

149272

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health  
Committee on Ways and Means  
House of Representatives

For Release on Delivery  
Expected at  
10:00 a.m.  
Thursday  
May 20, 1993

MEDICAL MALPRACTICE

Experience with Efforts  
to Address Problems

Statement of Lawrence H. Thompson  
Assistant Comptroller General  
Human Resources Division



149272

CS1280/149272

\_\_\_\_\_

\_\_\_\_\_

## SUMMARY

A major challenge facing the new Congress and administration is finding a better way to manage and finance the U.S. health care system while preserving the high quality, innovative medical care it has achieved. The precise extent to which medical malpractice has contributed to the nation's spiralling health care bill is unknown. However, there is no question that the costs associated with it--such as medical malpractice insurance and associated defensive medicine costs--run into the billions of dollars.

During the last 20 years, the issue of medical malpractice has been identified largely in terms of the cost and availability of malpractice insurance. For example, the cost of medical malpractice insurance has increased from \$2.0 billion in 1983 to \$5.9 billion in 1990 for physicians and from \$800 million in 1983 to \$2.1 billion in 1990 for hospitals. But the implications of the medical malpractice problem go well beyond insurance issues alone.

Consumers, attorneys, insurers and health care providers are concerned with, and often affected by: (1) the quality of medical care being provided and the costs associated with the practice of defensive medicine, (2) the large number of injuries due to negligence, and (3) the widespread agreement that the current system for compensating patients injured by negligent practices is neither efficient nor equitable.

States' primary response to malpractice problems has been tort reform. For the most part, tort reforms have been designed to reduce the rate of increase in medical malpractice insurance premiums by reducing the number of claims filed and the size of malpractice awards and settlements. Studies have suggested that some of these reforms--such as caps on the amount of the award or prohibitions against receiving duplicative payment from various sources for economic losses--have achieved these objectives.

To address the problems associated with an inefficient and inequitable compensation system and the adverse effects on the way physicians practice medicine, states and the private sector have initiated a number of efforts. Four that are currently receiving much attention are risk management at the Harvard medical institutions, the use of practice guidelines in Maine, fault-based alternatives to litigation in several states and some health maintenance organizations, and no-fault approaches in Virginia and Florida.

Although these efforts are all ongoing, their experience to date provides insights that may be helpful as the Congress considers various malpractice reform proposals. Whatever approach is taken, reform of the malpractice system should address the fundamental issues of (1) reducing the incidence of negligent care, (2) fairly compensating individuals injured through medical negligence, and (3) dealing with the complexities involved in efforts to enhance the overall quality of care provided in this country.



Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our views on the problems created by medical malpractice and on efforts to address aspects of these problems, particularly as these efforts pertain to the cost and quality of health care and have implications for reforming the health care system.

A major challenge facing the new Congress and administration is finding a better way to manage and finance the U.S. health care system while preserving the high quality, innovative medical care the United States has achieved. It is expected that this country will spend over \$900 billion on health care this year, and if the present growth rate continues, health expenditures will exceed \$1.7 trillion by the year 2000. These growing costs are being shared by individuals and the business community as well as federal and state governments.

The precise extent to which medical malpractice has contributed to the nation's spiralling health care bill is unknown. But there is little question that the costs associated with it run into the billions of dollars. The United States faces higher costs for medical malpractice insurance and associated defensive medicine costs than other nations. Of equal importance are the profound effects that medical malpractice is having on the way medicine is practiced in this country--effects that can be expected to grow in the future if the malpractice system is not reformed.

Today I want to share with you our views on

- the relationship between the insurance crisis and malpractice problems,
- the extent of the malpractice problem,
- dealing with the practice of negligent medicine,
- flaws in the current system for resolving malpractice claims,
- the effect the malpractice problem has on the practice of medicine, and
- efforts to try to improve the claims resolution process and improve the way physicians provide care.

Our testimony is based primarily on our earlier extensive work on the medical malpractice insurance problem. More recently, we have looked at some alternatives to the litigation system for resolving malpractice claims. We are continuing to address the malpractice issue through a variety of studies focused on such

areas as practice guidelines, claims experience for Medicare and Medicaid patients, and insurance coverage for federally-supported health centers. Collectively, our work shows that malpractice is a difficult and complex problem.

