HB

492

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. HB 492

Revision Date:
Title: Civil Liability: Medical Malpractice

Sponsor: House HESS Committee
Requestor:

Department Affected: Commerce and Economic Development
BRU: Insurance
Component: Operations

COMPONENT SERIAL NO. 354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL EXPENDITURES	0	0	0	0	0	0
CHANGE IN REVENUES ( )	0	0	0	0	0	0
FUND SOURCE						
1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

Estimate of current year (FY 94) cost: $ 0

POSITIONS						
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact.

Prepared by: Joan Brown, Administrative Officer
Division: Insurance

Phone: 465-2597
Date: 3/4/94

Approved by Commissioner: Paul Fuhs
Agency: Commerce and Economic Development

Date: 3-7-94

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COMMERCE & ECONOMIC DEVELOPMENT - INSURANCE- ZERO FISCAL NOTE

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March 9, 1994

Representative Toohey, Co-Chair, House HESS
Representative Bunde, Co-Chair, House HESS
Representative Davis, Vice-Chair, House HESS
Representatives Vezey, Kott, Olberg, Davis, Nicholia and Brice

Dear Members of House Health, Education and Social Services Committee,

The Alaska trial lawyers thank you for the opportunity to provide testimony and materials on HB 492 and HB 493, health care liability compensation reform. Dan Hensley will provide testimony before your committee March 10th. In advance of his appearance before your committee, I have put together some materials for your review.

HB 429 and HB 493 are being proposed by the Alaska trial lawyers as an alternative health care liability proposal. This plan would require major changes in the health care liability compensation system and addresses the real or perceived inequities that exist.

Clearly, from the standpoint of the medical professional, there is a continuing anxiety that their assets and livelihoods are continually placed in danger by the "threat" of medical negligence litigation. This real or perceived threat causes them to provide medical care and services which may not be warranted or needed and has also resulted in a number of health care professionals not being insured and relying upon other devices in order to attempt to protect their interests. Further, there is an asserted concern about the filing of non-meritorious claims.

From the standpoint of the trial lawyers and their constituents, there is the anxiety that the rights of injured people will continue to be eroded and those who have sustained injury will no longer have a fair and just forum in which to resolve their disputes. There is a perception that those health care professionals who negligently cause injuries are not willing to accept the social responsibility to pay for the costs in obtaining adequate insurance. It is also felt that a civil jury must have freedom to resolve disputes between members of our society,

unfettered by artificially imposed limitations with regard to the type and amount of damages that they can find to fairly compensate an injured person. There is also the perception that the system is unbalanced, unduly favors the medical profession, causes excessive delay and costs, and that only the most seriously injured can receive just compensation.

It is our belief that HB 492 and HB 493 address these major issues.

Mandatory Insurance: This plan requires mandatory insurance for all health care providers which would be issued through a State Authority. This would guarantee to individuals who are injured as a result of medical negligence that there would be sufficient assets to compensate them for the injuries they sustain. The plan establishes a mechanism providing insurance coverage to those health care providers in rural areas or in certain high risk specialties where the physicians' income is not sufficient to afford insurance. The Authority would be in a position to accurately determine premium income, insurance administrative costs, the frequency and severity of claims asserted, and their resolution.

Limitation of Liability: While trial lawyers are adamantly opposed to any "caps" with regard to damages that may be asserted, they realistically understand that cost containment in some form must be an integral part of any proposal that is to be adopted. No recovery for either compensatory or punitive damages may exceed the amount of the liability coverage required by the Authority. Thus, while no "caps" on types of damages are imposed, leaving the jury free to make these fundamental and important decisions, there is still a limitation placed on the amount of overall assets that are available for the compensation of the injured. This limitation would certainly provide full coverage for most claims asserted and would give a degree of predictability that the insurance companies claim is necessary in order to underwrite claims.

Furthermore, all medical negligence litigation is depersonalized by removing the health care provider as a named defendant. All health care providers would be covered under a single insurance policy. All claims in a case would be defended by a single attorney thereby materially expediting litigation and substantially reducing costs. There would be universal medical coverage for all health care providers and the problems that Jackson v. Powers appears to have created on behalf of the hospitals would no longer exist. Also the plan would preclude the award of compensatory or punitive damages in excess of the amount of the insurance provided by the Authority and the perceived need to practice "defensive medicine" would no longer exist.

Resolution of Non-Catastrophic Damage Claims: The present court system is not well designed to handle the non-catastrophic damage claims. Therefore, under this plan all medical negligence claims

of less than $200,000 would be resolved by arbitration, with costs shared by the parties. The costs of the arbitration procedure would also be reduced by limiting the number of experts and the length of the proceedings. The plan also provides a disincentive for the losing party to appeal, but still preserves the ultimate right to jury trial.

Non-Meritorious Claims: There presently exists the medical malpractice screening panel, which does not work. The panel is biased by its form, is time consuming for those who participate, substantially delays litigation, and does not generally result in the resolution of claims. This plan eliminates the panel. In its place the plaintiff would be required to file a certificate of merit by a Board certified or Board eligible medical care provider asserting to the validity of the claim. The attorney would be required to file the certificate with the court, asserting that in his or her good faith belief, the value of the claim which he or she is filing is worth more than $200,000. The attorney would be liable for monetary sanctions under Civil Rule 11 for asserting a frivolous claim or for not asserting in good faith reasonable case value.

The materials offered the committee come from a variety of sources. They are consistent in their message though -- there is little correlation between medical malpractice "reforms" and health care costs. Medical liability is not a factor in rising health care costs and tort "reforms" will have an insignificant effect on health care costs. The proposal offered by the Alaskan trial lawyers would however, address the real or perceived concerns of the medical community.

Thank you again for the opportunity to participate in this very important debate. If I can provide additional materials or information, please call me here in Juneau at 586-1033.

Sincerely,

Debra C. Gravo

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Executive Director
dch/encl.

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M E M O R A N D U M

To: Presidents, Presidents-Elect and Executive Directors -- State and Major Local Bar Associations

From: J. Michael McWilliams Mike

Subj: Health Care Costs and Tort "Reform"

Date: June 18, 1993

During the past year, I have, like you, seen on numerous occasions assertions -- such as those contained in the enclosed articles -- that caps on noneconomic damages in medical malpractice cases result in lower health care costs for everyone. The American Bar Association's Special Committee on Medical Professional Liability recently completed research on the matter. The Special Committee found that personal health care spending per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted.

I believe you will be interested in the enclosed chart that was developed by the Special Committee. If you would like more information about this document, please contact Lillian Gaskin of the ABA Governmental Affairs Office at 202/331-2604.

Enclosure

cc: R. William Ide III
Members, ABA Board of Governors
Members, NABE Governmental Relations Section
Members, NABE Public Relations Section

Justice for all

HEALTH CARE COSTS and TORT "REFORM"

Attached is a chart showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

Health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted, as is demonstrated by the attached chart.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

The attached chart was developed by the American Bar Association Special Committee on Medical Liability and the ABA Governmental Affairs Office. May 1993.
Contact: Lillian B. Gaskin, Staff Liaison to the Special Committee (202/331-2604).

Percentage of Increase from 1982 to 1990 in Personal Health Care Costs Per Capita, State by State

1982 RANKING	*STATE**	*1982 HCFA data**	*1990 LEWIN/ICF Estimates**	*% of INCREASE***
1	Massachusetts	$1,508	$3,031	101
2	California	1,451	2,894	99
3	New York	1,417	2,818	99
4	Nevada	1,380	2,757	100
5	Rhode Island	1,351	2,707	100
6	Connecticut	1,348	2,699	100
7	North Dakota	1,325	2,661	101
8	Illinois	1,308	2,619	100
9	Missouri	1,285	2,568	100
10	Michigan	1,281	2,569	101
11	Pennsylvania	1,273	2,536	99
12	Kansas	1,271	2,548	100
13	Ohio	1,247	2,493	100
14	Maryland	1,232	2,436	98
15	Minnesota	1,229	2,480	102
16	Hawaii	1,228	2,469	101
17	Florida	1,228	2,427	98

1982 RANKING/STATE*		1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
18	Wisconsin	1,219	2,449	101
19	Nebraska	1,216	2,452	102
20	Colorado	1,209	2,415	100
21	Alaska	1,187	2,367	99
22	Iowa	1,176	2,351	100
23	Washington	1,165	2,311	98
24	Oregon	1,165	2,312	98
25	South Dakota	1,154	2,322	101
26	Delaware	1,153	2,268	97
27	Tennessee	1,144	2,262	98
28	New Jersey	1,115	2,224	99
29	Arizona	1,112	2,211	99
30	Texas	1,110	2,192	97
31	Louisiana	1,106	2,185	98
32	Indiana	1,101	2,201	100
33	Maine	1,091	2,175	99
34	Oklahoma	1,086	2,139	97
35	West Virginia	1,057	2,088	98

1982 RANKING	STATE*	1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
36	Virginia	1,054	2,076	97
37	Georgia	1,048	2,072	98
38	Montana	1,036	2,059	99
39	Alabama	1,033	2,286	121
40	Arkansas	994	1,944	96
41	New Hampshire	986	1,981	101
42	Vermont	978	1,956	100
43	Kentucky	957	1,875	96
44	North Carolina	931	1,833	97
45	New Mexico	904	1,792	98
46	Mississippi	897	1,751	95
47	Utah	896	1,784	99
48	Wyoming	873	1,756	101
49	Idaho	868	1,726	99
50	South Carolina	857	1,689	97
	U.S. Average	1,220	2,425	99

* *This data was obtained from a February 1992 GAO report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences." Note that the Lewin/ICF estimates are not directly comparable with the HCFA data because the Lewin/ICF estimates also include administrative costs for private insurance which are excluded from HCFA's data on personal health care expenditures. GAO reported that it conducted its review "in accordance with generally accepted government auditing standards." HCFA estimates that 1990 U.S. personal health expenditures per capita averaged $2,255.*

** *Rounded off to the nearest whole number.*

The Wrong Diagnosis:

The Impact of Medical Malpractice Costs on the Rising Cost of Health Care

A Report of the
Coalition for Consumer Rights,
a center for public interest research and education

By Ken Padgett and Nancy Cowles

March 1991

The Wrong Diagnosis:
The Impact of Medical Malpractice Costs on the Rising Cost of Health Care

Health care costs skyrocket

Health care costs have more than doubled since 1980 and the cost of health insurance continues to soar at a rate two times above the rate of inflation[1].

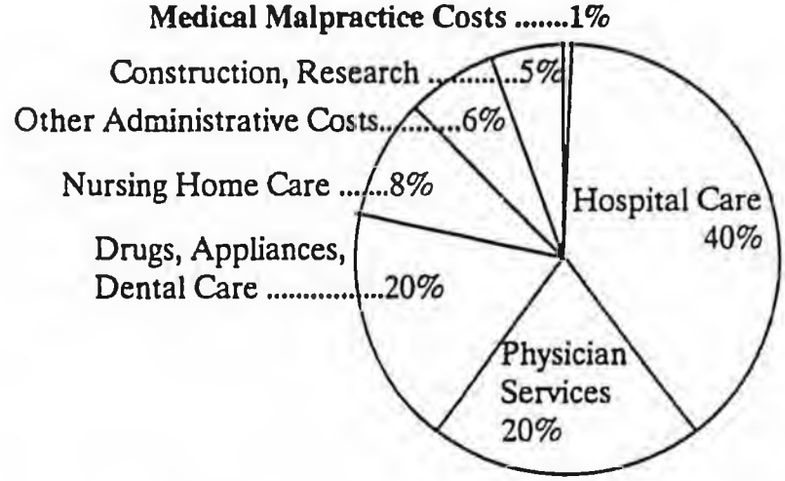
Americans now spend over $600 billion each year for health care -- more than $2,100 per person and over 11% of our Gross National Product (GNP). This total includes all expenses for personal health care (e.g. health insurance and out of pocket expenses) as well as hospital and physician expenses[2].

Rising health care costs are widely recognized as one of the biggest problems facing Illinois and the nation. Solutions to the problem of rapidly rising health care costs are not easily found. Unfortunately in this crisis atmosphere, some politicians and organized medicine are peddling old prescriptions which will not work.

Specifically, the medical society and Governor Edgar would have people believe that the legal system and the present method of malpractice compensation are causing skyrocketing health care costs. Their prescription is to limit the amount of compensation injured patients can receive.

This report examines the relationship between medical malpractice costs and overall health care costs. It also examines the results of compensation limits which have been tried in other states.

Medical malpractice costs are not a major contributor to rising health care costs



Of the $539.9 billion total spent in the United States on health care in 1988, only 1% was medical liability cost[3]. Medical liability costs include doctors' premiums, hospitals' premiums, and insurance companies' legal fees and claims defense.

For all physicians in 1987, medical liability insurance was 4% of gross revenue and 6.5%

of expenses. Table 1 lists selected specialties. Table 2 is a comparison of physician fees to medical malpractice insurance costs. Of the average $31.82 fee for a doctor visit, $1.88 from each doctor visit goes to pay medical malpractice insurance premiums, $12.49 goes to expenses such as rent, mortgage, utilities, non-physician payroll, medical supplies, outside lab work, and depreciation, rent, or lease of equipment, and $16.45 goes to the doctor's net income.

Clearly, medical malpractice costs comprise a negligible portion of the overall health bill.

Table 1: Breakdown of physician income and expenses by specialty

Specialty	Gross Income *	Net Income*	Exp-enses*	Med Mal Premium*	% of Income	% of Expenses
All Physicians	$256.0	$132.3	$123.7	$15.0	5.9 %	12.0%
General/Family	212.7	91.5	121.2	8.9	4.2%	7.3%
Internal Medicine	239.6	121.8	117.8	8.4	3.5%	7.1%
Surgery	352.6	187.9	164.7	24.5	6.9 %	15.0%
Pediatrics	185.5	85.3	100.2	7.1	3.8%	7.0%
Ob/Gyn	336.4	163.2	173.2	35.3	10.5%	20.4%

*In thousands of dollars

Source: Socioeconomic Characteristics of Medical Practice 1988, AMA Center for Health Policy Research

Table 2: Breakdown of physician fees by specialty

Specialty	Fee for Doctor Visit	Med Mal Premium	Net Profit
All Physicians	$31.82	$1.88	$16.45(51.7%)
General/Family	$24.52	$1.03	$10.54(43.0%)
Internal Medicine	$34.11	$1.19	$17.11(50.8%)
Surgery	$32.51	$2.24	$17.32(53.3%)
Pediatrics	$31.57	$1.20	$14.51(46.0%)
Ob/Gyn	$36.65	$3.85	$17.78(48.5%)

Source: Socioeconomic Characteristics of Medical Practice 1988, AMA Center for Health Policy Research

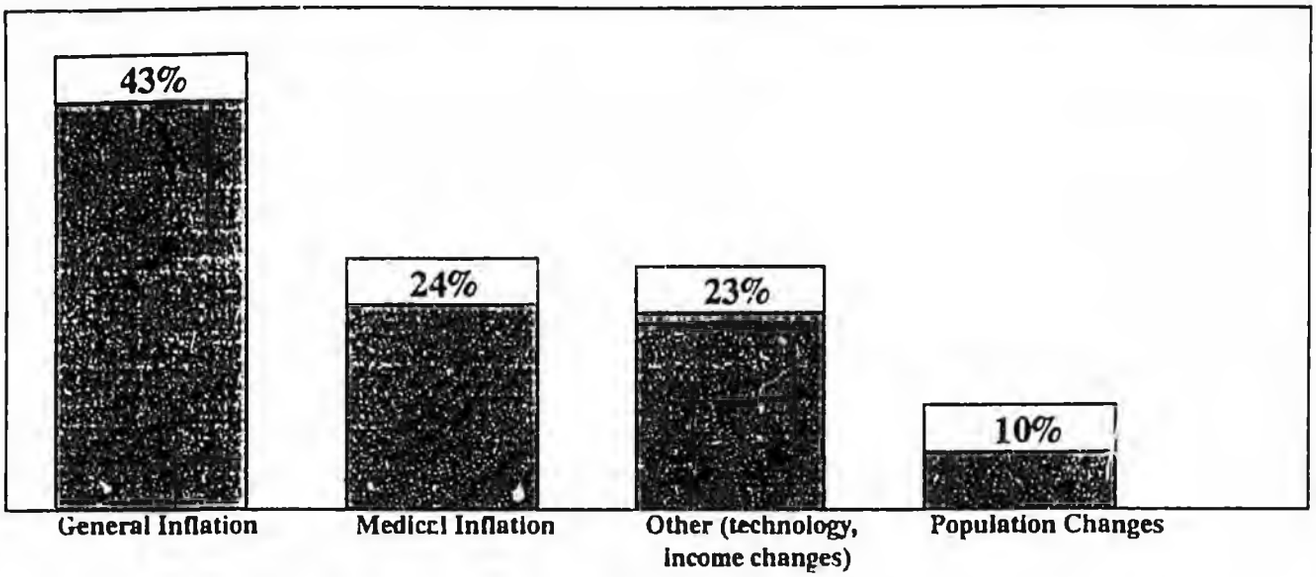
Many factors cause health care costs to increase

A report from the United States Commerce Department[4] projects that the total for health care costs in 1990 will reach $675.7 billion and for 1991, $756.3 billion. Unless some action is taken, health care costs are expected to rise from between 12 and 15% per year for the next five years.

The Commerce Department attributes the rising costs of health care to factors such as sophisticated, but expensive technology; innovative, but costly treatments for AIDS, heart disease, and cancer; the increasing number of seniors, and health care related to chemical dependency.

1990 was the sixth consecutive year that health care spending grew faster than the economy. A close examination of cost increases over time identifies some of the specific causes of health care inflation. For example, health care costs rose 10% from 1987 to 1988.

Table 3: Breakdown of 1989 increase in health care costs



According to the Department of Health and Human Services, the following factors explain the increase[5]. General inflation accounted for 43% of the growth in costs, medical inflation accounted for 24%, population changes 10%, and all other changes accounted for 23%[6]. General inflation and medical inflation are usually not separated from one another. Separating the two shows more clearly the various sources of cost increases. Population changes are increases in the size of the population and the effect that more consumers have on price. All other factors are factors which are difficult to separate such as technology, changes in sex or age distribution in the population, or changes in real income.

Over the last 28 years, the physician services component of the Consumer Price Index (CPI) has increased at an annual rate of 6.9%. This rate of growth consistently has been greater than that of inflation.

Rising health care costs inherent in U.S. health system

The Commerce Department outlines other important factors increasing health care costs such as waste, fraud, and limited competition.

Hospitals drive up the costs of health care through unnecessary procedures. One of the areas in which this problem occurs most frequently is in Caesarian sections. A California study of 316 non-military hospitals showed that the hospitals that stood to gain the most financially had the highest repeat C-section rates -- as high as 95.1% in private, for profit hospitals[7]. Hospitals which were not-for-profit had noticeably lower rates of repeat C-sections. C-sections cost significantly more than natural births, thus the hospitals reap financial benefits.

At a panel meeting of the National Conference of State Legislatures' State Alliance for Access to Health Care, Dr. David Himmelstein noted that the insurance industry in the United States pushes up the costs of health care, as well.

"Overall, we pay $519 per person per year in this country for cost of billing and administration.[8]"

This is nearly one quarter of total per capita health care spending.

Economist Rashi Fein, Professor of Social Medicine and Health Policy at Harvard attributes part of the increase in costs to: "the growth of the complexity of insurance ..... which adds to the cost of administration and doesn't buy health care[9]."

Malpractice costs do not drive up the cost of health care

Organized medicine and their insurers claim that increasing medical malpractice lawsuits and skyrocketing awards, especially those for non-economic damages have raised the cost of health care through rising medical malpractice premiums and defensive medicine. They present this argument despite the fact that annual claims per 100 physicians dropped from 10.2 in 1985 to 6.7 in 1987[10]. In addition, Best's reported that, in 1989 underwriting losses in medical malpractice dropped to a decade low[11]. Even using the figures provided by insurers and organized medicine, the total cost of liability insurance is small[12].

The Illinois State Medical Inter-Insurance Exchange (ISMIIE), a doctor-owned liability insurer, and St. Paul Fire and Marine Insurance Company, the nation's largest medical liability insurer, have reduced the premiums they have been charging doctors. ISMIIE did not raise its premiums from 1985 to 1990[13], and ISMIIE paid a 5.4% dividend to its physician members in 1990[14]. St. Paul reduced its premiums from 6% to 25% in 22 states in 1990[15].

The story is very similar for hospitals. During the period July-September 1989, median monthly insurance expenditures as a percentage of total expenditures varied by size of the hospital, but ranged from a low of 1.47% in hospitals of 150-199 beds to a high of 2.05% in hospitals of 50-74 beds.[16]

Defensive medicine is beneficial to health care quality

Organized medicine often points to defensive medicine as a negative result of the threat of liability suits. However, unnecessary practices should not be confused with defensive medicine or reasonable standards of care. In the event of a medical malpractice suit, tort law requires that doctors show they met a "reasonable standard of care" in the treatment they follow. That requires them to do as much or as little as the average physician would have done when presented with a similar situation. To the extent that tort law forces doctors to exercise a reasonable standard of care, costly injuries and adverse events are actually limited. Reducing the actual amount of doctor negligence should be the cost-containment strategy for policy makers concerned about medical malpractice.

A recent study by the Harvard Medical Practice Group found that 4% of hosptializations in New York resulted in injury or illness to patients . 28% of those 'adverse events' were caused by negligence. Often, the methods that doctors use to insure that they meet that standard of care are beneficial to patients. These practices consist of additional record-keeping, tests, therapy, time with patients, and follow-up visits.[17] Defensive medicine is a way to prevent these injuries, while unnecessary procedures only lead to more.

The Harvard study also found that only about one in eight patients injured through neglience ever file a medical malpractice suit and only one in 16 receive any compensation.

According to William Ira Bennett, the editor of the Harvard Medical School Health Letter,

"A common complaint is that the costs of 'defensive medicine' are also raised by the current fear of malpractice. This is hard to prove. ...In reality, though, failure to order a questionable test is the basis for only a small minority of malpractice judgements; most(other than slips and falls in the hospital), involve clearly wrong procedures or diagnoses."[18]

Revisions in tort law will not lower health care costs or medical malpractice premiums

Restrictions on medical malpractice suits as a means to contain costs is ineffective. The costs of medical malpractice have been shown to be a very small percentage of total health care spending. To focus on controlling this minor portion of health care cost increase is to miss the bigger picture. The necessary solution to the problem of high health care costs is large-scale cost containment. In addition, capping the amount of non-economic damage awards and other tort revisions have not reduced premiums for doctors.

A 1986 General Accounting Office report, "Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms", studied six states which had enacted many different revisions in tort laws, including caps.

> "Officials of the interest groups GAO surveyed in California and Indiana said that the changes to the tort laws of their states had helped to moderate upward trends in the cost of insurance and the average amount paid per claim. Representatives from the groups surveyed in Arkansas, Florida, New York, and North Carolina generally believed the tort law changes in their states **had little effect. GAO identified no studies undertaken in the six states to determine the impact of any specific reforms."**[19] (emphasis added)

Premiums do not fall in states which enact caps.

In Idaho, the year after implementing a cap for non-economic damages, medical malpractice premiums rose 49%. Minnesota and Missouri saw rate increases of 22% and 39% respectively after enacting caps.[20]

Doctors and insurance companies don't claim that rates will drop either. Bob Trunzo of St. Paul, quoted in Medical Economics Magazine says,

> "St. Paul has made it abundantly clear that we aren't going to reduce our rates up front just because some type of tort reform gets passed. ...[N]owhere has it been proved that tort reform will affect our loss costs. Experience tells us that these reforms don't always have the intended effect."[21]

Table 4: St. Paul's 1987 Rate Increase for Medical Malpractice Insurance in States with Caps on Damages

STATE	NON-ECONOMIC CAP ENACTED Year Enacted-Amount of Cap	1987 RATE HIKE
Alabama	1987- $400,000	30%
California	1975- $250,000	25%
Colorado	1986- $250,000	50.8%
Idaho	1987- $400,000	49.4%
Louisiana	1975- $500,000 (total award)	25%
Minnesota	1986- $400,000	22%
Missouri	1986- $350,000	38.6%
Utah	1986- $250,000	15.3%
Virginia	1981- $1 million (total award)	15%

Extensive Minnesota study shows no relation between premiums and claims

A study in 1988 by the Commissioner of the Minnesota Department of Commerce found that recent malpractice premium increases are not the result of high jury awards, or in fact the result of any insurer costs. Department examiners sought to review every claim filed in these states since 1981- a total of 4,747 medical malpractice files from Minnesota, North Dakota and South Dakota. The study concluded that between 1982-1987, while malpractice premiums tripled, there was no increase in claim frequency or severity or the percentage of jury awards for malpractice cases.[22]

Indiana costs as high as Illinois

In 1975, Indiana passed a revamped tort system touted as the way to control the costs of health care[23] .The net effects of the changes have been large profits for insurers and limits on the amount of compensation that claimants can receive. These laws did not result in cost containment.

As of 1982, the last year data were available, health care cost per capita in Indiana was $1101. In Illinois, the cost per capita was $1308 -- a difference of only $200. Hospital costs per capita show the same relationship: Indiana $512 , Illinois $700.

Reform of the current tort system is not the answer to containing health care costs. Many of the differences between the cost of health care per capita in Indiana and Illinois can be attributed to the more urban, more populous nature of Illinois. Some differences in the cost of living are to be expected. What has been demonstrated here is that changing the tort system is not an effective means of controlling costs.

ENDNOTES

1. U.S. Industrial Outlook U.S. Commerce Department. 1991.

2. Ibid.

3. "Costs of Medical Malpractice Drop After An 11-Year Climb." The New York Times. Milt Freudenheim. 1989.

4. Op. Cit. in 1

5. "National Health Expenditures, 1988." Health Care Financing Review Health Care Financing Administration. 1990.

6. Ibid.

7. "Some Hospitals Are Found To Cash-In on C-Sections." National Underwriter. Christopher Dauer. Feb. 1991.

8. "Private Health Sector is Blasted." National Underwriter. Neil McGhee. Feb. 1991.

9. Ibid.

10. "Medical Professional Liability Claims and Premiums, 1985-1987." Socioeconomic Characteristics of Medical Practice. Eric J. Slora and Martin L. Gonzalez. 1988.

11. Medical Liability Monitor. Vol. 15 No. 9 Sep. 1990.

12. "Will Defensive Medicine Really Protect You?" Medical Economics. Arthur Owens. 1988.

13. "Medical Malpractice Insurance Cap Urged." Southern Illinoisian. Cindy Humphrys. April 25, 1990.

14. "Exchange to Give Dividends." Illinois Medicine. April 1990.

15. "Insurers Reducing Malpractice Fees For Doctors In U.S." The New York Times. Robert Pear. September 9, 1990.

16. "Datawatch." Hospitals. Feb, 1990.

17. Op. Cit. in 12.

18. "Pluses of Malpractice Suits." New York Times Magazine. July 24, 1988.

19. "Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms." United States General Accounting Office, GAO/HRD-87-21, December 1986.

20. St. Paul's 1987 Rate Hike Percentages

21. " Statement of Thomas F. Londrigan," Report to the Comission to Improve the Insurance Liability System," American Bar Association. February 1989.

22. "Medical Malpractice Claim Study: 1982-1987, " Michael A. Hatch, Comissioner, Minnesota Department of Commerce. 1989.

23. "MEDICAL MALPRACTICE: Case Study on Indiana." United States General Accounting Office, GAO/HRD-87-21S-4. 1986.

Coalition for Consumer Rights

a center for public interest research and education

False Claims:

The Relationship Between Medical Malpractice "Reforms" and Health Care Costs

By Andrea Durbin

March 1993

Robert J. Hudek, Executive Director

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False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs

BACKGROUND

A public policy debate over medical malpractice costs has been alive for nearly two decades. The first time the debate reached the public was during the so-called "medical malpractice crisis" of the 1970s and 1980s when doctors found that their medical malpractice insurance premiums were skyrocketing and in some cases, that their policies were being cancelled.

At that time, the insurance industry blamed rising medical malpractice premiums on lawsuits. Therefore, the American Medical Association joined with insurance groups to lobby state legislatures across the country to institute tort "reforms." Many states did change their tort laws to make it more difficult for victims of medical malpractice to file lawsuits, and to place limits on the amount a plaintiff could be awarded by a jury.

THE CURRENT DEBATE

Today, medical malpractice costs are debated in a different context: rising medical costs and public concern over access to health care. Policy makers at the state and federal levels are feeling greater pressure from voters to contain medical costs and provide universal access to health care.

For example, health care costs and health insurance drew consistent attention during the recent presidential campaign. Medical costs are forcing increasing numbers of Americans into bankruptcy.[1] National opinion polls consistently show that health care is one of the key issues that voters want the new president to address. For example 67% of those polled say either that significant changes are needed in the health care system, or that it is beyond repair.[2]

As the context of the medical malpractice debate has changed, so have the number of problems blamed on lawsuits. During the presidential election campaign, George Bush and Dan Quayle blamed lawyers and lawsuits for health care inflation, eroding access to health care, as well as medical malpractice premium hikes. Bush charged, during the October 15 debate, that "these malpractice lawsuits [are] breaking the system."[3]

Meanwhile, the American Medical Association and the insurance industry continue to push tort "reforms" regulating medical malpractice lawsuits as the solution to containing and controlling the rising price of health care. In a somewhat new twist, doctors now claim that it is not simply medical malpractice premiums, since they are going down, but rather the fear of lawsuits which forces them to practice expensive "defensive medicine." They argue that limiting lawsuits and awards will eliminate the need for "defensive medicine" and presumably reduce costs.

ANALYSIS

This report examines the relationship between medical malpractice tort "reform" and health care costs.

Over the past 18 years, every state in the country has enacted at least one "reform" measure. By tightening access to the courts or limiting the amount a victim can recover in damages, these "reforms" were originally proposed to control health care costs by lowering malpractice premiums and presumably reducing the costs of "defensive medicine."

In order to test the effectiveness of tort "reforms," we decided to compare the states' tort "reform" initiatives and per capita health care costs.

We reviewed documents that compiled information on tort "reforms" and per capita health care costs. The AMA Tort Reform Compendium describes the tort "reforms" enacted in each of the 50 states up until 1989. Caps on damage recovery, limits on attorney fees, changing or eliminating joint and several liability, and periodic payment of damages are just a few of the ten tort "reforms" recommended by the American Medical Association.

The best estimates of per capita health care costs in 1990 are found in a February 1992 report by the U.S. General Accounting Office entitled Health Care Spending: Nonpolicy factors account for most state differences.

After reviewing the data, we have found that there is no indication that enacting major tort "reforms" is positively correlated with lower health care costs.

In fact, the states with the lowest per capita health care spending are less likely than average to have enacted the caps on damages, limits on attorney fees, periodic payment of damages or modified the collateral source rule. The states with the lowest per capita expenditures are more likely to have enacted fewer tort "reforms" overall than the average. (See chart A on the following page.)

Chart A: A Review of Tort Restrictions in the States Spending the Most and LeastPer Capita on Health Care

Ten Most Expensive States	Attorney Fee Regulations Enacted in	Collateral Source Rule Modified in	Limits on Recovery Enacted in	Periodic Payment of Damages Enacted in
Massachusetts	1986	1986	1986	
California	1975	1975	1975	1975
New York	1976, 85	(1975-81) 1981		1985
Nevada				
Rhode Island		(1976-86) 1986		1986
Connecticut	1986	1985, 87		(1986-87) 1987
North Dakota		(1977-83) 1987	(1977-83)	(1977-83) 1987
Illinois	1985	1976, 85	(1975-79)	1985
Michigan	1981	1986	1986	1975, 86
Missouri			1986	1986
Ten Least Expensive States				
South Carolina				1976
Idaho	(1975-81)	(1975-81)	(1977-81) 1987	1987
Mississippi				
Wyoming	1977			
Utah	1985	1985	1986	1986
New Mexico			1976	1976
North Carolina				
Kentucky		1988		
Arkansas				1979
Vermont				

Please note: Years in parentheses indicate that a state had previously enacted a statute which was allowed to expire or was declared unconstitutional. A date followed by a comma and another date indicates that the statute was amended.

Caps on Damages

Since the medical establishment has made caps on damages its single highest priority, we would expect to see some correlation between states which have limits on recovery and inexpensive health care. However, only 30% of the ten states spending the least in health care have enacted limits on recovery of damages; 55% of the remaining 40 states have such a statute. A closer examination of the states ranked by spending shows that there is no correlation between the least expensive states and limits on damages. (See Chart B on the following page.)

Our findings are consistent with previous research we have conducted on the "health care savings" of caps. Indiana has one of the most restrictive caps laws in the nation, and yet a 1992 survey of hospital bed costs and delivery charges in comparable cities in Illinois and Indiana revealed that the small variance in fees could not be attributed to lower medical malpractice costs coming from caps on awards.[4]

Periodic Payment of Damages

Sixty-two percent of all states have a rule permitting periodic payment of damages. Only 50% of the ten states with the lowest per capita health expenditures allow periodic payments. A periodic payment plan doesn't help a victim who may need the bulk of his award immediately to help defray medical costs or pay the mortgage. But, the AMA notes that periodic payments do help the insurance company hedge its bets in the event the victim "dies prematurely," by preventing a "windfall" to the victim's heirs.[5] In the meantime, the doctor's insurance company is free to reinvest and earn interest on the unpaid damages.

Attorney Fee Regulation

Only 20% of the states with the lowest per capita health spending have attempted to limit attorney's fees; 57.5% of the remaining 40 states have laws which limit attorney's fees. In its 1980 review of the constitutionality of New Hampshire's medical liability statute, the New Hampshire Supreme Court noted that there was "no direct evidence that juries consider attorney fees in coming to a verdict" and concluded that limiting attorney fees would do little to reduce medical liability insurance rates or control health care costs.[6]

Eliminating the Joint and Several Liability Rule

Changing or eliminating the joint and several liability rule is another popular "reform." While 60% of the states with low per capita spending have enacted such laws, 56% of all states also do.

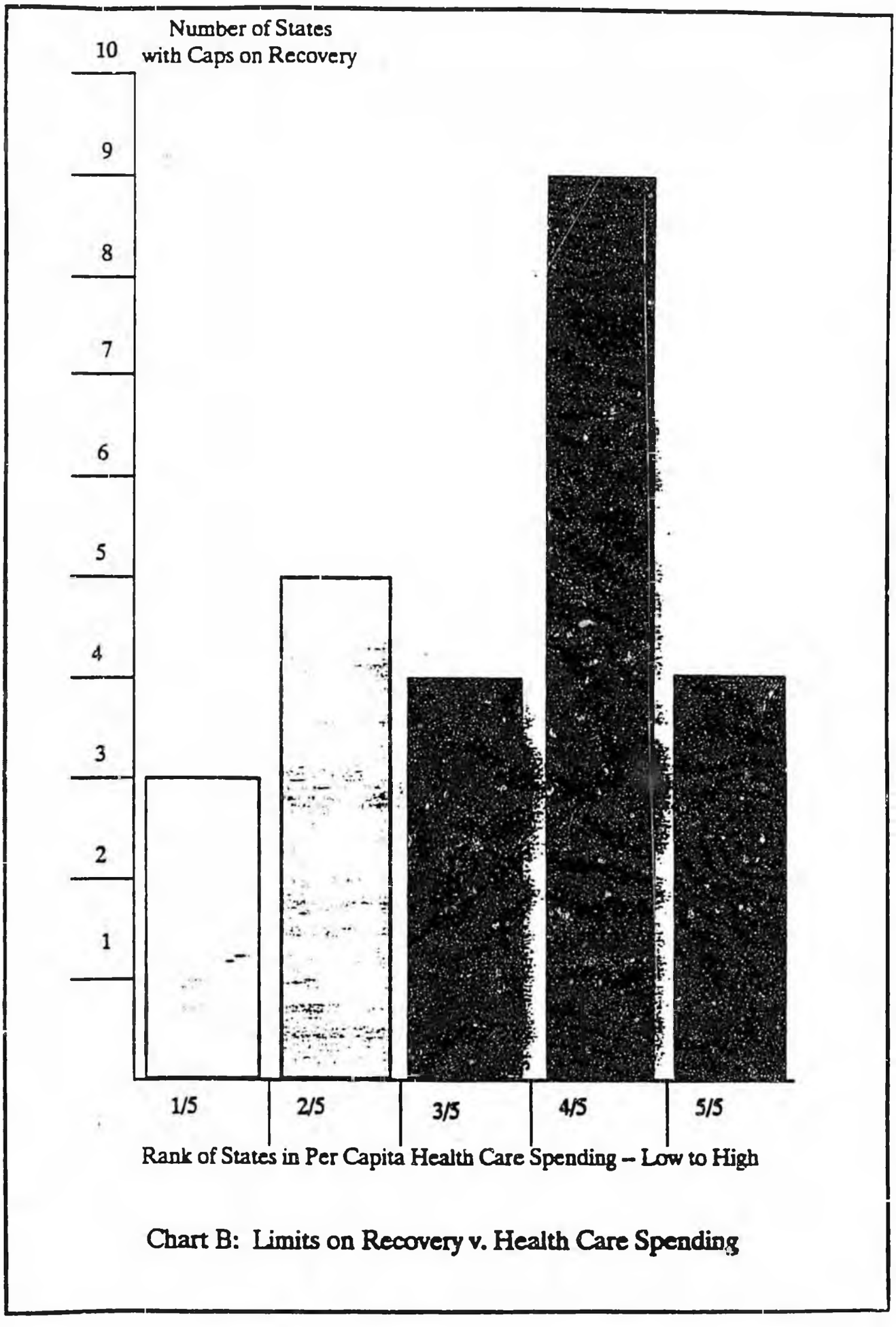

Chart B: Limits on Recovery v. Health Care Spending

Modifying the Collateral Source Rule

Only two of the ten states with the lowest health spending have enacted a law modifying the collateral source rule; 54% of the remaining 40 states have done so.

Controlling for Time

We were also concerned that different "reforms" were enacted at different points in time, making it difficult to gauge whether enough time had elapsed for a law to demonstrate its intended effect. Nearly half of the of the four statutes examined in Chart A were enacted at least ten years ago. Only one statute was enacted after 1987. The per capita spending data we examined was estimated for 1990.

Malpractice Premiums and Defensive Medicine

According to a study done by the Congressional Budget Office in 1992, the cost of doctors' medical malpractice premiums amount to less than 1% of the total health care tab in the United States. But the medical industry believes that the cost of medical malpractice premiums do not tell the whole story: doctors claim that the fear of medical malpractice lawsuits has led them to practice "defensive medicine" by conducting unnecessary tests as a protection against lawsuits.

A study released in February 1993 by proponents of tort "reform," the National Medical Liability Reform Coalition, concluded that "defensive medicine" could cost about $7 billion per year. The study's author, Lewin-VHI, Inc., admits that defensive medicines costs are difficult to quantify because "physicians have a variety of possible motivations besides defensive medicine to perform excess procedures, including financial incentives in some cases."[7] Even accepting the proponents' conclusions, defensive medicine accounts for less than one per cent of total health care costs.

Other studies dispute the whole premise that defensive medicine is inherently wasteful, contending that practices associated with "defensive medicine" are also associated with sound diagnostic procedures and reduced risk of wrong or incomplete diagnoses.--In its October 1992 study, the Congressional Budget Office states that "it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform." The report concludes: "Restructuring malpractice liability alone would not generate large savings in U.S. health care costs."[8]

The primary medical malpractice insurer in the country, St.Paul Fire and Marine Insurance Company, has even admitted in an addendum to the Florida State Supreme Court that it expects little to no savings from tort reform initiatives.[9]

Demographic Factors Help Explain Health Care Costs

States with a higher per capita income had a strong correlation to higher per capita health care spending, according to a report released in February 1992 by the General Accounting Office. That same study noted that "state policies play a limited role in reducing spending differences" between states. [10]

Illinois' Experience

In Illinois, the medical lobby pushed through the legislature a "reform" package in the mid-1970s which included caps on awards, provision for arbitration, and establishment of a pretrial screening panel. Both the limits on recovery and the pretrial screening panel were declared unconstitutional by the Illinois State Supreme Court. The Court said that limits on recovery, in particular, were "arbitrary and constituted a special violation of the state constitution." However, that didn't stop the Illinois State Medical Society from pursuing caps and other restrictions on Americans' constitutional rights as a "solution" to the health care crisis.

In 1985, the ISMS convinced the General Assembly to enact further restrictions on medical malpractice suits in the name of lower insurance premiums These new restrictions included the elimination of punitive damages against negligent health care providers, certification of the merit of the case by another doctor, periodic payments of damages exceeding $250,000, reduction of awards by the amount received from collateral sources such as the victim's own health insurance, and strict limitations on attorneys' fees. In 1987, the General Assembly approved a bill which reduced the statute of limitations on medical malpractice suits for minors. All these limitations put together make pursuing a medical malpractice lawsuit in Illinois even more difficult than before.

What effect did these changes have on overall health costs? Our research reveals that Illinois was estimated to be the 8th most expensive state in terms of per capita health care spending in 1990. In 1982, the last year the Health Care Financing Administration reported such data, Illinois was also ranked 8th.

CONCLUSION

Doctors and insurance companies argue that introducing tort "reforms" at the state and federal level will reduce the exorbitant costs of health care in the United States. However, despite the fact that every state in the nation has enacted some kind of tort "reform," we found no evidence that tort "reform" is an effective method of controlling health care costs.

APPENDIX A

Brief summaries of the major tort "reform" efforts across the United States.

1. Changes or elimination of the ad damnum clause. An ad damnum clause states the amount of monetary damages the plaintiff is claiming. Changes to or elimination of the clause is designed to prevent widespread publicity over potentially inflated claims.

2. Arbitration. Some states have set up a system in which the patient and the health care provider enter into a voluntary written agreement to submit any injury claim to binding arbitration. Agreeing to submit to arbitration is not a condition of receiving treatment. Arbitration is viewed as an alternative to and in lieu of a trial and subsequent judicial review of the claim will be limited. Many states statutes make specific reference to a consumer's waiver of a right to a trial and many also regulate whether there is a grace period in which the written agreement may be revoked.

3. Plaintiff Attorney Fee Regulation. Statutes regulate the fees plaintiff attorneys may collect in a variety of ways – by establishing a sliding scale for fees, by establishing a maximum percentage attorneys may collect and by providing for court review of the reasonableness of attorney fees. In addition, attorneys are prohibited from charging any fees if the plaintiff loses in court.

4. Collateral Source Rule. The collateral source rule prohibits the introduction into evidence at trial any indication that a patient has been compensated or reimbursed for his injury from any source other than the defendant. Under this rule, a plaintiff may receive double compensation for his injury. Some states have sought to limit double compensation by modifying the collateral source rule to introduce evidence of compensation received.

5. Frivolous Lawsuit Penalties. These statutes generally require that a party making a frivolous claim or defense may be held liable for payment of the other party's reasonable attorney fees and court costs.

6. Joint and Several Liability Rule. The joint and several liability rule provides that a person who causes an injury concurrently with another person can be held liable for payment of the entire judgment. Where joint liability is eliminated, each defendant is liable only for that portion of damages attributed to his percentage of fault. Several states have restricted or eliminated the doctrine of joint liability or have restricted the situations in which it can be applied.

7. Caps or Limits on Recovery. Some states have sought to limit the amount of money a plaintiff may be awarded either by limiting specific types of damages, such as non-economic damages, or by placing an absolute limit on the amount of money that may be recovered. Some statutes provide for exceptions to the caps.

8. Patient Compensation Funds. A few states have set up patient compensation funds which give the participating health care providers additional insurance coverage for high payments. Participating health care providers must demonstrate that they have medical liability insurance or financial responsibility to pay the amount below which the fund will not pay.

9. Periodic payment of damages. Statutes legislating the periodic payment of damages over the lifetime of the plaintiff or the actual period of disability have been enacted in most states.

10. Pretrial Screening Panels. Pretrial screening panels are designed to provide a review of the merits of medical malpractice claims. The decision of the panel is not binding on a judge or jury and does not prevent a plaintiff from pursuing a trial.

NOTES

1. Jacobson, Sherry, "Medical Bankruptcies Rising," Chicago Sun-Times, August 9, 1992.

2. Hasson, Judi, "Democrats skeptical of chances for reform" USA Today, June 29, 1992.

3. Neus, Elizabeth. "Lawsuits Disputed as Health Care Woe." Gannett News Service in the Chicago Sun-Times. October 19, 1992.

4. "The Myth of Medical Malpractice Savings: The Nothing for Nothing Trade-off in Indiana's Health Care System." The Coalition for Consumer Rights. Chicago, Illinois. February 1992.

5. AMA Tort Reform Compendium, 1989, American Medical Association, Chicago.

6. AMA Tort Reform Compendium, 1989, American Medical Association, Chicago.

7. Brostoff, Steven. "Stopping 'Defensive Medicine' Can Save Billions, Study Says." National Underwriter, February 8, 1993.

8. Economic Implications of Rising Health Care Costs, Congressional Budget Office, October 1992.

9.Addendum to Florida Supreme Court

10. Health Care Spending: Nonpolicy factors account for most state differences, General Accounting Office, February 1992.

MEDICAL AND HOSPITAL PROFESSIONAL LIABILITY

A REPORT PREPARED FOR THE
TEXAS HEALTH POLICY TASK FORCE

BY

TONN AND ASSOCIATES

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I.. EXECUTIVE SUMMARY

There are concerns in Texas, as well as in other states, about the economic impact that medical and hospital professional liability has on the overall health care delivery system. There is also concern about how it affects patient access to health care. This report examines the complex issues and initiatives that make up the framework of medical and hospital professional liability.

Physicians, hospital executives, consumers, insurers and plaintiff attorneys have different perspectives on many aspects of this process. To the credit of the Texas Medical Association, the Texas Trial Lawyers Association, and the Texas Hospital Association, they have all demonstrated cooperation and support through their assistance with this study. In addition, insurers and self-insured hospitals have assisted by providing extensive data.

The issues presented are complex and involve financial, medical, legal, and insurance issues. The findings indicate that changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas. Medical professional liability costs for premiums and indemnity payments are estimated to be less than one percent of health care expenditures, both in Texas and the U.S. as a whole.

