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_pt13**

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

United States General Accounting Office

GAO

Report to Congressional Requesters

May 1987

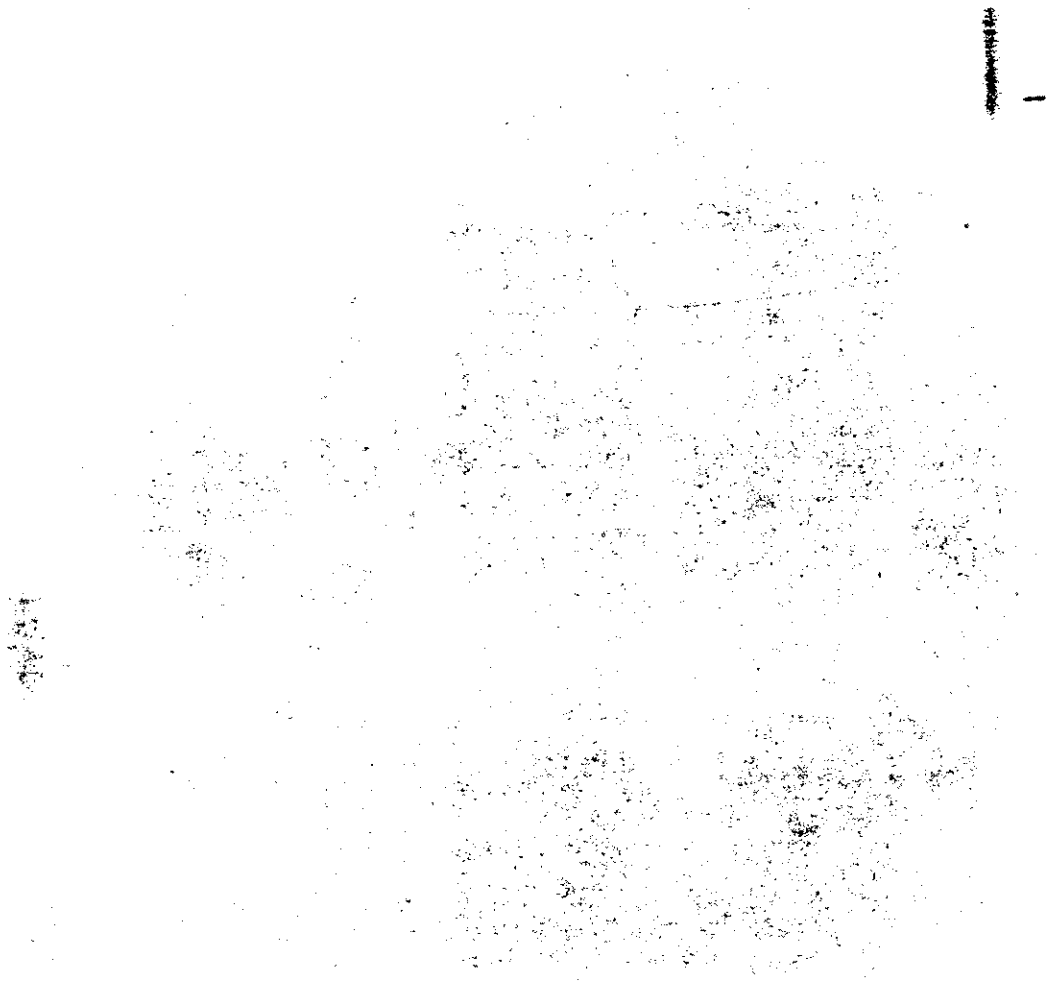
MEDICAL MALPRACTICE

A Framework for Action

RESTRICTED——Not to be released outside the General Accounting Office except on the basis of specific approval by the Office of Congressional Relations.

536957

GAO/HRD-87-73



GAO

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

Comptroller General
of the United States

B-221239

May 20, 1987

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

The Honorable John Edward Porter
House of Representatives

Over the past 2 years, at your request, we have issued a series of reports presenting information relating to increases in the cost of medical malpractice insurance. Those reports have provided us a basis for presenting in this, the final report on the subject, our conclusions, recommendations, and suggestions.

More than anything else, our work has convinced us that actions need to be taken by all groups affected—physicians, lawyers, hospitals, insurers, and patients—if we are to see progress in addressing the problems. Debate on the medical malpractice problem has often become very emotional. Who cannot have compassion for a person who has suffered a serious permanent injury as a result of a particular medical procedure? But given the advances in medical technology, the difficulty of procedures that would not even have been attempted 10 or 15 years ago, what degree of perfection should we expect from our medical community? These types of issues are not resolved merely by increasing our knowledge of what the data show about a particular problem. They strike at the heart of the ethics and values that are a part of our society. Our conclusions, recommendations, and suggestions are designed to further the debate on how states and the federal government may want to look at the issue. We believe carefully contemplated actions can have a positive effect.

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 the Secretary of Health and Human Services, the Attorney General, appropriate committees and members of Congress, and leaders of state legislatures, as well as other interested groups and individuals.

Charles A. Bowsher

Charles A. Bowsher
Comptroller General
of the United States

Executive Summary

Purpose

Increases in the costs of medical malpractice insurance over several years resulted in Senator John Heinz and Representative John Edward Porter's requesting that GAO assess the nature of the problems, how various states have tried to deal with them, and what federal and state actions may be warranted.

The purpose of this report, the final one in a series of five, is to suggest actions that appear to GAO to be appropriate beginnings to address medical malpractice problems.

Background

Malpractice insurance costs for physicians and hospitals rose from $2.5 to $4.7 billion from 1983 to 1985. As a percentage of average gross business expenses, insurance costs for physicians rose from 8 to 10 percent during this period. For physicians in certain specialties, costs increased more. About 43 percent of the medical malpractice claims closed by insurance companies in 1984 were closed with an indemnity payment. Eighty percent of the injuries occurred in hospitals, and about 71 percent of the providers involved were physicians. The average payment for injury was about $81,000. The median payment was $18,000.

Medical malpractice affects us all in one way or another—either through injury or increased costs to health care providers, insurers, or consumers. Even though the injured party is compensated for such injuries, the real hurt or damage cannot be fully measured. The damage to an accused health care provider can also not be fully measured even when the provider is found not to be at fault.

A key policy question to be addressed is who or what is responsible for medical malpractice problems. Is it physicians who are negligent? Is it insurance companies trying to get higher profits? Is it lawyers bringing suits to increase their income? Is it patients who have unreasonable expectations of medical procedures and health care providers? Is it the system for resolving claims?

Results in Brief

Overall, GAO's work showed that there is no clear answer as to the causes of the increases in the cost of medical malpractice insurance. And there is no specific action that GAO could identify that would guarantee that insurance rates will not continue to increase. But there are actions all affected parties could take that may have some promise of reducing the cost of insurance.

These actions include reducing the incidence of medical malpractice by assuring that physicians are held accountable by their peers and others for the manner in which they practice medicine; improving efficiency, predictability, and equity in the way medical malpractice claims are resolved (by determining appropriate changes in state tort laws or developing viable alternatives to the tort system); determining the extent to which regulatory agencies have and use information to make decisions about rates and solvency; and better educating patients as to what their expectations should be from the health care system.

Those taking such actions, particularly concerning the tort system, must consider the consequences of these actions on the injured. Policymakers must give serious consideration to the inherent trade-offs any solution will have since most potential solutions to the problems are at the expense of one or more of the affected parties.

GAO Analysis

Reducing Medical Malpractice Incidence

Eliminating, to the extent possible, the conditions that lead to malpractice is the ideal way to deal with the problem of increasing insurance costs. Doing this requires aggressive action at the state level and by the providers of health care, primarily physicians and hospitals.

For example, state legislatures, where they have not yet done so, could require health care providers to participate, as a condition of licensure, in risk management programs, which are designed to educate providers about better ways of delivering an acceptable quality of health care to help minimize the possibility of malpractice suits. (See pp. 16-18.) Physicians and other health care practitioners could also be more aggressive in assuring that the members of their profession are adequately trained, supervised, and, where appropriate, disciplined. Past reports have shown that relatively few physicians and other practitioners are disciplined by appropriate professional or state agencies. (See pp. 13-15.)

