WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

Task Force on Medical Malpractice (ATF-MM)

Sample:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Appointments* ... *Appt*
- **

- *Clearinghouse Rules* ... *CRule*
- **

- *Committee Hearings* ... *CH*
- **

- *Committee Reports* ... *CR*
- **

- *Executive Sessions* ... *ES*
- **

- *Hearing Records* ... *HR*
- **

- *Miscellaneous* ... *Misc*
- **05hr_ATF-MM_Misc_pt12a**

- *Record of Comm. Proceedings* ... *RCP*
- **

United States General Accounting Office

GAO

Report to Congressional Requesters

April 1987

MEDICAL MALPRACTICE

Characteristics of Claims Closed in 1984

538701

GAO/HRD-87-55

Requests for copies of GAO reports should be sent to

U.S. General Accounting Office
Post Office Box 6015
Gaithersburg, Maryland 20877

Telephone 202-275-6241

The first five copies of each report are free. Additional copies are $2.00 each.

There is a 25% discount on orders for 100 or more copies mailed to a single address.

Orders must be prepaid by cash or by check or money order made out to the Superintendent of Documents.

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-221239

April 22, 1987

The Honorable John Heinz
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable John Edward Porter
House of Representatives

In response to your requests and later discussions with your offices, we have undertaken a major effort to review the medical malpractice situation in the United States This report, the fourth of a series we plan to issue on medical malpractice, contains information on the characteristics of a sample of malpractice claims closed during 1984

The first report, Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb 24, 1986), provided the views of major interest groups on the nature of malpractice problems and alternative approaches for resolving claims The second report, Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112, Sept. 15, 1986), contained information on the cost of malpractice insurance for physicians and hospitals. The third report, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, Dec. 31, 1986), contained information on the medical malpractice insurance situation, problems, and reforms in six states (Arkansas, California, Florida, Indiana, New York, and North Carolina) Separate documents prepared as supplements to that report discussed our work in each state Our fifth report, and last in the series, will provide our recommendations concerning the medical malpractice situation.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date At that time, we will send copies to interested parties and make copies available to others upon request.

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

How many malpractice claims were closed? How many health care providers were involved? What were the allegations of negligence leading to the claims? How much was paid to those who filed claims? What were insurers' costs to investigate and defend the claims? National data on malpractice claims had not been collected since 1978.

At the request of Representative John Edward Porter and Senator John Heinz, Ranking Minority Member of the Senate Special Committee on Aging, GAO undertook a review to obtain information that would assist the Congress in addressing public policy issues regarding (1) the effect of medical malpractice on the quality, availability, and affordability of health care; (2) the equity of compensation for malpractice injuries, and (3) who should be responsible for taking corrective actions The purpose of this report, the fourth in a series of five, is to present nationally representative information on malpractice claims closed in 1984

Background

To do this review, GAO analyzed data from a random sample of malpractice claim files closed in 1984 by 25 insurers. The insurers were randomly selected from a universe of 102 insurers that wrote a total of $2 3 billion in direct premiums in 1983 for medical malpractice insurance. Malpractice insurance costs for physicians and hospitals totaled an estimated $2.5 billion in 1983. Although some insurers limit their markets to a single state, the universe included at least one insurer writing medical malpractice insurance in each of the 50 states and the District of Columbia.

Results in Brief

In 1984 the 102 insurers closed an estimated 73,500 medical malpractice claims involving about 103,300 health care providers. About 43 percent of the claims were closed with an indemnity payment These payments totaled $2.6 billion and ranged from $1 to $2.5 million. The median and average payments were $18,000 and $80,741, respectively Claims closed with indemnities of $250,000 or more (about 9 percent of the paid claims) accounted for 61 percent of the total indemnity. (See pp 18 to 20.)

In addition, insurers paid $807 million to investigate and defend all of the claims closed in 1984. These costs ranged from $0 to $983,810 The median and average costs were $2,390 and $10,985, respectively (See pp. 20 and 21)

Eighty percent of the claims resulted from injuries that occurred in a hospital Three-quarters of the claims involved surgical, diagnostic, treatment, and obstetrics errors (See pp 22 to 25)

For the approximately 31,800 claims closed with payment, insurers often did not know the portion of paid claims that related to economic losses, noneconomic losses, and attorney's fees, however,

- for about 18,300 claims for which economic losses could be estimated, injured patients recovered equal to or more than their economic losses in 70 percent of these claims,
- for about 15,000 claims for which the expected value of the noneconomic losses could be estimated, (1) about 62 percent of the total compensation paid for noneconomic losses was for amounts more than $200,000, but this money went to only about 2 percent of these claims and (2) compensation for noneconomic losses was between $1 and $50,000 for 67 percent of these claims that included compensation for such losses, and
- for about 16,300 claims for which plaintiff attorney's fees could be estimated, such attorney's fees equaled from 31 to 40 percent of the expected value of the indemnity in about 52 percent of these claims (See pp. 44 to 50.)

GAO's Analysis

Awards/Settlements

Indemnity varied for the 31,800 claims closed with payment. About 9 percent of the paid claims were for less than $1,000, while less than 1 percent were for $1 million or more. (See pp. 18 to 20.) The payments varied by type and severity of the injury By type, about 27 percent of the total indemnity was paid for obstetrics errors (about 10 percent of paid claims). Obstetrics errors had the highest median and average payments. By severity, about 52 percent of the indemnity was for "permanent total disabilities" (10 percent of paid claims). (See pp. 39 to 42)

Patient Injuries

About 30 percent of the patients suffered "minor temporary disabilities," about 6 percent of the injuries were "emotional," and about 15 percent of the patients died. (See p 24.)

Claim Processing and Resolution

The length of time from the injury to the claim ranged from less than 1 month to 219 months The median and average were 13 and 16 4 months, respectively About 6 percent of the claims were filed in the same month as the injury, and 6 percent were filed more than 3 years after the injury (See p 32)

For claims closed with an indemnity payment, the median time from filing to closing was 23 months The median for those claims closed without payment was 17 months. Only 0.3 percent of the claims were resolved in the same month in which they were filed Three and one-half percent ranged from 73 to 132 months from filing to closure Generally, the more severe injuries and those resulting in the largest indemnity payments took longer to resolve (See pp. 33 to 36)

Health Care Providers Involved in Claims

Of health care providers involved in malpractice claims, about 71 percent were physicians and about 21 percent were hospitals Obstetricians/gynecologists and general surgeons were the physicians most often named in claims (See pp. 52 to 55.)

Insurers often were not able to provide data related to the training, board certification, and malpractice claims history of the physicians involved in the claims closed in 1984. However, the limited data for which estimates could be made suggest that at least

- 42 percent had claims filed against them previously,
- 52 percent may have been in practice from 11 to 30 years,
- 23 percent were foreign medical graduates (about the same as their percentage representation in the physician population), and
- 51 percent were board certified in the medical specialty in which the injury occurred (about the same as the percentage of board certified physicians in the population) (See pp 56 to 58.)

Recommendations

Recommendations on the malpractice problem will be provided in the overall report to be issued shortly.

