
Jury Verdicts in Medical Malpractice Cases and the MICRA Cap

J. Clark Kelso & Kari C. Kelso



**INSTITUTE FOR LEGISLATIVE PRACTICE
MCGEORGE SCHOOL OF LAW
UNIVERSITY OF THE PACIFIC**

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Table of Contents

Chapter 1. Executive Summary	1
A. General Principles of Tort Law	2
B. Background of MICRA	3
C. Jury Verdicts in Medical Malpractice Actions	3
Chapter 2. Tort Liability: Theoretical Considerations	5
A. Government’s Response to Injuries in Society	5
B. Tort Law’s Role in Addressing the Problem of Injuries	7
Chapter 3. MICRA Reform: The Damage Cap`	11
A. Background of MICRA	11
B. MICRA Reform: Raising or Removing the Cap on	
Non-Economic Damages	14
1. Jury Verdicts in Medical Malpractice Cases	15
a. Research Focus	15
b. Data Collection	17
c. Results	17
2. Likelihood of Adverse Consequences	24
3. Legislative Possibilities	25
a. Cost-of-Living Adjustment	26
b. Stepping-Up the MICRA Cap	26
c. Limiting Non-Economic as a Proportion of Economic Damages ...	28
d. Removing the MICRA Cap	29

Institute for Legislative Practice
Jury Verdicts in Medical Malpractice Cases and the MICRA Cap

Chapter 1

Executive Summary

The Legislature has before it a bill that would add a cost-of-living adjustment to the cap on non-economic damages in medical malpractice actions (AB 1380 (Villaraigosa)), thereby modifying one of the major components of the Medical Injury Compensation Reform Act (“MICRA”). Civ. Code § 3333.2. Legislation to modify important elements of the civil tort system generate a great deal of attention from interested parties. There is no shortage of opinions and advocacy. As a matter of strict policy, the Institute for Legislative Practice does not support or oppose any legislation. Instead, the Institute hopes to facilitate legislative deliberation by presenting nonpartisan, legal analysis of issues that are raised by pending bills.

In this report, we first present background information regarding general principles of tort law (Chapter 2). These principles provide the context for a statistical analysis of medical malpractice verdicts in California from 1993 to the present (Chapter 3).

Predicting how the medical malpractice insurance industry or the health care industry might respond to any increases in total payments to plaintiffs resulting from an increase in or removal of the MICRA cap (e.g., whether increases in tort judgments would result in decreased profits, increased premiums or costs, or decreased health care services) is beset with difficulties and is not the focus of this report. Nor does the report attempt to suggest any particular point at which limitations on non-economic recovery might be appropriate (e.g., that \$250,000 is too low, that \$500,000 is too high, and that \$375,000 is just right). Those decisions require the application of careful judgment by legislators and the Governor in light of a wide array of considerations that are beyond the scope of this report. However, based on the jury verdict data in our sample, we are able to provide some information that may assist policy-makers in evaluating the possible consequences of modifying the MICRA cap. For example, our study indicates that raising the MICRA cap to \$500,000 or \$750,000 would result in a substantial increase in the percentage of cases where there is full recovery of non-economic

damages while causing a relatively modest increase in the total amount of damages paid by defendants.

A. General Principles of Tort Law

The law of torts has been one of the major systems used by government both to provide *compensation* for injuries and to achieve the right amount of *deterrence* for wrongful conduct (i.e., enough deterrence to reduce unreasonably risky conduct, but not so much deterrence that the cost of avoiding accidents rises to unproductive levels). The general measure of tort damages – which permits recovery “for all the detriment proximately caused” by the defendant’s wrongful conduct (Civ. Code § 3333) – serves both of these interests. Compensation “for all the detriment proximately caused” is designed to ensure that the injured person is neither under-compensated nor over-compensated. In addition, economic theory indicates that requiring the defendant to pay compensatory damages generally achieves the right amount of deterrence (neither too little, nor too much).

Our public system of dispute resolution generally entrusts decisions about the amount of damages in tort cases to the jury, the right to which is expressly guaranteed by the California Constitution. As a result of this constitutional provision and our historic tradition of placing great reliance upon juries to reflect the community’s wisdom, experience, values and common sense, it is appropriate to assume that the jury system is fulfilling its intended role and, consequently, that the tort system is functioning as intended, absent strong evidence to the contrary.

Accordingly, limitations upon damages for tort liability are justifiable only if there is clear evidence either (1) that the tort system is not working as intended because of one or more dysfunctions within the system (e.g., systematic over-compensation and over-deterrence), or (2) that the actual consequences of the tort system in practice (even assuming the system is working as intended) threaten other important public interests (e.g., insurance protection or health care at a reasonable cost), and the threat to those interests outweighs the benefits of the tort system.

B. Background of MICRA

The Medical Injury Compensation Reform Act (“MICRA”) was enacted in 1975 to address a perceived crisis in the medical malpractice insurance industry and a possible threat to the availability of some health care services. Nearly every state enacted some form of medical malpractice reform during the late 1970's and early 1980's. Each state's combination of reform measures is somewhat different, but the basic menu of choices (e.g., caps on non-economic damages, modification of the collateral source rule, creation of medical screening boards, and shortened limitation periods) has been essentially the same from state to state.

One of the most common damages limitation has been to cap non-economic damages at some arbitrary figure. MICRA imposed a \$250,000 cap upon recovery of non-economic damages in medical malpractice actions. Civ. Code § 3333.2. The cap has not been modified since its enactment in 1975.

C. Jury Verdicts in Medical Malpractice Actions

We examined jury verdicts in medical malpractice cases in California from 1993 to the present to address the question of whether there is strong evidence that juries are over-compensating injured plaintiffs with non-economic damages and, as a consequence, creating a substantial risk of over-deterrence. The data does not support the conclusion of systematic jury irrationality in assessing non-economic damages. Instead, the data suggests that juries take care in assessing non-economic damages in medical malpractice cases by arriving at numbers that seem to bear a reasonable relationship to the harm suffered.

The sum of all non-economic damages awarded by juries, before MICRA reductions, was only 31% of the total sum of verdicts. The 31% figure results from the fact that the largest medical malpractice judgments, which occur in injuries to newborns, consist primarily of economic damages. Non-economic damages are slightly larger than economic damages in medical malpractice cases involving injuries to adults, but the average non-economic award in such cases equals \$480,000.

