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Report to Congressional Requesters

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MEDICAL MALPRACTICE

Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms

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GAO

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The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate

The Honorable John Edward Porter
House of Representatives

In response to your request 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 third of a series we plan to issue on medical malpractice, contains 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 this report discuss our work in each state.

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. Subsequent reports will provide information on the characteristics of malpractice claims closed in 1984 and 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

Did actions taken by states since the mid-1970's to address medical malpractice insurance problems reduce insurance costs, the number of claims filed, and the average amount paid per claim? Representative John Edward Porter and Senator John Heinz, Chairman, Senate Special Committee on Aging, asked GAO to do work in selected states to address this question. GAO did work in Arkansas, California, Florida, Indiana, New York, and North Carolina.

Background

During the mid-1970's, the unavailability and increasing cost of medical malpractice insurance prompted 49 states to enact various reforms. GAO obtained views of organizations representing physicians, hospitals, insurers, and lawyers in the six selected states on perceived malpractice insurance problems—such as the cost and availability of insurance, number of claims filed, and size of malpractice awards/settlements—actions taken to deal with them, the results of these actions, and the need for federal involvement. GAO also surveyed nonfederal hospitals in each state about the sources, coverage limits, and costs of their malpractice insurance. GAO requested leading insurers in each state to provide data for physicians and hospitals regarding the cost of malpractice insurance, the frequency of claims, the average amount paid per claim, and the cost to investigate and defend against malpractice claims. For comparison, we obtained country-wide claims data from the St. Paul Fire and Marine Insurance Company, the largest malpractice insurer in the United States.

Results In Brief

Reforms to deal with medical malpractice problems can focus on changing the tort system, changing the way public bodies and peer groups regulate health care providers, changing the way the insurance industry is regulated, and developing realistic consumer expectations about the health care delivery system. Most of the changes made by the six states to respond to the crisis of the mid-1970's focused on tort reforms designed to assure the availability and to reduce the cost of malpractice insurance.

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

While it is possible that the reforms which focused on changing the laws moderated upward trends in some states, GAO data showed that since 1980, insurance costs for many physicians and hospitals increased dramatically, as did the number of malpractice claims filed and the average amounts paid.

Although Florida and New York enacted further tort law changes in 1985 and 1986, both also enacted measures that focused on improved identification and disciplining of physicians with malpractice history and increased oversight of malpractice insurance rates. However, it is too early to assess the effects of these measures for resolving malpractice problems.

GAO's Analysis

Since the mid-1970's the six states have taken a variety of actions designed to assure the availability of malpractice insurance and to reduce the cost of insurance. Table 1 summarizes the status, as of August 1986, of the major tort reforms in each state.

Table 1: Summary of Tort Reforms Enacted in Selected States

Tort reforms	AR	CA	FL	IN	NY
Ad damnum	1	1	1	2	1
Arbitration		1	1		1
Attorney's fees		2[a]	2	2	1
Awarding costs	1		1		1
Collateral source		2	2	1	1
Expert witness			1		
Limits on liability		2[a]	1	2	
Patient compensation fund			4	2	
Periodic payment	1	2	1	1	1
Pretrial screening panel	3		1	2	1
Res ipsa loquitur		1	1		
Statute of limitations	1	1	1	2	1
Special statute of limitations for minors	1	1		2	1
Standards of care	1		1		

Legend:
1 = Provision exists
2 = Provision found constitutional by highest state court
3 = Provision repealed or allowed to expire
4 = Provision exists in statute, but not implemented

[a]The U.S. Supreme Court declined to review the decision of the highest state court.

Cost of Insurance

From 1980 to 1986, the cost of malpractice insurance increased in each of the six states—often much more than the consumer price index and the medical care index, which increased 41 and 65 percent, respectively. The greatest increases were experienced by physicians in New York, Florida, and North Carolina. For example, malpractice insurance costs for an obstetrician increased 345 percent in New York, 395 percent in Florida, and 547 percent in North Carolina.

Although North Carolina experienced among the highest percentage increases, insurance rates for North Carolina physicians were still considerably lower than those for physicians in New York, California, and Florida. In January 1986, for example, premiums for obstetricians in North Carolina were $16,904 compared to $35,133, $42,928, and $59,537 for obstetricians in New York, California, and Florida, respectively.

Nationally, from 1983 to 1985, hospitals experienced a 76-percent increase in annual costs per bed for malpractice insurance. For the six states, rates of increase from 1983 to 1985 in annual costs per hospital bed ranged from 33 percent in New York to 141 percent in North Carolina.

Frequency of Claims

Country-wide, from 1980 to 1984, the frequency of claims reported against physicians and hospitals insured by the St. Paul Company increased 56 and 71 percent, respectively.

Claims reported against physicians increased in each of the six states. Indiana experienced the largest percentage increase—92 percent. The frequency of claims reported against hospitals increased in five of the six states, but the frequency of claims against Arkansas hospitals was the same in 1980 and 1984. North Carolina experienced the largest percentage increase—27 percent.

Average Paid Claims

Country-wide, from 1980 to 1984, the average paid claim against physicians and hospitals insured by the St. Paul Company increased 102 and 137 percent, respectively.

The average paid claim against physicians increased significantly in Arkansas, California, Florida, New York, and North Carolina. Except for

New York, however, where the average paid claim increased 124 percent—from $46,789 in 1980 to $104,810 in 1984—all increases were less than the country-wide average.

The average paid claim against hospitals increased in Arkansas, California, and North Carolina (data were not available for Florida hospitals). The largest percentage increase was experienced by North Carolina hospitals—183 percent. Although the average paid claim against New York hospitals decreased slightly, it was still much higher than the other three states. For example, in 1984 the average paid claim was $88,917 in New York compared to $18,345 in Arkansas.

The average paid claim by primary insurers for physicians in Indiana decreased from $23,801 in 1980 to $19,510 in 1984 but increased for hospitals from $7,146 in 1981 to $11,244 in 1984. The number of paid claims by the Indiana Patient's Compensation Fund, which is responsible for paying claims between $100,000 and $500,000, rose from 11 to 36 and the amount paid increased from $3.9 million to $11.7 million between 1980 to 1985.

Perceived Effect of Reforms

Four of the six groups GAO surveyed in Indiana believed that the state's $500,000 statutory cap on malpractice awards had a major effect on decreasing the size of awards/settlements. Also, three of six groups surveyed believed Indiana's pretrial screening process had a major effect on decreasing the number of claims that go to trial. Several officials in Indiana and California believed that their state's comprehensive malpractice legislation has helped to moderate upward trends in the cost of malpractice insurance and size of awards. However, Indiana officials were concerned that the increasing number and size of payments from the state Patient's Compensation Fund may adversely affect the Fund's solvency.

Role of the Federal Government

Many officials and organizations GAO contacted indicated that medical malpractice insurance was a problem that should be dealt with at the state level. There was little support for federal involvement.

Recommendations

GAO is making no recommendations.

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Introduction

During the period 1974-76, malpractice claims were driving up the cost of malpractice insurance so quickly that premiums in some specialties increased several hundred percent in a single year. Notwithstanding the increases in premiums, many insurers pulled out of the market entirely. These circumstances combined to create a situation—labeled by the medical profession as a "medical malpractice crisis"—in which both the affordability and availability of malpractice insurance were problems for health care providers. As the medical malpractice crisis peaked in 1975, health care providers in several states pursued state legislative changes to deal with the crisis.

Two factors were primarily responsible for the increased underwriting risk that contributed to the problems of the availability and affordability of malpractice insurance: (1) an unexpected increase in the number of claims filed and (2) an unexpected increase in the size of malpractice awards and settlements. Many insurers found somewhat abruptly in the mid-1970's that they had underestimated their potential claim losses and that, as a result, the premiums charged in prior years were inadequate to pay the losses resulting from malpractice incidents occurring in those years.

In addition to the underwriting losses resulting from increases in the number of claims filed and size of awards and settlements, insurance companies reportedly experienced losses in their investment portfolios. The volatility of malpractice losses and the unpredictability of profits from continuing to write medical malpractice insurance prompted some major commercial insurers to discontinue writing this line of insurance.

Even where insurance was available, health care providers faced concerns about its affordability as insurance companies dramatically increased medical malpractice insurance premiums.

Most of the responses to the mid-1970's crisis dealt with changes in the insurance industry to increase the availability of insurance and in legal procedures to reduce the cost of malpractice insurance.[1]

New sources of medical malpractice insurance also came into being from the establishment of joint underwriting associations, physician and hospital-owned insurance companies, hospital self-insurance programs, and state-administered patient compensation funds. The provider-owned companies became major sources of malpractice insurance for

[1]See GAO/HRD-86-50, pp. 75-82.

physicians and hospitals for a number of states, including California, Florida, New York, and North Carolina. In Indiana, most physicians and hospitals participate in the state patient's compensation fund.

Except for West Virginia, every state enacted some form of change in its statutes to respond to the medical malpractice crisis. The number of changes enacted varied considerably from state to state. The statutory changes concerning legal rules can generally be grouped into those that affect (1) filing claims, (2) determining amounts recoverable, (3) defining standards of medical care or burden of proof, and (4) using courts in resolving malpractice claims. Most were intended to affect the tort system and were generally designed to indirectly reduce the cost of malpractice insurance by directly reducing the number of claims filed, the size of awards and settlements, and the time and costs associated with resolving claims. Since the statutory changes were enacted, some have been tested and upheld as constitutional, while others have been declared unconstitutional, repealed, or allowed to expire.[2]

Key Indicators

Cost of insurance is a major concern of health care providers. The two key components affecting cost are the number of claims filed and the average amount paid per claim; however, the rates actually charged are developed by also considering other costs, such as taxes, administration, commissions, and profits. In addition, investment income, availability of reinsurance, extent of competition in the market, and extent of insurance regulation all influence malpractice insurance rates.

A number of factors—such as the number of malpractice injuries, an increasing tendency to sue, patient-physician relationships, the perception of the likelihood of recovery, and the length of time after the injury for filing claims—could affect the number of claims filed. Similarly, the cost of medical care could affect the average amount paid per claim.

Objective, Scope, and Methodology

Our objective was to determine the problems related to medical malpractice insurance experienced by each of the six states, their responses, the current situation, anticipated future problems, and whether representatives from the various interest groups we surveyed felt there was a need for federal involvement. We judgmentally selected the states with the intention of providing a cross-section of variables, such as

[2]See GAO/HRD-86-50, p. 83.

- geographic region,
- population characteristics,
- mixture of reforms or alternatives to the traditional civil litigation system,
- high and low malpractice insurance costs and incidence of claims, and
- availability of malpractice insurance.

In each state we obtained (1) the views of the interest groups having a stake in the issue about the nature of any problems, their solutions, and the need for federal involvement, (2) data from nonfederal hospitals about the cost of their medical malpractice insurance, and (3) data from leading malpractice insurers on key indicators of the insurance situation. We also examined relevant studies, articles, and publications on the malpractice situation in each state.