Agency Comments

GAO did not obtain comments on this report

Contents

Executive Summary		2
Chapter 1 Introduction		12
	Objective, Scope, and Methodology	14
Chapter 2 General Questions and Answers Regarding Medical Malpractice Incidents and the Resulting Claims		18
	How Many Claims Were Closed and How Much Were the Total Indemnity Payments?	18
	What Costs Did Insurers Incur to Investigate and Defend Claims (Allocated Loss Expenses)?	20
	How Did Companies' Allocated Loss Expenses Vary Between Claims Closed With and Without Indemnity Payments?	21
	What Were the Principal Allegations of Negligence Leading to Claims?	22
	How Severe Were the Injuries for Which Claims Were Filed?	24
	Where Did Injuries Occur?	2[illegible]
	How Many Health Care Providers Were Involved in Claims?	2[illegible]
	How Were the Patients Compensated?	2[illegible]
	What Were the Characteristics of Patients Involved in Malpractice Claims?	2[illegible]
	What Were the Annual Earnings of the Patients Involved in Malpractice Claims?	3[illegible]
	What Were the Sources of Payment of Patients' Health Care Costs?	3[illegible]
	How Much Time Elapsed Between the Malpractice Injury and Claim Filing?	3[illegible]
	How Long Did It Take to Resolve Claims?	3[illegible]
	How Did the Severity of Injury and Amount of Indemnity Relate to the Disposition Time for Claims?	3[illegible]
	How Frequently Did the Health Care Providers' Insurers Initiate Contact With the Patients?	3[illegible]
	At What Stage in the Claims Settlement Process Was the Claim Resolved?	3[illegible]

Chapter 3 Questions and Answers Regarding Medical Malpractice Claims Closed With an Indemnity Payment — 38

How Much Were Patients Compensated for the Errors? — 39
How Much Were Patients Compensated by Severity of Injury Categories? — 40
How Much Were Patients Compensated for Injuries of the Same Severity? — 42
What Economic Losses Were Incurred by Injured Patients? — 43
To What Extent Were Patients' Economic Losses Resulting From Malpractice Injuries Compensated? — 44
What Percent of Indemnity Payments Are Plaintiff Attorney's Fees? — 48
How Did Compensation for Noneconomic Losses Relate to Indemnity Payments? — 49
How Much Were Medicare/Medicaid Patients Compensated for Their Injuries Compared to Others? — 51

Chapter 4 Questions and Answers Regarding Health Care Providers Involved in Medical Malpractice Claims — 52

Against Whom Were Claims Filed and Payments Made? — 52
What Were the Physician Specialties Most Often Named in Claims? — 54
How Did Companies' Indemnity Payments Differ by Physician Specialty? — 55
Did the Physicians Have Previous Claims Made Against Them? — 56
When Did the Physicians Graduate From Medical School? — 57
To What Extent Were Foreign-Trained Physicians Involved in Malpractice Claims? — 57
To What Extent Were Board Certified Physicians Involved in Patient Injuries? — 58
In What Type of Practice Were the Physicians? — 58

Appendixes

Appendix I: Previous Closed Claims Studies — 60
Appendix II: Closed Claims Data Collection Instrument — 61
Appendix III: Principal Allegations of Negligence That Led to Injury or Complication for Which Claim Was Made — 74
Appendix IV: Categories Used to Classify Injuries by Severity — 77
Appendix V: Supplemental Estimated Closed Claims Data — 78

Appendix VI Key Estimated Closed Claims Data and Related Sampling Errors 84

Tables

Table 2.1 Number of Paid Claims and Total Indemnity Payments by Payment Ranges 20
Table 2.2. Number of Claims and Amount of Allocated Loss Expenses by Size of Allocated Loss Expenses 20
Table 2.3 Costs to Investigate and Defend Claims Closed With Indemnity Payments 21
Table 2.4: Costs to Investigate and Defend Claims Closed Without Indemnity Payments 22
Table 2.5: Comparison of Defense Counsel and Total Allocated Loss Expenses to Indemnity Payments 22
Table 2.6. Number of Claims by Principal Allegations of Negligence Leading to the Injuries Involved 23
Table 2.7 Number of Claims by Severity of Injury Categories 24
Table 2.8: Number of Claims by Type of Facility Where Injury Occurred 25
Table 2.9: Number of Health Care Providers Involved in Claims 26
Table 2.10: Number of Paid Claims and Indemnity Payments by Payment Form 27
Table 2.11. Number of Claims by Ranges of Patients' Ages at the Time of the Injury 27
Table 2.12: Number of Claims by Patients' Sex 28
Table 2.13: Number of Claims by Patients' Occupational Status at the Time of the Injury 29
Table 2.14: Number of Claims by Ranges of Patients' Annual Earnings 30
Table 2.15 Number of Claims With No Annual Earnings by Patients' Occupational Status 3
Table 2.16. Number of Claims by the Length of Time From the Injury Occurrence to the Claim Filing 3
Table 2.17 Number of Paid Claims and Disposition Time by Severity of Injury Categories 3
Table 2.18: Number of Claims and Disposition Time by Indemnity Payment Ranges 3
Table 2.19: Number of Paid Claims and Indemnity Payments by Disposition Time 3
Table 2.20: Number of Claims Involving One Provider by Stage of Settlement

Table 3 1 Distribution of Total Indemnity Payments by Principal Allegations of Negligence	39
Table 3 2. Number of Paid Claims and Indemnity Payments by Principal Allegations of Negligence	40
Table 3 3 Number of Paid Claims and Indemnity Payments by Severity of Injury Categories	41
Table 3.4. Distribution of Total Indemnity Payments by Severity of Injury Categories	42
Table 3 5 Total and Average Amount of Patient Economic Losses by Categories	44
Table 3 6 Number of Paid Claims and Indemnity Payments by Size of Patients' Economic Losses	45
Table 3 7 Number of Paid Claims and Patients' Economic Losses by Severity of Injury Categories	46
Table 3 8. Number of Paid Claims and Indemnity Payments by Severity of Injury Categories	47
Table 3 9 Comparison of Patients' Economic Losses to Indemnity Payments	47
Table 3 10 Analysis of Plaintiff Attorney's Fees as a Percent of Indemnity Payments	49
Table 3 11. Number of Claims and Compensation for Noneconomic Losses by Size of Noneconomic Losses	50
Table 3.12. Analysis of Compensation for Noneconomic Losses as a Percent of Indemnity Payments	50
Table 3.13. Number of Paid Claims and Indemnity Payments by Source of Payment for Health Care Costs	51
Table 4.1: Number of Providers Involved in Claims and Their Payment Status by Type of Provider	53
Table 4.2: Number of Physicians Involved in Claims Compared to All Physicians by Physician Specialty	54
Table 4.3: Payment Status for Physicians Involved in Claims by Physician Specialty	55
Table 4.4. Number of Paid Claims Involving Only One Physician Provider and Indemnity Payments by Physician Specialty	56
Table 4.5: Number of Physicians Who Had Previous Claims Filed Against Them	56
Table 4.6: Number of Physicians Involved in Claims Compared to All Physicians by Years of Graduation	57
Table 4.7: Board Certification Status for Physicians Involved in Claims Closed in 1984	58
Table 4.8: Number of Physicians by Type of Practice	59

Table V 1 Number of Claims for Surgical Errors by Specific Allegations 78
Table V 2 Number of Claims for Diagnostic Errors by Specific Allegations 78
Table V 3 Number of Claims for Treatment Errors by Specific Allegations 78
Table V 4 Number of Claims According to Payment Status by Type of Facility Where Injury Occurred 79
Table V 5 Number of Paid Claims and Indemnity Payments by Type of Facility Where Injury Occurred 79
Table V 6 Number of Claims According to Payment Status by Patients' Age Ranges 79
Table V.7 Number of Paid Claims and Indemnity Payments by Patients' Age Ranges 80
Table V 8 Number of Claims According to Payment Status by Patients' Sex 80
Table V 9. Number of Paid Claims and Indemnity Payments by Patients' Sex 80
Table V 10 Number of Claims According to Payment Status by Patients' Occupational Status 81
Table V 11: Number of Paid Claims and Indemnity Payments by Patients' Occupational Status 81
Table V 12 Number of Claims According to Payment Status by Claim Resolution Period 81
Table V 13 Number of Claims and Disposition Time by Severity of Injury Categories 82
Table V 14. Number of Claims Involving One Provider According to Payment Status by Stage of Settlement 82
Table V 15. Economic Losses Compared to Indemnity Payments for Claims Where Losses Were Less Than Payment 83
Table V 16 Economic Losses Compared to Indemnity Payments for Claims Where Losses Were Greater Than Payment 83
Table V 17: Number of Claims With Economic Losses Less or Greater Than Indemnity Payments by Severity of Injury Categories 83
Table VI.1: Total Indemnity Payments and Related Sampling Error by Indemnity Payment Ranges 84
Table VI.2: Number of Claims and Related Sampling Error by Principal Allegations of Negligence Leading to the Injuries Involved 85