The data indicates that under the existing \$250,000 cap, full recovery of non-economic damages occurs in 54% of the cases. Increasing the cap to

Institute for Legislative Practice
Jury Verdicts in Medical Malpractice Cases and the MICRA Cap

\$500,000 from \$250,000 would result in full recovery of non-economic damages in 74% of all the cases while increasing the total amount paid by defendants by only 5.52%. Increasing the cap to \$750,000 from \$250,000 would result in full recovery for non-economic damages in 81% of the cases while increasing the total amount paid by defendants by only 8.86%. Entirely removing the cap would increase the total amount paid by defendants by approximately 30%.

Chapter 2

Tort Liability: Theoretical Considerations

A. Government’s Response to Injuries in Society

Traditionally, one of the most important functions of government has been to promote and protect public health, safety and morals. The importance of laws directed at public health, safety and morals, and the legislature’s paramount role in safeguarding these interests, is recognized by the courts in, among other ways, the deferential standard of review used by courts in assessing the constitutionality of such laws. *See, e.g., Cory v. Shierloh*, 29 Cal.3d 430, 438 (1981) (“appellate courts sensitive to the restraints imposed by [the separation of powers] fully respect the deference which must uniformly and reciprocally be extended between equal and coordinate branches of government”); *Williamson v. Lee Optical of Oklahoma*, 348 U.S. 483 (1955).

Providing for public health, safety and morals includes dealing with the problem of “harm” in society (where “harm” is broadly defined to include any detrimental change in someone’s physical, emotional or economic status). There are many types of harms that do not necessarily trigger governmental intervention because they are too inconsequential, too private or too much a part of everyday living. However, when harm becomes sufficiently serious in its consequences, legislatures and courts have stepped in with statutes and judicially-created rules of law. For the remainder of this report, we shall use the word “injury” to refer to those harms for which government provides some type of regulation. These definitions of “harm” and “injury” are similar to the definitions found in the *Restatement (Second) of Torts*, § 7 (“(1) The word ‘injury’ is used . . . to denote the invasion of any legally protected interest of another. (2) The word ‘harm’ is used . . . to denote the existence of loss or detriment in fact of any kind to a person resulting from any cause.”).

There are two issues government must address when dealing with injuries in society.¹ First, determining how to respond when an injury occurs; and, second, determining how to prevent injuries from occurring (either by reducing the number of injuries or their severity). The first issue directs the government's attention to treating and/or compensating someone for their injuries. The second issue directs the government's attention to regulating and/or deterring conduct that creates risks of injuries.

There are many different systems, both public and private, for compensating injured persons (e.g., Medicare and Medicaid, disaster relief programs, workers' compensation systems and private insurance). Most of these institutionalized systems are premised in one way or another upon a risk-sharing arrangement that spreads the financial cost and burden widely throughout society (either because the system is supported by tax revenues or because the system is based on the existence of a healthy insurance market).

There are also many different ways of regulating or deterring conduct that creates risks of injuries. Risky conduct can be directly proscribed by detailed statutes or administrative regulations (e.g., workplace safety rules and environmental regulation). Risky conduct can be indirectly deterred through certain forms of taxation, as well as by holding a person who engages in such conduct legally responsible for any resulting injuries. The law of torts focuses on this last option: determining responsibility for personal injuries.

Reducing the number and severity of injuries is not a goal that society pursues limitlessly. Instead, we recognize that a certain number of injuries – even deaths – are an inevitable feature of organized society. In general, if the cost of avoiding a particular type of injury-causing accident is too great when compared to the utility of the conduct that creates the risk of the injury, the government may rationally determine that the risky conduct in question should *not* be proscribed or deterred. That is, government can rationally decide to deter risky conduct if and only if the social cost of reducing the risk by adopting additional safety measures

¹ Government also must address the issue of which harms are serious enough to justify treating them as injuries subject to governmental regulation. This report does not address that question since the type of harms discussed (i.e., physical and emotional injuries resulting from medical malpractice) have generally been viewed as serious enough to warrant governmental regulation.

is less than the social cost of the resulting injuries. As Judge Guido Calabresi has explained, the overall function of accident law should be to “reduce the sum of the costs of accidents and costs of avoiding accidents.” Guido Calabresi, *The Costs of Accidents*, p. 26 (1970).

B. Tort Law’s Role in Addressing the Problem of Injuries

The law of torts has been one of the major systems used by government both to provide compensation for injuries and to achieve the right amount of deterrence (i.e., enough deterrence to reduce risky conduct, but not so much deterrence that the cost of avoiding accidents rises to unproductive levels). The law of torts can conveniently be defined as that body of rules by which courts and others adjudicate and resolve claims by one or more persons against other(s) for compensation arising out of injuries suffered by the claimant(s) (other than for breach of contract). See J. Clark Kelso, *One Lesson from the Six Monsanto Lectures on Tort Law Reform and Jurisprudence: Recognizing the Limits of Judicial Competence*, 26 Valparaiso University Law Review 765, 773 (1992). The result of a successful tort lawsuit is the invocation of the power of the state (in the form of an enforceable court judgment) to compel one person (the defendant) to compensate another (the plaintiff) for injuries for which the defendant has been judged “responsible.”

The law of torts furthers both the compensation and deterrence goals described above. An award of damages *compensates* the plaintiff for some or all of the injuries suffered. By requiring the defendant to pay those damages, the law secures a measure of *deterrence*, encouraging the defendant and others who are similarly situated to reduce unreasonably risky behavior.

One of the central challenges for the tort system has been to determine the optimal level of compensation to satisfy society’s dual interests in seeing that the plaintiff is adequately reimbursed for losses suffered and that the defendant is appropriately deterred. The general measure of tort damages – which permits recovery “for all the detriment proximately caused” by the defendant’s wrongful conduct (Civ. Code § 3333) – serves both of these interests. Compensation “for all the detriment proximately caused” is designed to ensure that the injured person

is neither under-compensated nor over-compensated.² In addition, economic theory indicates that requiring the defendant to pay compensatory damages generally achieves the right amount of deterrence. See Richard A. Posner, *Economic Analysis of Law*, p. 143 (2d ed. 1977) (“As it happens, the right amount of deterrence is produced by compelling negligent injurers to make good the victim’s losses. Were they forced to pay more . . . some economical accidents might also be deterred; were they permitted to pay less than compensation, some uneconomical accidents would not be deterred.”).