MALPRACTICE IS MORE THAN  
A PROBLEM OF COSTLY INSURANCE

During the last 20 years, the issue of medical malpractice has been largely identified in terms of the cost and availability of malpractice insurance. But these are just two aspects of a multi-dimensional problem.

Medical malpractice was termed a crisis in the mid-1970s, when the premiums in some specialties rose several hundred percent in a single year and many insurers stopped selling malpractice insurance. As a result, many physicians could not obtain coverage from their traditional insurers, or even if available, they could not afford it.

In response to this crisis, all states but one enacted legislation addressing the problem. The emphasis was on measures to create alternative sources of insurance and to reduce the number and cost of claims. Another response to this problem was for physicians and hospitals to create their own insurance companies to provide malpractice insurance. Over the next decade, these responses helped to make insurance more readily available in a market that is now dominated by these provider-owned companies.

Although the number and cost of malpractice claims continued to climb in the early to mid-1980s, insurers kept premium increases to a minimum because investments made at high interest rates were returning high yields. This changed, however, when interest rates began to decline in 1984. In response, insurers once again imposed large premium increases on health care providers. This was labeled as a crisis of affordability of insurance.

Physicians' malpractice insurance costs increased from \$2.0 billion in 1983 to \$5.9 billion in 1990 and hospitals' insurance costs increased from \$800 million in 1983 to \$2.1 billion in 1990. Although premium rates declined somewhat in the late 1980s, the cost of insurance remains high.

Physician malpractice insurance premiums vary widely depending on the specialty involved and the physician's geographic location. For example, a Chicago neurosurgeon now pays almost \$191,000 annually for the same coverage a colleague in North Carolina obtains for about \$28,000. (Attachment I illustrates these variations in rates.) These premiums represent uniform rates paid by all physicians in a given medical specialty and defined

geographical area. They are not based on an individual's own claims experience.

The implications of the medical malpractice problem go well beyond insurance issues as demonstrated by the views of groups primarily affected by malpractice--consumers, attorneys, insurers, and health care providers. Consumers are concerned about the quality of medical care they are receiving and the long time required to settle malpractice claims. Attorneys believe that the large number of medical injuries due to negligence is the basic issue in discussions of malpractice. Insurers are concerned about the effects the unpredictability of the tort system has on insurance rate-making. Physicians and hospitals believe that malpractice insurance costs too much, patients' expectations are unrealistic, awards are excessive, claims take too long to settle, and legal costs to defend against claims are too high.

NEGLIGENT MEDICAL PRACTICES  
MUST BE ADDRESSED

Malpractice claims are not a true indication of the extent of medical injuries due to negligence. Further, a claim does not necessarily indicate the existence of medical malpractice or the need for disciplinary action. But, the large number of injuries in relation to the small number of malpractice claims and disciplinary actions suggests that the current system does not do a good job identifying and disciplining negligent providers.

A Harvard University study of medical malpractice in New York indicated that, as a percentage of 1984 hospital discharges, the rate of negligence by providers was 1 percent.<sup>1</sup> Further, the Harvard study found that the number of malpractice claims filed was far less than the actual level of negligently-caused injuries. These findings are consistent with the findings of the other major study of this subject, which involved an analysis of 1974 hospital admissions in California.

While 1 percent may not appear to be large, it is significant considering the effects of medical injuries on individuals. In New York, it represented about 27,000 patients found to be injured as a result of medical negligence. The Harvard data would suggest that, nationally, there were an estimated 150,000

---

<sup>1</sup>Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, A Report by the Harvard Medical Practice Study to the State of New York, Feb. 1990.

fatalities and 30,000 serious injuries in 1984 caused by physician or hospital negligence.<sup>2</sup>

Despite the large number of fatalities and serious injuries attributable to negligence, few disciplinary actions were taken against practicing physicians. The Federation of State Medical Boards reported that a total of 2,108 disciplinary actions were taken against physicians in 1985. Of the nation's 552,716 licensed physicians, the Federation reported that state medical boards in 1985 revoked the licenses of 406, suspended the licenses of 235, placed on probation 491, and penalized 976--in ways ranging from reprimands to restrictions on practicing, such as preclusion from performing certain procedures.<sup>3</sup>

State medical boards, which are responsible for imposing sanctions on physicians found to be incompetent or impaired by debilitating conditions such as alcoholism, drug abuse, or mental illness, are often criticized for not doing more. But, before they can impose sanctions against physicians, negligent actions or impaired performance must be reported to them. To date, many health care providers have been reluctant to speak out against their colleagues.

