. According to Lindsey, “The company had originally been attracted to the malpractice field because of the prospect of using hundreds of millions of dollars annually in premiums to collect interest in the bond and stock markets.” But by 1975 the company was telling a different story. A headline in the Feb. 19 Wall Street Journal read, “Tele-dyne Says It Erred in Letting Unit Cover Medical Malpractice.”

On June 16, 1975, Argonaut’s president Lawrence Baker (a former chief deputy commissioner of the California Insurance Department) testified before a Congressional subcommittee that the company had received $35 million in malpractice insurance premiums nationally over the previous year and had paid out $24,000 (that’s 24 thousand, not 24 million) in claims. Baker asserted the company would need to have $69 million in reserve to pay claims arising from the policies it had written, but he did not explain how that number was derived, nor was he asked to do so by the committee.

### MICRA Timeline

**1975**
MICRA went into effect after Assembly Bill 1xx was passed in a special legislative session and signed by Gov. Jerry Brown. Key provisions include a non-indexed $250,000 cap on non-economic damages, periodic payments, a limitation on attorney fees, and the elimination of the collateral source rule.

**1985**
MICRA limits were upheld by the California Supreme Court in Roa v. Lodi Medical Group, 37 Cal.3d 920. Prior to this decision the courts had varied on whether or not the MICRA limits were enforceable.

**1987**
Legislative leaders Willie Brown and Bill Lockyer spearheaded intense negotiations in the final days of the legislative session that produced the comprehensive tort package known as the “Napkin Deal.” The discussions began after the passage of Proposition 51 in 1986 (revising the rules of joint and several liability) led to the threat of more initiatives by all sides. The “Napkin Deal” raised the MICRA contingency fee limits and made changes to punitive damages and public entity liability, and all parties agreed to a five-year truce on initiatives.

**1997**
Two MICRA bills were sponsored: AB 250 (Kuehl), increasing the cap to $950,000 and eliminating it in worst cases, and AB 1220 (Migden), eliminating the cap in certain cases. AB 250 passed the Assembly Judiciary Committee but was not put before the full Assembly because it didn’t have enough support to pass.

**1999**
Assembly Speaker Antonio Villaraigosa carried AB 1830 calling for MICRA reform. But after opposition from Republicans and “Business Democrats,” the bill was amended to limit it to enacting a cost-of-living adjustment to the cap from the time of enactment forward. CAOC did not support the amended bill because of its reduced scope.

**2000**
CAOC began a different approach to changing MICRA, focusing its efforts on electing pro-consumer legislators who understood the injustice of MICRA. The “Business Democrats” who voted as a group to block consumer legislation were decimated by CAOC’s political efforts in primaries.

**2002**
Gov. Gray Davis committed to seriously consider MICRA changes in his second term, only to be recalled in 2003 when Arnold Schwarzenegger was elected governor.

**2003**
CAOC began to assist the American Association of Justice in organizing votes against the Bush administration’s efforts over the next three years to implement MICRA caps in all states. Thanks to AAJ and CAOC, the attempts to make the cap part of federal law failed.

**2008**
Jay Angoff, a respected insurance lawyer and a former state Insurance Commissioner of Missouri, represented CAOC before the California Department of Insurance to challenge the proposed acquisition of SCPIE Holdings, Inc. by The Doctors Company. That challenge produced statistical data and a report proving the only ones benefitting from MICRA are the insurers.

**2010**
State supreme courts in Georgia and Illinois overturned caps on non-economic damages in medical malpractice cases. The Missouri Supreme Court followed suit in 2012.
“Prior to 1985, neither insurance rating organizations nor regulators collected data on medical malpractice insurance separate from general liability,” New York University law professor Sylvia Law wrote in a 1986 paper. “Without rigorous information, policymakers relied on anecdote and political argument.”

Law said the 1975 malpractice insurance “crisis” came about when Teledyne pulled Argonaut out of the business completely in May. “Argonaut had been the primary provider of malpractice insurance in several states,” she wrote. “Argonaut demanded massive rate increases, but neither the insurance industry nor the state regulators had sufficient data to understand that Argonaut’s demands were not dictated by their risk experience. Ignorance generated panic.”