The law of tort remedies accounts for those situations where a compensatory award would be *insufficient* to achieve the right amount of deterrence by permitting an award of punitive damages. The ordinary measure of damages, which limits the plaintiff to a compensatory award, is premised on the assumption that the defendant did not deliberately injure the plaintiff and that the defendant is therefore likely to alter his or her behavior in response to an award of compensatory damages. However, it sometimes happens that one person deliberately injures another or deliberately exposes another to a substantial risk of serious injury. In these circumstances, the defendant may actually have calculated in advance the likely cost of paying a plaintiff his or her compensatory damages and decided to expose the plaintiff to the risk of injury notwithstanding the expense of compensatory damages. The defendant in these cases can be found to have acted with “oppression, fraud, or malice,” thereby justifying an award of punitive damages “for the sake of example and by way of punishing the defendant.” Civ. Code § 3294(a).

The tort system works by compensating injured persons adequately and promoting the right amount of deterrence. In theory, it functions as intended so long as liability is generally imposed in the right cases, the amount of compensatory damages roughly reflects the actual injuries caused by the

² In practice, the tort system appears systematically to under-compensate injured persons by, among other things, denying compensation for attorneys fees incurred by an injured person in the course of pursuing legal remedies. This results from application of the so-called “American Rule” which ordinarily forbids recovery of attorneys fees from the losing party. The American Rule is now subject to literally scores of statutory and judicially-created exceptions. However, the American Rule still applies generally in the area of personal injury torts (including medical malpractice), and attorneys fees are generally paid by the plaintiff based on a contingency fee arrangement with his or her counsel.

defendant's conduct, punitive damages are imposed in appropriate cases, and the amount of punitive damages achieves an appropriate level of deterrence. Our public system of dispute resolution generally entrusts these decisions in tort cases to the jury, the right to which is expressly guaranteed by the California Constitution. *See* Cal. Const., Art. I, § 16 (“Trial by jury is an inviolate right and shall be secured to all, but in a civil cause three-fourths of the jury may render a verdict.”). As a result of this constitutional provision and our historic tradition of placing great reliance upon juries “to represent the community’s wisdom, experience, values and common sense” (*see* J. Clark Kelso, *Final Report of the Blue Ribbon Commission on Jury System Improvement*, 47 *Hastings Law Journal* 1433, 1474 (1996)), it is appropriate to assume that the jury system is fulfilling its intended role and, consequently, that the tort system is functioning as intended, absent strong evidence to the contrary.

Accordingly, those who propose limitations upon damages for tort liability bear the burden of establishing by clear evidence either (1) that the tort system is not working as intended because of one or more dysfunctions within the system (e.g., systematic over-compensation), or (2) that the actual consequences of the tort system in practice (even assuming the system is working as intended) threaten other important public interests (e.g., insurance protection or health care at a reasonable cost), and the threat to those interests outweighs the benefits of the tort system’s compensatory and deterrence characteristics.

From this brief review of basic principles of tort liability, we next turn to a discussion of the Medical Injury Compensation Reform Act and the question of whether to modify or remove the Act’s \$250,000 cap on recovery of non-economic damages.

Chapter 3

MICRA Reform: The Damage Cap

A. Background of MICRA

The Medical Injury Compensation Reform Act (“MICRA”) was enacted in 1975. Although the cost and availability of medical malpractice insurance had long been the subject of study by the California Legislature, the immediate event which precipitated legislative action was the announcement on January 1, 1975, that Pacific Indemnity and Star Insurance Companies would not renew insurance coverage for some 2,000 Southern California physicians. At about the same time, Argonaut Insurance announced a 380% increase in premiums for 4,000 doctors located in Northern California. *See* Assemblyman Barry Keene, California’s Medical Malpractice Crisis, in David Warren & Richard Merritt (eds.), *A Legislator’s Guide to the Medical Malpractice Issue*, p. 27 (Health Policy Center & National Conference of State Legislatures 1976).

When the Legislature failed to act by April of 1975, doctors in Northern California went on strike, complaining that they could no longer absorb the increases in malpractice insurance rates. The public, sensing a threat to the availability of medical care, put pressure on the Legislature for a solution. *Id.*, p. 29. The Legislature enacted MICRA later that year during an extraordinary session devoted to medical malpractice insurance.

MICRA was a comprehensive package of bills which proponents argued required sacrifices from all sides, an approach described by Assemblyman Keene as the “equal bite” theory. *Id.*, p. 33. In summary, MICRA contained the following sets of reforms:

- Recovery of non-economic damages was capped at \$250,000.
- The collateral source rule was eliminated. By eliminating the collateral source rule, a plaintiff’s recovery in a medical malpractice action would be reduced by any amounts the plaintiff received as

payment from another source to compensate for the plaintiff's injuries (e.g., payments from the plaintiff's own insurance company).

- Attorney contingency fees were regulated.
- The limitation period (i.e., the time in which the plaintiff was required to file suit) was changed to one year from discovery of the injury, and a maximum of three years from occurrence except in cases where a foreign object was left inside the patient after surgery.
- The plaintiff was required to give a 90-day notice of intent to sue.
- The court was authorized to enter periodic payment judgments for future damages of \$50,000 or more.
- Arbitration clauses were required to be specially disclosed.
- Judgments, awards, settlements, and general professional information were required to be reported for use in statistical reports.
- Medical licensing boards were required to keep records of all court actions, complaints, and disciplinary actions for each medical practitioner.
- The Insurance Commissioner was authorized to regulate medical malpractice rates.

Nearly every state enacted some form of medical malpractice reform during the late 1970's and early 1980's. Each state's combination of reform measures is somewhat different, but the basic menu of choices (e.g., modification of the collateral source rule, caps on damages, creation of medical screening boards, shortened limitation periods) has been essentially the same from state to state.

