Learning To Live With MICRA

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Despite MICRA, California plaintiffs are in a better position than those in several other states

In the 36 years since MICRA was enacted in California, tens of thousands of patients injured by preventable medical errors, have been denied just compensation for their injuries. The value of the $250,000 cap in 1975 dollars has steadily decreased to less than $70,000 today. For the child who suffers severe brain damage because a nurse doesn't recognize fetal distress during labor or for the family of a patient who dies unnecessarily because of medical neglect, the cap severely limits the value of the case.

In catastrophic-injury cases, the value of the non-economic damages is often insufficient to cover attorneys' fees and costs. This means that the lawyer, the experts and the court reporters must be paid out of economic damages which have been determined to be necessary for the patient's future care.

To compound the problem, both for potential clients looking for legal representation and for the attorneys who would like to help, attorneys' fees are both capped and calculated only on the net recovery to the client. These factors make it extremely difficult for the lawyer to justify the cost and risk of handling medical malpractice cases generally. For patients with smaller claims, there is effectively no access to justice in California.

Unfortunately, MICRA's "success" in increasing insurance company profits and mollifying doctors who feel under siege by lawyers has resulted in many more states enacting laws to curtail the rights of patients. In comparison to other jurisdictions which have enacted limits on medical malpractice litigation, California patients and their attorneys still enjoy certain advantages.

Medical-Malpractice Tort Teform in Other Jurisdictions

A number of states have capped all damages. In Virginia, the total amount a medical-malpractice plaintiff can recover for economic, non-economic and punitive damages is currendy $2 million. (Va. Code Ann. § 8.01-58l.15.) The Virginia Supreme Court has twice held that these caps do not violate the U.S. or Virginia constitutions. Virginia does not cap attorneys' fees.

Indiana's original cap limited liability against any single qualified health-care provider at $100,000, with a maximum recovery to the patient of $500,000. (Ind. Code Ann. § 34-18-14-3.) For claims arising since 1999, the limit for each provider increased to $250,000 with the total cap for economic and non-economic damages increased to $l.25 million. In a birth-injury case in which the economic damages are $7 million, a California plaintiff would recover a maximum of $7.25 million; the same plaintiff's damages in Indiana would be $1.25 million.

Colorado caps total damages at $1 million with no more than $250,000 attributable to non-economic damages. (Colo. Rev. Stat. Ann. § 13-64-302.) However, if the court finds that future economic damages exceed this cap, it may award damages in excess of the limit, if to do otherwise would be "unfair." (Ibid.)

Ohio caps non-economic damages at the larger of $250,000 or three times economic damages, subject to a maximum of $350,000 per plaintiff and a maximum of $500,000 per occurrence. These maximums increase to $500,000 per plaintiff and $1 million per occurrence if the plaintiff suffered "permanent and substantial physical deformity, loss of use of a limb, loss of a bodily organ system or permanent injury that prevents self-care." (Ohio Rev. Code Ann § 2323.43.) The caps do not apply to wrongful-death cases. A probate judge must approve attorneys' fees if they exceed the amount of the cap on noneconomic damages. (Ohio Rev. Code Ann. § 2323.43(F).)

West Virginia previously capped damages in medical-malpractice cases at $1 million. In 2003, the legislature reduced the non-economic cap to $250,000 for most cases, regardless of the number of plaintiffs or defendants. (W.Va. Code §55-7B-8.) The Supreme Court of Appeals of West Virginia upheld the constitutionality of the cap in MacDonald v. City Hospital a controversial decision handed down in June of this year with a blistering dissent by one justice. [Ed. note: Justice Wilson's dissent is published in full in this issue, at page 66.]

The news isn't all bleak. State Supreme Courts in Alabama, Florida, Georgia, Illinois, Kansas, Louisiana and New Hampshire have ruled caps on damages in medical malpractice cases unconstitutional.

MICRA

California law has been stable for more than 35 years. Although this has meant ongoing erosion in the value of the $250,000 cap on non-economic damages, economic damages are not limited by MICRA. The value of those damages has increased significantly since 1975. A medical-malpractice case in which economic damages totaled $1 million in 1975 would have a value well in excess of $5 million today, even with the limitation of $250,000 in non-economic damages.

Joint and Several Liability

Despite the limitation on non-economic damages, there are two aspects of the law in California that provide plaintiffs with an advantage over many other states, where the laws pertaining to medical- malpractice litigation are even more restrictive. First, although joint and several liability no longer applies to noneconomic damages, it does apply to economic damages. This means that any liable defendant, even if less than five percent at fault, may be liable for the entire amount of economic damages.