#### Federal Actions to Help Identify Negligent Providers

The Health Care Quality Improvement Act of 1986 and the Medicare and Medicaid Patient and Program Protection Act of 1987 were significant legislative attempts to facilitate the identification and reporting of providers who are practicing substandard medicine. The centerpiece of the 1986 legislation is the National Practitioner Data Bank, which contains information on disciplinary actions taken by state licensing boards, actions by hospitals and other institutions to deny or revoke clinical privileges, and medical malpractice claims paid by insurance companies that involve a licensed practitioner. Information contained in the data bank is expected to restrict providers' ability to move from state to state without discovery of their previous damaging or negligent performance. The act also seeks to facilitate the identification and reporting of incompetent practitioners by granting immunity from liability to individuals participating in peer review activities.

The data bank became operational in September 1990. As of

---

<sup>2</sup>Paul C. Weiler, Medical Malpractice on Trial, Harvard University Press, Cambridge, Mass., 1991.

<sup>3</sup>In 1991, state medical boards took 2,804 prejudicial disciplinary actions against physicians, ranging from license revocation to a letter of warning.



May 7, 1993, the data bank contained 57,793 reports. Of these reports, 48,435 are for medical malpractice payments and 9,358 are for adverse actions including those pertaining to licensure (6,729), clinical privileges (2,523), and professional society membership (106).

In addition to setting up the data bank, the Congress took steps to try to protect Medicare and Medicaid patients from practitioners whose licenses were revoked or suspended by another state's licensing board because they did not meet minimum professional standards. The 1987 legislation authorized the Department of Health and Human Services to establish national exclusions from Medicare and Medicaid of practitioners who are excluded from either program, convicted of crimes involving federal or nonfederal programs, or disciplined by state licensing boards. The Department has decided to include data regarding state disciplinary licensure actions under this act in the data bank. In fiscal year 1992, Peer Review Organizations took the punitive approach of recommending that the Department of Health and Human Services exclude a physician from further participation in the Medicare and Medicaid program 14 times.

THE COMPENSATION SYSTEM FOR  
THOSE INJURED BY MEDICAL  
NEGLIGENCE NEEDS IMPROVEMENT

In addition to addressing negligent medical practices, the system for compensating patients injured by negligent practices needs to be improved. There is widespread agreement that the current system is neither efficient nor equitable. Claims take a long time to be resolved, legal costs are high, and settlements and awards are unpredictable. Further, there are concerns about whether the system serves as a deterrent to the negligent practice of medicine.

Since the mid-1970s, every state has revised its tort system to address the medical malpractice insurance problem. Despite these reforms, it continues to take a long time for claims to be resolved and the cost of resolving them is high.<sup>4</sup> Our work showed that, for claims closed in 1984, it took an average of 25 months, with a range of up to 11 years, from the date a claim is filed until final resolution. Also, insurers paid \$800 million to investigate and defend claims closed in 1984. Such costs were in addition to the companies' total claim payments of \$2.6 billion.

Concerning the equity of the system, studies have shown that only a small proportion of injuries due to malpractice result in

---

<sup>4</sup>Medical Malpractice: A Framework for Action (GAO/HRD-87-73, May 20, 1987).

claims or lawsuits. Harvard researchers have corroborated the findings of previous research that many claims are not being filed even though they may be justified. Specifically, the Harvard study pointed out that only 1 of 8 patients admitted to New York hospitals in 1984 who suffered injury from negligence filed a claim. About 16 times as many patients suffered an injury from negligence as received compensation through the New York tort system. Thus, the tort system does not reach many individuals who are injured by medical negligence.

In addition, we found that even when a claim is successfully pursued, a large proportion of claim proceeds do not go to the injured parties. In over half the claims that were closed in 1984, plaintiff legal fees exceeded 30 percent of the payments to the injured party. Plaintiffs, in addition to their attorney fees, were responsible for paying other expenses, such as court costs and the costs of obtaining evidence.