In 1984 GAO reported that a health care practitioner licensed in more than one state could have one of those licenses revoked or suspended by a state licensing board, but could relocate to another state and continue to treat patients. H.R. 1444 and S.661, currently being considered by the Congress, would nationally exclude these practitioners from participation in Medicare and Medicaid. (See pp. 15-16.)

Some Tort Reforms May Improve Claims Resolution

In response to the lack of availability of medical malpractice insurance in the mid-1970's, all but one state enacted some form of change in its tort laws. Most of these changes were intended to lower the cost of malpractice insurance by reducing the number of claims filed, the size of awards, and the time and cost associated with resolving claims. However, in many states reforms were overturned on constitutional grounds, repealed, or allowed to expire.

Since the mid-1970's the frequency of claims and the size of awards and settlements, for the most part, have continued to increase. Few empirical studies have evaluated the effect of specific reforms, but the following reforms appear to have been given the broadest support by those advocating tort reform as one way of eventually reducing the cost of insurance:

- Shortening the statute of limitations for filing claims could reduce claims frequency (see pp. 21-22).
- Revising joint and several liability rules, to require a defendant to pay damages commensurate with his or her share of the fault that contributed to the injury, could be more equitable to defendants (see p. 22).
- Reducing malpractice awards by collateral source payments, such as health insurance, could preclude plaintiffs from being compensated more than once for the same loss (see pp. 25-26).
- Limiting attorney contingency fees to provide a greater proportion of awards or settlements to the injured parties could reduce legal costs associated with malpractice cases and encourage plaintiff attorneys to settle larger cases sooner (see pp. 22-25).
- Requiring periodic payment of awards over the life of the injured party or period of disability rather than lump sum payments could better assure that funds are available when medical costs are incurred and wages are lost (see p. 26).
- Placing reasonable caps on awards for noneconomic damages, such as pain and suffering, could limit and bring more predictability to these damages, which are highly subjective, controversial, and not susceptible to easy quantification (see pp. 26-28).

Fundamental to deciding whether tort reform is needed is a judgment as to whether the present system results in inordinate or just compensation for the injured and inordinate or just penalties for providers.

State Reporting Requirements

The goals of state insurance commissioners are to assure that insurance companies operating in their states are solvent and that the rates applied are adequate, not excessive, and not unfairly discriminatory. To discharge their responsibilities, state insurance departments need complete and accurate data and effective data analysis procedures. Policy questions that need to be addressed are whether the data that state insurance departments require insurers to provide are sufficient, needed, and used effectively. GAO believes that states that have not resolved these issues should do so (see p. 33).

Additional Actions

Alternative ways of resolving malpractice claims, such as mediation, screening panels, arbitration, and no-fault compensation programs, have not been fully tested and evaluated to identify their advantages over the present system (see pp. 30-31). Cooperation among the affected groups—health care providers, patients, lawyers, and insurers—in testing various alternatives appears to GAO to be worthwhile. Similarly, the various groups and the Department of Health and Human Services (HHS) should embark on a program to better educate the public in what to realistically expect from the health care system (see pp. 18-19).

Recommendations

No one knows how specific actions will directly affect insurance rates. Yet, to take no action seems unreasonable. Logic and actions already taken by several states seem to GAO to provide a good basis for a more systematic attack on the problem. GAO's recommendations are thus based on the assumption that carefully contemplated actions should have a salutary effect. Follow-up assessments of the effect these actions have on insurance rates could then provide a clearer picture of whether they make a difference.

GAO is making recommendations to the following: the Congress, to enact H.R. 1444 and S.661 (see p. 33); the Secretary of HHS, to take the lead in efforts to educate the public on expectations of the health care system (see p. 34); the Secretary of HHS and the Attorney General, to work closely with states and affected parties in evaluating the merits of individual tort reforms and developing model legislation the states could enact (see p. 34); and the Secretary of HHS, to fund demonstration projects to test alternatives to the tort system (see pp. 34-35).

GAO is also suggesting actions at the state level concerning oversight of health care provision (see p. 35).

Contents

Executive Summary		2
Chapter 1 Introduction		8
	Background	8
	Objective, Scope, and Methodology	10
Chapter 2 Actions to Address Medical Malpractice Problems		12
	Reducing the Incidence of Medical Malpractice Injuries	12
	Improving Communication	18
	Reforming Tort Laws	19
	Evaluating Alternative Dispute Resolution Mechanisms	30
	Studying the Insurance Industry	31
	Recommendations and Suggestions	33
Appendix	Appendix I: GAO Reports Related to Medical Malpractice	36

Abbreviations

GAO	General Accounting Office
HHS	Department of Health and Human Services

Chapter 1

Introduction

For the third time in less than 20 years, national attention is focused on medical malpractice problems—(1) the increase in frequency of claims and size of malpractice awards and settlements and (2) the rapidly growing malpractice insurance premiums. Each time, medical malpractice has generated study, debate, and an agenda for action, yet agreement on the fundamental nature of the problem seems as elusive as its solution. Increasing medical malpractice insurance premiums in the late 1960's focused attention on the problem. A mid-1970's crisis prompted every state except one to enact tort reforms. The withdrawal of some commercial insurers from the medical malpractice insurance market led to a restructuring of this market—with many commercial insurers being replaced by provider-owned insurers and state-created insurance programs.

Although the frequency of claims and size of awards and settlements continued to rise, the problems did not regain public attention for almost a decade. During the late 1970's and early 1980's, the effects of increasing claim frequency and size of awards and settlements were softened by investment income from increasing interest rates. However, when interest rates began to decline in 1984, insurers once again sought large premium increases, suggesting to some that another medical malpractice insurance crisis was in the making.

Background

Medical malpractice is complex and controversial; it affects patients, physicians, lawyers, hospitals, and insurers. Our survey of major interest groups most directly affected by medical malpractice[1] disclosed that the health care provider group (physicians and hospitals) generally believes that the increasing cost of medical malpractice insurance is a serious problem. Two factors leading to higher costs are the increasing number of malpractice claims and sizeable awards and settlements. As we have reported,[2] malpractice rates vary by specialty and location. As of July 1, 1985, malpractice rates of $50,000 and above per year were concentrated in three specialties—obstetrics/gynecology, neurosurgery, and orthopedic surgery—and in Florida, Illinois, Michigan, New York, and the District of Columbia. To deal with this problem, the provider group generally supports changes in our present legal system to reduce the number of claims filed and the size of malpractice awards.

[1] Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb. 24, 1986).

[2] Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals, (GAO/HRD-86-112, Sept. 15, 1986).

The Association of Trial Lawyers of America believes the cause of malpractice claims is medical carelessness. The National Insurance Consumer Organization believes the profits of malpractice insurers are excessive. Both organizations support more stringent measures to discipline or remove from practice physicians who do not provide quality care; the consumer organization supports increased regulation of insurance rates. Both oppose tort law changes on the basis that such changes infringe on the patient's right to recovery for injuries.

Medical malpractice insurers perceive a major problem to be the uncertainty of the present system in estimating future losses. They point out that the increasingly high insurance rates merely reflect the premiums needed to meet current and anticipated future loss payments. W. James MacGinnitie (managing principal of Tillinghast, Nelson, and Warren, an international consulting and actuarial firm providing services to medical malpractice insurers) pointed out in May 1985 that several provider-owned insurers, as well as some joint underwriting associations, patient compensation funds, and reinsurers, are significantly underfunded, i.e., rates have not been adequate to cover the costs of claims.

The insurers generally support changes in the legal system that are designed to decrease the uncertainty in the way malpractice claims are resolved. They believe that such changes would improve their ability to accurately price malpractice insurance.