Later the National Association of Insurance Commissioners found the medical malpractice insurance industry had indeed been profitable in the “crisis” year of 1975. Citing a report from the association, Sylvia Law wrote, “In 1975 operating profit for all lines of insurance was one percent, while for malpractice insurance it was nine percent.”

On June 27, 1975, California Trial Lawyers Association president Elmer Low debated William McColl, a physician who was co-sponsor of a ballot initiative that would limit malpractice contingency fees, at a town hall meeting in Los Angeles. (CTLA is the organization we now know as Consumer Attorneys of California.) Low told the audience that in 1974 only 52 of the 167 malpractice cases that went to trial were decided in favor of the plaintiffs, with total damage awards of $7.7 million, and another $23 million was paid by doctors’ insurance companies in settlements. “That’s only about $30 million the insurance companies had to pay,” Low said. “They got $140 million in premiums from doctors. Where did they spend all that extra money?”

Argonaut’s financial problems were far from the only reason California medical malpractice insurance rates were bound to rise in 1975. But its decision to dramatically increase rates and then abandon the business entirely set the tone for the discussion that led to the drastic changes brought about by MICRA. Argonaut’s decision to bail out, after deciding that writing medical malpractice insurance would not be the gold mine it had anticipated, left the California medical malpractice market in disarray. And if the doctors and hospitals and remaining insurance companies couldn’t fix the stock market, they could certainly work to reduce the amount that would be paid out in claims.

The California Medical Association labeled the situation a “crisis” in February 1975. But the CMA’s proposed solution to bringing insurance costs down was not a cap on damage awards. Instead it suggested moving malpractice cases from the courts to a five-member arbitration commission. The organization clearly felt such a commission would give smaller awards than juries would, but a statutory cap on awards was not discussed. Another change suggested by the CMA was basing the statute of limitation in medical malpractice cases on the date of the injury rather than the date the injury was discovered, a change that would serve to reduce the number of lawsuits that could be filed.

The prospect of a cap on damages was first raised at a California Assembly Select Committee on Malpractice hearing on Feb. 21, 1975. State Attorney General Evelle Younger suggested malpractice fall under what was then known as the state Workers’ Compensation Insurance Fund, with compensation beyond medical treatment capped at $1,000 a month and $300,000 lifetime. The CMA expressed approval of this idea. Howard Berman, then a Democratic Assembly member who later spent 30 years as a member of Congress, said at the hearing there had been 34 malpractice awards of more than $300,000 in 1974, although it appears that dollar figure included economic damages. (The largest award was reported to be a settlement for $4.5 million, although no details were given as to whether that amount included the cost of a lifetime of specialized medical care.)

Meanwhile, in advance of Argonaut’s May 1 deadline for ending much of its malpractice coverage, a number of doctors warned hospitals and patients they would suspend practice as of May 1 in the absence of what they considered affordable coverage. The doctors’ euphemism for this was “withdrawal of service.” The popular term would be “doctors’ strike.” The key players were physicians in high-risk specialties who paid the highest rates, particularly anesthesiologists, neurosurgeons and orthopedists. This very real threat that doctors would not show up for work led to a push to pressure Gov. Brown and legislators to come up with a solution.

When the strike began, on May 1 in San Francisco, patients were diverted to public or federal hospitals where the physicians were employees and as such were covered under hospital malpractice plans. At the hospitals where doctors were absent, hours were reduced for the rest of the medical work force, administrators took pay cuts, vacations were offered and leaves of absence were encouraged, as the hospitals’ incomes were reduced. As a result, other hospital employees were motivated to support the doctors’ cause. The strike spread to other parts of the state before the month was over.

After hundreds of hospital employees descended on the capitol May 13 and waited outside the governor’s office until they were able to make their case directly to the governor, Gov. Brown called a special session on malpractice. Legislation passed in a special session could take effect sooner than legislation passed in a regular session, although in the case of MICRA the difference turned out to be a matter of less than three weeks. By the beginning of June the doctors agreed to go back to work while negotiations on legislation continued.

On June 13 the Assembly Judiciary Committee approved, on an 8-1 vote, a malpractice reform bill (Assembly Bill 1xx, the x’s indicating the bill was part of the second special session) introduced by Eureka Democrat Barry Keene. The bill as approved did not include any cap on damages, after the committee deleted a provision that capped certain non-economic damages, including pain and suffering, at $800 a month and prohibited any non-economic damages for plaintiffs who earned more than $1,500 a month. That deletion led a group called the California Physicians Crisis Committee to call the Judiciary Committee “no more than a lawyers’ lobby.”