One of the most common damages limitation has been to cap non-economic damages at some arbitrary figure (ranging from \$250,000, the limit

imposed by MICRA, to as much as \$1 million). *See, e.g.*, W. Va. Code § 55-7B-8 (“In any medical professional liability action brought against a health care provider, the maximum amount recoverable as damages for noneconomic loss shall not exceed one million dollars and the jury may be so instructed.”). In all, fourteen states have enacted caps on the recovery of non-economic damages in medical malpractice actions (Alaska, California, Florida, Hawaii, Idaho, Kansas, Maryland, Massachusetts, Michigan, Missouri, Oregon, Utah, West Virginia, and Wisconsin).

The constitutionality of caps on damages – both on economic damages and on non-economic damages – has been frequently litigated around the country with varying results. Cases striking down caps (often on state constitutional grounds) include the following: *Moore v. Mobile Infirmary*, 592 So.2d 156 (Ala. 1991); *Smith v. Department of Insurance*, 507 So.2d 1080 (Fla. 1987); *Jones v. State Board of Medicine*, 555 P.2d 399 (Idaho 1976), *cert. denied*, 431 U.S. 914 (1977); *Wright v. Cenral DuPage Hospital*, 347 N.E.2d 736 (Ill. 1976); *Kansas Malpractice Victims Coalition v. Bell*, 757 P.2d 251 (Kan. 1988); *Brannigan v. Usitalo*, 587 A.2d 1232 (N.H. 1991); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Morris v. Savoy*, 576 N.E.2d 765 (Ohio 1991); *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988); *Sophie v. Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989).

California’s cap on non-economic damages, Civ. Code § 3333.2, has been upheld against constitutional challenge. The Ninth Circuit Court of Appeals rejected an equal protection clause challenge to the cap in *Hoffman v. United States*, 767 F.2d 1431 (9th Cir. 1985). Finding no discrimination on the basis of a suspect or quasi-suspect class and no burden on a fundamental or quasi-fundamental right, the court subjected Section 3333.2 to rational basis scrutiny, requiring only that the legislation have a legitimate purpose which reasonably could be furthered by the classification. The court found that Section 3333.2 was enacted in response to dramatic increases in medical malpractice insurance rates which the Legislature reasonably could have believed was having an adverse impact upon medical care. Reducing the medical malpractice insurance rates to safeguard the availability of medical care was plainly a legitimate state purpose. The court also found that the Legislature reasonably could believe that imposing a cap on non-economic damages, which would reduce both verdicts and

settlements, would lead to a general reduction in medical malpractice insurance rates. It is worth noting, in this regard, that according to a 1984 study of paid claims, a very small percentage of malpractice cases (approximately 2%) account for a large percentage of all non-economic damage recoveries (around 60%). See U.S. Congress, General Accounting Office, *Medical Malpractice: Characteristics of Claims Closed in 1984* GOA/HRD-87-55 (Wash. D.C., April 1987). Thus, the burden imposed by Section 3333.2 was arguably concentrated on a relatively small number of large claims.

The California Supreme Court also upheld Section 3333.2 against constitutional challenge in *Fein v. Permanente Medical Group*, 38 Cal.3d 137 (1985), *appeal dis'd*, 474 U.S. 892 (1985), for the same basic reasons found in *Hoffman* (i.e., the cap was one reasonable response to the problem of increasing medical malpractice premiums). Other MICRA provisions have also been upheld against constitutional challenge. See *American Bank & Trust Co. v. Community Hospital*, 36 Cal.3d 359 (1984) (period payment provision constitutional); *Roa v. Lodi Medical Group*, 37 Cal.3d 920 (1985) (attorneys fees limitations constitutional).

B. MICRA Reform: Raising or Removing the Cap on Non-Economic Damages

The Legislature considered several bills last year to raise the cap on non-economic damages. AB 250 (Kuehl); AB 1220 (Migden). Neither bill passed out of the Legislature. AB 1380 (Villaraigosa), introduced earlier this year, would, in its present form, add a cost-of-living adjustment to the \$250,000 cap on non-economic damages.

Consistent with the principles set out at the end of Chapter 2, retaining the \$250,000 cap on non-economic damages without modification is justifiable if (1) there is strong evidence that the tort system itself is not functioning properly because juries are routinely awarding excessively high non-economic damages, or (2) there is strong evidence that raising or entirely removing the MICRA cap would result in serious adverse consequences within the insurance or health care industries, and those adverse consequences outweigh the value of larger damage judgments in terms of compensation and deterrence.

1. Jury Verdicts in Medical Malpractice Cases

a. Research Focus

If there were evidence that juries in medical malpractice cases were routinely making inappropriately large awards for non-economic damages, a cap on those damages (or some other type of control) might be justifiable. As explained in Chapter 2, the tort system assumes that compensatory damages, properly measured by juries, achieve the right amount of deterrence. However, inappropriately large awards of non-economic damages would systematically over-compensate plaintiffs and over-deter defendants (which might result in an increase in so-called “defensive medicine,” an increase in medical costs, or a decrease in access to care).

Determining whether a particular award of non-economic damages is excessive is inherently difficult because of the absence of a well-defined metric for measurement. Jury instructions do not provide much substantive guidance. According to the *California Jury Instructions -- Civil (8th ed.)*, “[t]he term non-economic damages means subjective, non-monetary losses including, but not limited to pain, suffering, inconvenience, mental suffering, emotional distress, loss of society and companionship, loss of consortium, humiliation and injury to reputation.” BAJI 14.00. In fact, jury instructions expressly acknowledge the subjective and imprecise nature of non-economic damage awards. BAJI 14.13 explains as follows:

“No definite standard or method of calculation is prescribed by law by which to fix reasonable compensation for pain and suffering. Nor is the opinion of any witness required as to the amount of such reasonable compensation. Furthermore, the argument of counsel as to the amount of damages is not evidence of reasonable compensation. In making an award for pain and suffering you shall exercise your authority with calm and reasonable judgment and the damages you fix shall be just and reasonable in the light of the evidence.”

Although placing a dollar figure upon pain and suffering can be problematic, there are several reasons which support permitting juries to attempt to quantify the essentially unquantifiable.

First, the injury to the plaintiff in medical malpractice cases is very real. Whether it is pain and suffering from physical injuries or humiliation and embarrassment from disfigurement, the non-economic injuries suffered by plaintiffs in medical malpractice actions are genuine and often serious. To deny any compensation for these type of injuries would systematically under-compensate plaintiffs and, equally important, would systematically under-deter defendants. Therefore, *some* compensation seems appropriate.