The debate and concern about the economic impact of "defensive medicine" is ongoing, but findings indicate that

reducing defensive practices and over-utilization of health care services is more complex than "tort reform" and will require more consensus on practice standards and peer review initiatives. A recent Harvard study concluded, "Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as a result of a specific suit. Thus, it was unclear whether defensive medicine resulted from the malpractice ervironment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO), state and hospital requirements, or a combination of factors."[1] In hospitals, many "defensive practices" have become institutionalized.

While the overall economic impact to the health care delivery system is minimal, the impact is very significant to a patient who has been injured and believes they have received negligent treatment. The potential impact is also significant to a health care provider who feels falsely accused of malpractice.

In Texas, the legal processes appear to be in the mainstream of how most states address tort law. The findings indicate that further study may be warranted for many areas presented in this report. Assertions that there are frivolous claims may be caused in part by confusion about what constitutes a "claim" for data compilation

purposes as well as by statutes of limitation. Under current law, parties who are potentially, but not primarily, liable are sued to avoid the limitations bar and then dismissed before trial without any indemnity being paid. Even so, over one half of all claims filed are closed with no indemnity payment and further review of the effectiveness of Rule 13 may be warranted.

The study found that very few claimants have received multi-million dollar payments, overall caps would tend to shift costs versus reducing overall costs, few cases are resolved by jury judgments and non-economic damages do not appear to be a major factor in settlements paid to claimants.

The high costs associated with the medical expense component of claims involving newborns indicate a need to address the underlying problems that contribute to risk, treatment, and injury to newborns.

Numerous studies concur that Medicaid patients do not file disproportionate numbers of malpractice claims.

The process of reporting medical malpractice claim information to the State Board of Medical Examiners is cumbersome. Additionally, there is a need to more closely examine whether there is a correlation between multiple liability claims against a provider and the provider's professional competence.

Physicians in Texas, as well as other states, carry a large share of the medical professional liability financial

burden. However, malpractice premiums for Texas physicians compare favorably with other states. The availability of insurance has been increasing and there is competition among the companies. Analyzing the availability of hospital professional liability is difficult because of differences between limits of liability, self-insuring mechanisms, and the use of non-admitted or licensed carriers.

Comparing the actual indemnity payments on behalf of physicians in 1980 constant dollars indicates that the average payments have leveled off in Texas since the middle 1980's. For hospitals, both claims frequency and average payments have continued to increase.

A number of state statutes that affect this subject are scheduled to expire during 1993 and will need to be addressed by the next legislative session.

CALIFORNIA'S MICRA:
PROFILE OF A FAILED EXPERIMENT
IN TORT LAW RESTRICTIONS

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EXECUTIVE SUMMARY

As the Clinton Administration prepares to present its health care proposal to the nation, doctors, insurance companies, hospitals, HMOs, and other participants in the health care industry are aggressively campaigning for restrictions on the legal rights of medical malpractice victims. The model for this campaign is a 1975 California statute, the Medical Injury Compensation Reform Act, or MICRA. Its provisions:

- Place a $250,000 cap on the amount of compensation paid to malpractice victims for their "non-economic" injuries.

- Eliminate the "collateral source rule" that forces those found liable for malpractice to pay all the expenses incurred by the victim.

- Permit those found liable for malpractice to pay the compensation they owe victims on an installment plan basis.

- Enable health care providers to require patients to waive their right to a jury trial in the event of malpractice.

- Impose a short "statute of limitations" on malpractice victims.

- Establish a sliding scale for attorneys fees which discourages lawyers from accepting serious or complicated malpractice cases.

Supporters of a similar federal law have promised the White House that it would reduce overall national health care costs. The purpose of this analysis is to determine what impact, if any, MICRA has had on the cost of health care in California. Because MICRA has been in effect for seventeen years, it is possible to test the validity of the assertions that a federal law based on MICRA would lower the nation's health care costs.

HEALTH CARE EXPENDITURES. Health care costs have grown by 533%, faster than the inflation rate in California, since the passage of MICRA in 1975. Since 1985, the California Medical CPI has grown nearly twice as fast as the rate of general inflation.

Health care costs in the state are as high, and by some measures higher, than the national average. California's CPI for medical care has grown faster than national health care costs since 1975, and the rate of growth in California is accelerating compared to the U.S.. In short, California is experiencing the same, if not a more destabilizing, health care crisis than the nation now faces.

malpractice insurance both in California and nationally, and have been the major beneficiaries of the MICRA restrictions on victims.

Moreover, to the extent that the data show that reductions in payouts have been passed on to medical care providers through reduced premiums, particularly in California, the physicians and hospitals have not passed the savings through to consumers in the form of overall lower health care costs. The providers themselves have profited from the restrictions on victims' rights.

Restrictions on compensation of malpractice victims should reduce premiums. But MICRA has not done so in California. Contrary to the assertions of the medical lobby, MICRA has not reduced health care costs in California. Imposition of such a law on a federal basis would not significantly reduce health care costs.

DEFENSIVE MEDICINE. The data do not support the assertion that MICRA-like restrictions on victims' rights will lower health care costs by reducing the practice of "defensive medicine," which is increasingly viewed as a misnomer. According to a review of Cesarean sections – a procedure which is routinely said to be performed because of physicians' fears of malpractice suits – tort restrictions in California and other states do not reduce the use or misuse of c-sections compared to other states.

Imposition of MICRA on a federal basis would not reduce health care costs arising from unnecessary medical procedures.

Introduction

As the Clinton Administration prepares to present its health care reform plan to the nation, increasing attention is being paid to proposals to restrict the legal rights of victims of medical malpractice.

In calling for such restrictions, the medical lobby – principally the 294,000 member American Medical Association, health insurance companies, and hospital trade associations – argues that the cost of malpractice suits is a major driving force behind the nation's health care crisis. Restrictions on malpractice suits, it is claimed, would significantly lower the cost of health care.[1]

Advocates of restrictions on malpractice suits have urged the President and members of Congress to utilize a California statute, the Medical Injury Compensation Reform Act, or MICRA, as the model for national legislation to be incorporated in the Clinton health care plan.

MICRA was enacted by the California Legislature in 1975 in response to rapidly-increasing medical malpractice insurance premiums. The powerful insurance and physicians' lobbies told state legislators that medical malpractice lawsuits and jury awards were responsible for the higher premiums.

Insurance companies threatened that the costs associated with malpractice insurance were rising at such a rate that their only option was to raise health care professionals' liability premiums or to withdraw from the market altogether.[2] Physicians and hospitals emerged as high visibility advocates for the legislation: many opted to "go bare" (practice without malpractice insurance), some discontinued providing certain high-risk procedures, while others threatened to quit.[3]

It is ironic that MICRA is being portrayed as a solution to the nation's health care crisis, for the law has become increasingly controversial in California. In recent years, MICRA has come under severe criticism from victims' support organizations, consumer groups, legislators and others. They have questioned whether MICRA has achieved any benefits for California's consumers, and have noted its profound impact upon the victims of medical malpractice. Many have demanded amendment or repeal of MICRA.

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1 "Medical Liability: Key Facts" and "Medical Liability: Principles for Reform," published by the National Medical Liability Reform Coalition, February, 1993. See also, "The Continuing Need for Legislative Reform of the Medical Liability System," American Medical Association (AMA), National Medical Specialty Society, February, 1987. "Keeping Californians Healthy," Californians Allied for Patient Protection (CAPP), The Coalition to Preserve MICRA, 1992.

2 Medical Malpractice: Case Study on California, General Accounting Office (GAO), December 1986, p. 8.

3 Id.

Summary Of California's MICRA

The key provisions of MICRA are:

1. Limitation on Compensation of Injured Victims

MICRA places a cap of $250,000 on the amount of compensation paid to malpractice victims for their "non-economic" injuries.

Non-economic injuries include pain, physical and emotional distress and other intangible "human damages." Such damages compensate for severe pain; the loss of a loved one; loss of the enjoyment of life that an injury has caused, including sterility, loss of sexual organs, blindness or hearing loss, physical impairment, and disfigurement.[6]

The MICRA cap is not adjusted for inflation. In order to provide the same level of compensation in today's dollars, the cap would have to be approximately $630,000.[7] Put another way, the $250,000 MICRA cap has decreased in value since 1975, when compared to the Consumer Price Index, to approximately $91,000.[8] Though health care costs – hospital charges, medical fees, etc. – have risen dramatically since 1975, compensation for non-economic damages has been frozen by the statute.[9]

2. Abolition of the Collateral Source Rule

The collateral source rule prohibits defendants charged with negligence from informing the jury that the plaintiff has other sources of compensation, such as health insurance or government benefits, including social security and disability. The purpose of this long-established doctrine is to ensure that the jury holds the defendant responsible for the full cost of the harm the defendant caused by requiring the defendant to pay all the victim's expenses – even if a collateral source has already paid them.

Application of another legal doctrine, known as subrogation, ensures that the collateral source rule does not result in "double recoveries" for injured victims. Under subrogation rights – which are applicable to virtually all health insurance policies, government programs, and workers' compensation systems – the third-

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6 Economic damages, the other type of legal damages, compensate for wage loss, doctor bills, etc. Intangible values are routinely recognized, quantified and awarded by our courts. For example, courts have awarded monetary damages to protect the value of corporate good will, art work and the right to maintain the view from a penthouse apartment.

7 Based on the U.S. consumer index as published by the U.S. Dept. of Labor, Bureau of Labor Statistics.

8 Id.

9 Tom Dressler, "Unfreeze Pain-and-Suffering Damages," Los Angeles Daily Journal, Nov. 4, 1991.

If the defendant enters bankruptcy or simply ceases to pay, the victims are forced to return to court and engage in another lengthy legal proceeding. Another problem is that an inflexible payment schedule leaves the victim without sufficient resources in the event that unanticipated medical or other expenses arise. This is most likely to occur in the years immediately following the injury, when the periodic payments are unlikely to cover the aggregate costs.

4. Mandatory Arbitration

MICRA provides that any contract for medical services may contain a provision for arbitration of any dispute regarding malpractice so long as it is disclosed. The malpractice victim's right to a jury trial may be completely foreclosed by such clauses, which are now routinely inserted in agreements patients must sign before receiving treatment. Most consumers are completely unaware of this restriction when they sign the legal forms in the doctor's office or at the hospital.

5. Statute of Limitations

MICRA imposes a short statute of limitations for medical malpractice cases. Victims must file a malpractice suit within three years after the date of injury, or one year after the discovery or when the injury should have been discovered, whichever occurs first. Actions by a minor under the age of 6 years must begin within 3 years or before his/her 8th birthday, whichever provides a longer period. Minors are required to bring suit while they are still minors (under 18).

There have been many instances in which malpractice involving children has not readily been detected or for which no action is taken initially because the family is unfamiliar with the legal system. Such cases are precluded by the statute of limitations.

6. Attorney's Fees

MICRA sets a sliding contingency fee schedule for plaintiffs' attorneys representing victims of medical malpractice. The fees are limited to 40% of the first $50,000 recovered; 33 1/3% of the next $50,000; 25% of the following $100,000, and 15%[10] of any amount exceeding $200,000. MICRA does not limit the fees of the defendant's lawyers.

This provision of MICRA discourages attorneys from taking the most severe malpractice cases. Combined with the cap on damages -- which proportionately reduces the plaintiffs' attorneys' fees -- medical malpractice cases have become prohibitively expensive for plaintiffs' attorneys to accept on a contingency basis.

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10 As originally enacted, MICRA limited attorneys fees to 10% of any amount over $200,000. This provision was amended in 1987 as part of a "truce" between the California Medical Association and the California Trial Lawyers Association, during which period no further amendments to MICRA were to be permitted.

Growth in health care costs in California has been nearly identical to national growth rates. Appendix A also contains data which permit comparison of the growth in the California and national consumer price indices since the passage of MICRA.

Between 1975 and 1991, the California medical CPI rose 286%, 5% more than the national medical CPI, which grew 273%. The annual growth rate of the national medical CPI averaged 8.6%, while California medical CPI growth averaged 8.8%.

Per capita health care expenditures have been higher in California than in the nation since the passage of MICRA. Health care costs for California and the nation can also be compared by considering per capita health care costs and their growth. Based on expenditures and per capita cost data developed in Appendix B, Appendix C displays a comparison of California and U.S. health care expenditures on a per capita basis.

Per capita health care expenditures in California exceeded the national average every year between 1975 and 1991, by an average of 13% per year. California per capita expenditures were, on the average, $186 higher than in the United States as a whole each year between 1975 and 1991.

Hospital patient costs are higher in California than in other major states. Another accurate indicator of health care expenditures is the average hospital patient cost per adjusted day, which reflects outpatient as well as inpatient services. Hospital patient data is displayed for California and other industrial states in Appendix D.

In 1990, the most recent year for which data is available, California's average hospital patient cost per adjusted day was the second highest of the state's studied; in 1985 and 1989, California's hospital patient costs were the highest.

Conclusions. The health care consumer price index in California has increased since the passage of MICRA in 1975. Indeed, most indicators show that California's health care costs are as high or higher than the national average and that the rate of growth of these costs has outpaced the nation since 1975.

This conclusion is confirmed by other studies. The General Accounting Office has noted that personal health care expenditures per capita in California were second highest in the nation in both 1982 and 1990, 18.9% and 19.3% percent higher than the national average, respectively.[12]

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12 "Health Care Spending: Nonpolicy Factors Account for Most State Differences," US GAO, GAO/HRD 92-36, February 1992, p. 16-17.

Between 1985 and 1990,[16] medical malpractice incurred losses as a percentage of health care costs averaged only 0.53% in California. Medical malpractice losses were only 0.24% of the state's health care costs in 1990.

These data explain why MICRA has not affected overall health care costs in California, as documented in the preceding section. The amount which malpractice insurers expect to pay out for malpractice claims is a minuscule portion of California's total health care bill.

The ratio of malpractice payments to California's total health care expenditures is similar to the national average. Appendix E also shows the "incurred losses" reported by national malpractice insurance carriers as a percentage of the nation's overall health care expenditures since 1976.

The extremely small percentage of California health care expenditures for which malpractice incurred losses are responsible is very similar to corresponding national data. The total amount of claims paid by insurance companies each year from 1976 through 1990 for medical malpractice averaged 0.57% of national health care costs – about 6/100 of a point more than in California (0.51%).

Medical malpractice incurred losses in California are consistent with national trends. Appendix E permits consideration of loss trends in California and the nation.

The amount of compensation insurers estimated they would have to pay for medical malpractice in California and nationally grew until the mid-1980's. Incurred losses then began to fall, both in absolute terms and as a percentage of health care costs.

Incurred losses associated with medical malpractice as a percentage of national health care costs decreased by more than 50% from their high of .82% in 1986 to .39% in 1990. This data tracks a similar study by the National Insurance Consumers Organization.[17] The decrease was more pronounced in California – incurred losses as a percentage of state health care costs fell by about 68% from 1986 (.76% of state health care costs) to 1990 (.24%).

These data reveal that estimated malpractice losses, already a tiny fraction of health care costs nationally and in California, are now shrinking. As a percentage of health care costs, they have dropped dramatically since the mid-1980's.

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16 As noted in Appendix E, the California data reflects an unusually large drop in the incurred losses reported by insurers for the last available year, 1991. For the reasons noted, we have excluded the 1991 data in making these comparisons between premiums and losses.

17 "Medical Malpractice Insurance: 1985-1991 Calendar Year Experience," The National Insurance Consumer Organization, (NICO), March 1993. The NICO study obtained incurred loss data from 1986 through 1991 from a recent NAIC report which made adjustments to previously reported annual data. To present consistent data from 1976, the data presented here was obtained directly from annual reports.

After 1986, insurers' estimates of payments they will make to malpractice victims began to fall. However, MICRA is not responsible for the reduction, which has occurred nationally as well. The reason for this trend is uncertain. However it is likely related to the insurance companies' actions in the mid-1980's, which precipitated the insurance "crisis" experienced throughout the nation during that period. We will return to the subject of the insurance industry's role in the next section.

In any case, MICRA itself has not reduced, in absolute terms, insurers' estimates of payments they will make to malpractice victims in California. At most, MICRA may have lowered the insurers' estimates of payouts in California compared to the national average, as would be expected.

Finally, it must be noted that there is no data publicly available which would permit analysis of the size or kind of claims made by victims in the years after the passage of MICRA. The U.S. General Accounting Office, which has published the only available data on the subject, has noted that malpractice claims increased in California between 1980 and 1984 (the study was published in 1986).[18] While we have aggregate information on losses expected by insurers, we do not know whether the number of claims rose or fell during these periods.

III. Malpractice Premiums and MICRA'S Impact on Health Care Costs

As noted previously, MICRA was enacted in 1975 in response to rapid increases in the price of malpractice liability coverage sold to medical providers by insurance companies. Insurance carriers told physicians' groups that rates had increased because of the growth of lawsuits. Medical providers supported the measure as a way to lower health insurance premiums.

Today, advocates of placing similar restrictions on medical malpractice suits throughout the nation make the same claim. They say that malpractice premiums are a critical factor in skyrocketing health care costs, and that MICRA would lower insurance premiums throughout the nation, thus reducing overall health care costs.

Implicit in these assertions are two assumptions: first, that insurance companies will pass-through to their policyholders the savings which result from reductions in the compensation insurers must pay to victims under such restrictions. If insurers experience fewer claims and their payouts to malpractice victims are reduced, premiums paid by medical providers should be reduced as a result. Otherwise, only insurance company balance sheets benefit from tort restrictions.

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18 Medical Malpractice: Case Study on California, General Accounting Office (GAO), December 1986.

expenditures in both the United States and California after reaching all-time highs in the late 1980's.

In absolute terms, earned malpractice premiums in California rose 191% from 1976 before reaching their high point in 1988. However, between 1988 and 1991, premiums dropped by 20%. The same pattern emerges nationally: premiums increased 331% between 1976 and 1989, the all time high, but by 1991 had dropped 5% from 1989.

Malpractice premiums as a percentage of health care costs fell 58% in California – from the high of 1.26% of state health expenditures in 1976 to 0.53% in 1991.

Nationally, malpractice premiums as a percentage of health care costs fell from a record high of 0.93% in 1988 to 0.65% in 1991, a drop of 30%.

As noted in Section II, insurance company losses on malpractice claims have fallen significantly in California and the United States. Theoretically, premiums would be expected to drop commensurably, and the drop would be expected to be reflected in the percentage of health care costs attributable to malpractice premiums. The data bear out some of these expectations, but reveal other trends worthy of comment.

The reduction in premiums has not been commensurate with the reduction in incurred losses. Comparison between the premiums charged by insurers and the incurred losses reported under the malpractice coverage they wrote reveals that insurers have not fully passed through to policyholders the savings that resulted from the reduction in incurred losses reported nationally and in California.

As noted in the preceding section, the insurers' estimates of payouts under malpractice liability policies have fallen since the mid-1980's, a phenomenon present both in California and national data and thus not a result of MICRA.[19] In California, incurred losses dropped 38% between 1988 and 1990,[20] while earned premiums fell only 9% from their 1988 high to 1990.

Nationally, incurred losses fell 31% from 1988 to 1990. However, malpractice premiums fell only 3% during the same period.

Thus, insurers do not appear to be passing through to policyholders more than a small portion of the savings reflected in the reductions in losses. However, a greater percentage has been returned to California policyholders. The

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19 See Section II for the discussion of this point.

20 As noted previously and in Appendix E, the California data reflect an unusually large drop in the incurred losses reported by insurers for the last available year, 1991. For the reasons noted, we have excluded the 1991 data in making these comparisons between premiums and losses.

The per capita malpractice premium in California has been higher than the national average in most years since the passage of MICRA. Another way to compare medical malpractice insurance premiums between the U.S. and California is to consider the per capita malpractice premium, using the population size. Appendix H shows that per capita medical malpractice premiums in California have been consistently higher than the U.S. since the passage of MICRA, falling below the national average in 1991 by $2.02.

Premiums of insurance companies are excessive in California and nationally. Appendix I displays the profits of insurers, as a percentage of premiums earned, for California and the United States.

As noted above, the recent drop in malpractice losses has not been accompanied by a commensurate drop in malpractice premiums. Appendix I confirms the suspicion raised by the prior data. It shows that insurance carriers writing medical malpractice liability policies in California -- many of them non-profit carriers[24] -- are charging excessive premiums. A strong indication that medical malpractice premiums are overpriced is revealed by the loss ratios -- the amount estimated as losses shown as a percentage of premiums sold. Carriers which sell medical malpractice policies in California had an average loss ratio of 36% in 1990. Put another way, these carriers paid out only 36 cents for every $1 in premiums they took in.[25]

Profits of the national carriers are also excessive. However, California carriers' profits are more excessive.

Conclusions. The data presented show that medical malpractice premiums are a negligible component of overall health care costs in California and in the nation. Regardless of MICRA's impact on premiums, imposition of such restrictions would be irrelevant to the total costs of the system.

This conclusion is confirmed by other observers. The National Insurance Consumers Organization (NICO) concluded that, since 1976, "the cost of malpractice insurance, nationwide, has actually been steadily declining as a percentage of total health care costs."[26] Similarly, a recent report by the Congressional Budget Office (CBO) noted that the total cost of malpractice

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24 Non-profit, doctor owned companies control virtually the entire malpractice insurance market in California, in contrast to the dominance of private for-profit insurers before 1975.[24] These "bed-pan" mutuals, as they are called, were established by medical providers several years after the passage of MICRA, when the reduction in malpractice premiums promised by the private insurers did not materialize. The mutuals are capable of offering lower rates than the private insurers because they are not run for profit, and because they emphasize risk avoidance procedures which encourage safe medical practices.

25 Note that 1991's unusually low losses, mentioned elsewhere, allowed California malpractice insurers to achieve a 9% loss ratio.

26 Medical Malpractice Insurance: 1985-1991 Calendar Year Experience," The National Insurance Consumer Organization, (NICO), March 1993.

IV. Defensive Medicine

Supporters of MICRA contend that the data on premiums, claims and health care costs addressed above do not provide a full picture of the impact of malpractice claims on health care costs. They say that the real impact of malpractice suits on the health care system is the practice of "defensive medicine," that is, procedures, tests or even surgeries, otherwise unnecessary, but undertaken by practitioners solely to avoid malpractice suits by patients.[30]

Recently, the cost of "defensive medicine" was estimated to be $36 billion nationally.[31] Proponents of MICRA argue that tort restrictions will save billions of dollars by making "defensive medicine" unnecessary.[32]

If the proponents of tort restrictions are correct concerning the application of laws to restrict malpractice victims' rights, the practice of "defensive medicine" in California should have been sharply reduced, if not eliminated, by the passage of MICRA.

It must be noted preliminarily that "defensive medicine" is virtually impossible to quantify. The AMA itself has defined "defensive medicine" as "doing more diagnostic tests, sticking with the safest possible treatments, telling patients more about treatment risks, and keeping more complete records."[33] Obviously, such practices could equally be used as the definition of "high quality medical care." Indeed, the most recent report on the subject released by the AMA noted that estimating the cost of "defensive medicine" is "subjective" and "dependent on a variety of assumptions."[34]

MICRA has not limited "defensive medicine" in California, according to the most reliable indices. An empirical way to measure "defensive medicine" is to look at high-profile, costly procedures that are acknowledged by medical authorities to be susceptible to overutilization.

Cesarean sections are an excellent procedure to study because of the breadth of the data and the cost impact of a c-section compared to a vaginal delivery. In 1991, for example, the average costs for cesarean and vaginal deliveries were $7,826 and $4,720, respectively.[35]

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30 "Malpractice: A Straw Man," Consumer Reports, July 1992, p. 44.

31 Mike Snider, "Defensive Medicine adds $36 billion to Bill," USA Today, February 3, 1993.

32 "Estimating the Costs of Defensive Medicine," Lewin-VHI, Inc., January 27, 1993.

33 "Malpractice: A Straw Man," Consumer Reports, July 1992, p. 44.

34 "Estimating the Costs of Defensive Medicine," Lewin-VHI, Inc., January 27, 1993, p. 1.

35 Reuters News Service, April 23, 1993.

"defensive medicine," MICRA has not deterred the practice of such "defensive medicine" in California.

The c-section rate is no different in states with or without MICRA-type caps on malpractice damages. Data in Appendix K confirm this conclusion. The data compare c-section rates in states with and without caps on awards for pain and suffering arising from medical malpractice. Additionally, the Appendix utilizes data provided by the Public Citizen Health Research Group to determine the number of "unnecessary" c-sections. In the Public Citizen report, researchers used 10-12% as a proper c-section rate for a state and designated as unnecessary those c-sections occurring above this 12% rate.[40]

First, the data show that states which have imposed a cap on pain and suffering have as high a rate of cesarean sections as those states that do not have restrictive caps.

Second, the data show that the rate of unnecessary c-sections is virtually identical in states with or without caps on awards.

Conclusions. Proponents of MICRA assert that "defensive medicine" is a direct result of the tort system. They claim that restrictions on malpractice suits will lower health care costs by obviating the need for "defensive medicine."

However, this contention is without merit, according to a review of data associated with one procedure which is often said to reflect physicians' fears of malpractice suits: the cesarean section. Data show that tort restrictions in California and other states do not reduce the use – or misuse – of c-sections compared to other states.

As the claims of medical providers are subject to greater scrutiny, the validity of the concept of "defensive medicine" has been questioned.

It has been pointed out that what may be termed defensive medicine may simply be high quality care,[41] which saves consumers money in the long run and avoids malpractice. The Congressional Budget Office concluded that much of what is dubbed "defensive medicine" is standard medical care that would be provided anyway.[42]

> Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do

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40 Sidney Wolfe, "Cesarean and Hysterectomy Statistics," Women's Health Alert, Public Citizen Health Research Group, 1991, p. 96.

41 "The Problem of Defensive Medicine, Science Magazine, May 1978, Vol. 200. p. 879.

42 Economic Implications of Rising Health Care Costs, Congressional Budget Office, October, 1992, p. 27.

The CPI v. Health Care Costs in California and U.S., 1975 TO 1991, (1982-84 = 100)

Year	CA CPI All Items	% Growth CA CPI All Items	Cum. Growth CA CPI All Items	CA CPI Medical*	% Growth CA CPI Medical	Cum. Growth CA CPI Medical	U.S. CPI Medical	% Growth U.S. CPI Medical	Cum. Growth U.S. CPI Medical
1975	52.3	—	—	46.6	—	—	47.5	—	—
1976	55.6	6.31%	6.31%	51.8	11.16%	11.16%	52.0	9.47%	9.47%
1977	59.6	7.19%	13.96%	56.8	9.65%	21.89%	57.0	9.62%	20.00%
1978	64.4	8.05%	23.14%	61.8	8.80%	32.62%	61.8	8.42%	30.11%
1979	71.3	10.71%	36.33%	67.7	9.55%	45.28%	67.5	9.22%	42.11%
1980	82.4	15.57%	57.55%	75.2	11.08%	61.37%	74.9	10.96%	57.68%
1981	91.4	10.92%	74.76%	83.2	10.64%	78.54%	82.9	10.68%	74.53%
1982	97.3	6.46%	88.04%	93.8	12.74%	101.29%	92.5	11.58%	94.74%
1983	98.9	1.64%	89.10%	100.7	7.36%	116.09%	100.6	8.76%	111.79%
1984	105.2	6.37%	101.15%	105.5	4.77%	126.39%	106.8	6.16%	124.84%
1985	108.6	3.23%	107.65%	111.4	5.59%	139.06%	113.5	6.27%	138.95%
1986	112.0	3.13%	114.15%	119.6	7.36%	156.65%	122.0	7.49%	156.84%
1987	116.6	4.11%	122.94%	129.2	8.03%	177.25%	130.1	6.64%	173.89%
1988	121.9	4.55%	133.08%	139.5	7.97%	199.36%	138.6	6.53%	191.79%
1989	128.0	5.00%	144.74%	152.1	9.03%	226.39%	149.3	7.72%	214.32%
1990	135.0	5.47%	158.13%	165.7	8.94%	255.58%	162.8	9.04%	242.74%
1991	140.6	4.15%	168.83%	179.8	8.51%	285.84%	177.0	8.72%	272.63%
Avg. % Growth:		6.43%			8.82%			8.58%	

*Source: U.S. Dept. of Labor, Bureau of Labor Statistics, All Urban Consumers; California Statistical Abstracts; *California Medical CPI derived from an average of Medical Care CPI for Los Angeles, San Francisco, and San Diego metropolitan areas.*

APPENDIX A

Method #2. Use a 1986 estimate published by the California Almanac as a baseline for extrapolation. According to The California Almanac (5th Edition, 1991), California's personal health care expenditures amounted to $52.5 billion. During that same year, personal health care expenditures in the nation were estimated to be 88.1% of total health care expenditures for the nation.

To calculate total health care expenditures in California for each year under this method:

1. Assuming that the national ratio of personal/total health care expenditures (88.1%) applies to California, California's total health care expenditures for 1986 were $59.5 billion.

2. Next, using population data for California and the nation, California's total health care expenditure figure for 1986 is translated to a per capita basis. This will allow us to develop the percentage by which California's total health care expenditures exceed the nation's in that year. Estimated total per capita health care expenditures in California in 1986 were 116.29% of the nation's per capita expenditures, or about 16% higher.

3. Assuming that California's total per capita health care expenditures are 116.29% of the nation's each year, California's total health care expenditures each year can be calculated by multiplying the national per capita amount by 116.29%. (In other words, the national total expenditures are adjusted for population growth and then multiplied by 116.29%).

4. Finally, the per capita numbers are translated back into total dollar expenditures by multiplying the per capita figures by the population for each year.

Note: This calculation depends on one key assumption: that California's per capita health care expenditures are always 116.29% of the national figure. Since costs have been increasing in California in recent years (see the CPI data in Appendix A), this assumption probably yields a liberal estimate for years prior to 1986, and a conservative estimate for subsequent years.

Method #3. Use the average of the medical CPI available for three metropolitan areas in California to estimate the medical care CPI for California. Using the method described under #2 above, the total and personal per capita expenditures can be calculated for each year. Then use CPI data to adjust the figures each year for inflation.

To calculate total health care expenditures in California for each year under this method:

1. Utilize the Medical CPI data contained in Appendix A to adjust the per capita data each year.
2. Translate the per capita numbers back into total dollar expenditures by multiplying the per capita figures by the population for each year.

APPENDIX B -- Con't.

Comparing the Annual Dollar and % Growth in Per Capita Health Care Expenditures, U.S. and CA, 1975 to 1991

Year	US Health Care Expend. Per Cap.	US Actual Growth Annually (in $)	CA Health Care Expend. Per Cap.	CA Actual Growth Annually (in $)
1975	$617	—	$731	—
1976	$700	$83	$822	$92
1977	$783	$83	$913	$91
1978	$872	$89	$1,008	$95
1979	$967	$95	$1,113	$105
1980	$1,101	$134	$1,255	$142
1981	$1,265	$164	$1,423	$167
1982	$1,408	$143	$1,591	$168
1983	$1,534	$126	$1,724	$133
1984	$1,652	$118	$1,839	$115
1985	$1,776	$124	$1,964	$126
1986	$1,894	$118	$2,100	$136
1987	$2,039	$145	$2,264	$164
1988	$2,233	$194	$2,466	$203
1989	$2,448	$215	$2,699	$232
1990	$2,706	$258	$2,968	$269
1991	$2,981	$275	$3,253	$285

Source: See Appendix B for California health care expenditures; California Statistical Abstract; U.S. Bureau of the Census.

APPENDIX C

Medical Malpractice Losses and Health Care Costs
California, 1976 to 1991

Year	[1] Health Care Costs* (000)	[2] Med Mal Incurred Losses (000)	[2]/[1] Losses as a % of Health Care Costs
1976	$18,039,288	$139,308	0.77%
1977	20,406,705	88,303	0.43%
1978	23,022,674	102,837	0.45%
1979	25,883,146	100,619	0.39%
1980	29,851,396	101,890	0.34%
1981	34,537,409	132,057	0.38%
1982	39,456,555	172,598	0.44%
1983	43,680,210	324,597	0.74%
1984	47,466,100	347,625	0.73%
1985	51,863,717	363,600	0.70%
1986	56,804,376	428,978	0.76%
1987	62,737,857	399,420	0.64%
1988	70,030,126	347,412	0.50%
1989	78,651,303	249,402	0.32%
1990	88,980,440	215,736	0.24%
1991	99,695,910	47,610*	0.05%
Average:			0.45%

Source: See Appendix B for estimate of California health expenditures; National Association of Insurance Commissioners, Profitability Results, 1976- 1991.

Medical Malpractice Losses and Health Care Costs
United States, 1976 to 1991

Year	[1] Health Care Costs (000,000)	[2] Med Mal Incurred Losses (000)	[2]/[1] Losses as a % of Health Care Costs
1976	$152,200	$557,890	0.37%
1977	172,000	529,240	0.31%
1978	193,700	824,457	0.43%
1979	217,200	943,888	0.43%
1980	250,100	1,037,074	0.41%
1981	290,200	1,397,562	0.48%
1982	326,100	1,724,380	0.53%
1983	358,300	1,925,136	0.54%
1984	389 600	2,382,125	0.61%
1985	422,600	3,235,776	0.77%
1986	454,900	3,750,880	0.82%
1987	494,200	3,903,900	0.79%
1988	546,100	3,831,408	0.70%
1989	604,300	2,693,120	0.45%
1990	675,000	2,657,809	0.39%
1991	751,800	2,708,134	0.36%
Average:			0.54%

Source: Health Care Financing Administration; National Association of Insurance Commissioners, Profitability Results, 1976 - 1991.

***Note on incurred losses in California in 1991.** The unusually large reduction in estimates of incurred losses in 1991 probably resulted from decisions by insurers to reduce reserves which were inflated in excess of requirements during the mid-1980's. Such reductions, including reserves built up over many years, may be taken in one year as appears to have occurred here. Regulatory activity mandated by Proposition 103 may have led insurers to take this action. Because of this anomaly, 1991 is omitted from certain calculations in the report, as noted.

APPENDIX E

Growth in Medical Malpractice Premiums, United States and California 1976-1990

Year	[1] U.S. Earned Premiums (000,000)	[2] CA Earned Premiums (000,000)	[3] U.S. Number of Physicians	[4] CA Number of Physicians	[1]/[3] U.S. Estimated Average Med-Mal Premium	[2]/[4] CA Estimated Average Med-Mal Premium
1976	$1,187	$228	(NA)	(NA)	(NA)	(NA)
1977	1,310	' 227	362,043	45,611	3,618	4,977
1978	1,381	249	381,122	47,891	3,624	5,199
1979	1,384	239	398,735	50,653	3,471	4,718
1980	1,333	230	417,758	54,082	3,191	4,253
1981	1,429	219	425,117	55,041	3,361	3,979
1982	1,526	211	443,467	57,225	3,441	3,687
1983	1,844	287	460,036	59,151	4,008	4,852
1984	2,125	375	(NA)	(NA)	(NA)	(NA)
1985	2,661	450	489,523	63,009	5,436	7,142
1988	3,803	629	497,473	64,066	7,655	9,818
1987	4,550	634	512,946	66,184	8,870	9,579
1988	5,068	683	(NA)	(NA)	(NA)	(NA)
1989	5,120	633	577,605	76,272	8,864	8,299
1990	4,931	606	592,166	78,285	8,327	7,741

Sources: National Association of Insurance Commissioners, Profitability Results; 1991-1992 Hospital Fact Book, California Association of Hospitals and Health Systems. * Data was not collected in 1984 and 1988, thus the 1985 and 1989 information reflect a two-year period.
(NA) = Not Available

APPENDIX G

Profit and Losses of Insurance Companies: Medical Malpractice, California, 1976 to 1991

Year	[1] Premiums Earned (000,000)	[2] Losses Incurred (000)	[2]/[1] Loss Ratio: Losses Incurred/ Premiums Earned	[3] Profit (000)	[3]/[1] Operating Profit: Profit as a % of Premiums Earned
1976	228	139,308	61.1%	3,192	1.40%
1977	227	88,303	38.9%	50,621	22.30%
1978	249	102,837	41.3%	53,286	21.40%
1979	239	100,619	42.1%	59,511	24.90%
1980	230	101,890	44.3%	61,180	26.60%
1981	219	132,057	60.3%	31,098	14.20%
1982	211	172,598	81.8%	19,201	9.10%
1983	287	324,597	113.1%	-90,979	-31.70%
1984	375	347,625	92.7%	18,375	4.90%
1985	450	363,600	90.8%	37,350	9.30%
1986	629	428,978	68.2%	89,318	14.20%
1987	634	399,420	63.0%	63,933	10.10%
1988	663	347,412	52.4%	137,904	20.80%
1989	633	249,402	39.4%	232,311	36.70%
1990	606	215,736	35.6%	241,794	39.90%
1991	529	47,610	9.0%	354,959	67.10%

Source: "Report on Profitability, By Line, By State," National Association of Insurance Commissioners, 1976 to 1991.

Profit and Losses of Insurance Companies: Medical Malpractice United States, 1976-1991

Year	[1] Premiums Earned (000,000)	[2] Losses Incurred (000,000)	[2]/[1] Loss Ratio: Losses Incurred/ Premiums Earned	[3] Profit (000,000)	[3]/[1] Operating Profit: Profit as a % of Premiums Earned
1976	$1,187	558	47.0%	239	20.1%
1977	1,310	529	40.4%	316	24.1%
1978	1,381	824	59.7%	175	12.7%
1979	1,384	944	68.2%	119	8.6%
1980	1,333	1,037	77.8%	91	6.8%
1981	1,429	1,398	97.8%	11	0.8%
1982	1,526	1,724	113.0%	-65	-4.3%
1983	1,844	1,925	104.4%	44	2.4%
1984	2,125	2,382	112.1%	187	8.8%
1985	2,661	3,236	121.6%	-513	-19.3%
1986	3,808	3,751	98.5%	-99	-2.6%
1987	4,550	3,904	85.8%	86	1.9%
1988	5,068	3,731	75.6%	415	8.2%
1989	5,120	2,693	52.6%	1,428	27.9%
1990	4,931	2,658	53.9%	1,450	29.4%
1991	4,862	2,708	55.7%	1,420	29.2%

Source: "Report on Profitability, By Line, By State," National Association of Insurance Commissioners, 1976 to 1991

APPENDIX I

Cesarean Section Rates in States With Cap on Non-Economic Damages

State	[1] Cesarean Rate - %	[2] Total Deliveries	[3] Total C-Sections	[4] # of Unnecessary C-Sections	[4]/[3] % of Unneces. C-Sections Out of Total C-Sections	[4]/[2] % of Unneces. C-Sections Out of Total Deliveries
CA	25.00%	479,902	119,975	62,388	52.00%	13.00%
CO	19.40%	23,058	4,473	1,706	38.14%	7.40%
HI	21.20%	19,123	4,054	1,759	43.39%	9.20%
ID	19.20%	15,830	3,039	1,139	37.47%	7.20%
IN	21.30%	80,895	17,231	7,524	43.67%	9.30%
ME	21.50%	16,292	3,503	1,548	44.19%	9.50%
MD	24.50%	65,980	16,160	8,245	51.02%	12.50%
MA	24.40%	89,433	21,822	11,090	50.82%	12.40%
MICH	24.80%	140,466	34,836	17,933	51.48%	12.77%
MI	23.40%	35,663	8,345	4,065	48.71%	11.40%
NM	19.20%	26,686	5,124	1,922	37.51%	7.20%
OR	22.00%	38,103	8,383	3,811	45.46%	10.00%
SD	17.40%	11,108	1,933	601	31.09%	5.41%
UT	20.00%	31,610	6,322	2,529	40.00%	8.00%
WV	25.40%	18,767	4,767	2,515	52.76%	13.40%
Avg.	21.91%				49.54%	11.76%

Source: Sidney Wolfe, Cesarean and Hysterectomy Statistics, Women's Health Alert, Public Citizen Health Research Group, 1991.

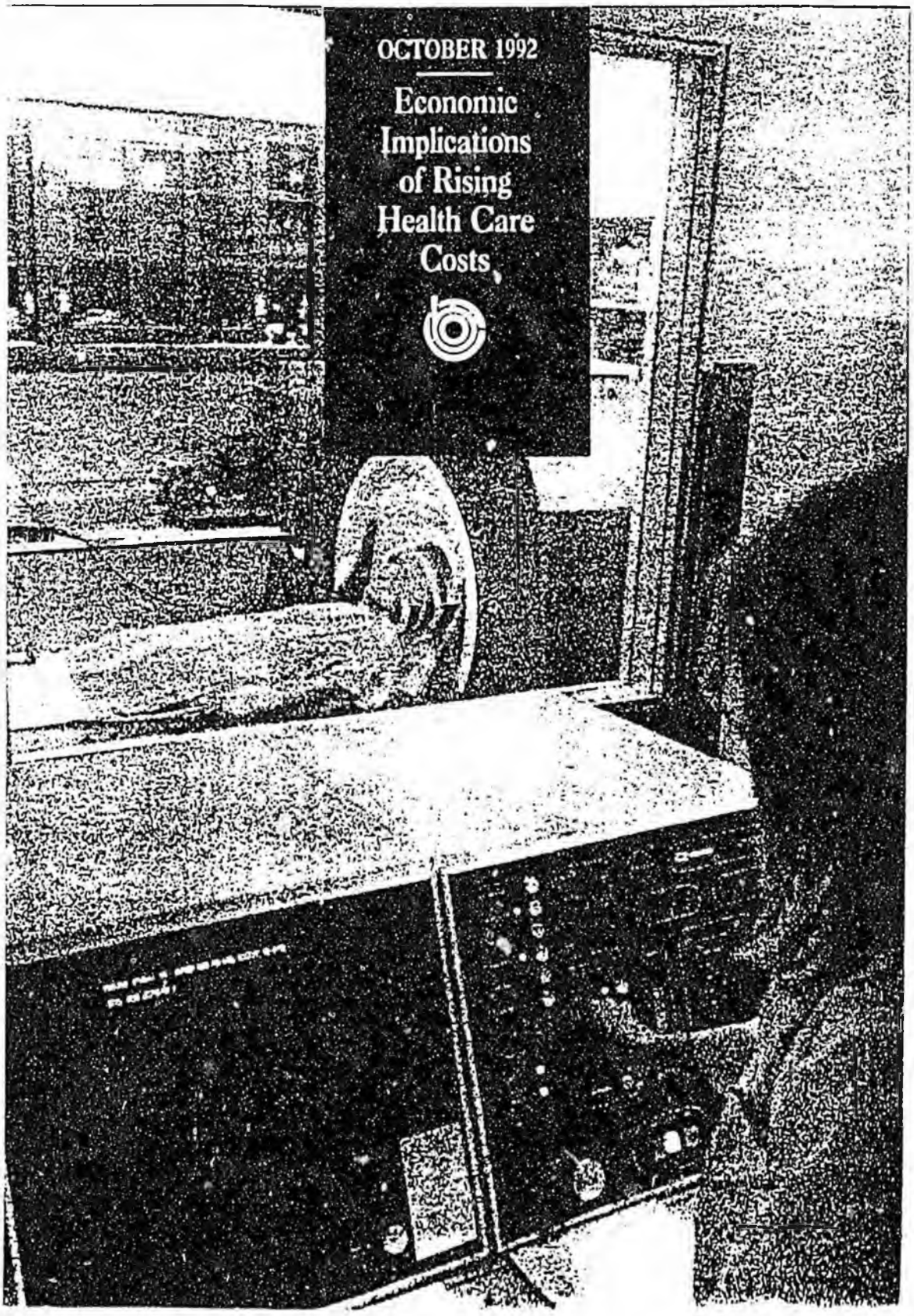
APPENDIX K

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

A

CBO

STUDY



OCTOBER 1992

Economic Implications of Rising Health Care Costs

The Malpractice Issue

Some analysts believe that the possibility of malpractice lawsuits has substantially increased health care expenditures, not only by raising malpractice insurance premiums but also by inducing physicians to adopt "defensive" medical practices aimed at reducing the risk of lawsuits.[13] For several reasons, however, CBO infers from the available evidence that the larger published estimates are too high and that restructuring malpractice liability alone would not generate large savings in U.S. health care costs.[14]

First, malpractice premiums amount to less than 1 percent of national health expenditures. Thus, these premiums directly contribute little to the nation's overall health costs. Second, much of the care that is commonly dubbed "defensive medicine" would probably still be provided for reasons other than concerns about malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this "defensive care" helps to reduce the uncertainty of medical diagnoses, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform.

Conclusions

Health care spending is propelled upward by powerful forces. Dramatic technological breakthroughs have improved medical care, but at a very high cost. Moreover, the presence of insurance and heavy government involvement has eased the pressures on consumers to reject high-cost treatments. This means that new medical technologies do not have to meet the usual market tests that face other goods and services. As a result, when the boundaries of science are pushed out, medical breakthroughs that increase costs are not discouraged. Although several other factors--rising incomes, demographic changes, and higher medical malpractice costs--have been blamed for increasing the nation's health care bill, they do not appear to account for much of the increase.

12. See David Parkin and others, "Aggregate Health Care Expenditures and National Income: Is Health Care a Luxury Good?" *Journal of Health Economics*, vol. 6, no. 2 (1987), pp. 109-127; and Newhouse, "Medical Care Costs: How Much Welfare Loss?"

13. Roger A. Reynolds, John A. Rizzo, and Martin L. Gonzalez, "The Cost of Medical Professional Liability," *Journal of the American Medical Association*, vol. 257, no. 20 (May 22-29, 1987), pp. 2776-2781.

14. See Statement of Robert D. Reischauer, Director of the Congressional Budget Office, before the House Committee on Ways and Means, March 4, 1992.

Coalition for Consumer Rights

a center for public interest research and education

THE MYTH OF MEDICAL MALPRACTICE SAVINGS:

The Nothing for Nothing Trade Off in Indiana's Health Care System

The Coalition for Consumer Rights

February, 1992

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THE MYTH OF MEDICAL MALPRACTICE SAVINGS:

The Nothing for Nothing Trade Off in Indiana's Health Care System

Medical malpractice suits and the costs associated with them are often blamed for soaring health care costs. However, trends now show double digit health care inflation continuing into its fifth year despite declines in medical malpractice claims. This has cast doubt on the relationship between the two. The Coalition for Consumer Rights decided to further test the relationship between medical malpractice and health care costs with a comparative study on specific health care costs in two states.