The bill as approved did include a cap on attorney fees and a shorter statute of limitations while giving the state insurance commissioner new powers to review malpractice rate increases. It also created a Board of Medical Quality Assurance, to replace the existing Board of Medical Examiners. The new board would have a majority of public members (unlike the existing board that had just one public
member along with 10 physicians) and would be empowered to remove incompetent doctors from practice.

Keene’s bill, supported by the CMA (and opposed by the California Trial Lawyers Association) was approved by the full Assembly the following week on a vote of 65-8. At that same time the state Senate shot down a Republican bill that would have capped malpractice damages at $500,000 while moving malpractice cases from the court system to a “patient compensation board.”

But Keene’s bill was amended in the Senate Insurance and Financial Institutions Committee to include a $250,000 cap on awards for pain and suffering. (Keene had arranged for the bill to be referred to that committee instead of the Judiciary Committee, whose members were inclined to oppose it.) Why $250,000? What was the rationale or justification for that number? Amanda Edwards did exhaustive research on the MICRA cap for a 2006 paper in the Harvard Journal on Legislation (she was then a student at Harvard Law School). Her work, which included review of more than 1,500 pages of California legislative records, was unable to turn up a reason why that amount was chosen.

In a 2005 email to Edwards, Keene said the choice of $250,000 was “subjective,” adding, “The theory was that you could never really and adequately compensate for pain and suffering, no matter how much money you provided. But $250,000 [in addition to economic damages], properly invested to the extent that it elevated the quality of life over and above the post-injury status, was thought to be enough to do that job.”

Edwards also quoted from a Department of Consumer Affairs report issued after the bill was passed by the Legislature that said the $250,000 limit “may be acceptable for consumers” because it “would not change the amount awarded to most claimants.”

As the bill progressed through the Senate, there was a suggestion to include a provision indexing the cap to inflation; Edwards credits the idea to Bion Gregory, then the chief counsel to the Senate Judiciary Committee. Such an index would have been especially significant at the time, with the country going through one of the most extended and dramatic periods of inflation in its history (as anyone who remembers President Gerald Ford’s “Whip Inflation Now” buttons will recall). From the beginning of 1974 through the summer of 1975 the rate of inflation was typically between 10 and 12 percent.

But indexing the MICRA cap never gained traction, in part because of opposition from an unexpected source: the California Trial Lawyers Association. Leaders of the predecessor to Consumer Attorneys of California thought indexing the cap would improve the chances the bill would be approved by the Legislature and signed by the governor, so the strategy was to increase the potential for defeating the bill by keeping out an inflation adjustment. (In fairness to CTLA’s leaders of that era, the indexing feature likely wouldn’t have been added even if it had CTLA’s support, as the doctors and hospitals were strongly opposed.)

On Aug. 14 the state Senate passed two bills dealing with malpractice insurance. Neither was Keene’s bill, which was then in the Senate Finance Committee.
malpractice bill authored by Republican Dennis Carpenter included the $250,000 cap on non-economic damages. The other, from Democrat Omer Rains, capped those damages at $800 a month for life. A United Press International report said the bills were “seeking, but not guaranteeing, a reduction in medical malpractice insurance rates.” Carpenter himself said, “If you ask categorically will this solve the problem, I say I don’t have the foggiest idea.”

Among the Senators who opposed the bills was Democrat George Moscone of San Francisco, who later that year was elected the city’s mayor. “If you’re not convinced it would reduce premiums,” Moscone said, “then I think you’re a darn fool to take away rights of your constituents without being sure of helping other of your constituents. Do you really want to give up no less than eight basic rights of an individual whose only mistake was that he picked the wrong practitioner?”

The Senate approved Keene’s bill on Sept. 2 by a vote of 34-4, sending it back to the Assembly for approval of amendments, including the $250,000 cap. An Associated Press report on the vote was prescient: “In Senate debate, critics contended that the measure would take away rights of patients without demanding substantial sacrifice from doctors and insurance companies. They also said the bill did not ensure that skyrocketing insurance rates would be cut.”

But doctors were insistent that the Keene bill be approved in the form it passed the Senate, with the cap included, because the immediate past president of the American Medical Assn. threatened another doctors’ strike if it were not.