Compare this to Colorado's law in which defendants are not liable for an amount larger than that percentage of the judgment equal to the percentage of fault attributable to them. (Colo. Rev. Stat. Ann. § 13-21-111.5.)

Most physicians in California maintain $1 million in liability insurance, the same amount most doctors carried in 1975. That sum is inadequate in any case where the plaintiff sustains permanent injuries restricting his or her ability to work or where a lifetime of medical care may be necessary. Joint and several liability for economic damages may enable a plaintiff to recover an amount of damages that is far closer to their actual damages, especially when a hospital is also a defendant and may end up with exposure in excess of its responsibility for causing the injury.

In other states, which have eliminated joint and several liability for all damages, victims of medical negligence are more likely to be forced to accept the limited coverage possessed by a physician, even though damages are fur in excess of such insurance.

Screening Cases Before Filing Suit

Unlike some other jurisdictions, California does not require screening panels or declarations from experts before the filing of a complaint in Court. New Hampshire requires cases to be screened by a panel before the complaint is filed. According to the New Hampshire Business Review, 387 cases of medical malpractice were considered between 2007 and 2010, of which 147 resolved prior to panel review, 87 were dismissed, 84 were heard and 69 were pending.

Only 18 medical-malpractice cases went to jury trial during that time. It was unclear from the data whether the panels were having any appreciable impact on the cost of professional liability insurance, the ostensible reason for enacting them. (Kibbe, The Jury is Still Out on Malpractice Panels, New Hampshire Business Journal (Feb. 2011).)

In Georgia, the Supreme Court struck down caps on damages after a jury awarded Betty Nestlehutt more than $1.26 million for permanent disfigurement she suffered when a surgeon cut off the blood supply to portions of her face. (Atlantic Oculoplasty Surgery, P.G., t< Nestlhutt (Ga. 2010) 691 S.E. 2d 218.) The Nestehutt case was also notable because her case was pre-screened by numerous doctors, all of whom agreed that the defendant did not meet the standard of care. Despite these medical opinions validating her case, defendant's insurance company refused to resolve her case.

Indiana requires that all allegations of negligence be reviewed hy a panel of three doctors before a lawsuit can be filed. The panel reviews information submitted by the parties and concludes in writing whether the evidence does or does not support the conclusion that the medical defendants were negligent; whether there are any material issues of fact not requiring an expert opinion that must be considered by a judge or jury; whether the conduct complained of did or did not cause the claimed damages; the extent and duration of any disability and the percentage of impairment. The panel's opinion is admissible in evidence and can be used to support the defendant's motion for summary judgment. (Ind. Code Ann. § 34-18-8-4.)

Some states, like Nevada, require a plaintiff to file detailed declarations from experts as part of the filing of any complaint. (Nev. Rev. Stat. Ann. 41A.071.) These declarations mean that plaintiff's counsel or the client must retain experts and provide them with the medical records as the basis for their opinions. One of the problems with this process is that the evidence of medical negligence is not always clear from the medical records. It may not be possible for the expert to conclude that the medical treatment was below the standard of care simply based on the written records.

At one time, California law required an attorney declaration that the malpractice case had been reviewed by an expert who found it to have merit. That law, however, had a sunset provision and expired by operation of law on January 1, 1989. (Code Civ. Proc., former §411.300).) Currently, there are no pre-filing

requirements in California. This is an advantage because it is not always possible to determine issues of liability and causation based solely on the medical records. Medical records may be incomplete, inaccurate or even fabricated to hide the true facts. Attorneys in California can conduct the necessary discovery to uncover all of the facts after the complaint is filed and before plaintiff's claim may be challenged by a summary judgment motion.

Two other parts of MICRA, which have in the past had a significant role in reducing the value of cases with future medical cost damages - especially in cases involving birth injuries or children - are the abrogation of the collateral source rule (Civ. Code, § 3333.1) and periodic payments (Code Civ. Proc" §667.7).

Civil Code Section 3333.1

Under Civil Code section 3333.1, a defendant can introduce evidence of benefits paid by both private health insurance and public benefits for a jury to consider. Defendants consider these as viable offsets for settlement purposes, but juries are reluctant to assume that a young plaintiff will be able to depend on either private health insurance benefits or public benefits to continue. Public debt problems, the rising cost of health insurance, and declining benefits make the prospect of future coverage speculative.