The Debate

Debate on the malpractice problem has been based more on rhetoric, speculation, and misconception than on factual, quantitative data. From the outset of our work, we have sought to gather objective, meaningful data on medical malpractice and to use that data to define and quantify the problems. We have also sought to obtain data that could be used to assess the validity of the common assertions made about the subject. We previously reported these findings:

- Major interest groups do not agree on the nature of the malpractice problem, its severity, its solution, or the proper role of the states or the federal government.[3]
- Total medical malpractice insurance costs for physicians and hospitals rose from $2.5 billion to $4.7 billion from 1983 to 1985. The 100 percent increase in physicians' malpractice insurance costs and the 57 percent increase in hospitals' costs for that period are both much greater than

[3]Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb. 24, 1986).

the change in either the consumer price index or the medical care index.[4] As a percentage of average total practice expenses, average malpractice insurance costs increased from 8 percent in 1983 to 10 percent in 1985; however, the increase was much more dramatic for some specialties. For example, for obstetrics and gynecology, the increase was from 13 percent in 1983 to 18 percent in 1985.

- Officials of the interest groups GAO surveyed in California and Indiana believed that changes to the tort laws of their states, such as limits on awards, had helped to moderate upward trends in the cost of insurance and the average amount paid per claim. Representatives of the groups surveyed in Arkansas, Florida, New York, and North Carolina, however, generally believed the tort law changes in their states had little effect.[5]
- In 1984, 102 insurers closed an estimated 73,472 claims involving 103,255 providers. About 43 percent of the claims were closed with indemnity payments ranging from $1 to $2.5 million, with a median of $18,000 and an average of $80,741. About 80 percent of the injuries occurred in hospitals. Of the health care providers involved, 71 percent were physicians. Insurers paid an average of $9,107 per claim for defense legal costs. For about 8,518 of the 16,348[6] paid claims, plaintiffs' lawyer fees represented from 31 to 40 percent of the expected value of the indemnity payments. For 6,017 of 14,995[7] paid claims, compensation for noneconomic losses represented from 41 to 70 percent of the expected value of the indemnity payments.[8]

From this work we have gained an appreciation of the complexity of the issues and an understanding of the interactions between the interest groups.

Objective, Scope, and Methodology

The objective of this report is to present our conclusions and recommended actions so that federal and state leadership can begin dealing with medical malpractice problems.

[4]The medical care index is an element of the consumer price index relating to the cost of providing medical services. See Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112, Sept. 15, 1986).

[5]Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, Dec. 31, 1986).

[6]The characteristics of the remaining 15,438 paid claims may or may not be the same as the 16,348 paid claims for which we were able to make estimates of plaintiffs' lawyer fees.

[7]The characteristics of the remaining 16,791 paid claims may or may not be the same as the 14,995 paid claims for which we were able to make estimates of compensation for noneconomic losses.

[8]Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55, April 22, 1987).

This report represents the culmination of our work in medical malpractice over the past 3 years. Our views are based on the previous reports we have issued on this subject and other related reports (see app. I), as well as an extensive review of the literature available; discussions with many knowledgeable individuals; views of organizations which, by and large, constitute the major interest groups concerned with medical malpractice issues; and our analysis of a large amount of statistical malpractice claims data. (See the individual reports for details of our scope and methodology.)

Chapter 2

Actions to Address Medical Malpractice Problems

The groups that have the best chance of developing a solution to the malpractice problems appear unwilling to work together to achieve a consensus. In the absence of a cooperative effort, it seems unlikely that a lasting solution will emerge. Because our work showed no agreement among major interest groups about the problems—their severity and solutions—or the proper role for states or the federal government, we believe federal and state leadership will be required to make any progress.

To say that there is no easy answer or quick fix to the malpractice problems is to understate the obvious. The varied nature of the problems associated with medical malpractice suggests the need for concurrent actions in several areas. We believe that specific actions should be taken to

- reduce the incidence of medical malpractice;
- better communicate potential risks of medical treatment to patients;
- improve the efficiency, predictability, and equity in the way medical malpractice claims are resolved; and
- test and evaluate different ways of resolving and paying medical malpractice claims.

We believe these actions represent a balanced approach to dealing with the problems. Any change to the current system will be viewed favorably by some interest groups and negatively by others. It is important to recognize that some changes to the tort system to reduce the number of claims and amount of settlements and awards will be at the expense of what some now see as proper for injured parties to receive. Policymakers must carefully compare the benefits to society as a whole with the costs to those who are wrongfully injured. We expect that considerable debate will take place concerning the propriety and reasonableness of these actions; we encourage that debate.

Reducing the Incidence of Medical Malpractice Injuries

The best way to deal with medical malpractice is to prevent its happening. Efforts to accomplish this may include (1) disciplining or removing from practice those physicians not providing an acceptable quality of care; (2) protecting patients from physicians who lose their licenses in one state but have them in another; and (3) developing and expanding risk management programs to educate providers concerning better ways of delivering an acceptable quality of health care, minimizing the possibility of future malpractice suits.

It may be unrealistic to expect medical malpractice to be completely eliminated since medicine is an inexact science, subject to human error, and there are risks associated with all types of medical treatment. However, the actions taken thus far by the medical profession and state licensing boards do not appear to have been adequate.

Physicians Not Providing an Acceptable Quality of Care Should Be Disciplined or Removed From Practice

Although state licensing boards have recently increased their disciplinary actions against physicians, we believe more aggressive efforts are needed to ensure that physicians not providing an acceptable quality of care are identified and disciplined or removed from practice.

A June 1986 report[1] by the Department of Health and Human Services (HHS) indicated that strikingly few disciplinary actions are imposed on the basis of medical malpractice or incompetence. Major factors contributing to this minimal response reportedly include —

"(1) the complexity, length, and cost of cases concerning alleged incompetence, even where a malpractice judgment has been rendered; (2) the substantial burden of proof that tends to call 'for clear and convincing' evidence rather than the 'preponderance of evidence' and (3) the considerable variations among physicians themselves about what constitutes acceptable practice in many facets of medicine."

HHS reported that most disciplinary actions were the result of inappropriate writing of prescriptions and drug or alcohol abuse, which tend to be easier cases for investigators to develop. Much less prominent were cases involving medical incompetence, which are among the most difficult cases to develop.

The Federation of State Medical Boards reported that its total of 2,108 disciplinary actions against physicians in 1985 marked an increase of 37 percent over the 1984 total of 1,540. Of the nation's 552,716 licensed physicians,[2] the Federation reported that state medical boards in 1985 revoked the licenses of 406, suspended the licenses of 235, placed on probation 491, and penalized 976—in ways ranging from reprimands to restrictions on practicing, such as preclusion from performing certain procedures.

[1]Department of Health and Human Services, Medical Licensure and Discipline: An Overview (P-01-86-00064, June 1986).

[2]Obtained from the American Medical Association's Department of Data Release. Represents federal and nonfederal physicians as of December 31, 1985.

Our closed claim study[3] showed that 71,930 physicians were involved in 73,472 medical malpractice claims closed in 1984. Of these physicians, at least 42 percent had previous claims filed against them. About 43 percent of the claims were closed with payment. We recognize that a paid claim does not necessarily indicate medical malpractice or the need for disciplinary actions. But the large number of paid claims in relation to the small number of disciplinary actions raises questions about the adequacy of professional peer review, that is, whether peer reviewers are identifying providers with recurring quality problems that may warrant further review.

In view of our closed claim study, which showed that about 80 percent of the malpractice claims closed in 1984 involved an injury that occurred in a hospital, we believe that hospital-based peer review activities are particularly relevant. Our 1986 report[4] on our review of three peer review organizations indicated that the organizations were identifying instances of questionable care, but they were not compiling and analyzing the data to identify patterns, focus investigations, and implement corrective action.

The Health Care Quality Improvement Act of 1986, enacted on November 14, 1986, as part of Public Law 99-660, requires reports to be made to the Secretary of HHS and to state licensing boards on (1) medical malpractice payments and (2) certain professional review actions, taken by such health care entities as state licensing boards and hospitals, that adversely affect the clinical privileges of a physician. The act further requires reports to be made to the Secretary of HHS on sanctions taken by boards of medical examiners. Hospitals are required to request such information from the Secretary in these instances: (1) a physician or licensed health care practitioner applies to be on the medical staff or for clinical privileges at the hospital and (2) once every 2 years for any physician or practitioner who is on the hospital's medical staff. The Secretary is also required to provide such information, if requested, to state licensing boards, hospitals, and to other health care entities (such as health maintenance organizations) for physicians or practitioners who have applied for clinical privileges or appointment to the medical staff.