Table VI.3. Number of Claims and Related Sampling Error by Severity of Injury Categories 85
Table VI.4: Average Disposition Time and Related Sampling Error by Severity of Injury Categories 85
Table VI.5: Average Disposition Time and Related Sampling Error by Indemnity Payment Ranges 86
Table VI.6: Average Indemnity Payments and Related Sampling Error by Disposition Time 86
Table VI.7: Average Indemnity Payments and Related Sampling Error by Principal Allegations of Negligence 87
Table VI.8: Average Indemnity Payments and Related Sampling Error by Severity of Injury Categories 87
Table VI.9: Average Indemnity Payments and Related Sampling Error by Size of Patients' Economic Losses 88
Table VI.10: Average Patient Economic Losses and Related Sampling Error by Severity of Injury Categories 88
Table VI.11. Compensation for Noneconomic Losses and Related Sampling Error by Size of Noneconomic Losses 89
Table VI.12: Average Indemnity Payments and Related Sampling Error by Source of Payment for Health Care Costs 89

Figures

Figure 2.1: Outcome of Claims Closed in 1984 19
Figure 2.2. Percent of Claims by Source of Payment of Patients' Health Care Costs 31
Figure 2.3: Percent of Claims by Resolution Time (Months) 33
Figure 4.1 Distribution of Providers Against Whom Claims Were Filed 53
Figure 4.2. Distribution of Physicians by Location of Medical Education 58

Abbreviations

GAO	General Accounting Office
HMO	Health Maintenance Organization

Introduction

Medical malpractice involves "bad, wrong, or injudicious treatment of a patient, professionally and in respect to the particular disease or injury, resulting in injury, unnecessary suffering, or death to the patient, and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rules or principles, neglect, or a malicious or criminal intent."[1]

When a patient is injured in the course of medical treatment and believes the injury resulted from negligent care by a health care provider, the patient can bring an action against the provider seeking financial compensation for the economic (special damages) and noneconomic losses (general damages)[2] resulting from the injury According to A Russell Localio, Director of Research, Risk Management Foundation of the Harvard Medical Institutions, the health care provider's insurer may open a claim file related to the incident for one of several reasons, such as:

- The insurer has been notified by the health care provider that an incident has occurred that may lead to a claim being filed.
- A suit for damages has been filed by the injured person (plaintiff)
- The injured person or family member has made either an oral or a written claim for damages, or a statement charging an insured with malpractice and demanding an investigation or explanation.
- An attorney has sent a letter of representation (other than a request only for medical records) to an insured or to the insurer's claims department.
- As a result of a loss arising out of clear negligence, the insurer has decided to approach a patient or family for purposes of exploring the possibility of a settlement and avoiding a likely formal claim or suit

Once the file has been opened, the insurer may begin an investigation to gather preliminary information on the incident by having the hospital or a consultant review the patient's medical records and interviewing those involved in providing the medical care that led to the incident. From this the insurer forms an initial perception of what has happened and makes a judgment on the allocated expenses for investigation and defense and the amount of damages if the insured is liable. This amount becomes the

[1]Henry Campbell Black, Black's Law Dictionary, Revised Fourth Edition, West Publishing Co St Paul, MN, 1968, p 1111

[2]Economic losses include medical expenses, lost income, and rehabilitation expenses Noneconomic losses include pain and suffering, marital losses, and anguish

"reserve" associated with the case and may be adjusted as the investigation continues and the insurer's estimate of the ultimate cost of the case changes

Insurers' costs for investigation and defense consist of allocated and unallocated loss expenses The unallocated loss expenses include costs to operate the company's claims department and to pay its staff, which may include claims managers, supervisors, and adjusters These costs are not apportioned to individual cases Allocated loss expenses are those incurred in relation to specific cases and may include defense attorneys, medical experts, private investigators, public stenographers for depositions; special photography to document broken equipment, etc.; and other experts, such as engineers, pharmacists, and economists

Factors that could affect payment for economic losses include the patient's age at the time of the injury, earning capacity, medical expenses, and extent of rehabilitation services needed In addition, the award may include compensation of noneconomic losses, the value of which is a very subjective determination

When the resolution of the claim results in a payment to the plaintiff, the payment may be made in a lump sum; as a structured settlement (periodic payments) usually implemented through the purchase of an annuity; as free services; or some combination of these Ordinarily, the structured settlement is part of a package designed to cover up-front costs, such as prior medical expenses, court costs, lost income, attorney's fees, and other immediate needs as well as to provide a lifetime income with the total package tailored to meet the requirements of each specific case.[3]

Newspaper headlines about millions of dollars due to be paid over a claimant's lifetime may have no relationship to the actual dollars currently set aside by an insurance company to fund or structure a stream of benefits that will be paid periodically.[4]

Lawyers handling malpractice cases for plaintiffs usually do so on a contingency fee basis, i e., the lawyer is compensated only if an award or

[3]Donald E Danner and William J Robinson, "Structured Settlements Controlling Calamity Best's Review, November 1985, p 83

[4]James R Posner, "Trends in Medical Malpractice Insurance, 1970-1985." Law and Contemporary Problems, Spring 1986, pp 47-48

settlement results in payment to the plaintiff Generally the attorney will get a percentage of the award

A claim file is closed when (1) a claim for damages is not made, (2) the plaintiff drops the claim, (3) the insurer and plaintiff agree to a financial settlement, (4) a court renders a verdict, or (5) a settlement is reached through arbitration

Objective, Scope, and Methodology

Our work in the medical malpractice area was undertaken to obtain information that would assist the Congress in addressing public policy issues regarding (1) the effect of medical malpractice on the quality, availability, and affordability of health care, (2) the equity of compensation for medical malpractice injuries; and (3) who should be responsible for taking corrective actions. The objective of our closed claims study was to provide nationally representative data relating to cost and equity issues, such as the economic losses of injured patients in relation to awards/settlements, cost to insurers to resolve the claims, length of time it takes to resolve claims, and similarity of awards/settlements for injuries of similar severity. National data on the characteristics of malpractice claims had not been collected since 1978.

To establish a data base of claims, we collected data on a sample of claims closed in 1984 by a sample of insurers writing malpractice insurance in 1983.[5] We identified a universe of 102 insurers, which wrote malpractice insurance in the United States, consisting of 25 commercial companies, 39 physician-owned companies, 28 hospital-owned companies, and 10 joint underwriting associations. Direct premiums written by these insurers totaled $2.3 billion in 1983.[6] Included was at least one insurer writing medical malpractice insurance in each of the 50 states and the District of Columbia.

These insurers were first stratified by type of insurer and then rank-ordered by premium volume. Selection within insurer-type was random, but proportionate-to-size with larger companies having a greater

[5]Insurers define and count claims differently For this study we defined a "claim" as the incident, regardless of how many providers may have been involved or how many claim files may have been opened A claim was considered closed only if all claim files associated with the incident had been closed and all appeals were final

[6]1983 malpractice insurance costs for physicians and hospitals (including $256 million for hospital self-insurance and $31 million for hospital losses paid from general revenues and reserves) totaled an estimated $2 5 billion See Medical Malpractice Insurance Costs Increased but Varied Among Physicians and Hospitals, GAO/HRD-86-112 Sept 15, 1986, pp 2 and 39

probability of selection Twenty-five companies were selected to participate in the closed claims study—six commercial companies, seven physician-owned companies, seven hospital-owned companies, and five joint underwriting associations Ten of the original 25 companies selected declined to participate These companies were replaced in the study in a random manner by companies of the same type and, as nearly as possible, of the same premium volume using the method of selection with probability proportional to size The reasons cited for nonparticipation included the lack of staff and time constraints Based on these reasons, we believe the replacement companies would not be much different in terms of the characteristics of claims closed than the originally selected insurance companies

Each of the 25 companies was requested to provide a listing of claim numbers and indemnity amounts for all claims closed in 1984 The insurers reported a total of 31,395 claims

The claim numbers were stratified for each company into 10 groups by indemnity amount For example, all claims closed without an indemnity payment were put into stratum 0, while stratum 9 included all claims closed with an indemnity payment of $1 million or more Within each stratum we randomly selected the claims to be reviewed