Organization Views

To obtain organizational views, we sent a questionnaire to the insurance department, medical society, hospital association, bar association, chapter of the Association of Trial Lawyers of America, chapter of the medical specialty societies, and the leading medical malpractice insurers in each of the six states. In addition, we held follow-up discussions with representatives of organizations (except state chapters of medical specialty societies) responding to the questionnaire. The organizations surveyed are listed in the supplements on each state.

The questionnaire and our follow-up discussions focused on the existence and severity of a number of past, current (1985), and possible future problems in each state. We also asked the organizations to (1) provide their perceptions of the effects of the state tort reforms and (2) identify the extent to which they supported either federal or state actions to implement additional measures for resolving malpractice claims and to address other malpractice problems.

The questionnaire, the same as that used to survey the views of nationally based interest groups, was initially mailed to the various state organizations in May and June 1985. Follow-up discussions with representatives of the selected organizations responding to the questionnaire were held during the period December 1985 through June 1986.

In analyzing the responses, we categorized the organizations completing the questionnaire into six interest groups for each state—(1) physician, (2) hospital association, (3) bar association, (4) trial lawyers association, (5) medical malpractice insurers, and (6) state insurance department.

For those groups (physicians and medical malpractice insurer) havi more than one organization, we required a majority of the organizat responding within each group to have the same response before we sidered it the predominate views of the group. In those instances in which there were three or fewer organizations in a group, we requi unanimous response among the organizations in the group before w considered it the group's predominate view.

Hospital Survey

To obtain information on hospital costs, we sent questionnaires to a random sample of hospitals in the six states. The survey instrumen used to collect malpractice insurance cost data from hospitals in th states and our methodology for analyzing the data were the same a used in our second report.[3]

Because of the large number of hospitals surveyed, we did not obta documentation to verify the accuracy of the data they provided. Ho ever, we reviewed the data provided for consistency and completen Where data items appeared inconsistent or incomplete, we contacte hospital personnel by telephone and attempted to obtain the missin data or resolve the inconsistencies.

The estimated values discussed in this report and their sampling er are presented in the supplements on each state.

Data From Insurers

To collect data on the key indicators of the insurance situation in th states, we first identified the leading malpractice insurers in each s through data obtained and discussions with the state's medical soci hospital association, insurance department, and medical malpractic insurers. We then requested these insurers to provide data for the p cians and hospitals they insured in the state. The insurers requeste provide data are listed in the supplements on each state.

Data requested included (1) the frequency of malpractice claims reported (1980-84), (2) the size of awards/settlements (1980-84), a the insurers' cost to investigate and defend claims. At the time we requested the statistical data from insurance companies, 1985 data not available. In those cases where data were unavailable for 1980, presented the results for 1981-84. We also requested these insurers provide data on the cost of medical malpractice insurance during th

[3]See GAO/HRD-86-112, pp. 19-23.

period January 1, 1980-January 1, 1986. To provide a range of low-risk to high-risk specialties, we requested data for the following specialties, shown in general order of ascending risk:

- General practice (no surgery).
- Internal medicine (no surgery).
- Pediatrics (no surgery).
- Pathology.
- Psychiatry.
- Radiology.
- General practice (minor surgery).
- Internal medicine (minor surgery).
- Pediatrics (minor surgery).
- Ophthalmology/surgery.
- General surgery.
- Plastic surgery.
- Anesthesiology.
- Obstetrics/gynecology.
- Orthopedic surgery.
- Neurosurgery.

Because we did not have right of access to many of the records of insurers, we did not independently validate the accuracy of the data they provided. However, we reviewed the data for completeness and reasonableness. Where there were inconsistencies, we contacted the insurer to resolve them. In addition, Mr. David R. Bickerstaff, a principal with Milliman and Robertson, Inc., Consulting Actuaries, Pasadena, California, assisted us in analyzing and interpreting the data received from the insurers.

In analyzing the data, we computed state aggregate values for the following indicators:

- frequency of malpractice claims per 100 insured physicians and per 100 insured occupied hospital beds,
- average amount paid for claims against physicians and hospitals,
- average cost to investigate and defend malpractice claims against physicians and hospitals, and
- percentage of claims against physicians and hospitals closed with indemnity payment to or on behalf of the injured party, closed with cost only to investigate and defend the claim, and closed with no indemnity payment or cost to investigate.

To provide a basis for comparison, we also obtained data from the St. Paul Fire and Marine Insurance Company (St. Paul Company) on country-wide data regarding (1) the number of malpractice claims reported per 100 physicians and per 100 occupied hospital beds and (2) the average amount paid per claim against physicians and hospitals. In 1985 the St. Paul Company insured more than 55,000 physicians in 44 states and about 1,555 hospitals in 47 states; it is the largest malpractice insurer in the United States. Because of the size and distribution of its insured population, we believe the St. Paul Company provides the best nationally representative data base available. We recognize, however, that its claims experience may not be representative of all malpractice insurers.

We also computed the change in the consumer price index and the medical care index (an element of the consumer price index relating to the cost of providing medical services) for three time periods relevant to our data analysis—1983-85; 1980-84; and January 1980-January 1986. For these time periods, the consumer price index increased 8, 26, and 41 percent, respectively, and the medical care index increased 13, 43, and 65 percent, repectively.

We did our work for this report between March 1985 and August 1986.

Malpractice Insurance Premiums, Number of Claims, and Size of Awards Have Increased Since 1980

Despite state efforts to curb the problems associated with medical malpractice, physician insurance costs in the six states for seven selected specialties[1] included in this report increased between 1980 and 1986—ranging from 35 percent for anesthesiologists in California to 547 percent for obstetricians/gynecologists in North Carolina. In addition, between 1980 and 1984 the number of claims filed continued to increase in all six states. This increase ranged from 19 to 92 percent. Increases in the average paid claim for physicians in five of the states ranged from 63 to 124 percent. Similar percentages could not be computed in Indiana because the state's Patient's Compensation Fund pays claims in excess of $100,000. The St. Paul Company advised us that from 1980 to 1984 its national experience indicated that the frequency of claims and the average paid claim against physicians increased 56 percent and 102 percent, respectively.

With regard to hospitals, the increases in malpractice insurance costs per bed in the six states ranged from 33 to 141 percent from 1983 to 1985. Nationally, these costs for hospitals increased 76 percent between 1983 and 1985. The increases in frequency of claims per 100 occupied beds in five of the six states ranged from 9 to 27 percent, and the increases in average paid claim per hospital ranged from 53 to 183 percent in three of the four states where this factor could be measured. The St. Paul Company's experience indicated that from 1980 to 1984 the frequency of claims and the average paid claim against hospitals increased 71 percent and 137 percent, respectively.

During our review, we identified no studies conducted in the six states to measure the effect of any specific tort reforms. However, officials in Indiana and California told us that they believed their malpractice legislation had helped to stabilize the cost of malpractice insurance and the size of malpractice awards. Concern was expressed, however, about the increasing number and size of payments from the Indiana Patient's Compensation Fund and their impact on the Fund's solvency. For example, claims paid by the Fund increased from 11 claims in 1980 to 36 claims in 1985 and amounts paid increased from $3.9 million to $11.7 million during the same period. The surcharge rate increased from 50 percent in April 1984 to 100 percent in April 1986. According to the consulting actuary for the Indiana Department of Insurance, the Fund had accrued

[1]For simplicity of presentation, we have included information on the cost of malpractice insurance for the following seven specialties—internal medicine (minor surgery), general practice (minor surgery), general surgery, anesthesiology, obstetrics/gynecology, orthopedic surgery, and neurosurgery. The supplements to this report contain information on these and additional specialties.

$90 million in unfunded liabilities as of December 31, 1985. If this t continues, further increases in the surcharge may be needed.

In California, state officials have similarly credited the state's comp hensive legislation—the Medical Injury Compensation Reform Act- with holding down increases in the cost of insurance.

We did not attempt to isolate the effects of individual tort reforms enacted in the six states on the cost of insurance, frequency of clair average paid claim, because of the large number of factors that infl ence these items.

Cost of Insurance Increased in All States

As shown in table 2.1, the highest percentage increases in premium occurred in New York, North Carolina, and Florida. Although Nortl Carolina had one of the highest percent increases in premiums, its p miums in January 1986 were still far below those in California, Flo and New York. Details on premium changes occurring for the perio 1980-82, 1982-84, and 1984-86 are shown in appendix II.

Table 2.1: Percent Increases in Malpractice Insurance Rates[a] for Selected Specialties Between January 1, 1980 and January 1, 1986[b]

	AR	CA[c]	FL[d]	IN[e]	NY[f]
General practice (minor surgery) ('80-'86)	58	173	199	93	335
Internal medicine (minor surgery) ('80-'86)	58	61	199	93	326
General surgery ('80-'86)	80	88	256	56	175
Anesthesiology ('80-'86)	61	35	217	56	96
Obstetrics/gynecology ('80-'86)	147	140	395	116	345
Orthopedic surgery ('80-'86)	50	88	198	83	216
Neurosurgery ('80-'86)	136	113	370	96	273

[a]Computation based on rates obtained from the state's leading insurer of physicians for the pre nately purchased coverage limits and policy form for the rating territory in which there was the g total number of physicians insured.

[b]In Florida, percentage increases between March 1, 1980, and January 1, 1986.

[c]Computation based on rates applicable to Southern California.

[d]Computation based on rates applicable to the entire state, except for Dade and Broward Coun

[e]Computation based on rates that include surcharge to participate in the Patient's Compensatic On January 1, 1980, the surcharge rate was 10 percent of the provider's premium for basic insu coverage. On January 1, 1986, the surcharge rate was 75 percent.

[f]Computation based on rates applicable to the entire state except Nassau, Suffolk, Bronx, Kings Queens, Richmond, Rockland, Sullivan, New York, Orange, Ulster, and Westchester Counties.

Although medical malpractice insurance costs for physicians increased in each of the six states from 1980 to 1986, there are large variations in the cost of insurance among the states and physician specialties. In some states there are also large variations in cost by location of practice within the state.[2]

Table 2.2 shows the malpractice rates across the six states for selected specialties as of January 1, 1986.

Table 2.2: Malpractice Insurance Rates[a] as of January 1, 1986 for Selected Specialties

	AR	CA[b]	FL[c]	IN[d]	NY[e]	NC
General practice (minor surgery)	$1,907	$10,024	$10,448	$2,328	$9,220	$2,760
Internal medicine (minor surgery)	1,907	5,924	10,448	2,328	7,233	2,760
General surgery	6,063	28,576	35,794	7,760	20,642	8,896
Anesthesiology	5,407	20,492	31,837	7,760	13,598	7,924
Obstetrics/ gynecology	9,940	42,928	59,537	11,380	35,133	16,904
Orthopedic surgery	7,985	33,632	47,667	10,605	36,472	11,812
Neurosurgery	12,612	37,984	75,367	11,380	43,019	18,595

[a]Rates are those applicable to the state's leading insurer of physicians for the predominately purchased coverage limits and policy form for the rating territory in which there was the greatest total number of physicians insured.