Second, if there is uncertainty in the measure of non-economic damages, the risk of that uncertainty is most appropriately placed upon the defendant whose wrongful conduct created the uncertainty. This is a bedrock principle of remedies observed in virtually all areas of civil liability. As explained by the Supreme Court of the United States in *Bigelow v. RKO Radio Pictures, Inc.*, 327 U.S. 251 (1946), “[t]he most elementary conceptions of justice and public policy require that the wrongdoer shall bear the risk of the uncertainty which his own wrong has created.” *Id.*, 327 U.S. at 265.

Third, as noted in Chapter 2, we should ordinarily presume that the jury system is functioning properly and that a jury’s estimate of non-economic damages reflects the community’s judgment about the seriousness of the injury which the plaintiff has suffered. Absent clear evidence that juries are unable to make rational or reliable assessments of non-economic damages, we should presume that the damages awarded by juries are reasonable estimates.

In light of these considerations, our research focus is on the question of whether jury verdicts in medical malpractice actions in California show strong evidence of over-compensation for non-economic injuries.

As discussed below, we did not see evidence of systematic jury irrationality in assessing non-economic damages. Instead, the data suggests that juries take care in understanding their responsibility to assess non-economic damages in medical malpractice cases by arriving at numbers that seem to bear a reasonable relationship to the harm suffered (consistent with the jury instruction quoted

above).

b. Data Collection

The data for this empirical study was obtained from the Westlaw database for the *California Jury Verdict Reporter*. We reviewed 1,283 medical malpractice cases dating from January 1, 1993 to March 10, 1999.³ Of those 1,283 cases, only 310 resulted in a plaintiff verdict, a success rate of 24.1%. This is consistent with results recently reported by other researchers. Neil Vidmar, Felicia Gross & Mary Rose, *Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DePaul Law Review 265, 293 (1998) (plaintiffs prevailed in 22.5% of the California medical malpractice cases from 1991 through 1997). The 24.1% success rate in California compares to a national average of approximately 30% success rate in medical malpractice actions. *Id.*, 48 DePaul Law Review at 293.

There was insufficient data in 116 of the 310 pro-plaintiff verdict reports to be useful for our study (e.g., because the report did not indicate the total verdict amount or, more commonly, did not report the breakdown between economic and non-economic damages). Thus, the total sample for complete analysis was 194 cases.

c. Results

The sum of jury verdicts in all cases in the sample, before MICRA reductions, was \$436,966,279. The sum of non-economic damages awarded by juries, before MICRA reductions, was \$136,775,343 (i.e., 31% of the sum of verdicts). As a result of the MICRA cap, the sum of non-economic damages was reduced by 74% to \$35,306,312. The sum of net judgments awarded to plaintiffs (i.e., total judgments after MICRA reductions) was \$328,791,918, a 25%

³ The database contains jury verdict reports going back to February, 1991. However, the format of the reports prior to January, 1993, does not reliably report the breakdown between economic and non-economic damages.

Institute for Legislative Practice
Jury Verdicts in Medical Malpractice Cases and the MICRA Cap

reduction from the sum of verdicts.⁴

The summary of descriptive statistics for the entire sample of 194 cases is as follows:

	N	5 th Percentile	Median	Mean	5% Trimmed Mean	95 th Percentile	SD
Jury Verdict	194	319,000	383,076	2,252,406	1,246,855	13,523,163	5,738,490
Economic	194	0	62,000	1,535,614	624,869	8,271,766	5,185,494
NonEconomic	194	12,561	250,000	705,028	454,205	4,125,000	1,362,958
Net Award (after cap)	194	18,764	274,250	1,694,804	787,569	8,521,766	5,197,505

Table 1. Summary of Medical Malpractice Jury Verdicts from 1993-1999.

Several features of Table 1 are worth special note. First, the economic component of medical malpractice verdicts generally dominates over the non-economic component. Both the mean⁵ and trimmed mean⁶ figures show that non-economic damage awards are, on average, *lower* than economic damages in medical malpractice cases. Looking at mean awards, only 31% of the award reflects non-economic damages. For trimmed mean awards, the percentage rises to 36% because trimming the sample discards a number of high damage

⁴ While most of the jury verdict reports clearly set forth the economic and non-economic awards and the MICRA reductions, some of the reports required interpretation (e.g., as to whether future damages as reported had already been reduced to present value or whether non-economic damages as reported had already been reduced by MICRA). As noted above, we discarded 116 cases where there simply was insufficient data to determine the breakdown between economic and non-economic damages.

⁵ The “mean” is a measure of the central tendency of a sample. It is the arithmetic average of the sample which is calculated by dividing the sum of the cases by the number of cases.

⁶ The trimmed mean figures are calculated after discarding the highest and lowest 5% of the sample. Trimmed means better reflect the central tendency of the data and are appropriate to use when a sample is highly skewed (and thus non-normal). The sample of damage judgments is highly skewed in a positive direction as a result of a small number of extremely large judgments (most of which consist of economic damages). The five highest total verdicts are \$53,490,000, \$30,000,000, \$26,053,000, \$21,789,549, and \$17,162,272. The five highest non-economic awards are \$8,730,152, \$7,500,000, \$7,000,000, \$6,000,000, and \$5,900,000.

judgments that primarily consist of economic damages.

However, the median ⁷ for non-economic damages is \$250,000 (prior to the MICRA cap reduction), which is 4 times larger than the median for economic damages (\$62,000). This reflects the fact that in 140 of the 194 cases in the sample (i.e., 72%), the non-economic portion of the verdict is *larger* than the economic portion of the verdict. In other words, non-economic damages are higher than economic damages in more cases, but the total amount awarded for economic damages exceeds the total amount awarded for non-economic damages.

Second, there appears to be less variation in non-economic awards than in economic awards. The standard deviation ⁸ for non-economic damages is substantially lower than for economic damages, indicating that non-economic damages are not dispersed as widely as economic damages. In particular, the standard deviation for economic damages is 338% of the mean for economic damages, and the standard deviation for non-economic damages is only 193% of the mean for non-economic damages. The figures for variance provide additional confirmation that economic awards are more dispersed than non-economic awards.⁹ These results suggest that juries are not making erratic assessments of non-economic losses in medical malpractice cases.