Contrasting Two Systems: Illinois v. Indiana

Illinois and Indiana have vastly different compensation systems for victims of medical malpractice. Illinois has a tort based system which gives judges and juries the responsibility to decide if a doctor is guilty of negligence and to award compensation as they see fit, without limits.

Indiana has a review system, where medical malpractice cases are not heard by a judge and jury, but by a Medical Review Panel. Compensation is limited to $750,000, (only $100,000 is paid by the doctor's insurance), regardless of the extent of the injury and its impact on the person or their family.

These two systems have resulted in very different medical malpractice premiums for their doctors. Illinois doctors pay more for malpractice insurance. Indiana consumers have forfeited more rights under their system, but Indiana doctors pay lower malpractice premiums. This trade off has sometimes been justified by the suggestion that lower malpractice premiums are passed on to Indiana consumers in the form of lower health care costs.

Our surveys were designed to answer this question: What economic benefits do Indiana consumers realize by giving up their right to full recovery? Does the Indiana's 'rights trade off', which saves doctors money on malpractice premiums, result in lower costs to health care consumers?

Indicators: Room Rates and Childbirth Fees

Our first survey tested the hospital room fees in Indiana and Illinois, to provide a benchmark for differences between the two states. Since room fees alone could not be expected to reflect all differences between the states, a second survey was designed to incorporate more data.

Baby delivery fees were expected to show a greater responsiveness to malpractice costs because malpractice rates for obstetrical procedures have often been cited as a reason for soaring health care costs. Therefore we decided to test the hospitals fees associated with baby delivery.

Methodology

Calls were made on September 17, 1991 to hospitals in similar municipalities in Indiana and Illinois asking for the basic room rates for private and semi-private rooms. Calls were made in December, 1991 and January, 1992 to hospitals in the same municipalities asking for the average cost of baby delivery in a normal birth, and the average length of stay for a normal birth mother and baby.

Findings

Neither of the two separate surveys of the major hospitals in selected municipalities in Indiana and Illinois found any variance in fees that could be attributed to differences in medical malpractice costs.

In the four sets of similar municipalities surveyed, Illinois residents paid approximately the same rate or less per room. For the same municipal areas, there were only modest differences in hospital fees for baby delivery. In fact, for two sets of comparable municipalities, reported average fees were higher in Indiana.

Do Malpractice Premiums Make a Difference?

A brief review of the two indicators of health care costs -- baby delivery costs and hospital room rates -- shows that lower malpractice costs do not lead to lower health care costs.

If lower medical malpractice costs are saving anyone money in Indiana, it is not the health care consumer. Although the Indiana medical compensation system requires consumers to forfeit their legal rights, it gives them nothing in return.

APPENDIX A

COMPARISON OF HOSPITAL ROOM RATES BETWEEN INDIANA AND ILLINOIS COMMUNITIES

Bloomington, Indiana Population 51,646

Hospital	$ for Semi-Private	$ for Private
Bloomington	$371.50	$431.50
Bloomington Meadows	Closed for Construction	

Bloomington, Illinois Population 44,189

Hospital	$ for Semi-Private	$ for Private
Brokow	$258	$276
St. Joseph	$261	$288
Mennonite	$240	$258

Muncie, Indiana Population 77,216

Hospital	$ for Semi-Private	$ for Private
Ball Hospital	$240	$250

Moline/Rock Island, Illinois Population 92,000

Hospital	$ for Semi-Private	$ for Private
United Medical Center	$237	$253
Franciscan	$235	$245

Springfield, Illinois Population 99,637

Hospital	$ for Semi-Private	$ for Private
Memorial Med Ctr	$270	$290
St. Johns	$305	$325

South Bend, Indiana Population 109,727

Hospital	$ for Semi-Private	$ for Private
Memorial	$405	$455
St. Joseph Med Ctr	$420	$455

Evansville, Indiana Population 130,496

Hospital	$ for Semi-Private	$ for Private
St. Mary's	$327	$348
Deaconess	$317	$357
Wellborn	$335	$378

Rockford, Illinois Population 139,712

Hospital	$ for Semi-Private	$ for Private
Rockford Memorial	$305	$330
St. Anthony Med Ctr	$285	$300
Swedish American	$324	$374

Estimated 1986 population figures.
Research conducted in September 1991 by Kim S. Gray
Coalition for Consumer Rights

APPENDIX B

COMPARISON OF DELIVERY COSTS IN THE CASE OF A NORMAL DELIVERY BETWEEN INDIANA AND ILLINOIS COMMUNITIES

TOWNS UNDER 100,000

Bloomington, Illinois	Population 44,189
Hospital	**Average Reported Delivery Charge**
Brokow	2,900
St. Joseph	2,531
Bloomington, Indiana	Population 51,646
Hospital	**Average Reported Delivery Charge**
Bloomington	2,500
Terre Haute, Indiana	Population 61,125
Hospital	**Average Reported Delivery Charge**
Terre Haute	2,600
Union	2,500
Muncie, Indiana	Population 77,216
Hospital	**Average Reported Delivery Charge**
Ball Hospital	2,500
Aurora, Illinois	Population 81,293
Hospital	**Average Reported Delivery Charge**
Copley Medical Ctr.	3,200
Mercy Health Ctr	1,400-2,000
Moline/Rock Island, Illinois	Population 92,000
Hospital	**Average Reported Delivery Charge**
United Medical Ctr.	3,000

Franciscan	2,000-2,500

Champaign/Urbana,Illinois Population 93,000

Hospital	**Average Reported Delivery Charge**
Carle Foundation	2,500
Covenant	2,700-3,500
FINDINGS:	Average cost for Indiana: $2,525 Average cost for Illinois: $2,647 A difference in cost of only $122.62

TOWNS OF COMPARABLE SIZE:
SPRINGFIELD, IL AND SOUTH BEND, IN

Springfield, Illinois Population 99,637

Hospital	**Average Reported Delivery Charge**
Memorial Med Ctr.	2,000
St. Johns	1,500-2,400

South Bend, Indiana Population 109,727

Hospital	**Average Reported Delivery Charge**
Memorial	3,500
St. Joseph Med Center	1,982
FINDINGS:	Average cost for Indiana: $2,741 Average cost for Illinois: $1,975 $766 higher costs in Indiana

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TOWNS OF COMPARABLE SIZE:
EVANSVILLE, IN; ROCKFORD, IL; AND GARY, IN

Evansville, Indiana Population 130,496

Hospital	**Average Reported Delivery Charge**
St. Mary's	2,258
Deaconess	2,875
Welborn	1,600

Rockford, Illinois	Population 139,712
Hospital	**Average Reported Delivery Charge**
Rockford Memorial	1,886
St. Anthony's	2,500
Swedish American	1,600-2,500
Gary, Indiana	Population 151,953
Hospital	**Average Reported Delivery Charge**
Methodist	2,500
FINDINGS:	Average cost for Indiana: $2,308 Average cost for Illinois: $2,145 Difference in cost of $163

TOWNS OF COMPARABLE SIZE:
FORT WAYNE, IN AND PEORIA, IL

Fort Wayne, Indiana	Population 172,196
Hospital	**Average Reported Delivery Charge**
Parkview Memorial	2,538
St. Joseph	2,500
Peoria, Illinois	Population 200,466
Proctor Community	2,500
Methodist Medical Ctr.	3,400
St. Francis	1,848
FINDINGS:	Average cost for Indiana: $2,519 Average cost for Illinois: $2,582 Difference in cost of only $63

Estimated 1986 population figures.
Research conducted in December 1991 and January 1992 by Kim S. Gray, Coalition for Consumer Rights

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A Few Comments About Tort Reform and Medical Negligence

By Lawrence D. Weiss December 1993

MEDICAL MALPRACTICE

Medical malpractice involves the negligent treatment of patients by a variety of health care providers including physicians. Negligent physicians may be drunk, drug impaired, incompetent, or otherwise unable to exercise adequate judgement or skill in the treatment of patients. The consequences of physician negligence range from no effect to full permanent disability or death. From a public health perspective the key issues involve the negligence of the physician and the consequences for the patient. In other words, what social structures or processes detect and deter medically negligent physicians from harming their patients, and what structures act as obstacles to the detection and deterrence of negligent physicians? What patients are at risk as victims of malpractice, and what are the consequences for those patients?

The media image of medical malpractice has been predominantly formed and conditioned not by the public health perception of malpractice, but rather by the institutions involved with the financial consequences of medical malpractice. These social institutions include primarily the private insurance industry and physicians through their professional organizations. As a result medical malpractice is commonly discussed in the context of the high cost of malpractice insurance premiums and the issue of tort reform rather than the effective control of negligent physicians and the toll they take in medical injury and human suffering.

Public health institutions in both the private and public sectors are starved for resources and have minimum access to the powerful media machines that churn out public opinion. On the other hand the $1.6 trillion insurance industry (Weiss 1992, 17) and the American Medical Association engage legions of public relations flacks, hundreds of lobbyists and scores of millions of dollars each year to influence the media and public opinion. This uneven access to the media during the last couple of decades has resulted in a highly skewed public perception of the various issues related to medical negligence and malpractice. As a result the public discussion has been heavily weighted by vested interests wielding ideological arguments. The bright light of non-ideological research and analysis has been noticeably absent from most public discussion.

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Magnitude of The Medical Negligence Problem

Until the last few years the only major piece of research addressing the relationship between medical negligence, patient injuries, and malpractice claims was a study conducted in the mid-1970s published by the California Medical Association (Mills 1977). In that study a convenience sample of nearly 21,000 medical records was analyzed for evidence of medical negligence. This study revealed a negligence rate of 0.8 percent, or about eight injuries due to medical negligence for every 1,000 hospitalizations. It was estimated that only about ten percent of those injured as a result of medical negligence ever filed a claim for damages (Danzon 1985, 19).

A more recent and methodologically stronger study confirms the magnitude of the medical negligence problem and suggests that a much smaller fraction of those injured seek compensation than was indicated in the California study. The Harvard Medical Practice Study (Hiatt 1989) selected a random sample of approximately 31,000 records from 51 hospitals in the state of New York in the year 1984. Teams of physicians evaluated these records to uncover injuries caused by medical negligence, i.e. "the failure to meet standards reasonably expected of the average physician, other provider, or institution..." (Hiatt et al. 1989, 481).

The Harvard study revealed a medical negligence rate of 10 in every 1,000 hospitalizations, somewhat higher than the California study (Localio et al. 1991). The injuries included in the study were [illegible] serious enough to result in a longer hospital stay, disability upon discharge, or death. Further, projecting their findings to the entire state of New York in the year of the study, the researchers estimated over 27,000 serious injuries due to medical negligence among 2.6 million patients discharged from acute care hospitals. These projected injuries included nearly 7,000 deaths and almost 900 cases of permanent and total disability. Table 4.1 summarizes the relationship between adverse events (injuries or illnesses caused by medical intervention) not resulting from negligence, adverse events resulting from negligence, and the resulting litigation.

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Table 4.1 Negligent Injury and Resulting Litigation
Of Every 10,000 Hospital Patients

9,630 will experience no adverse events and
370 will suffer adverse events, but
270 of those will be without negligence. Of the
100 negligent adverse events, in
98 no claims for compensation will be made. Of the
2 claims made, only
1 will receive any compensation.

Source: Saks 1993, 9. (Based on findings of the Harvard Medical Practice Study)

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People 65 years of age and older were particularly likely to be victims of medical negligence regardless of the severity of their initial illness (Brennan et al. 1991, 373) indicating a greater propensity among the elderly to be treated by substandard medical practitioners. In addition, "[t]here was more negligence among the Medicaid patients than the privately insured, and much, much more among the uninsured." (Hiatt 1992, 258) In other words, there is an inverse relationship between wealth and negligent medical treatment.

While the California study (Danzon 1985) found that an estimated 90 percent of those injured by medical negligence never filed a claim, the Harvard Medical Practice Study found that more than 98 percent of all the injuries caused by medical negligence were not followed by a malpractice claim (Localio et al., 1991). In summary the investigators observed that:

> the civil-justice system only infrequently compensates injured patients and rarely identifies and holds health care providers accountable for substandard medical care....The abandonment of malpractice litigation is unlikely unless credible systems and procedures, supported by the public, are instituted to guarantee professional accountability to patients (Localio et al. 1991, 250).

Detection and Deterrence

There is an extensive array of institutional structures across the nation with the nominal purpose of deterring, limiting, or terminating the practices of negligent physicians. Nevertheless, nationwide projections based on the Harvard Medical Practice Study (Brennan et al. 1991) as well as other studies (Wolfe 1992) indicate that physicians cause 100,000 to 300,000 serious injuries and deaths every year resulting from medical negligence. Clearly these facts put in serious question the actual effectiveness of institutional safeguards.

Hospital Peer-review Committees Hospital peer-review committees have the benefit of knowing the professional strengths and weaknesses of physicians with whom they share hospital privileges. The intimacy of the hospital setting, however, makes effective self-regulation among friends and colleagues unlikely. The threat of suits against individuals sitting on the peer-review committees adds to the obstacles inhibiting effective detection and deterrence of negligent physicians by these committees (Schwartz and Mendelson 1989, 1342). In 1991, for example, American hospitals sanctioned only 750 physicians with restrictions lasting longer than one month (Wolfe 1992, 1). This

is the equivalent of 1.25 such sanctions for each 1,000 physicians. Contrast this rate to physician-owned malpractice insurance companies which terminated insurance for 6.6 physicians per 1,000 due to medical negligence (Schwartz and Mendelson 1989:1345). In the latter case physicians are personally liable for a colleague's malpractice, in the former case they are not.

State Licensing Boards At the state level licensing boards have the authority to investigate and discipline physicians for medical negligence as well as other problems relating to their practice of medicine. A maximum of 5 per 1,000 physicians nationally have been disciplined by state boards in a any recent year, and the figure is a fraction of that for serious disciplinary actions such as license revocation or suspension. Moreover, only about 12 percent of all disciplinary actions actually relate to medical negligence. The rest have to do with criminal behavior, overprescribing drugs, ethics issues, etc. The most aggressive states discipline about 10 per 1,000 physicians annually, while the most reticent discipline about one per 1,000. In 1991 state medical boards disciplined only 3,034 physicians, whereas in that same year an estimated 150,000 to 300,000 serious injuries or deaths occurred due to physician negligence in hospitals. These figures do not include estimates of medical negligence that occur in physician office settings outside the hospital (Wolfe 1993c).

Apart from the periodic situation of friends and colleagues reluctant to enforce sanctions against each other, most of these boards face a number of additional obstacles. A most difficult one is the standard of proof state boards are required to use to identify and manage negligent physicians. "'Clear and convincing evidence'" must be produced rather than the less stringent "'preponderance of evidence'" that is typically used in other settings such as state courts (Schwartz and Mendelson 1989, 1345). Another serious obstacle is the widespread shortage of investigators and resources necessary for boards to effectively conduct investigations. As a result boards often have backlogged cases numbering in the hundreds. A third obstacle is that state boards generally do not have extensive peer-review capabilities, inhibiting the quantity and quality of information received during an investigation. Finally, the case of an accused physician who fully contests State licensing board charges typically drags on six to eight years. The physician may remain in practice that entire time. One public interest lawyer wryly noted that '"This system is so slow, so meager, and so trivial that death is weeding out incompetent physicians much faster than is the board."' (Chesteen and Lally 1991)

DRAFT Comments to: Larry Weiss (907) 333-5862 - 5862 Kennyhill Dr. Anchorage AK 99504 (Professor of Sociology, UAA)

Medicare Peer Review Organizations Medicare Peer Review Organizations (PROs) were created in each state by the federal government in 1982 to monitor the quality and cost of hospital care reimbursed by Medicare. Theoretically these organizations wield a big stick. They can discipline problem physicians and hospitals by denying them participation in Medicare, refer serious quality of care problems to the state medical licensing board, or "educate" the offender. A review of their work in the mid-1980s indicates that the rate of PRO recommendations for exclusions from Medicare and Medicaid declined dramatically. The trend corresponds with an emerging policy revision in the Health Care Financing Administration (HCFA) which oversees the PROs. HCFA has decided to adopt the strategy of "educating" errant physicians rather than disciplining them.

A study of eight randomly selected PROs by the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) during a six month period in 1990 found 131 physicians responsible for serious medical negligence or other breaches of quality of care. Despite the fact that these problems had led to hospital readmission, disability, or death; and despite the fact that 30 percent of these physicians had multiple infractions, only two were ever referred to the OIG for termination with Medicare, and three were referred to the state licensing board. The rest of the physicians were notified that a problem had been discovered and were monitored more closely by the PROs to a greater or lesser extent. Most of the physicians also received a phone call or brief letter from the PRO, and that served as the additional "education" they were supposed to receive.

> In fact, the study reveals that PROs squander opportunities for genuine improvement of substandard physicians' skills. And by categorically rejecting more punitive measures in favor of ineffective education, they fail to deter repetition of serious problems by the same--or other--incompetent doctors. (Wolfe 1991)

Physician-owned Insurance Companies Approximately 40% of all physicians in patient care are insured against medical negligence claims through physician-owned insurance companies (Schwartz and Mendelson 1989). Unlike the alternative of commercial insurance, and unlike either state licensing boards or hospital peer-review committees, members of physician-owned insurance companies are personally liable for claims made against any of their co-owners. As a result of this financial accountability, applicants to physician-owned insurance companies are often carefully screened for competence by a committee of members prior to admission. Once admitted, members who have had

claims for malpractice filed against them may be rigorously evaluated by peers, outside consultants, and underwriters.

Sanctions against negligent physicians may include additional surcharges on their insurance premiums, deductibles in the event of successful claims, restrictions on practice, additional training, or the termination of insurance. In about a third of the cases, however, the latter sanction takes the form of a resignation from part ownership in the insurance company (and therefor termination of coverage) under pressure from the insurance company. Schwartz and Mendelson (1989, 1345) estimate that in 1985 state boards suspended or revoked the licenses of about 0.08% of all practicing physicians, less than one per 1,000, because of incompetence or negligence. During the same year physician-owned insurance companies terminated coverage for 6.6 per 1,000 member physicians due to medical negligence. In other words the maximum sanction was applied by the physician-owned insurance companies over eight times more frequently than the maximum sanction applied by state boards.

Certainly it can be argued that suspension of license is considerably more serious than loss of insurance so that the penalties are not comparable. However, lesser sanctions for negligence were levied by the physician-owned insurance companies at a rate about thirteen times more frequently than lesser sanctions applied by the boards. There is a strong suggestion in these research findings that structurally the physician-owned insurance companies, characterized by personal financial liability, are far more effective at weeding out negligent physicians than are the state licensing boards.

The occasional revocation of a physician's license by the state board due to negligence, the board's ultimate sanction, may effectively prevent a physician from endangering the people of a particular state. However, that same negligent physician is free to start a practice in another state whose licensing board may be entirely unaware of the physician's history of incompetence. Physician-owned insurance companies administer their ultimate sanction, termination of insurance, far more frequently than boards revoke or suspend licenses, however the social result is the protection of member-physicians' finances rather than protection of the public's health. The sanctioned physician is relatively free to continue his or her flawed practice of medicine with commercial insurance or without insurance coverage at all. In addition he or she may be accepted to practice in the military, or in a state or municipal hospital.

National Practitioner Data Bank In the fall of 1990 the Department of Health and Human Services initiated the National

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Practitioner Data Bank. The nominal purpose of this data bank is to collect and disseminate information about medical malpractice payments and a range of adverse professional actions involving physicians and other health care practitioners:

> This system...was created to help meet a national need to restrict the ability of incompetent practitioners to move from state to state without disclosure or discovery of the practitioner's previous damaging or incompetent performance. The data bank contains information on adverse actions taken against a practitioner's license, clinical privileges, and professional society memberships, as well as information on malpractice payments resulting from judgements or settlements (U.S. General Accounting 1992b, 2).

Unfortunately, the political compromises made during the formation of the data bank legislation have seriously flawed the use of this information to protect the public's health. Congress refuses to allow disclosure to consumers of any information that might reveal the identity of an individual practitioner. The only organizations allowed to obtain this information are hospitals and other health care entities, professional societies, state licensing boards, and individual practitioners. Of these, only hospitals are actually required to query the data bank when hiring, granting clinical privileges, or evaluating physicians. Despite the stated major purpose of the data bank, state licensing boards are not required to evaluate data bank information prior to granting new licenses. A recent study by the U.S. General Accounting Office (1993) found that the data bank's effectiveness is further hampered by long delays in providing requested information, lax security regarding sensitive information, inadequate federal monitoring of the data bank contractor, and poor planning for the data bank's future.

<u>Verifying Physicians' Credentials</u> There is no single, public source for information about physicians who have been disciplined because they were drug impaired, incompetent, negligent, unethical, or engaged in criminal behavior. Most state medical societies will release a list of names of physicians that they have disciplined, but that list will not contain the names of physicians who have been disciplined by a myriad of federal agencies, other state medical boards, hospital peer review boards, or a number of other institutions. The closest thing to such a list that may be as accessible as the local library is a book updated every couple of years under the title *Questicnable Doctors* (Van Tunen 1991), produced by Public Citizen Health Research Group, a consumer advocacy Ralph Nadar spinoff group. This publication lists in one source physicians

who have been disciplined by several federal agencies and most state medical societies.

While it is almost impossible to find out if a particular physician has been disciplined by all of the institutions that potentially might do so, it is even more difficult for a person seeking health care to verify that a physician has the training and experience that he or she claims. In a study conducted by Reade and Ratzan (1989) their conclusion was that "obtaining access to complete, up-to-date, and verified information about physicians is all but impossible."

> Physicians listed in the yellow pages of the phone book typically are free to list just about whatever they want. The phone companies typically run no independent checks on state licensure or specialty credentials listed.
>
> Many state or county medical societies do not independently verify biographical information given to them by physicians such as medical school, residencies, or board certification. Whether they verify such information or not, often medical societies will not release crucial information to the inquiring public such as whether or not the physician is board certified.
>
> The 23 specialty and subspeciality boards of the American Board of Medical Specialities (ABMS) are wildly inconsistent to public inquiries about board certification and other information concerning the qualifications of member-physicians. Some released all pertinent information over the phone, but most did not. Some would release such information only to hospitals, or only to mailed inquiries. Some would only release information with a signed release from the physician, and some boards referred inquiring members of the public to the library, often to a copy of Marquis' *Directory of Medical Specialists* (American Board of Medical Specialities 1991-92)
>
> The *Directory of Medical Specialists* in theory only lists physicians who are board certified. A serious problem with this compendium is that, for a number of reasons, a physician who is board certified in a specialty area may not be listed in here. Finally, only board certification is independently certified. Other biographical information, for example regarding residency and fellowship training, simply reflects what the physician indicated, and is not independently verified.

> The American Medical Association directory does contain verified information about state licensure, medical school, and specialty-board certification, but the directory is not easy to find, is heavily coded making it quite user unfriendly, and can be quite misleading to the lay person. In addition the directory provides no information on advanced training or certification in subspecialties.
>
> State licensing boards verify training and certification information to a greater or lesser degree initially, but may not verify additional information given during licensure renewal, for example about advanced training. State boards vary in terms of how much information they will release to the public, and under what circumstances.

Sleep-Deprived Medical Residents. Residents are typically recently graduated medical students who are doing one to four years of additional clinical training, usually on the house staff of a hospital. Residents are terribly exploited, working 100 to 120 hours per week or more, and often working up to 36 hours straight with no sleep or only a quick nap (U.S. General Accounting Office 1992a). A substantial body of research dating back to the early 1970s supports the common sense assumption that fatigued residents are likely more prone to medical negligence than well rested physicians.

The Accreditation Council for Graduate Medical Education (ACGME) accredits the nearly 7,000 residency programs across the United States. For several years during the late 1980s ACGME, the AMA, and the Association of American Medical Colleges (AAMC) worked together to develop accreditation standards that would limit the excessive hours typically worked by medical residents. These efforts were opposed by the American Boards of Medical Specialities (ABMS), in particular the six surgical specialty areas of the 24 medical specialities in the ACGME. Only one of these six surgical specialities restricted the maximum number of hours a resident could work per week, only one of them limited the number of days per week a resident had on-call duty, and only one of them required a minimum of one day per week off (U.S. General Accounting Office 1992a, 45). The surgical specialities wanted virtually no restrictions on their exploitation of medical residents.

Nevertheless, as a compromise ACGME finally adopted the following language the end of 1991:

> 'It is desirable that residents' work schedules be designed so that on the average, excluding exceptional patient care needs, residents have at least one day out of

> seven free of routine responsibilities and be on-call in the hospital no more often than every third night.' (U.S. General Accounting Office 1992a, 3)

This sounds like a mushy equivocating statement because it is. Under these guidelines residents can still work 96 hours or more per week. The guidelines are the result of opposition to a more meaningful policy by the surgical specialties of the ACGME, the American Board of Surgeons, and the American College of Surgeons. Surgeons objected to any ACGME regulations on the basis that "such limits interfere with the development of the resident's sense of commitment to the patient and impede the continuity of care necessary for patient safety." (U.S. General Accounting Office 1992a, 3). Apparently severe fatigue and stress, and the resultant increased risk of medical negligence was not thought to interfere with "patient safety" to a significant degree.

New York State is the only state that attempts to regulate the number of hours residents work. The impetus for this regulation arose from a 1986 New York county grand Jury investigation of the suspicious death of a teenager admitted to New York Hospital who was treated by two overworked and undersupervised residents. New York limits residents to 80 hours per week, averaged over a four week period. The state also requires one full day off each week, a minimum of eight hours off between scheduled on-duty assignments, and a specific level of supervision. The additional personnel required to replace the medical residents now limited to "only" 80 hours per week cost the hospitals of the State of New York an estimated $227 million the first year. This cost projection along with others indicates how widespread the exploitation of cheap, abundant medical resident labor is to the current practice of hospital-based health care nation-wide (U.S. General Accounting Office 1992a, 32-36.

Unfortunately there have been no published studies regarding why surgeons and possibly other groups of physicians are so resistant to allowing residents to have reasonable working conditions, thereby reducing medical negligence caused by fatigue, stress, and sleep deprivation. The additional costs may be a factor, but presumably that is the worry of the hospital administrator and not physicians with training responsibilities or hospital privileges. Perhaps the systematic overwork of the residents is seen as a kind of hazing ritual that functions to bond the residents to the profession while simultaneously loosening ties with patients, family, and non-physician friends. Surely an important impetus to the gross exploitation of the residents' time is fear by the physician-educators that their own

time would be severely impacted by additional work if residents were allowed to cut back. In any case these questions need additional research because the medical and social consequences of the systematic overwork of residents are so serious.

Tort Reform

The American Medical Association and its state affiliates, insurance companies, and the media have combined to make the issues of medical malpractice and tort reform almost inseparable in the public consciousness. A tort is a legal action specifying:

> ...allegations of injury or wrong committed either against a person or against a person's property by a party or parties who either failed to do something that they were obliged to do or did something that they were obligated not to do (Ostrom et al., 1993, 19).

Torts include a wide variety of court actions such as product liability, automobile torts, personal injury, libel, etc. A medical malpractice suit is a particular type of tort requiring a patient to show that he or she was injured during medical treatment, that the physician's treatment (or lack of appropriate treatment) caused the injury, and that the physician failed to provide the generally accepted standard of care. In 1991 an estimated 1.2 million tort cases of all kinds were filed in state courts, a figure which has been fairly stable for several years (Ostrom et al., 1993, 19). However, only about 10% of all torts decided at trial are medical malpractice cases (Ostrom et al., 1992, 81).

Organized Physicians' groups and the insurance industry take the lead in arguing that there is need to reform the legal structure as it pertains to torts, and in particular to medical malpractice cases. Some of the commonly cited reasons include:

> There is an explosion of medical malpractice litigation, and much of it is trivial or unwarranted.
>
> Lawyers' contingency fees are the cause of the high cost of medical malpractice insurance.
>
> Enormous, unfair settlements are the cause of the high cost of medical malpractice insurance.
>
> The high and rising cost of health care can in large part be attributed to the high cost of medical malpractice insurance.

DRAFT Comments to: Larry Weiss (907) 333-5862 - 5862 Kennyhill Dr. Anchorage AK 99504 (Professor of Sociology, UAA)

> Defensive medicine, the ordering of largely unnecessary tests and procedures by physicians trying to avoid malpractice suits, is driving up the cost of health care.
>
> High medical malpractice insurance premiums are forcing physicians to stop delivering babies, to reduce or eliminate other medical procedures, and to quit the practice of medicine altogether.

These allegations provide important ideological ammunition for their respective adherents. The AMA has an interest in diverting attention from the responsibility of physicians in committing widespread medical malpractice, and the insurance industry has an interest in diverting attention from the fact that its profits are derived from increasingly higher premiums. In other words, the insurance industry has historically had little reason for taking an active role in reducing the incidence of malpractice because it has been able to cash in on it (Peck 1986). Nevertheless, two decades of frequently unproven, ideologically-driven allegations pumped up by massive media campaigns and political lobbying efforts have resulted in wide spread tort reform across the United States.

Some of the tort reforms have been aimed at creating barriers to legal suits (Spernak and Budetti 1991). Many states, for example, have "frivolous suit" penalty statutes requiring the party with an allegedly weak claim or defense to pay court costs and attorney fees for the other party. Some states have shortened various statutes of limitation applying to medical injury claims, and a number of states have "good samaritan" statutes giving immunity to negligent physicians who provide emergency care at the scene.

Many states have initiated tort reforms intending to alter the plaintiff's burden of proof. Some of these have increased the plaintiff's burden of proof beyond the standard "preponderance of the evidence." Others, such as *res ipsa loquitur* greatly ease the burden of proof on the plaintiff by allowing the judge to instruct the jury in certain very self-evident cases that negligence did in fact cause the injury. These cases typically settle out of court.

Finally, a major category of tort reform involves laws designed to reduce damage awards. In its most direct form, states have enacted caps on the economic, non-economic, and punitive damages a plaintiff may receive from a jury. Some states allow defendants to pay out large awards in installments rather than all at once. For the defendant this has the added

benefit that the plaintiff may die, perhaps saving the defendant a considerable sum of money.

The consequences of these reforms have varied considerably. (Spernak and Budetti 1991, 13-15). Several studies indicate that limits on damage awards are associated with slightly or modestly reduced insurance premiums, and reduced amount paid per claim. Many of the reforms seem to have had no measurable effect on insurance rates, claims filed or damages paid. Some of the reforms have had consequences opposite those anticipated. For example, the establishment of mandatory pre-trial screening panels has increased average claim payments by over 50 percent.

Most importantly, however, there is no evidence that any of the tort reforms have actually helped to detect or deter the widespread incidence of malpractice known to exist. Further, there is no evidence that any of the tort reforms have made the attainment of compensation easier for the overwhelming majority of victims of medical negligence who never file a claim, who never make a settlement, and who are never paid a penny by the negligent physician or medical facility. These, however, are not the goals of tort reform.

DRAFT Comments to: Larry Weiss (907) 333-5862 - 5862 Kennyhill Dr. Anchorage AK 99504 (Professor of Sociology, UAA)

Box 4.1

MEDICAL MALPRACTICE INSURANCE IN CANADA: MUCH CHEAPER

Canadian physicians are sued about one fifth as often as U.S. physicians despite the lack of evidence that the incidence of medical negligence is significantly less in Canada than in the United States. Moreover, their malpractice insurance costs about one ninth as much as it does for U.S. physicians. The medical malpractice insurance premium in Canada costs on average a mere 1.5% of a physician's net professional income. There are a number of factors that may account for why this is so:

In most Canadian provinces the limitation period, that is the period during which the plaintiff may file a malpractice claim, is considerably shorter than in the U.S.

In Canada punitive damages are rarely awarded, and damages for pain and suffering are considerably less than in the U.S., due in part to a nation-wide cap.

Since there is universal access to health care in Canada, estimated costs for past and future health care needs are a minimal component in the decision to sue, and a smaller part of any award or settlement compared to the United States.

Social security programs in Canada are generous and relatively comprehensive compared to the U.S., minimizing the incentive to sue primarily for these kinds of benefits.

Contingent fee systems are not typically used by lawyers in Canada. This may reduce speculation, but it may also reduce access to compensation by low income people.

Under the Canadian legal system losers must pay a large portion of the winner's legal costs.

Over 95 percent of all medical malpractice claims are defended by one professional liability association, the Canadian Medical Protective Association, in contrast to hundreds of associations and insurance companies in the U.S. This concentration of resources and experience more effectively protects physicians and inhibits marginal claims.

Despite the above facts, the growth of malpractice actions in Canada is comparable to that in the United States. Between 1971 and 1989 the number of malpractice claims against Canadian Physicians grew nearly 700 percent, however only about one third

of those claims resulted in payments. The average malpractice award was $150,640 in 1989 (expressed in 1991 Canadian dollars), and had grown at the rate of 9.7 percent per year between 1971 and 1989, adjusted for inflation. The Average malpractice insurance premium increased nearly 15 percent per year between 1976 and 1988, adjusted for inflation.

In summary, Canadian physicians pay much lower medical malpractice premiums than their U.S. counterparts in large part because Canadian physicians are sued far less often. This appears to be the case due to obstacles in the legal system to the pursuit of compensation, and due to more encompassing health care and social security programs in Canada. The negative consequences of the Canadian system are that low income people and people with legitimate but difficult to prove cases are discouraged from seeking compensation. Furthermore, the Canadian system does not appear to be any more likely to identify and deter negligent physicians from practicing in the first place. Finally, the rate of growth of malpractice claims and payments is comparable to that in the U.S.. This portends controversy in the future for Canadians.

Source: Coyte, Peter C. et al. Medical Practice--The Canadian Experience. *The New England Journal of Medicine* 324 no. 2:89-93.

MEDICAL MALPRACTICE:

PERCEPTIONS AND MISPERCEPTIONS

March 1993

Developed by
The American Bar Association
Special Committee on Medical
Professional Liability and the
ABA Governmental Affairs Office

MEDICAL MALPRACTICE:
PERCEPTIONS AND MISPERCEPTIONS

March 1993

Table of Contents

Cost of Health Care in the United States

U.S. health care outlays, accounting for approximately 14 percent of the GNP, totaled $838.5 billion in 1992, up about 11.5 percent from $738 billion in 1991.[1] The medical-legal component in the same period appears to have decreased, since health care costs greatly increased during this period and malpractice premiums declined slightly.[2]

Factors Contributing to Cost

Among the factors cited as contributing to the rising cost of health care:

* Reliance on sophisticated and expensive treatment;
* Innovative treatment of such illnesses as heart disease, AIDS and cancer;
* An aging population which adds to Medicare and Medicaid expenditures; and
* High administrative costs of the health care system.

Some cite the cost of defensive medicine. However, no one has reliably measured what, if anything, defensive medicine costs. An October 1992 study of the Congressional Budget Office concluded that health care spending is propelled upward by high cost technological and medical breakthroughs. The study finds that rising incomes, demographic changes, and medical malpractice costs do not appear to account for much of the increase in the nation's health care bill. The report states that malpractice insurance premiums account for less than one percent of the dollars spent annually on the nation's health care.

Factors Contributing to Cost continued

The report also concluded that "much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this 'defensive care' helps to reduce the uncertainty of medical diagnosis, it seem unlikely that physicians would change their practice patterns dramatically in response to malpractice reform."[3]

"Defensive Medicine"

Varying figures for the cost of "defensive medicine" have been estimated.[4] To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. There is no agreement upon the definition. That uncertainty has resulted in the inability to statistically measure the cost.[5] In published studies, "defensive medicine" has included erroneously the cost of the consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest.[6] Some have considered the cost of new technology and advancements in medical knowledge, care, and treatment. In that regard, patients expect the use of very modern, sophisticated and expensive technology to refine diagnosis and eliminate uncertainties.

Therefore, to examine the impact of the medical-legal system, the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There is no study to measure that cost, and there is no basis for assuming that competent and reputable physicians impose such expenses upon their patients without a justifiable medical reason.

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable.[7] When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.[8] Thus, if liability concerns are a deterrent, statutory provisions that relieve physicians of concern regarding negligent practices can actually result in an increase of health care cost.

Because no reliable studies have been done to determine the cost of so-called defensive medicine, the Office of Technology Assessment has been asked to study the issue and is expected to complete its study before the end of the year.

Number of Malpractice Claims

The number of malpractice claims peaked in 1985. Since 1985, the overall rate has declined at an average annual rate of 8.9 percent.[9] As an aside, one should note that even when the number of claims does grow, it is not clear precisely what this signifies, as different insurance companies define a "claim" differently. Some, for example, require their insureds to be covered for an occurrence, to notify them whenever an occurrence might lead to a lawsuit. Each such notice then becomes a "claim" whether or not a lawsuit, or any other claim by the patient, is ever filed. In addition, when there is initial uncertainty about liability, parties who are potentially liable are listed as parties to a lawsuit to avoid a bar under a statute of limitations. After further investigation, those determined not to be liable are dropped from the suit before trial and without any indemnity being paid.

Costs of Malpractice Coverage

The cost of medical malpractice insurance, for the most part, reflects the cost of the medical-legal system. In contrast to the increase in health care costs, medical malpractice costs have decreased slightly.[10] Medical advances have made many severe injuries more survivable, particularly for the newborn, as well as for others. What might have been a wrongful death case is now more often a case brought by a living plaintiff who has a lifetime of actual economic costs. These cases result in larger overall awards.

In 1989, malpractice insurance premiums were less than three-quarters of one percent of the total health care costs in the United States, and premium cost decreased by about four percent for 1990. The Physician Payment Review Commission agrees that the cost of malpractice insurance is "probably not excessive."[11] In comparison to other components of health care costs, administrative costs, for example, are 10 to 24 times the cost of all medical malpractice claims.[12]

General Claims Information

A February 1989 report of the Department of Commerce of the State of Minnesota reviewed all claims filed with two insurers in Minnesota, North Dakota and South Dakota against physicians from January 1, 1982, through December 31, 1987. Among its conclusions are the following:

* With the exception of self-insured groups, the St. Paul Companies and Minnesota Medical Insurance Exchange insure nearly 100 percent of Minnesota's physicians. This report represents the only known comprehensive study of physician loss experience for any jurisdiction over the time period of the study.

* The frequency of claims per year did not materially change over the time period of the study.

* The severity of the claims payment did not materially change over the time period of the study.

* Claims determined by the insurer to be frivolous did not increase over the time period of the study.

* The likelihood of receiving compensation as a result of filing a malpractice claim was approximately 25 percent. The rate did not materially change over the time period of the study.

* No punitive damages were awarded against a physician.

General Claims Information continued

* The average cost of investigating and defending a claim changed little over the time period of the study. Indeed, the amount appeared to be decreasing.

* Despite unchanging claims frequency and declining loss payments and loss expenses, physicians, on average, paid approximately triple the amount of premiums for malpractice insurance in 1987 than in 1982.

Additionally, the Harvard Medical Study Group estimated that, in 1984, eight times as many patients suffered an injury from negligent medical treatment as filed a malpractice claim in New York State. About 16 times as many patients suffered an injury from negligence as received compensation from the medical malpractice system.[13]

Juries

A recent study of medical malpractice cases suggests that unjustified payments to plaintiffs are probably uncommon. In cases in which "physician care was deemed to meet community standards," the physician typically won. The study found that "[t]he defensibility of the case and not the severity of patient injury predominantly influences whether payment is made. Even in cases that require a jury verdict, the severity of the patient injury has little effect in whether any payment is made." The study is based on 8,231 New Jersey medical malpractice cases from 1977 to 1992.[14]

Empirical research done on medical malpractice juries leads to the conclusion that there is no support for claims that medical malpractice juries are biased against defendants or unjustifiably generous in determining awards.[15]

Obstetricians/Gynecologists

Physicians enter the field of obstetrics in large numbers and obstetricians continue to maintain a profitable field of practice. The mean-net income of obstetricians/gynecologists, after expenses (and including liability premiums) and before taxes, was $207,300 in 1990.[16] To become a recognized obstetrician/gynecologist, a person with a medical degree becomes certified by the American Board of Obstetrics and Gynecology. Before 1980, there were 18,663 board certified obstetrician/gynecologists. In the period between 1980 and 1989, 10,153 new obstetrician/gynecologists received certificates. As of July 1991, there were 25,043 board certified physicians obstetrician/gynecologists.[17]

The percent of obstetrician/gynecologists who incur claims annually dropped at an average annual rate of 22.7 percent between 1985 and 1990.[18]

Research suggests that only a "small proportion of injury causing medical errors ever lead to a claim against the physician, and fewer result in a jury trial. Of the small portion of obstetrics and gynecology errors that result in a jury trial, physicians win most of the time. When physicians lose, it is likely to be in situations that do not involve specific procedures but that do involve severe injuries and in situations involving older, well-established technologies... The fact that it is older established technologies rather than newer, frontier technologies that are generally involved suggests that targeted attempts at quality assurance may be more appropriate than radical tort reform in reducing obstetrics and gynecology malpractice litigation."[19]

AMA's Tort Proposals: Impact on Health Care Costs

The Congressional Budget Office states that medical-legal costs, as measured by medical malpractice insurance premiums, account for 0.74 percent of the nation's health expenditures.[20] The pending proposals would result in a negligible impact on health care costs. A recent study funded by the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association reported that its findings indicated that "changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas."[21]

A recent study examined the relationship between medical malpractice tort "reform" and health care costs and found there to be "no indication that enacting major tort 'reforms' is positively correlated with lower health care costs." In fact, the study found that "states with the lowest per capita expenditures are more likely to have enacted fewer tort 'reforms' overall than the average."[22]

- **Collateral Source Rule**

  The collateral source rule forbids evidence from being introduced to show that a patient's costs, such as medical bills, have already been paid by another source, such as their own insurance. (Note that the collateral source has a right of "subrogation" -- that is, the right to recover from the successful plaintiff whatever monies the collateral source laid out that are recovered by the plaintiff from the tortfeasor.)

Collateral Source Rule continued

Elimination of the collateral source rule solely favors physicians by passing on the cost of the medical injury to another health care provider or to other providers of benefits to the injured person as a result of his injury. For example, often an injured person has the benefit of health or disability insurance which pays for a portion of the additional medical or other costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a lien against its insured's recovery or pursue a subrogation claim. Under some proposals, to change the collateral source rule, it has been suggested that health care costs would be saved if the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health insurer will be an increase in those premiums. The net result is no reduction in health care costs but a windfall benefit to the defendant physician or more precisely to his or to her insurer at the expense of the injured person.

o **Limiting Non-Economic Damages**

The total cost of medical malpractice, including awards, is less than one percent of health care spending.[23] Limiting awards in medical malpractice suits as a means of containing those costs is clearly an ineffective solution. In addition to being ineffective, such legislation falls hardest on those who have been the most grievously harmed -- the most severely injured victims of medical negligence who are prevented from being made whole.

There is also a question as to whether this type of proposal would be legally effective if enacted. There is some experience at the state level regarding caps on damages. Although there are variations in the legislation that has been enacted at the state level, some states have held that different types of proposals to cap damages violate various provisions of their constitutions.[24]

ENDNOTES

1 See the 1993 U.S. Industrial Outlook, U.S. Department of Commerce, page 42-1.

2 1989 Profitability Study (By Line By State) and 1990 Profitability Study (By Line By State), National Association of Insurance Commissioners, 1990 and 1991.

3 Congressional Budget Office, Economic Implications of Rising Health Care Costs (October 1992) page 27.

4 The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. Its estimate was $15.1 billion dollars for 1989. The AMA, moreover, recognized other reasons contributed to an affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care." Statement on behalf of the American Medical Association to the Senate Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 18, 1991, page 6.

5 The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates." Physician Payment Review Commission 1991 Annual Report to Congress, page 374.

See also Patricia M. Danzon, "Liability for Medical Malpractice," Journal of Economic Perspectives, Vol.5, no.3, Summer 1991, pages 51-69.

6 Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities. It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

A study of radiation centers in Florida found that doctor-owned centers appeared to result in a substantial increase in use and cost of the services. See Mitchell, Jean M.; Sunshine, Jonathan H.; "Consequences of Physicians' Ownership of Health Care Facilities - Joint Ventures in Radiation Therapy, The New England Journal of Medicine, Vol.327, No.21, Nov. 19, 1992, pages 1497-1501.

[6] continued
Another study examined workers' compensation claims in California and found that self-referral increases the cost of medical care covered by workers' compensation for physical therapy, psychiatric evaluation services and MRI Scans. Swedlow, Alex; Johnson, Gregory; Smithline, Neil; and Milstein, Arnold, "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," The New England Journal of Medicine, Vol.327, No.21 Nov. 19, 1992, pages 1502-1506.

[7] Patricia M. Danzon, "Liability for Medical Malpractice," Journal of Economic Perspectives, Vol.5, No.3, Summer 1991, pages 51-69. Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice.

The Physician Payment Review Commission Annual 1991 Report also discusses other possible causes of inefficient and inappropriate defensive medicine.

* Physicians and hospitals often benefit financially by delivering more care.

* Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford.

* So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care.

[8] Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

[9] Martin L. Gonzalez "Medical Professional Claims and Premiums 1985-1990," Socioeconomic Characteristics of Medical Practice 1992, page 23.

[10] 1989 and 1990 Profitability Studies, see endnote 2.

[11] Physician Payment Review Commission 1991 Annual Report to Congress, page 372.

[12] See Woolhandler S., Himmelstein D.U., "The Deteriorating Administrative Efficiency of the U.S. Health Care System," The New England Journal of Medicine, 1991; 324; 1253-1258. Administrative costs are estimated to range between 10 percent and 24 percent of health care costs.

13 Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, a report by the Harvard Medical Practice Study to the State of New York (1990).

14 Mark I. Taragin et al, "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," Annals of Internal Medicine, November 1992; Vol.117, No. 9, page 780.

15 Neil Vidmar, "The Unfair Criticism of Medical Malpractice Juries," Judicature, October-November 1992, Vol.76, No.3., page 118.