[b]Rates applicable to Southern California.

[c]Rates applicable to entire state except for Dade and Broward Counties.

[d]Includes surcharge rate to participate in the Patient's Compensation Fund.

[e]Rates applicable to entire state except for Nassau, Suffolk, Bronx, Kings, Queens, Richmond, Rockland, Sullivan, New York, Orange, Ulster, and Westchester Counties.

Hospital malpractice insurance costs also increased across the six states. As shown in table 2.3, increases in the average annual malpractice insurance cost per bed ranged from 33 to 141 percentage. North Carolina hospitals experienced the largest percentage increase between 1983 and 1985. Despite the large increase, North Carolina's costs were still considerably below those in California, Florida, and New York.

[2]See GAO/HRD-86-112, pp. 35-37, 70-79.

Table 2.3: Estimated Average Annual Malpractice Insurance Costs per Bed in Selected States, 1983-85

State	Average annual malpractice cost per bed[a]			1983-85 Increase[c]	
	1983	1984	1985	Amount	Percent
AR	$353	$418	$474	$121	34
CA	2,312	2,674	3,160	848	37
FL	1,523	2,276	2,939	1,416	93
IN	426	489	732	306	72
NY	1,212	1,181	1,609	397	33
NC	315	441	758	443	141
All hospitals[b]	944	1,145	1,659	715	76

[a]To determine the average annual malpractice cost per bed, we computed the daily occupied bed rate (the total number of inpatient days divided by 365) and increased that number by one bed for every 2,000 outpatient visits (emergency room visits were counted as outpatient visits). This number was divided into the hospital's total annual malpractice insurance cost. We considered 2,000 outpatient/emergency room visits to equal one hospital bed because the St. Paul Company, in developing hospital malpractice insurance rates, considers 2,000 outpatient visits to be equivalent in risk exposure to one hospital bed, which could produce 365 inpatient days.

[b]Estimated average annual malpractice insurance costs per bed are included with sampling errors in appendix V.

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

Frequency of Claims Increased in Most States

The frequency of malpractice claims filed against physicians increased in all six states. The frequency of claims filed against hospitals increased in all the states except Arkansas, where it remained the same. As shown in table 2.4, Indiana experienced the largest percentage increase in the frequency of claims against physicians between 1980 and 1984; however, Indiana's claim frequency was still lower than that of California, Florida, or New York.

Table 2.4: Frequency of Claims Reported per 100 Physicians in Selected States, 1980-84

State	1980	1981	1982	1983	1984	1980-84 percent increase
AR	6.6	8.4	8.8	7.7	8.6	30
CA	20.4	22.3	22.5	24.6	26.0	27
FL	20.8	31.6	32.3	29.1	26.1	25
IN	5.3	6.0	7.9	9.8	10.2	92
NY	27.1	28.9	31.4	38.1	35.7	32
NC	[a]	7.5	8.7	8.9	8.9	19[b]
Country-wide (St. Paul)	10.6	11.4	13.3	15.1	16.5	56

[a]Data not available.

[b]Percent computed from 1981 to 1984.

As shown in table 2.5, North Carolina experienced the largest percentage increase in the frequency of malpractice claims against hospitals between 1980 and 1984. However, the frequency of claims per 100 occupied beds in North Carolina in 1984 was still much lower than that for either California or New York.

Table 2.5: Frequency of Claims Reported per 100 Occupied Hospital Beds in Selected States, 1980-84

State	1980	1981	1982	1983	1984	1980-8 Percer increas
AR	1.2	1.5	1.3	1.1	1.2	
CA	8.6	9.6	10.4	10.4	10.1	1
FL	2.1	2.2	2.2	2.3	2.4	1
IN	[a]	2.2	2.2	2.9	2.4	
NY	7.5	7.3	7.0	8.4	8.7	1
NC	1.5	2.0	1.7	1.8	1.9	2
Country-wide (St. Paul)	2.1	2.5	2.6	3.0	3.6	7

[a]Data not available.

[b]Percent computed from 1981 to 1984.

Average Paid Claim Increased in Most States

As shown in the table 2.6, the average paid claim against physicians increased considerably between 1980 and 1984 in Arkansas, California, Florida, and New York. For example, the average paid claim in New York increased from $46,789 in 1980 to $104,810 in 1984—124 percent. In North Carolina, the increase was from $36,064 in 1981 to $62,043 in 1984—72 percent.

Table 2.6: Average Paid Claim for Physicians in Selected States, 1980-84[a]

State[b]	1980	1981	1982	1983	1984	1980-1984 percent increase
AR	$31,619	$35,974	$50,783	$20,182	$51,685	6
CA	32,963	43,570	60,123	55,419	61,774	8
FL	80,556	74,572	123,384	112,862	140,594	7
NY	46,789	76,203	80,865	105,552	104,810	12
NC	[c]	36,064	36,967	48,938	62,043	7
Country-wide (St. Paul)[a]	28,059	36,824	45,421	53,380	56,739	10

[a]These amounts may be understated in some states if insurance companies only initially began v malpractice policies in the state in recent years. Generally, those claims closed earlier are smalle those closed later.

[b]Information on Indiana is presented separately on pp. 19-20 because we could not compute an average paid claim that combined the experiences of primary insurers with that of the state's Pa Compensation Fund.

[c]Data not available.

[d]Percent computed from 1981 to 1984.

[e]For purposes of computing this average, the St. Paul Company limits each paid claim to a maxi $1 million.

As shown in table 2.7, the average paid claim against hospitals increased from 1980 to 1984 in Arkansas, California, and North Ca lina. Although the average paid claim in New York decreased slight over this period, it was still much higher than that of the other thre states.

Table 2.7: Average Paid Claim for Hospitals in Selected States,[a] 1980-84

State	1980	1981	1982	1983	1984	P inc (19
AR	$12,000	$13,222	$16,706	$15,957	$18,345	
CA	13,025	13,188	16,482	20,507	24,874	
FL[b]	•	•	•	•	•	
NY	90,577	70,091	91,085	90,540	88,917	
NC	7,098	10,035	11,185	22,667	20,091	
Country-wide (St. Paul)[c]	12,802	15,165	17,095	26,735	30,279	

[a]These amounts may be understated in some states if insurance companies only initially began malpractice policies in the state in recent years. Generally, those claims closed earlier are smalle those closed later.

[b]Data not available.

[c]For purposes of computing this average, the St. Paul Company limits each paid claim to a maxi $1 million.

In Indiana, the average paid claim by primary insurers (whose per losses are limited to $100,000 per claim for providers participating the Patient's Compensation Fund) for claims against physicians decreased from $23,801 in 1980 to $19,510 in 1984. The average pa claim by primary insurers for claims against hospitals, however, increased from $7,146 in 1981 to $11,244 in 1984. The number of c paid by Indiana's Patient's Compensation Fund rose from 11 to 36 the total amount paid out increased from $3.9 million to $11.7 milli between 1980 and 1985. As shown in table 2.8, the average amount

per claim by the Fund dropped from 1980 to 1981, but increased steadily from 1981 to 1985.

Table 2.8: Average Claim Paid by the Indiana Patient's Compensation Fund, 1980-85[a]

1980	1981	1982	1983	1984	198
$354,545	$281,786	$299,780	$302,045	$311,139	$325,41

[a]The Indiana Patient's Compensation Fund pays awards or settlements in excess of $100,000 up to the state's $500,000 cap. Claims below $100,000 are covered by a provider's basic insurance.

Insurers' Costs to Investigate and Defend Claims Increased in All States

As shown in tables 2.9 and 2.10, insurers' average cost to investigate and defend malpractice claims increased in all of the selected states. For physician claims, insurers in California, New York, and North Carolina experienced the largest increases. For example, the average cost to investigate and defend a physician claim in California increased from $2,284 in 1980 to $9,358 in 1984, or 310 percent. The largest increases in insurers' average cost to investigate and defend hospital claims occurred in North Carolina, Arkansas, and New York.

Table 2.9: Insurers' Average Cost to Investigate and Defend Physician Malpractice Claims for Selected States, 1980-84

State	1980	1981	1982	1983	1984	Percent Increase (1980-84)
AR	$2,714	$1,817	$2,934	$4,216	$5,269	94
CA	2,284	3,358	5,904	9,084	9,358	310
FL	5,047	5,298	7,224	7,453	7,918	57
IN	3,012	3,304	3,374	3,033	3,567	18
NY	3,822	5,600	6,719	8,694	10,063	163
NC	[a]	2,216	3,991	4,332	4,722	113

[a]Data not available.

[b]Percent computed from 1981 to 1984.

Table 2.10: Insurers' Average Cost to Investigate and Defend Hospital Malpractice Claims for Selected States, 1980-84

State	1980	1981	1982	1983	1984	Percent increase (1980-84)
AR	$2,263	$4,231	$2,759	$1,977	$4,120	82
CA	3,422	3,230	4,230	5,286	5,608	64
FL[a]	•	•	•	•	•	•
IN	[a]	1,075	1,024	934	1,275	19[b]
NY	4,922	4,358	6,885	9,774	8,900	81
NC	3,083	3,422	4,602	4,067	5,704	85

[a]Data not available.

[b]Percent computed from 1981 to 1984.

State Situations Vary but All Expect Malpractice Problems to Continue

A number of groups we surveyed in each state perceived major current problems.[1] The most prevalent problems concerned the size of malpractice awards and settlements, the high cost of malpractice insurance, the high legal costs associated with defending malpractice claims, and physician actions to reduce or prevent malpractice claims. In spite of these problems, there was little support for federal involvement or legislation to deal with medical malpractice problems. Many organizations believed the problem should be addressed at the state level.

For each of the six states, this chapter summarizes

- the mid-1970's malpractice problems,
- the state response to these problems,[2]
- the current situation and future concerns, and
- views on possible solutions, including federal involvement.

A more detailed description of each state's malpractice situation is included in the supplements on each state.

Arkansas: Few Current Concerns but Future Problems Expected

The cost of malpractice insurance and the number of claims filed in Arkansas are less than the other five states. However, insurance costs, frequency of physician claims, and the average paid claim for physicians and hospitals all have increased in recent years. Three or more of the six interest groups indicated that they expected major problems to develop during the next 5 years concerning the availability and cost of malpractice insurance for providers, legal expenses/attorney fees for malpractice claims, and physicians' actions to reduce or prevent malpractice claims. None of the groups we surveyed believed the tort reforms enacted in Arkansas had any major effect on any aspect of the malpractice situation.