The legislation also seeks to promote effective medical professional review activities by providing participants on peer review panels, who

[3]Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55, Apr. 22, 1987).

[4]Medicare: Reviews of Quality of Care at Participating Hospitals, (GAO/HRD-86-139, Sept. 15, 1986).

are in compliance with the act, with immunity from tort liability for such activities. Collection of the information (called for by the act) and actions by the affected parties, such as hospitals and licensing boards, should help reduce the incidence of medical malpractice.

Patients Should Be Protected From Physicians Who Lose Their Licenses

We reported in 1984[5] that a health care practitioner licensed in more than one state could have his or her license suspended or revoked by one state licensing board but relocate to another state and continue to treat patients. In these instances, patients would be treated by a practitioner who had been determined to be unfit to provide care. In addition, we found that because of limitations included in HHS's Medicare and Medicaid exclusion authority (when applied to practitioners, sanctions are for other than criminal convictions or civil monetary penalties),

- practitioners who lose the right to participate in Medicaid in one state can continue to practice under Medicare in that state or relocate to another where they hold licenses and practice under both programs,
- practitioners who lose the right to participate in Medicare can continue to participate in Medicaid in any state where they hold licenses,
- practitioners who lose their licenses in one state can relocate to another state where they hold licenses and practice under Medicare and Medicaid, and
- practitioners who are convicted of crimes not directly related to Medicare and Medicaid can continue to practice under both programs.

In the 1984 report, we recommended that the Secretary of HHS revise HHS's practitioner exclusion legislation proposal so that it includes provisions authorizing HHS to establish sanctions nationally for Medicare and Medicaid practitioners who are

- excluded by any state Medicaid program,
- excluded by Medicare,
- convicted of crimes involving any federal or nonfederal health program, or
- the subjects of sanctions by any state licensing board.

The Medicare and Medicaid Patient and Program Protection Act of 1985, H.R. 1868, which included the above recommended actions, was passed

[5]Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients From Health Practitioners Who Lose Their Licenses (GAO/HRD-84-53, May 1, 1984).

by the House of Representatives on June 4, 1985. This bill has been reintroduced in the 100th Congress as H.R. 1444 and S. 661. We support the provisions of these bills.

Risk Management Programs Should Be Expanded and Strengthened

Risk management programs have the potential to reduce medical malpractice claims. These programs generally include early warning systems of adverse patient outcomes, which enable the provider organization to promptly investigate the situation and take appropriate actions to prevent a recurrence and avert a potentially litigious situation.

Malpractice claims are not confined to a small portion of the physician population. According to data from the 1986 American Medical Association's Socioeconomic Monitoring System surveys,[6] about 37 out of every 100 physicians had at least one claim filed against them during their careers. Among specialties, the survey showed that 64 percent of obstetricians/gynecologists, 50 percent of surgeons, 39 percent of radiologists, and 36 percent of anesthesiologists had at least one claim filed against them. Mr. Donald G. Steffes, President and Dr. Joseph A. Ricci, Medical Director and Vice President for Risk Management, PHICO Insurance Company (the provider-owned insurance company sponsored by the Hospital Association of Pennsylvania), stated in November 1986 that

> "While it is recognized that there may be a cohort of physicians whose practice is continually substandard, it should also be recognized that all physicians may very well be a target for a malpractice action . . . If all physicians are at risk, then we should emphasize those areas that can best diminish those risks and reduce the exposures. This can best be accomplished by a strong, conscientious and diligent effort at risk management."

As previously discussed, about 80 percent of the malpractice claims closed in 1984 involved an injury that occurred in a hospital. Moreover, most practicing physicians have clinical privileges at a hospital. Thus, we believe that the hospital should be the focal point for strengthening and expanding risk management programs to reach more physicians.

[6]Martin L. Gonzalez, "Trends in Physicians' Professional Liability Claims and Insurance Premiums," in Socioeconomic Characteristics of Medical Practice 1986 (American Medical Association, 1986), pp. 13-14.

In its May 1986 report,[7] the American Hospital Association stated that it vigorously endorses risk management and loss prevention programs in all hospitals and recommended the adoption of generic screening programs. The report stated that the design of these programs varies from one facility to another, but key features common to all are (1) criteria that establish specific, identifiable in-hospital occurrences that are considered potentially adverse and must be reported to risk management personnel; (2) incident-reporting processes for specific adverse events based on direct observation or patient chart review (or both) at varying intervals and using varying criteria, depending on the particular program; and (3) data collection on either a concurrent or retrospective basis (or both), which will generate data while the patient is in the hospital or subsequent to discharge (or both).

The St. Paul Fire and Marine Insurance Company has developed an extensive risk management program, which is a systematic management-oriented approach to the safety of patients, employees, and the general public. Basic elements of the program include (1) incident reporting (to help pinpoint where in a medical facility malpractice is most likely to occur so that preventive or corrective action can be taken), (2) occurrence screening (to uncover possible problems in patient care), (3) a computerized information system (to provide data on current loss control information and the newest and most effective methods of risk control and management), and (4) specialized claim studies (to help determine the precise nature and causes of key types of malpractice claims).

Six states (Alaska, Florida, Kansas, New York, Massachusetts, and Washington) require their hospitals to have risk management programs. In addition, as a condition of licensure, Massachusetts has recently required its physicians to participate in risk management programs; Florida, as part of its continuing education program, requires its physicians to complete at least 5 hours of risk management training every 2 years.

We believe that state legislatures, where they have not yet done so, should require health care providers to participate in risk management programs as a condition of licensure. These programs should be designed to educate providers on better ways of delivering health care

[7]Medical Malpractice Task Force Report on Tort Reform and Compendium of Professional Liability Early Warning Systems for Health Care Providers (American Hospital Association, May 1986).

of an acceptable quality to minimize the possibility of future malpractice injuries.

Improving Communication

The growth of medical technology, with its increased sophistication, has increased patients' expectations that medical care will provide the desired results. Patients may not understand all the potential risks associated with medical technology and the practice of medicine. For example, according to American Medical Association officials, when Americans visit a physician or enter a hospital, often they forget the following: in many circumstances medicine is still a young and uncertain science, with varying outcomes, and American medicine is not always as advanced as its image. In 1985, Dr. James H. Sammons, Executive Vice President, American Medical Association, said, "There's a mindset in this country now that every single thing should turn out 100 percent right every single time."[8] Dr. James Todd, Deputy Executive Vice President, American Medical Association, told us, in March 1987, that he concurs with Dr. Sammons's statement. During hearings before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, held in March and July 1986, several reports submitted for the record cited deteriorating patient-physician relationships, unjustified patient expectations, and a willingness to look to the courts for redress of perceived wrongs. A report submitted for the record by the Massachusetts Medical Society stated:

> "Technological advances in medicine have forced a degree of specialization not seen in the past. As the practice of medicine becomes more fragmented, physicians lose opportunities to communicate effectively with patients. This general trend toward depersonalization of many physician-patient relationships is reinforced by the efforts of health insurers to contain costs. Health insurance systems provide disincentives for spending time with patients. Our faith in technology has been blindly applied to medical technology leading to unfounded expectations."

Further, an orthopedic surgeon testified that, over the last 15 to 20 years, orthopedic surgery has advanced from relatively simple procedures (such as setting broken bones) to complex procedures (such as replacing joints and doing involved surgeries with what is a very young and evolving technology) to help people who are suffering with long-term and disabling arthritis. Consequently, he said, there is going to be a higher complication rate and many uncertain outcomes; in fact, 5 percent of the procedures will have disastrous results. He also pointed out

[8]Joel Brinkley, "Physicians Have an Image Problem—It's Too Good," The New York Times (Feb. 10, 1985).

that it is very difficult for physicians to say this at the outset of cases. Physicians try to ignore the problem or try to pass over it. In addition, patients tend not to hear that kind of information, even when you look them right in the eye and say, "You have a 5 percent chance of doing terribly." They do not hear this because they do not want to and then, when they do not do well, they call their lawyers. He concluded that there is a real problem with unrealistic expectations and issues of informed consent.