16 Martin L. Gonzalez, "Medical Professional Liability Claims and Premiums, 1985-90," Socioeconomic Characteristics of Medical Practice 1992, published by the American Medical Association, at page 132.

17 ABMS Compendium of Certified Medical Specialists, 3rd Edition, 1990-91, Vol.1, at page vii, published by the American Board of Medical Specialties; 1991 ABMS Compendium Supplement, at page viii.

18 Gonzalez, Supra endnote 16 at page 24.

19 Steven Daniels & Lori Andrews, "The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases," Medical Professional Liability and the Delivery of Obstetrical Care, Volume II, 161 published by the National Academy Press, for the Institue of Medicine (Victoria P. Rostow & Roger J. Bulger, eds, 1989, at page 91.

20 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, page 18.

21 "Medical and Hospital Professional Liability," a report prepared for the Texas Health Policy Task Force by Tomm and Associates, July 1992.

22 Andrea Dubin, False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs, prepared for the Coalition for Consumer Rights, March 1993, at page 2.

23 Testimony, Robert D. Reischauer. See endnote 20.

24 See Florida (Smith v. Department of Insurance, 507 So.2d 1080 (Fla.1987)); Illinois (Wright v. Central Du Page Hospital Association, 63 Ill.2d 313, 347 N.E.2d 736 (1976)); New Hampshire (Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980)); North Dakota (Arneson v. Olson, 270 N.W.2d 125 (N.D.1978)); Ohio (Morris v. Savoy, 61 Ohio St.3d 576 N.E.2d 765 (1991)).

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PATIENTS, DOCTORS, AND LAWYERS:

MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK

A Report By the Harvard Medical Practice Study
To the State of New York

PREFACE

Concern about the medical malpractice problem and the tort litigation system as it deals with that problem led the then Deans Howard Hiatt of the Harvard School of Public Health and James Vorenberg of the Harvard Law School to bring together certain members of their faculties to form the Harvard Medical Practice Study in 1984. The complexity of the issues confronting legislative and executive bodies of government as well as the courts, physicians, lawyers, and society itself, and the paucity of facts that could illuminate those issues required the participation of members of both faculties and others if a comprehensive research program were to be carried out. An equally important requirement for such work was the sponsorship of a state government prepared to open to investigators hospital records, insurance records, and the participation of administrative units of hospitals, physicians, and several state and municipal agencies.

Benjamin Barnes and Harvey Fineberg of the School of Public Health and Paul Weiler of the Law School were members of the original study group. Weiler, who is also Chief Reporter of the American Law Institute's Tort Reform Project, has continued to serve as a principal architect and investigator. After Fineberg replaced Hiatt as Dean, he asked Hiatt, who is Professor of Medicine and whose background included nine years as Physician-in-Chief at a Harvard teaching hospital, to become a member of the group in 1985.

As the scope of the Study broadened, several colleagues from a range of disciplines joined it. William Hsiao, an economist at the School of Public Health, helped in the planning phase. Russell Localio, a lawyer-statistician, then Director of Research at the Risk Management Foundation, was recruited to manage the project and to work on medical record review design and execution and claims data analysis. Ann Lawthers, a health policy analyst who was at Boston University, was initially administrative director and later

coordinator and designer of the provider studies. Troyen Brennan, a lawyer-physician, member of the Division of General Medicine and Primary Care at Brigham & Women's Hospital, and a Lecturer at the Law School, became a senior member of the physician-reviewer group and a contributor to the provider studies. William G. Johnson, an economist at the Maxwell School of Syracuse University, assumed responsibility for the patient interview phase of the study. Nan Laird, a statistician at the School of Public Health, took charge of statistical design and methodology. Ken Thorpe, an economist at the School of Public Health, joined in the deterrence studies. Sol Fleishman and Howard Frazier, both internists, and Lucian Leape, and Lynn Peterson, both surgeons, were recruited to serve as senior physician reviewers for the record review portion of the study. In 1988, Leape, formerly chairman of the Department of Pediatric Surgery, Tufts Medical School, replaced Barnes as leader of the record review, and Joseph Newhouse, a health economist, formerly Director of the RAND-UCLA Center for Health Financing Studies and the new McArthur Professor and head of Harvard's Division of Health Policy Research and Education, replaced Hsiao as leader of the econometric study. Liesi Hebert, an epidemiologist, joined the research team in 1989.

Consultants to the project included:

Floyd J. Fowler, Jr., Director of the Center for Survey Research, University of Massachusetts, who helped in planning the design of the hospital record survey.

Graham Kalton, Chairman of the Department of Biostatistics at the University of Michigan, who worked on the analysis of the survey sample.

Ruth Kilduff, Risk Manager at New England Medical Center, who helped design the survey on hospital injury prevention activities.

Donald Rubin, Head of the Department of Statistics at Harvard University, Alan Zaslavsky, Lecturer in Statistics, who assisted with the analysis of deterrence, and Theresa Dailey, who provided computational assistance for Chapter 10.

Members of the Medical Practice Study office who provided

invaluable assistance during all phases of the study included: Sybil Carey, who provided administrative direction; Elaine Gebhardt and Steven Marcus, who assisted with computation and data management; Chris Braudaway-Bauman, Wendy Vander Hart, and Robert Chaufornier, who provided secretarial assistance; and Roger Dempsey, who filed endless boxes of adverse event forms.

From the Metropolitan Studies Program, Maxwell School, Syracuse University, the following individuals assisted with the report: Bruce L. Riddle, academic computing specialist; Esther Gray and Martha Bonney, secretaries; Mary C. Daly, graduate research assistant; Linda McCarthy, research assistant; Robert Guell, programmer.

A team from Mathematica Policy Research, Inc, of Princeton, New Jersey, under the leadership of Richard Strouse, carried out the patient interviews -- often under extremely difficult conditions -- very skillfully.

Support for the exploratory stages of the research came from the Klingenstein Fund of New York and a grant from the Risk Management Foundation of the Harvard Medical Institutions.

The relationship with the New York State Legislature and Department of Health under its Commissioner, Dr. David Axelrod, has been especially important. The Department's impartiality and commitment were crucial to that relationship, for the areas of medical malpractice and tort reform have been in urgent need of facts gathered and analyzed with methods that are scientifically sound. Also essential was the State's grant of complete confidentiality of information collected and the protection by New York law against subpoena of data.

Members of our group began with different views of the most promising ways to achieve reform. Some so regarded increased tort litigation, while others favored "no-fault" or other approaches. But as is necessary for every scientific enterprise, all agreed

that our function was to gather the best possible empirical information. We emphasize this point for it has been suggested by some that the Study set out to prove that one approach was better than another. Rather, we believe we have succeeded in our goal--to gather unbiased information which will help inform and elevate the ongoing debate.

EXECUTIVE SUMMARY

Introduction

The Harvard Medical Practice Study, carried out under contract to the State of New York, was designed to inform the policy debate now going on in New York and elsewhere about how society can best deal with its medical injuries and malpractice. To do so, we had to understand and isolate the key issues and assumptions that divide the protagonists of the current tort system, a reformed tort system, and no-fault alternatives. We have not prejudged the feasibility of any such no-fault program for injured patients, nor have we endorsed the criticisms that are made about present day malpractice litigation. Rather, we believe we have provided relevant empirical data that will permit informed judgments and sound policy-making concerning this complex area.

The Study had four principal components:

1. A population based measure of the incidence of injuries resulting from medical interventions, which we called "adverse events," and a determination of the percentage of such events that resulted from fault or negligence of the physician or other provider.

2. A determination of the percentage of adverse events, both negligent and non-negligent, that led to claims and suits. In addition, we obtained information about the numbers of claims and suits by patients in whose hospital records we found no evidence of injury.

3. Measures of the costs of medical expenses, lost wages, and lost household production to the victims of medical injuries and to their families, and their compensation for such losses under current arrangements.

4. Estimates of the degree to which variations in the threat of litigation affected the incidence of adverse events.

The following summarizes some of our methods and major findings.

1. The incidence of adverse events

The hospital medical record review was key to estimating the incidence of adverse events associated with medical management. The record review focused on two critical issues: causation and negligence. We asked, "Was the patient's condition attributable to medical management rather than to the disease under treatment (causation)? Was negligence involved?"

In addition to establishing causation and negligence, we determined where injuries occurred, the types of injury and then the magnitude of disability experienced.

The review was conducted by teams of trained medical record administrators and nurses for the screening phase, and board-certified physicians for the physician-review phase.

Methods were devised to resolve the logistic problems that arose because of the infrequency of adverse events: we found efficient and reliable ways to sift through thousands of medical records to find the few that indicated the patient disability caused by medical management. We also developed ways to deal with the methodologic problems that arose: the medical record administrators had to make valid judgments regarding the presence of screening criteria and physicians had to make valid and reliable judgments about whether a patient's injury resulted at least in part from medical management, and, if so, whether management failed to meet a standard of medical care.

In order to make our results generalizable to the entire population of hospital discharges in New York, we drew a probability sample of more than 31,000 hospital records. Our ability to obtain such a sample was made possible by the

availability of the Statewide Planning and Research Cooperative System (SPARCS) data system. The basic sampling design of the Study was an implicitly stratified, systematic, two-stage cluster sample of discharges. We first selected hospitals with probabilities proportional to the number of non-psychiatric discharges and then secured the cooperation of all 51 hospitals selected. Records within hospitals were selected with three different sampling frequencies determined by patient age and diagnosis-related group (DRG). Using SPARCS information on patient discharges, we drew a sample with a distribution that conformed closely to the population on important hospital and patient characteristics.

We analyzed 30,121 (96%) of the 31,429 records selected for the study sample. After preliminary screening, physicians reviewed 7,743 records, from which a total of 1,133 adverse events were identified that occurred as a result of medical management in the hospital or required hospitalization for treatment. Of this group, 280 were judged to result from negligent care. Weighting these figures according to the sample plan, we estimated the incidence of adverse events for hospitalizations in New York in 1984 to be 3.7%, or a total of 98,609. Of these, 27.6%, 27,179 cases, or 1.0% of all hospital discharges, were due to negligence.

Physician confidence in the judgments of causation of adverse events spanned a broad range, but only 1.3% of all discharges were in the close-call range (defined as a confidence in causation of just under or just over 50-50). An even smaller fraction, 0.7% of discharges were close-call negligent adverse events, but they constituted a larger proportion of total negligent adverse events.

The majority of adverse events (57%) resulted in minimal and transient disability, but 14% of patients died at least in part as a result of their adverse event, and in another 9% the resultant disability lasted longer than 6 months. Based on these

figures, we estimated that about 2,500 cases of permanent total disability resulted from medical injury in New York hospitals in 1984. Further, we found evidence that medical injury contributed at least in part to the deaths of more than 13,000 patients in that year. Many of the deaths occurred in patients who had greatly shortened life expectancies from their underlying diseases, however. Negligent adverse events resulted, overall, in greater disability than did non-negligent events and were associated with 51% of all deaths from medical injury.

Risk factors

The risk of sustaining an adverse event increased with age. When rates were standardized for DRG level, persons over 65 years had twice the chance of sustaining an adverse event of those in the 16-44 years group. Newborns had half the adverse event rate of the 16-44 years group. The percent of adverse events resulting from negligence was increased in elderly patients. We found no gender differences in adverse event or negligence rates. Although the rates were higher in the self-pay group than in the insured categories, the differences were not significant. Blacks had higher rates of adverse events and adverse events resulting from negligence, but these differences overall were not significant. However, higher rates of adverse events and negligent events were found in hospitals that served a higher proportion of minority patients. At hospitals that cared for a mix of white and minority patients, blacks and whites had nearly identical rates.

Adverse event rates varied 10-fold between individual hospitals, when standardized for age and DRG level. Although standardized adverse event and negligence rates for small hospitals (fewer than 8,000 discharges/year) were less than for larger hospitals, these differences were not significant. Hospital ownership (private, non-profit, or government) also was not associated with significantly different rates of adverse

events. The fraction of adverse events due to negligence in government hospitals was 50% higher than in non-profit institutions, however, and three times that in proprietary hospitals. These differences were significant. The standardized rate of adverse events in upstate, non-MSA hospitals was one-third that of upstate metropolitan hospitals and less than one-fourth that in New York City. These differences were highly significant. The percent of adverse events due to negligence was not significantly different across regions. Non-teaching hospitals had half the adverse event rates of university or affiliated teaching hospitals, but university teaching hospitals had rates of negligence that were less than half those of the non-teaching or affiliated hospitals.

The nature of adverse events

Nearly half (47%) of all adverse events occurred in patients undergoing surgery, but the percent caused by negligence was lower than for non-surgical adverse events (17% vs 37%). Adverse events resulting from errors in diagnosis and in non-invasive treatment were judged to be due to negligence in over three-fourths of patients. Falls were considered due to negligence in 45% of instances.

The high rate of adverse events in patients over 65 years occurred in three categories: non-technical postoperative complications, complications of non-invasive therapy, and falls. A larger proportion of adverse events in younger patients was due to surgical failures. The operating room was the site of management for the highest fraction of adverse events, but relatively few of these were negligent. On the other hand, most (70%) adverse events in the emergency room resulted from negligence.

The most common type of error resulting in an adverse event was that involved in performing a procedure, but diagnostic errors and prevention errors were more likely to be judged

negligent, and to result in serious disability.

The more severe the degree of negligence the greater the likelihood of resultant serious disability (moderate impairment with recovery taking more than six months, permanent disability, or death).

2. Litigation data

We estimated that the incidence of malpractice claims filed by patients for the study year was between 2,967 and 3,888. Using these figures, together with the projected statewide number of injuries from medical negligence during the same period, we estimated that eight times as many patients suffered an injury from negligence as filed a malpractice claim in New York State. About 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system.

These aggregate estimates understate the true size of the gap between the frequency of malpractice claims and the incidence of adverse events caused by negligence. When we identified the malpractice claims actually filed by patients in our sample and reviewed the judgments of our physician reviewers, we found that many cases in litigation were brought by patients in whose records we found no evidence of negligence or even of adverse events. Because the legal system has not yet resolved many of these cases, we do not have the information that would permit an assessment of the success of the tort litigation system in screening out claims with no negligence.

Confining our analysis to the adverse events that involved strong or certain evidence of negligence, however, we estimate that 12,859 injuries from medical negligence did not lead to malpractice claims. Of these injuries, 22% (2,833) occurred in patients under age 70 years who suffered moderate or greater incapacity. Our projections suggest that if this group of

patients had litigated, the malpractice claims frequency for year 1984 would have increased by 75%.

3. Economic Consequences of Medical Injury

Having documented from the medical records survey which patients were injured, and from the litigation survey which patients filed tort suits, we used the patient survey to determine from the patients themselves what losses they suffered as a result of these injuries and what compensation they received from non-tort sources. For that purpose we divided our patient sample into five categories -- worker, homemaker, child, retired, and disabled -- and assembled data about lost wages and fringe benefits, medical costs, lost household production, and levels of physical and functional impairment. Our data for that final category have not been analyzed for this Report.

We faced two major difficulties in this survey. First, we had to locate, in 1989, people who had been hospitalized in 1984 in order to interview them about their experience since 1984. In fact, we were successful in finding and interviewing 71% of all injured patients, a response rate which is quite respectable for a survey of this type.

Our second problem was how to disentangle the effects of the adverse event itself from those that were properly attributable to the underlying illness, which itself would naturally be expected to entail considerable medical costs, time off work, and inability to perform normal household tasks. Two different strategies were devised for this purpose. One was to interview a control group of uninjured patients who were matched with our "experimental" group on the relevant dimensions, thus permitting econometric analysis of the precise difference which the iatrogenic injury made in the aggregate economic experience of the two groups. While we have collected all the data for the two groups, we have not completed this analysis for purpose of presentation in this Report.

Instead our primary focus has been on an alternative method -- estimating the compensable losses that might be paid under a hypothetical no-fault plan in which each patient's experience was assessed individually (as would have to be done in a real no-fault program), and then totaled. For that purpose we had to make a number of assumptions about program design: two important ones are noted here. First, all financial losses and compensation received during the first six months from hospital admission were deleted. These short-term losses are likely reimbursed from other sources (e.g., sick pay for time off work). Further, this reduces the number of cases in which disentangling the effect of the injury from the underlying illness may be very difficult. Second, we assumed that a no-fault patient compensation scheme would involve a second insurer, standing behind primary sources of general medical or disability insurance.

Our key findings with respect to these two criteria were that the bulk of disabilities were of short duration -- e.g., 42% of absences from work lasted for less than a month and 76% lasted less than six months. However, the average economic losses were much larger in the smaller number of more serious or fatal disabilities. With respect to these longer-lasting disabilities, more than 85% of the medical bills were covered by some form of health insurance, but only 20% of the lost earnings, and no detectable portion of lost household production.

Our ultimate finding is that the present discounted value of the net compensable losses (past and future) suffered by patients injured in New York hospitals in 1984 amounted to $894 million (in 1989 dollars). These compensable losses consisted of $285 million in lost wages and fringe benefits, $103 million in uninsured medical costs, and $506 million in lost household production (the latter having been valued at the market wages earned by the working women in our patient cohort).

To provide some perspective for these figures, the malpractice premiums paid by New York doctors and hospitals in 1988 amounted to $850 million. When one includes the amount spent by self-insured hospitals and the health care organizations, the total malpractice insurance burden is over $1 billion. However, these tort costs incorporate two major factors not reflected in our estimate. One is damage for pain and suffering, which typically are not compensated under no-fault programs. The other component is administrative and legal expenses which definitely would be a significant factor over and above the patient's economic losses. The administrative share of claims costs in no-fault workers compensation is usually estimated to be around 20%, though we believe it would be somewhat higher for no-fault patient compensation.

Since the sample of injured and interviewed patients in our different categories was rather small despite the relatively large sample of 31,000 hospitalizations, the confidence intervals surrounding our point estimates are large: the figures might be as much as 50% less or 100% more than those presented.. On the other hand, the estimate of net wage losses and medical costs -- these being the items typically covered by a no-fault scheme, and even then not in full fault - totalled just $335 million. Thus, there is considerable room within the current tort "envelope" to adjust even for an outcome at the highly improbable outer limit of these confidence estimates.

4. Malpractice Litigation and Deterrence

We examined the presumed deterrent effects of the tort system in two ways -- a series of physician surveys as well as an econometric study that compared the rates of adverse events and negligent adverse events, on the one hand, with the threat of a claim on the other.

The physician surveys revealed that the overall perceived risk of being sued in a given year was 20%, approximately 3 times the actual risk of being sued. The perceived risk of suit for

The final part of our study examined the relationship between variations in claims rates and variationsin cost and in injury rates in the sample of study hospitals. We found some evidence that total cost per discharge was greater in hospitals that faced higher claims rates, although the relationship that we estimated was sensitive to how we specified the relationship. Even conceding that there is an effect on cost, however, does not tell us whether the effect is good or bad. On the one hand, greater efforts to prevent injuries or ameliorate the consequences of those that occur may well require greater resources. On the other hand, additional resources in response to a greater threat may simply represent wasteful defensive medicine and not contribute to a reduction in patient injuries.

The important test, therefore, is whether hospitals that face higher claims rates actually do exhibit lower injury rates. We find no evidence that they do, but the precision of our estimates is not good, and we cannot rule out the possibility that there are in fact substantially reduced rates of injuries at the hospitals in our sample with higher claims rates. More specifically, the point estimate relating injuries to claims is actually positive in most specifications and never close to significantly negative. However, the confidence intervals around the coefficient include values that would demonstrate substantial deterrence.

We illustrate how our data cannot rule out a substantial deterrent effect by choosing one of the relationships we estimated, that for the probability that an adverse event is negligent, controlling for a number of other hospital characteristics. The point estimate of the claims variable is slightly positive; however, if we reduce the point estimate by approximately one standard error, it shows substantial deterrence. In quantitative terms, the reduced estimate would suggest that, other things equal, hospitals in the highest quartile of claims rates would have about 24% fewer negligent

negligent care was about 60%, a figure substantially greater than the actual risk of litigation from injuries caused by negligence. Additionally, perceived risk was significantly greater for high-risk specialties such as obstetrics, orthopedics and neurosurgery and for physicians in Nassau and Suffolk counties, lending credence to the responses.

Physicians who perceived themselves to be at greater risk of suit said that in the past ten years they had ordered more tests and procedures and reduced their practice scope more than had their colleagues with perceived risk.

The tort system's deterrence signal to physicians appeared mixed. For example, physicians often considered the severity of punishment to depend on whether a case went to trial or whether the media publicized it. The evidence was not clear, however, on whether the severity of the punishment and the actual transgression were related: most physicians perceived their suits as having arisen from circumstances beyond their control. Many seemed to believe that the threat of the tort system was too broad and lacked specificity.

Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as the result of a specific suit. Thus, it was not clear whether defensive medicine resulted from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO), state and hospital requirements, or a combination of factors.

Another important finding concerned physician attitudes about iatrogenic injury and negligence. Physicians tended to equate a finding of negligence with a judgment of incompetence. Thus, although willing to admit that all doctors make mistakes, physicians were often unwilling to label substandard care as negligent and were opposed to compensation for iatrogenic injury.

events (conditional upon an adverse event) as those in the lowest quartile.

Moreover, there may be a bias in our results toward showing no deterrent effect. Our goal was to determine whether there is a negative relationship between claims rates and injuries, but hospitals and physicians that have higher injury rates may have more claims filed against them. This possible positive relationship between injuries and claims would tend to mask any true deterrent effect. We have tested for this bias and do not find any evidence of it, but our test could simply be failing to detect it.

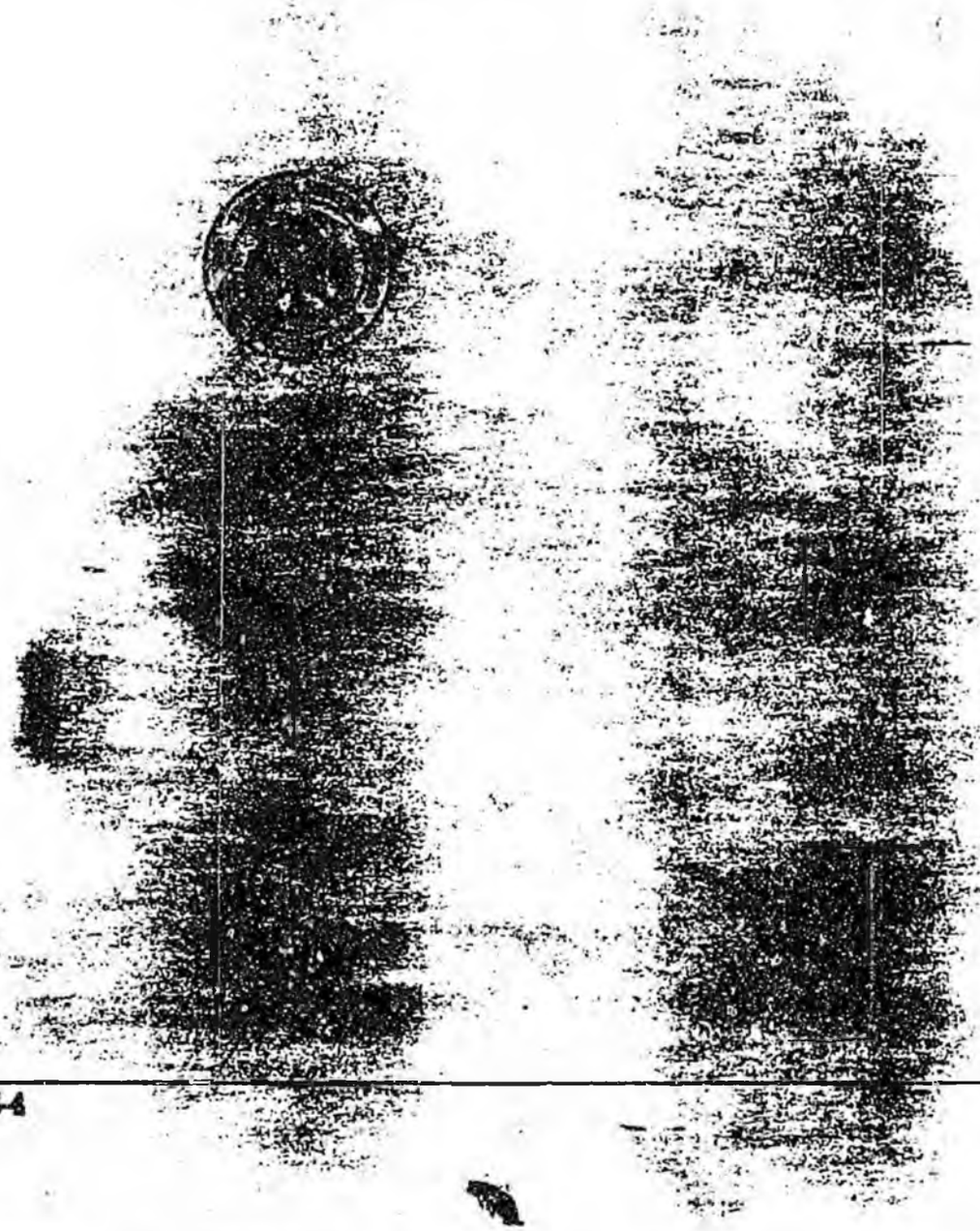
Finally, even if we had been able to conclude that our data ruled out all but a negligible deterrent effect, we could not conclude that abolishing the tort system would have no effect on injury rates. All the hospitals in our sample faced some threat of a claim if an injury occurred, and the most we could hope to learn was the effect on injury rates of variation in that threat. Abolishing the tort system could reduce that threat to zero (depending on what, if anything replaced it), and we cannot learn from our data what the effect of that might be.

GAO

December 1986

MEDICAL MALPRACTICE

Case Study on Indiana



GAO/HRD-87-21S-4

Preface

December 31, 1986

Representative John Edward Porter and Senator John Heinz, Chairman, Senate Special Committee on Aging, asked GAO to identify the actions taken by the states to address medical malpractice insurance problems and to determine changes in insurance costs, the number of claims filed, and the average amount paid per claim. These case studies discuss the situation in each state.

This study on Indiana focuses on the views of various interest groups on perceived problems, actions taken by the state to deal with the problems, the results of these actions, and the need for federal involvement. A summary of the findings for all six case studies can be found in our overall report, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, December 31, 1986).

Richard L. Fogel
Assistant Comptroller General
for Human Resources Programs

Overview

Indiana officials generally believed that Indiana's Medical Malpractice Act of 1975 and subsequent amendments have greatly stabilized the state's malpractice insurance situation over the past 11 years by holding down premium costs and attracting additional companies into the market. They support these views by pointing out that the cost of insurance for Indiana physicians and hospitals is among the lowest in the nation,[1] compared to the mid-1970's, when it was higher than most neighboring states. In addition, they pointed out that the Rockwood Insurance Company, the Pennsylvania Hospital Insurance Company, and the Physicians Insurance Company of Indiana entered the Indiana medical malpractice market in 1978, 1981, and 1982, respectively, which helped ensure the continued availability of insurance at competitive prices.

Indiana officials also commented that the leading physician medical malpractice insurer had no rate increases from January 1, 1975, until July 1985, when the rate increased by 12 percent. However, most physician insurers increased their premiums in 1985. For example, the Department of Insurance reported rate increases in 1985 ranging from 12 to 76 percent.

A key provision of the act was the establishment of a Patient's Compensation Fund to pay malpractice awards or settlements in excess of $100,000 up to a $500,000 cap. To participate, physicians and hospitals pay a surcharge based on the premiums paid to their insurance companies for the basic coverage.

Indiana officials were concerned that the increasing number and size of payments from the Fund might adversely affect its solvency. For example, claims paid by the Fund increased from 11 in 1980 to 36 in 1985, while amounts paid increased from $3.9 million to $11.7 million. The surcharge rate increased from 50 percent in April 1984 to 100 percent in April 1986. According to the consulting actuary for the Indiana Department of Insurance, the Fund had accrued $90 million in unfunded liabilities as of December 31, 1985. If this trend continues, further increases in the surcharge may be needed.

Our consulting actuary noted that because of the normal development pattern of payouts, increases in the number of claims paid and the total amount paid out by the Fund during this period would have been

[1]See Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112), September 15, 1986, pp.31-34, 60-69.

expected. He added that since the fund was established on a pay-as-you-go basis, increases in the surcharge rate would have been expected as the number of claims and total amount paid out increased.

According to the Department of Insurance, the state Patient's Compensation Fund was kept solvent in 1984 only by a transfer of $7.2 million from the reserves of the state's medical malpractice joint underwriting association.

Several actions have been taken in recent years to strengthen the Fund's ability to remain solvent. These actions include (1) increasing surcharges, (2) allowing the Department of Insurance to hire private-sector lawyers and other personnel to help defend claims against the Fund, and (3) permitting periodic payments in lieu of lump-sum payments.

While many state officials believed that Indiana's legislation has benefitted the state's malpractice situation, the state's trial lawyers have expressed the view that injured parties have lost certain rights. They are principally concerned that the $500,000 cap on total awards may be insufficient to compensate some individuals who sustain major injuries from malpractice incidents. The Trial Lawyers Association believes that Indiana's cap should be raised to at least $1 million per claim and that insurance companies should be required to accept liability for the first $200,000 of each claim and the Patient's Compensation Fund the remainder.

Contents

Figures

Indiana: Low Rates but Solvency of State Patient's Compensation Fund a Concern

Background

Population, Physician, and Hospital Characteristics

Almost two-thirds of Indiana's 5.5 million people live in urban areas.[2] Indiana is the 14th most populous state. Indiana had 8,542 physicians as of December 31, 1985,[3] and 116 nonfederal community hospitals with 24,696 available beds in 1984.[4] A total of 7,270 physicians were providing patient care—5,904 were office-based and 1,366 were hospital-based. Table 1 shows the distribution of patient care physicians among 13 selected specialties:

Table 1: Number of Nonfederal Patient Care Physicians in Indiana in Selected Specialties as of December 31, 1985

		Hospital-based practice		
	Office-based practice	Residents	Full-time physician staff	Total
General practice	1,562	206	51	1,819
Internal medicine	661	192	30	883
Pediatrics	299	65	28	392
Psychiatry	188	34	56	278
Pathology	149	31	40	220
Radiology	159	0	16	175
Ophthalmology	204	25	1	230
General surgery	453	88	14	555
Anesthesiology	334	82	21	437
Plastic surgery	38	3	0	41
Orthopedic surgery	234	30	5	269
Obstetrics/gynecology	352	57	6	415
Neurosurgery	45	7	4	56

Of Indiana's community hospitals, 60 were nongovernment, not-for-profit; 52 were state and local government institutions; and the remaining four were investor-owned. Sixty-nine percent of the state's hospital beds were located in nongovernment, not-for-profit hospitals; 28 percent in state and local government hospitals; and 3 percent in investor-owned hospitals. The most prevalent hospital size was 50 to 99

[2]Population and ranking are as of July 1, 1984 (preliminary), and the urban/rural mix is as of April 1, 1980, from the Statistical Abstract of the United States 1986, 106th Edition, pp. 10, 12.

[3]Physician Characteristics and Distribution in the U.S., 1986 Edition, Department of Data Release Services, Division of Survey and Data Resources, American Medical Association (forthcoming).

[4]Hospital Statistics, 1985 Edition, American Hospital Association, p. 70.

beds. However, the 36 hospitals of this size accounted for only 11 percent of the hospital beds. Indiana has 1 . hospitals with more than 500 beds each, which accounted for 30 percent of the hospital beds in the state The occupancy rate of the state's community hospitals averaged 68 percent for 1984.

Regulation of Insurance Rates and Description of Medical Malpractice Insurers

Indiana is a "file and use" state. Companies must file proposed rate changes with the Department of Insurance before they become effective; however, prior approval is not required before the effective date. State Department of Insurance officials advised us that the highly competitive insurance situation in Indiana has kept rates low and has made their regulatory responsibilities easier. These officials stated that most of their effort is directed toward ensuring that the rates are not discriminatory and that they are adequate to ensure each company's continued solvency without being excessive.

The Medical Protective Insurance Company insures over 70 percent of the physicians in the state. The remainder are insured by either the St. Paul Fire and Marine Insurance Company (St. Paul Company), the Physician's Insurance Company of Indiana, or the Rockwood Insurance Company (Rockwood). The three companies participating in our study[6] insured over 85 percent of the physicians seeking malpractice insurance in the state.

The Pennsylvania Hospital Insurance Company and the St. Paul Company were the two major insurers of Indiana hospitals, and they both participated in our study.[6] Rockwood also insures some hospitals in the state.

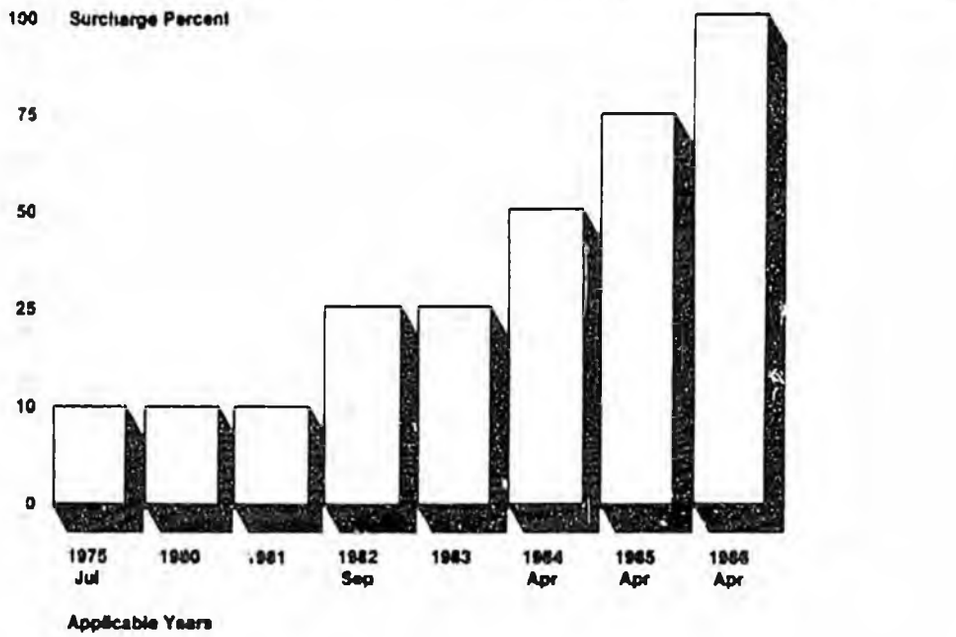
The Pennsylvania Hospital Insurance Company and the St. Paul Company insure over 70 percent of total occupied hospital beds in Indiana. If the self-insured occupied hospital beds are not considered as part of the insurance market, the two companies insure over 90 percent of the beds.

Indiana's Patient's Compensation Fund, created by the medical malpractice legislation of 1975, is a major source of insurance for both physicians and hospitals in the state. At the time of our review, Indiana officials stated that virtually all of the state's physicians and hospitals

[6]See appendix I for a list of malpractice insurers requested to provide data for Indiana.

were voluntarily participating in the Fund. To participate, each physician and hospital is assessed a surcharge. The surcharge remained constant at 10 percent of the premium paid by the provider for basic coverage from July 1975 through August 1982. However, since September 1982, the surcharge rate has increased four times to reach its current rate of 100 percent. Figure 1 shows the changes in the Fund surcharge rate.

Figure 1: Surcharge Rate of the Indiana Patient's Compensation Fund, 1975-86



Medical Malpractice Situation in the Mid-1970's

In the mid-1970's, Indiana's health care system was approaching a crisis due to the increasing number of medical malpractice suits being filed and the large amounts of damages being awarded for such suits. The Indiana Medical Malpractice Commission reported that between 1970 and 1975, the frequency of claims filed against physicians had increased by 42 percent, and the average damage award had increased from $12,993 to $34,297. The Indiana Medical Malpractice Study Commission also reported that physicians' medical malpractice insurance premiums increased by 410 percent from 1970 to 1975. During this period, 7 of the 10 primary medical malpractice insurance companies in Indiana stopped writing new policies, canceled policies, or limited their new business and

their liability. As a result, many physicians were left with inadequate malpractice insurance coverage, or no coverage at all.

The insurance availability crisis was also affecting the practice of medicine. For example, some primary care physicians opted for early retirement, while others stopped doing the more complicated procedures that entailed greater risks. Hospitals discontinued some emergency services and canceled some types of surgery due to threat of malpractice claims. The increasing threat of medical malpractice suits, coupled with the decreasing availability of medical malpractice insurance, had begun to adversely affect how and what type of medical care was provided to patients.

Response to Problems

To ensure the continuation of medical services in Indiana, the state legislature passed the Medical Malpractice Act of 1975 on April 4, 1975. The bill was signed into law on April 24 and became effective on July 1, 1975. This was the first comprehensive malpractice statute in the nation. The Indiana Supreme Court has upheld the constitutionality of key aspects of the legislation given that its goal is to protect the health of the citizens of Indiana by preventing a reduction of health care services. These key aspects include (1) placing limits on recoverable amounts, (2) establishing the Patient's Compensation Fund, (3) setting a statutory time limit for filing malpractice claims, and (4) requiring submission of claims to medical review panels.

Limits on Recoverable Amounts

Indiana's Medical Malpractice Act of 1975 limits the total amount recoverable for any patient injury or death to $500,000. This limit applies to any and all damages, including pain and suffering, economic losses, and the cost of future medical care. The Indiana Supreme Court has held that the limitation on recovery was a reasonable means to achieve the goals of securing medical malpractice insurance availability and assuring that medical practitioners continue practicing in Indiana.

State Patient's Compensation Fund

Indiana's Medical Malpractice Act created the Fund, in which surcharges are collected from health care providers to pay claims filed for amounts greater than $100,000. The Fund receives no funds appropriated by the legislature or tax dollars, and all administrative expenses are paid from the Fund. The Department of Insurance may use money from the Fund to retain risk managers, defense counsel, and financial

advisors. Claims against the Fund are either settled by negotiation or may be litigated in court.

The cost of a patient's award is apportioned between the health care providers (or their insurers) and the state-run Fund. As a condition of participation in the Fund, health care providers are required to purchase basic coverage ($100,000/$300,000 for physicians; $100,000/$2 million for hospitals under 100 beds and $100,000/$3 million for hospitals of 100 beds or more) or prove self-insurability. To recover more than $100,000, the plaintiff must file a claim against the Fund. Claims against the Fund may be litigated only as to the amount of damages as the liability is established either by litigation or settlement against the individual health care provider or his insurer on the initial $100,000 of liability.

Statute of Limitations

Indiana's statute of limitations requires claims to be made within 2 years of the alleged act, omission, or neglect. Minors alleging injury at any time before their sixth birthday have until their eighth birthday to file a claim. According to an Indiana Hospital Association official, the courts of Indiana have held this statute runs from the time of alleged incident rather than from the date of discovery. Officials of the Indiana Medical Association and a malpractice insurer stated that this shortened period enables insurers in Indiana to better defend malpractice claims by reducing many of the problems caused by the long periods which may elapse between the incident and the claim and between the claim and its closure.

Medical Review Panels

Indiana's Medical Malpractice Act provides for the establishment of panels to review all proposed malpractice complaints against health care providers before the claim can be filed in court. A panel is composed of a health care provider selected by the plaintiff, a health care provider selected by the defendant or defendants, and a third health care provider selected by the first two panel members. The panel is chaired by an attorney, who is charged with advising panel members on legal matters and drafting the panel's final opinion, but he has no vote on the final opinion. The panel's sole duty is to consider evidence submitted by both parties and to express an opinion as to whether the defendant(s) acted or failed to act within the appropriate standards of care as charged in the complaint. The panel opinion is not binding upon any party, but it may be admitted into evidence by either side if litigation results. The aim of the panels is to reduce nuisance suits and to avoid

lawsuits whenever possible by advocating quicker settlements of claims outside of the court system.

Claims Reporting

Under Indiana's Medical Malpractice Act, all malpractice claims settled or adjudicated against a health care provider (including hospitals) must be reported to the Department of Insurance. The department must then report claims against individual practitioners to the Medical Licensing Board and other licensing authorities of the state. This board may then review the health care provider's fitness to remain in practice and censure, place on probation, suspend, or revoke the provider's license.

Indiana's Medical Malpractice Act also

- established the Indiana Residual Malpractice Insurance Authority to provide liability insurance to physicians unable to obtain it from commercial insurers, commonly referred to as a joint underwriting association;
- precluded inclusion of dollar amounts in medical malpractice pleadings; and
- limited attorney's fees to 15 percent of any recovery from the Patient's Compensation Fund.

Recent Changes to Indiana's Medical Malpractice Act

In the last 2 years, the Indiana legislature enacted the following changes:

- Allowed the Fund and insurers to use periodic payments in lieu of lump-sum payments in paying awards or settlements to the claimant.
- Permitted Fund dollars to be used to purchase the services of persons, firms, and corporations to aid in protecting the fund against claims.
- Allowed the Fund to make payments to claimants twice a year (January 15 and July 15) instead of only once a year.
- Raised the Fund's annual surcharge rate in April 1985 to 75 percent of the cost of needed medical malpractice insurance and to 100 percent in April 1986.
- Required a health care provider's insurer to notify the insurance commissioner of any malpractice case upon which it has placed a reserve of $50,000 or more.
- Allowed a patient to commence court action against a provider for malpractice without a Panel opinion as long as damages sought are no greater than $15,000.

- Allowed defendants to introduce evidence to the jury that a plaintiff received reimbursement of costs from other sources.

Effect of Indiana Tort Reforms

Officials of Indiana's Medical Association, Hospital Association, Bar Association, and leading malpractice insurers believe that Indiana's tort reforms have greatly stabilized Indiana's medical malpractice situation over the last 11 years. Regarding specific provisions of the act, three or more interest groups believed the limitation on total size of awards/settlements and the use of pretrial screening panels had a major stabilizing effect.[6]

Four of the six interest groups believed that Indiana's $500,000 statutory limit on the recoverable amount for medical malpractice awards/settlements had a major effect on decreasing the size of awards/settlements. As pointed out by an Indiana Medical Association official, the limit has precluded any million-dollar settlements. Officials of a large malpractice insurance company added that the limit on awards, along with Indiana's pretrial screening panels, had helped keep the legal costs associated with defending malpractice claims in Indiana well below those for the rest of the country. However, the Indiana Trial Lawyers Association believed that the $500,000 limit deprives severely injured patients of fair compensation.

Three of the six interest groups believed there had been some major effect from the act's provision requiring claims in excess of $15,000 to obtain a medical review panel opinion before any court action. The physician group, Indiana Bar Association, and Indiana Department of Insurance agreed that the panel process had decreased the number of claims that go to trial. The Indiana Medical Association stated that the panel process substantially decreases the number of claims going to trial and decreases the time required to close claims. According to officials of a large Indiana malpractice insurance company, only 2 percent of claims filed against the company go to court. They stated that such a low percentage of claims going to court can be attributed to Indiana's panel process. This company also attributed its much lower legal costs to defend claims in Indiana to the panel process. For example, according to company officials, the company's average cost of defending a claim in Indiana is about $2,100 versus about $10,000 in Michigan and Illinois.

[6]Our methodology for obtaining the views of major interest groups and for analyzing their responses is described in GAO/HRD-87-21, pp. 10-11. The specific interest groups for Indiana are presented in appendix II of this report.

Key Indicators of the Situation Since 1980

Malpractice insurance premiums for physicians and hospitals have risen during the last 6 years. Most of the increases occurred in 1985 and 1986 and resulted primarily from increases in the Fund surcharge rate as the Fund experienced a dramatic increase in both the number of claims and total amount paid. From 1980 through 1984, frequency of claims against physicians almost doubled, but the average paid claim decreased slightly. The frequency of claims against hospitals increased only slightly from 1981 to 1984; however, the average paid claim increased by 57 percent. Insurers' average costs to investigate and defend claims increased by 18 percent over this period for claims against physicians and 19 percent for claims against hospitals.

Physicians

Cost of Malpractice Insurance

As of January 1, 1986, there was a wide variation in malpractice insurance rates among different physician specialties in Indiana. For example, The Medical Protective Company's annual premium, including the Fund surcharge, ranged from $1,293 for the specialties of general practice (no surgery), internal medicine (no surgery), pediatrics (no surgery), and pathology to $11,380 for obstetrics/gynecology and neurosurgery.

The rate of increase in medical malpractice premiums has not been uniform among physician specialties. High-risk specialties, such as neurosurgery and obstetrics/gynecology, have experienced the highest percentage increases. As shown in table 2, the increases in premiums (including the Fund surcharge) from 1980 to 1986 ranged from 53 percent for ophthalmology to 116 percent for obstetrics/gynecology.

Table 2: Cost of Insurance[a] for Selected Specialties, 1980 and 1986

Specialty	Insurance rate plus Fund surcharge 1980	1986	Percent increase 1980-1986
General practice (no surgery)	$725	$1,293	78
Internal medicine (no surgery)	725	1,293	78
Pediatrics (no surgery)	725	1,293	78
Pathology	725	1,293	78
General practice (minor surgery)	1,208	2,328	93
Internal medicine (minor surgery)	1,208	2,328	93
Pediatrics (minor surgery)	1,208	2,328	93
Radiology	1,208	2,328	93
Psychiatry	1,208	2,328	93
Ophthalmology/surgery	2,120	3,234	53
General surgery	4,973	7,760	56
Anesthesiology	4,973	7,760	56
Plastic surgery	5,271	9,312	77
Orthopedic surgery	5,798	10,605	83
Obstetrics/gynecology	5,271	11,380	116
Neurosurgery	5,798	11,380	96

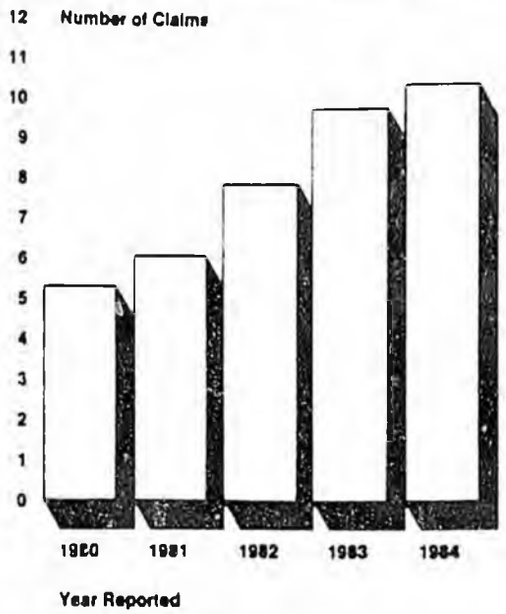
[a]Rates shown are those of The Medical Protective Company for a $100,000/$300,000 occurrence policy plus the Fund surcharge as of January 1 each year. Total coverage is $500,000/unlimited for providers participating in the Fund. Under an occurrence policy, the insurance company is liable for any incidents that occurred during the period the policy was in force, regardless of when the claim may be filed

The St. Paul Company and the Physicians Insurance Company of Indiana increased their rates by an average overall increase of 76 percent and 17 percent, respectively, during 1985, according to the Department of Insurance. It should be noted, however, that this represented the first increase for the latter company since it began providing medical malpractice insurance on July 1, 1982.