A claim was considered ineligible for this study if

- it was closed without an actual demand for compensation being made by or on behalf of the patient,
- it involved a malpractice incident for which other files were still open,
- it involved general liability rather than professional liability,
- the company's involvement in the claim was only as a reinsurer,[7]
- it was inaccessible (i.e., claim file that was either permanently lost or would not be available during the entire data collection period), or
- it did not meet study criteria for other reasons (e g , the claim was closed in a year other than 1984)

When developing our data collection instrument and instruction manual, we considered those used in previous studies (See app I for a brief description of several previous closed claims studies.) We pretested drafts of our data collection instrument and instruction manual at three of the four types of insurance companies represented in our sample The

[7] Insurance companies buy reinsurance from other insurers to cover potential losses that may be too large for the individual company to absorb

information obtained was used to refine the questions and terminology used in the final data collection instrument and instruction manual (app II contains a copy of the data collection instrument) Appendix III provides the "allegations of negligence" used to categorize the type of error alleged to have caused injury Appendix IV provides the categories of severity used to classify the seriousness of patient injuries

The data collection instrument consisted of two forms One collected data on the incident The other collected data on each health care provider associated with the claim who was insured by the participating insurer One of each form was completed for each eligible claim, however, more than one provider form was completed when the claim involved multiple defendants

The companies reviewed 2,781 claims and completed 1,706 data collection instruments. The companies judged the remaining 1,075 claims to be ineligible for our study

A GAO representative met with each insurer to provide instructions for completing the data collection instruments; however, we did not independently validate the accuracy of the data they provided. The insurers sent the completed data collection instruments to GAO

We began visiting the insurers in June 1985 and completed the visits in December 1985 We received the first completed questionnaires in August 1985 and the last in May 1986

As the completed data collection instruments were received, we reviewed the data question by question for completeness and consistency before coding the responses for entry into a data file Where data items appeared incomplete or inconsistent, the companies were asked to complete the item or to resolve the inconsistency. After the data file was completed for the 25 companies, the data were projected to the 102 companies in the universe.

For our analyses, we concentrated on frequencies and cross-tabulations of the data elements that would answer selected questions regarding medical malpractice incidents, the resulting claims, and health care providers involved. Primarily, we analyzed the allegations of negligence leading to claims and where they occurred, the extent to which patients received compensation and the variance by severity of injury, how long claims were in process, at what stage they were resolved, the companies' costs associated with defending the claims, and what types of health

care providers were involved in the claims Chapters 2, 3, and 4 present this information in a question and answer format Supplementary data developed during our analysis are presented in appendix V Unless otherwise indicated, all data presented in this report are estimates

Our estimates are based on weighting procedures applied to the 25 participating insurance companies' data In instances where data were missing on a claim, the estimated values will be for less than the total number of claims Estimates in chapter 3 of this report which are based on about half of the claims where data were provided are noted These estimates are representative of about one-half of the claims We do not know anything about the other half Therefore, it should not be assumed that the characteristics of the unknown half are the same or not the same as those of the known half We randomly verified the accuracy of data entry tasks and reviewed the computer programs to ensure the reliability of our analysis

Because our estimates are based upon a sample of claims, each estimate has a certain amount of sampling error The sampling errors associated with several key estimates are presented in appendix VI. These sampling errors are stated at the 95-percent confidence level This means that the chances are 19 out of 20 that the true universe characteristic being estimated falls within the range defined by our estimate minus the sampling error and our estimate plus the sampling error

Chapter 2

General Questions and Answers Regarding Medical Malpractice Incidents and the Resulting Claims

An estimated[1] 73,472 medical malpractice claims were closed in 1984 Fifty-seven percent were closed with no indemnity, however, payments for claims closed with indemnity totaled $2 6 billion and ranged from $1 to $2 5 million. The median was $18,000 and the average was $80,741 Claims closed with an indemnity of $250,000 or more (about 9 percent of the claims) accounted for 61 percent of the total payments

In addition to the indemnity payments, the insurers spent $807 million to investigate and defend all of the claims closed in 1984 These costs ranged from $0 to $983,810, with a median of $2,390 and an average of $10,985. Insurers incurred costs to investigate and defend the claims whether or not payment was made. The median and average costs were $4,866 and $14,413 for claims closed with indemnity and $1,500 and $8,372 for claims closed without indemnity

Injuries most frequently occurred in hospitals Three-quarters involved four allegations of negligence—surgical, diagnostic, treatment, or obstetrics errors. About 30 percent of all injuries resulted in "minor temporary disabilities."

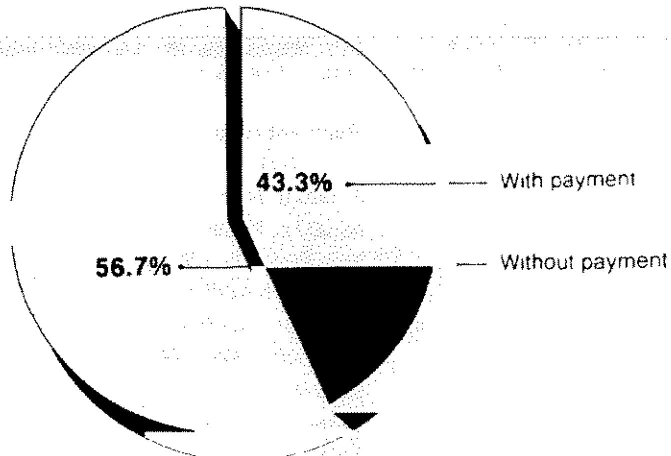
There was a wide variance in the length of time both from the injury to the claim and from the claim to its disposition The average times were 16 months and 25 months, respectively About half of the claims were closed after suit but before trial, while 5 percent were resolved by court verdict. Generally, the more severe injuries and those receiving the largest indemnity payments took longer to resolve Claims with indemnity payments of $1 million or more had the highest median and average time from claim to disposition, 76 months and 65 months, respectively

How Many Claims Were Closed and How Much Were the Total Indemnity Payments?

We estimated that 73,472 medical malpractice claims were closed by the 102 insurance companies in 1984 Figure 2 1 shows that about 43 percent (31,786 claims) were closed with an indemnity payment

[1] Unless otherwise indicated, all data presented in this chapter are estimated Key estimated values used in this chapter are presented with their related sampling errors in tables VI 1 through VI 6

Figure 2.1: Outcome of Claims Closed in 1984



The companies' indemnity payments (present value at the time of closure) for these awards/settlements totaled about $2.6 billion [2] Indemnity payments ranged from $1 to about $2 5 million, with a median of $18,000 and an average of $80,741[3] As shown in table 2 1, about 9 percent of the paid claims were for less than $1,000, while less than 1 percent were for $1 million or more About 69 percent of the paid claims were for less than $50,000 Claims closed with an indemnity payment of $250,000 or more (about 9 percent of paid claims) accounted for about 61 percent of the total indemnity paid

[2]Closed claims represent only a part of an insurer's medical malpractice experience These data should not be considered as a reflection of profitability According to the National Association of Insurance Commissioners profit measures should be based on comparable earned premium and incurred loss data Neither of these measures is included in this study

[3]All the indemnity payments cited in this report are stated as present value at the time of closure unless otherwise noted

Table 2.1: Number of Paid Claims and Total Indemnity Payments by Payment Ranges

Total indemnity payments in millions

	Paid claims		Indemnity payments	
Payment ranges	**Number**	**Percent**	**Total**	**Percent**
$1 to $999	2 950	9 3	$1 4	0 1
$1 000 to $4,999	5 281	16 6	13 1	5
$5,000 to $9,999	4,103	12 9	26 7	1 0
$10 000 to $24,999	4 565	14 4	67 6	2 6
$25,000 to $49 999	5,078	16 0	161 5	6 3
$50,000 to $99 999	3,968	12 5	264 2	10 3
$100 000 to $249,999	2,998	9 4	474 1	18 5
$250,000 to $999,999	2 585	8 1	1,229 4	47 9
$1 million or more	258	8	328 4[a]	12 8
Total	**31,786**	**100.0**	**$2,566.4**	**100 0**

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

What Costs Did Insurers Incur to Investigate and Defend Claims (Allocated Loss Expenses)?

In addition to the indemnity payments, insurers incurred about $807 million in costs to investigate and defend all of the claims closed in 1984 The median and average costs were $2,390 and $10,985, respectively As shown in table 2 2, the allocated loss expenses ranged from $0 to $983,810.