In addition, the May 1986 report by the American Hospital Association's Medical Malpractice Task Force on Tort Reform stated,

> ". . . Consumers also have contributed to the liability problem primarily by their distorted notions about compensation for injury. Whether through conditioning or lack of understanding, consumers have developed a collective mentality which presumes entitlement to excessive monetary relief for mishaps and other untoward results, irrespective of actual damages or actual fault."

Deteriorating patient-physician relationships are also a result of the increasing specialization in medicine. Today, several physicians may be involved in delivering medical care to the patient. This increases the (1) likelihood that breakdowns in communication may occur between the patient and physician, increasing the degree of disappointment and dissatisfaction when the outcomes of medical care fall short of what was expected, and (2) need for improved patient-physician communication and better education of patients about the potential risks and outcomes associated with various medical treatments.

Reforming Tort Laws

Each state's tort laws generally govern the way in which medical malpractice claims or lawsuits are resolved. In response to the medical malpractice crisis in the mid-1970's, all but one state enacted some change in their laws. Most of these changes were intended to reduce the cost of medical malpractice insurance by reducing the number of claims filed, the size of awards and settlements, and the time and costs associated with resolving claims. However, in many states some tort reforms were overturned on constitutional grounds, repealed, or allowed to expire. In addition, in some states, the tort reforms merely codified existing practices.

Meanwhile, since the mid-1970's, the frequency of claims and the size of awards and settlements—two factors that drive the cost of insurance—

have continued to increase. Additionally, the following continue to prevail:

- Claims take a long time to be resolved. For malpractice claims closed in 1984, the length of time from injury occurrence to the filing of a claim averaged 16 months, with a range of up to 18 years. From the date a claim is filed until final resolution, we found an average time of 25 months elapsed, with a range of up to 11 years.
- Defendants minimally at fault may be forced to pay most or all of a claimant's damages. Although this may be beneficial to the injured party, the provider (physician or hospital) with the most assets may have to pay all or a large portion of the claimant's damages, under joint and several liability, even though the provider may be responsible for only a small degree of the injury.
- High legal costs are associated with defending malpractice claims. For medical malpractice claims closed in 1984, we found that, for defense counsel, insurers paid an average of $9,107 per claim or $668 million in total. Defense counsel costs were about 83 percent of the total costs to investigate and defend malpractice claims.
- A large proportion of a settlement or award may go to the lawyer rather than to the injured party. Our closed claim study found that for 44 percent of the claims closed in 1984 with payment, 30 percent or less of the expected value of the indemnity payments would go to pay plaintiffs' lawyers' fees; in about 52 percent of the cases, lawyers' fees consumed from 31 to 40 percent of the expected value of the indemnity payments; and in about 4 percent of the cases, lawyers' fees exceeded 40 percent of the expected value of the indemnity payments. In addition, the plaintiff is responsible for other expenses, such as court costs and the cost of obtaining evidence.
- The injured party may recover more than once for some damages. Because injured parties may have insurance coverage from health insurance and disability benefits, they may recover their costs from these sources while also collecting for these costs as part of a malpractice lawsuit.
- Noneconomic damages are impossible to accurately ascertain, can be manipulated by emotion, and are inevitably subject to speculation.
- Money from lump-sum awards or settlements may not be available when needed to cover lost earnings or future medical costs incurred by injured patients.

Fundamental to deciding whether tort reform is needed is a judgement as to whether the present system results in inordinate or just compensation for the injured and inordinate or just penalties for the health care

providers. There are few empirical studies that have evaluated the effect of specific reforms on the above. Because many states have changed their tort laws, however, they apparently believe that tort reforms hold some promise of bringing more efficiency, predictability, and equity to the way in which medical malpractice claims are resolved. These tort reforms are described below:

Statute of Limitations

The length of time it takes to resolve malpractice claims can cause hardship to the injured patients, who must bear the expenses for the damages, and can be stressful to the health care providers involved. The "long tail" for malpractice insurance, which affects both reserve and actuarial calculations, is caused by the combination of (1) the length of time allowed to file a claim under the statute of limitations; and (2) the time period from the beginning of the claim to its disposition. The length of time allowed is further complicated in special situations involving children, who cannot file lawsuits on their own behalf; foreign objects (such as sponges or clamps) left in the body; and late discovery of injuries (such as those resulting from misdiagnosis or inappropriate treatment).

A 1986 study,[9] using nationwide claims experience over the decade 1975 through 1984 to estimate how tort reforms and other factors have affected trends in claims frequency and severity, reported that states that have enacted shorter statutes of limitations for adults had less growth in claim frequency than states with statutes more lenient for filing claims. The study found that reducing the statute of limitations for adults by 1 year reduced total claim frequency by 8 percent and the paid claim frequency by 6 to 7 percent. As the study points out, the number of claims filed declines with the years elapsed from the date of injury; therefore, the 1-year reduction on a statute of limitations of more than 5 years probably has less effect than on a statute of limitations of less than 5 years.

The primary purpose of a short statute of limitations is to require that a claim be filed when the pertinent evidence and witnesses are available and to insure that the threat of a claim does not continue for a long time.

[9]Patricia M. Danzon, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," Medical Malpractice: Can the Private Sector Find Relief? Law and Contemporary Problems (Durham, North Carolina: Duke University School of Law, spring 1986) vol. 49, no. 2, pp. 57-84.

We believe the time period in which a patient has the right to file a claim against a health care provider should be reasonable. For minors, statutes of limitations in some states begin to run when a minor reaches the age of majority. This allows suits to be filed 18 years or more after the alleged malpractice incident. We believe statutes of limitations for minors should allow a reasonable period to discover injuries and to file a claim, but should not extend the potential liability of providers for many years into the future. We recognize that this may place a burden on parents who must file claims on behalf of their children.

Joint and Several Liability

Under the rule of joint and several liability, in most states plaintiffs may require any one of two or more codefendants to pay the full amount of the award. Although the paying defendant frequently has a right to recover from codefendants, if the codefendants are insolvent or immune from suit, this right may be meaningless. As a result, under joint and several liability, any defendant, even if only slightly negligent, may be required to pay the full amount of the award.

According to the American Hospital Association's May 1986 Medical Malpractice Task Force Report on Tort Reform,

> "A few states have abolished the joint and several rule by statute; judicial decisions in other states have substituted a rule of 'several liability.' Under the rule of several liability, a plaintiff would receive payment of damages from the several defendants in proportion to each defendant's fault. Abolition of the joint and several liability rule places the plaintiff at risk that any given defendant may not be able to satisfy the portion of the judgement equal to his or her share of the negligence."

We recognize that abolition of joint and several liability increases the risk that the plaintiff may not fully recover damages if any of the codefendants are insolvent. However, abolition of this rule could help reduce codefendants' fear that each defendant could be responsible for the entire damages even though only minimally responsible for the injury; abolition of joint and several liability would, therefore, be more equitable to defendants.

Lawyer Contingency Fees

Health care providers contend that contingency fees encourage and prolong litigation. They also contend that limits on contingency fees would reduce the size of awards and settlements and lower insurance premiums. On the other hand, lawyers support the use of contingency fees as (1) necessary to provide access to the legal system for patients who

may be unable otherwise to pursue a claim and (2) a deterrent to frivolous suits.

A 1983 study,[10] which used data from medical malpractice claims closed in 1974 and 1976 to examine the effect of some tort reforms on the disposition of malpractice claims, stated as tentative conclusions that limits on lawyers' contingency fees (1) reduced the size of out-of-court settlements by 9 percent, (2) reduced by 1.5 percent the percentage of cases litigated until verdict was reached, and (3) increased by 5 percent the percentage of cases dropped.

A 1986 study,[11] using nationwide claims experience over the full decade 1975 through 1984, stated that limiting contingency fees appeared to have no systematic effect on the number of malpractice claims filed or the size of awards.