Mid-1970's Malpractice Problems

During the mid-1970's, the possible unavailability of malpractice insurance became a major concern after the Aetna Insurance Company withdrew from the malpractice market. The St. Paul Company was left as essentially the state's only malpractice insurer, according to an Arkansas Medical Society official.

[1]See appendix III for a summary of the state's interest groups perceptions of current and future medical malpractice problems.

[2]See appendix IV for a more detailed description of the tort reforms enacted in each of the six states.

Response to Mid-1970's Problems

To assure an available market for medical professional liability in
ance, in 1975 the Arkansas General Assembly created the Profess
Liability Reinsurance Exchange. The exchange was never used an
allowed to expire on March 31, 1981, because malpractice insuran
become readily available from the normal insurance market, acco
to officials with the Arkansas Insurance Department. Also in 197
General Assembly created a Professional Malpractice Insurance C
mission to hear and rule upon malpractice claims submitted to the
mission by or on behalf of the injured person. However, like the
Reinsurance Exchange, the commission was allowed to expire in J
1979. According to an Arkansas Medical Society official, physicia
that the commission was a vehicle for discovery of claims, rather
deterrent for frivolous claims, since claims could still be taken to
even if the panel found no cause for negligence or damages.

In 1979, the General Assembly enacted a package of tort reforms
taining to medical malpractice cases, including the establishment
year statute of limitations from the occurrence date of the injury,
for cases involving the subsequent discovery of a foreign object. I
cases legal action must be started 1 year from discovery. For case
involving minors, legal action must be started before the 19th birt
provided the injury occurred when the person was under the age

Current Situation and Future Concerns

The cost of medical malpractice insurance in Arkansas was not vi
as a major current problem by the interest groups we surveyed. C
increases from 1980 to 1986 for 13 selected physician specialties
by the St. Paul Company ranged from 22 percent for ophthalmolo
surgery to 147 percent for obstetrics/gynecology. The median inc
was 80 percent. The cost of a claims-made policy with limits of
$300,000/$900,000 for hospitals insured with the St. Paul Compa
increased 51 percent over the 6-year period 1980-86. Our hospital
survey indicated that the average annual malpractice insurance c
bed in Arkansas increased 34 percent, from $353 in 1983 to $474
1985.

The frequency of claims per 100 physicians increased from 6.6 in
to 8.4 in 1981 but then remained relatively stable from 1981 to 19
However, the average paid claim for physicians increased from $
in 1980 to $51,685 in 1984, or 63 percent. The frequency of hospi
claims was 1.2 claims per 100 occupied beds in both 1980 and 198
the average paid claim for hospitals increased from $12,000 in 19
$18,345 in 1984—53 percent.

The insurers' average cost to investigate and defend claims increased from 1980 to 1984 for both physicians and hospitals. This cost increase about 94 percent from $2,714 in 1980 to $5,269 in 1984 for physicians and about 82 percent from $2,263 to $4,120 for hospitals.

The Arkansas Bar Association, the Arkansas Trial Lawyers Association and the Arkansas Insurance Department believed a major current problem was the high legal costs incurred by the plaintiff in pursuing malpractice claims. Also, the state's physician group, malpractice insurer group, and Insurance Department expect high legal costs associated with defending malpractice claims to be a major problem in the future.

The state's physician group, malpractice insurer group, and Insurance Department expected major problems to develop in the next 5 years regarding the cost of malpractice insurance for physicians. Insurance Department officials cited an increase in the number of lawyers and lawyer advertising, an overall increase in the litigiousness of the state, and a decrease in insurers capacity to write insurance as reasons for their concerns. An Arkansas Medical Society official stated that he has not heard outcries from physicians regarding the cost of insurance in the state, but this may soon occur, because trends in Arkansas are always several years behind the rest of the country.

Possible Solutions

Regarding solutions to medical malpractice problems, the state's Hospital Association, Trial Lawyers Association, and Bar Association strongly supported

- imposing sanctions or disciplinary measures against physicians and hospitals with medical malpractice histories and
- increasing peer review of physicians' medical practices.

There was little support among the groups surveyed for federal intervention to address the medical malpractice situation in Arkansas. Most groups believed that problems should be addressed at the state rather than the federal level.

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

Several California officials we contacted expressed the opinion that the state's medical malpractice legislation has had a considerable effect on moderating increases in the cost of malpractice insurance and size of malpractice awards. The average paid claim has continued to rise from 1980 through 1984, the last year complete data were available. Depending on the specialty, premiums for physicians increased from 16 to 337 percent in southern California—less so in the northern part of the state—between 1980 and 1986. Hospital premiums decreased from 1980 to 1984 and then increased sharply in 1985 and 1986.

Mid-1970's Malpractice Problems

A crisis developed in California in the mid-1970's regarding the lack of available and affordable medical malpractice insurance. As the number and size of malpractice judgments escalated, some commercial carriers reacted by withdrawing from the market entirely, while others raised their premiums to unprecedented levels. When the medical malpractice crisis peaked in 1975, among the first to feel the pinch of skyrocketing premiums were the high-risk specialties in northern California. Some doctors in the state decided to stop performing high-risk procedures, some moved their practices to other states, and some opted to "go bare" (practice without malpractice insurance).

Response to Mid-1970's Problems

In response to the mid-1970's medical malpractice insurance turmoil, the state passed the Medical Injury Compensation Reform Act in September 1975. The act included the following key provisions:

- Established a sliding scale contingency fee schedule for attorney fees.
- Imposed a maximum $250,000 limit on the amount recoverable for noneconomic losses (pain and suffering).
- Permitted introducing into evidence amounts received by the plaintiff from collateral sources, such as health insurance.
- Required the court, at the request of either party, to order periodic payments as opposed to a lump-sum payment of awards over $50,000.
- Imposed stricter limitations on the time period in which claims could be filed after discovery of a problem.
- Required specific boards and courts to keep and report to licensing boards information concerning convictions and judgments against physicians.

Current Situation and Future Concerns

Although the act was passed in 1975, its provisions have been contested in California courts over the past 10 years. Attempts to repeal key provisions of the act in 1985 were unsuccessful. Some officials believe past actions challenging the constitutionality have kept the act from functioning as intended but now believe the act will begin to have an even greater impact since its constitutionality has been tested and upheld. While it is not possible to assess the extent to which the act has had an impact on the state's malpractice situation, our analysis of key indicators indicated that the problem is continuing to worsen in California.

From 1980 to 1986, the rate of premium increases for selected specialties ranged from 16 percent for general practice (no surgery) and pathology to 337 percent for radiology, with a median increase of 99 percent for physicians practicing in southern California and insured by The Doctors' Company. The change in premium rates between 1980 and 1986 for NORCAL Mutual Insurance Company, the leading insurer of physicians in northern California, ranged from a decrease of 27 percent for anesthesiology to an increase of 92 percent for obstetrics/gynecology, with a median increase of 69 percent. The cost of primary malpractice coverage with California's largest hospital insurer, The Farmers Insurance Group of Companies, decreased each year from 1980 through 1984 but then increased 66 percent in 1985 and 71 percent in 1986. Our hospital survey indicated that the average annual malpractice cost per bed for California hospitals increased from $2,312 in 1983 to $3,160 in 1985, or 37 percent.

The frequency of physician claims per 100 physicians increased from 20.4 in 1980 to 26.0 in 1984, or 27 percent, while the average paid claim for physicians increased from $32,963 in 1980 to $61,774 in 1984, an overall increase of 87 percent over the 4-year period.

The frequency of hospital claims per 100 occupied beds increased from 8.6 in 1980 to 10.1 in 1984, a 17-percent increase. The average paid claim for hospitals increased 91 percent from $13,025 in 1980 to $24,874 in 1984.

The insurers' average cost to investigate and defend malpractice claims against physicians in California more than quadrupled from $2,284 in 1980 to $9,358 in 1984. This cost for hospitals increased from $3,422 in 1980 to $5,608 in 1984, or about 64 percent.

California's physician group, Hospital Association, and malpractic insurer group agreed that California had major problems in the fol lowing areas:

- Cost of medical malpractice liability insurance.
- Size of awards/settlements for medical malpractice claims.
- Legal expenses/attorney fees for medical malpractice claims.
- Physicians having strong incentives to perform medically unneces tests or treatments to reduce their risk of liability.

The California District of the American College of Obstetricians an Gynecologists commented that the "cost of insurance coverage [is] increasing rapidly. Coverage is available but very expensive." Offi of the California Hospital Association told us that hospitals were s a dramatic increase in the cost of excess medical malpractice insur coverage.[3]

Officials of the California Hospital Association told us that awards given based on emotions rather than on hard economic costs and believed the cap on pain and suffering, recently upheld as constitu tional, should eliminate some of this.

The Association of California Hospital Districts commented "the s is inefficient with too small a percentage of the total dollar spent g to the injured party."

California's physician group, Hospital Association, and malpractic insurer group also told us that physicians had strong incentives to form medically unnecessary tests or treatments to reduce their ris liability.

Possible Solutions

There was little support for federal involvement in the medical ma tice problem. The officials contacted generally thought it should b with at the state level. The California Department of Insurance su ported federal action to establish a national policy regarding comp tion of medically induced injuries and commented that "national guidelines as to what is fair and reasonable would be helpful." Th fornia Hospital Association supported federal actions to provide fi cial incentives or penalties to encourage states to take certain acti

[3]The first layer of insurance coverage is commonly known as basic or primary coverage. Thc erage above the basic level is known as excess or above primary coverage.

Florida: Premiums Continue to Rise Sharply but Recent State Reforms May Help

Florida has continued to experience increasing premiums as well as rising frequency and size of claims, despite several legislative attempts to correct these problems.

Mid-1970's Malpractice Problems

In the mid-1970's, Florida experienced major problems with the availability of medical malpractice insurance as more than 20 medical malpractice insurers canceled their coverage of physicians and withdrew from the market between 1970 and 1975 primarily because of the increasing amounts paid for medical malpractice claims. For example, the average paid claim jumped from $8,000 to $19,500 between 1973 and 1974, according to the Florida Medical Association. Argonaut Insurance Company, which insured about 50 percent of Florida's physicians, raised rates 96 percent in January 1975 and in April of the same year requested another 96-percent rate increase. Argonaut subsequently withdrew from the Florida malpractice insurance market. During this period, some Florida physicians chose to withdraw from practice or drop their insurance coverage, according to a 1985 Florida Medical Association Medical Malpractice Policy Guidebook.

Response to Mid-1970's Problems

The mid-70s situation prompted the Florida legislature to pass the 1975 Medical Malpractice Reform Act and an omnibus malpractice bill in 1976. Some provisions of these acts include

- setting the statute of limitations at 2 years from discovery and
- requiring that payments from collateral sources be deducted from the total award/settlement.