Table 2.2: Number of Claims and Amount of Allocated Loss Expenses by Size of Allocated Loss Expenses

Amount of allocated expenses in millions

	Claims		Allocated expenses	
Expense ranges	**Number**	**Percent[a]**	**Amount**	**Percent[a]**
Unknown	110	0 1	$ •	•
$0	17,092	23 3	0 0	0 0
$1 to $999	10,676	14 5	5 0	0 6
$1 000 to $4,999	19,943	27 1	54 0	6 7
$5,000 to $9,999	8,519	11 6	60 0	7 4
$10,000 to $24,999	10,020	13 6	161 0	20 0
$25,000 to $99,999	5,921	8 1	241 0	29 9
$100,000 to $249 999	1,060	1 4	195 0[b]	24 2
$250,000 to $983 810	131	0 2	91 0[b]	11 3
Total	**73,472**	**100.0**	**$807.0**	**100.0**

[a]Detail does not add to total due to rounding

[b]Estimate subject to a large sampling error and should be used with caution

About $668 million, or almost 83 percent, of the total allocated loss expenses was for defense counsel Defense counsel expenses ranged from $0 to $702,780 and had an average and median of $9,107 and $1,973, respectively Expert witness expenses and other allocated expenses were about $69 million and $70 million with averages of $942 and $961, respectively

How Did Companies' Allocated Loss Expenses Vary Between Claims Closed With and Without Indemnity Payments?

Insurance companies spent more money to investigate and defend claims closed with payment even though more claims were closed without a payment. Of the estimated $807 million in expenses incurred by companies to investigate and defend the claims closed in 1984, about $458 million, or about 57 percent, was spent on claims closed with payment The average allocated loss expense per paid claim was $14,413 and included 6,443 paid claims where the companies incurred no allocated loss expenses. About 80 percent of this was for defense counsel, which averaged $11,485 per claim. Table 2 3 shows how much companies spent on the claims closed with payment

Table 2.3: Costs to Investigate and Defend Claims Closed With Indemnity Payments

Total costs in millions

	Costs				
				Range	
Categories	**Total**[a]	**Median**	**Average**	**Lowest**	**Highest**
All claims	**$458.1**	$4 866	$14 413	$0	$983 810
Defense counsel	**365.0**	3 907	11,485	0	702 780
Expert witness	**49.9**	100	1,573	0	400 000
Other expenses	**43.1**	167	1,365	0	598 969

[a]Detail does not add to total due to rounding

Table 2 4 shows the allocated loss expenses incurred for the 41,686 claims closed without an indemnity payment For about a quarter of these claims (10,649), the companies incurred no allocated loss expense Total expenses ranged from $0 to $247,100 and averaged $8,372 Costs for defense counsel comprised about 87 percent of the total and averaged $7,288

Table 2.4: Costs to Investigate and Defend Claims Closed Without Indemnity Payments

Total costs in millions

Categories	Costs: Total	Median	Average	Range: Lowest	Highest
All claims	**$349.0**	$1,500	$8,372	$0	$247 100
Defense counsel	**302.8**	1,293	7 288	0	246 952
Expert witness	**19.0**	0	459	0	26 875
Other expenses	**27.2**	4	655	0	16 495

For each paid claim, we compared the company's defense counsel expense and total allocated expenses to the indemnity payment made to the injured patient. For about 14 percent of these claims, the companies' total defense and investigation expenses were greater than the payment to the injured patient. Further, as shown in table 2.5, defense counsel expenses alone exceeded the payment in about 12 percent of these claims.

Table 2.5: Comparison of Defense Counsel and Total Allocated Loss Expenses to Indemnity Payments

Comparison	Defense counsel: Paid claims	Defense counsel: Percent[a]	Total expenses[a]: Paid claims	Total expenses[a]: Percent
Expense less than payment	26,978	84 9	25 940	81 6
Expense equal to payment[b]	846	2 7	1 286	4 0
Expense greater than payment	3,960	12 5	4,557	14 3
Total	**31,784**	**100.0**	**31,784**	**100.0**

[a]Detail does not add to total due to rounding

[b]For purposes of this comparison, we considered expense to equal payment if expense was within 10 percent (less or greater) of the payment

Note The total number of claims is based on the number of claims for which the relevant data were provided

What Were the Principal Allegations of Negligence Leading to Claims?

GAO divided the allegations of negligence leading to injuries for which the claims were filed into 12 general categories. These were further divided into 77 specific categories that described the allegations in more detail [4] (See app III.) As shown in table 2.6, three quarters of the claims closed in 1984 involved allegations[5] of surgical, diagnostic, treatment, or obstetrics errors.

[4]The allegations of negligence used in this study were developed by the Risk Management Foundation of the Harvard Medical Institutions and are used with their permission

[5]Only the principal allegation was used in those cases where a secondary allegation was also provided by the insurer

Table 2.6: Number of Claims by Principal Allegations of Negligence Leading to the Injuries Involved

	Claims		
Type of error	Number[a]	Percent[a]	Cumulative percent
Surgery	18,697	25.4	25.4
Diagnosis	17,372	23.6	49.0
Treatment	14,635	19.9	68.9
Obstetrics	5,517	7.5	76.4
Medication	3,019	4.1	80.5
Medication administration	2,735	3.7	84.2
Anesthesia	2,720	3.7	87.9
Physiology/behavior monitoring, biomedical equipment, intravenous, and blood products[b]	3,284	4.5	92.4
Other[b]	5,491	7.5	99.9
Total	**73,468**	**100.0**	

[a]Detail does not add to total due to rounding

[b]Combined estimates shown with sampling errors in table VI 2 differ due to rounding

Note The total number of claims is based on the number of claims for which the relevant data were provided

As shown in table 2.6, surgical errors were cited in about 25 percent of the closed claims. Of these, about 75 percent involved improper performance of a surgical procedure, and about 6 percent involved foreign bodies[6] left in patients. Diagnostic errors, cited in about 24 percent of the claims, involved failure to diagnose (about 37 percent) or a misdiagnosis (about 33 percent). Treatment-related errors were often associated with improper performance (about 45 percent) and improper choice (about 22 percent) The estimated number of claims for these three types of errors by specific category of allegation is shown in tables V 1 through V 3.

Obstetrics-related errors were listed as the principal allegation of negligence in about 8 percent of the claims, of which about 24 percent were for failure to identify fetal distress. Reliable estimates for the other specific categories of obstetrics errors could not be determined because of limited data in the sample. Also, about 8 percent of the claims had errors that were grouped in the "other" category Reliable estimates show that patient falls (about 39 percent) and failure to insure patient safety (about 22 percent) occurred most often.

[6]Foreign bodies can include objects such as a surgical sponge or clamp

How Severe Were the Injuries for Which Claims Were Filed?

The severity of injury range included nine severity classifications and extended from "emotional" injuries to "death" (See app IV for examples used to classify the seriousness of patient injuries) As shown in table 2 7, the patients involved in about 30 percent of the closed claims experienced "minor temporary disabilities " "Minor permanent partial disabilities" (about 16 percent) and "death" (about 15 percent) accounted for another 31 percent of the claims About 6 percent of the injuries were "emotional," and the fewest number of claims (about 2 percent) involved "grave permanent total disabilities"

Table 2.7: Number of Claims by Severity of Injury Categories

	Claims		
Severity of injury	Number	Percent[a]	Cumulative percent
Emotional	4,660	6 4	6 4
Insignificant	6.823	9 3	15 7
Temporary disability—minor	21,969	30 0	45 7
Temporary disability—major	8 101	11 1	56 8
Permanent partial disability—minor	11,551	15 8	72 6
Permanent partial disability—major	4,225	5 8	78 4
Permanent total disability—major	2 788	3 8	82 2
Permanent total disability—grave	1,794	2 4	84 6
Death	11,179	15 3	99 9[a]
Total	**73,090**	**100.0**	

[a]Detail does not add to total due to rounding

Note The total number of claims is based on the number of claims for which the relevant data were provided

Where Did Injuries Occur?