Concerning the relationship between the contingency fee system and frivolous suits, a 1978 study[12] stated:

"The lawyer who is paid a contingency fee . . . is not likely to invest time and several thousand dollars in out-of-pocket expenses on a case with little prospect of success. Under the system of contingency fees, lawyers thus have the incentive to filter out capricious suits, which otherwise would overload the courts, harass physicians and produce no social benefits."

Although contingency fees may provide access to the legal system for some injured parties who do not have the resources to pursue a claim, an injured party with a small claim may still have difficulty obtaining representation. According to Jeffrey O'Connell, Professor of Law, University of Virginia Law School, most lawyers will not accept a medical malpractice case with an anticipated recoverable amount less than $50,000.

Under the contingency fee system, lawyers receive no fees unless and until they obtain an award for their clients; their fee is based on a percentage of that award (usually about one-third). In addition, the client is responsible for paying the expenses incurred in pursing the claim, such

[10]Patricia Munch Danzon and Lee A. Lillard, "Settlement Out of Court: The Disposition of Medical Malpractice Claims," Journal of Legal Studies, vol. 12 (June 1983), pp. 345-77.

[11]Danzon, "Medical Malpractice Claims: New Evidence," Medical Malpractice, p. 78.

[12]William B. Schwartz and Neil K. Komesar, Doctors, Damages and Deterrence, R-2340-NIH/RC (Santa Monica, Calif.: Rand, 1978), p. 17.

as the costs of expert witnesses and investigation fees. Together, the lawyers' fees and these legal expenses may consume a large portion of the award or settlement. The effect of the legal expenses on the portion going to the injured party is very significant when the amount of the award or settlement is insufficient to cover economic damages, such as medical expenses and lost wages. Our study of claims closed in 1984 showed that, of 18,279 paid claims[13] for which estimates of economic damages could be made, the economic damages alone for 5,486 claims exceeded the indemnity payments by more than 10 percent.

States have taken three approaches to limiting lawyers' contingency fees:

- a sliding scale that limits the fee as the claimant's award or settlement increases;
- a specified percentage of the amount recovered; and
- a limit on attorney fees to a "reasonable" amount, as determined by the court.

We believe that the contingency fee system serves a useful purpose in many cases, enabling injured parties without resources to obtain access to the legal system and providing incentives to lawyers to get the best possible award or settlement. We also believe, however, that limiting lawyers' contingency fees could provide a greater proportion of awards or settlements to the injured patients, reduce legal costs associated with pursuing malpractice cases, and encourage plaintiff lawyers to settle large cases sooner. We favor the use of a sliding scale, which would decrease the percentage of the award or settlement going to the lawyer as the amount of money increases. For example, in California, the sliding contingency fee schedule is 40 percent for the first $50,000 recovered, 33 1/3 percent for the next $50,000; 25 percent for the second $100,000; and 10 percent for any amount over $200,000. The Attorney General's Tort Policy Working Group[14] recommended the following schedule: 25 percent for the first $100,000; 20 percent for the second $100,000; 15 percent for the third $100,000; and 10 percent for the remainder.

[13]The characteristics of the remaining 13,507 claims paid in 1984 may or may not be the same as the 18,279 paid claims for which we were able to make estimates of economic damages.

[14]Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability, 491-510:40094 (Washington, D.C.: U.S. Government Printing Office, Feb. 1986).

Thus, for an award or settlement of $50,000, the plaintiff's lawyer, under the California schedule, would receive $20,000; under the Attorney General's recommended schedule, $12,500; and assuming a flat contingency fee of one-third, $16,667. For an award or settlement of $1,000,000, under the California schedule, the plaintiff's lawyer would receive $141,667; under the Attorney General's recommended schedule, $130,000; and assuming a flat contingency fee of one-third, $333,333.

Collateral Source Payments

The collateral source rule prohibits introducing into evidence any information about compensation a plaintiff may receive from sources other than the defendant. In some cases, as mentioned earlier, plaintiffs may receive compensation more than once for the same loss.

The trial lawyers[15] oppose elimination of the collateral source rule because they believe that to do so would

"shift the costs of carelessness away from the careless and to the innocent victim, who paid for his health insurance, the innocent employer of the victim, who paid for the victim's group insurance, or the innocent taxpayer, who paid for the government benefits."

According to a 1976 report,[16] the main purpose of the collateral source rule was to help the tort system deter harmful conduct by preventing the negligent defendants' benefitting from the prudence of the plaintiffs who had insured themselves. However, the report further stated that defendants in malpractice actions do not pay directly for plaintiffs' damages because health care providers invariably carry liability insurance; in addition, plaintiffs' insurance—such as Medicare, Medicaid, disability payments, workers' compensation, Blue Cross/Blue Shield, and other health plans—is generally publicly financed or part of an employment or union benefit program. As a result, insurance costs for both plaintiffs and defendants may be passed on to the general public.

A 1986 study[17] found that states that permit or mandate the offset of collateral benefits have apparently reduced average paid claims by 11 to 18 percent and the frequency of claims by 14 percent compared with states without collateral source offset. Since collateral source offset

[15]Thomas G. Goddard, The American Medical Association is Wrong—There is No Medical Malpractice Insurance Crisis (Association of Trial Lawyers of America, Mar. 5, 1985), p. 11.

[16]Report of the Special Advisory Panel on Medical Malpractice (State of New York, Jan. 1976), p. 39.

[17]Danzon, "Medical Malpractice Claims: New Evidence, "Medical Malpractice, p. 78.

reduces the potential recovery for a large number of claims, the incentives to file a claim are reduced.

Periodic Payment of Awards

A requirement for periodic payment of awards over the life of the injured party or period of disability assures that funds will be available when needed for the purpose intended. This type of settlement is designed to (1) meet the plaintiffs' needs and (2), at the same time, avoid recoveries by the plaintiffs' heirs of amounts intended only to compensate for economic losses, such as medical expenses or lost wages. It may also cost insurers less to fund awards that are paid over an extended period rather than in a lump sum.

Traditionally, judgments for damages, and settlements in malpractice cases have been distributed in one lump-sum payment. For example, our closed claims study showed that lump-sum payments accounted for about 62 percent of the insurance companies' total indemnity payments. Lump-sum payments have often been required of the defendant even when much of the award is intended to compensate the plaintiff for anticipated future medical care expenses or lost earnings. In this context, the lump-sum payment mechanism may be ill-suited to medical malpractice cases.

Several factors seem to favor the use of periodic payments to meet future needs and expenses rather than a lump-sum payment. These include (1) better matching of damage payments to future medical costs and lost earnings incurred by the injured party and (2) reduction of malpractice costs if insurance companies can achieve savings through purchase of annuities. We believe that periodic payment for future expenses offers more long-term protection to the injured party and may reduce the costs to insurers. Any such savings could help hold down the rates of increase in insurance premiums.

Caps on Indemnity Payments

The general purpose of caps on indemnity payments is to limit and bring more predictability to medical malpractice awards and settlements. The most unpredictable part of a medical malpractice damage award is the amount paid for noneconomic losses, such as pain and suffering, disfigurement, physical impairment, and inconvenience. Economic damages, such as medical expenses and wage losses, can be more precisely measured than noneconomic damages. As mentioned earlier, noneconomic damages are highly subjective, controversial, and not susceptible to easy quantification.

Concerning the impact of caps on indemnity payments, a 1986 study[18] disclosed that the average effect of caps on all or part of the plaintiff's recovery has been to reduce the average paid claim by 23 percent. Although the majority of cases are unaffected by such caps, large payments account for a disproportionate amount of the total dollars. For example, the study reported that 5 percent of the malpractice cases accounted for over 50 percent of the total dollars paid. The study points out that caps that severely reduce claims with very large amounts can have a significant impact on the average and the total payout.