Two other provisions of the 1975 act that are no longer operational are:

- The establishment of a state-run patient's compensation fund intended to limit the liability of participants to $100,000 by paying the full excess over $100,000 of any judgment or settlement against a member. This fund became insolvent in 1983.
- The establishment of medical malpractice mediation panels. This was later declared unconstitutional.

The state legislature also passed the Comprehensive Medical Malpractice Reform act of 1985 and the Tort Reform and Insurance Act of 1986. The 1985 act placed limitations on attorney contingency fees based on the stage at which the case is resolved. For example, fees range from 15 percent for quick settlements to 45 percent for cases appealed and won, with a limit of 15 percent for awards/settlements in excess of $2 million. The 1986 act includes a $450,000 cap on noneconomic damages and a minimum 10-percent reduction of insurance premiums for policies in effect between October 1, 1986, and January 1, 1987 (equating to a 40-percent annual reduction). In October 1986, a Florida circuit court upheld all provisions of the act except the premium rollback applicable to policies written before July 1, 1986, the law's effective date. This decision has been appealed.

Current Situation and Future Concerns

Florida officials did not believe that the Florida's tort reforms had materially affected their malpractice problems. Several officials stated it was too early to determine what the effect of the 1985 act would be. A cap on noneconomic damages, which was included in the 1986 act, was strongly favored by most officials contacted as a means for controlling the rise in medical malpractice awards.

During the period 1980 to 1986, physicians insured in all areas of the state except for Dade and Broward Counties by the St. Paul Company experienced increases in malpractice insurance premiums ranging from 129 percent for ophthalmology/surgery to 395 percent for obstetrics/gynecology, with a median increase of 255 percent. During the same period, Florida's leading hospital insurer increased its premiums by 146 percent.[4] According to our hospital survey data, the average annual per bed cost for malpractice insurance increased by 93 percent between 1983 and 1985, from $1,523 to $2,939.

The frequency of claims against physicians increased from 20.8 claims per 100 physicians in 1980 to a high of 32.3 in 1982 and dropped to 26.1 in 1984, with an overall increase of 25 percent from 1980 to 1984. Additionally, claim frequency against hospitals increased from 2.1 claims per

[4]Between 1980 and 1986 the Florida Hospital Trust Fund went from 1 rating territory to 3 rating territories, changed from occurrence to claims-made policies, and increased its coverage limits. The percentage of increase is based on the rate charged for the entire state in 1980 and for territory 3, the territory with the most hospital beds insured in 1986. The rate of increase for territories 1 and 2 is 242 and 217 percent, respectively. A claims-made policy covers malpractice events that occur after the effective date of the coverage and for which claims are made during the policy period. Under an occurrence policy, the insurance company is liable for any incidents that occurred during the period the policy was in force, regardless of when the claim may be filed.

100 occupied beds in 1980 to 2.4 in 1984, or 14 percent. According to th Insurance Department's closed claim system, the average indemnity per claim for physicians, including amounts paid by the Florida patient's compensation fund, increased from $80,556 in 1980 to $140,594 in 1984 or 75 percent.

Current or future major problems identified by three or more of the six groups surveyed included

- availability of malpractice insurance for physicians and hospitals,
- cost of medical malpractice insurance,
- the number of medical malpractice claims filed and injuries for which claims were not filed,
- the size of malpractice awards/settlements,
- length of time to resolve medical malpractice claims,
- equity of awards/settlements for medical malpractice claims,
- legal expenses/attorney fees for medical malpractice claims, and
- individual physician actions to reduce or prevent medical malpractice claims.

Four of the six groups surveyed believed the availability of excess liability insurance would become a major problem for physicians in the next 5 years. Three or more groups also noted major problems with the availability and cost of reinsurance. According to Florida Hospital Trust Fund representatives, their excess trust fund now absorbs the entire amount of the excess insurance offered to its members because reinsurance has become too expensive, and member hospitals may be assessed as necessary to cover very large payouts. Another insurer advised us that its ability to provide adequate levels of coverage had become very limited because many reinsurers are pulling out of the market or refusing to reinsure the larger amounts.

Major future problems were also identified by three or more of the groups surveyed regarding the cost of excess liability coverage and tail coverage for physicians.[5] In addition, four of the six groups were concerned about the high cost of patient compensation fund participation for hospitals.

Problems identified regarding the size of awards concerned the excessive amounts paid in relation to economic costs arising from the injury,

[5]Insurance to cover claims filed after a claims-made policy has expired is known as "tail" coverage.

excessive amounts paid for pain and suffering, and the number of
practice awards and settlements over $1 million.

Possible Solutions

Three or more of the interest groups supported the use of pretrial
screening panels, modification of the fault-based litigation system,
expansion of the use of risk management programs, and strengthe
licensing and relicensing procedures for physicians and hospitals.
was little support for federal involvement in resolving the state's n
practice problems.

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

Indiana officials generally believed that Indiana's 1975 medical ma
practice legislation and subsequent amendments have greatly stabi
Indiana's medical malpractice insurance situation over the past de
These views may be supported by the fact that the cost of insuran
Indiana physicians and hospitals is now among the lowest in the na
compared to the mid-1970's, when they were higher than most nei
boring states. However, our data showed that the frequency of clai
against physicians and the average paid claim for hospitals climbe
between 1980 and 1984. Further, the number of claims paid and th
total dollars paid by the Patient's Compensation Fund have risen s
1980, with an attending rise in the Fund surcharge rate. Our consu
actuary noted that because of the normal development pattern of
endar year payouts, increases in the number of claims paid and tot
dollars paid by the Fund would have been expected. He added that
the Fund was established on a pay-as-you-go basis, increases in the
surcharge rate would have also been expected.

Mid-1970's Malpractice Problems

In the early 1970s, Indiana's health care system was approaching a
crisis due to the increasing number of medical malpractice suits be
filed, the large amounts of damages being awarded for such suits,
the reduced availability of malpractice insurance. For example, be
1970 and 1975, the frequency of malpractice claims filed against p
cians increased 42 percent, the average award increased from $12,
1970 to $34,297 in 1975, and the average malpractice insurance pr
mium for physicians increased 410 percent, according to the India
Medical Malpractice Study Commission established in 1975. In add
7 of the 10 primary malpractice insurers discontinued writing new
cies, canceled policies, or otherwise limited their new business and
bility. These problems in Indiana prompted some physicians in the

to retire early and others to stop performing the more complicated procedures which entailed greater risk, and prompted hospitals to discontinue some emergency services and to cancel some types of surgery.

Response to Mid-1970's Problems

To ensure the continuation of medical services in Indiana, medical malpractice legislation was enacted on April 4, 1975, with a July 1, 1975, effective date. The legislation as it currently exists

- set an absolute cap of $500,000 for medical malpractice claims;
- established a Patient's Compensation Fund to pay medical malpractice claims filed for amounts greater than $100,000;
- established a restrictive statute of limitations which requires claims to be filed within 2 years of the alleged act, omission, or neglect (except minors alleging injury before to their sixth birthday have until their eighth birthday in which to file a claim);
- limited attorney's fees to 15 percent of any recovery from the Fund;
- established a medical review panel and required all claims exceeding $15,000 to have a panel opinion before a claimant can commence any action in court; and
- required all malpractice claims settled or adjudicated against a health care provider to be reported to the Insurance Department.

Current Situation and Future Concerns

Officials from four of the six interest groups believed that Indiana's tort reforms have greatly stabilized Indiana's medical malpractice situation over the last 10 years. Regarding specific aspects of the act, three or more of the interest groups perceived a major impact resulting from the limitation on total size of awards/settlements and the use of pretrial screening panels (such as Indiana's medical review panels).

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

Three of the interest groups perceived some major impact from Indiana's tort reform requiring claims in excess of $15,000 to obtain a Medical Review Panel opinion before commencing any court action. The state's physician group, Bar Association, and Department of Insurance noted that the panel process had a major effect on decreasing the number of claims that go to trial. A leading Indiana insurance company disclosed that only 2 percent of claims filed against it actually go to court, which is quite low and can be attributed to Indiana's pretrial screening process.

During the period 1980-86, physicians insured by The Medical Protective Company (the state's leading physician insurer) and participating in the state Patient's Compensation Fund experienced cost increases ranging from 53 percent for ophthalmology/surgery to 116 percent for obstetrics/gynecology with an 81-percent median rate of increase. This rise was primarily due to the escalating Fund surcharge rates, which increased from 10 percent to 75 percent of basic premium costs between January 1, 1980, and January 1, 1986. Despite these recent increases, Indiana still has among the lowest physician premium costs in the entire nation. (See our second report, Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112)).

Hospitals insured by the Pennsylvania Hospital Insurance Company (the state's leading hospital insurer) and participating in the Fund experienced a 112-percent increase in their rate per occupied bed between 1981 and 1986. Once again, most of the increase was due to the increases in the Fund surcharge rates. Our consulting actuary stated that increases in the surcharge would have been expected since the Fund was basically established to operate on a "pay-as-you-go" basis. From our hospital survey data, we also noted that the average annual per bed cost for malpractice insurance increased by 72 percent, from $426 in 1983 to $732 in 1985.

From 1980 to 1984, claims frequency for physicians increased from about 5 claims to about 10 claims per 100 physicians. On the other hand, the average paid claim by the primary physician insurers decreased by 18 percent from 1980 to 1984.[6] For hospitals, claims frequency increased slightly from 2.2 to 2.4 claims per 100 occupied beds between

[6]Losses are limited to $100,000 for qualifying insurers for physicians and hospitals participating in state Patient's Compensation Fund.

1981 and 1984. However, the average paid claim by the primary hospital insurers increased during this period from $7,146 to $11,244. To complete the Indiana picture, one must also look at what has happened to the number and size of claims paid against the Indiana Patient's Compensation Fund. For example, the number of claims paid by the Fund rose from 11 claims to 36 claims, and the amount paid increased from $3.9 to $11.7 million between 1980 and 1985. Our consulting actuary commented that an increase would have been expected since the Fund was established July 1, 1975, and this pattern appears to reflect the time lag and normal development of payouts for the larger claims.

The insurers' average cost to investigate and defend claims against physicians increased by 18 percent between 1980 and 1984. Similarly, these costs associated with hospital claims increased by 19 percent between 1981 and 1984.

Many Indiana officials regarded the continued solvency of the state-run Patient's Compensation Fund to be a major concern. An Indiana Bar Association official said the Fund was not set up to be actuarily sound, and now payments have caught up with and exceed the amount set aside to handle claims.

Additionally, the Indiana Hospital Association, the Indiana Trial Lawyers Association, and the Department of Insurance perceived major current problems with the lack of remedial action by medical societies and physician specialty boards against members with malpractice histories. All three groups also expressed the opinion that peer review groups did not take remedial action against physicians or hospitals with malpractice histories.