The Assembly caved to the threat, rejecting calls by Speaker Leo McCarthy and Assemblyman Keene to send the amended bill back to the Assembly Judiciary Committee, which had removed a damages cap in an earlier version of the bill. As the Legislature entered the final week of the session on Sept. 8, AB 1xx was passed on a vote of 57-20, and the $250,000 cap was part of the bill for good.

CTLA president Elmer Low responded to the Assembly’s passage of the bill with this statement: “Two powerful special interests – the CMA and the insurance industry – have won a major victory at the expense of the citizens of this state. We are fully prepared to go before the highest court, if necessary, to overturn a law we consider both inequitable and unconstitutional.”

In an editorial published on Sept. 5, the Long Beach Press-Telegram said the cap “has an element of unfairness to it, since no such limit is set for victims of negligence other than medical. But at least at current cost-of-living levels, the $250,000 limit is reasonably generous.” The Press-Telegram went on to say that “huge judgments are actually relatively rare” and opined that insurance companies would find the proposed change in the statute of limitations more important for reducing rates.

Democrat George Moscone of San Francisco questioned, “Do you really want to give up no less than eight basic rights of an individual whose only mistake was that he picked the wrong practitioner?”

On Sept. 23, just hours before the deadline under which the bill would have become law without his signature, Gov. Brown signed AB 1xx without comment. In addition to the $250,000 cap, the legislation also instituted a sliding scale for contingency fees, reduced the statute of limitations for medical malpractice cases, added seven non-physician members (still a minority) to the state Board of Medical Examiners (now known as the Medical Board of California) and increased that board’s power to screen and discipline doctors. The law also included other elements that got little or no attention from the press at the time, including elimination of the collateral source rule and the approval of periodic payments of damage awards.

(Two elements that Brown had hoped would be included in malpractice legislation went ignored by the Legislature. One was a requirement that a second doctor grant approval for each operation, the idea being that too much “unnecessary” surgery was being performed, thus increasing the possibility of malpractice. The other was what Brown called a “medical Peace Corps,” in which doctors who worked in medically underserved areas would receive a break on their malpractice insurance rates.)

Assemblyman Keene wrote, in a letter to Gov. Brown after his bill was sent to the governor’s desk, that he thought the legislation would reduce malpractice premiums by 18 to 24 percent. State insurance commissioner Wes Kinder predicted the bill would “eventually” lead to a 30 percent decrease in malpractice rates. (At that time the insurance commissioner was appointed by the governor, not elected by the people.) Instead premiums continued to soar, rising more than 190 percent from 1976 until 1988, when Proposition 103 gave the state Department of Insurance more power over regulating malpractice rates. Only then did rates level off.

There was one change made to MICRA, as part of the legendary “Napkin Deal” negotiated by then-Assembly Speaker Willie Brown and then-state Senator Bill Lockyer in 1987. Under AB 1xx, plaintiffs’ attorneys in malpractice cases could receive no more than 40% of the first $50,000 in net recovery (after litigation expenses were recouped), 33-1/3% of the next $50,000, 25% of the next $100,000 and 10% of anything beyond $200,000. The “Napkin Deal” agreement did not change the percentage for the first $200,000 of net recovery, but it raised the rate to 25% for the amount from $200,000 to $600,000 and to 15% for anything beyond $600,000. MICRA was challenged in court, but unsuccessfully. In 1985 the California Supreme Court upheld the $250,000 cap in Fein v. Permanente Medical Group, saying the cap “is rationally related to the objective of reducing the costs of malpractice defendants and their insurers.” That meant opponents of MICRA would have to change the law in the Legislature. Several bills were crafted in the late 1990s, most notably AB 250 (Kuehl) in 1997 and AB 1830 (Villaraigosa) in 1999, both of which passed the Assembly Judiciary Committee. AB 1830 actually passed the full Assembly, but only after it was amended to adjust the cap for cost-of-living increases only from that point forward, with no compensation for inflation from 1975 to 1999. CAOC decided not to proceed with the bill in that form.

That leaves us today exactly where we were when MICRA took effect in December 1975: with a law that unfairly limits compensation for those harmed by medical negligence. Except the limit is vastly more unfair today, as it does not reflect 38 years of decreased value of the dollar and increased costs of litigation.