As shown in table 2 8, about 80 percent of the claims closed involved an injury that occurred in a hospital, and about 13 percent in a physician's office. The remaining injuries occurred in nursing homes, patients' homes, health maintenance organizations (HMOs), emergency care centers, and other types of facilities

Specifically, about 58 percent of the injuries took place in nonteaching community[7] hospitals, 18 percent in teaching community hospitals, and about 4 percent in other types of hospitals About 30 percent of the errors that occurred in both teaching and nonteaching hospitals were surgery related Treatment-related errors accounted for about 37 percent of the errors that occurred in physicians' offices Patients experienced "minor temporary disabilities" in about 24, 29, and 33 percent of the claims where the injuries occurred in teaching hospitals, nonteaching hospitals, and physicians' offices, respectively

Table 2.8: Number of Claims by Type of Facility Where Injury Occurred

	Claims		
Type of facility	**Number[a]**	**Percent**	**Cumulative percent**
Community hospital—nonteaching	42,666	58 1	58 1
Community hospital—teaching	13,229	18 0	76 1
Other hospital	3,240	4 4	80 5
Physician's office	9,274	12 6	93 1
Nursing home	1,503	2 0	95 1
Emergency care center	1,160	1 6	96 7
HMO, patient's home, other, and unknown	2,399	3 3	100 0
Total	**73,472**	**100.0**	

[a]Detail does not add to total due to rounding

For the claims closed involving injuries that occurred in nonteaching hospitals, about 38 percent received an indemnity payment and 62 percent did not. About 44 percent of the injuries that took place in teaching hospitals and about 55 percent that occurred in physicians' offices resulted in payment. (See table V.4.) Higher median and average indemnity payments were made for injuries occurring in teaching hospitals than in nonteaching hospitals and physicians' offices (See table V 5)

[7]The American Hospital Association defines a community hospital as a nonfederal, short-term general and other special hospital, excluding hospital units of institutions, whose facilities and services are available to the public There were a total of 5,736 community hospitals in the United States in 1984 Of these, 903 (15 7 percent) were teaching hospitals and 4,833 (84 3 percent) were nonteaching hospitals Although there were fewer teaching hospitals, in general, they tended to be larger in terms of the number of beds than the nonteaching community hospitals Of the teaching hospitals 800 (88 6 percent) consisted of 200 or more beds each, whereas 957 of the nonteaching hospitals (19 8 percent) had 200 or more beds

How Many Health Care Providers Were Involved in Claims?

The number of health care providers involved in the 73,472 closed claims that were insured by the 102 companies totaled 103,255, or an average of 1 4 providers per claim The number ranged from 1 to 13, however, as shown in table 2.9, about 77 percent of the claims involved only one provider Also, at least 70 percent of all the health care providers were physicians.

Table 2.9: Number of Health Care Providers Involved in Claims

Number of providers involved	Claims: Number	Claims: Percent[a]	Claims: Cumulative percent	Total number of providers
1	56,376	76 7	76 7	56,376
2	9,855	13 4	90 1	19 710
3	3,822	5 2	95 3	11,466
4	2,069	2 8	98 1	8,276
5 to 13	1 350	1 8	99 9[a]	7 427
Total	**73,472**	**100.0**		**103,255**

[a]Detail does not add to total due to rounding

How Were the Patients Compensated?

Indemnity payments for most patients—about 90 percent—were made as lump sum (only) payments, while about 2 percent consisted of free services alone or a combination of free services with another payment form. As shown in table 2.10, the balance of cases involved structured payments alone or in combination with a lump sum payment. Indemnity paid through these forms totaled $951.4 million. Because some of the claims closed in 1984 involve structured payments that will be made over time, the payments received by patients for all the claims closed in 1984 may ultimately total about $5.4 billion. For example, the largest indemnity payment of about $2.5 million had an expected value of about $7.8 million for the patient These expected payments ranged from $1 to $27.2 million, with a median of $18,000 and an average of $169,786 The $951.4 million in payments made through structured payments alone or in combination with a lump sum may have an expected yield of $3.8 billion

Table 2.10: Number of Paid Claims and Indemnity Payments by Payment Form

Dollars in millions

Payment form	Paid claims Number[a]	Paid claims Percent	Indemnity payments Total	Indemnity payments Percent[a]
Lump sum	28 763	90 5	$1 601 6	62 4
Lump sum and structured	1 264	4 0	490 7	19 1
Structured	1 121	3 5	460 7	18 0
Free services only and combinations with lump sum or lump sum and structured	628	2 0	11 4[b]	0 4
Total	**31,775**	**100.0**	**$2,564.4**	**100.0**

[a]Detail does not add to total due to rounding

[b]Estimate is subject to a large sampling error and should be used with caution

Note The total number of claims is based on the number of claims for which the relevant data were provided

What Were the Characteristics of Patients Involved in Malpractice Claims?

People of all ages were involved in medical malpractice claims. Table 2.11 shows the distribution of patients' ages at the time of the injury As shown in the table, about 9 percent of the patients were injured at birth About 14 percent were 65 years or older. The age range most often represented was 18 to 29 years. The average and median ages of the patients were 37 and 35 years, respectively.

Table 2.11: Number of Claims by Ranges of Patients' Ages at the Time of the Injury

Age ranges (years)	Claims Number	Claims Percent	Claims Cumulative percent
At birth	6,209	8 8	8 8
Less than 1	933	1 3	10 1
1 to 17	5,879	8 3	18 4
18 to 29	14,607	20 7	39 1
30 to 39	11,013	15 6	54 7
40 to 49	10,097	14 3	69 0
50 to 59	8,886	12 6	81 6
60 to 64	3 401	4 8	86 4
65 and over	9,616	13 6	100 0
Total	**70,641**	**100.0**	

Note The total number of claims is based on the number of claims for which the relevant data were provided

As might be expected, about 62 percent of the patients injured at birth experienced obstetrics-related errors. Patients 18 to 29 years old often

suffered surgical (about 30 percent) and treatment (about 25 percent) errors, and the oldest patients (65 years and over) experienced other types of errors, such as falls and diagnostic and surgical errors The most severe injuries were experienced most often by the youngest patients About 28 percent of the patients injured at birth died, while about 26 percent of the 65 years or older patients died Patients 18 to 29 years old and those who were 65 years and older experienced "minor temporary disabilities" in about 34 and 30 percent of the claims, respectively

Indemnity payments were made for almost half of the claims that involved injuries occurring at birth These patients received higher median and average payments ($200,000 and $300,500) when compared to patients of all other age ranges. Patients 18 to 29 years old had the lowest percentage of paid claims (about 37 percent), whereas the oldest patients' claims were paid in about 43 percent of the cases (See tables V.6 and V 7)

Table 2 12 shows the distribution of claims by patients' sex As shown, about 57 percent of the patients were female, and 43 percent were male

Table 2.12: Number of Claims by Patients' Sex

	Claims	
Sex	**Number**	**Percent**
Male	31,630	43 1
Female	41 747	56 9
Total	**73,377**	**100.0**

Note The total number of claims is based on the number of claims for which the relevant data were provided

The injuries experienced by male and female patients were generally similar. Both sexes suffered surgical and diagnostic errors most often Males suffered more diagnostic than surgical errors (about 28 percent and 23 percent), whereas females experienced more surgical than diagnostic errors (about 27 and 21 percent). For both sexes the most frequently indicated severity of injury category was "minor temporary disabilities" (about 30 percent). Females experienced slightly more "emotional" and "insignificant" injuries, whereas males had more serious injuries—"major permanent partial disabilities," "grave permanent total disabilities," and "deaths."

Although females were involved in more claims, males had a slightly higher percentage of paid claims (about 45 percent for males and 42 percent for females) Both sexes received the same median payment ($18,000), but males had a higher average payment (See tables V 8 and V 9)

As shown in table 2 13, about one-third of the patients involved in medical malpractice claims were either employed or self-employed, while about 9 percent were unemployed The remainder of the patients were homemakers, retired persons, dependent children/students, and independent students The occupational status of about 12 percent of the patients was unknown.