Frequency of Claims

The claims experience for The Medical Protective Company and the St. Paul Company indicated that the frequency of claims filed (per 100 physicians) for all physicians increased each year from 1980 to 1984. As shown in figure 2, the frequency of claims filed against physicians insured by these companies almost doubled from— 5.3 in 1980 to 10 2 in 1984.

Figure 2: Frequency of Claims per 100 Physicians, 1980-84



These data also showed variations in the frequency of claims filed (per 100 physicians) among the selected specialties. As shown in table 3, the frequency of claims for the majority of specialties fluctuated from year to year. For example, the frequency of claims for general surgery increased from 12.0 in 1980 to 21.2 in 1981 and then remained relatively constant through 1984. For orthopedic surgery and obstetrics/gynecology, however, the frequency of claims increased dramatically between 1980 and 1984, 159 and 251 percent, respectively. The frequency of claims for the remaining specialties fluctuated from year to year but, with the exception of plastic surgery, each had more reported claims in 1984 than in 1980.

Table 3: Frequency of Claims per 100 Physicians for Selected Specialties, 1980-84

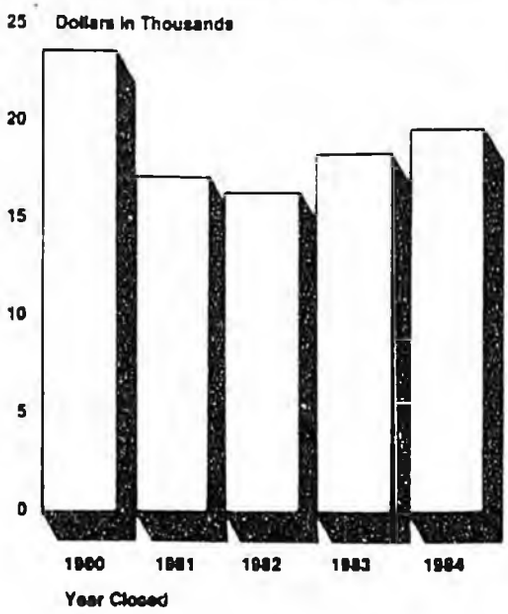
Specialty	1980	1981	1982	19_3	1984	Percent increase (1980-1984)
General practice	1.0	3.9	3.3	4.1	4.3	330
Internal medicine	2.7	1.8	4.4	5.6	4.2	56
Pediatrics	1.7	1.2	2.4	3.9	5.5	224
General surgery	12.0	21.2	19.8	19.4	19.3	61
Neurosurgery	23.7	19.2	30.2	36.6	24.5	3
Ophthalmology/surgery	6.8	4.0	7.2	6.1	9.1	34
Orthopedic surgery	13.2	16.9	24.4	33.5	34.2	159
Plastic surgery	25.1	37.0	9.6	44.9	18.1	(28)
Obstetrics/ gynecology	9.5	14.5	21.6	26.8	33.3	251
Radiology	2.9	2.7	6.3	3.2	5.7	97
Psychiatry	1.8	3.0	0.6	5.2	5.2	189
Anesthesiology	3.7	5.8	7.3	6.1	5.9	59
Pathology	0	1.5	0.9	2.4	2.5	[a]

[a]Cannot compute due to zero value in 1980.

Size of Awards/Settlements

The average size of awards/settlements (average paid claim) for all physicians fluctuated somewhat. For example, figure 3 shows the paid claims experience of The Medical Protective Company and the St. Paul Company. The average paid claim in 1984 was smaller than it was in 1980.

Figure 3: Average Paid Claim[a] for Physicians, 1980-84



[a]Each indemnity payment limited to $100,000.

As shown in table 4, no clear trend is evident in the average paid claim for the selected specialties. Because the number of physicians in any one specialty is relatively small, the base of spreading total claims paid is small. As a result, a few large claims paid in a given year for a given specialty could have a significant effect on the average paid claim for that specialty that year.

Table 4: Average Paid Claim for Selected Specialties, 1980 and 1984

	1980	1984
All Physicians	$23,801	$19,510
Specialty		
General practice	2,337	14,679
Internal medicine	50,500	20,286
Pediatrics	17,250	15,214
General surgery	22,214	29,208
Neurosurgery	3,750	17,565
Ophthalmology/surgery	0	26,516
Orthopedic surgery	74,167	30,677
Plastic surgery	5,333	0
Obstetrics/ gynecology	6,021	18,772
Radiology	5,750	21,083
Psychiatry	1,625	600
Anesthesiology	31,909	15,450
Pathology	0	4,909

Cost to Investigate and Defend Claims

The average cost to investigate and defend claims against Indiana physicians, based on the experience of The Medical Protective Company and the St. Paul Company, increased from $3,012 in 1980 to $3,567 in 1984—an increase of 18 percent.

Nine percent of the malpractice claims closed against physicians in 1984 involved no expense to the insurer. Forty-three percent of the claims were closed with an indemnity payment, while 49 percent were closed with costs only for investigating and defending the claim. The percentage of the latter remained about the same in 1984 compared to 1980. Over the same period, however, the percentage of claims closed with indemnity payment rose from 37 to 43 percent and the percentage of claims closed with no expense dropped from 13 to 9 percent.

Hospitals

Cost of Malpractice Insurance

As shown in table 5, the estimated malpractice insurance costs for hospitals in Indiana[7] increased from $6.6 million in 1983 to $9.4 million in 1985—an increase of 42 percent.

[7]See GAO/HRD-87-21, p. 11, for methodology for obtaining and analyzing hospital cost data. See appendix III of this report for information on the number of Indiana hospitals in the universe, GAO's sample, and the survey response. Unless otherwise indicated, the estimates presented in this study are also included with sampling errors in tables IV.1 through IV.6.

Table 5: Estimated Hospital Malpractice Insurance Costs by Type of Expenditure, 1983-85

Dollars in millions

Expenditure	1983	1984	1985	1983-85 increase[a] Amount	Percent
Total	**$6.6**	**$7.1**	**$9.4**	**$2.8**	**42**
Contributions to self-insurance trust funds	0.7	0.8	1.6	0.9	129
Premiums for purchased insurance	5.8	6.1	7.6	1.8	31
Uninsured losses	0.1	0.1	0.1	0.0	0

[a]Sampling errors for the amount and percentage of increase are not presented in appendix IV but they are comparable to the errors for the estimated costs.

Note: Detail may not add to total due to independent estimation.

In 1985, 57 percent of the hospitals had annual malpractice insurance costs of less than $50,000, as shown in table 6. No Indiana hospital had annual insurance costs of $1 million or more in 1983 or 1985.

Table 6: Estimated Distribution of Annual Malpractice Insurance Costs for Hospitals, 1983 and 1985

Annual costs	1983 No.	1983 Percent	1983 Cum. percent	1985 No.	1985 Percent	1985 Cum. percent
Less than $10,000	8	9.6	9.6	6	7.0	7.0
$10,000 to $24,999	27	31.9	41.5	18	20.9	27.9
$25,000 to $49,999	14	16.5	58.0	25	28.7	56.6
$50,000 to $99,999	13	15.1	73.1	6	7.5	64.1
$100,000 to $249,999	20	22.8	95.9	23	27.0	91.1
$250,000 to $499,999	2	2.8	98.7	4	4.3	95.4
$500,000 to $999,999	1	1.4	100.1[a]	4	4.5	99.9[a]
$1 million or more	0	0.0	•	0	0	•
Total	**85[a]**	**100.1[a]**		**86**	**99.9[a]**	

[a]Detail does not add to adjusted universe or 100 percent due to independent rounding.

Note: The total number of hospitals each year is based on the number of responding hospitals that provided the relevant data for that year.

As shown in table 7, the estimated average malpractice insurance cost per inpatient day increased 89 percent from 1983 to 1985. The average annual cost per bed increased 72 percent for the same period.

Table 7: Estimated Average Hospital Malpractice Insurance Costs per Inpatient Day and per Bed,[a] 1983-85

	1983	1984	1985	1983-85 increase[b] Amount	Percent
Average malpractice cost per inpatient day	$1.41	$1.73	$2.67	$1.26	89
Average annual malpractice cost per bed	$426	$489	$732	$306	72

[a]To determine the average annual malpractice cost per bed, we computed the daily occupied bed rate (the total number of inpatient days divided by 365) and increased that number by one bed for every 2,000 outpatient visits (emergency room visits were counted as outpatient visits). This number was divided into the hospital's total annual malpractice insurance cost.

[b]Sampling errors for the amount and percentage of increase are not presented in appendix IV, but they are comparable to the errors for the estimated costs.

As table 8 shows, from 1983 to 1985, 51 percent of Indiana's hospitals had increases in malpractice insurance costs per inpatient day ranging from 10 to 99 percent. Twenty-seven percent had increases between 100 and 199 percent, while 14 percent had increases of 200 percent or more.

Table 8: Estimated Distribution of Changes in Malpractice Insurance Costs per Inpatient Day From 1983 to 1985

		Hospitals	
Percentage change	Number	Percent	Cum. Percent
Increases of less than 10 percent or all decreases	6	7.4	7.4
+10 to 49	20	23.4	30.8
+50 to 99	24	28.0	58.8
+100 to 199	23	27.1	85.9
+200 to 299	9	10.9	96.8
+300 or more	3	3.2	100.0
Total	**85**	**100.0**	

Note: The total number of hospitals is based on the number of responding hospitals that provided data for both 1983 and 1985 so that the percent change could be calculated.

Malpractice Insurance Rates for Hospitals

The Pennsylvania Hospital Insurance Company, Indiana's leading insurer of hospitals, increased its rates for a $100,000/$3 million occurrence policy[8] from $286 per bed in 1981 to $382 in 1986—34 percent.

[8]Under an occurrence policy, the insurance company is liable for any incidents that occurred during the period the policy was in force, regardless of when the claim may be filed.

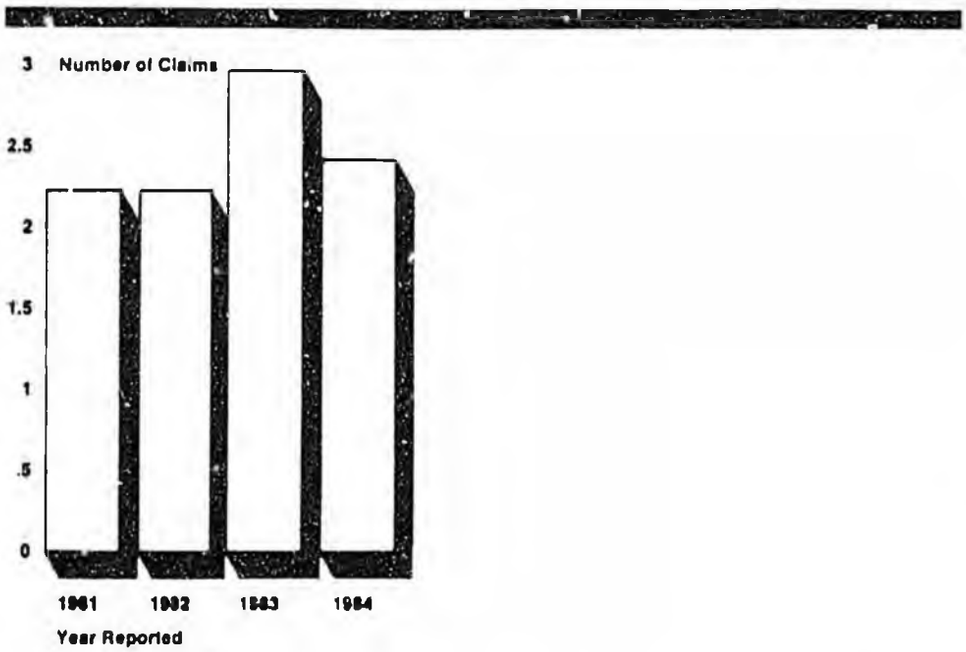
The St. Paul Company's rates for hospital malpractice insurance increased from $230 per bed in 1980 to $361 in 1986—57 percent—for a claims-made policy[9] with the same coverage limits.

With the surcharge added, the Pennsylvania Hospital Insurance Company's rates increased 112 percent—from $315 in 1981 to $669 in 1986—and the St. Paul Company's rate increased 150 percent—from $253 in 1980 to $632 in 1986.

Frequency of Claims

The combined claims experience of the Pennsylvania Hospital Insurance Company and the St. Paul Company shown in figure 4 indicated that the frequency of malpractice claims filed per 100 occupied beds in the state increased from 2.2 to 2.4 during the period 1981-84.

Figure 4: Frequency of Claims per 100 Occupied Hospital Beds, 1981-84

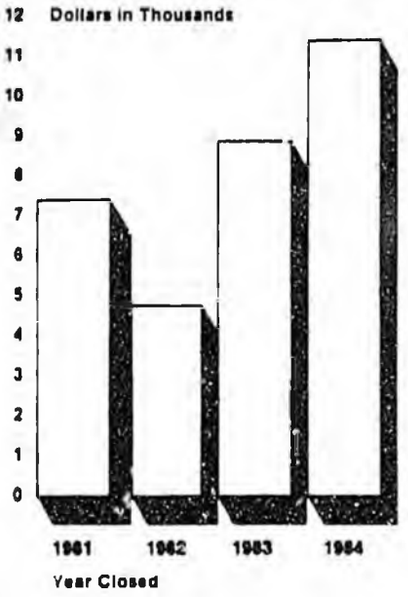


Size of Awards/Settlements

Based on the combined claims experience of these two insurers, the average paid claim against Indiana hospitals increased from $7,146 in 1981 to $11,244 in 1984, as shown in figure 5.

[9]A claims-made policy covers malpractice events that occur after the effective date of the coverage and for which claims are made during the policy period.

Figure 5: Average Paid Claim[a] for Hospitals, 1981-84



[a]Each indemnity payment limited to $100,000.

Cost to Investigate and Defend Claims

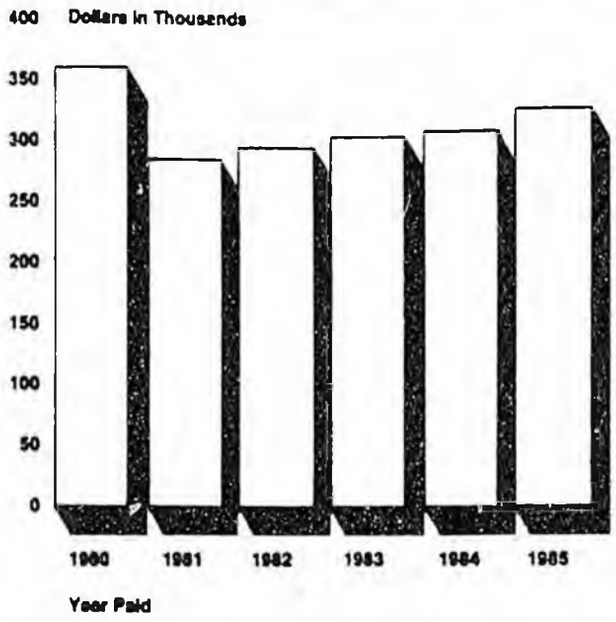
Based on the claims experience of the Pennsylvania Hospital Insurance Company and the St. Paul Company, the average cost to investigate and defend claims against Indiana hospitals increased by 19 percent, from $1,075 in 1981 to $1,275 in 1984.

Thirty-five percent of the malpractice claims closed against hospitals in 1984 involved no expense to the insurer. Thirty percent of the claims were closed with an indemnity payment, while 36 percent were closed with costs only for investigating and defending the claim. Between 1981 and 1984, the percentage of claims closed with costs only for investigating and defending the claim increased from 28 to 36 percent, while the percentage of claims closed with no expense dropped from 46 to 35 percent. The claims closed with indemnity increased from 26 to 30 percent during this period.

Claims Against the Indiana Patient's Compensation Fund

Between 1980 and 1984, the Fund experienced a significant increase in the number and amount of claims paid. Specifically, the Fund paid $3.9 million for 11 claims in 1980 versus $17.7 million for 57 claims in 1984, and then decreased to $11.7 million for 36 claims in 1985. The average amount paid for each claim closed against the Fund decreased from $354,545 in 1980 to $325,417 in 1985. However, as shown on figure 6, the average paid claim by the Fund has increased each year since 1981, from $281,786 to $325,417 in 1985—a 15-percent increase.

Figure 6: Average Paid Claim by the Indiana Patient's Compensation Fund, 1980-85



Major Medical Malpractice Problems—Current and Future

Major current or future concerns identified by the Indiana Hospital Association, the Indiana Trial Lawyers Association, and the Indiana Department of Insurance included

- medical societies not taking remedial action (e.g., sanctions or disciplinary measures) against members with malpractice histories; and
- physician specialty boards not taking remedial action against physicians with malpractice histories; and
- peer review groups not taking remedial action against physicians or hospitals with malpractice histories.

An Indiana Hospital Association official commented that effective sanctions against incompetent physicians have been marginal to nonexistent, and physicians are usually disciplined by the state's medical licensing board only for immoral or dishonest acts.

The president of the Indiana Trial Lawyers Association said there are no self-regulating actions by physician or hospital groups to reduce medical malpractice events. He was of the opinion that something similar to the State Bar Association's Attorney's Disciplinary Committee, which conducts hearings, disciplines, reprimands, and/or disbars lawyers, as necessary, is needed.

The Solvency of the Patient's Compensation Fund

Officials from each of the six interest groups[10] expressed major concerns about the continued solvency of the Fund and the large surcharge increases needed to keep the Fund intact. In the last 2 years, the Indiana legislature has enacted several changes designed to aid the Fund, but officials still foresee future problems for the Fund.

An Indiana Bar Association official said the Fund was not set up to be actuarially sound and that payments have caught up with and exceed the amount set aside to handle claims. In fact, according to the Department of Insurance, the Fund was kept solvent in 1984 by the transfer of $7.2 million of reserves from the state's medical malpractice joint underwriting association known as the Indiana Residual Malpractice Insurance Authority. According to the consulting actuary for the Indiana Department of Insurance, the Fund had accrued $90 million in unfunded liabilities as of December 31, 1985.

Solutions to Malpractice Problems

State actions to strengthen licensing and relicensing for physicians was the most widely supported action among the six groups we surveyed in Indiana. Specifically, the physician group, the Indiana Hospital Association, the Indiana Bar Association, the Indiana Trial Lawyers Association, and the State Department of Insurance firmly supported stronger physician licensing and relicensing practices at the state level. An official of the Department of Insurance commented that Indiana's Medical Licensing Board is doing more now than 5 years ago, but there still needs to be more disciplining of the medical profession. An Indiana Bar Association official said the Medical Licensing Board should be given more power to monitor the quality of practicing physicians.

[10]The specific interest groups for Indiana are listed in appendix II of this report.

Indiana's Hospital Association, Bar Association, Trial Lawyers Association, and Department of Insurance supported state action to increase peer review of physicians' medical practices. An Indiana Trial Lawyers Association official believed peer review practices should be taught in the medical educational process. An Indiana Bar Association official also expressed the view that there was a need for more physician education about peer review and more emphasis on physicians monitoring other physicians.

Significant support existed for state use of pretrial screening panels, such as the medical review panel currently in place in Indiana. Indiana's physician group, Bar Association, malpractice insurers, and Department of Insurance supported the use of pretrial screening panels. An Indiana Bar Association official added that pretrial screening panels greatly reduce the number of claims going to court.

Indiana's Bar Association, Trial Lawyers Association, and Department of Insurance strongly supported state actions to increase the amount of information available to consumers about physicians and hospitals with medical malpractice histories. An Indiana Trial Lawyers Association official remarked that consumers should be provided more information regarding incompetent doctors but that this is difficult and he is unsure of how this could be done. An Indiana Bar Association official added that information should be available to consumers to demonstrate that physicians can make mistakes and are not "God-like."

Role of the Federal Government

None of the six interest groups in Indiana expressed strong support for any form of federal intervention because they felt these problems can best be addressed at the state level.

Medical Malpractice Insurers Requested to Provide Statistical Data for Indiana

	Provided data for		Did not provide requested data
	Physicians	Hospitals	
The Medical Protective Company	X		
Pennsylvania Hospital Insurance Company		X	
Physicians Insurance Company of Indiana	X[a]		
Rockwood Insurance Company			X
St. Paul Fire and Marine Insurance Company	X	X	

[a]Data not included in our data base due to several missing data elements.

Organizations Receiving GAO Questionnaire for Indiana

Completing questionnaire	Not completing questionnaire
Physician group:	
Indiana State Medical Association	Indiana Chapter of the American College of Physicians and Surgeons
Indiana Association of Pathologists, Inc.	Indiana Chapter, American Academy of Pediatrics
Indiana Psychiatric Society	
Indiana Roentgen Society, Indiana Chapter of American College of Radiology	
Indiana Section, American College of Obstetrics and Gynecology	
Indiana Orthopedic Society	
Indiana Academy of Ophthalmology	
Indiana Academy of Family Physicians	
Hospital association:	
Indiana State Hospital Association	
Bar association:	
Indiana Bar Association	
Trial lawyers:	
Indiana Trial Lawyers Association	
Malpractice insurers:	
The Medical Protective Company The Physicians Insurance Company of Indiana	St. Paul Fire and Marine Insurance Company Rockwood Insurance Company of Indiana Pennsylvania Hospital Insurance Company
Insurance department:	
Indiana Department of Insurance	

Number of Indiana Hospitals in the Universe, GAO Sample, and Survey Response

Number of hospitals		Hospitals completing questionnaire	
Universe[a]	Sample	Number	Percent
115	64	50	78

[a]1983 data.

Estimated Hospital Data and Related Sampling Errors for Policy Years 1983, 1984, and 1985

Table IV.1: Hospital Malpractice Insurance Costs and Related Sampling Errors by Type of Expenditure

Dollars in millions

	1983		1984		1985	
Expenditure	Amount	Sampling error[a]	Amount	Sampling error[a]	Amount	Sampling error[a]
Total cost	**$6.6**	**$.8**	**$7.1**	**$.8**	**$9.4**	**$1.2**
Contribution to self-insurance trust funds	.7	6	.8	.5	1.6	1.0
Premiums for purchased insurance	5.8	7	6.1	8	7.6	8
Uninsured losses	.08	05	13	08	.13	07

[a]Sampling errors are stated at the 95-percent confidence level.

Note: Detail may not add to total due to independent estimation. The adjusted universe of hospitals to which the estimated amounts related was 86 for 1983, 1984, and 1985. The adjusted universe is that portion of the total universe based on the sample response rate for which we can estimate data.

Table IV.2: Distribution of Annual Malpractice Insurance Costs and Related Sampling Errors for Hospitals

Figures in percents

	1983		1985	
Annual cost	Hospitals	Sampling error[a]	Hospitals	Sampling error[a]
Less than $10,000	9.6	3.7	7.0	0.0
$10,000 to $24,999	31.9	8.0	20.9	6.8
$25,000 to $49,999	16.5	7.8	28.7	8.5
$50,000 to 99,999	15.1	5.3	7.5	4.4
$100,000 to $249,999	22.8	4.8	27.0	5.7
$250,000 to 499,999	2.8	1.4	4.3	2.0
$500,000 to $999,999	1.4	1.1	4.5	2.4
$1 million or more	0	0.0	0	0.0

[a]Sampling errors are stated at the 95-percent confidence level.

Note: The adjusted universe of hospitals was 86 in 1983 and 1985.

Table IV.3: Average Malpractice Insurance Costs per Inpatient Day and Related Sampling Errors

1983		1984		1985	
Cost per day	Sampling error[a]	Cost per day	Sampling error[a]	Cost per day	Sampling error[a]
$1.41	$.22	$1.73	$.29	$2.67	$.40

[a]Sampling errors are stated at the 95-percent confidence level.

Table IV.4: Average Annual Malpractice Insurance Costs per Bed and Related Sampling Errors

1983		1984		1985	
Cost per bed	Sampling error[a]	Cost per bed	Sampling error[a]	Cost per bed	Sampling error[a]
$426	$61	$489	$64	$732	$100

[a]Sampling errors are stated at the 95-percent confidence level.

Table IV.5: Distribution of Changes in Malpractice Insurance Costs per Inpatient Day From 1983 to 1985 and Related Sampling Errors

Figures in percents

Changes	Hospital	Sampling error[a]
Increases of less than 10% or decreases	7.4	4.6
Increases of 10% to 49%	23.4	7.8
Increases of 50% to 99%	28.0	8.9
Increases of 100% to 199%	27.1	9.6
Increases of 200% to 299%	10.9	7.1
Increases of 300% or more	3.2	2.2

[a]Sampling errors are stated at the 95-percent confidence level.

Note: The adjusted universe of hospitals was 85.

GAO

Report to [illegible] Requesters

FILE NO.
05-190.650-010

December 1986

MEDICAL MALPRACTICE

Case Study on California

GAO/HRD-87-21S-2

Preface

December 31, 1986

Representative John Edward Porter and Senator John Heinz, Chairman, Senate Special Committee on Aging, asked GAO to identify the actions taken by the states to address medical malpractice insurance problems and to determine changes in insurance costs, the number of claims filed, and the average amount paid per claim. These case studies discuss the situation in each state.

This study on California focuses on the views of various interest groups on perceived problems, actions taken by the state to deal with the problems, the results of these actions, and the need for federal involvement. A summary of the findings for all six case studies can be found in our overall report, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, December 31, 1986).

Richard L. Fogel
Assistant Comptroller General
for Human Resources Programs

Overview

California health care and insurance officials we contacted generally believe that the state's comprehensive 1975 medical malpractice legislation, which has survived numerous constitutional challenges, has helped to moderate increases in the cost of malpractice insurance and in the size of malpractice awards/settlements. Key provisions of the legislation are a $250,000 limit on awards for noneconomic damages, a fee schedule for plaintiff attorneys, and provisions for periodic payment of awards $50,000 or over for future damages. These officials told us that they expect the legislation to have a greater effect in the future since the California Supreme Court has upheld the major provisions as constitutional, and the U.S. Supreme Court has twice refused to hear cases regarding this legislation. Despite these efforts, however, physician and hospital malpractice premiums are continuing to rise, as are the number and size of malpractice claims and settlements.

The California Trial Lawyers Association believed the legislation has impaired the rights of the injured malpractice victim to receive fair compensation for injuries caused by health care providers' negligence.

California's health care providers and malpractice insurers still believe that there are major problems in the state regarding the high cost of malpractice insurance, the excessive size of malpractice awards/settlements, the high legal costs associated with defending claims, and the incentive to perform medically unnecessary procedures to reduce the risk of liability (i.e., defensive medicine).

There was no widespread support among the groups we surveyed for any federal involvement. Officials generally believed that malpractice problems should be addressed at the state level.

Contents

Figures

California: State Officials Believe Reforms Have Helped to Moderate Increases in Claims and Premiums

Background

Population, Physician, and Hospital Characteristics

California is the most populous state. Over 90 percent of its 25.6 million people live in urban areas.[1] California had 69,208 physicians as of December 31, 1985,[2] and 483 nonfederal community hospitals with 83,033 available beds in 1984.[3] A total of 55,936 physicians were providing patient care— 46,122 were office-based and 9,814 were hospital-based. Table 1 shows the distribution of patient care physicians among 13 selected specialties.

Table 1: Number of Nonfederal Patient Care Physicians in California in Selected Specialties as of December 31, 1985

		Hospital-based practice		
	Office-based practice	Residents	Full-time physician staff	Total
General practice	7,075	636	286	**7,997**
Internal medicine	7,193	1,672	382	**9,247**
Pediatrics	3,156	656	228	**4,040**
Psychiatry	3,110	482	429	**4,021**
Pathology	966	197	145	**1,308**
Radiology	1,025	56	109	**1,190**
Ophthalmology	1,592	138	17	**1,747**
General surgery	2,898	779	113	**3,790**
Anesthesiology	2,358	[illegible]08	171	**2,637**
Plastic surgery	549	[illegible]1	16	**606**
Orthopedic surgery	1,967	264	57	**2,288**
Obstetrics/gynecology	3,173	394	105	**3,672**
Neurosurgery	409	61	19	**489**

Of California's 483 community hospitals, 242 were nongovernment, not-for-profit hospitals; 101 were state and local government hospitals; and 140 were investor-owned (for-profit) hospitals. Sixty-one percent of the state's community hospital beds were in nongovernment, not-for-profit hospitals; 19 percent were in state and local government hospitals; and 20 percent were in investor-owned hospitals. The most prevalent hospital size in California was the 100- to 199-bed facility. The hospitals of

[1]Population and ranking are as of July 1, 1984 (preliminary), and the urban/rural mix is as of April 1, 1980, from the Statistical Abstract of the United States 1986, 106th Edition, pp. 10, 12.

[2]Physician Characteristics and Distribution in the U.S., 1986 Edition, Department of Data Release Services, Division of Survey and Data Resources, American Medical Association, (forthcoming)

[3]Hospital Statistics, 1985 Edition, American Hospital Association, p. 50.

that size accounted for 23 percent of the total community hospital beds. California had 13 community hospitals with more than 500 beds each, which accounted for about 11 percent of the state's community hospital beds. The occupancy rate for California community hospitals was 64 percent in 1984.

Regulation of Insurance Rates and Description of Medical Malpractice Insurers

California insurers are not required to obtain rate approval from the state insurance department, but they must provide rates and supporting information to the department if requested.

According to officials of the state insurance department, competition is keen among the physician-owned insurers, so availability of malpractice insurance is not a problem in California.

With about 22 percent of the physician market, the Doctors' Company is the leading medical malpractice insurer in California. Most physicians insured by the Doctors' Company are located in southern California. NORCAL Mutual Insurance Company is the leading medical malpractice insurer in northern California. NORCAL insures about 15 percent of the state's physicians. Two other companies that provided requested data were Physicians and Surgeons Underwriters Corporation and Cooperative of American Physicians, Inc. The Cooperative is a trust organization and is exempt from the state insurance department regulation. Two large insurers did not participate in our survey—Southern California Physicians Insurance Exchange in southern California and Medical Insurance Exchange of California in northern California. Agency officials we contacted agreed that the companies that participated in our survey would be representative of the physician medical malpractice market in California.

With respect to the malpractice insurance market for hospitals, the Farmers Insurance Group of Companies insured about 77 percent of the California hospitals in 1984. The St. Paul Fire and Marine Insurance Company (St. Paul Company) and the Association of California Hospital Districts also write malpractice insurance for California hospitals. All three companies participated in our survey.

Insurance companies in California use different rating territories. They vary among the insurance companies from as few as one to as many as five. The Doctors' Company uses three rating territories—northern California, southern California, and San Diego. The most predominately written coverage limits for physician medical malpractice policies were

$1 million/$3 million. For hospital malpractice policies, coverage limits varied among insurers. However, the predominately written coverage limits of the largest hospital insurer, Farmers Insurance Group of Companies, was $500,000/unlimited.

Medical Malpractice Situation in the Mid-1970's

In the mid-1970's, a crisis developed in California regarding the lack of available and affordable medical malpractice insurance. The number of malpractice claims and size of the awards and settlements were escalating in the state. Some commercial insurers, such as Argonaut and Cignal-Imperial, reacted by withdrawing from the market. Others raised their premiums to unprecedented levels. When the malpractice crisis peaked in 1975, among the first to feel the pinch of skyrocketing premiums were the high-risk specialties in northern California. According to an official of the Doctors' Company, premiums for these high-risk specialties increased by as much as 422 percent. Officials of the California Hospital Association told us that some doctors in California decided to discontinue providing medical care involving high-risk procedures, some moved their practices to other states, and some opted to "go bare" (practice without malpractice insurance). Further, medical care was not available in all parts of California, and patients treated by uninsured doctors faced the probability of unenforceable judgments if they suffered serious injury as a result of malpractice.

Response to Problems

In response to the statewide malpractice insurance turmoil, physician and insurance lobbyists urged passage of tort reforms. On May 16, 1975, the governor issued a proclamation that convened the state legislature in an extraordinary session. The proclamation called for the legislature to "enact laws which will change the relationship between the people and the medical profession, the legal profession, and the insurance industry and thereby reduce the costs which underlie these high insurance premiums." In September 1975 the legislature enacted the Medical Injury Compensation Reform Act of 1975 which:

- Established a sliding contingency fee schedule for plaintiff attorneys of 40 percent for the first $50,000 recovered; 33-1/3 percent for the next $50,000; 25 percent for the next $100,000; and 10 percent of any amount over $200,000.
- Imposed a $250,000 limit on the amount recoverable for noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damage.

- Permitted a defendant to introduce evidence that the plaintiff is entitled to compensation for injuries from insurance; however, the plaintiff may then introduce evidence of premiums paid by the defendant for the insurance coverage.
- Required that the superior court, at the request of either party, order periodic payment of future damages rather than a lump-sum payment if the award equals or exceeds $50,000 in future damages.
- Imposed a statute of limitations of 3 years after the date of injury or 1 year after the plaintiff discovers, or should have discovered, the injury, whichever occurs first. Actions by a minor under 6 have to begin within 3 years or before his 8th birthday, whichever provides a longer period.
- Required specific boards to keep certain records regarding convictions and judgments against their physicians and required reports from courts on judgments against physicians. Provided for additional reports from hospitals, health care service plans, or medical care foundations to licensing boards regarding the removal of staff physician privileges.
- Changed the name of the Board of Medical Examiners to the Board of Medical Quality Assurance, increased the membership to 19, and divided the work into three divisions.
- Required every insurer providing professional liability insurance to report to the licensing agency any malpractice settlement or arbitration award over $3,000. (In 1979, the $3,000 amount was increased to $30,000 for physicians and surgeons.)
- Required a 90-day notice to health-care providers of the plaintiff's intention to sue for malpractice.
- Provided that any contract for medical services that contains a provision for arbitration of any dispute regarding malpractice also contain a specified disclosure statement as the first article of the contract.

On June 3, 1986, California voters passed Proposition 51, the Fair Responsibility Act, which amended the joint and several liability doctrine for noneconomic damages. Under a "joint and several liability" rule, all parties named in a suit are held equally responsible for damages. If the plaintiff wins the case, he can collect the full amount from any one of the defendants, even from a defendant who bears only a minor responsibility for the damages. The rule is sometimes referred to as the "deep pocket" rule, so named because the defendant with the deepest pocket sometimes ends up paying for injuries for which he was only partially responsible. Proposition 51 limits awards for noneconomic damages, such as pain and suffering, to a defendant's degree of fault causing the damages. However, the law retains joint and several liability for economic damages, such as lost wages and medical expenses.

Effect of California Tort Reforms

No major effect from any specific tort reform or action was perceived by three or more interest groups we surveyed.[4] However, numerous health care and insurance officials we contacted credited the state's medical malpractice legislation with moderating California's increases in the cost of malpractice insurance and in the size of malpractice awards, particularly when compared to other states. Agency officials said the legislation has helped to slow the upward trend in escalating insurance premiums and jury awards. An official of the Doctors' Company stated that the Medical Injury Compensation Reform Act has been cited as a model for other states and has been credited with California's relative stability while a malpractice crisis is emerging across the nation. Further, a May 1985 California Medical Association-sponsored study concluded that the state's malpractice legislation had been effective in holding down malpractice claim costs. The study attributed savings in claims costs ranging from 8 percent in 1976 to 49 percent in 1985 to California's malpractice legislation.

Since the legislation was enacted in 1975, its provisions have been frequently contested in California courts. The act has withstood four separate California Supreme Court challenges. The U.S. Supreme Court has refused to hear two cases that were brought before it. An attempt to repeal the act in the California legislature was defeated in 1985. We were told that some plaintiff attorneys negotiating malpractice settlements and some courts frequently functioned on the basis that the act would be found unconstitutional and, as a result, did not abide by its provisions. Several officials believe that the full impact of the act will now be felt since the U.S. Supreme Court in 1985 refused to hear a case questioning the constitutionality of California's cap on noneconomic losses, such as pain and suffering, which, in effect, upheld the provision's constitutionality.

Key Indicators of the Situation Since 1980

Malpractice insurance premiums for physicians have increased at a moderate rate since 1980. Rates of the largest hospital insurer decreased each year from 1980 through 1984, but increased sharply in 1985 and again in 1986. Frequency of claims against physicians increased 27 percent between 1980 and 1984, while the average paid claim against physicians increased about 87 percent. The frequency of claims against hospitals increased 17 percent, but the average paid claim increased 91

[4]Our methodology for obtaining the views of major interest groups and for analyzing their responses is described in GAO/HRD-87-21, pp. 10-11. The specific interest groups for California are shown in appendix II of this report.

percent. Further, from 1980 to 1984, insurers' average cost to investigate and defend malpractice claims more than quadrupled for claims against physicians and increased 64 percent for those against hospitals.

Physicians

Cost of Malpractice Insurance

As of January 1, 1986, there was a wide variation in malpractice insurance rates among various specialties in California. For instance, The Doctors' Company annual premium for coverage limits of $1 million/$3 million in southern California ranged from $4,260 for general family practice (no surgery) to $42,928 for obstetrics/gynecology. The NORCAL Mutual Insurance Company's rate in northern California ranged from $3,632 for pathology and psychiatry to $40,388 for neurosurgery. The annual premiums are higher in southern California than in northern California for most specialties.

The rate of increase in malpractice premiums has not been uniform among physician specialties. As shown in table 2, the increases in premiums from 1980 to 1986 for the selected specialties in Southern California ranged from 1[illegible] to 337 percent.

Table 2: Cost of Insurance[a] for Selected Specialties in Southern California, 1980 and 1986

Specialty	1980	1986	Percent increase (1980-86)
General practice (no surgery)	$3,674	$4,260	16
Internal medicine (no surgery	3,674	5,924	61
Pediatrics (no surgery)	2,042	7,524	268
Pathology	3,674	4,260	16
General practice (minor surgery)	3,674	10,024	173
Internal medicine (minor surgery)	3,674	5,924	61
Pediatrics (minor surgery)	2,042	7,524	268
Radiology	3,674	16,056	337
Psychiatry	2,042	4,260	109
Ophthalmology/ surgery	6,133	10,024	63
General surgery	15,182	28,576	88
Anesthesiology	15,182	20,492	35
Plastic surgery	13,437	28,576	113
Orthopedic surgery	17,869	33,632	88
Obstetrics/ gynecology	17,869	42,928	140
Neurosurgery	17,869	37,984	113

[a]Rates shown are those of The Doctors' Company for a $1 million/$3 million claims-made policy as of January 1 each year. A claims-made policy covers malpractice events that occur after the effective date of the coverage and for which claims are made during the policy period.

As shown in table 3, in Northern California the change in premiums from 1980 to 1986 ranged from a decrease of 27 percent for anesthesiology to an increase of 92 percent for obstetrics/ gynecology.

Table 3: Cost of Insurance[a] for Selected Specialties in Northern California, 1980 and 1986

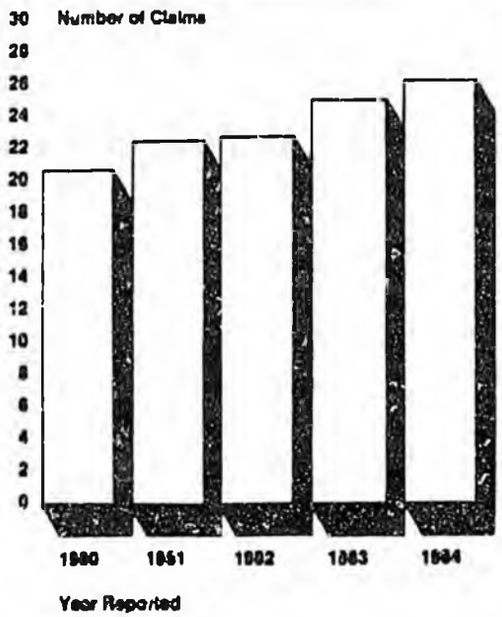
Specialty	1980	1986	Percent increase (1980-86)
General practice (no surgery)	$4,200	$7,340	75
Internal medicine (no surgery)	4,200	5,012	19
Pediatrics (no surgery)	3,056	5,012	64
Pathology	3,056	3,632	19
General practice (minor surgery)	4,200	7,340	75
Internal medicine (minor surgery)	4,200	5,012	19
Pediatrics (minor surgery)	3,056	5,012	64
Radiology	4,200	5,012	19
Psychiatry	2,008	3,632	81
Ophthalmology/ surgery	4,200	7,340	75
General surgery	12,740	22,096	73
Anesthesiology	19,212	14,064	(27)
Plastic surgery	12,740	22,096	73
Orthopedic surgery	23,272	33,348	43
Obstetrics/ gynecology	19,212	36,872	92
Neurosurgery	23,272	40,388	74

[a]Rates shown are those of NORCAL Mutual Insurance Company for a $1 million/$3 million claims made policy as of January 1 each year

Frequency of Claims

Combined data from Cooperative of American Physicians, The Doctors' Company, Physicians and Surgeons Underwriters Corporation, and NORCAL Mutual Insurance Company indicated that the frequency of claims against physicians increased slightly from 1980 to 1984. As shown in figure 1, the frequency of claims per 100 physicians increased by 27 percent from 20.4 in 1980 to 26.0 in 1984.

Figure 1: Frequency of Claims per 100 Physicians, 1980-84



There were wide variations in the frequency of claims filed per 100 physicians among the selected specialties. For example, as shown in table 4, from 1980 to 1984 the number of claims per 100 physicians in psychiatry increased 118 percent, while the number of claims against anesthesiologists remained the same.

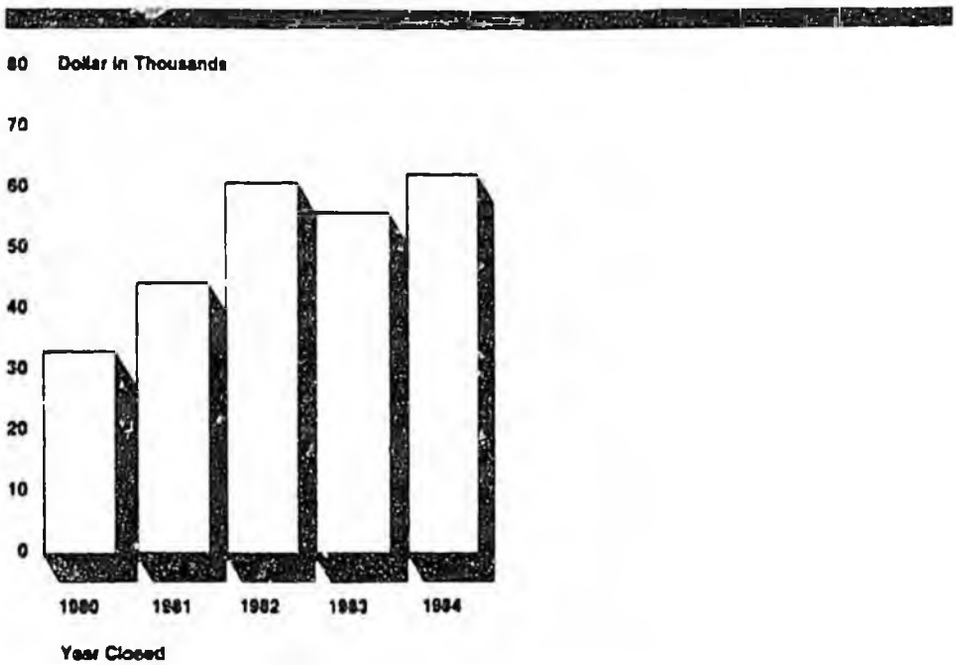
Table 4: Frequency of Claims per 100 Physicians for Selected Specialties, 1980-84

Specialty	1980	1981	1982	1983	1984	Percent Increase (1980-84)
Anesthesiology	20 1	19.3	17.5	20.7	20.1	0
General surgery	31 3	31.4	32.0	36.2	37.5	20
Neurosurgery	40 2	42.5	67.0	54.7	53.5	33
Plastic surgery	45 0	53.2	55.8	54.9	60.1	34
Orthopedic surgery	37 5	40.7	42.9	47.0	51.2	37
Ophthalmology/ surgery	12 6	15.1	12.4	18.4	18.0	43
Pathology	6 1	9.2	7.7	8.5	9.2	51
Obstetrics/ gynecology	33 9	41.7	44.1	49.6	51.1	51
Internal medicine	10 7	12.4	11.9	16.0	16.4	53
Pediatrics	8 1	11.3	11.4	11.1	13.4	65
Radiology	12 6	15.5	18.4	19.6	21.6	71
General practice	6 9	9.1	12.5	14.1	14.4	109
Psychiatry	3 8	6.9	6.1	7.8	8.3	118

Size of Awards/Settlements

As shown in figure 2, the average paid claim for the combined claims experience of the participating insurers of physicians in California increased from $32,963 in 1980 to $61,774 in 1984, an aggregate increase of 87 percent.

Figure 2: Average Paid Claim for Physicians, 1980-84



As shown in table 5, the average payment per claim increased between 1980 and 1984 for the selected specialties included in our review. Because the number of physicians in any one specialty is relatively small, the base for spreading total claims paid is small. As a result, a few large claims paid in a given year for a given specialty could have a significant effect on the average paid claim for that specialty that year.