Third, MICRA's cap substantially reduces jury verdicts. The sample includes a few cases where a partial reduction in the jury's verdict was made pursuant to comparative fault principles (i.e., a reduction to reflects the plaintiff's

⁷ The "median" is the value above and below which half the cases fall (i.e., the 50th percentile). The median is a measure of central tendency not sensitive to outlying values in a skewed sample.

⁸ "Standard deviation" is a measure of dispersion around the mean of a sample. In a normal distribution, 68% of cases fall within one standard deviation of the mean, and 95% of cases fall within 2 standard deviations of the mean. For example, if the mean verdict of a sample is \$150, with a standard deviation of \$20, 68% of the cases would be between \$130 and \$170 in a normal distribution, and 95% of the cases would be between \$110 and \$190 in a normal distribution.

⁹ "Variance" is another measure of dispersion around the mean, equal to the sum of squared deviations from the mean divided by one less than the number of cases. The variance figures for the sample are as follows: Verdict= 3.29×10^{13} ; Economic= 2.69×10^{13} ; NonEconomic= 1.86×10^{12} ; Net= 2.70×10^{13} .

contribution to his or her own injury). After excluding those cases, there remains a 28% reduction from the jury's verdict to the net award based on the median, a 27% reduction based on the mean, and a 37% reduction based on the trimmed mean. There is thus no question the MICRA cap is systematically reducing compensation and substantially reducing the damages paid by culpable defendants.

We hypothesized that damage judgments in medical malpractice actions might vary depending upon the type of case. One of the most common methods of categorizing malpractice cases is by using a severity-of-injury scale developed by the National Association of Insurance Commissioners ("NAIC"). The scale's nine categories are as follows:

1. Emotional damage only (fright; no physical damage)
2. Temporary insignificant (lacerations, contusions, minor scars, rash; no delay)
3. Temporary minor (infections, misset fracture, fall in hospital; recovery delayed)
4. Temporary major (burns, surgical material left, drug side-effect brain damage; recovery delayed)
5. Permanent minor (loss of fingers, loss or damage to organs, includes non-disabling injuries)
6. Permanent significant (deafness, loss of limb, loss of eye, loss of one kidney or lung)
7. Permanent major (paraplegia, blindness, loss of two limbs, brain damage)
8. Permanent grave (quadriplegia, severe brain damage, lifelong care, or fatal prognosis)
9. Death.

Recent research by Professors Vidmar, Gross & Rose on medical malpractice verdicts in New York, Florida and California confirms prior findings of "a consistent relationship between the amount of verdict awards and the seriousness of injury suffered by the plaintiff" as measured by the NAIC scale. Neil Vidmar, Felicia Gross & Mary Rose, *Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DePaul Law Review 265, 296 (1998). They also found, again consistent with prior research, that there is a sharp

Institute for Legislative Practice
Jury Verdicts in Medical Malpractice Cases and the MICRA Cap

decrease in the amount of awards when death occurred (that is, there is a sharp decrease from NAIC scale 8 to NAIC scale 9). *Id.* The sharp decrease is because of the substantially different measure of damages awarded in wrongful death cases.

Based in part on these findings and in part on distinctions made in last year's MICRA reform legislation between injuries to adults and injuries to children, we categorized the cases in our sample as follows:

1. Injury to child at or near birth
2. Injury to minor (other than injury to child at or near birth)
3. Injury to adult (other than dental)
4. Dental injury
5. Adult wrongful death
6. Child wrongful death

The summary of descriptive statistics for the entire sample of 194 cases by case type is as follows:

		N	Median	Mean	5% Trimmed Mean	Standard Deviation
Birth Inj.	Verdict	21	6,350,000	11,606,290	9,896,237	12,089,294
	Economic	21	5,879,000	10,065,056	8,284,642	11,893,913
	NonEco	21	500,000	1,574,567	1,263,201	2,137,988
	Net	21	6,129,000	10,119,490	8,318,669	12,004,185
Child Inj.	Verdict	13	1,637,629	5,254,600	4,389,111	7,382,930
	Economic	13	1,065,629	3,448,377	2,717,474	5,520,955
	NonEco	13	572,000	1,806,223	1,616,081	2,458,394
	Net	13	1,315,629	3,660,600	2,937,444	5,546,973
Adult Inj.	Verdict	106	295,000	831,055	473,635	1,992,315
	Economic	106	49,643	322,929	135,037	1,208,965
	NonEco	106	222,500	480,657	303,451	1,012,369
	Net	106	260,000	491,850	308,422	1,231,925

Institute for Legislative Practice
Jury Verdicts in Medical Malpractice Cases and the MICRA Cap

Dental	Verdict	19	94,000	243,591	204,665	328,875
	Economic	19	10,000	21,595	15,284	37,587
	NonEco	19	84,000	221,996	184,800	319,827
	Net	19	94,000	131,338	123,322	114,255
Adult wd	Verdict	29	507,534	909,456	719,062	1,220,977
	Economic	29	80,200	241,525	186,504	368,086
	NonEco	29	312,500	665,517	487,203	1,081,621
	Net	29	308,950	445,802	402,858	351,471
Child wd	Verdict	6	266,750	971,677	868,332	1,444,407
	Economic	6	3,782	11,511	10,012	19,053
	NonEco	6	262,500	960,167	858,519	1,450,752
	Net	6	219,250	189,177	193,332	82,107

Table 2. Summary of Medical Malpractice Jury Verdicts by Case Type from 1993-1999.

Breaking down medical malpractice verdicts along these lines produces several interesting results. Injuries to children at or near birth produce the largest damage judgments by a substantial margin, with a mean verdict of \$11,606,290, a trimmed mean verdict of \$9,896,237, and a median verdict of \$6,350,000. Four of the five largest verdicts in the entire sample involved injuries at or near birth: \$53,490,000, \$30,000,000, \$21,789,549, and \$17,162,272 (the fifth case, \$26,053,000, involved an injury to a minor other than an injury at or near birth). In these cases, economic damages are, on average, substantially larger than non-economic damages, with non-economic damages consisting of only 14% of the mean verdict, 13% of the trimmed mean verdict, and 9% of the median verdict. However, even though non-economic damages make up only a small portion of the total award in these cases, because the total damages are so large, the MICRA cap still has a substantial impact, decreasing mean verdicts by 13%, trimmed mean verdicts by 16% and the median verdict by 3%. Nevertheless, even after the MICRA reduction, net awards in these cases are in the high seven or eight figures (mean net of \$10,119,490, trimmed mean net of \$8,318,669, and median net of \$6,129,000).