In cases where plaintiff's medical bills have been paid by private insurance and, thus, are subject to section 3333.1, plaintiff is well advised to introduce evidence of such payments, as well as the cost to plaintiff of securing and maintaining the health insurance. Doing so makes it more difficult for the defendant to argue that reimbursement, either for the medical bills themselves or the cost of insurance to secure that coverage, should not be part of the compensation awarded by the jury.

There are a number of federal and state agencies that are exempt from the provisions of Civil Code section 3333.1.

A motion in limine to exclude evidence of payment made by these programs should be granted by the trial court. Plaintiff should recover these economic damages.

Although section 3333.1 refers to bene6ts paid under the Social Security Act, federal law requires States to assert and collect Medicare and Medicaid (in California, Medi-Cal) liens, as a condition of future receipt of funds. (42 USC § l396a; 42 CFR § 433. l36(3)(1980).) The Medicare Secondary Payer provision authorizes reimbursement of benefits when a Medicare beneficiary suffers an injury covered by a tortfeasor's liability insurance. (42 U.S.C. §1395(b)(2)(B)(ii); see Zinman" Shalala (9th Cir. 1995) 67 F.3d 841, 843.) Medicare is entitled to recover benefits paid, less its proportionate share of procurement costs, from any settlement amount, jury verdict or arbitration award. In some situations, generally where the Medicare lien is large and the value of the case limited, the benefit of recovering these payments will accrue to the lawyer and not to the client.

Medi-Cal bene6ts are partially funded by the federal government pursuant courts have held that section 3333.1 include payments by Medi-Cal. (Lima " Tilu;" (2009) 174 Cal.App.4th 242, 253-254.) Therefore, Medi-Cal also has a lien on a medical malpractice victim's recovery.

Other public benefits, such as Califorrua Children's Services [CCS] and the Regional Center, which previously provided benefits regardless of income, have lien rights which legally exempt them as collateral sources, in the same way that Medi-Cal is exempted from Civil Code section 3333.1. (Health & Saf.Code, § 123982; see also, Tapia v. Pohlmann (1998) 68 Cal.App.4th 1126,1132-1133.) Therefore, defendants should not be permitted to introduce evidence of payment by CCS or the Regional Center.

Large companies that have self-funded health plans are exempted from state laws by the Employee Retirement Income Security Act [ERISA]. A self-funded plan under ERISA is not subject to Civil Code section 3333.l and is entitled to enforce its lien.

Code of Civil Procedure Section 667.7

Under Code of Civil Procedure section 667.7, medical-malpractice defendants can request that the court order any jury award be converted into a periodic payment judgment, under which the obligation to make payments ends with the death of the plaintiff. Under this provision, the defendant would then go to the annuity insurance market and purchase an annuity to make these payments at a cost that is substantially less than the jury's award for future damages.

However, it should be noted that, in my experience, some insurance companies are becoming increasingly reluctant to take substantial risk on the life expectancy of a disabled plaintiff. This has resulted in a significant increase in the cost of these annuities. In many cases the cost to obtain an annuity is more than the present cash value of the jury award for future care costs, making periodization less attractive to the defense.

Invoking the right to periodicize also subjects the defendant to a judgment that cannot be satisfied until all payments are made. A doctor defendant is unlikely to want a judgment to remain open for decades because of the impact it will have on his or her credit rating.

The Kaiser Connection

Although most lawyers may not think of it as such, another advantage to litigating medical-malpractice cases in California is Kaiser, which is the state's largest health-care system. The Kaiser system exemplifies the concept of "enterprise liability," in which liability rests with the entity rather than a specific hospital or doctor. Most doctors have liability insurance limits of $1 million, which is inadequate to satisfy a catastrophic injury claim. In order to "open up· the policy in a medical malpractice case. a policy limits demand must be made. If liability is strong and damages exceed the $1 million, the insurance carrier may be willing to pay the policy, thus limiting plaintiff's damages to a sum substantially less than the value of the case.

If the defendant physician is a Kaiser doctor, however. even if the total liability rests with an individual physician, under enterprise liability, the responsibility for payment of the entire claim rests with Kaiser.

The biggest drawback to Kaiser cases is its binding arbitration agreement. There is anecdotal evidence to suggest that plaintiffs may be more likely to win at arbitration than in a jury trial, but that the arbitration award is likely to be less than a jury would award. The arbitrator who wants to do "right" by way of the plaintiff, but who also wants to continue the lucrative work Kaiser arbitrations represent, may be inclined to compromise in the amount of the award.