Concerning the possible effect of limiting the portion of the payment for noneconomic losses, in a February 1986 report[19] the Attorney General's Tort Policy Working Group made a statement to this effect: Although it is estimated that only 5.6 percent of all paid medical malpractice claims (verdicts and settlements) receive noneconomic compensation in excess of $100,000, jury awards for noneconomic damages over $100,000 represent, on the average, 80 percent of the total award[20]. The report concluded that a $100,000 limitation on noneconomic damage awards would affect very few claims, but would introduce substantial predictability into the tort system.

According to the Attorney General's report,

"The open-ended nature of such [non-economic] damages makes them a particular problem from the standpoint of achieving predictability. Unlike economic damages (medical expenses, lost earnings, etc.), which can be reviewed objectively and thus can be predicted within a given range, non-economic damages are entirely subjective and unpredictable. Non-economic damages also can serve as a significant obstacle in the settlement process. Plaintiffs and defendants often can agree quickly on the amount of economic damages, but disagree sharply on non-economic damages. Plaintiffs frequently have unrealistic expectations of non-economic damages in the hundreds of thousands or millions of dollars to which defendants simply are unwilling to agree. Plaintiffs thus often reject settlement offers that from the standpoint of compensation for economic damages are quite reasonable. Plaintiffs' attorneys also often see high non-economic damage awards as necessary to justify high contingency fees, which may lead them to press for a high non-economic damage award when it may be in their clients' interest to obtain a quick and fair settlement. Nevertheless, plaintiffs should be entitled to reasonable compensation for their pain and suffering and mental anguish. The key in this regard is to provide such compensation, but to ensure that it will be kept within reasonable bounds."

[18]Danzon, "Medical Malpractice Claims: New Evidence," Medical Malpractice, p. 78.

[19]Report of the Tort Policy Working Group, pp. 66-67.

[20]A jury award is subject to review and adjustment by the trial judge or, if appealed, by the appellate judge.

Using data obtained in our study of claims closed in 1984, estimates of noneconomic loss compensation could be made for 14,995 of the 31,786 claims closed with payment.[21] These limited data show that a small number of claims accounted for a large portion of total noneconomic loss compensation paid. For example, 759 of these 14,995 paid claims (about 5 percent) received noneconomic loss compensation in excess of $100,000; however, this compensation represented 42 percent of the total expected value of the indemnity payments for these 759 claims.

We believe caps on economic losses could deny just compensation to injured parties for current or future out-of-pocket costs; however, we also believe that caps that limit but provide reasonable compensation for the noneconomic losses are worthy of consideration.

Public Attitudes

In March 1987 Louis Harris and Associates, Inc. released a survey representative of all adult Americans' attitudes toward the civil justice system and tort law reform.[22] The survey, based on interviews with a cross section of 2,130 adult Americans, was aimed at evaluating the strengths and weaknesses of the civil justice system, assessing the need for changes, and rating the acceptability of proposed changes. The survey showed that almost all Americans want some changes in the civil justice system and that people are dissatisfied with these areas: the rising cost of lawsuits; the failure by the courts to hear cases promptly; and, what is seen as a growing tendency by the courts, the giving of excessive damage awards. According to the Harris report on this survey, "Nine out of ten Americans see a need for some changes to improve the civil justice system." The report stated that "what most of the public currently demands is greater efficiency at a lower cost to both individuals and society."

Specifically, the survey showed that although Americans support the civil justice system, a large majority support many significant reforms—even when reminded that reforms may affect their own ability to recover damages. These are some of the survey findings:

- A large majority (71 percent) would find it acceptable to limit a defendant's liability to his or her own share of the damages suffered by

[21]The characteristics of the remaining 16,791 paid claims may or may not be the same as the 14,995 paid claims for which we were able to make estimates of compensation for noneconomic losses.

[22]Public Attitudes Toward the Civil Justice System and Tort Law Reform, study no. 864014 (New York, New York: Louis Harris and Associates, Inc., Mar. 1987).

the injured party, even if this meant the injured party would receive a smaller settlement than the court awards. According to the Harris survey, "This result shows strong opposition to the 'joint and several' liability doctrine."

- Sixty-seven percent of Americans favor requiring the judge to reduce the damages awarded by a jury by subtracting other compensation already received by the victim from other sources.
- Sixty-six percent of Americans favor a $250,000 cap on "pain and suffering" and other noneconomic damage awards.
- Sixty-four percent of Americans favor a sliding scale for contingency fees so that a plaintiff's lawyer would receive a smaller percentage as damage awards grow larger.

According to the Harris report, Americans believe the perceived increase in the frequency and costliness of civil suits is caused by the self-interest of litigants and the institutional arrangements that transfer liability risks from individual plaintiffs and defendants to law firms and insurers.

In support of this position, the report cited the following:

- Seventy-nine percent of Americans believed that a major reason for the rising cost of lawsuits is "people who figure they can make a lot of money from such suits."
- Seventy-two percent cited "reports in the media of multi-million dollar damages being awarded to victims" as a major reason for the rising cost of lawsuits.
- Sixty-four percent saw "the knowledge that defendants have insurance" as a major reason for the rise in the cost of lawsuits.
- Sixty-four percent saw "a system in which people can sue without financial risk" because of contingency fees as a major reason for the rise in the overall cost of lawsuits.
- Sixty percent cited "insurance companies that hold out and aren't willing to settle promptly or fairly" as a major reason for the rise in the overall cost of lawsuits.
- Sixty percent cited "the idea that anyone who suffers a personal injury should be able to get compensation" as a major reason for the rise in the overall cost of lawsuits.

Evaluating Alternative Dispute Resolution Mechanisms

Although we believe that a number of actions are needed to improve the present system for resolving medical malpractice claims, alternative approaches have been proposed that may offer advantages over our traditional way of resolving claims. However, a number of questions regarding the cost-effectiveness and merits of these alternatives remain unanswered. For example, alternatives may reduce the administrative costs, but increase the total number of claims filed; thus, the effect on total cost is uncertain.

Our present legal system has both advantages and disadvantages. The advantages include the protection of an individual's substantive and due process rights, the screening out of unreliable evidence through the use of formal rules of evidence, and an impartial process for resolving claims. In addition, the process for establishing provider fault may serve as a deterrent to medical malpractice. However, the present system has limitations, including the need for the injured party to obtain a lawyer to gain access to the system and the unpredictable nature of and lack of uniformity in loss compensation.

A number of alternative approaches for resolving medical malpractice claims have been proposed, ranging from fault-based to no fault-based approaches.[23]

Alternative dispute resolution mechanisms may offer the potential for resolving claims in a more efficient, timely, and equitable manner. For example, within the framework of our present tort system, pretrial screening panels may reduce the number of malpractice cases going to court by (1) discouraging further litigation of nonmeritorious claims and (2) encouraging early settlement of meritorious claims. If pretrial screening panels are successful in reducing the number of cases going to court, this could help avoid clogging court calendars with an increasing number of medical malpractice cases. In cases where provider liability is found, screening panels, which specify the damages suffered by the plaintiff, may bring more consistency to malpractice awards. Other alternatives—such as the use of mediation, arbitration, or contractual agreements between health care providers and patients—may also offer advantages over the present system.

[23]See our earlier report, Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb. 24, 1986) for a description of some of these approaches and their advantages and trade-offs.

There may also be advantages to moving toward some form of compensation scheme that would provide compensation to injured patients when specified events occur but would not establish negligence on the part of the health care provider. However, the lack of data on how such no-fault approaches would affect total costs and the practicality of the approaches preclude objective assessments. Because there are many unresolved questions about the success of alternative dispute mechanisms, we support increased testing and experimentation to determine their effectiveness and feasibility.

Studying the Insurance Industry

Two of the factors that drive the cost of medical malpractice insurance are the number and cost of malpractice claims, which have previously been discussed in this report. Factors that also affect malpractice insurance premiums include administrative expenses, marketing costs, investment income, taxes, profits, extent of state regulation, and amount of competition in the market. The previous reports in this series were not designed to assess the extent to which these factors affect insurance premiums.