Possible Solutions

Regarding possible solutions to medical malpractice problems, Indiana officials in three or more of the six interest groups strongly supported

- use of pretrial screening panels,
- strengthening licensing and relicensing for physicians and hospitals,
- increasing peer review of physicians' medical practices, and
- increasing information available to consumers about physicians and hospitals with medical malpractice histories.

No group within Indiana expressed strong support for federal intervention because they felt these problems could best be addressed at the state level.

New York: Claims and Premiums Are High but Recent State Reforms May Help

Although New York has taken a number of actions to deal with malpractice problems, the average paid claim and premium costs for physicians have increased in recent years and remain among the highest in the nation.

New York's medical malpractice insurance crisis in the mid-1970's was one of availability, due largely to the withdrawal of several of the largest medical malpractice insurers in the state. By the 1980's, the problem shifted from one of availability to one of affordability, as companies raised their rates rather than withdraw from the market.

Mid-1970's Malpractice Problems

The principal insurer of physicians, Employers Mutual of Wausau, withdrew from the malpractice market in July 1974. Argonaut entered the market and immediately increased rates by 94 percent. Argonaut planned a further increase of 197 percent to be effective in January 1976; however, it reversed itself and withdrew from the New York malpractice market in July 1975. In the face of major premium increases, physicians threatened to withhold treatment and medical services until insurance was available at reasonable rates.

Response to Mid-1970's Problems

The New York state legislature responded with several actions. A state joint underwriters association was created. Subsequently, two other companies, a hospital company and a physician company, were formed. Numerous other tort reforms were enacted between 1975 and 1986. Several key reforms that have been enacted in New York are to

- reduce the statute of limitations from 3 to 2-1/2 years from incident except for an action based upon subsequent discovery of a foreign object, in which case it is 1 year after discovery (statute for infants limited to 10 years after cause of action);
- create pretrial screening and mediation panels for all medical malpractice suits;
- establish a sliding plaintiff attorney's fee schedule; and
- require mandatory reduction of awards by any amounts paid by collateral sources, such as payments made by an individual's health insurer.

Current Situation and Future Concerns

There was no agreement among the six groups we surveyed that any specific reforms have had any major effect on medical malpractice problems in New York.

Cost increases from 1980 to 1986 for the selected physician specialties insured by the Medical Liability Mutual Insurance Company ranged from 96 percent for anesthesiology to 355 percent for psychiatry, with a median increase of 307 percent. From our hospital survey data, we also noted that the average annual malpractice cost per bed increased 33 percent, from $1,212 in 1983 to $1,609 in 1985. Hospital rates for $1 million/$3 million coverage with the state's largest insurer of hospitals remained unchanged from 1980 to 1985, with a 32-percent increase in 1986.

The frequency of claims for the predominate physician insurer, with about 70 percent of the market, increased from 27.1 to 35.7 claims per 100 physicians between 1980 and 1984, or 32 percent. The average paid claim for physicians increased steadily from $46,789 in 1980 to $104,810 in 1984. The leading physician insurer began insuring physicians in 1975, and our consulting actuary stated that some of this growth can be attributed to the normal expected insurance claim payout pattern (i.e., smaller claims normally get paid earlier than larger ones).

The frequency of claims for hospitals increased from 7.5 to 8.7 claims per 100 occupied beds between 1980 and 1984. The average paid claim for hospitals remained relatively stable, with a decline from $90,577 in 1980 to $88,917 in 1984.

The insurers' average cost to investigate and defend claims against physicians increased by 163 percent between 1980 and 1984. The costs associated with claims against hospitals increased by 81 percent.

Three or more of the six groups surveyed identified major current and/or future malpractice problems in New York with the

- length of time to resolve medical malpractice claims,
- cost of medical malpractice liability insurance,
- individual physician actions to reduce or prevent medical malpractice claims,
- availability of medical malpractice liability insurance,
- number of medical malpractice claims filed and injuries for which claims were not filed,
- size of awards/settlements for medical malpractice claims, and
- legal expenses/attorney fees for medical malpractice claims.

The New York Bar Association commented that the difficulty in obtaining physicians' depositions, together with a requirement for panel

screening of cases, greatly and unnecessarily lengthens the claims resolution process. The Trial Lawyers Association also commented that the delays have been exacerbated by medical malpractice panel hearings, which virtually are an additional trial that must be held before the real trial can take place. The Hospital Underwriters Mutual Insurance Company commented that "All time frames - court delays (including panel) are outrageous in New York. Patients without other resources are in trouble financially and emotionally."

Regarding the cost of insurance, the physician group, Trial Lawyers Association, malpractice insurer group, and Insurance Department believed that the cost of basic liability coverage for physicians was too expensive and expected it to continue to be so in future years. They also believed that the cost of basic liability coverage for hospitals was too expensive. The leading insurer of physicians commented that the excessive cost was

> "... caused by [the] frequency and severity of awards-concern[ed] that rates will continue to be [a] very 'substantial' problem for providers [over the] next 5 years without significant legislative action."

Possible Solutions

Three of the interest groups strongly supported strengthening licensing and relicensing requirements for physicians. There was little support for any specific federal role in resolving medical malpractice problems.

North Carolina: Insurance Situation Worsening for Physicians and Hospitals

In recent years, North Carolina's medical malpractice insurance premiums and average paid claim have climbed. Moreover, additional malpractice problems are expected to develop in the future.

Mid-1970's Malpractice Problems

During 1974 and 1975, the availability of malpractice insurance became a major concern of physicians and hospitals in North Carolina when the St. Paul Company, the state's major malpractice insurer, threatened to stop writing malpractice insurance in the state unless its requested rate increases were approved. Also, during the summer of 1975, Employers Mutual of Wausau discontinued writing medical malpractice insurance

for hospitals in the state, according to a North Carolina Hospital Association Trust Fund official.

Response to Mid-1970's Problems

To address concerns about the availability of medical malpractice insurance at reasonable rates, the North Carolina Medical Society established its own mutual insurance company, and the North Carolina Hospital Association established an insurance trust fund for its member hospitals in 1975. The North Carolina Legislature also responded with tort reforms in legislation enacted in 1976. A feature of the 1976 legislation included a shorter statute of limitations for filing medical malpractice lawsuits. The change reduced the maximum time for filing a lawsuit for injuries that were not discovered or reasonably discoverable from 10 years to 4 years from the time of the injury. The change also reduced the statute of limitations applicable to minors injured at birth by medical malpractice from 3 years to 1 year after age 18 for known injuries and from 10 years to 1 year after age 18 for undiscovered injuries. Legislation also created the health care reinsurance exchange to reinsure high-risk insurance policies and established a health care excess liability fund to provide participating health care providers with excess liability coverage. However, neither the health care reinsurance exchange nor the health care excess liability fund became operational because the reinsurance exchange was ruled unconstitutional, and according to a Medical Mutual Insurance Company official, a need never developed for the excess liability fund.

Current Situation and Future Concerns

None of the six groups surveyed believed that any of the tort reforms enacted by the state had any major effect on any aspect of medical malpractice.

In recent years, major increases have occurred in the cost of malpractice insurance and in the amount per paid claim for both physicians and hospitals in North Carolina. For example, cost increases from 1980 to 1986 for the selected physician specialties insured by the Medical Mutual Insurance Company of North Carolina ranged from 173 percent for radiology to 547 percent for obstetrics/gynecology with a median increase of 276 percent. Rates for primary hospital malpractice insurance coverage of $1.5 million/$3 million with the North Carolina Hospital Association Trust Fund were the same in 1980 and 1985; however, they increased 177 percent from 1985 to 1986. Moreover, our hospital survey indicated that the average annual malpractice cost per bed increased 141 percent, from $315 in 1983 to $758 in 1985.

The frequency of physician malpractice claims per 100 physicians increased from 7.5 in 1981 to 8.7 in 1982 and remained at 8.9 in 1983 and 1984. During this period the average paid claim for physicians increased from $36,064 in 1981 to $62,043 in 1984, or 72 percent.[7]

Although the frequency of hospital claims had remained relatively stable, increasing from 1.5 claims per 100 occupied beds in 1980 to 1.9 in 1984, the average paid claim for hospitals increased from $7,098 in 1980 to $20,091 in 1984, or 183 percent.

The insurers' average cost to investigate and defend physician malpractice claims more than doubled from 1981 to 1984, increasing from $2,216 to $4,772. This cost for hospital malpractice claims also increased from $3,083 to $5,704 per claim from 1980 to 1984.

Three or more of the six groups surveyed identified the following problems as major current problems in North Carolina:

- The size of malpractice awards/settlements.
- The equity of malpractice awards/settlements.
- The legal expenses/attorney's fees for malpractice claims.

These problems were expected to continue during the next 5 years. Three or more of the six groups also expected the cost of malpractice insurance, including the cost of reinsurance and the number of frivolous claims, to be major problems in North Carolina during the next 5 years.

A Medical Mutual Insurance Company of North Carolina official told us that North Carolina lagged about 5 years behind the rest of the nation in medical malpractice trends up until a year ago but the state has rapidly caught up. For example, he said the largest malpractice award was $200,000 in North Carolina 4 years ago; however, in March 1985 there was a malpractice award of $6.5 million, which he fears may set a benchmark for future cases. The official attributed the larger awards and settlements to an increasing public awareness of the benefits of pursuing a claim, more aggressive plaintiff attorneys, and higher public expectations of medical care. A Medical Society official told us that the increasing size of malpractice claims has the medical community "really scared."

[7]The leading insurers for physicians and hospitals began writing coverage in 1975, and some of this average paid claim growth can be attributed to the normal expected insurance claim payout pattern, (i.e., smaller claims normally get paid earlier than larger ones).

A North Carolina Hospital Association Trust Fund official commented

"Often awards have little relationship to the seriousness of the injury. There is no way to predict how a jury will rule on a particular set of facts. Often awards bear nc relationship to economic losses. Generally, awards range from adequate to excessive, with a few being inadequate. Today, juries often make awards regardless of the 'fault' of anyone out of sympathy for an injured person. More and more the public attitude is that insurance will compensate the injured party and the defendant will not sustain any loss."

A Medical Society official commented that the plaintiff's attorney may receive more of the award or settlement than the injured party in some medical malpractice cases, which he believes is unfair. The North Carolina Chapter of the American College of Radiology commented that contingency fee arrangements are a double-edged sword; if the contingency fee is too low, many minor but meritorious claims go uncompensated; however, if it is too high, not enough of the award/settlement goes to the plaintiff.

Possible Solutions

Four of the interest groups supported state action to expand the use of risk management programs to avoid future malpractice incidents. While there was no widespread support for federal action, the physician group and the North Carolina Department of Insurance supported federal action to establish a national policy concerning compensation for medically induced injuries.