Table 2.13: Number of Claims by Patients' Occupational Status at the Time of the Injury

	Claims		
Occupational status	**Number**[a]	**Percent**[a]	**Cumulative percent**
Employed	23,921	32 6	32 6
Self-employed	3,462	4 7	37 3
Homemaker	9,311	12 7	50 0
Retired	8,492	11 6	61 6
Unemployed	6,713	9 1	70 7
Dependent child/student	12,532	17 1	87 8
Independent student and other	447	0 6	88 4
Unknown	8 596	11 7	100 1[a]
Total	**73,472**	**100.0**	

[a]Detail does not add to total due to rounding

About 32 percent of both the employed and unemployed patients experienced surgical errors. Homemakers had diagnostic (about 28 percent) and surgical (about 26 percent) errors most often. For dependent children/students, diagnostic and obstetrics errors each accounted for about 32 percent For about 30, 43, and 28 percent of the claims closed for employed and unemployed patients and dependent children/students, respectively, "minor temporary disabilities" were reported. About 19 percent of the homemakers experienced "major temporary disabilities "

Dependent children/students' claims were paid more than half of the time. Employed and unemployed patients and homemakers' claims received payment in about 41, 44, and 42 percent of the cases, respectively. Although the payment percentage was slightly lower for employed patients than the other three patient occupations discussed, they received higher median and average payments than unemployed

patients and homemakers Dependent children/students' median and average payments were the highest of these four categories (See tables V 10 and V 11)

What Were the Annual Earnings of the Patients Involved in Malpractice Claims?

Patients' annual earnings at the time of the injury could be estimated for 55,235 of the 73,472 claims closed (about 75 percent) Table 2 14 provides the distribution for claims where data were available. The earnings ranged from $0 to $1 million The average annual patient earnings for these claims was $7,166 and the median was $0

Table 2.14: Number of Claims by Ranges of Patients' Annual Earnings

Ranges of patients' annual earnings[a]	Claims		
	Number[b]	Percent	Cumulative percent
$0	33,282	60 3	60 3
$1,000 to $4 000	1,293	2 3	62 6
$5,000 to $9,000	2,607	4 7	67 3
$10,000 to $19,000	11 613	21 0	88 3
$20,000 to $29,000	4,197	7 6	95 9
$30,000 to $39,000	1,311	2 4	98 3
$40,000 to $49,000	526	1 0	99 3
$50,000 or more	405	0 7	100 0
Total	**55,235**	**100.0**	

[a]Earnings data were provided to us rounded up to the next $1 000 Earnings do not reflect total family income

[b]Detail does not add to total due to rounding

Note The total number of claims is based on the number of claims for which the relevant data were provided

Considering only the claims where the earnings were greater than $0, the distribution shows that about 18 percent had earnings less than $10,000; about 53 percent were from $10,000 to $19,000; and about 29 percent were $20,000 or more. The average and median patient earning at the time of the patient's injury for these claims were $18,030 and $15,000, respectively. The patients' occupational status for the 33,282 claims (about 60 percent) with $0 annual earnings are shown in table 2 15.

Table 2.15: Number of Claims With No Annual Earnings[a] by Patients' Occupational Status

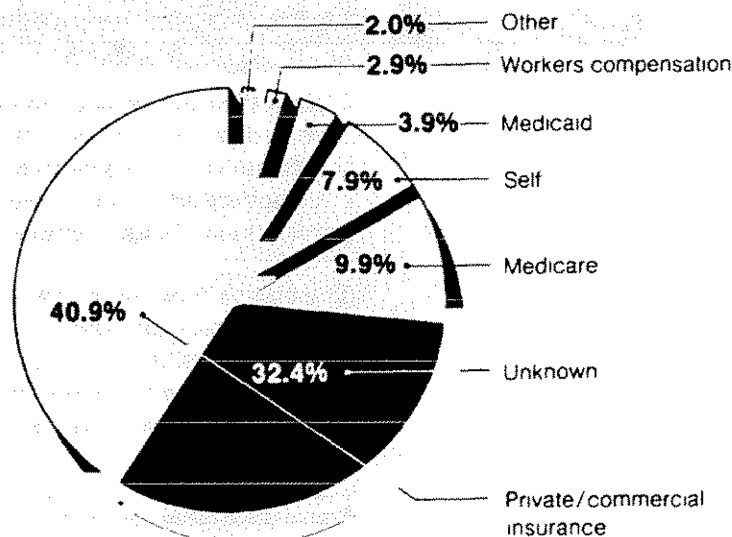
Occupational status	Claims Number	Claims Percent	Cumulative percent
Dependent child/student	11,144	33 5	33 5
Homemaker	8 451	25 4	58 9
Retired	6 756	20 3	79 2
Unemployed	6 391	19 2	98 4
Independent student other, and unknown	540	1 6	100 0
Total	**33,282**	**100.0**	

[a]Although annual earnings were not reported for these patients some may have had an income

What Were the Sources of Payment of Patients' Health Care Costs?

As shown in figure 2 2, health care costs for about 41 percent of the patients involved in medical malpractice claims were paid by private/commercial insurance before the liability injury A small percentage of malpractice claims involved medicare and medicaid recipients, about 10 percent and about 4 percent, respectively However, the source of payment of the patients' health care costs was unknown for a large number of claims—23,803, or about 32 percent.

Figure 2.2: Percent of Claims by Source of Payment of Patients' Health Care Costs



Note Detail does not add to total due to rounding

How Much Time Elapsed Between the Malpractice Injury and Claim Filing?

The length of time from injury occurrence to the claim filing ranged from 0 (less than 1 month) to 219 months (18 25 years) The median and average periods were 13 months and 16 4 months, respectively About 6 percent of the claims were filed within the same month as the injury occurred, and 6 percent took more than 3 years (37 to 219 months) to be filed, as shown in table 2 16.[8]

Table 2.16: Number of Claims by the Length of Time From the Injury Occurrence to the Claim Filing

	Claims		
Time (months)	Number	Percent	Cumulative percent
0 (less than 1)	4,141	5 6	5 6
1 to 3	10,408	14 2	19 8
4 to 8	9,348	12 8	32 6
9 to 12	11,906	16 2	48 8
13 to 18	10,625	14 5	63 3
19 to 24	13,253	18 1	81 4
25 to 36	8,956	12 2	93 6
37 to 219	4,667	6 4	100 0
Total	**73,304**	**100.0**	

Note The total number of claims is based on the number of claims for which the relevant data were provided

Claims filed in the same month as the injury occurred primarily involved surgical (about 19 percent), diagnostic (about 18 percent), and treatment (about 18 percent) related errors The two most frequently cited severities of injury were "minor temporary disabilities" (about 39 percent) and "major temporary disabilities" (about 24 percent)

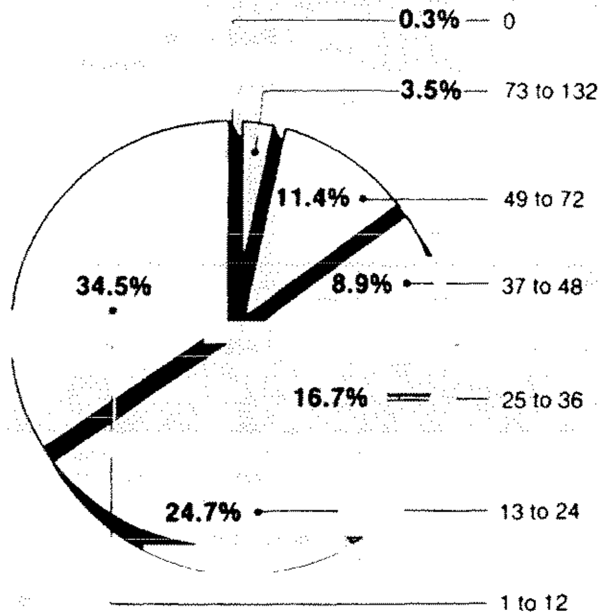
The claims filed more than 3 years after the injury involved obstetrics (about 25 percent) and medication administration (about 22 percent) related errors. Injuries resulting in "minor and major temporary disabilities" accounted for about 36 percent of the claims, and "minor and major permanent partial disabilities" accounted for 32 percent of the claims.