Table 5: Average Paid Claim for Selected Specialties, 1980 and 1984

	1980	1984
All physicians	$32,963	$61,774
Specialty		
Orthopedic surgery	101,377	36,337
Ophthalmology/ surgery	49,700	22,816
Psychiatry	75,000	66,500
Radiology	30,630	29,276
Anesthesiology	62,567	70,925
Internal medicine	57,243	73,128
General practice	23,122	36,520
General surgery	54,471	90,582
Plastic surgery	23,236	41,216
Obstetrics/gynecology	50,973	92,628
Neurosurgery	41,667	91,619
Pediatrics	3,127	135,874
Pathology	1,324	71,250

Cost to Investigate and Defend Claims

Insurers' average cost to investigate and defend claims closed against physicians more than quadrupled from $2,284 in 1980 to $9,358 in 1984.

In 1980, 49 percent of the malpractice claims against California physicians closed by insurers participating in our study were closed with no expense to the insurers. By 1984, the percentage of claims closed with no expense had decreased to 40 percent, while the percentage of claims closed with indemnity increased from 15 percent to 24 percent. The percentage of claims closed with only the costs incurred to investigate and defend the claim was 36 percent in 1980, increased to 41 percent in 1982, and then decreased to 36 percent in 1983 and 1984.

Hospitals

Cost of Malpractice Insurance

As shown in table 6, the total estimated malpractice insurance costs for hospitals in California[5] increased from $75.4 million in 1983 to $98.6 million in 1985— 31 percent.

[5]See GAO/HRD-87-21 p. 11, for methodology for obtaining and analyzing hospital cost data. See appendix III of this report for information on the number of California hospitals in the universe.

Table 6: Estimated Hospital Malpractice Insurance Costs by Type of Expenditure, 1983-85

Dollars in millions

Expenditure	1983	1984	1985	1983-85 increase[a] Amount	Percent
Total	**$75.4**	**$82.9**	**$98.6**	**$23.2**	**31**
Contributions to self-insurance trust funds	5.6	7.3	12.1	6.5	116
Premiums for purchased insurance	67.3	72.2	83.0	15.7	23
Uninsured losses	2.5	3.5	3.4	9	36

[a]Sampling errors for the amount and percentage of increase are not presented in appendix IV but the, are comparable to the errors for the estimated costs

Note: Detail may not add to total due to independent estimation

In 1985, 68 percent of the hospitals had malpractice insurance costs of less than $500,000, but 8 percent had annual insurance costs of $1 million or more, as shown in table 7. There were no hospitals in the state with annual insurance costs less than $25,000.

Table 7: Estimated Distribution of Annual Malpractice Insurance Costs for Hospitals, 1983 and 1985

	1983			1985		
Annual costs	**Number**	**Percent**	**Cum. percent**	**Number**	**Percent**	**Cum. percent**
Less than 10,000	0	0	0	0	0	0
$10,000 to $24,999	0	0	0	0	0	0
$25,000 to $49,999	30	13.9	13.9	25	11.7	11.7
$50,000 to $99,999	19	8.7	22.6	10[a]	4.4[a]	16.1
$100,000 to $249,999	58	26.7	49.3	55	25.5	41.6
$250,000 to $499,999	64	29.6	78.9	58	26.7	68.3
$500,000 to $999,999	32	14.9	93.8	50	23.4	91.7
$1 million or more	13	6.2	100.0	18	8.2	99.9[b]
Total	**216**	**100.0**		**216**	**99.9[b]**	

[a]Estimates subject to relatively large sampling error and should be used with caution

[b]Detail does not add to 100 percent due to independent rounding

Note: The total number of hospitals each year is based on the number of responding hospitals that provided the relevant data for that year

As shown in table 8, both the estimated average malpractice insurance costs per day and annual per bed costs increased 37 percent from 1983 to 1985.

GAO's sample, and the survey response. Unless otherwise indicated, the estimates presented in this study are also included with sampling errors in tables IV.1 through IV.5.

Table 8: Estimated Average Hospital Malpractice Insurance Costs per Inpatient Day and per Bed,[a] 1983-85

				1983-85 Increase[b]	
	1983	1984	1985	Amount	Percent
Average malpractice cost per inpatient day	$8.03	$9.68	$11.01	$2.98	37
Average annual malpractice cost per bed	$2,312	$2,674	$3,160	$848	37

[a]To determine the average annual malpractice cost per bed, we computed the daily occupied bed rate (the total number of inpatient days divided by 365) and increased that number by one bed for every 2,000 outpatient visits (emergency room visits were counted as outpatient visits). This number was divided into the hospital's total annual malpractice insurance costs.

[b]Sampling errors for the amount and percentage of increase are not presented in appendix IV, but they are comparable to the errors for the estimated costs.

As shown in table 9, 65 percent of California hospitals had increases in inpatient day malpractice insurance costs of 10 to 99 percent from 1983 to 1985, while another 16 percent had increases of 100 percent or more.

Table 9: Estimated Distribution of Changes in Malpractice Insurance Costs per Inpatient Day From 1983 to 1985

	Hospitals		
Percentage change	Number	Percent	Cum. percent
Increases of less than 10 or all decreases	41	19.0	19.0
+10 to 49	93	42.9	61.9
+50 to 99	49	22.5	84.4
+100 to 199	20	9.3	93.7
+200 to 299	10[b]	4.4[b]	98.1
+300 or more	4[b]	1.8[b]	99.9[a]
Total	**217[a]**	**99.9[a]**	

[a]Does not add to adjusted universe or 100 percent due to independent rounding.

[b]Estimates subject to a relatively large sampling error and should be used with caution.

Note: The total number of hospitals is based on the number of responding hospitals that provided data for both 1983 and 1985 so that the percent change could be calculated.

Malpractice Insurance Rates for Hospitals

The cost of medical malpractice insurance with the Farmers Insurance Group of Companies, California's largest hospital insurer, decreased each year from 1980 through 1984 but increased significantly in 1985 and 1986. More specifically, the annual average premium per occupied bed for an occurrence policy[a] increased 78 percent, from $836 in 1980 to $1,485 in 1986. Table 10 shows the rates on a year-to-year basis.

[a]Under an occurrence policy, the insurance company is liable for any incidents that occurred during the period the policy was in force, regardless of when the claim may be filed.

Table 10: Rates per Occupied Hospital Bed[a] for Primary Coverage, 1980-86

1980	1981	1982	1983	1984	1985	1986
$836	$695	$669	$568	$522	$869	$1,485

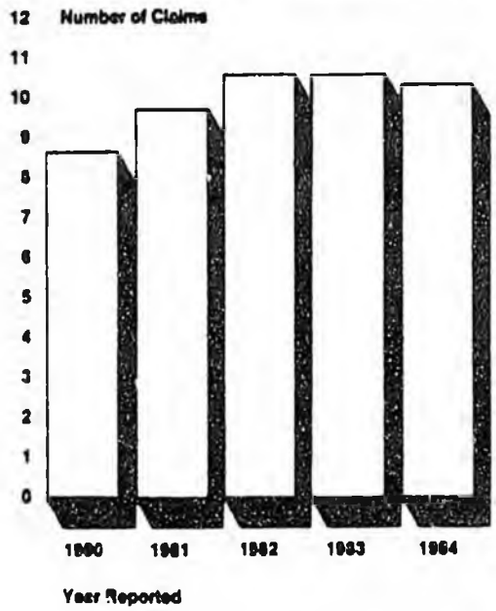
[a]Rates shown are those of the Farmers Insurance Group of Companies for an occurrence policy as of January 1 each year. The policies most hospitals purchased from this insurer include a $5,200 per occurrence deductible. The rates shown are for different limits of coverage since the per-occurrence coverage changed significantly over time. For example, the per-occurrence coverage increased from $110,000 in 1980 to $500,000 in 1986.

A Farmers Insurance Group of Companies official stated that rate decreases for 1981, 1982, 1983, and 1984 were due to excess premiums the company collected during the late 1970's. The excess monies were used to offset premiums charged from 1981 through 1984. Further, the Farmers Group had a contract with the California Hospital Association to provide insurance to Association members at an agreed-upon rate. In this respect, the Farmers Group established a member's reserve account for excess premiums to be used to dampen premium swings for member hospitals. The account had grown to $41 million by 1981, and this enabled the company to offer premium reductions for the years 1981 through 1984. However, by the latter part of 1984, member reserves dropped sharply. This necessitated premium increases in 1985 and 1986. Also, in 1984 the California Hospital Association ended its contract with the Farmers Group.

Frequency of Claims

The combined claims experience for insurers of California's hospitals (The Farmers Insurance Group of Companies, the St. Paul Company, and the Association of California Hospital Districts) indicated that the frequency of claims reported per 100 occupied hospital beds increased 17 percent, from 8.6 claims in 1980 to 10.1 in 1984, as shown in figure 4.

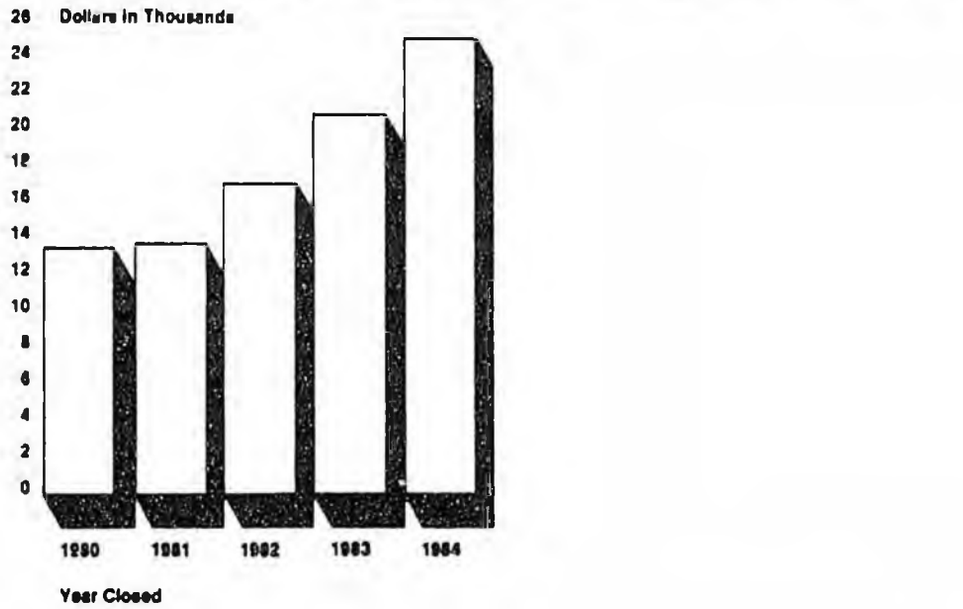
Figure 3: Frequency of Claims per 100 Occupied Hospital Beds, 1980-84



Size of Awards/Settlements

The average paid claim against California hospitals increased 91 percent, from $13,025 in 1980 to $24,874 in 1984, as shown in figure 4.

Figure 4: Average Paid Claim for Hospitals, 1980-84



Cost to Investigate and Defend Claims

The combined data of the California hospital insurers shows that the average cost to investigate and defend claims closed against hospitals increased from $3,422 in 1980 to $5,608 in 1984—64 percent.

In 1984, 30 percent of claims against California hospitals were closed with no expense to the companies, and 30 percent were closed with only the costs incurred to investigate and defend the claim.

Major Medical Malpractice Problems—Current and Future

Major current or future malpractice problems in California identified by three or more of interest groups we surveyed[7] related to the following:

- Cost of medical malpractice liability insurance.
- Size of awards/settlements for medical malpractice claims.
- Legal expenses/attorney fees for medical malpractice claims.
- Individual physician actions to reduce or prevent medical malpractice claims.

[7]Our methodology for obtaining the views of major interest groups and for analyzing their responses is described in GAO/HRD-87-21, pp. 10-11. The specific interest groups for California are shown in appendix II of this report.

Cost of Malpractice Insurance

Most physician organizations, the California Hospital Association, and malpractice insurers believed the high cost of basic and excess liability coverage for physicians is a major problem.

The Cooperative of American Physicians commented that higher malpractice insurance costs are due to increased numbers of claims filed and excessive malpractice verdicts. The Association of California Hospital Districts cited the unprofitability of the medical malpractice insurance business caused by excessive costs of claims. The California Society of Plastic Surgeons commented:

"... malpractice premiums approximate 20 to 25 [percent] of the average physician's net take home [pay]. Without relief the next 5 years will find this trend accelerating. This is true of excess liability insurance as well as basic and [tail coverage]. Hospitals will face the same problem, as will the insurance carriers."

An official of the California Hospital Association told us that hospitals were seeing a dramatic increase in the cost of excess malpractice insurance coverage over $1 million.[8]

Size of Awards and Settlements for Malpractice Claims

Excessive malpractice awards/settlements in relation to economic costs arising from injuries are viewed by the physician group, the California Hospital Association, and malpractice insurers as a major problem that will continue over the next 5 years.

Officials of the California Hospital Association told us that they believe awards are based on emotion rather than on hard data on economic costs. They believed the legislative cap on pain and suffering should eliminate some of this.

The California Society of Plastic Surgeons said that "while obviously damaged individuals should be compensated, it seems inappropriate to make every injured person an instant millionaire."

Also, the Cooperative of American Physicians said "juries have become desensitized to the value of the dollar and find multimillion dollar verdicts common."

[8]We refer to the basic level of insurance liability coverage as primary and the coverage above the basic level as excess or above-primary coverage.

Legal Expenses and Attorney's Fees for Malpractice Claims

The physician group, California Hospital Association, and malpractice insurer group expressed the opinion that legal costs associated with defending malpractice claims are excessive. They believed this was a major problem that will also occur into the next 5 years. An official of The Doctors' Company said that about 45 percent of the amount paid on its claims was consumed by defense and claims handling costs.

The California Hospital Association stated that "when the costs of defending cases is equal to or greater than amounts paid to claimants, legal costs are far out of line with the intent of the judicial system."

The Association of California Hospital Districts commented "the system is inefficient with too small a percentage of the total dollar spent going to the injured party." An official of Professional Risk Management of California, Inc., believed an ominous trend exists in escalating legal costs, for both the plaintiff and the defendant. Officials from the California Hospital Association also said that costs to defend and to pursue claims are entirely too high compared to the amount paid to the injured party.

Incentives to Practice Defensive Medicine

California's physician group, hospital association, and malpractice insurer group stated that there are strong incentives for physicians to perform medically unnecessary tests or treatments to reduce their risk of liability. The California Society of Pathologists stated that "the malpractice crisis has caused physicians to practice defensive medicine and thereby increase the cost of health care."

The Farmers Insurance Group of Companies commented that physicians have strong incentives to practice defensive medicine. They said:

"... attorneys have advised physicians that they must protect themselves against allegations of misdiagnosis because of their failure to perform certain tests which were readily available."

The Physicians and Surgeons Underwriters Corporation commented that "the threat of legal action has caused M.D.s and hospitals to overreact in practicing defensive medicine."

An official of The Doctors' Company said:

"Defensive medicine is very real, but it is most difficult to quantify. The decisions of physicians regarding tests (not so much for treatments) is a conscious act of the doctor, resulting from a number of factors at work on his decision making process

such as the complaints of the patient or findings on physical examination. Others are a complex combination of subconscious influences that are a distillation of the physician's experience, education, and of the social and legal pressures that bear upon him."

Professional Risk Management of California, Inc. commented:

". . . there is a substantial degree of medicine which is now practiced for the sake of legal protection rather than medical or diagnostic necessity. This drives up costs of health care and does represent a serious problem."

NORCAL Mutual Insurance Company expressed the following opinion:

"It may be an overstatement to opine that performance of 'unnecessary' tests is a substantial problem. However, the threat of a lawsuit arising from an untoward medical result encourages physicians to try everything in the dual effort of leaving no stone unturned in treating a patient and protecting the flanks, should a disappointed patient turn litigious."

Solutions to Malpractice Problems

There was no agreement among three or more of the interest groups we surveyed in California for any specific solution to address current or future medical malpractice problems.

Role of the Federal Government

Most organizations surveyed did not want federal involvement in the medical malpractice area. Officials of the California Medical Association, California Hospital Association, and three malpractice insurance companies we visited thought medical malpractice problems should be resolved at the state level.

The State of California Department of Insurance, however, strongly supported federal action to establish a national policy regarding compensation of medically induced injuries and commented that "national guidelines as to what is fair and reasonable would be helpful."

The California Hospital Association strongly supported federal action to establish a mechanism to provide financial incentives and/or penalties to encourage states to take certain actions. An official of the association commented that other states may obtain substantial benefits from enacting legislation similar to the California act which limits payments for noneconomic losses and contingency fees and considers collateral source payments.

Medical Malpractice Insurers Requested to Provide Statistical Data for California

	Provided data for		Did not provide requested data
	Physicians	Hospitals	
Association of California Hospital Districts		X	
Cooperative of American Physicians	X		
The Farmers Insurance Group of Companies		X	
Medical Insurance Exchange of California			X
NORCAL Mutual Insurance Company	X		
Physician and Surgeons Underwriters Corporation	X		
Professional Risk Management of California, Inc.	X[a]	X[a]	
Southern California Physicians Insurance Exchange			X
St. Paul Fire and Marine Insurance Company		X	
The Doctors' Company	X		

[a]Data not included in our data base due to several missing data elements

Organizations Receiving GAO Questionnaire for California

Completing questionnaire	Not completing questionnaire
Physician group:	
California Medical Association	California Psychiatric Association
California Society of Pathologists	California Association of Neurological Surgeons
California Radiological Society	California College of Surgeons (Northern and Southern Divisions)
District IX, American College of Obstetricians and Gynecologists	California Orthopedic Association
California Society of Plastic Surgeons	California Association of Ophthalmology
American Academy of Pediatrics, California District	
American College of Physicians, Northern California	
American College of Physicians, Southern California	
California Academy of Family Physicians	
California Society of Anesthesiology	
Hospital association:	
California Hospital Association	
Bar association:	
None	California Bar Association
Trail lawyers:	
California Trial Lawyers Association	
Malpractice insurers:	
The Farmers Insurance Group of Companies	St. Paul Fire and Marine Insurance Company
Physicians and Surgeons Underwriters Corporation	Southern California Physicians Insurance Exchange
The Doctors' Company	
Association of California Hospital Districts	
Cooperative of American Physicians	
NORCAL Mutual Insurance Company	
Medical Insurance Exchange of California	
Professional Risk Management of California, Inc.	
Insurance department:	
State of California, Department of Insurance	

Number of California Hospitals in the Universe, GAO Sample, and Survey Response

Number of hospitals		Hospitals completing questionnaire	
Universe[a]	Sample	Number	Percent
483	113	56	50

[a]1983 data

Estimated Hospital Data and Related Sampling Errors for Policy Years 1983, 1984, and 1985

Table IV.1: Hospital Malpractice Insurance Costs and Related Sampling Errors by Type of Expenditure

Dollars in millions

	1983		1984		1985	
Expenditure	Amount	Sampling error[a]	Amount	Sampling error[a]	Amount	Sampling error[a]
Total costs	**$75.4**	**$9.2**	**$82.9**	**$11.2**	**$98.6**	**$13.8**
Contributions to self-insurance trust funds	5.6	5.2	7.3	5.1	12.1	7.5
Premiums for purchased insurance	67.3	11.2	72.2	13.3	83.0	16.4
Uninsured losses	2.5	.8	3.5	1.6	3.4	1.4

[a]Sampling errors are stated at the 95-percent confidence level.

Note: Detail may not add to total due to independant estimation. The adjusted universe of hospitals to which the estimated amounts relate was 216 in 1983, 1984, and 1985. The adjusted universe is that portion of the total universe based on the sample response rate for which we can estimate data.

Table IV.2: Distribution of Annual Malpractice Insurance Costs and Related Sampling Errors for Hospitals

Figures in percents

	1983		1985	
Annual cost	Hospitals	Sampling error[a]	Hospitals	Sampling error[a]
Less than $10,000	0	0.0	0	0.0
$10,000 to $24,999	0	0.0	0	0.0
$25,000 to $49,999	13.9	5.0	11.7	4.7
$50,000 to $99,999	8.7	7.3	4.4[b]	5.0
$100,000 to $249,999	26.7	10.3	25.5	10.6
$250,000 to $499,999	29.6	10.0	26.7	10.8
$500,000 to $999,999	14.9	5.5	23.4	7.6
$1 million or more	6.2	3.4	8.2	4.1

[a]Sampling errors are stated at the 95-percent confidence level.

[b]Estimate subject to a relatively large sampling error and should be used with caution.

Note: The adjusted universe of hospitals was 216 in 1983 and 1985.

Table IV.3: Average Malpractice Insurance Costs per Inpatient Day and Related Sampling Errors

1983		1984		1985	
Cost per day	Sampling error[a]	Cost per day	Sampling error[a]	Cost per day	Sampling error[a]
$8.03	$1.40	$9.68	$1.83	$11.01	$1.[illegible]

[a]Sampling errors are stated at the 95-percent confidence level.

Table IV.4: Average Annual Malpractice Insurance Costs per Bed and Related Sampling Errors

1983		1984		1985	
Cost per bed	Sampling error[a]	Cost per bed	Sampling error[a]	Cost per bed	Sampling error[a]
$2,312	$336	$2,674	$361	$3,160	$[illegible]

[a]Sampling errors are stated at the 95-percent confidence level.

Table IV.5: Distribution of Changes in Malpractice Insurance Costs per Inpatient Day From 1983 to 1985 and Related Sampling Errors

Figures in percents

Changes	Hospitals	Sampling error[a]
Increases of less than 10% or decreases	19.0	10.2
Increases of 10% to 49%	42.9	12.4
Increases of 50% to 99%	22.5	10.5
Increases of 100% to 199%	9.3	7.5
Increases of 200% to 299%	4.4[b]	5.0
Increases of 300% or more	1.8[b]	2.9

[a]Sampling errors are stated at the 95-percent confidence level

[b]Estimates subject to a relatively large sampling error and should be used with caution

Note The adjusted universe of hospitals was 216

GAO

Report to Requesters

FILE NO.
05-190.05-010

December 1986

MEDICAL MALPRACTICE

Case Study on Arkansas

GAO/HRD-87-21S-1

Preface

December 31, 1986

Representative John Edward Porter and Senator John Heinz, Chairman, Senate Special Committee on Aging, asked GAO to identify the actions taken by the states to address medical malpractice insurance problems and to determine changes in insurance costs, the number of claims filed, and the average amount paid per claim. These case studies discuss the situation in each state.

This study on Arkansas focuses on the views of various interest groups on perceived problems, actions taken by the state to deal with the problems, the results of these actions, and the need for federal involvement. A summary of the findings for all six case studies can be found in our overall report, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, December 31, 1986).

Richard L. Fogel
Assistant Comptroller General
for Human Resources Programs

Overview

Although medical malpractice insurance rates have increased since 1980, the cost of malpractice insurance for physicians and hospitals in Arkansas was not viewed as a major current problem by the six interest groups we surveyed. Major problems were expected to develop in the future, however, regarding the cost of malpractice insurance, the availability of such insurance, legal expenses/attorney's fees for malpractice claims, and physician actions to reduce or prevent malpractice claims. Although the state enacted some tort reforms to address medical malpractice problems, the interest groups we surveyed believed the reforms have not had much effect. There was little support for federal involvement in the medical malpractice situation in Arkansas. Most groups believe that problems should be addressed at the state rather than the federal level.

Contents

Figures

Arkansas: Few Current Concerns but Future Problems Expected

Background

Population, Physician, and Hospital Characteristics

With a population of 2.3 million, Arkansas is the 33rd most populous state. The population is almost equally divided between urban and rural areas.[1] Arkansas had 3,532 physicians as of December 31, 1985,[2] and 92 nonfederal community hospitals with a total of 11,394 beds in 1984.[3] A total of 3,017 physicians were providing patient care—2,504 were office-based and 513 were hospital-based. Table 1 shows the distribution of patient care physicians among 13 selected specialties.

Table 1: Number of Nonfederal Patient Care Physicians in Arkansas in Selected Specialties as of December 31, 1985

		Hospital-based practice		
	Office-based practice	Residents	Full-time physician staff	Total
General practice	774	80	11	865
Internal medicine	244	72	7	323
Pediatrics	115	42	3	160
Psychiatry	78	13	21	112
Pathology	60	9	7	76
Radiology	73	1	5	79
Ophthalmology	102	15	1	118
General surgery	185	35	7	227
Anesthesiology	94	28	2	124
Plastic surgery	12	0	0	12
Orthopedic surgery	103	19	4	126
Obstetrics/gynecology	159	16	3	178
Neurosurgery	19	8	2	29

The occupancy rate of the state's community hospitals averaged 62 percent in 1984. About 42 percent of the hospitals were nongovernment, not-for-profit; 41 percent were state and locally owned; and 17 percent were investor-owned. The most common hospital size was 50 to 99 beds. The 31 hospitals of that size accounted for 20 percent of the hospital beds in the state. Arkansas has three hospitals with 500 or more beds each, which accounted for 17 percent of the beds.

[1]Population and ranking are as of July 1, 1984 (preliminary), and the urban/rural mix is as of April 1, 1980, from Statistical Abstract of the United States, 1986, 106th Edition, pp. 10 and 12.

[2]Physician Characteristics and Distribution in the U.S., 1986 Edition, Department of Data Release Services, Division of Survey and Data Resources, American Medical Association (forthcoming).

[3]Hospital Statistics, 1985 Edition, American Hospital Association, p. 48.

Regulation of Insurance Rates and Description of Medical Malpractice Insurers

Before 1979, Arkansas was a "prior approval state." Insurers were required to file proposed rates and obtain the approval of the state insurance department before the rates could be used, according to an Arkansas Insurance Department official. Since 1979, Arkansas has been a "file and use" state. Each insurer must now file rates with the state insurance department before the effective date; however, prior approval is not required before the effective date. Although the state insurance department can reject rate increases because of "excessiveness," Arkansas Insurance Department officials told us that they cannot recall ever having rejected a rate increase. They stated it is difficult to show that the rates are excessive in a file and use state.

In 1986, the two largest medical malpractice insurers of physicians in Arkansas were the St. Paul Fire and Marine Insurance Company (St. Paul Company) and the American Physicians Insurance Exchange. The St. Paul Company insures about 70 percent of the physician market. According to Arkansas Medical Society and St. Paul Company officials, the American Physicians Insurance Exchange insures most of the remaining physicians.

According to Arkansas Hospital Association officials, the St. Paul Company and the Ohio Hospital Insurance Company are the leading hospital insurers in the state. In January 1985, the St. Paul Company insured 58 Arkansas hospitals, and the Ohio Hospital Insurance Company insured 7.

In 1984, the predominately written malpractice coverage limits for Arkansas physicians were $1 million/$1 million. For hospital malpractice policies, the predominately written coverage limits were $300,000/$900,000 for policies written by the St. Paul Company and $200,000/$600,000 for policies written by the Ohio Hospital Insurance Company. For both hospitals and physicians, there is only one rating territory in the state.

Medical Malpractice Situation in the Mid-1970's

According to an Arkansas Medical Society official, the availability of malpractice insurance was the major concern in Arkansas when Aetna, one of the two major insurers in the state, withdrew from the malpractice insurance market in 1975. The St. Paul Company was left as essentially the state's only malpractice insurer.

In late 1978, the American Physicians Insurance Exchange began writing malpractice insurance for physicians in the state, according to a

company official. An Arkansas Medical Society official stated that the effect of this company's entry into Arkansas was immediate as many physicians changed their insurance to this company in the initial years because of its lower rates. The official added that the St. Paul Company lowered its rates shortly thereafter in order to remain competitive. The same official noted that in 1983 the Medical Protective Company entered the Arkansas physician market.

Response to Problems

The General Assembly of Arkansas created the Professional Liability Reinsurance Exchange in 1975 to assure an available market for medical malpractice insurance. The exchange consisted of all insurers writing general liability insurance in the state. Each was required to issue malpractice insurance policies in proportion to their general liability market share. The exchange was never used and was allowed to expire on March 31, 1981, because malpractice insurance had become readily available from the normal insurance market, according to Arkansas Insurance Department officials.

In 1975, a Professional Malpractice Insurance Commission was established. The Commission was to hear and rule upon any claim submitted to it which involved medical injury, death or monetary loss as a result of medical malpractice. However, similar to the Insurance Exchange, the Commission's authority was allowed to expire in 1979. According to an Arkansas Medical Society official, physicians believed the Commission did not deter frivolous claims because claims could still be taken to court, after the panel found no cause for negligence or damages.

In 1979, the General Assembly of Arkansas enacted the following tort reforms related to medical malpractice:

- Burden of proof. In any action for medical injury, the plaintiff has the burden of proving that the medical standards of his locality were not met by the provider. Also, when the medical provider failed to supply adequate information to obtain the informed consent of the injured person, the plaintiff has the burden of proving that the treatment was performed in other than an emergency situation and that the medical provider did not supply the type of information that would customarily have been given a patient by other medical providers with similar training and experience in the locality in which the medical provider practices.
- Qualifications for expert testimony. In any action for medical injury, no medical care provider should be required to give expert testimony

against himself at a trial, and no expert witness is permitted to give testimony if his compensation depends on the outcome of the case.

- Statute of limitations. All actions involving medical injury shall be commenced within 2 years from the date the cause of the injury occurs, with the exception of the subsequent discovery of a foreign object, in which case, the action shall be commenced within 1 year from date of discovery or the date the foreign object should reasonably have been discovered. With regard to minors, legal action must be commenced before the 19th birthday, provided that the injury occurred when the individual was under the age of 18. Any person who had been adjudicated incompetent at the time of the injury has 1 year after the disability is removed to commence an action.
- Notice of intent to sue. No legal action may be started until at least 60 days after the medical provider is given written notice of alleged injuries and the damages claimed.
- Elimination of ad damnum. In any action for medical injury, the pleading shall not specify the amount of damages claimed but instead that the damages are within the minimum or maximum of that particular court.
- Damages recoverable. In any verdict for the plaintiff, damages may be awarded for both economic losses and pain and suffering and other noneconomic loss; however, the award must separately state the amounts for both. Also, the court, at the request of either party, may order that awards for future damages exceeding $100,000 be paid in periodic payments rather than a lump sum.
- Baseless pleadings. If any action for medical injury is intentionally made without reasonable cause and found to be untrue, the plaintiff shall pay the reasonable costs incurred by the defendant.

Effect of Arkansas Tort Reforms

None of the interest groups we surveyed believed that the tort reforms enacted by the state have had any major effect.

Key Indicators of the Situation Since 1980

Malpractice insurance premiums for physicians and hospitals have increased moderately during recent years. For example, the selected physician specialties experienced a median rate of increase of 51 percent from 1980 to 1986. Hospital rates increased by 51 percent during the same period. The frequency of claims per 100 physicians increased from 6.6 in 1980 to 8.4 in 1981 and then remained relatively stable.

1981 to 1984. The average paid claim for physicians increased substantially between 1980 and 1984—from $31,619 to $51,685. The frequency of claims against hospitals was 1.2 claims per 100 occupied beds in both 1980 and 1984, but the average paid claim increased from $12,000 to $18,345. The insurers' average cost to investigate and defend claims also increased substantially for both physician and hospital insurers.

Physicians

Cost of Malpractice Insurance

As of January 1986, there was a wide variation in malpractice insurance rates among different physician specialties in Arkansas. For example, the St. Paul Company's annual premium for $1 million/$1 million claims-made[4] coverage ranged from $1,323 for general practice (no surgery) and internal medicine (no surgery), pediatrics (no surgery), psychiatry, and pathology to $12,612 for neurosurgery. Table 2 shows the variation in premiums among the selected specialties.

As also shown in table 2, the rate of increase in the medical malpractice premiums has not been uniform among physician specialties. High-risk specialties, such as neurosurgery and obstetrics/gynecology, have experienced the highest percentage increases. Since 1980, neurosurgery and obstetrics/gynecology have experienced 136 percent and 147 percent increases, respectively, while the other selected specialties experienced increases ranging from 22 to 88 percent. The median increase was 80 percent between 1980 and 1986.

[4]A claims-made policy covers malpractice events that occur after the effective date of the coverage and for which claims are made during the policy period.

Table 2: Cost of Insurance[a] for Selected Specialties, 1980 and 1986

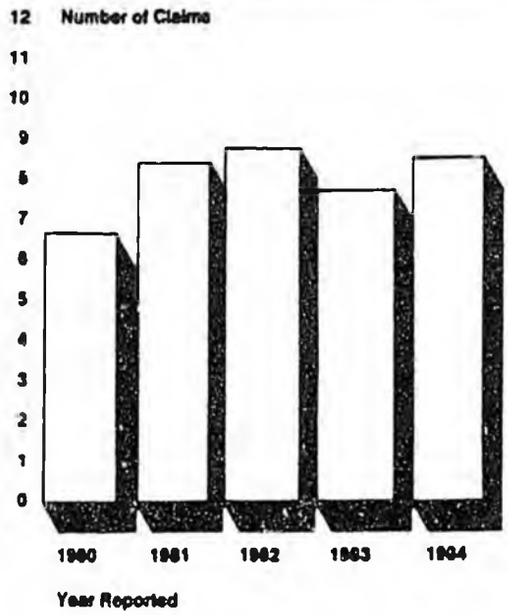
Speciality	1980	1986	Percent increase 1980-86
Ophthalmology/surgery	$2,050	$2,494	22
Orthopedic surgery	5,337		7 985
General practice (minor surgery)	1,204	1,907	58
Internal medicine (minor surgery)	1,204	1,907	58
Radiology	1,204	1,907	58
Pediatrics (minor surgery)	1,204	1,907	58
Anesthesiology	3,366	5,407	61
Plastic surgery	3,366	6,063	80
General surgery	3,366	6,063	80
Internal medicine (no surgery)	704	1,323	88
Psychiatry	704	1,323	88
Pathology	704	1,323	88
General practice (no surgery)	704	1,323	88
Pediatrics (no surgery)	704	1,323	88
Neurosurgery	5,337	12,612	136
Obstetrics/gynecology	4,023	9,940	147

[a]Rates shown are those of the St. Paul Company for a $1 million/$1 million claims-made policy as of January 1 each year

Frequency of Claims

The combined claims experience for the St. Paul Company and the American Physicians Insurance Exchange indicated that the frequency of claims per 100 physicians in Arkansas increased from 6.6 claims in 1980 to 8.6 claims in 1984—30 percent—but as shown in figure 1, the frequency of claims was relatively constant between 1981 and 1984.

Figure 1: Frequency of Claims per 100 Physicians, 1980-84



As shown in table 3, in 1984 the frequency of claims per 100 physicians for 13 selected specialties ranged from zero for radiologists and psychiatrists to 59 for plastic surgeons. The percentage change from 1980 to 1984 varied from specialty to specialty. The most dramatic increase in claims frequency was the 446-percent increase for plastic surgeons—from 10.8 claims in 1980 to 59 claims in 1984.

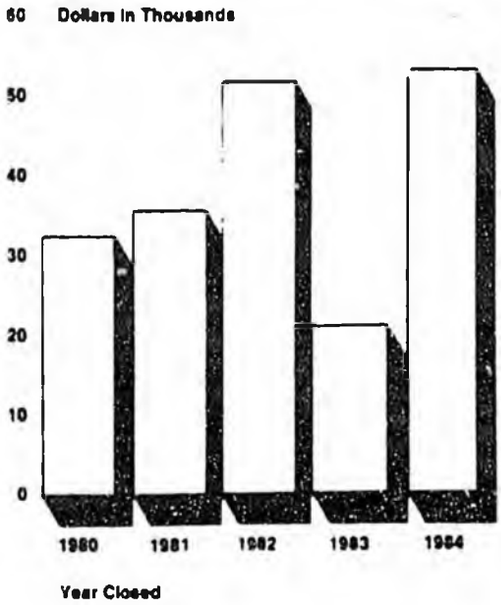
Table 3: Frequency of Claims per 100 Physicians for Selected Specialties, 1980-84

Speciality	1980	1981	1982	1983	1984	Percent increase 1980-84
General practice	7 1	4 3	3 4	5 4	4 2	(41)
Internal medicine	3 6	4 5	2 4	6 0	0 7	(81)
Pediatrics	2 8	7 2	1 1	2 0	2 0	(29)
General surgery	12 9	17 4	23 2	17 3	19 0	47
Neurosurgery	15 6	6 4	39 7	6 6	12 3	(21)
Ophthalmology/surgery	2 7	4 9	5 0	1 3	5 1	89
Orthopedic surgery	12 8	18.0	32 6	14 1	22 2	73
Plastic surgery	10 8	44 4	25 8	20 0	59 0	446
Obstetrics/ gynecology	20 3	30 4	28 1	24 5	28 4	40
Radiology	0	0	13 8	0	0	0
Psychiatry	4 7	3 6	9 3	1 4	0	(100)
Anesthesiology	8.1	1 7	2.3	9 2	11 7	44
Pathology	5 0	3 6	1 7	1 8	13 4	168

Size of Awards/Settlements

As shown in figure 2, the average paid claim for physicians in Arkansas increased 63 percent between 1980 and 1984—from $31,619 in 1980 to $51,685 in 1984.

Figure 2: Average Paid Claim for Physicians, 1980-84



As shown in table 4, no clear trend is evident in the average paid claim for the selected specialties. Because the number of physicians in any one specialty is relatively small, the base for spreading total claims paid is small. As a result, a few large claims paid in a given year for a given specialty could have a significant effect on the average paid claim for that specialty that year.

Table 4: Average Paid Claim for Selected Specialties, 1980 and 1984

	1980	1984
All physicians	$31,619	$51,685
Specialty:		
General practice	0	7,500
Internal medicine	0	30,250
Pediatrics	35,000	0
General surgery	102,000	35,000
Neurosurgery	0	20,000
Ophthalmology/surgery	0	0
Orthopedic surgery	0	120,600
Plastic surgery	0	0
Obstetrics/gynecology	0	81,370
Radiology	0	0
Psychiatry	0	0
Anesthesiology	0	17,500
Pathology	0	19,000

Cost to Investigate and Defend Claims

The average cost to investigate and defend claims against Arkansas physicians insured by the St. Paul Company and the American Physicians Insurance Exchange increased from $2,714 in 1980 to $5,269 in 1984—a 94-percent increase.

The percentage of claims closed with costs only to investigate and defend the claim remained fairly constant during the period 1980-84. However, the portion of claims closed with an indemnity paid increased from 18 percent in 1980 to 32 percent in 1984. Over this period, the percentage of claims closed with no expense decreased from 41 to 28.

Hospitals

Cost of Malpractice Insurance

As shown in table 5, the total estimated malpractice insurance costs for hospitals in Arkansas[a] increased from $1.8 million in 1983 to $2.2 million in 1985—22 percent.

Table 5: Estimated Hospital Malpractice Insurance Costs by Type of Expenditure, 1983-85

Dollars in millions

Expenditure	1983	1984	1985	1983-85 increase[a] Amount	Percent
Total	**$1.8**	**$1.8**	**$2.2**	**$0.4**	**22**
Contributions to self-insurance trust funds	.5	.4	.7	.2	40
Premiums for purchased insurance	1.3	1.4	1.5	.2	15
Uninsured losses	0	0	0	0	0

[a]Sampling errors for the amount and percentage of increase are not presented in appendix IV but they are comparable to the errors for the estimated costs.

Note: Detail may not add to total due to independent estimation

As shown in table 6, 65 percent of the hospitals had total annual malpractice insurance costs of less than $25,000 in 1985. No Arkansas hospital had annual insurance costs greater than $500,000 in 1983 or 1985

Table 6: Estimated Distribution of Annual Malpractice Insurance Costs for Hospitals, 1983 and 1985

	1983			1985		
Annual costs	**Number**	**Percent**	**Cum. Percent**	**Number**	**Percent**	**Cum. Percent**
Less than $10,000	16	35.6	35.6	13	26.1	[illegible]
$10,000 to $24,999	13	30.4	66.0	20	38.5	[illegible]
$25,000 to $49,999	7	16.1	82.1	8	16.1	[illegible]
$50,000 to $99,999	3	6.0	88.1	3	5.7	[illegible]
$100,000 to $249,999	3	7.4	95.5	6	11.6	[illegible]
$250,000 to $499,999	2	4.5	100.0	1	2.0	[illegible]
$500,000 to $999,999	0	0.0	•	0	0.0	•
$1 million or more	0	0.0	•	0	0.0	•
Total	**44**	**100.0**		**51**	**100.0**	

Note: The total number of hospitals each year is based on the number of responding hospitals that provided the relevant data for that year

[a]See appendix III of this report for information on the number of Arkansas hospitals in the [illegible] our sample, and the survey response. Unless otherwise indicated, the estimates presented in this study are also included with sampling errors in tables IV.1 through IV.5. Also, see GAO HRD-[illegible] p. 11, app. II, for methodology for obtaining and analyzing hospital cost data.

As shown in table 7, from 1983 to 1985 the estimated average malpractice insurance cost per inpatient day increased 38 percent, while the annual malpractice cost per bed increased 34 percent.

Table 7: Estimated Average Hospital Malpractice Insurance Costs per Inpatient Day and per Bed,[a] 1983-85

	1983	1984	1985	1983-85 increase[b] Amount	Percent
Average malpractice cost per inpatient day	$1.09	$1.24	$1.50	$.41	38
Average annual malpractice cost per bed	$353	$418	$474	$121	34

[a]To determine the average annual malpractice cost per bed, we computed the daily occupied bed rate (the total number of inpatient days divided by 365) and increased that number by one bed for every 2,000 outpatient visits (emergency room visits were counted as outpatient visits). This number was divided into the hospital's total annual malpractice insurance cost.

[b]Sampling errors for the amount and percentage of increase are not presented in appendix IV but they are comparable to the errors for the estimated costs.

Our estimates indicate that the changes in inpatient day insurance costs varied considerably among the hospitals in the state. As shown in table 8, from 1983 to 1985, 30 percent of the hospitals had increases of less than 10 percent or decreases in inpatient day malpractice insurance costs, 35 percent had increases of 10 to 49 percent, and 35 percent had increases of 50 percent or more.

Table 8: Estimated Distribution of Changes in Malpractice Insurance Costs per Inpatient Day From 1983 to 1985

	Hospitals		
Percentage change	Number	Percent	Cum. Percent
Increases of less than 10 or all decreases	13	30.3	[illegible]
+10 to 49	15	35.1	[illegible]
+50 to 99	11	25.5	[illegible]
+100 to 199	4	9.2	[illegible]
+200 to 299	0	0	[illegible]
+300 or more	0	0	[illegible]
Total	**43[a]**	**100.1[a]**	

[a]Does not add to adjusted universe or 100 percent due to independent rounding.

Note: The total number of hospitals is based on the number of responding hospitals that provided data for both 1983 and 1985 so that the percentage change could be calculated.

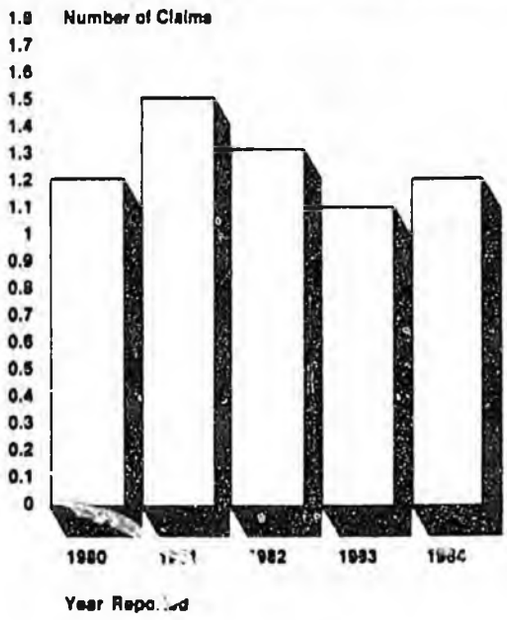
Malpractice Insurance Rates for Hospitals

For $300,000/$900,000 claims-made coverage, the St. Paul Companies hospital malpractice insurance rates increased from $173 per occupied bed in 1980 to $262 in 1986—51 percent.

Frequency of Claims

Based on the combined claims experience shown in figure 3 for the two largest insurers of Arkansas hospitals—the St. Paul Company and the Ohio Hospital Insurance Company—except for 1981, the frequency of claims filed against Arkansas hospitals remained relatively constant around 1.2 claims per 100 occupied beds from 1980 to 1984.

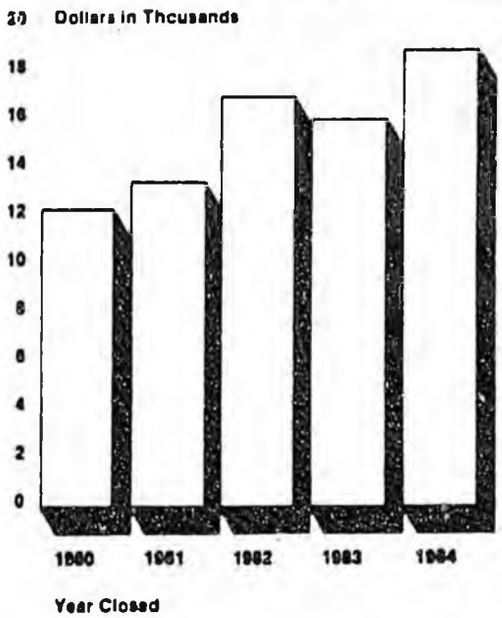
Figure 3: Frequency of Claims per 100 Occupied Hospital Beds, 1980-84



Size of Awards/Settlements

Based on the combined claims experience of the St. Paul Company and the Ohio Hospital Insurance Company shown in figure 4, the average paid claim against Arkansas hospitals increased from $12,000 in 1980 to $18,345 in 1984.

Figure 4: Average Paid Claim for Hospitals, 1980-84



Cost to Investigate and Defend Claims

The combined claims experience of the state's leading hospital insurers showed that the average cost per claim to investigate and defend claims against Arkansas hospitals almost doubled between 1980 and 1984—from $2,263 to $4,120.

The combined data of the leading hospital insurers in Arkansas show that the percentage of claims closed against hospitals with an indemnity decreased from 39 percent in 1980 to 26 percent in 1984. However, the percentage of claims closed with costs only to investigate and defend the claim doubled over the same period—from 14 to 28 percent. The percentage of claims closed with no expense remained relatively constant.