Finally, questions have been raised as to whether the tort system actually provides an effective deterrent to malpractice. One of the system's fundamental objectives is to deter negligent behavior by requiring parties causing injury through negligence to pay damages to the injured patients. However, in regard to medical malpractice, health care providers' liability insurance may insulate them from most of the financial effects of their negligent behavior. Moreover, malpractice insurance companies do not generally vary rates based on an individual physician's claims experience, and most premium costs are ultimately borne by consumers, insurers, and the public sector. This further reduces the deterrent effect.

#### MALPRACTICE CONTINUES TO AFFECT THE PRACTICE OF MEDICINE

The high cost of malpractice insurance and the threat of litigation have affected how providers deliver care to their patients. But views differ on the extent to which these changes improve the quality of medical services provided, decrease the incidence of negligent medical practice, or unnecessarily add to the cost of delivering health care.

As the quality of care delivered by institutions and individuals has become more closely monitored, some believe providers have become increasingly defensive. Placing greater emphasis on not making mistakes, providers may be performing additional tests and treatment procedures, giving more attention to increased medical recordkeeping, spending more time with patients explaining alternative treatments, obtaining patients' informed consent, and refusing to treat certain high-risk patients. Some of these actions may, in fact, be desirable. But when defensive medicine results in providers' performing unnecessary procedures or

limiting services to high-risk individuals or underserved groups, the effect is undesirable.

The extent to which physicians practice defensively is unknown and estimates of the costs of such practices vary. The American Medical Association estimated that in 1989, costs associated with physician defensive medicine practices were about \$15.1 billion. Much higher estimates have been cited in both the general media and medical publications.

Quality Assurance Activities  
Helpful in Reducing the Potential  
for Malpractice

Concerns about the threat of malpractice claims and associated financial losses have been a motivating force in the development of quality assurance activities. Among the many activities being carried out to help assure that the quality of health care remains high are two that could be particularly helpful in reducing the potential for medical malpractice--the refinement of risk management activities and the development of practice guidelines.

Risk management programs were initiated in the 1970s to reduce the potential for medical malpractice in hospitals. They are used by hospital management to identify, assess, and reduce areas of practice where patients are at highest risk of injury. Many organizations that deal directly or indirectly with hospitals believe that risk management helps reduce the incidence of malpractice and are taking an active role to either require or encourage the implementation of risk management programs or functions. These organizations include the Joint Commission on Accreditation of Healthcare Organizations, several states, insurance companies, and the Department of Health and Human Services. The American Medical Association, numerous medical specialty societies, and other elements of organized medicine are also involved in promoting the use of risk management in physician offices.

Although there is little direct evidence showing that implementing hospital risk-management programs reduces the number of accidents and malpractice claims, a study of acute-care general hospitals in Maryland reported that in-hospital educational programs targeted toward physician and nurse

responsibilities in quality-assurance and risk-management activities correlated with fewer paid claims against hospitals.<sup>5</sup>

In addition to risk management programs, practice guidelines can help improve the quality of care provided to patients. Practice guidelines assist physicians in determining how diseases, disorders, and other health conditions can most effectively be prevented, diagnosed, treated, and clinically managed. They can also assist physicians in their efforts to improve service to patients, avoid unnecessary patient injury, and reduce the frequency of litigation. The American College of Physicians has been a strong proponent of their development and, along with other advocates, believes that their use has resulted in fewer malpractice claims and lower insurance premiums. Developing these guidelines is a complex process that requires considerable consensus-building among practitioners within individual medical specialties. It will be some time before their full impact can be assessed.

#### EFFORTS TO ADDRESS PROBLEMS

States' primary response to malpractice problems has been tort reform. However, some states and private sector organizations have initiated other efforts to address the problems associated with an inefficient and inequitable compensation system and the adverse effects on the way physicians practice medicine. Four that are getting the greatest amount of attention are risk management at the Harvard medical institutions, the use of practice guidelines in Maine, fault-based alternatives to litigation in several states and some health maintenance organizations, and no-fault alternatives to litigation in Virginia and Florida.