[8]Claims closed during a period of time, such as those in this study, may not fairly represent the patterns arising from occurrences in any period Incidents in this report occurred during several prio time periods, and claims for incidents now occurring will be resolved in several different future year the difference in sets of economic and social factors may alter the patterns of time duration and indemnity amounts Patterns may also be distorted by the different state statutes of limitations

How Long Did It Take to Resolve Claims?

For the 73,204 claims in our universe where data were provided, the length of time from claim filing to complete disposition against all providers involved ranged from 0 (less than 1 month) to 132 months (11 years), with a median of 19 months and an average of 25 months Figure 2 3 shows the percentage of claims for each range of time periods for resolution Paid claims had a median of 23 months for resolution, while those without payment had a median of 17 months. The distribution of time to resolve claims by payment status is shown in table V 12

Figure 2.3: Percent of Claims by Resolution Time (Months)



How Did the Severity of Injury and Amount of Indemnity Relate to the Disposition Time for Claims?

Generally, the more severe and costly cases took longer to resolve For all claims, the highest medians for time between filing and disposition were for "major permanent partial disabilities" and "major permanent total disabilities"—33 and 32 months, respectively. "Major permanent partial disabilities" also had the highest average (34.5 months) and the widest range (0 to 132 months). "Emotional" injuries had the lowest values for all of these measures (See table V.13 for the disposition times for all claims by severity of injury)

For the claims closed with payment, the highest median for time between filing and disposition was for "major permanent total disabilities"—45 months—while the lowest was 12 months for "emotional" injuries As shown in table 2 17, the highest average was 38 8 months for "grave permanent total disabilities "

Table 2.17: Number of Paid Claims and Disposition Time by Severity of Injury Categories

Disposition time in months

Severity of injury	Paid claims		Disposition time			
					Range	
	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims[b]	31 642	43 3	23 0	28 0	0 0[c]	132 0
Emotional	1,194	25 6	12 0	14 9	0 0	55 0
Insignificant	3 258	48 7	14 0	21 8	0 0	110 0
Temporary disability—minor	8,021	36 6	19 0	25 7	0 0	108 0
Temporary disability—major	2,989	37 2	18 0	22 4	0 0	81 0
Permanent partial disability—minor	6,288	54 4	23 0	28 9	0 0	114 0
Permanent partial disability—major	1,678	40 6	31 0	31 7	0 0	132 0
Permanent total disability—major	1,928	69 2	45 0	37 2	2 0	90 0
Permanent total disability—grave	1,302	72 6	34 0	38 8	1 0	115 0
Death	4,976	44 6	28 0	33 2	1 0	109 0

[a]Shows paid claims as a percentage of total claims within each of the severity of injury categories For example, an estimated 4 654 claims involved emotional injuries Of these, 1 194 (about 25 6 percent) were closed with payment

[b]Detail does not add to total because not all paid claims were classified by the severity of injury categories

[c]A 0 0 in this column indicates that the claim was filed and resolved within the same month

Note The total number of claims is based on the number of claims for which the relevant data were provided

Claims closed with an indemnity payment of $1 million or more had the highest median and average time between filing and disposition (76 0 and 64.9 months). Table 2.18 shows that those claims for which no payment was made had a median disposition time of 17.0 months, and the claims that received the smallest indemnity payments ($1 to $999) had the lowest median and average disposition times of 6.0 and 11 9 months

Table 2.18: Number of Claims and Disposition Time by Indemnity Payment Ranges

Disposition time in months

	Claims[a]		Disposition time			
					Range	
Payment ranges	**Number**	**Percent**	**Median**	**Average**	**Lowest**	**Highest**
All claims	73 204	100 0	19 0	25 1	0 0[b]	132 0
$0	41 562	56 8	17 0	22 9	0 0	92 0
$1 to $999	2 812	3 8	6 0	11 9	0 0	62 0
$1 000 to $4 999	5 276	7 2	16 0	22 4	1 0	97 0
$5,000 to $9,999	4 103	5 6	22 0	28 7	0 0	108 0
$10,000 to $24,999	4 565	6 2	19 0	22 7	0 0	92 0
$25,000 to $49 999	5 078	6 9	28 0	32 0	1 0	114 0
$50 000 to $99 999	3 968	5 4	29 0	31 6	1 0	110 0
$100,000 to $249,999	2 998	4 1	29 0	33 0	0 0	132 0
$250,000 to $999,999	2 585	3 5	46 0	41 8	0 0	115 0
$1 million or more	258	0 4	76 0	64 9[c]	6 0	84 0

[a]Detail does not add to total due to rounding

[b]A 0 0 in this column indicates that the claim was filed and resolved within the same month

[c]Estimate subject to a large sampling error and should be used with caution

Note The total number of claims is based on the number of claims for which the relevant data were provided

Table 2.19: Number of Paid Claims and Indemnity Payments by Disposition Time

	Paid claims		Indemnity payments			
					Range	
Time (months)	**Number**	**Percent of total[a]**	**Median**	**Average**	**Lowest**	**Highest**
All claims	31 642	43 2	$18 000	$81 105	$1	$2 472 020
0 (less than 1)	158	62 7	515	16 814[b]	100	266 800
1 to 12	8 899	35 2	7 500	31 411	1	1 000 000
13 to 24	8 062	44 6	15 000	69 793	18	2 472 020
25 to 36	5 300	43 4	25 000	73 125	90	1 625 000
37 to 48	3,988	61 4	60 000	134 354	25	1 800 000
49 to 72	3 731	44 8	30 000	109 212	200	2 000 000
73 to 132	1,504	58 0	45 000	259 656[b]	1,000	2 059 388

[a]Shows paid claims as a percentage of total claims within each of the time periods For example an estimated 6 490 claims took 37 to 48 months between filing and disposition Of these 3 988 (about 61 4 percent) were closed with payment

[b]Estimate subject to a large sampling error and should be used with caution

Note The total number of claims is based on the number of claims for which the relevant data were provided

As shown in table 2 19, the median indemnity payments were the highest ($60,000) for claims that took 37 to 48 months between filing and disposition Those paid claims that were filed and resolved in the same month had a median payment of $515

How Frequently Did the Health Care Providers' Insurers Initiate Contact With the Patients?

Files for 5,323 claims (about 7 percent) were initially opened because the practitioner or the hospital notified the insurance companies of a malpractice incident In other cases, insurance companies opened the files because (1) the patient's attorney notified the insured of a claim—about 30 percent, (2) suit papers were served on the insured—about 38 percent, or (3) the patient, or the patient's relative, guardian, or friend complained to the insured—about 18 percent.

In the cases where the claims were opened when the practitioner or the hospital notified the insurance company of a malpractice incident, the company initiated contact with the patient or the patient's representative about 13 percent of the time (707 cases) For these cases, payment was almost always made to the patient—about 99 percent The median indemnity payment was $5,500; the average was $155,019; and the range was $100 to $1 8 million

At What Stage in the Claims Settlement Process Was the Claim Resolved?

Settlement stage data were collected for each health care provider associated with the claim. Since a number of claims involved two or more providers and, thus, two or more potential stages of settlement, we can only relate these data to individual claims where only one provider was involved and the settlement stage was provided. For those 56,355 claims—about 77 percent of the total, about 51 percent settled after the suit was initiated but before the trial. Of these, about 53 percent resulted in payment to the patient.

As shown in table 2 20, the second most frequent settlement stage was after the claim was filed but before the suit was initiated—about 38 percent. Of these, about 36 percent resulted in payment to the patient See table V 14 for details on the claims' payment status by settlement stage

Table 2.20: Number of Claims Involving One Provider by Stage of Settlement

	Claims		
Settlement stage	**Number**	**Percent**	**Cumulative percent**
Claim filed before suit	21,106	37.5	37.5
Suit, before trial	28,541	50.6	88.1
During trial, before verdict	838	1.5	89.6
After verdict by jury	1,642	2.9	92.5
After verdict without jury	114	0.2	92.7
After appeal	1,010	1.8	94.5
Suit, before arbitration	1,713	3.0	97.5
After arbitration	113	0.2	97.7
Other	1,278	2.3	100.0
Total	**56,355**	**100.0**	

Note: The total number of claims is based on the number of claims for which the relevant data were provided