Report Supplements[a]

Medical Malpractice: (GAO/HRD-87-21S-1)	Case Study on Arkansas
Medical Malpractice: (GAO/HRD-87-21S-2)	Case Study on California
Medical Malpractice: (GAO/HRD-87-21S-3)	Case Study on Florida
Medical Malpractice: (GAO/HRD-87-21S-4)	Case Study on Indiana
Medical Malpractice: (GAO/HRD-87-21S-5)	Case Study on New York
Medical Malpractice: (GAO/HRD-87-21S-6)	Case Study on North Caroli

[a]Instructions for requesting copes of the supplements are on the inside back cover of this report.

Percent Increase in Malpractice Insurance Rates[a] for Selected Specialties for Specified Periods

	AR	CA[b]	FL[c]	IN[d]	NY[e]	NC
General practice (minor surgery):						
(80-86)	58	173	199	93	335	239
(80-82)	49	17	24	0	64	48
(82-84)	3	55	48	14	76	41
(84-86)	3	51	63	70	50	64
Internal medicine (minor surgery):						
(80-86)	58	61	199	93	326	239
(80-82)	49	(9)	24	0	64	48
(82-84)	3	17	48	14	72	41
(84-86)	3	52	63	70	50	64
General surgery:						
(80-86)	80	88	256	56	175	306
(80-82)	57	17	29	0	48	56
(82-84)	(6)	7	37	14	24	50
(84-86)	22	51	102	37	59	74
Anesthesiology:						
(80-86)	61	35	217	56	96	262
(80-82)	57	3	29	0	48	56
(82-84)	(6)	(2)	37	14	(12)	50
(84-86)	9	34	79	37	50	55
Obstetrics/gynecology:						
(80-86)	147	140	395	116	345	547
(80-82)	57	32	29	0	73	56
(82-84)	9	21	60	14	72	50
(84-86)	45	51	140	90	50	175
Orthopedic surgery:						
(80-86)	50	88	198	83	216	241
(80-82)	38	17	13	0	48	57
(82-84)	(19)	7	17	14	42	13
(84-86)	35	51	124	61	50	92
Neurosurgery:						
(80-86)	136	113	370	96	273	438
(80-82)	115	32	77	0	48	57
(82-84)	(11)	7	31	14	68	36
(84-86)	23	51	103	73	50	151

[a]Computation based on rates, as of January 1 each year, that were obtained from the state's leading insurer of physicians for the predominately purchased coverage limits and policy form in the rating territory in which there is the greatest number of physicians insured. In Florida, 1980 rates are as of March 1, 1980.

[b]Computation based on rates applicable to southern California.

[c]Computation based on rates applicable to entire state except for Dade and Broward Counties.

[d]Computation based on rates that include surcharge to participate in the Patient's Compensation Fun

[e]Computation based on rates applicable to entire state except for Nassau, Suffolk, Bronx, Kings, Queens, Richmond, Rockland, Sullivan, New York, Orange, Ulster, and Westchester Counties.

State Interest Group Perceptions of Medical Malpractice Problems[a] in the Selected States

POSSIBLE PROBLEMS	AR	CA	FL	IN	NY	NC
Availability of medical malpractice insurance	F		F		C, F	
Cost of medical malpractice insurance	F	C	C, F		C, F	F
Number of medical malpractice claims			C, F		C, F	F
Size of medical malpractice claims		C, F	C, F		C, F	C, F
Length of time to resolve medical malpractice claims			C, F		C, F	
Equity of awards/settlements for medical malpractice claims			C			C, F
Legal expenses/attorney's fees for medical malpractice claims	C, F	C, F	C, F		C, F	C, F
Responses by physician groups and hospitals to reduce or prevent medical malpractice events				C		
Individual physician actions to reduce or prevent medical malpractice claims	F	C	C, F		C	
Individual hospital actions to reduce or prevent medical malpractice claims						

Legend:
C = Viewed as a current (1985) problem.
F = Viewed as a future problem (during the next 5 years, 1986-90).

[a]Three or more state interest groups expressed major concerns with at least one aspect of this problem.

Tort Reforms Enacted in the Selected States

Table IV.1 summarizes the status, as of August 1986, of major tort reforms enacted in each of the selected states in response to medical malpractice problems. Tables IV.2-IV.7 provide a brief description of tl tort reforms enacted in each state.

Table IV.1: Summary of Tort Reforms Enacted in Selected States

Tort reforms	AR	CA	FL	IN	NY	I
Ad damnum	1	1	1	2	1	
Arbitration		1	1		1	
Attorney's fees		2[a]	2	2	1	
Awarding costs	1		1		1	
Collateral source		2	2	1	1	
Expert witness			1			
Limits on liability		2[a]	1	2		
Patient compensation fund			4	2		
Periodic payment	1	2	1	1	1	
Pretrial screening panel	3		1	2	1	
Res ipsa loquitur		1	1			
Statute of limitations	1	1	1	2	1	
Special statute of limitations for minors	1	1		2	1	
Standards of care	1		1			

Legend:
1 = Provision exists
2 = Provision found constitutional by highest state court
3 = Provision repealed or allowed to expire
4 = Provision exists in statute, but not implemented

Source: American Medical Association, Division of Legislative Activities, Department of State Legislation.

[a]The U.S. Supreme Court declined to review the decision of the highest state court.

Table IV.2: Arkansas Tort Reforms

Ad damnum clause	Required pleading not to specify the amount of damages claimed but state that damages are within the minimum or maximum of that particular court.
Awarding cost	Requires the plaintiff to pay the reasonable cost incurred by the defendant if any actions for medical injury are intentionally made without reasonable cause and found to be untrue.
Periodic payment	Allowed the court at the request of either party to order that payment be made in periodic payments rather than in a lump sum, if the award for future damages exceeds $100,000.
Pretrial screening panel	Created a Professional Malpractice Insurance Commission to hear and rule upon any claim submitted to it involving medical injury, death, or monetary loss on account of medical malpractice. Expired in 1979.
Statute of limitations	Required all actions involving medical injury to begin within 2 years from the date the cause of the injury occurs, with the exception of the subsequent discovery of a foreign object, in which case the action shall be started within 1 year from date of discovery or the date the foreign object should reasonably have been discovered. With regard to minors, legal action must begin before the 19th birthday, provided that the injury occurred when the individual was under the age of 18 at the time of the act.
Standards of care	Required in any action for medical injury that the plaintiff have the burden of proving that the medical standards of his/her locality were not met by the provider. Also, when it is claimed that the medical provider failed to supply adequate information to obtain the informed consent of the injured person, the plaintiff has the burden of proving that the treatment was performed in other than an emergency situation and that the medical provider did not supply that type of information as would customarily have been given a patient by other medical providers with similar training and experience in the locality in which the medical provider practices.
Qualifications for expert testimony	In any action for medical injury, no medical care provider should be required to give expert testimony against himself, and no expert witness is permitted to give testimony if his compensation is dependent upon the outcome of the case.
Notice of intent to sue	Prohibited legal action from commencing until at least 60 days after written notice is served to the medical provider.
Damages recoverable	In any verdict for the plaintiff, damages may be awarded both for economic losses and for pain and suffering; however, the award must separately state the amount for both.
Professional Liability Reinsurance Exchange	Established to assure available market for medical professional liability insurance. However, it was never used and was allowed to expire on March 31, 1981.

Table IV.3: California Tort Reforms

Ad damnum clause	Prohibited stating the amount of damages demanded in actions brought in superior court to recover damages for personal injury or wrongful death.
Arbitration	Provided that any contract for medical services containing a provision for arbitration of any dispute as to medical malpractice shall contain a specified disclosure statement as the first article of the contract.
Attorney's fees	Established a sliding contingency fee schedule for plaintiff attorneys of 40 percent of the first $50,000 recovered; 33-1/3 percent of the next $100,000; and 10 percent of any amount exceeding $200,000.
Collateral source	Permitted defendant to introduce evidence that the plaintiff is entitled to receive compensation for injuries from insurance; however, plaintiff may then introduce evidence of premiums paid for the insurance coverage.
Limits on liability	Imposed a $250,000 limit on the amount recoverable for noneconomic losses, such as pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damage.
Periodic payment	Required that the superior court, at the request of either party, in any action for injury or damages against a provider of health care services, to order periodic payment of future damages rather than a lump-sum payment if the award equals or exceeds $50,000 in future damages.
Res ipsa loquitur	Clarified the manner in which the doctrine will operate.
Statute of limitations	Imposed a statute of limitations of 3 years after the date of injury or 1 year after the discovery or when the injury should have been discovered, whichever occurs first. Actions by a minor under the full age of 6 years have to begin within 3 years or before his 8th birthday, whichever provides a longer period.
Reporting of claims to Board of Medical Quality Assurance	Required any malpractice settlement or arbitration award over $30,000 against a physician or surgeon to be reported to the Board of Medical Quality Assurance or the Board of Osteopathic Examiners, as appropriate.
Notice of pending suit	Required 90-day notice to defendant of intention to sue.
Joint and several liability	Modified joint and several liability to limit awards for noneconomic damages to the degree of responsibility found by the court.

Table IV.4: Florida Tort Reforms

Ad damnum clause	Ad damnum clause deleted.
Arbitration	Required defendant's insurer to investigate claim during a 90-day "cooling off" period. At the end of the 90-day period, the insurer must (1) reject the claim, (2) make a settlement offer, or (3) offer an admission of liability and for arbitration on the issue of damages. If plaintiff accepts the offer to admit liability, the parties have 30 days to settle the amount of damages. If no agreement is reached after 30 days, the amount of damages is determined by binding arbitration.
Attorney's fees	Established graduated contingency fees based on the stage at which the malpractice case is resolved.
Awarding costs	Required plaintiff attorney to submit a certificate of counsel that a good-faith investigation has been made and written opinion of expert has been received that there appears to be evidence of medical negligence. If certificate not made in good faith and there is no justifiable issue against the health care provider, court must award attorney's fees and cost to the defendant and refer the attorney to the Florida bar for disciplinary review. Required plaintiff to pay defendant's attorney's fees and costs when the award is 25 percent less than the defendant's settlement offer, which was rejected, and the defendant to pay such costs for the plaintiff when the award is 25 percent greater than the plaintiff's settlement offer, which was rejected.
Collateral source	Required that malpractice awards be reduced by compensation received from collateral sources.
Expert witness	Required expert witness to have been practicing or teaching in the specialty or related field of medicine within the 5-year period before the incident giving rise to the claim.
Patient's Compensation Fund	Established to limit the liability of participants to $100,000 by paying the full excess over $100,000 of any judgment or settlement against a member. Fund became insolvent in 1983.
Periodic payment	Required court at request of either party to order periodic payment of awards for future economic damages over $250,000.
Pretrial screening panel	Established medical malpractice mediation panels to expedite prescreening of malpractice claims. Declared unconstitutional by Florida Supreme Court in 1980. Legislation passed in 1985 allowed the court, at the request of either party, to require submission of claim to nonbinding arbitration. Arbitration panels consist of a plaintiff attorney, a defense attorney, and a third attorney who does not work extensively in medical malpractice. The decision of the panel is nonbinding and if rejected cannot be disclosed at a trial.
Res ipsa loquitur	Limited doctrine of res ipsa loquitur to "instrument-in-the-body" cases; however, courts have not been so restrictive.
Statute of limitations	Established statute of limitations at 2 years from time of incident or within 2 years of discovery; however, in no event can action be commenced later than 4 years from date of incident.