#### States Enact Tort Reforms to Reduce Malpractice Insurance Costs

For the most part, tort reforms have been designed to reduce the rate of increase in medical malpractice insurance premiums by reducing the number of claims filed and the size of malpractice awards and settlements. Empirical studies suggest that some tort reforms have achieved these objectives. The following three reforms are noteworthy:

- A reform that caps either the total award or the portion of the award that goes to compensate such noneconomic

---

<sup>5</sup>Laura L. Morlock and Faye E. Malitz, "Do Hospital Risk Management Programs Make a Difference?: Relationships Between Risk Management Program Activities and Hospital Malpractice Claims Experience," Law and Contemporary Problems, Duke University School of Law, Vol. 54, Number 2, Spring 1991.

losses as pain and suffering, reduces the size of awards and settlements.

- A reform of the collateral source rule prohibits claimants from receiving payment through the malpractice system for economic losses resulting from the injury if such losses have already been compensated from other sources such as health insurance or disability insurance. Because economic losses constitute such a major portion of awards, limiting their double recovery reduces the potential size of the award and settlement, making it less attractive to a plaintiff's attorney. As a result, collateral source reforms also have the effect of reducing the number of claims filed.
- A reform of the statute of limitations that shortens the length of time allowed for filing a malpractice claim reduces the number of claims filed.

Tort reform efforts have had some effect on the number of claims filed and the amounts of awards and settlements. In addition, they may have been a contributing factor in the reduction of malpractice insurance premiums in the late 1980s. However, this has been achieved at the expense of injured patients and, very likely, without improvement in the efficiency of the tort system.

Harvard's Aggressive Risk Management Effort Reduces Costs Associated With Anesthesia-Related Injuries

Although anesthesia mishaps are relatively few in number, when they occur, they generally result in injuries more catastrophic than those experienced in other specialties, and may, therefore, be quite costly in terms of personal and financial loss. Reductions of anesthesia-related losses in some malpractice insurance programs appear to correlate with involvement by anesthesiologists in risk management and loss prevention activities and with the implementation of risk management interventions such as development of clinical standards.

A study conducted at Harvard University-affiliated hospitals by the Risk Management Foundation of the Harvard Medical Institutions reported that following the implementation of an aggressive risk management program in anesthesia, costs

associated with anesthesia liability decreased and led to a marked reduction in malpractice insurance premiums for anesthesiologists.<sup>6,7</sup>

In 1983, the anesthesia chiefs from the Harvard teaching hospitals formed a risk management committee with a goal to minimize related accidents, errors, and patient injuries associated with anesthesia. The committee reviewed case summaries on prior malpractice claims provided by the Foundation. As a result of this review, the committee developed clinical standards for monitoring patients during anesthesia that were implemented throughout the Harvard system in the spring of 1985.

Following implementation of these standards, the average loss for anesthesia-related claims declined. For the period 1976 to 1985, the average anesthesia-related loss was about \$153,000. In the 33 month-period following implementation of the standards, the average cost per claim was about \$34,000. As a result, anesthesiologists in the Harvard system's insurance program saw their 1989 premiums cut by almost one-third over the previous year's rate.

The development of the anesthesia standards also helped to stimulate interest among other clinical departments, including obstetrics and radiology.

#### Maine Uses Practice Guidelines as a Strategy to Reduce Costs

Several states, including Vermont, Minnesota, and Maine, have turned to practice guidelines as one approach to reducing health care costs. Maine has progressed further than other states in developing and implementing the approach.<sup>8</sup>

Maine, like the rest of the country, was experiencing an alarming increase in the cost of health insurance. To respond to this problem, leaders in the state representing organizations that were affected by rising health care costs formed a coalition. The coalition was especially concerned about defensive medicine, which was identified as one of the factors leading to increased health care costs. Physicians' primary motivation for practicing

---

<sup>6</sup>James F. Holzer, "Liability Insurance Issues in Anesthesiology," International Anesthesiology Clinics, Vol. 27, No. 3, Fall 1989.

<sup>7</sup>James F. Holzer, "The Advent of Clinical Standards for Professional Liability," Quality Review Bulletin, Vol. 16, No. 2, Feb. 1990.