Injuries to children (other than injuries at or near birth) produce the second largest damage judgments, again by a substantial margin over the remaining

categories, with a mean verdict of \$5,254,600, a trimmed mean verdict of \$4,389,111, and a median verdict of \$1,637,629. Once again, economic damages are, on average, substantially larger than non-economic damages, and non-economic damages consist of only 34% of the mean verdict, 37% of the trimmed mean verdict, and 35% of the median verdict. In these cases, the MICRA cap decreases mean verdicts by 30%, trimmed mean verdicts by 33%, and median verdicts by 20%.

Each of the remaining categories has mean verdicts, trimmed mean verdicts and median verdicts *below* one million dollars. However, in each of these categories, non-economic damages are, on average, *larger* than economic damages. The disparity is greatest in wrongful death cases involving children where non-economic damages are 98-99% of the verdict. There were only six such cases in the sample, and five of those cases involved death at or near the time of birth. In wrongful death at time of birth cases, economic damages will usually be very small since it is generally not possible to prove what economic contributions the decedent might make to heirs (e.g., as to the parents, the expense of raising the child would often cancel out any subsequent economic support from the child, and, in any event, it is speculative what the decedent might ultimately earn). As a consequence, most of the verdict in these cases consists of non-economic damages. Because non-economic damages predominate, the effect of the MICRA cap is more pronounced, resulting in decreasing mean verdicts by 81%, trimmed mean verdicts by 78%, and median verdicts by 18% (the large variation in these numbers results in part from the very small sample (N=6)).

Non-economic damages constituted 89-91% of the mean, trimmed mean and median verdicts in dental injury cases. The high proportion of non-economic damages appears, in part, to be attributable to the fact that the injuries in dental cases in the sample tended to be permanent and the medical expenses were relatively low. In addition, although this is purely speculative without conducting juror interviews, it is plausible that jurors are particularly sensitive to claims of dental pain and suffering because nearly everyone has experienced dental pain and suffering during routine check-ups. Because dental injury verdicts are much smaller than other malpractice verdicts (i.e., mean verdict of \$243,591, trimmed mean verdict of \$204,665, and median verdict of \$94,000), the effect of MICRA's cap is not nearly as pronounced as in child wrongful death actions. The mean

reduction is 46%, the trimmed mean reduction is 40%, and there is *no reduction* in the median verdict.

In adult injury and adult wrongful death cases, non-economic damages ranged between 58% and 75% of the calculated means and medians. In particular, for adult injury cases, non-economic damages were 58% of the mean verdict, 64% of the trimmed mean verdict, and 75% of the median verdict. For adult wrongful death cases, non-economic damages were 73% of the mean verdict, 68% of the trimmed mean verdict, and 62% of the median verdict. The MICRA cap reduced damages from between 12% to 51%. For adult injury cases, the mean reduction was 41%, the trimmed mean reduction was 35%, and the median reduction was 12%. For adult wrongful death cases, the mean reduction was 51%, the trimmed mean reduction was 44%, and the median reduction was 39%.

The results reported above do not appear to support the contention that juries are systematically over-compensating plaintiffs for pain and suffering or emotional distress in medical malpractice cases.

2. Likelihood of Adverse Consequences

The Legislature has been presented by both proponents and opponents of MICRA reform with substantial information on the issue of whether the insurance and/or health care industries would be seriously affected by raising or removing the MICRA cap. Our empirical investigation on jury verdicts in medical malpractice cases provides useful information in assessing the likelihood of adverse consequences since the likelihood of adverse consequences depends, to some extent, upon the likely increase in total damages that would result from increasing or removing the MICRA cap.

If, for example, removing the MICRA cap were to result in a doubling or trebling of the total defendant payments to injured plaintiffs, that would seem to suggest that removing the MICRA cap would have a serious impact upon medical malpractice insurance rates and/or the availability of some types of health care services. On the other hand, if removing the MICRA cap were to have only a minimal affect on total defendant payments (e.g., increasing payments by under 1%), that would seem to suggest that removing the MICRA cap might not have a serious impact upon the medical malpractice insurance and/or health care

industries.

Predicting how the medical malpractice insurance industry or the health care industry might respond to any increases in total payments to plaintiffs resulting from an increase in or removal of the MICRA cap (e.g., whether increases in tort judgments would result in decreased profits, increased premiums or costs, or decreased health care services) is beset with difficulties and is not the focus of this report. Nor do we attempt to suggest any particular point at which limitations on non-economic recovery might be appropriate (e.g., that \$250,000 is too low, that \$500,000 is too high, and that \$375,000 is just right). Those decisions require the application of careful judgment by legislators in light of a wide array of considerations that are not discussed in this report. However, based on the jury verdict data in our sample, we are able to provide some information in the next section that may assist policy-makers in evaluating the possible consequences of modifying the MICRA cap.

3. Legislative Alternatives

The jury verdict data does not provide strong support for the contention that juries are regularly over-compensating plaintiffs with very large non-economic damages in medical malpractice actions. Absent evidence of systematic over-compensation, maintaining the MICRA cap at its present level can be justified only if increasing the cap is likely to result in serious adverse consequences within the insurance or health care industries, and those adverse consequences outweigh the benefits of the tort system's rule favoring full recovery of compensatory damages. The MICRA cap can be modified in many different ways, and the jury verdict data gives us the ability to make some forecasts about the likely consequences of different modifications. In this section, we consider a number of possibilities.

a. Cost-of-Living Adjustment

AB 1380 (Villaraigosa), as amended in the Assembly May 24, 1999, proposes to add a cost-of-living provision to the MICRA cap that, beginning next year, would annually adjust the cap "to reflect the cumulative percentage change

in the Consumer Price Index for all items published by the United States Bureau of Labor Statistics . . . for the preceding calendar year.” The theoretic premise for a cost-of-living provision is that the MICRA cap should be adjusted to reflect changes in the value of money (as indicated by changes in the Consumer Price Index). As pointed out in the findings for AB 1380, “[s]ince [MICRA] was enacted 24 years ago, the cost of living has increased so that the two hundred fifty thousand dollars (\$250,000) cap on damages is estimated to be worth eighty-four thousand dollars (\$84,000) today.”