Major Medical Malpractice Problems—Current and Future

Three or more interest groups[6] we surveyed perceived major current and future problems with the size of legal costs and attorney's fees for medical malpractice claims. Three or more groups also expected major problems to develop during the next 5 years concerning the cost and availability of malpractice insurance for physicians, the cost and availability of reinsurance for primary insurers, and physicians having strong incentives to perform medically unnecessary tests or treatments.

Legal Expenses and Attorney's Fees for Malpractice Claims

The Arkansas Bar Association, the Arkansas Trial Lawyers Association, and the Arkansas Insurance Department believed that plaintiffs' legal costs in pursuing a claim are too high. These groups expect the problem to be a major concern in the future as well. The Arkansas Insurance Department officials stated that increased legal expenses, such as for expert witnesses and depositions, are currently a problem both for defending and pursuing a claim.

Officials of the Arkansas Trial Lawyers Association stated that many lawyers will spend $2,000 to $3,000 for expert review to assess the adequacy of evidence supporting a claim. They stated that malpractice suits are not a way to make money in Arkansas since a lawyer can easily spend $5,000 to $18,000 on such items as expert witnesses, depositions, and medical review of records. The Trial Lawyers Association said that if the amount of the fee is capped, the amount of the claim will simply be raised to cover legal expenses. An Arkansas Bar Association official stated:

"Health care providers, their insurance companies, and lawyers have made processing a patient's claim so expensive that the small case is not economically viable. But the contingency fee is not at fault. The vast majority of patients can't pay any other type of fee."

The physician group, medical malpractice insurers, and the Arkansas Insurance Department expect the high legal costs associated with defending malpractice claims to be a major problem during the next 5 years (1986-90).

Cost of Malpractice Insurance

The physician group, the medical malpractice insurer group, and the Arkansas Insurance Department expected the cost of basic liability

[6]Our methodology for obtaining the views of major interest groups and for analyzing their views is described in GAO/HRD-87-21, pp. 10-11. The specific interest groups for Arkansas are presented in appendix II of this report.

insurance for physicians to be a major problem in the next 5 years. As was shown in table 2, physician rates have increased somewhat since 1980. Arkansas Insurance Department officials told us that relative to physicians' incomes, they believe the cost of malpractice insurance in Arkansas is still reasonable. They believe, however, that the problems with the cost of malpractice insurance will become a major future problem. They attributed their concern to an increase in the number of lawyers and lawyer advertising, an overall increase in the litigiousness of the state, and a decrease in insurers' capacity to write insurance.

Officials of the Arkansas Trial Lawyers Association pointed out that because there are now at least three carriers writing malpractice insurance in Arkansas, premiums may be going up, but not as much as in other states. An Arkansas Medical Society official stated that he has not heard outcries from physicians regarding the cost of malpractice insurance in the state, but that it may be just around the corner, because trends in Arkansas are always several years behind the rest of the country.

Availability of Malpractice Insurance

Major future concerns regarding the availability of insurance identified by three or more interest groups we surveyed were that

- physicians would be unable to find a source to purchase excess liability coverage and
- insurers would be unable to find a source from which to purchase sufficient reinsurance.

Specifically, the physician group, the Arkansas Hospital Association, and the Arkansas Insurance Department expected major problems to develop in the next 5 years regarding insufficient sources of excess liability coverage for physicians. The Arkansas Ophthalmological Society commented that because insurers are motivated by profitability, and because there are unknowns involved in "tail" coverage and excess liability coverage, insurers will not want to continue to assume this unknown risk. An Arkansas Hospital Association official commented that excess liability coverage will be difficult, but not impossible, to find in the future.

The Arkansas Hospital Association, the Arkansas Insurance Department, and the medical malpractice insurers believed that insufficient sources of reinsurance will be a major problem in the next 5 years. American Physicians Insurance Exchange officials stated that the

number of insurance companies providing reinsurance is decreasing and those that are, are doing so at increased costs. This, they stated, is in turn driving up the company's malpractice insurance rates.

Incentives to Practice Defensive Medicine

Arkansas' physician group, Hospital Association, malpractice insurers, and Insurance Department expected future problems related to the incentives for physicians to perform medically unnecessary tests or treatments to reduce their risk of liability. American Physicians Insurance Exchange officials noted that they are seeing a tendency for physicians to increase the number of tests in order to cover any possible questions at a later date. For example, they stated that they have seen the number of X-rays and electrocardiographs double, even though such tests are not warranted in many cases. They added that lawyers are encouraging physicians to perform more tests to protect themselves. The President of the Arkansas Society of Pathology stated that "common sense no longer dictates when to order tests."

Solutions to Malpractice Problems

To address malpractice problems, the state's hospital association, trial lawyers association, and bar association strongly supported (1) imposing sanctions or disciplinary measures against physicians and hospitals with medical malpractice histories and (2) increasing peer review of physicians' medical practices as means of addressing malpractice problems.

Role of the Federal Government

The Arkansas Hospital Association was the only group to express strong support for federal action. The Association strongly supported federal action to (1) establish a national policy regarding compensation for medically induced injuries, (2) establish a mechanism to provide financial incentives to states that take certain actions, (3) establish a mechanism to provide technical assistance to states and/or organizations, and (4) mandate a uniform system for resolving malpractice claims.

Officials of the Arkansas Bar Association stated that the individual states should be given time to see if they can resolve their own problems. The Arkansas Trial Lawyers Association stated that the federal government should stay out of the medical malpractice area because there is no way a uniform system can be developed because of differences in the states, people, and localities, which could cause individual judges to interpret laws differently.

Medical Malpractice Insurers Requested to Provide Statistical Data for Arkansas

	Provided Data for	
	Physicians	Hospitals
American Physicians Insurance Exchange	X	
Ohio Hospital Insurance Company		X
St Paul Fire and Marine Insurance Company	X	X

Organizations Receiving GAO Questionnaire for Arkansas

Completing questionnaire	Not completing questionnaire
Physician group:	
Arkansas Medical Society	Arkansas Chapter of American Academy of Pediatrics
Arkansas Society of Pathology	Arkansas Orthopaedic Society
Arkansas Section, American College of Obstetricians and Gynecologists	Arkansas Psychiatric Society
Arkansas Society of Plastic and Reconstructive Surgeons	Arkansas Chapter, American College of Radiology
Arkansas Ophthalmological Society	Arkansas Chapter, American College of Surgeons
Association of Arkansas Neurosurgeons	Governor for Arkansas, American College of Physicians
Arkansas Academy of Family Physicians	
Arkansas Society of Anesthesiologists	
Hospital association:	
Arkansas Hospital Association	None
Bar association:	
Arkansas Bar Association	None
Trial lawyers:	
Arkansas Trial Lawyers Association	None
Malpractice insurers:	
American Physicians Insurance Exchange	St. Paul Fire and Marine Insurance Company
Mid-American Insurance Managers	
State insurance department:	
Arkansas Insurance Department	None

Number of Arkansas Hospitals in the Universe, GAO Sample, and Survey Response

Number of Hospitals		Hospitals completing questionnaire	
Universe[a]	Sample	Number	Percent
92	44	27	61

[a]1983 data

Estimated Hospital Data and Related Sampling Errors for Policy Years 1983, 1984, and 1985

Table IV.1: Hospital Malpractice Insurance Costs and Related Sampling Errors by Type of Expenditure

Dollars in millions

	1983		1984		1985	
Expenditure	**Amount**	**Sampling error[a]**	**Amount**	**Sampling error[a]**	**Amount**	**Sampling error[a]**
Total costs	**$1.8**	**$.3**	**$1.8**	**$.4**	**$2.2**	**$.4**
Contributions to self-insurance trust funds	5	2	4	1	7	5
Premiums for purchased insurance	1 3	3	1 4	4	1 5	2
Uninsured losses	0	0	0	0	0	0

[a]Sampling errors are stated at the 95-percent confidence level

Note Detail may not add to total due to independent estimation The adjusted universe of hospitals to which the estimated amounts relate was 44 in 1983 and 51 in 1985 The adjusted universe is that portion of the total universe based on the sample response rate for which we can estimate data

Table IV.2: Distribution of Annual Malpractice Insurance Costs and Related Sampling Errors for Hospitals

Figures in percents

	1983		1985	
Annual cost	**Hospitals**	**Sampling error[a]**	**Hospitals**	**Sampling error[a]**
Less than $10,000	35.6	11 2	26 1	[illegible]
$10,000 to $24,999	30 4	12 2	38 5	[illegible]
$25,000 to $49,999	16.1	8.5	16 1	[illegible]
$50,000 to $99,999	6.0	0 0	5 7	[illegible]
$100,000 to $249,999	7 4	6 3	11 6	[illegible]
$250,000 to $499,999	4 5	0 0	2 0	[illegible]
$500,000 to $999,999	0	0 0	0	[illegible]
$1 million or more	0	0 0	0	[illegible]

[a]Sampling errors are stated at the 95-percent confidence level

Note The adjusted universe of hospitals was 44 in 1983 and 51 in 1985

Table IV.3: Average Malpractice Insurance Costs per Inpatient Day and Related Sampling Errors

1983		1984		1985	
Cost per day	**Sampling error[a]**	**Cost per day**	**Sampling error[a]**	**Cost per day**	**Sampling error[a]**
$1 09	$ 18	$1 24	$ 32	$1 50	[illegible]

[a]Sampling errors are stated at the 95-percent confidence level

Table IV.4: Average Annual Malpractice Insurance Costs per Bed and Related Sampling Errors

1983		1984		1985	
Cost per bed	**Sampling error[a]**	**Cost per bed**	**Sampling error[a]**	**Cost per bed**	**Sampling error[a]**
$353	$68	$418	$129	$474	[illegible]

[a]Sampling errors are stated at the 95-percent confidence level

Table IV.5: Distribution of Changes in Malpractice Insurance Costs per Inpatient Day From 1983 to 1985 and Related Sampling Errors

Figures in percents

Change	Hospitals	Sampling error[a]
Increases of less than 10% or decreases	30.3	14.6
Increases of 10% to 49%	35.1	15.7
Increases of 50% to 99%	25.5	14.2
Increases of 100% to 199%	9.2	7.6
Increases of 200% to 299%	0.0	0.0
Increases of 300% or more	0.0	0.0

[a]Sampling errors are stated at the 95-percent confidence level

Note: The adjusted universe of hospitals was 44

Addressing the Myths & Misconceptions about Personal Injury & the Civil Justice System

Compiled by
The Alaska Academy of Trial Lawyers

January 1993

TABLE OF CONTENTS

EXECUTIVE SUMMARY

A. Access to Justice

1. Right of Trial by Jury -- The Foundation of Our Society
   a. A fundamental guarantee in the Alaska State Constitution.
   b. The jury, as conscience of the community, promotes safety and equity.
   c. Critics of the jury system are the most likely to request a jury trial.

B. Tort Restrictions Do Not Reduce Insurance Rates

1. Evidence indicates that tort restrictions have no significant impact on insurance premiums or availability
2. A case history -- medical negligence restrictions have little impact on rates

C. The Litigation Crisis: Debunking the Myths

1. Personal injury cases represent a small percentage of the courts' workload
2. If there is a "litigation explosion", it is being driven by businesses suing businesses, not by personal injury actions
3. Most cases are resolved prior to trial

D. Large Jury Verdicts are Uncommon

1. Huge jury verdicts, such as million dollar verdicts, are the exception rather than the rule
2. Jury verdicts can be reduced -- the actual payout to the plaintiff may be less than the jury verdict

E. "Horror Stories" Make Bad Public Policy

1. Some examples of "horror stories"

F. The Costs of Personal Injury

1. Injured Persons Bear the Burden of Personal Injury
   a. The injured person bears the brunt of the cost of injury.
   b. Personal injury liability compensation does not pay for the actual cost of injuries.

G. Civil Justice System Promotes Safety in America's Economy

1. Tort Law Improves American Products
   a. The tort system saves lives, reduces injuries and promotes public safety.
   b. Insurers reap benefits while projections of future losses have decreased.

c. Claims that the tort system stifles innovation is a ruse.
d. The cost of liability claims is minor compared to the GNP.

H. Medical Negligence Facts vs. Myth

1. Medical Negligence Claims -- The Real Facts
   a. Lawsuits protect the public -- the benefits outweigh the costs.
   b. The frequency and severity of medical negligence claims has remained relatively constant.

I. Medical Negligence -- Debunking the Myths

1. Liability claims without merit are not compensated, and the size of the payment is commensurate with the severity of the injury
2. Rather than seeking large settlements, most injured patients sue for other reasons
3. Very few incidents of medical negligence result in a claim
4. Elderly and minority patients are at a greater risk of being injured by medical negligence

J. Physician Discipline System Does Not Remove Bad Doctors

1. The cause of medical negligence is medical negligence -- negligent doctors committing preventable errors
2. A small number of physicians are responsible for most of the negligence
3. Medical disciplinary boards do a very poor job of regulating physicians

K. Medical Negligence Insurance -- Costs and Profits

1. Medical liability insurance is less than 1% of the total cost of health care
2. Medical negligence insurance is highly profitable for both private and physician-owned insurance companies

L. Medical Negligence Restrictions Are No Solution

1. Tort restrictions will not resolve the problem of access to health care

Preface

We have recently celebrated the Bicentennial of the Bill of Rights of the American Constitution. That Constitution and those of the States, including Alaska, declare as fundamental, the right to jury trial and equal access to civil justice for all.

And yet today our civil justice system and the rights of injured victims and consumers are under attack. Politicians in search of solutions to such complex matters as runaway medical costs, the budget deficit and America's competitiveness in the market, oftentimes skew statistics to perpetuate unfounded myths and misconceptions about our legal system in an attempt to pin the problem on lawyers and the injured victims they represent. The multi-million dollar propaganda efforts of insurance companies and their corporate colleagues have borne fruit in biased judges, alienated juries, regressive state and federal legislative efforts, and a social environment permeated by an uncaring attitude toward the rights of the injured victims.

For more than a decade, the legislative debate over the "liability insurance crisis" has assumed that a crisis existed and focused on restriction of the rights of victims of negligence to recover fair compensation to resolve that crisis. Despite any hard data to support their claims, representatives of the insurance industry have asserted that restriction of victims' tort rights will result in lower liability insurance rates. In response to these assertions, the Alaska Legislature has adopted some of the most severe restrictions of those rights of any state in the country.

In 1989, then Speaker of the House, Sam Cotton, at the request of several fellow representatives, formed the Alaska Liability Insurance Task Force. The task force was comprised of legislators and members of medical, insurance, consumer and legal organizations familiar with li bility insurance issues. The most significant finding from the data collected by the task force was that, with some exceptions, there is <u>no liability insurance crisis in Alaska.</u>

Although there were minor differences in the conclusions reached in the various studies collected by the Liability Insurance Task Force, the general consensus was that, at best, restrictions on the rights of victims to receive fair compensation through the tort system have had only a "modest", if any, impact on liability insurance rates. More importantly, the consensus among the scholars was that state legislatures should direct their attention away from the tort system and towards alternative solutions to resolving any existing liability insurance problems.

What these studies did not address is the extent to which the public is forced to financially support those tort victims who have been disenfranchised from the legal system because of existing restrictions on tort recovery and the extent to which this gap would widen if further restrictions on tort victims' rights were enacted.

ACCESS TO JUSTICE

RIGHT OF TRIAL BY JURY -- THE FOUNDATION OF OUR SOCIETY

A fundamental guarantee in the Alaska State Constitution.

- A Guaranteed Right: Article I, Section 16 holds that in civil cases where the amount in controversy exceeds $250, the right of trial by jury is preserved.

The jury, as conscience of the community, promotes safety and equity.

- Juries Promote Safety: Over 5 million Americans serve on juries each year. As the conscience of the community, their decisions determine guilt or innocence, safety and security, life and death. Countless improvements aimed at preventing injuries and saving lives might never have occurred without trial by jury and its time-tested ability to bring about changes for the better.

- A Triumph of American Democracy: According to the consumer group, Public Citizen, "The right to collect damages through the civil justice system is one of the great triumphs of American democracy. It allows anyone, no matter how poor, to challenge the largest corporation or government agency and reclaim compensation for wrongful injuries. It forces wrongdoers to change their products and practices to prevent further injuries and avoid further liability."[1]

Critics of the jury system are the most likely to request a jury trial.

- The Ultimate Irony: The loudest critics of the jury system are insurance companies and the defendants they represent in personal injury litigation -- corporations, local government, and doctors. Ironically, the party most likely to request a jury trial in personal injury litigation is the defendant. In fact, insurers almost always demand a jury trial.

TORT RESTRICTIONS DO NOT REDUCE INSURANCE RATES

Evidence indicates that tort restrictions have no significant impact on insurance premiums or availability.

- Insurance Services Office (ISO) Says "NO REDUCTION": A 1987 ISO study determined that tort "reforms" enacted in 1986 would have little or no impact for the majority of liability claims filed with insurers.[2] In October 1986, ISO determined that

its rates would not reflect recent state tort restrictions because ISO was unable to determine any cost effect of the tort law changes.[3]

• Insurers Say "NO REDUCTION": Insurers required to provide Washington State Insurance Commissioner Richard Marquardt with evaluations of the effects of tort reforms on proposed rate filings indicated that there was no way to make such a determination, and that the 1986 law would have a minimal effect on rates. Responses from insurers in other states indicate that tort restrictions do not resolve insurance price fluctuation, reduce rates or increase availability.[4]

• Washington State Insurance Commissioner Says "NO REDUCTION": In 1987, Commissioner Marquardt told a U.S. House committee, "It is difficult, if not impossible, to pin a price tag on tort reform or to even assess accurately its effect on insurance availability and affordability. Based on our research, by the middle of 1986, general liability rates had begun to stabilize throughout the United States -- not just in the states that had adopted tort reform.[5]

• 1991 Washington Insurance Commissioner Report Says "NO REDUCTION": A 1991 report by Marquardt to the Legislature notes that insurance rates in recent years have stabilized and coverage is more readily available, however, tort changes cannot be credited as the reason. Insurers still find it difficult to quantify the impact tort reform on insurance rates. A 1989 law requiring insurers to consider investment income in setting rates was projected to have a much greater impact on insurance rates than changes in the tort system.[6]

• Best's Says "NO REDUCTION": A 1989 Best's Review article on a presentation by David B. Mathis, CEO of Kemper Reinsurance, quoted Mathis as saying, "The only way to achieve stability in the market is through adequate price levels. First of all, despite the publicity it has received, tort reform has turned out to be a non-event in terms of its impact on the big picture.".[7]

A case history -- medical negligence restrictions have little impact on rates.

• 1970 Limitations Fail: A study of medical negligence legislative limits passed in various states from 1974 to 1978 concluded that the changes, either individually or collectively, did not reduce or stabilize insurance rates.[8] Following adoption of MICRA in 1975, California's medical liability insurance premiums continued to rise (increases of 16% to 337% between 1980 and 1986.) Indiana, which adopted the most restrictive medical negligence laws of any state, had premium increases of 53% to 116% during the early 1980s.[9]

• The Crisis of 1985-1986: Despite the fact that tort restrictions had little or no effect on resolving the so-called crisis of the 1970s, a number of states passed laws restricting medical negligence actions during the mid-1980s when liability premiums began to skyrocket.

• Rate Reduction Not Due to Liability Restrictions: Nationwide, medical liability premiums began dropping early in 1989 due to a reduction in claim filings and a reduced increase in the costs to settle claims.[10]

THE LITIGATION CRISIS: DEBUNKING THE MYTHS

Personal injury cases represent a small percentage of the courts' workload.

• The courts are overburdened with over 18 million civil lawsuits filed in state courts each year: This 18 million dollar figure includes millions of routine cases such as small claims, traffic and other ordinance violation cases, domestic relations, estate and contract matters. The most recent figures from the National Center for State Courts show that the number of tort cases filed in state courts was less than half a million, or less than three percent of all state filings.

• Federal Courts: Studies of federal tort filings show lawsuits are on the decline. Over the last thirty years, tort cases as a percentage of federal civil cases dropped by nearly half, from 38.4 percent in 1960 to 20.1 percent in 1990. Product liability litigation is shrinking even faster. It has been reported that federal product liability cases, other than those involving asbestos, have been shrinking steadily in recent years, falling 40 percent between 1985 and 1990.

If there is a "litigation explosion," it is being driven by businesses suing businesses, not by personal injury actions.

• Businesses Suing Businesses: According to a University of Wisconsin study, federal litigation between corporations has increased astronomically, growing more than 1000% between 1971 and 1986.[11]

• State Courts: According to the National Center for State Courts, tort filings are not increasing at a faster rate than other major categories of civil filings. The most dramatic increases in civil cases are real property and contract cases, not torts.[12]

• Federal Courts: Nationally, between 1979 and 1987 contract cases filed in Federal District Courts more than

tripled and property cases quadrupled -- far exceeding growth in personal injury filings.[13]

Most cases are resolved prior to trial.

• Most Cases Are Settled: Only 5% of all personal injury cases filed in state courts go to trial. Complex actions, such as medical negligence cases, are more likely to go to trial than cases such as automobile personal injury (11% of medical negligence cases filed result in trials). Most cases are settled, withdrawn or dismissed prior to trial. 6% of all personal injury cases are uncontested by the defendant.[14]

LARGE JURY VERDICTS ARE UNCOMMON

Huge jury verdicts, such as million dollar verdicts, are the exception rather than the rule.

• Huge Verdicts are Rare: Huge personal injury payouts are a rarity. The largest settlements and verdicts are made to the most seriously injured victims.[15] If anything, juries are very cautious and reticent to adequately compensate injured persons. The multi-million dollar advertising campaigns of the insurance industry have used anecdotal information to make the public feel guilty about fairly compensating persons negligently injured by others.[16]

• Million Dollar Verdicts are Uncommon: According to Business Week, "Over the past 14 years in our nation of 240 million people there has been only 1,642 awards of $1 million or more. Furthermore, two-thirds of the 1,642 cases involved victims who suffered either permanent paralysis, brain damage, amputations or death."[17]

• Alaska Personal Injury Verdicts are Lower than National Verdict Average: Alaska personal injury verdicts currently average 8.1% below national verdict values.[18]

• The Most Severely Injured Persons Receive the Higher Verdicts: Product liability and medical negligence victims generally sustain more severe injuries and are more likely to receive a larger jury verdict. While the 1988 average verdict for personal injury litigation in U.S. state courts was $89,622, the highest average verdict was in the area of medical negligence ($146,831).[19]

Jury verdicts can be reduced -- the actual payout to the plaintiff may be less than the jury verdict.

• Verdicts Can be Reduced on Appeal or Settlement: The actual payout to the plaintiff is reduced after the trial verdict in about 20% of cases. The larger the verdict, the greater the likelihood that the verdict will be reduced. Of the cases where a verdict is reduced, the average actual payout is about half (53%) of the original verdict amount.[20]

"HORROR STORIES" MAKE BAD PUBLIC POLICY

Use of outrageous and atypical examples to create the impression of abuses and/or weaknesses in the civil justice system are common. Cases cited by tort critics alleging frivolous lawsuits and excessive jury verdicts are very often misleading and inaccurate.

Some examples of "horror stories":

• The Pure Fabrication -- The Lawn Mower and the Hedge Story: A widely-circulated story given in the mid-'80s as an example of our litigious society told of a man who successfully sued a lawn mower manufacturer for injuries suffered while using one of their lawn mowers to trim his hedge. In fact, this case is fictitious. It does not exist. It was a fabrication of tort reform proponents.

• Failure to Disclose All Pertinent Facts -- The Phone Booth Near the Road: In 1986, President Reagan noted that it was absurd for a California man to recover damages from a telephone company because he was in one of their booths when it was struck by a drunk driver.[21] The facts conveniently left unstated included: 1) The company knew the booth was too close to the street because it had been hit before; 2) complaints had been filed with the telephone company stating that the booth was difficult to exit because the door jammed; 3) the trial court had granted a lower court summary judgment to the company, but the California Supreme Court remanded the case to the lower court because the risk of injury was foreseeable by the telephone company; and 4) the case was ultimately settled.[22]

• Not Appropriately Placing Blame - Beware of Horse Manure: In 1987, a CBS "60 Minutes" segment focused on a lawsuit against a ladder manufacturer in which the plaintiff recovered $300,000. According to the manufacturer, the plaintiff was injured when the temperature increased from 20 to 40 degrees and the ladder slipped because it had been placed in a manure pile. "We didn't warn him about the viscosity of horse manure," said the manufacturer. To their credit, "60 Minutes" ran a follow-up segment in which a number of

alleged tort horror stories were rebuked. In re-examining the ladder story, reporter Ed Bradley noted, "Several jurors...told us the viscosity of horse manure had nothing to do with their verdict. They said they were persuaded by the plaintiff's contention that the ladder was defective, and that's why he was injured."[23]

• The Tort System Works -- The Psychic and the CAT Scan: A Philadelphia jury awarded $1 million to a woman who claimed she lost her psychic powers after undergoing a CAT scan. In fact, the woman had warned the doctor of previously having had an adverse reaction to a similar procedure. She then suffered anaphylactic shock when the procedure was performed. The jury that returned a $988,000 verdict had been instructed to disregard the woman's alleged loss of earnings because she was no longer able to "read auras." The judge found the verdict excessive and ordered a new trial. This case demonstrates that the safeguards in the process work.[24]

THE COSTS OF PERSONAL INJURY

INJURED PERSONS BEAR THE BURDEN OF PERSONAL INJURY

The injured person bears the brunt of the cost of injury.

• The Injured Person Pays First: Whether or not an injured person is reimbursed for a personal injury from another source, the initial cost of the injury is borne by the injured person and his or her family. The costs of injury include medical bills, lost wages and property damage. Personal injury often causes additional losses, such as the inability to pay bills (the house, the car), increased debt obligations and interest payments, and increased stress on family relationships. The burden of locating reimbursement for medical, wage loss, and other costs of injury falls on the injured person.

• When Defendants Don't Pay and Victims Can't, Taxpayers Do: Most personal injury cases involve significant medical and related expenses. When the victim can't pay and the defendants aren't required to fully compensate for injuries, the uncompensated cost of care is usually borne by government agencies -- in other words, by you and me as taxpayers.

• 38% of Economic Damages are Paid Out of Pocket: The total annual economic loss associated with nonfatal injuries in the U.S. is $175.9 billion. 38% of this total economic burden is not reimbursed by any outside source and is paid for out-of-pocket by those who are injured. 64% of wages lost due to injury are not

reimbursed and are borne exclusively by those injured.[25]

Personal injury liability compensation does not pay for the actual cost of injuries.

• Only a Small Number of Victims Receive Personal Injury Liability Compensation: Only 10% of all accident victims receive personal injury liability compensation. The personal injury system plays a greater role in compensating motor vehicle injury victims. Those injured in motor vehicles are more likely to receive personal injury liability compensation (31%) compared to persons injured in some other manner.[26]

CIVIL JUSTICE SYSTEM PROMOTES SAFETY IN AMERICA'S ECONOMY

TORT LAW IMPROVES AMERICAN PRODUCTS

The tort system saves lives, reduces injuries and promotes public safety.

• Product Liability and Tort Law Promote Safety: There are huge benefits of the current tort system. Businesses devote greater attention to safety. There is a heightened consumer perception that products are safer and of higher quality. Workplace and other injuries have been reduced resulting in thousands of lives saved and millions of injuries prevented. The existence of these very large benefits should give policymakers cause for careful reflection as they are pressed to weaken product liability and tort law in general. Reducing the costs of the system may reduce the benefits and leave society worse off.[27]

• The Tort System Contributes to a Competitive Society: Without a strong tort law, the ethical corporation would have a competitive disadvantage and would be tempted to put profits before public safety. The American focus on safety in conjunction with punitive damages will produce the top quality products needed to compete in the international marketplace. "Our analysis suggests that the rules of product liability make a good deal of economic sense."[28]

• Punitive Damage Awards Do Not Undercut United States Competitiveness: Perhaps nothing is more grossly exaggerated than claims about punitive damage awards, particularly in product liability cases. The most comprehensive study ever conducted on punitive damages in product liability cases -- a survey of the past 25 years -- indicated just 355 cases in the entire country. That's only ten per year for the entire country. The

median punitive damage jury award was $1.5 million, with post-trial activity sharply reducing the median amount actually paid to $250,000. The study also found that 82 percent of businesses assessed punitive damages subsequently implemented safety measures such as product recalls or improved warnings and instructions.[29]

• Harmful Products are Removed or Altered: Examples of unsafe products which have been removed from the marketplace due to the tort system include the Dalkon Shield, asbestos, flammable baby clothes, and unsafe infant formula. Examples of products redesigned to improve safety resulting from the tort system include the Ford Pinto, safety devices on machinery and childproof caps.[30]

• Product Liability Expense Adds Little Cost to Consumer Goods: A new study by the National Insurance Consumer Organization (NICO) found that product liability expenses added but a tiny amount to the cost of consumer goods. The total cost of product liability insurance amounts to 0.14 percent of the cost of the more than $1.8 trillion worth of retain sales in the U.S. in 1991. The study used insurance industry data which broke out liability premiums as a separate line item for the first time.[31]

Insurers reap benefits while projections of future losses have decreased.

• A Shift Toward Defendants: During the mid-80's judicial decisions in product liability cases nationwide shifted toward defendants. Dismissal of product claims and new legal grounds for defendants have increased during the past half decade.[32]

• Insurers Continue to Make Big Profits: While projections of future losses have decreased, insurers' reserving practices and insurance rates have not. Why? Insurers are focusing on restricting state and federal liability laws. They can't claim a need for change while recognizing reduced losses and greater profits.[33]

• Insurers Use Natural Disasters to Raise Rates: The day Hurricane Andrew rolled into Miami, a top insurance company executive for American International Group, issued a memo to regional presidents and vice presidents saying "This is an opportunity to get price increases now. We must be first and it begins by establishing the psychology with our own people."[34]

Claims that the tort system stifles innovation is a ruse.

• Dangerous Products Kept From Market for Good Reason: Tort restriction proponents claim that the threat of litigation keeps products off the market. When Consumer Union examined the list of products being held from the market, the reasons they were pulled of the market were based on valid safety concerns. For example, the Jeep CJ-7, which tends to roll over at low speeds, and an anesthesia gas machine for which the manufacturer had failed to conduct tests of the design of critical components, were on the list of products pulled from the market because the tort system was "stifling innovation".[35]

• Corporate Report Says Liability Suits Do Not Impede Competition: "The most striking finding is that the impact of the liability issue seems far more related to rhetoric than to reality...For the major corporations surveyed, the pressures of product liability have hardly affected larger economic issues, such as revenues, market share, or employee retention...Where product liability has had a notable impact - where it has most significantly affected management decision making - has been in the quality of the products themselves."[36] In addition, numerous federal agency studies of industry competitiveness conducted during the 1980's fail to mention the liability system.

The cost of liability claims is minor compared to the GNP.

• The Cost of Liability Claims v. U.S. Productivity: The total compensation from tort liability claims to persons with nonfatal traumatic injuries in the U.S. amounts to only three-tenths of one percent of the Gross National Product of the United States.[37] The total cost of all commercial liability insurance premiums in the U.S. in 1990, including general liability, automobile liability, and umbrella insurance was only $48 billion, less than 1% of the U.S. Gross National Product.[38]

MEDICAL NEGLIGENCE FACTS vs. MYTH

MEDICAL NEGLIGENCE CLAIMS -- THE REAL FACTS

Lawsuits protect the public -- the benefits outweigh the costs.

• Restrict Patients' Rights at Our Peril: One very important aspect of medical negligence litigation is the useful examination of the practice of medicine itself. Because the buyer of medical care cannot be expected to evaluate the quality of medical care, the market cannot adequately identify incompetent health care providers. "The data suggest that to eliminate or seriously restrict

a patient's right to file a malpractice claim is a step we would undertake at our peril."[39]

• Medical Negligence Standard of Care: Under Alaska law, a physician is responsible for the harm caused when the physician fails to use reasonable care in providing medical care. Other professionals, such as architects, bankers, and lawyers are also required to exercise reasonable care in their professional activities.

The frequency and severity of medical negligence claims has remained relatively constant.

• Closed Claim Study in Minnesota: The Minnesota Insurance Commissioner conducted a study of medical negligence insurance claims filed in Minnesota, North Dakota and South Dakota. The study examined all claims filed from 1982 to 1987 for the two largest medical negligence insurers in the region. 27% of the claims were closed with a payment average of $54,629; the median was zero. Only one-tenth of one percent of the claims resulted in a payment exceeding $1 million, and only 4% exceeded $100,000. Of the 3% of cases that actually went to trial, the defense prevailed in 81 percent of them. In the 20 favorable jury verdicts for the period, no pain and suffering damages were awarded. No cases involved punitive damages. A final note on the Commissioner's study: Saint Paul announced a rate cut of 25 percent on its medical malpractice premiums in Minnesota.[40]

• Unjust Payments are Rare: A new study of medical malpractice cases finds that, despite popular belief, unjustified payments are rare. The study is one of the first systematic attempts to asses the quality of care in malpractice cases and was based on 8,231 cases filed in New Jersey over the past 15 years. The data came from the state's doctor-owned insurance company and the authors contend that their findings are relevant to the nation as a whole. In concluding that unjustified payments are not the norm, the study contradicts the conventional wisdom among doctors, which is that malpractice litigation is a lottery and that verdicts often depend on the whim of jurors.[41]

• Stable Rate of Frequency: The Minnesota closed claims study identified little measurable change in claim frequency over a six year period. The frequency rate was actually greater in 1983 than in 1987 and the average payment appeared to be decreasing over the period of the study. In fact, the study concluded the "data does not substantiate the litigation explosions assertion."[42]

Liability claims without merit are not compensated, and the size of the payment is commensurate with the severity of the injury.

- The System Works: The findings of a closed claims study of obstetric claims from a large physician-owned insurance company between 1982 and 1988 indicate that non-meritorious claims were not compensated. Where a claim was paid, poor physician judgment was the primary source of error and "the size of the settlement was commensurate with the seriousness of the injury." The study concluded that "These results should help to reassure physicians who are concerned that the tort process itself is unjust. Frivolous claimants do not, as a rule, prevail."[43]

Rather than seeking large settlements, most injured patients sue for other reasons.

- Lack of Communication -- What Really Happened: According to a recent survey of 187 families who filed suits against physicians, the primary reasons for pursuing litigation were to find out what happened.[44] Poor communication by medical personnel with the patient was often cited by respondents. In addition, a prior relationship with a medical provider did not protect the provider from legal action. Physicians are finding that apologizing reduces litigation and promotes quick resolution of claims. Douglas Phillips, President of the Physicians Insurance Association of America, said that "Communicating with the patient is probably the most important aspect of loss prevention."[45]

Very few incidents of medical negligence result in a claim.

- Few Negligently Injured Patients Receive Liability Compensation: Only one in every ten incidents of medical negligence result in a liability claim, and only one in twenty-five receive compensation through the liability system.[46] Is this evidence of litigiousness -- that 70 or 80 percent of the people injured by an incompetent or negligent act do nothing about it?

Elderly and minority patients are at a greater risk of being injured by medical negligence.

- Increased Risk of Being a Negligence Victim: In a study of New York hospital discharges, patients with the highest risk of being injured due to medical negligence included elderly patients, minority patients in hospitals that treat a high proportion of minorities, patients in

government-operated hospitals and patients in non-teaching hospitals.[47]

PHYSICIAN DISCIPLINE SYSTEM DOES NOT REMOVE BAD DOCTORS

The cause of medical negligence is medical negligence -- negligent doctors committing preventable errors.

- New York Study: A Harvard study reviewed 30,121 hospital patient discharges from 51 New York state hospitals in 1984. Of these, 280 patients included an adverse event which was caused by negligence. It is estimated that 27,177 cases of medical negligence occurred in New York during 1984, resulting in 6,895 deaths and 877 instances of severe permanent disability. Only 1 in 8 injured patients filed suit and only 1 in 16 received any liability compensation.[48]

- Many Deaths are Preventable: Physicians reviewing 182 hospital deaths in 12 hospitals found that in at least 14% of the cases examined, the deaths could have been prevented. In addition, a small number of factors caused most of the preventable deaths.[49]

A small number of physicians are responsible for most of the negligence.

- Florida: 4% of the physicians practicing medicine in Florida have had 2 or more liability claims filed against them. This group is responsible for 42% of the total claims paid out from 1975 - 1986.[50]

- Illinois, Pennsylvania and Texas: 2% of all physicians practicing in Cook County, Illinois (sued 6 or more times) were defendants in 36% of the medical negligence litigation from 1973 to 1986. 57% of the physicians were not named in any lawsuit and 79% of those sued during this period were named only once or twice.[51] Studies in Pennsylvania[52] and Texas[53] had similar results.

Medical disciplinary boards do a very poor job of regulating physicians.

- New York: The New York Office of Professional Conduct takes an average of 236 disciplinary actions annually compared to an estimated 27,000 cases of medical negligence occurring each year.

- A National Disgrace: An estimated quarter million injuries and death resulted from medical negligence in American hospitals in 1988. Medical disciplinary boards in the U.S. issued an annual average of only 1,481

serious disciplinary actions against physicians from 1987 to 1990.[54]

MEDICAL NEGLIGENCE INSURANCE -- COSTS AND PROFITS

Medical liability insurance is less than 1% of the total cost of health care.

• Premiums vs. National Health Care Costs: Insurance companies argue that liability expenses are a primary factor in skyrocketing health care costs. The facts refute this allegation. In 1989, medical negligence insurance premiums in the U.S. were $5 billion.[55] National health care expenditures for 1989 were $604 billion.[56] Thus less than 1% of the national cost of health care can be attributed to medical liability premiums.

• The Texas Experience: A recent study commissioned by the Texas Hospital Association, the Texas Medical Association and the Texas Trial Lawyers Association concluded that medical liability costs -- insurance premiums and damages from lawsuits -- make up less than 1 percent of health care expenditures in Texas, consistent with national findings. The study found that reforming the medical professional liability system would have minimal cost savings impact on the overall health care delivery system in Texas.[57]

• Losses Paid vs. National Health Care Costs: Nationwide, only 43% of medical negligence insurance premiums earned -- $2.14 billion or one third of 1% of the cost of health care -- were paid out for all losses in 1989.[58] Insurers are retaining 57% of the premiums earned.

Medical negligence insurance is highly profitable for both private and physician-owned insurance companies.

• National Data: In 1989, the net profit of medical negligence insurers in the U.S. was 27.9 cents for every dollar of premium earned. From 1985 to 1989, insurers' annual average profit on medical negligence insurance was 9.2% of premiums earned.[59] Between 1985 and 1990, the net worth of medical liability insurance companies more than doubled from $835 billion to $1,691 billion.[60]

• Minnesota Study: A study of medical negligence closed claims from 1982 to 1987 by the Minnesota Commerce Commissioner found no increase in claim frequency, loss payments and loss expenses. Yet, premiums tripled resulting in a determination that St. Paul Companies --

the nation's largest medical liability insurer -- was substantially overcharging policyholders. St. Paul agreed to refund $1.5 million to physicians in Minnesota.[61]

• Physicians Sue Insurer For Excessive Premiums: In 1989, physicians in Colorado won a $4.1 million judgment against PHICO Insurance Company. The court found that the insurer created a sense of crisis and panic to justify a large premium increase.[62] Physicians in Virginia also sued PHICO for illegal conduct when the company canceled thousands of doctors policies in 1986.

• Physician-Owned Companies: An investigation by the Arizona New-Times revealed that MICA, a doctor-owned company, paid out only 30 cents of every dollar it took in. In addition, the company received a 36% rate hike in 1987. Despite a reduction in lawsuits in 1987 and its own data showing claim frequency decreasing, the company still projected increased lawsuits for 1988.

MEDICAL NEGLIGENCE RESTRICTIONS ARE NO SOLUTION

Tort restrictions will not resolve the problems of access to health care.

• The Tail Wagging the Dog: Due to the high cost of health care, a large number of Americans have no health care coverage. Blaming medical liability costs, which are less than 1% of the cost of health care, for the problem of health care access is ludicrous. Altering less than 1% of the health care costs would have no significant impact on the total cost of health care.[63]

• Reasons for Costs of Medical Care: There are numerous reasons for the increased cost of medical care, including technological advances, increases in population, increased wages as well as general and medical inflation. In a recent GAO report, medical liability costs are not even mentioned as a contributing factor of increasing health care costs.[64]

• Restrictions on Compensation Don't Work: Conventional wisdom about medical liability is not supported by the facts. Limits on verdicts and attorney's fees will not curb the incidence of litigation. Nearly 80% of the injured patients receiving liability compensation have economic losses which exceed the compensation received. This percentage is even greater for settlements. Limits on compensation will only exacerbate the current short fall.[65]

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STRAIGHT TALK ON MEDICAL MALPRACTICE

Separating Fact from Fiction

The Association of Trial Lawyers of America
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Barry J. Nace, President
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STRAIGHT TALK ON MEDICAL MALPRACTICE
Separating Fact from Fiction

CONTENTS

STRAIGHT TALK ON MEDICAL MALPRACTICE
Separating Fact from Fiction

I. Introduction

Americans increasingly have focused their attention on a profound problem of national concern -- the escalating costs of our health care system. In 1990, the United States spent 12 percent of its gross domestic product (GDP) on health care.[1] This was more than twice as much as the country spent on national defense and nearly twice as much as it spent on education. If current trends go unchecked, the U.S. Congressional Budget Office estimates that health care spending will increase to 18 percent of GDP by the year 2000.[2]

In response to this grim forecast, federal and state policymakers have proposed solutions that would attempt to control spending and provide quality health care to all Americans. Too often, however, the resulting debate has diverged from the real issues and instead focused on America's medical liability laws.[3] The medical and insurance industries contend that America's medical liability system drives up health care costs by promoting unnecessary litigation and "defensive medicine." Therefore, they claim, we need to "reform" our liability laws to contain costs.

These false arguments do not surprise attorneys who represent health care consumers. For more than a decade, the medical and insurance industries have waged a public relations and marketing campaign to foster the perception that America is awash in medical malpractice lawsuits and outrageous jury verdicts. Neither claim is true, but the motive underlying this campaign is obvious: to promote a reordered legal system that protects the interests of health care providers and insurers.

Under the benign banner of "tort reform," the medical and insurance industries seek to:

- make it harder for injured health care consumers to bring lawsuits,
- make it tougher for consumers to prevail when they do, and
- arbitrarily limit the amount an injured consumer may recover, even after a judge or jury decides that the consumer is entitled to compensation.

These proposals are a direct assault on the Seventh Amendment's guarantee that every American has the right to trial by jury.[4] They also would interfere with the fundamental principle of federalism upon which our nation was founded.[5] The framers of our Constitution never intended that a national tort compensation scheme be established. Under federalism, the states have developed their own tort compensation schemes, including medical liability systems, taking into account the culture and history of the individual state. Differences among the states are a source of pride and symbol of strength in our legal system.

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[1] CBO, Economic Implications of Rising Health Care Costs 1 (Oct. 1992).

[2] Id.

[3] See, e.g., James S. Todd, "Reform of the Health Care System and Professional Liability," 329 New Eng. J. Med. 1733 (Dec. 2, 1993); Jessica Lee, "Malpractice: Big-ticket battle," USA Today, June 9, 1993, at 8A.

[4] The Seventh Amendment states: "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law."

[5] The Tenth Amendment provides: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

The medical and insurance industries, however, have not been deterred from seeking special treatment.[6] Predictably, these industries have glossed over the alarming frequency and often catastrophic results of medical malpractice. Their proposals fail to address methods of reducing or eliminating malpractice and would have no effect on cost control. As a result, the truth about medical malpractice has been distorted in the health care debate. It is essential, therefore, to examine what effect, if any, medical malpractice litigation has on health care costs. It is equally important to understand the effects that some proposals would have on the quality of care and, ultimately, health care consumers.

To that end, this paper separates fact from fiction by assessing the impact of medical liability on health care costs and the quality of care. Further, this paper illustrates how medical liability has a positive effect on the quality of health care. Finally, the paper offers proposals to improve the quality of care by reducing the incidence of malpractice and suggests methods to contain high insurance premiums experienced in some medical specialties.

II. Medical Liability Is NOT a Factor in Rising Health Care Costs

Neither the cost of medical malpractice litigation nor so-called "defensive medicine" play any appreciable role in health care costs. In fact, malpractice litigation accounts for less than 1 percent of total health costs. Instead, focusing on malpractice liability and defensive medicine simply diverts attention from an insidious cost driver in America's health care system: self-dealing by the medical industry.[7]

A. The Impact of Medical Liability on Health Care Costs

The impact of medical malpractice litigation on total health care costs is illustrated by considering the cost of medical liability insurance. In the event of malpractice, nearly all health care providers are protected from liability by insurance. Insurers obviously do not pay out all that they collect in malpractice premiums; in fact, the medical malpractice line is very profitable.[8]

In 1991, insurers collected about $4.8 billion from health care providers for malpractice insurance.[9] These premiums equaled about 0.64 of 1 percent of national health care expenditures of nearly $752 billion in 1991.[10] Thus, medical liability insurance contributed less than 1 percent to national health care costs. In everyday terms, that amounts to 26 cents out of a $40 office visit.

Given these facts, it is not surprising that the U.S. Congressional Budget Office, an independent arm of Congress, concluded in 1992:

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[6] Ironically, American physicians and their families already are the recipients of special treatment that is not available to other citizens. "Professional courtesy," the delivery of health care at no charge or a reduced rate by physicians to other physicians and their families, is offered and supported by almost all physicians in the United States. Mark A. Levy et al., "Professional Courtesy--Current Practices and Attitudes," 329 New Eng. J. Med. 1627 (Nov. 25, 1993).

[7] See discussion of physician self-referral infra p. 7.

[8] The National Association of Insurance Commissioners reported in 1991 that medical malpractice as a line had the highest profit as a percentage of premiums. Losses paid by insurers in 1991 for medical negligence amounted to 0.31 percent (or 31 cents out of every $100) of national health care costs, according to a specialty database prepared by A.M. Best Co. For a discussion of insurer profitability, see p. 15.

[9] A.M. Best Co., Best's Aggregates and Averages 109 (1992 ed.). By comparison, Americans spent an estimated $6.4 billion on dog and cat food in 1991, or nearly $1.5 billion more than doctors spent on medical liability insurance that year. Pet Food Institute, Fact Sheet (1993).