<sup>8</sup>Medical Malpractice: Alternatives to Litigation (GAO/HRD-92-28, Jan. 10, 1992)

defensive medicine is the uncertainty about the standard of care to which they will be held accountable if patients allege that injuries resulted from the physicians' failure to meet the acceptable standards of care. Fearing such allegations, physicians may be motivated to perform unnecessary tests and procedures to build a good record in the event they are sued for medical malpractice. The standard of care is usually established in court on a case-by-case basis through the testimony of expert witnesses.

The coalition believed that physicians could not be expected to change their practice patterns unless given some protection from litigation. They also believed that defensive medicine could be reduced and, ultimately, health care costs as well if (1) practice guidelines establishing the standard of care could be developed for some areas in which physicians most often practice defensive medicine and (2) physicians were given immunity from litigation when they practiced according to these guidelines.

Willing to give the concept a test, the Maine legislature established a 5-year demonstration project. Effective January 1, 1992, the standard of care is incorporated into law for 20 procedures in 4 specialties--obstetrics and gynecology, radiology, anesthesiology, and emergency medicine. Physicians choosing to participate in the demonstration project can use the guidelines as a legal or affirmative defense in a malpractice lawsuit. An affirmative defense in this context means that when a physician follows the practice guidelines, the physician has met the standard of care and thus there can be no negligence and no damages recovered.

Most of the state's physicians in the four specialties have signed up to participate. The guidelines have broad-based support among physicians because they participated in their development and the guidelines mirror those of their national medical specialty societies. Thus, nationally accepted standards of care are reflected in the Maine guidelines.

The Maine project shifts the focus to the question of compliance with the approved standard and away from determining the standard on a case-by-case basis using expert witnesses. Maine officials expect that by codifying the standard of care, physicians will know at the outset of patient encounters the standards to which they will be held legally accountable, thus eliminating their motivation to perform the unnecessary diagnostic tests and procedures that add to the cost of health care.

Legal issues surrounding this project will probably be litigated in the courts, including questions about whether restricting the use of guidelines to physicians in lawsuits is constitutional and whether expert witnesses can challenge the guidelines. Malpractice insurers are concerned that if the use of practice

guidelines as an affirmative defense is found to be unconstitutional, insurers may be held liable retrospectively for claims arising from care provided by the insured physicians.

States and Health Maintenance  
Organizations Turn to Arbitration  
as an Alternative to Litigation

Because of concerns about the efficiency and equity of the tort system for resolving medical malpractice claims and compensating injured parties, a number of states and health maintenance organizations have turned to fault-based alternatives to litigation--primarily, voluntary and mandatory arbitration.<sup>9</sup>

Under arbitration, neutral third parties or panels resolve disputes. While these decisionmakers usually operate with less formality than the courts, the legal principle is the same--an injured party must prove that a health care provider's negligence or fault caused the injury. Generally, parties to a dispute who choose arbitration for resolving claims do so voluntarily. However, some health maintenance organizations have mandated that subscribers use arbitration to resolve claims.

Voluntary binding arbitration

We found that while 15 states had implemented statutes specifically covering the voluntary arbitration of medical malpractice claims, only Michigan had any significant experience with the alternative. The Michigan legislature established the arbitration program because it believed arbitration would result in faster claims resolution and lower patient compensation payments and defense costs. They expected that this, in turn, would lead to lower malpractice insurance costs.

Michigan was unique among these 15 states in that it was the only one that (1) had a method to make patients aware of the arbitration option and (2) established a program to implement the statute's requirements. Yet, despite these efforts, few plaintiffs selected arbitration rather than litigation. We found that in the more than 14 years the program had been in effect, 882 medical malpractice claims had been filed for arbitration in Michigan compared to an estimated 20,000 claims that were filed for litigation.<sup>10</sup>

---

<sup>9</sup>Medical Malpractice: Alternatives to Litigation (GAO/HRD-92-28, Jan. 10, 1992)

<sup>10</sup>As of March 31, 1993, 985 medical malpractice claims had been filed for arbitration in Michigan's program.



It was difficult to determine the effect of arbitration on the malpractice claims resolution process in Michigan because of the limited (1) number of claims that were filed for arbitration and (2) data that were available on both arbitrated and litigated claims.<sup>11</sup> However, we compared claims that were litigated and arbitrated in 1987 and 1988. We found that while it took less time to resolve arbitrated claims--the median time from claim filing to claim closing was 19 months for arbitration and 35 months for litigation--there was little difference in insurance companies' costs to defend the claims. In addition, arbitrated claims resulted in lower award payments to patients. (Attachment II provides more data on the arbitrated and litigated claims closed during 1987 and 1988.) During this period, malpractice insurance costs did not decrease, perhaps because the number of claims arbitrated was small.