Standards of care	Required plaintiff to prove that defendant violated the accepted standard of care practiced by similar health care providers in the same or similar community.
Cap on awards	Limited noneconomic damages to $450,000.
Joint and several liability	Eliminated joint and several liability for the noneconomic portion of damages. Regarding economic damages, joint and several liability was abolished for defendants who are less at fault than the claimant.
Establishment of self-insurance pools	Relaxed or eliminated restrictions on the formation of self-insurance pools to encourage greater use of such pools.
Establishment of joint underwriting association	Established a joint underwriting association to supply insurance to licensed health care providers regardless of th risk the provider may pose and regardless of whether the provider has been previously denied coverage.
Requirement for risk management programs at health care facilities	Required Department of Insurance to develop and enforce certification standards for risk managers.
Provisions for increased disciplinary measures against physicians with medical malpractice histories	Required governing boards of licensed facilities to investigate a staff member involved in one or more settlements exceeding $10,000. Strengthened immunity of medical review committees and peer review boards. Defined "repeated malpractice" as three or more claims within the previous 5 years resulting in payments or settlements over $10,000 and requiring Department of Insurance to report such incidents to the Board of Medical Examiners.
Remittur and additur	Allowed courts to modify a jury award if it appears to be excessive or inadequate in light of evidence.
Informed consent	Provided that no action can be taken in court against a health care provider on the basis of lack of informed consent when (1) the health care provider's action met the accepted standard of medical profession with similar training and experience in the same or similar medical community; and (2) under the circumstances and based on the information provided by the health care provider, a reasonable individual would understand the procedure and its alternatives recognized by other health care providers in the same or similar community who perform the same or similar treatment or procedures; or (3) under all surrounding circumstances, the patient would reasonably have undergone the treatment and had he been advised by the health care provider in accordance with (1) and (2) above.

Reporting claims	Required Florida insurers providing professional liability insurance (including self-insurers and Joint Underwriting Association) to report to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, negligence, or lack of consent, if the claim resulted in: (1) a final judgment (in any amount), (2) a settlement (in any amount), and (3) a final disposition not resulting in payment. Major components of the reports include: claim report date; date of occurrence; date and amount of judgment or settlement; in case of settlement, amount of injured's medical expenses, wage loss, and other expenses; expenses paid to defense counsel and other expenses; and description of procedure causing injury.

Table IV.5: Indiana Tort Reforms

Ad damnum	Deleted ad damnum clause.
Attorney's fees	Limited attorney's fees to 15 percent of recovery from Patient's Compensation Fund.
Limits on liability	Limited total amount recoverable for any patient injury or death to $500,000.
Patient's Compensation Fund	Created the Fund, administered by State Insurance Commissioner, to pay claims over $100,000 up to state's $500,000 limit. Financed by participant's surcharges.
Periodic payment	Allowed periodic payment of awards.
Pretrial screening panel	Established medical review panel and required all claims exceeding $15,000 to have a panel opinion before a claimant may commence any action in court.
Statute of limitations	Required claims to be made within 2 years of the alleged act, omission, or neglect. Minors alleging injury at any time before their 6th birthday have until their 8th birthday in which to file a claim.
Joint underwriting association	Established the Indiana Residual Malpractice Insurance Authority.
Reporting claims	Required all malpractice claims settled or adjudicated against a health care provider be reported to the Commissioner of Insurance. The commissioner must then report on individual practitioners to the appropriate board of professional registration and examination for review. The board may then review the health care provider's fitness to remain in practice and censure, place on probation, suspend, or revoke the license of a health care provider.
Collateral source	Allowed defendant to introduce evidence to jury of plaintiff receiving reimbursement of costs from other sources except for (1) life insurance payments, (2) health insurance paid for directly by plaintiff, or (3) payments made before trial by the state of Indiana or the United States.

Table IV.6: New York Tort Reforms

Ad damnum clause	Ad damnum clause deleted.
Arbitration	Permitted arbitration of damages under certain conditions. Professional liability policies required to include coverage fc claims subject to arbitration.
Attorney's fees	Established the plaintiffs' attorney's fee schedule at 30 percent of the first $250,000; 25 percent of the next $250,000; 20 percent of the next $500,000; 15 percent of th next $250,000; and 10 percent of any further amount.
Awarding costs	Permitted the court to award attorney's fees and court cost up to $10,000 if a party to an action either starts an action o interposes a frivolous defense. These costs may be awarde not only against the party, but directly against the attorney as well.
Collateral source	Required mandatory reduction of awards by future collatera source payments.
Expert witness	Required full disclosure of the qualifications of any expert witness and the substance of the testimony.
Periodic payment	Limited the immediate payment of any judgments for future damages to $250,000. The court was required to order judgments in lump sum for past damages, for future damages not exceeding $250,000, and for litigation expenses and attorney's fees. For awards of future damages over $250,000, the court was required to provide for payment of the amount in periodic payments over the period it expects such damages to be experienced. The period of time over which payments for pain and suffering can be made was limited to 10 years. Upon the death of the plaintiff, the liability for payment of future damages terminates except for the portion of any periodic payment attributable to future earnings of the plaintiff, which shall continue to be paid to persons which the plaintiff owed a duty of support.
Pretrial screening panel	Created pretrial screening and mediation panels for all medical malpractice suits. Panel recommendations may be admissible if three members concur on the question of liability.
Statute of limitations	Reduced from 3 to 2-1/2 years. If an action is based upon discovery of a foreign object, that action may be started within 1 year after discovery. With respect to infants, the statute is limited to 10 years after the cause of action accrues.
Joint and several liability	Modified the doctrine of joint and several liability in personal injury cases. In personal injury claims with jointly liable defendants when the liability of a defendant is 50 percent or less of the total liability assigned to all persons liable, such defendant's liability to the claimant for noneconomic loss shall not exceed the defendant's equitable share.
Establishment of joint underwriting association	Created the Medical Malpractice Insurance Association to provide a market for medical malpractice insurance. Required to insure any hospital or licensed physician in New York State.

Informed consent	Limited applicability of the doctrine of informed consent to nonemergency treatment, procedure, or surgery, or diagnostic procedures that involve invasion or disruption of the integrity of the body. Established that there is no cause of action unless it is established that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed.
Pre-calendar conference and expedited discovery	Required a pre-calendar conference to be held in order to encourage settlement, simplify or limit issues, and establish a timetable for disclosure. Required the completion of discovery proceedings no later than 12 months after notice of the action is filed and all parties to be ready for trial no later than 18 months after notice of the action is filed.
Excess physician coverage	Required insurers that issue a malpractice policy with limits equal to or greater than $1 million per occurrence and $3 million aggregate to provide, if requested by the policyholder, additional excess coverage of $1 million per occurrence and $3 million aggregate above the primary coverage. Hospitals must purchase this coverage for any requesting physician in their hospital.
Medical conduct	Created the Professional Medical Conduct Board to investigate and conduct hearings. In certain instances, physicians can be placed on probation and have their practices monitored by other physicians, including review of patient records and bills.
Risk management	Required each hospital to have a coordinated program for the identification and prevention of malpractice.
Reporting claims	Required quarterly reports on all medical malpractice claims and policy cancellations to be filed with the insurance superintendent and health commissioner, as well as any surcharge or merit-rating adjustments made on an insured's premium and the reason.
Itemized awards	Required amounts awarded by a jury or court that are to compensate for damages to be incurred in the future and the period of years over which such amounts are intended to be paid to be itemized.
Insurance department rate-setting authority	Expanded authority of the superintendent of insurance to establish and review medical malpractice rates. To assist the superintendent in reviewing the appropriateness of rates, insurers were required to establish segregated accounts for premiums, payments, reserves, and investment income and to submit periodic reports.

Table IV.7: North Carolina Tort Reforms

Ad damnum	Eliminated the ad damnum clause claiming damages over $10,000. Provided that any party may ask the claimant for a statement of the amount of monetary relief sought, which is required to be provided within 10 days. However, this amount is not to be filed with the court until the case is called for trial or entry of default judgment is requested.
Awarding costs	Permitted the court to award reasonable attorney's fees to the prevailing party when lawsuits are frivolous, i.e., there was a complete absence of a justiciable issue of either law or fact raised by the losing party in the court pleading.
Patient's compensation fund	Created the Health Care Excess Liability Fund to provide participating health-care providers with excess liability coverage of $2 million per occurrence and $2 million annual aggregate. In order to participate, health care providers were required to have primary malpractice coverage of at least $100,000 per occurrence and $100,000 annual aggregate. The fund was to be financed by assessments paid by participating providers. The fund did not become operational because a need for the fund never developed after the Medical Mutual Insurance Company of North Carolina was established.
Statute of limitations	Reduced the maximum time for filing a lawsuit for injuries that were not initially discovered or reasonably discoverable from 10 years to 4 years from the time of the injury. Reducec the statute of limitations applicable to minors injured at birth by medical malpractice from 3 years to 1 year after age 18 for known injuries and from 10 years to 1 year after age 18 for subsequently discovered injuries.
Standard of care	Codified the standard of care used in medical malpractice cases to be the prevailing level of care practiced in the provider's community at the time of the accident.
Informed consent	Established the standard for obtaining the patient's consent for treatment as (1) the standards of practice of similar providers in the same or similar community and (2) information such that a reasonable person would have a general understanding of the treatment and usual risks. The statute also provided that a health care provider is not liable for damages on the grounds of lack of informed consent when a reasonable person, under the surrounding circumstances, would have undergone such treatment had he been advised in accordance with the statute. It also provided that a patient's consent in writing obtained in compliance with the statute is presumed to be valid. The statute also requires that a provider's guarantee of treatment results must be in writing before a patient can sue on the basis that treatment did not produce the results promised.
Emergency treatment	Established a "good samaritan" law to provide protection to any person giving first aid or emergency health care treatment to an unconscious, ill, or injured person.
Reinsurance exchange	Established health care reinsurance exchange to insure high-risk policies with losses allocated among member companies. Never became operational because it was ruled unconstitutional.

Average Annual Malpractice Insurance Cost per Bed and Related Sampling Errors for All Hospitals

Year	No. of hospitals	Average annual cost per bed	
		Amount	Sampling error[a]
1983	4,966	$943.81	$56.97
1984	5,138	1,144.64	76.76
1985	5,221	1,659.13	121.55

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

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