[10] Health Care Financing Administration of the U.S. Department of Health and Human Services (1992).

> [R]estructuring malpractice liability alone would not generate large savings in U.S. health care costs.
>
> [M]alpractice premiums amount to less than 1 percent of national health care expenditures. Thus, these premiums directly contribute little to the nation's overall health care costs.[11]

Furthermore, restricting health care consumers' rights and access to courts will not eliminate the necessity of medical malpractice insurance. Since some level of malpractice insurance would be required under even the most Draconian proposals, savings achieved through such restrictions would amount to a small fraction of a demonstrably minuscule cost. Moreover, any savings achieved through lower malpractice premiums would be pocketed by the medical industry, not health care consumers.

B. State Experience with Medical Malpractice "Reform"

To understand the effect of medical liability changes on costs, policymakers should consider the states' experience with medical malpractice "reform." State efforts to control health care costs by "reforming" liability laws have failed miserably. Unfortunately, these efforts have simply cut back on health care consumers' rights and remedies.

In 1975, Indiana sought to control health care costs by enacting a total cap on damages. Injured consumers could recover no more than $500,000 (subsequently amended to $750,000) for noneconomic damages such as pain and suffering and economic damages such as medical expenses. However, this measure has done nothing to stem rising health care costs in Indiana. Between 1980 and 1990, Indiana's health care spending increased 139.4 percent -- which was even higher than the national average increase of 138.7 percent.[12] Instead, this measure has forced the most severely injured consumers to seek public assistance when their damages exceed the cap. The taxpayers of Indiana, rather than the wrongdoer, now ultimately bear responsibility for the continuing care of injured medical consumers.[13]

Likewise, California attempted to harness escalating health costs in 1975 by enacting MICRA (Medical Injury Compensation Reform Act). Among other "reforms," this law caps noneconomic damages at $250,000, eliminates the collateral source rule, allows health care providers to require patients to waive their right to a jury trial in the event of malpractice, and imposes a short statute of limitations. As in Indiana, these changes have not contained California's health care costs, which rose 143.9 percent between 1980 and 1990.[14] Again, this increase was higher than the national average. Moreover, malpractice premiums for doctors in southern California increased from 16 to 337 percent, depending upon physician specialty, between 1980 and 1986.[15]

The District of Columbia, in contrast to Indiana and California, has not enacted comprehensive changes to its medical liability laws. Nevertheless, the per capita increase in health care spending in the District between 1980 and 1990 was 108.4 percent, far below the national average of 138.7 percent.[16] Given that malpractice litigation is such an insignificant part

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[11] CBO, supra note 1, at 27.

[12] Lewin/ICF estimates as published by Families USA Foundation (Oct. 1990). Lewin/ICF is now known as Lewin/VHI.

[13] Frank Cornelius, "Malpractice Damage Caps Won't Help," Wall St. J., Oct. 13, 1993, at A23.

[14] Supra note 12.

[15] GAO, Medical Malpractice: Case Study on California 11 (Dec. 1986).

[16] Supra note 12.

of overall health care costs, it should surprise no one that states that have changed their liability laws have not succeeded in containing health costs.

C. "Defensive Medicine"

Another key element in the campaign to change America's medical liability system is the elusive concept of defensive medicine. While defensive medicine is nearly impossible to define or quantify, the medical and insurance industries assert that health care providers, fearing potential liability, order unnecessary medical tests that drive up costs.

However, defensive medicine may simply be careful medicine: using the newest testing to eliminate errors or rule out particular diagnoses; obtaining more consultations, second opinions and referrals; taking better histories, keeping better records and scheduling more follow-up visits. One study by two doctors notes:

> Standards in most specialties of medicine have not been clearly described, so that what might appear to be defensive medical practice to one clinician may, to another, be quality medical care.[17]

The American Medical Association itself concluded in 1975 that defensive medicine is good medicine.

> Generally, it is recognized that "defensive driving" is a good practice for motorists to follow. Similarly, it appears that "defensive medicine" is essentially beneficial for patients.[18]

However, after surveying the political terrain, the AMA more recently has concluded that it would be better served by decrying the costs of so-called defensive medicine.

Other members of the medical establishment remain skeptical about the very existence of defensive medicine. Dr. William Ira Bennett, former editor of the Harvard Medical School Health Letter, has written:

> A common complaint is that the costs of "defensive medicine" are also raised by the current fear of malpractice. This is hard to prove. Thanks to the abundance of health insurance, neither doctors nor patients are much deterred from spending money on excessive testing. In reality, though, failure to order a questionable test is the basis for only a small minority of malpractice judgments; most (other than slips and falls in the hospital) involve clearly wrong procedures or diagnoses.[19] (Emphasis added.)

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[17] Laurence R. Tancredi and Jeremiah A. Barondess, "The Problem of Defensive Medicine," 200 Science 879 (May 26, 1978).

[18] R.P. Bergen, "Defensive Medicine Is Good Medicine," 228 JAMA 1188 (May 27, 1974).

[19] William Ira Bennett, "The Pluses of Malpractice Suits," N.Y. Times, July 24, 1988, at 31 (Magazine). See also Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York 10 (Executive Summary) (1990). On the issue of defensive medicine, the Harvard researchers concluded:

> Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as a result of a specific suit. Thus, it was unclear whether defensive medicine resulted from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO), state and hospital requirements, or a combination of factors.

Nevertheless, the medical and insurance industries continually assert that defensive medicine is driving up health costs. After polling physicians, the AMA Committee on Professional Liability estimated that the cost of defensive medicine in 1983 was between $15 billion and $40 billion.[20] More recently, researchers for the AMA's Center for Health Policy Research used the physician survey to arrive at two estimates of the cost of defensive medicine in 1984: $13.7 billion and $12.1 billion.[21] It is noteworthy that these latter figures include physicians' insurance premiums, in addition to defensive medical practices. By 1991, the AMA estimated that defensive medicine cost $25 billion.[22]

Other studies, however, have concluded that the cost of defensive medicine is less than compelling. In a report released by a group advocating malpractice reform,[23] the consulting firm Lewin/VHI estimated in January 1993 that changing medical liability laws could save $35.8 billion over five years in insurance premiums and defensive medical practices.[24] Assuming the accuracy of these figures for the sake of argument, these reforms purportedly would save $7 billion a year in premiums and practice changes. Again, this is less than 1 percent of total health care costs of almost $752 billion in 1991.

The facts, when separated from fiction, led the Congressional Budget Office to conclude in 1992:

> [M]uch of the care that is commonly dubbed "defensive medicine" would probably still be provided for reasons other than concerns about malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this "defensive care" helps to reduce the uncertainty of medical diagnoses, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform.[25]

D. The Real Culprit of High Costs: Self-Referral

As long as the health care debate focuses on medical liability and defensive medicine, the medical industry can continue to deflect attention from self-referral practices that drive up health costs. As Dr. Arnold S. Relman, editor-in-chief emeritus of the New England Journal of Medicine, has observed:

> Self-referral is a prime example of the current and growing encroachment of commercialism on medical practice. . . . [T]his

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[20] American Medical Association, Report of the Board of Trustees, "Study of Professional Liability Costs" 93-102 (Dec. 1983).

[21] Roger A. Reynolds et al., "The Cost of Medical Professional Liability," 257 JAMA 2776-81 (May 22, 1989).

[22] Medical Malpractice in Health Care Reform, Nov. 10, 1993: Hearings Before the Subcomms. on Health and the Environment and Commerce, Consumer Protection and Competitiveness of the House Comm. on Energy and Commerce, 103d Cong., 1st Sess. (statement of Dr. Joseph T. Painter, President, American Medical Association).

[23] National Medical Liability Reform Coalition. In addition to the AMA and other medical associations, listed supporters of this coalition include Dow Chemical Company, the Health Insurance Association of America, the National Association of Manufacturers the Pharmaceutical Manufacturers Association, and the U.S. Chamber of Commerce.

[24] Lewin/VHI, Inc., Estimating the Costs of Defensive Medicine (Jan. 27, 1993).

[25] CBO, supra note 1, at 27.

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[24] Lewin/VHI, Inc., Estimating the Costs of Defensive Medicine (Jan. 27, 1993).

[25] CBO, supra note 1, at 27.

issue reflects the increasing tension between professional and business values.[26]

A growing body of evidence shows that a substantial purpose of "unnecessary" tests is to increase the income of physicians. The Consumer Federation of America (CFA) reported in 1991 that the most significant change in physicians' practices during the 1980s was the dramatic increase in self-dealing for ancillary medical services, including clinical laboratory tests, PAP smears, X-rays and other imaging services.[27] The CFA report found that doctors with a financial interest in a lab ordered 34 to 96 percent more tests and, as a result, their prices were 2 to 38 percent higher and total bills were 26 to 125 percent more than those of independent labs.[28]

Not surprisingly, the profit motive plays a major role in self-dealing. At least five recent studies of this practice show that self-referring doctors order testing up to eight times more often than referring doctors, and self-referring doctors' costs were up to seven and a half times higher than when outside services were used.[29]

Compounding the problem of self-referral is the fact that medical consumers lack the expertise to evaluate the necessity for testing. As a result, consumers have essentially no voice in the decision to use doctor-owned services. Moreover, it is unrealistic to expect a medical consumer, whose health is at stake, to vigorously question his or her doctor about the utility of a medical test.

Doctors, not patients, are the consumers of medical testing services. When they self-deal, doctors have interests on both sides of the same transaction, eliminating any market supply/demand check on the process. Yet, the medical industry vehemently opposes measures that would eliminate or regulate self-referral.[30] Thus, it has fallen on state legislatures to enact statutes requiring physicians to disclose their financial interest in lab facilities to patients before referral,[31] or statutes that prohibit doctors from having financial interests in testing facilities.[32] In addition, Congress has prohibited certain financial arrangements between referring physicians

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[26] Arnold S. Relman, "'Self-Referral' -- What's at Stake?" 327 New Eng. J. Med. 1522-24 (Nov. 19, 1992).

[27] Consumer Federation of America, Physician Self-dealing for Diagnostic Tests in the 1980s: Defensive Medicine v. Offensive Profits 3 (Oct. 1991).

[28] Id. at 8-9.

[29] Jean M. Mitchell and Jonathan H. Sunshine, "Consequences of Physicians' Ownership of Health Care Facilities -- Joint Ventures in Radiation Therapy," 327 New Eng. J. Med. 1497-501 (Nov. 19, 1992) (joint ventures appear to have an adverse effect on patients' access to care and increase the use of services and costs substantially); Alex Swedlow et al., "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," 327 New Eng. J. Med. 1502-06 (Nov. 19, 1992) (physical therapy initiated 2.3 times more often by self-referring physicians, while 38 percent of magnetic resonance imaging (MRIs) by self-referring doctors was found inappropriate); Bruce J. Hillman et al., "Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population," 268 JAMA 2050-54 (Oct. 21, 1992) (self-referring physicians ordered imaging examinations 1.7 to 7.7 times as often, and their charges were 1.6 to 6.2 times higher than doctors who did not self-refer); Jean M. Mitchell and Elton Scott, "Physician Ownership of Physical Therapy Services," 268 JAMA 2055-59 (Oct. 21, 1992) (visits per patient were 39 to 45 percent higher in joint venture facilites, while gross and net revenues were 30 to 40 percent higher in facilities owned by self-referring doctors); Bruce J. Hillman et al., "Frequency and Costs of Diagnostic Imaging in Office Practice -- A Comparison of Self-Referring and Radiologist Referring Physicians," 323 New Eng. J. Med. 1604-08 (Dec. 16, 1990) (self-referring doctors ordered imaging exams 4.0 to 4.5 more frequently and their average charges were 4.4 to 7.5 times higher).

[30] Relman, supra note 26, at 1523 (noting that six months after advising physicians to avoid self-referral, the AMA declared self-referral to be ethical as long as the patient is informed of the physician's financial interest in the facility).

[31] States that have enacted such statutes include: California, Kansas, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New York, Pennsylvania, Tennessee and Virginia.

[32] Georgia, Florida and Michigan have prohibited the ownership of financial interests in testing facilities.

and clinical laboratories in response to the abuse of the Medicare system and physician reimbursements.[33]

Again, when the facts are separated from fiction, it is clear that:

- malpractice litigation is not a factor in rising health care costs;
- medical liability "reforms" enacted in the states have failed to control costs;
- defensive medicine is impossible to quantify and, in any event, contributes little to overall costs; and
- self-referral adds significant costs to health care.

III. The Incidence of Medical Malpractice

For all their concern about medical liability, the medical and insurance industries have failed to address the underlying cause of malpractice lawsuits: negligent medical care. Rather than promote improvements in quality of care or root out incompetent doctors, health care providers and insurers have diverted public attention to medical liability laws and defensive medicine.

Meanwhile, medical malpractice injures and kills consumers each day, often with little chance of being brought to public attention. Understandably, consumer groups have lined up against proposals that would cut back on citizens' rights rather than eliminate malpractice. The consumer group Public Citizen observed in November 1993:

> [M]ost attempts to address the problem of medical malpractice have been embodied in attacks on victims and their right to recover damages from negligent providers, not on solving the problem at the source -- ensuring quality care and eliminating medical negligence.[34] (Emphasis in original.)

A. The Dimensions of Malpractice

Although most health care providers are competent and well-meaning, medical malpractice in America occurs far too frequently. The Harvard Medical Practice Study found that in New York state hospitals in 1984 there were more than 27,000 negligent adverse events, including nearly 7,000 deaths and almost 900 cases of permanent disability of more than 50 percent.[35] Extrapolating these figures to the nation as a whole, medical researchers have estimated that malpractice kills more than 80,000 Americans a year and injures hundreds of thousands more.[36]

As appalling as these figures are, they actually undercount the incidence of malpractice because they are based only on in-hospital negligence. The Harvard researchers, for

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[33] 42 U.S.C. § 1395nn (1992).

[34] Medical Malpractice in Health Care Reform, Nov. 10, 1993: Hearings Before the Subcomms. on Health and the Environment and Commerce, Consumer Protection and Competitiveness of the House Comm. on Energy and Commerce, 103d Cong., 1st Sess. (statement of Pamela Gilbert, Director, Public Citizen's Congress Watch). Other consumer groups that have stated their belief that malpractice reform might further harm injured consumers, while doing nothing to rein in costs, include the American Association of Retired Persons, Citizen Action, Coalition for Consumer Rights and Center for Patients' Rights.

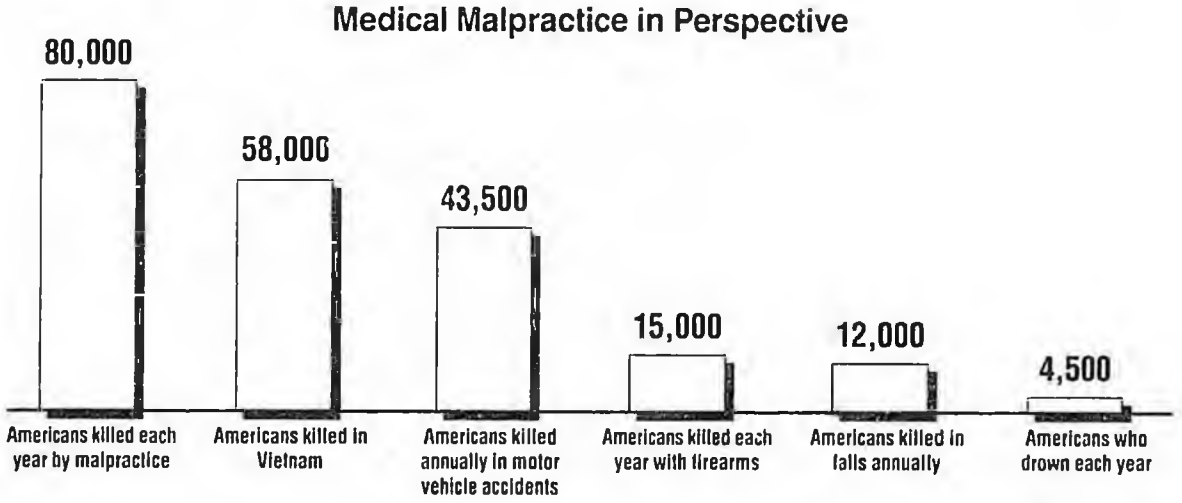
[35] Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York 11-1 (1990).

[36] Patricia Danzon, an economist and expert on malpractice in the United States, estimates that only about 10 percent of medical malpractice incidents result in a claim. Patricia Danzon, Medical Malpractice: Theory, Evidence and Public Policy (Harvard University Press, 1985). Thus, if the AMA is correct in estimating that 42,000 malpractice claims were filed in 1983, there would have been 420,000 malpractice incidents that year under Danzon's estimate.

example, did not attempt to quantify the extent of malpractice in clinics or private practice. Considering the number of negligence-related injuries and lawsuits actually filed, the Harvard researchers estimated that only one in eight negligently injured consumers ever brings a claim.

The 80,000 deaths annually from medical malpractice are even more chilling when put into perspective. Consider that --

- nearly 58,000 Americans were killed in the Vietnam War[37];
- about 43,500 Americans die annually in motor vehicle accidents[38];
- more than 15,000 citizens are murdered each year with a firearm[39];
- more than 12,000 Americans perish each year from falls[40]; and
- about 4,500 citizens drown annually.[41]



Unfortunately, the medical industry's only response to the incidence of medical malpractice has been to seek limits on injured consumers' remedies and access to courts. Reducing the risk of malpractice and disciplining negligent providers are not the medical industry's top priorities.

B. Hidden Malpractice

A great deal of information now exists about the quality of medical care, the competence of doctors, and mortality and morbidity rates. Yet, the institutional bias inherent in the medical industry shields most malpractice from public view. As a result, health care consumers have little basis to make informed choices about health care.

Malpractice is hidden at two levels. First, the medical culture protects its own, enforcing an informal conspiracy of silence. Early on, new health care providers learn the economic value of silence and the high price they will pay if they deviate from the norm.

Second, legislative and administrative actions shield much malpractice from ever coming to public attention. Most peer review records are not open to the public, and accreditation

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[37] Eric Schmitt, "Female Vietnam Veterans Welcomed Home," N.Y. Times, Nov. 12, 1993, at A1.
[38] National Safety Council, Accident Facts 4 (1992).
[39] FBI, Uniform Crime Reports (1992).
[40] Supra note 38.
[41] Id.

reports rarely see the light of day. The one major database that collects information on practitioner quality of care, the National Practitioner Data Bank, is off limits to health care consumers. Even doctors who want to make referrals are barred from obtaining information from the data bank.

Thus, pervasive secrecy and an almost total absence of professional discipline create an atmosphere that permits and fosters medical malpractice. Health care providers know there is little chance they will be held accountable for negligent treatment.

The rare state medical board that does act against an incompetent physician often finds that all it has done is encourage the physician to set up shop in another state. Incompetent physicians can evade disciplinary proceedings in one state by simply packing their bags and moving to another state.[42]

No one knows how many times medical boards have foisted bad doctors onto health care consumers in other states in return for a physician's promise to leave the original state. Unfortunately, if an incompetent doctor agrees to leave a state, the board often will agree to drop a complaint and the doctor's record remains unblemished.

Consumers and their families must blindly trust the medical industry as they are thrust into this information vacuum. In some instances, information about a health care provider's expertise may be obtained, but it is hard to get. More often, the competency of a doctor or hospital is not questioned until after a patient has been negligently injured.

The medical industry essentially defends secrecy on the ground that health care consumers would be misled by (i.e., are not smart enough to understand) quality-of-care data.[43] However, Americans have proved time and again that, given adequate information, they are quite capable of making extremely difficult choices. Patients who can choose between alternative courses of treatment, which they clearly have a legal right to do, can surely make more effective decisions when given access to quality-of-care information. Today, health care consumers are never given that choice.

IV. Medical Malpractice Claims Are NOT Exploding

Even though it is estimated that negligent medical treatment kills and injures hundreds of thousands of Americans each year, claims and jury awards actually are declining. In addition, studies show that juries are not biased toward plaintiffs nor do they render unjustified awards.

A. The Number of Medical Malpractice Claims

Over time, medical malpractice claims should increase as more Americans have access to health care. This is because:

- the delivery of care becomes more efficient and doctors can treat more patients daily;
- medical learning and technology advance so that doctors are held to a higher standard of care (i.e., doing nothing or too little breaches the applicable standard of care); and
- the population ages, resulting in an increased need for care.

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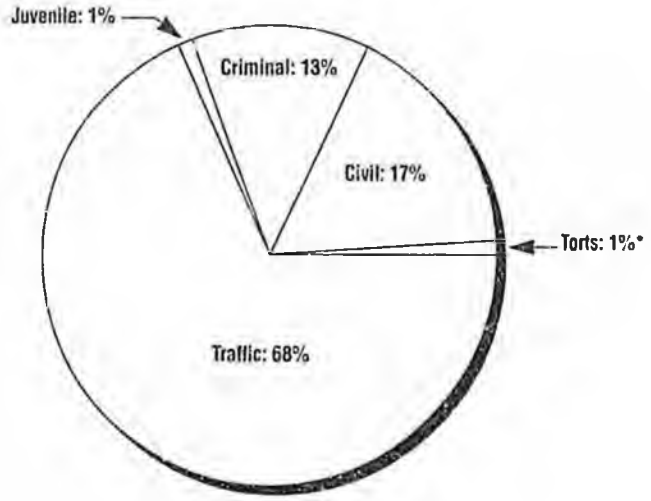
[42] See, e.g., Sandra G. Boodman, "What You Can't Know About Your Doctor," Wash. Post, Sept. 14, 1993, at 11 (Health Section); Charlotte L. Rosenberg, "How Bad Doctors Dodge Discipline," 62 Med. Econ. 240 (Mar. 18, 1985).

[43] Boodman, supra note 42. (This report notes that the AMA's House of Delegates has voted to seek the abolition of the National Practitioner Data Bank.)

Nevertheless, independent studies show that medical consumers do not bring dubious claims and, in general, are reluctant to file lawsuits against health care providers. The Harvard Medical Practice Study estimated that only one in eight negligently injured patients ever brings a claim.[44] The number of claims each year barely amounts to half of the deaths attributable to medical negligence and constitutes a very small percentage of the total injuries.[45] Thus, concluded the Harvard researchers: "[W]e do not now have a problem of too many claims; if anything, there are too few."[46]

1989 Trial Court Filings



* Tort filings accounted for about 950,000 cases or less than 1% of total filings of 98,464,661.
Sources: National Center for State Courts, 1989; Deborah R. Hensler the RAND Institute for Civil Justice

Rather than increase, the number of malpractice claims has dropped at an average annual rate of 8.9 percent since 1985.[47] The AMA reported in 1992:

> Claim frequency for all physicians was 7.7 claims per 100 physicians in 1990, as compared with 7.4 per 100 in 1989. While the claims rate did increase between 1989 and 1990, that increase was not statistically significant. In general, the results indicate a leveling off in the claims rate in contrast to the increases of the early- and mid-1980s.[48] (Emphasis added.)

Likewise, the Minnesota Department of Commerce, in a comprehensive analysis of all closed claims filed in Minnesota, North Dakota and South Dakota, found that the frequency of claims had decreased between 1982 and 1987. That study concluded:

> It would appear . . . that the data does not substantiate the litigation explosion asserted. Claim frequency has not changed measurably

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[44] See also Stephen Daniels, The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases 7 (American Bar Foundation Working Paper No. 8806, 1989) (estimates that only one in 25 negligently injured patients ever brings a claim); Deborah Hensler, Compensation for Accidental Injuries in the United States 55 (RAND Institute for Civil Justice, 1991) (estimates that one in 10 injured consumers seeks compensation from the tort liability system).

[45] The AMA estimated that there were 42,000 malpractice claims in 1983, compared to the estimated 80,000 deaths each year that are attributable in part to medical negligence.

[46] Harvard Medical Practice Study, supra note 35, at 11-4.

[47] Socioeconomic Characteristics of Medical Practice, Medical Professional Liability Claims and Premiums, 1985-1990, 23 (American Medical Association, 1992). In addition, the National Center for State Courts reported a drop in malpractice suits in the 1980s.

[48] Id.

> in the last six years. The 1987 frequency rate is actually less than the 1983 rate. . . . Average payments actually appeared to be decreasing over the period of study.[49]

Despite a decrease in claims frequency, the Minnesota study noted, physicians paid about three times more for malpractice insurance in 1987 than in 1982.[50]

Another myth that evaporates under even minimal scrutiny is that indigent patients are more likely to sue for medical malpractice than patients with greater economic resources. The General Accounting Office (GAO) found in 1993 that poor patients actually bring fewer claims than the general population and that awards to indigents "account for a relatively small share of total hospital malpractice losses."[51]

A more recent study corroborates the GAO finding. It concluded that poor and uninsured patients are "significantly less likely to sue for malpractice. . . ."[52] The authors noted that their results suggest that proposed legislation shielding physicians who serve the poor from malpractice suits should be reconsidered.

B. Jury Awards

Contrary to the assertions of the medical and insurance industries, malpractice claims seldom result in jury trials. In fact, most studies conclude that 10 percent of claims or less are tried.[53] Injured consumers receive compensation through negotiated settlements agreed to by both sides in about 50 percent of the remaining cases. No compensation is received by plaintiffs in 40 percent of cases.[54] Of the 10 percent of cases that go to trial, the evidence shows that (1) juries are not biased against doctors and (2) awards are not unjustified or out of control.[55]

Plaintiffs often must overcome several hurdles, not the least of which is jurors' generally favorable view of health care providers. If anything, plaintiffs bear an extra burden in malpractice cases because jurors are suspicious of plaintiffs' motives for suing and scrutinize their actions more closely than those of defendants. Further, plaintiffs generally begin from a weaker position since health care providers and insurers have vast resources. At least one court has observed that medical malpractice litigation is "galaxies apart" from typical cases and

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[49] Minnesota Department of Commerce, Medical Malpractice Claim Study, 1982-1987, 17 (1989).

[50] Id. at 31.

[51] GAO, Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses 2 (Aug. 1993).

[52] Helen R. Burstin et al., "Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status," 270 JAMA 1697 (Oct. 13, 1993).

[53] See, e.g., Mark I. Taragin, "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," 117 Annals Internal Med. 780 (Nov. 1, 1992) (about 12 percent of claims studied went to jury trial); Neil Vidmar, "The Unfair Criticism of Medical Malpractice Juries," 76 Judicature 118 (Oct.-Nov. 1992) (about 10 percent of claims were eventually tried by a jury); Michael J. Saks, "Do We Really Know Anything About the Behavior of the Tort Litigation System -- and Why Not?" 140 U. Pa. L. Rev. 1147, 1212-13, 1226 (Apr. 1992) (fewer than 10 percent of medical malpractice cases are tried); Brian Ostrom et al., "What Are Tort Awards Really Like? The Untold Story from the State Courts," 14 Law & Pol'y 77 (1992) (authors conclude that only 9.8 percent of all medical malpractice claims go to trial); Minnesota Department of Commerce, Medical Malpractice Claim Study, 1982-1987, 31 (1989) (less than half of 1 percent (0.5) of all claimants were awarded damages by a jury, while the likelihood of receiving any compensation was about 25 percent).

[54] Vidmar, supra note 53, at 118.

[55] Neil Vidmar, "Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases," 43 Duke L. J. 217 (Nov. 1993) (the reputation of juries for reaching into the perceived deep pockets of health care providers and giving excessive awards for pain and suffering is not warranted).

attorneys who represent medical consumers shoulder a heavy burden.[56] It is not surprising, then, that defendants win the majority of the malpractice cases.[57]

In addition, health care consumers do not benefit from large, unwarranted jury awards. The facts, when separated from the fiction, show that the median award -- which accurately reflects system-wide results -- is far less than the anecdotal claims of the medical and insurance industries. Moreover, awards are generally consistent with severity of injury. A New Jersey study showed that the defensibility of the case and not the severity of the injury was the predominant factor in whether any payment was made.[58] The authors concluded: "Our findings suggest that unjustified payments are probably uncommon."[59]

V. Medical Liability: A Force for Quality Health Care

By neglecting to police health care providers, the medical industry has failed to ensure quality health care. State medical boards, which are underfunded and understaffed, have not protected the public from negligent providers. Thus, without appropriate oversight, it has fallen on America's medical liability system to deter negligence.[60] Medical liability, through the civil justice system, has held bad doctors accountable for their mistakes and forced the medical industry to recall or improve the safety of dangerous products and bad drugs. Nevertheless, the medical industry continually pushes for liability "reforms" that would reduce the only effective deterrent to negligence.

State medical boards have failed to discipline negligent doctors. While over the years disciplinary actions -- license revocation, suspension and probation -- have increased, they actually have decreased proportionally due to the increase in number of doctors. In 1991, about 2,000 of the nation's 615,000 licensed physicians -- less than half of 1 percent -- were sanctioned by state medical boards.[61] While the Harvard Medical Practice Study found 27,000 negligent adverse events in one year in New York hospitals, that state's Office of Professional Medical Conduct averaged only 236 disciplinary actions a year between 1986 and 1990.[62] Many of the doctors who were disciplined were not even sanctioned for negligence, but for insurance fraud or falsifying records.

In addition, the AMA acknowledges that 30,000 to 40,000 physicians are impaired by alcohol or drugs.[63] Yet, only about 200 doctors lose their licenses a year and that includes those

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[56] Baker v. Varela, 416 So. 2d 1190 (Fla. Dist. Ct. App. 1982).

[57] See, e.g., Vidmar, supra note 53, at 118 (in cases that were tried, juries ruled in favor of plaintiffs 20 percent of the time); Taragin, supra note 53, at 782 (for the small number of cases in which there was a jury verdict, only 24 percent resulted in payment to the plaintiff).

[58] Taragin, supra note 53, at 783.

[59] Id. at 784.

[60] On the deterrent effect of medical liability, economist and researcher Patricia M. Danzon has stated: "The advantage of the tort system is that it provides a continual, ongoing system of 'regulation by incentives.' And it does not rely on enforcement by the medical profession which, like any other profession, is notoriously reluctant to police its own members." Testimony of Patricia M. Danzon, presented to the Committee on Labor and Human Resources, U.S. Senate, July 10, 1984.

[61] Boodman, supra note 42. See also Sidney Wolfe et al., 10,289 Questionable Doctors 8 (Public Citizen Health Research Group Report, Sept. 1993) (only 1,974 doctors out of 623,000 nationwide were disciplined in 1992).

[62] Kevin Sack, "More Malpractice Than Lawsuits, New York Medical Study Suggests," N.Y. Times, Jan. 29, 1990, at A1.

[63] Harvey F. Wachsman, "Doctors Who Maim and Kill and Get Away with a Wink and a Smile," N.Y. Times, Aug. 25, 1989. According to Dr. Arnold S. Relman, editor-in-chief emeritus of the New England Journal of Medicine: "20,000 physicians . . . for one reason or another probably ought not to be practicing medicine. They are either alcoholics, drug addicts, senile, criminals, or simply incompetent physicians." Richard Greene, "Quackus tyrannus," Forbes, Oct. 5, 1987, at 67.

who commit fraud or felonies.[64] On average, only 3.44 serious disciplinary actions are taken for every 1,000 doctors.[65]

When state medical boards do act, their investigations take years to complete. All the while, negligent doctors continue to treat patients. The actions of state boards also can have the unintended effect of spreading medical incompetence to other states by encouraging doctors to flee to avoid discipline.[66] A General Accounting Office study of 181 doctors whose licenses were to be revoked in Michigan, Ohio and Pennsylvania between 1977 and 1982 found that 33 simply set up shop in another state.[67] Some state boards have even agreed to dismiss a complaint in return for the doctor's promise to leave or quit practicing.

In this void of effective regulation, America's medical liability system stands alone as a check on the quality of care. As noted by one commentator in Hospital Practice:

> It is sad but true that many physicians practice more carefully than they did in the past because they have one eye on the potential litigant. . . . If the courts and insurance companies and the fear of malpractice become the most important disciplinary weapon in medicine -- distasteful as the idea may be to physicians -- so be it.[68]

Even the AMA has acknowledged the beneficial effect of medical liability on improving the quality of care.

> For all of its ills, the tort system's fault-based standard of care has prompted hospitals, medical societies and, most notably, physician-owned insurance companies to become very active in a variety of endeavors to reduce the risk of patient injuries.[69]

VI. The Need for Malpractice Insurance Reform

The root of the medical industry's push for liability "reform" is the cost of medical malpractice insurance. Premiums for high-risk specialties such as obstetrics and neurosurgery are frequently cited as examples.

Without question, some specialties pay very high premiums. However, this insurance issue is unrelated to malpractice claims. Even though some high-risk specialties have been hit with large premium increases, the cost of malpractice insurance has remained fairly constant at less than 1 percent of total health care costs. In the last few years, the cost of malpractice insurance actually has dropped. For example, malpractice premiums declined 3.4 percent (or $4.8 million) in 1991, and dropped 7.6 percent between 1989 and 1991.[70] It is noteworthy that this decline has occurred in states that have not changed their medical liability laws as well as in states that have.

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[64] Wachsman, supra note 63.

[65] Public Citizen Health Research Group, Comparing State Medical Boards (Jan. 1993).

[66] Rosenberg, supra note 42.

[67] Id.

[68] Robert S. Derbyshire, "Malpractice, Medical Discipline and the Public," 19 Hosp. Prac. 209, 216 (Jan. 1984). See also William B. Schwartz and Neil K. Komesar, "Doctors, Damages and Deterrence: An Economic View of Medical Malpractice," 298 New Eng. J. Med. 1282 (June 8, 1978) ("By finding fault and assessing damages against the negligent provider, the [civil justice] system sends all providers a signal that discourages future carelessness and reduces further damages.").

[69] Liability Wk., Mar. 5, 1990 (statement of Dr. James Todd, executive vice president of the American Medical Association).

[70] Best's Review, "Medical Malpractice," 30 (Dec. 1992).

Even with this decline in premiums, insurers' profits have soared. The National Association of Insurance Commissioners (NAIC) recently examined profitability by looking at premiums earned, losses incurred and return on insurers' net worth. For the medical malpractice line, the most recent NAIC figures show $4.86 billion in direct premiums earned in 1991, resulting in a total profit equal to 29.2 percent of the direct premiums earned (or $1.4 billion), and a 15.9 percent return on net worth (or $773 million). According to NAIC, the total investment gain in 1991 was $1.88 billion. Indeed, medical malpractice as a line has the highest profit as a percentage of premiums at 29.2 percent of direct premiums earned, with the next highest percentage being 15.6 percent realized by other liability lines.[71]

Some high-risk medical specialists continue to experience outrageous premiums. Nevertheless, the answer to this problem is not to restrict the rights of injured consumers, but to address the following problems in the insurance industry:

A. Skimming of Risk. Even though competing insurers may have nearly equal shares of the market, they have different percentages of associated risk. Doctor-owned companies set up during the insurance "crisis" in the 1970s were insurers of last resort. They insured doctors who could not obtain insurance from for-profit carriers. Consequently, doctor-owned carriers may have, for example, 50 percent of the market in premiums, but a much higher share of risk. Meanwhile, the for-profit carrier may have 50 percent of the market, but a much smaller percentage of risk. This tactic, known as "skimming," results when for-profit carriers keep the least risky groups or individual doctors for their own client base.

A way to solve this problem is to put all doctors into a unified pool from which all malpractice insurers could write insurance based on their willingness to accept a proportional share of risk. If doctors in this unified pool were risk-rated by a neutral agency (i.e., the state insurance department), insurers could be required as a condition of licensure to take a percentage of higher-risk doctors in the pool roughly equivalent to their share of the entire medical malpractice market.

Under the "two-tiered" system now in place, for-profit carriers earn a substantial income and saddle the doctor-owned companies with too much risk for their share of premiums.

B. Proliferation of Risk Categories. A related problem that boosts malpractice premiums is insurers' practice of dividing doctors into too many risk categories. This has resulted in some specialties (e.g., obstetrics and neurosurgery) paying huge malpractice premiums, while other providers pay very low premiums.

Malpractice underwriters have so fine-tuned the risk by the type of medicine a doctor practices that they may have unwittingly destroyed the cardinal rule of insurance -- spreading the risk. In many states, underwriters have subdivided the medical community into as many as 12 to 19 different specialties. Because of this proliferation of risk categories, there are too few doctors in many of the specialty pools, such as neurosurgery. This is particularly true in states where there is not a large physician population. Since negligence associated with neurosurgery or obstetrics often results in a lifetime of continuing care, the cost of such injuries is extremely high but is spread among only a small pool of doctors in the specialty pool.

The solution is to return risk categories to the way they were originally set up. When there were only three or four categories, underwriters could put a doctor in high, medium

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[71] National Association of Insurance Commissioners, Report on Profitability by Line, by State (Dec. 1992).

or low risk. By dividing the pool of doctors into a few groups, each pool has sufficient numbers to allow the concept of insurance -- spreading the risk among many insureds to permit affordable premiums -- to work. This will not increase the total premium dollars collected, but it will reallocate what certain classes of doctors pay.

If risk categories are reduced, specialists will see their premiums drop dramatically, while general and family practitioners will experience a modest increase. However, this will reflect the changing pattern of medicine over the past 20 years. Today, the general or family practitioner accepts little or no risk in his or her practice. He or she refers risky patients to a medical specialist who has little in-depth contact with patients. So long as the support system of specialists exists to take on the higher-risk procedures, the general practitioner ought to be willing to subsidize a slight change in malpractice premium allocation. Such a change permits the general practitioner to continue to access a specialized medical opinion in the high-risk case.

Medical associations do not like the idea of reallocating malpractice premiums because it is a potentially divisive issue within the medical community. Nevertheless, such a plan offers the best chance to alleviate the high premiums that certain medical specialists are now forced to pay.

C. Lack of Experience Rating. When an insurer writes malpractice insurance, it does not consider the claims experience of the individual doctor. By comparison, a poor automobile driver will pay a higher rate, which takes into account his or her accident and driving record. Bad doctors are not charged higher rates, and good doctors receive no insurance break because of their competence. Lack of experience rating of malpractice premiums is unfair to good doctors and untenable.

Since a few doctors often are responsible for a large share of malpractice claims paid,[72] insurers could deter malpractice by charging higher premiums to those most responsible for losses.

This proposal not only makes sense, but also is good public policy. It is long overdue. Basing premiums on claims experience will benefit medical consumers by deterring malpractice and encouraging good medicine.

D. Overreserving. Because medical malpractice claims generally take a long time to resolve, insurers establish reserves to cover their estimated future losses. Insurers label reserves as liabilities, but reserves are held and invested until claims and claim expenses are paid.

Insurers primarily base estimated future losses on historical loss patterns. Each year, estimates are adjusted when actual losses are compared to the estimated loss. If the income from the investment of reserves is included in calculating the annual change in the industry's medical malpractice reserve estimates, insurers overreserved by $1.4 billion between 1982 and 1991.[73]

This is not surprising when you consider how little insurers pay out in claims compared to the amount they receive in premiums. When annual premiums collected are

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[72] See, e.g., Testimony of Blaine F. Nye from public meeting entitled "Academic Task Force for the Review of the Insurance and Tort Systems" 169 (June 11, 1987) (less than 4 percent of doctors practicing in Florida in 1986 were responsible for approximately 45 percent of paid claims to injured consumers); Miller et al., Medical Malpractice: Crisis of Litigation or Crisis of Negligence? (Health Resources, Inc., March 18, 1987) (less than 2 percent of all physicians practicing in Cook County, Illinois, were defendants in 36 percent of malpractice claims filed between 1972 and 1986).

[73] A.M. Best Co., Casualty Loss Reserve Development Series -- Medical Malpractice (1992).

compared to actual annual losses paid, medical malpractice insurers paid out an average of only $45.88 for every $100 in premiums collected between 1979 and 1991.[74]

VII. Restricting Patients' Rights Is No Solution

In the current debate over health care, the medical and insurance industries are once again pushing for changes to medical liability under the banner of "tort reform." But when fact is separated from fiction, these "reforms" would: (1) make it harder for injured medical consumers to bring lawsuits, (2) make it tougher for consumers to prevail when they do, and (3) arbitrarily limit the amount an injured consumer may recover, even after a judge or jury decides that the consumer is entitled to compensation.

The medical and insurance industries' "reforms" are not intended to help consumers or improve the system, but rather to shield health care providers from responsibility for their negligent acts. As one commentator has noted, most of the empirical data on the medical liability system

> suggest[s] that the reforms that have generally been proposed would advance none of the goals of the malpractice tort system and would, in fact, exaggerate the system's most fundamental shortcomings (less compensation, larger gaps between losses and compensation) and weaken the one thing it may get right (deterrence).[75]

Proposals that would do nothing to contain costs or improve the quality of care but which would restrict injured consumers' rights are:

A. Federalization of Medical Malpractice. America has always celebrated its great diversity. Our forebears recognized that the norm in one area may be perceived as unusual in another. As a result, they balanced state and federal power, and secured states' rights in the Tenth Amendment to our federal Constitution. Tort law, of which medical liability is a part, has always been a state issue and should remain so. The federal government should not become the arbitrator of what historically has been a matter of state right.

B. Caps on Damages. Arbitrarily capping damages is unjust and further injures those who have had the misfortune of being severely injured since their damages are most likely to exceed the cap. As this paper has shown, damage caps have done nothing to control health care spending in California and Indiana. Meanwhile, a jurisdiction that has not enacted caps -- the District of Columbia -- has seen its health care costs increase at a rate below the national average. Further, damage caps permit a negligent wrongdoer to evade accountability for his or her acts. Ultimately, taxpayers must make up the difference when an injured consumer's damages exceed the cap.

C. Alternative Dispute Resolution (ADR). In its simplest form, ADR can expedite litigation by providing a process for earlier settlements while still allowing a case to proceed unfettered in court if a party is dissatisfied with the result. In that sense, increased use of ADR can be beneficial, and ATLA supports programs such as court-controlled mediation and voluntary

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[74] A.M. Best Co., Experience by State (by Line) (1992).

[75] Michael J. Saks, "Malpractice Misconceptions and Other Lessons About the Litigation System," 16 Just. Sys. J. 7 (1993).

arbitration. But many ADR proposals are promoted as substitutes for trial by jury, contain coercive penalties designed to force settlements or postpone the right to proceed in court until ADR has been completed. These forms of ADR are unfair, costly and interfere with the right of every American to have access to courts.

D. Mandatory Periodic Payments. Defendants who have been adjudicated as negligent should not be permitted to keep the plaintiff's compensation and dictate periodic payments. This only results in a windfall for defendants, since they are able to invest and earn income on the unpaid balance of an award. The injured consumer should receive this benefit. Moreover, there should never be any delayed payment without full posting of security to ensure future payments.

E. Abolition of the Collateral Source Rule. Permitting defendants and insurers to receive a windfall by requiring an injured patient to offset separately purchased benefits against an award turns the justice system on its head. The medical and insurance industries charge that plaintiffs "game the system" by receiving compensation in the form of an award and privately purchased insurance, i.e., a "double recovery." However, very few plaintiffs receive double recoveries. Further, there is no reason to benefit a wrongdoer simply because an injured consumer had the foresight to secure benefits from a collateral source.

F. Caps on Plaintiffs' Attorney Fees. Limiting plaintiffs' attorney fees is a Trojan horse intended to prevent injured medical consumers from retaining an attorney in the first place. Moreover, limiting plaintiffs' attorney fees while permitting defendants to spend unlimited sums on legal representation is patently unfair to health care consumers. This proposal attempts to stack the deck in favor of defendants.

VIII. Proposals to Improve the System

The Association of Trial Lawyers of America has never opposed change that will protect patients' rights. Thus, we advocate:

A. Improved Quality and Safety of Medical Care. The cause of medical malpractice is malpractice. Lawsuits would be greatly reduced if doctors would clean up the profession and drug companies would stop putting profits ahead of patient safety. State medical boards need to be strengthened. Performance audits and recertification for doctors, together with stronger regulation of hospitals, should be required.

The walls of secrecy should be torn down so that consumers will have meaningful access to reliable information concerning the quality of care -- particularly the National Practitioner Data Bank and peer review results. In this way, traditional market forces can weed out incompetent and dangerous health care providers.

Arbitrary limits on the liability system should be opposed or, where already enacted, repealed. The system should be allowed to work.

B. Elimination of Physician Self-Dealing. Taken alone, this will have an immediate and major impact on containing health care costs. As discussed in this paper, the medical establishment has opposed elimination or regulation of physician self-referral and, therefore, it generally has fallen on the individual states to try to limit or prohibit this costly practice.

C. Streamlining the Medical Liability System. At present, medical defendants obtain a decided advantage by delaying case resolution. Two changes at the state level would expedite case resolution:

1. Apply prejudgment interest in all medical liability cases. This would provide an incentive for liability insurers to seek early resolution as opposed to dragging cases out.

2. Develop a simplified system for handling small cases at the state level. Many cases currently are not filed because, given the medical and insurance industries' resources, litigation is simply too expensive. A simplified system for small cases would fill that void. It should, at a minimum, have strict time limits to ensure speedy resolution of claims, and simplified rules of proof and processes such as limits on experts and bans on costly discovery.

D. Reforming Malpractice Insurance. Necessary insurance reforms include compressed rate classifications and mandated experience ratings. Insurers also should not be allowed to either "skim" the risk or overreserve.

IX. Conclusion

Medical liability is a subject that has been driven largely by anecdotes and a public relations campaign supported by enormous budgets. It is too important to the quality of health care and the access to justice for millions of Americans to allow fiction to go unchallenged by fact.

We hope this paper helps separate fact from fiction and, ultimately, that the public and policymakers will realize that medical liability is not a factor in rising health care costs. Medical liability contributes to the overall quality of health care of our nation. Further, we hope that the health care debate will instigate reform -- not regressive measures of self-protection, but true reform that will secure equal justice for all.

ATLA
February 1994

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 3/10/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
* HB 492: CIVIL LIABILITY; MEDICAL MALPRACTICE
* HB 493: MEDICAL LIABILITY INSURANCE LIABILITY

* INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
ART SNOWDEN	COURTS					(Y)	N	HB 492
DAN HENSLEY	TRIAL LAWYERS					(Y)	N	492, 493
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	