The ability of Kaiser to enforce its arbitration agreement is not inviolate, particularly where the patient is a longtime Kaiser member. Old enrollment forms are subject to attack as not in compliance with Health and Safety Code section 1363.1, and like any large organization,

Kaiser cannot always produce the documentation to prove that the plaintiff agreed to arbitration.

Medical Malpractice in California

In my view, although the number of medical malpractice cases being filed is dropping because of MICRA, the number and severity of injuries caused by preventable medical mistakes will continue to increase over time. A recent study published in the journal "Health Affairs," found that adverse events occurred in 33.2 percent of hospital admissions and that current methods to detect adverse events missed 90 percent of such events. (Classen, et al., 'Global Trigger Tool' Shows that Adverse Events in Hospitals May Be Ten Times Greater Than Previously Measured (April 2011) 30 Health Affairs 581-589.) The reality is that medical negligence occurs every day in all 5,500 hospitals and in many more thousands of doctors' offices throughout the United States.

Despite all of the studies on the subject, there is no evidence that there has been, or will be, any significant reduction in the incidence of either adverse events or poor outcomes due to medical negligence.

The study published in Health Affairs estimated the cost of medical errors that harm patients at $17.1 billion in 2008. Despite this huge cost to society and patients' families, the underlying causes of most catastrophic injury cases are complex and have become part of the basic fabric of health care.

As a result, there is no shortage of medical-malpractice victims in California. More than 10 percent of the population in the United States lives in California. (U.S. Census Bureau <http:// quickfacts.census.gov/qfdlstates/06000.html>. It stands to reason that it also has more incidents of medical negligence than any other state. While many injured patients will go without representation because of MICRA, there are many patients with catastrophic injuries who can and should be helped by attorneys.

Birth-injury cases are a good example. Cerebral palsy rates per 1,000 live births ranged between 1.5 and 2.5 between 1970 and 2000. (Hankins, et al., "Defining the Pathogenesis and Pathophysiology of Neonatal Encephalopathy and Cerebral Palsy" (2003) 102 Obstet Gynecol 628-636.) According to the Hankins' article, only four percent of those were likely caused by intrapartum hypoxia without any antepartum risk factors. (Ibid.) Arguably, that figure is much higher. However, even if it is accurate, there are more than 500,000 annual births in California (www.dof.ca.gov/ research/demographic/reports/projections/ births). That means at least 1,000 babies a year are born with potentially preventable cerebral palsy. The cost of care for the most profoundly injured of these children increases at the rate of medical inflation. That cost is going to be paid - either by the party responsible for causing the harm or by the taxpayer. The experienced attorney representing the injured child not only can make a profound difference in his or her quality of life, but can also recover a fee that makes the risk of handling such complex and expensive cases worthwhile.

The Future of MICRA

The limitation on non-economic damages pursuant to Civil Code section 3333.2 is not likely to change any time in the near future, either through legal challenges within the Court system or through the California legislature. Although successful challenges have been mounted in other states, there currently are no cases under consideration by the California Supreme Court on this issue. Absent a decision to overturn Fein v. Permanente Medical Group (1985) 38 Cal.3d 137, which seems unlikely, the only potential remaining constitutional challenge which has not been considered in California is the right to a jury trial on the issue of damages.

The same governor who originally signed MICRA into law in 1975 is California's governor again. His position on MICRA at this time is unclear. Unfortunately, because all attention in Sacramento is focused on the State of California's finances, an increase in noneconomic damages for the victims of medical negligence is not likely to get any serious attention from either Governor Brown or the California legislature. Until the State improves its economic foundation, which could take many years, a serious discussion about MICRA will not be a priority.

The California Medical Association [CMA] is focused on maintaining the limit on non-economic damages and attorneys' fees, rather than making other changes in the law. Therefore, it is unlikely that the CMA will mount a challenge to do away with joint and several liability or to push for limits on economic damages. Any real discussion about further limiting patients' legal rights could expose the fact that it is the insurance industry, and not the physicians, who benefit most from curtailing the rights of victims of medical negligence.

There is some benefit to the fact that the law in the field of medical malpractice remains stable, in comparison to other states where medical associations and insurers are pushing to enact new medical-malpractice laws. This legal stability, together with the sheer number of potential claims of medical negligence, means that California will continue to be a state with significant verdicts and settlements of medical-malpractice cases, in spite of MICRA.

Although fewer attorneys may be filing fewer medical malpractice lawsuits, a case can be made that even with MICRA, California lawyers are in a better position than those in other states.

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