In responding to other congressional requests, we have studied the taxation of the property and casualty insurance industry and are currently studying how the profitability of the medical malpractice line of insurance compares with other lines of insurance and other industries. We testified that the profitability of the medical malpractice line depends on the manner in which reserves for future loss payments are established, the adequacy of the reserves, and whether those reserves are discounted to reflect their present values.[24] If the reserves established to cover future loss payouts are inadequate, boosting reserves to cover those losses will decrease the profitability of the line. Conversely, the profitability of the line improves if the reserves are discounted.

Further, we testified that over the 11-year period of analysis from 1975 to 1985,[25] the medical malpractice line yielded a cumulative after-tax

[24]Profitability of the Medical Malpractice and General Liability Lines of Insurance, Testimony before the Subcommittee on Commerce, Consumer Protection, and Competitiveness, Committee on Energy and Commerce, House of Representatives, by William J. Anderson, Assistant Comptroller General, General Government Programs, U.S. General Accounting Office (Washington, D.C.: GAO/T-GGD-87-13, April 21, 1987).

[25]Applies only to insurers whose data are included in reports of the A.M. Best Company, the leading insurance-rating service in the United States, which annually publishes financial data on insurance companies. The analysis does not include data on reinsurers, joint underwriting associations, patient compensation funds, some professionally sponsored provider-owned companies, some small commercial insurers, and self-insurance trust funds.

loss of $653 million on an undiscounted basis, assuming that reserves were appropriately established. If, however, the industry's established reserve figures are discounted, the medical malpractice line yielded a cumulative after-tax profit of $2.2 billion. As a percentage of premiums earned, the medical malpractice line's cumulative rate of return increases from a negative 4.6 percent to a positive 15.3 percent when reserves are discounted. Assuming that the undiscounted reserves were inadequate by 10 or 20 percent, the line's $653 million loss would increase to $1.2 billion and $1.8 billion losses, respectively. If, however, these reserves were discounted, the line yielded profits of $1.9 billion and $1.6 billion, respectively.

As to the malpractice insurance industry, we found that as commercial insurers began to withdraw from the malpractice market in the mid-1970's, they were replaced by noncommercial insurance mechanisms which are not necessarily profit oriented, such as these: professionally sponsored provider-owned companies, state-created joint underwriting associations that are usually forced markets of property and casualty insurers doing business in the state, and state-created patient compensation funds to pay claims in excess of a specific amount. In addition to these sources of insurance, a number of hospitals have underwritten all or part of their own malpractice risks through self-insurance trust funds.

In 1985 these noncommercial insurance mechanisms provided over 50 percent of the medical malpractice insurance.[26] The principal concern of these insurers is the sufficiency of rates. This is of concern to commercial insurers as well.

State insurance departments are responsible for ensuring that the rates are adequate, not excessive, and not unfairly discriminatory. The type of regulation varies from state to state. For example, some states require that insurance rates be approved by the state's insurance department before such rates can be used. Other states require insurance companies to file their rates with the insurance department and permit the companies to use the rate before approval. In addition, in other states, insurers are not required to obtain rate approval from the insurance department, but may be required to submit supporting information for the rates if requested. In order to discharge their responsibilities, state insurance

[26]According to A.M. Best Company, professionally sponsored companies formed during the 1974-1975 malpractice crisis underwrote more than 50 percent of the medical malpractice insurance in 1985.

departments need complete and accurate data with which to evaluate the insurance rates.

We have not analyzed the manner in which state insurance departments discharge their responsibilities, nor have we determined the specific information they need. A policy question that needs to be addressed is whether the data insurers are required to provide to state insurance departments are sufficient, needed, and used effectively. We believe that states that have not resolved these issues should do so.

Recommendations and Suggestions

The following recommendations are based on the assumption that carefully contemplated actions should have a salutary effect on malpractice problems. What we do not know and no one now knows is how specific actions will affect insurance rates. Yet, to take no action to address the problems does not seem reasonable. Logic and various actions already taken by several states seem to us to provide a good basis for a systematic attack on the problem.

We believe that the actions mentioned in the specific recommendations and suggestions that follow should be taken. Follow-up assessments of the effect these actions have on insurance rates could then provide a clearer picture of whether they make a difference. If they do not, laws could be changed or other actions could be proposed.

Recommendations to the Congress

To reduce the incidence of medical malpractice through improved delivery of medical care, we recommend the following:

- Cognizant Congressional committees should conduct periodic oversight hearings to determine the progress HHS, the states, and appropriate medical groups are making in (1) implementing the provisions of the Health Care Quality Improvement Act of 1986 and (2) using the information reported in the act to better assess the quality of care provided by health care practitioners.
- The Congress should enact H.R. 1444 and its companion bill S.661 to authorize the Secretary of HHS to exclude health care practitioners nationally from participation in the Medicare and Medicaid programs who are (1) excluded by any state Medicaid program, (2) excluded by Medicare, (3) convicted of crimes involving any federal or nonfederal health program, or (4) the subjects of sanctions by any state licensing board.

Recommendations to HHS and the Department of Justice

To reduce the incidence of medical malpractice through improved delivery of medical care, we recommend that the Secretary of HHS aggressively implement the provisions of the Health Care Quality Improvement Act of 1986 by developing a timely and effective system for making information about the competence or professional conduct of physicians and other practitioners available to hospitals, state licensing boards, and other health care entities.

To develop realistic consumer expectations regarding the potential risks of medical care, we recommend that the Secretary of HHS take the lead and work with the medical profession through its various professional organizations (such as the American Medical Association, the American Hospital Association, and physician specialty boards and societies) to initiate major efforts to (1) educate the public as to what to realistically expect from the health care system and (2) stress to physicians the need to fully communicate to the patient the potential risks associated with the medical treatment.

The federal government should become more involved with the states and affected parties in looking at how tort reforms could help bring more efficiency, predictability, and equity to the way in which medical malpractice claims are resolved. In this respect, we recommend that the Secretary of HHS and the Attorney General take the lead in working with states and affected interest groups to evaluate the merits of individual tort reforms and develop model laws that the states could enact. The following tort reforms and their benefits and trade-offs should be carefully considered for inclusion in these model laws:

- Shortened statute of limitations applicable to adults and minors for filing malpractice claims.
- Revised joint and several liability laws to require that provider damages be proportionate to degree of responsibility for the injury.
- Limits on fees for the plaintiff's lawyer through use of sliding fee schedules.
- Mandatory reductions of awards by amounts paid by collateral sources.
- Requirements that awards covering large future economic losses be made on a periodic basis.
- Reasonable caps on noneconomic losses.

To encourage increased experimentation with various alternative dispute resolution mechanisms for medical malpractice claims, we recommend that the Secretary of HHS fund a series of demonstration projects designed to test the efficiency and efficacy of various dispute resolution

mechanisms, including mediation, pretrial screening panels, use of arbitration, and no-fault compensation programs.

Suggestions for State Agencies and Professional Groups

We suggest that

- state licensing boards and professional peer review groups take more aggressive actions to identify, discipline, or remove from practice physicians who do not deliver an acceptable quality of medical care;
- state legislatures require, where they have not yet done so, health care providers to participate in risk management programs as a condition of licensure; and
- state legislatures resolve issues related to whether the data that insurers are required to provide to state insurance departments are sufficient, needed, and used effectively.

GAO Reports Related to Medical Malpractice[1]

Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50)

Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112)

Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21)

Medical Malpractice: Case Study on Arkansas (GAO/HRD-87-21S-1)

Medical Malpractice: Case Study on California (GAO/HRD-87-21S-2)

Medical Malpractice: Case Study on Florida (GAO/HRD-87-21S-3)

Medical Malpractice: Case Study on Indiana (GAO/HRD-87-21S-4)

Medical Malpractice: Case Study on New York (GAO/HRD-87-21S-5)

Medical Malpractice: Case Study on North Carolina (GAO/HRD-87-21S-6)

Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55)

Medicare: Reviews of Quality of Care at Participating Hospitals (GAO/HRD-86-139)

Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients from Health Practitioners Who Lose Their Licenses (GAO/HRD-84-53)

[1]Instructions for requesting copies of these reports are on the inside back cover of this report.

U.S. G.P.O. 1987-181-235:60014

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

Official Business
Penalty for Private Use $300

Address Correction Requested

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100