A cost-of-living provision is likely (in ordinary economic times) to result in very modest annual adjustments to the MICRA cap. For example, assuming a 4% increase in the Consumer Price Index in the year following enactment of a cost-of-living provision (and no other modification of the MICRA cap), the cap would increase only \$10,000 from \$250,000 to \$260,000 (i.e., $\$250,000 + (.04 * \$250,000)$). Even during times of relatively high inflation (e.g., 12-15% annually), the MICRA cap would increase in relatively small steps. Data reported in the next section show that these sort of small increases are likely to have a correspondingly small impact upon the total amounts paid by defendants (and, thus, a small impact upon the medical malpractice insurance industry).

b. Stepping-Up the MICRA Cap

The jury verdict results discussed above suggest that relatively modest increases in the MICRA cap would result in ameliorating the affects of the cap in a substantial percentage of cases while still providing protection to defendants and insurers against the relatively few very large awards (awards that, from a statistical perspective, may be considered outliers).

The following table shows what percentage of the cases in the sample have non-economic damages that fall *below* the indicated cap:

	\$250,000	\$375,000	\$500,000	\$625,000	\$750,000	\$875,000	\$1,000,000
Birth Inj.	33%	38%	52%	52%	57%	57%	62%
Child Inj.	38%	46%	46%	62%	62%	62%	62%
Adult Inj.	60%	72%	82%	86%	90%	90%	91%

Institute for Legislative Practice
Jury Verdicts in Medical Malpractice Cases and the MICRA Cap

Dental Inj.	79%	79%	84%	89%	89%	89%	95%
Adult WD	34%	55%	69%	76%	76%	79%	86%
Child WD	50%	67%	67%	67%	67%	67%	67%
All Cases	54%	64%	74%	78%	81%	82%	85%

Table 3. Percentage of Cases Falling Below Possible MICRA Caps

A few examples may assist readers in understanding how to use Table 3. For example, 33% of the birth injury cases in the sample had non-economic damages equal to or less than \$250,000 (the percentage comes from the upper left-hand corner of Table 3); 38% of the birth injury cases in the sample had non-economic damages equal to or less than \$375,000. Looking at the entire sample, 85% of all the cases had non-economic damages equal to or less than \$1,000,000 (the percentage comes from the lower right-hand corner of Table 3).

Based on Table 3, we can make some predictions about the impact of increasing the MICRA cap. Increasing the cap to \$500,000 from \$250,000 would result in full recovery of non-economic damages in an additional 37% of all the cases (from full recovery in 54% of the cases to full recovery in 74% of the cases). Increasing the cap to \$750,000 from \$250,000 would result in full recovery for non-economic damages in an additional 50% of the cases (from full recovery in 54% of the cases to full recovery in 81% of the cases).

These increases would *not* have as substantial an effect upon the total amount paid by defendants (because the total amount paid by defendants is so largely influenced by a small number of very large judgments). Based upon the sample, the 37% improvement gained by raising the cap to \$500,000 would increase the sum of net judgments by 5.52%.¹⁰ The 50% improvement gained by raising the cap to \$750,000 would increase the sum of net judgments by only 8.86%.¹¹ These figures are consistent with the change in claim costs reported by

¹⁰ Increasing the cap to \$500,000 from \$250,000 would have the result of increasing the sum of recoverable non-economic damages by \$18,171,321. This would result in an increase in net judgments from \$328,791,918 to \$346,963,239, a 5.52% increase.

¹¹ Increasing the cap to \$750,000 from \$250,000 would have the result of increasing the sum of recoverable non-economic damages by \$29,118,217. This would result in an increase in net

Mr. Birny Birnbaum in his study on Texas medical malpractice insurance closed claim data. See Birny Birnbaum, *The Impact on California Medical Malpractice Insurance of Raising the MICRA Cap on Non-Economic Damages*, p. 7 (May 1999) (reporting a change in claim costs of +4.5% with a new cap at \$500,000, and a change in claim costs of +7.1% with a new cap at \$750,000).

c. Limiting Non-Economic as a Proportion of Economic Damages

The Legislature could modify the MICRA cap by limiting the recovery of non-economic damages to some percentage of economic damages. For example, non-economic damages could be limited to a maximum of two or three times the plaintiff's economic loss.

The following table shows what percentage of the cases in the sample have non-economic damages that fall *below* the indicated proportionality test:

	NonEco. capped at Economic	NonEco. capped at 2 times Economic	NonEco. capped at 3 times Economic
Birth Injury	81%	90%	95%
Child Injury	38%	54%	54%
Adult Injury	25%	38%	51%
Dental Injury	11%	21%	37%
Adult WD	14%	34%	48%
Child WD	17%	17%	17%
All Cases	28%	42%	53%

Table 4. Percentage of Cases Falling Below Proportionality Test

Table 4 shows that if non-economic damages are capped at 3 times economic damages, there will be full recovery in 53% of all the cases (and, thus, a reduction in non-economic damages in 47% of the cases). This is virtually the

judgments from \$328,791,918 to \$357,910,135, an 8.86% increase.

same percentage of cases that now falls below the existing \$250,000 MICRA cap. However, because the cases which a proportionality test affects are different than the cases which the MICRA cap affects, adopting a treble-economic-damage-cap would increase the sum of net judgments by 17% (i.e., \$57,082,573). Using economic damages as the limit on non-economic damages would permit full recovery of non-economic damages in 28% of the cases, but it would still increase the sum of net judgments by 11% (i.e., \$34,870,853) compared to recoveries under the existing MICRA cap.

d. Removing the MICRA Cap

Finally, permitting full recovery of all non-economic damages in all medical malpractice cases would result in a substantial increase in total defense payments. Based on the jury verdict data, entirely removing the MICRA cap would result in at least a 30% increase in the amount of damages paid by defendants in medical malpractice actions (the increase might ultimately be larger because the absence of any cap might encourage plaintiff's counsel to spend more resources developing a basis for a higher non-economic award).