While arbitration is possible under statutes in 14 other states, none had a state-level program to assure that this alternative was offered to patients or to provide guidance, oversight, and documentation of arbitration activities. Interest group representatives we talked with indicated that arbitration appeared to be little used in these states.

#### Mandatory binding arbitration

Over 6 million enrollees at Kaiser Permanente and Ross-Loos accepted a mandatory arbitration provision as a condition of enrollment. While these health maintenance organizations would not provide detailed data on their malpractice claims experience, they indicated that they believe this alternative is successful because it results in faster claims resolution, lower defense costs, and more predictable and equitable decisions.

Plaintiffs in California challenged the (1) legality of requiring subscribers to health care plans to arbitrate claims and (2) constitutionality of an agreement that waives the right to a jury trial without express consent. However, the California supreme court found that such contracts were not illegal and did not violate the right to a jury trial.

#### Virginia and Florida Adopt No-Fault Programs to Address Rising Insurance Costs

In the 1980s malpractice insurance premiums were rising in Virginia and Florida, threatening the access to obstetrical care for some of their citizens. Many physicians could no longer afford to buy malpractice insurance. In some instances, such physicians stopped delivering babies. In addition, some insurers

---

<sup>11</sup>Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program (GAO/HRD-91-38, Dec. 27, 1990)

stopped writing new policies until the states took action to reduce the uncertainty and unpredictability of the risk associated with delivering seriously injured babies. To address these problems, both states enacted no-fault programs limited to resolving medical malpractice claims involving birth-related neurologically-injured infants.

No-fault programs are designed to remove the difficulty of proving that an injury resulted from a health care provider's negligence or fault. Generally, under the no-fault alternative, compensable injuries and compensation amounts are specified. After an injury has been established, it is not necessary to identify the cause.

In both the Virginia and Florida programs, claims involving neurologically-injured infants must be resolved through the no-fault process if (1) health care providers involved in the claims participate in the program and (2) the related injury meets the program's definition.

Virginia's program, which became effective in 1988, has had four claims filed as of May 14, 1993. Three have been accepted for compensation. The program has paid out less than \$60,000. In contrast, Florida's program, which became effective in 1989, has had 59 claims filed as of April 30, 1993. Twenty-two have been accepted for compensation. The program has paid out over \$3.5 million. A Florida program official stated that the requirement that hospitals and physicians provide information on the program's benefits has been a major factor contributing to the use of the program.

#### CONCLUSIONS

Mr. Chairman, as I have stated, costs for medical malpractice insurance and defensive medicine are higher in the United States than in other countries and undoubtedly contribute to our growing health care costs. Malpractice is more than an insurance problem. Providers may continue to practice substandard medicine without detection. Patients who are injured by health care providers' negligence, face a compensation system that is inefficient and inequitable. Providers, wary of their patients and the threat of lawsuits, may perform tests and procedures that are medically unnecessary.

The efforts I have discussed to address the problems associated with how patients are compensated and the way physicians practice medicine are still evolving. But, their experience to date provides insights that may be helpful as the Congress considers various malpractice reform proposals.

- Harvard's risk management program for anesthesia suggests that aggressive efforts to develop and implement clinical standards can reduce preventable injuries and death and reduce malpractice insurance costs.
- The practice guidelines demonstration project in Maine is a significant test of the viability of the concept of incorporating standards of care into law for application in medical malpractice lawsuits. Maine's ability to get the project implemented suggests the importance of using voluntary, physician-generated--rather than government-generated--standards for judging physicians' clinical performance.
- Michigan's experience suggests that when voluntary alternative systems operate parallel to litigation--they tend not to be selected. Further, there appears to be little potential for increasing participation in the Michigan program because it offers few incentives for patients to chose arbitration over litigation. When mandatory arbitration is linked to the provision of health care, as is done by some health maintenance organizations, experience suggests that it is an acceptable alternative to litigation.
- While the Virginia and Florida programs are relatively new, their establishment is an important beginning in testing a system that provides compensation to patients when a specific injury occurs without having to prove that the provider was negligent. Further, their experience suggests that it is possible to structure a program that defines an event broadly enough to include the intended injuries, while defining it narrowly enough to control costs.

Mr. Chairman, the implications of medical malpractice are far reaching. No matter what approach is taken, reform of the malpractice system should address the fundamental issues of (1) reducing the incidence of negligent care, (2) fairly compensating individuals injured through medical negligence, and (3) dealing with the complexities involved in efforts to enhance the overall quality of care provided in this country.

- - - - -

This concludes my prepared statement. We will be pleased to respond to your questions.

MALPRACTICE INSURANCE PREMIUMS  
ST. PAUL INSURANCE COMPANY  
FOR SELECTED SPECIALTIES, AREAS, AND YEARS<sup>a</sup>

	1988	1989	1990	1991	1992	1993
<b>Obstetrics</b>						
Chicago	\$156,580	\$155,510	\$155,512	\$146,338	\$140,561	\$144,516
Minnesota	57,130	42,330	35,461	29,232	21,410	21,410
North Carolina	20,620	16,270	16,275	16,183	19,038	21,012
<b>Neurosurgery</b>						
Chicago	197,330	195,950	195,952	193,327	185,775	190,990
Minnesota	71,870	53,290	44,567	38,485	29,101	29,101
North Carolina	25,900	20,400	20,402	21,237	25,187	27,644
<b>General Practice (No surgery)</b>						
Chicago	20,110	20,050	20,053	21,106	23,089	23,769
Minnesota	7,560	5,720	4,888	4,547	3,883	3,883
North Carolina	2,900	2,350	2,352	2,642	3,377	3,701

<sup>a</sup>Premiums shown are for coverage of \$1 million per occurrence and \$1 million in aggregate for a policy year.

COMPARISON OF AWARD PAYMENTS, RESOLUTION TIMES, AND COSTS TO DEFEND  
FOR ARBITRATED AND LITIGATED CLAIMS CLOSED DURING 1987 AND 1988

Table II.1: Award Payments for Arbitrated and Litigated Claims

	Number of claims		Award payments <sup>a</sup>			
	Total	Paid	Median	Average	Range	
Disposition	Total	Paid	Median	Average	Lowest	Highest
Arbitration	65	14	\$43,120	\$135,591	\$1,500	\$ 605,161
Litigation	471	85	69,500	148,862	767	1,600,000

<sup>a</sup>Excludes claims where payment was \$0.

Table II.2: Resolution Times for Arbitrated and Litigated Claims

Disposition	Number of claims <sup>b</sup>	Months to resolve <sup>a</sup>			
		Median	Average	Range	
				Lowest	Highest
Arbitration <sup>c</sup>	65	19	26	8	105
Litigation	438	35	37	3	123

<sup>a</sup>Represents months from claim filing to claim closing.

<sup>b</sup>Does not include 33 litigated claims for which data were missing and could not be obtained.

<sup>c</sup>Michigan statute established a 6-month discovery period for arbitrated claims.

Table II.3: Costs to Defend Arbitrated and Litigated Claims

		Defense costs <sup>a</sup>			
				Range	
Disposition	Number of claims <sup>b</sup>	Median	Average	Lowest	Highest
Arbitration	53	\$17,509	\$23,509	\$1,348	\$98,273
Litigation	462	17,798	20,202	47	78,997

<sup>a</sup>Defense costs represent the costs reported by defense attorneys and insurance companies at the time the claim was closed.

<sup>b</sup>Does not include 12 arbitrated and 9 litigated claims for which data were missing and could not be obtained.

---

### Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are \$2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

**Orders by mail:**

**U.S. General Accounting Office  
P.O. Box 6015  
Gaithersburg, MD 20884-6015**

**or visit:**

**Room 1000  
700 4th St. NW (corner of 4th and G Sts. NW)  
U.S. General Accounting Office  
Washington, DC**

**Orders may also be placed by calling (202) 512-6000  
or by using fax number (301) 258-4066.**

---

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

**Official Business  
Penalty for Private Use \$300**

<p><b>First-Class Mail Postage &amp; Fees Paid GAO Permit No. G100</b></p>
--