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Report to Congressional Requesters

December 1990

MEDICAL MALPRACTICE

Few Claims Resolved Through Michigan's Voluntary Arbitration Program

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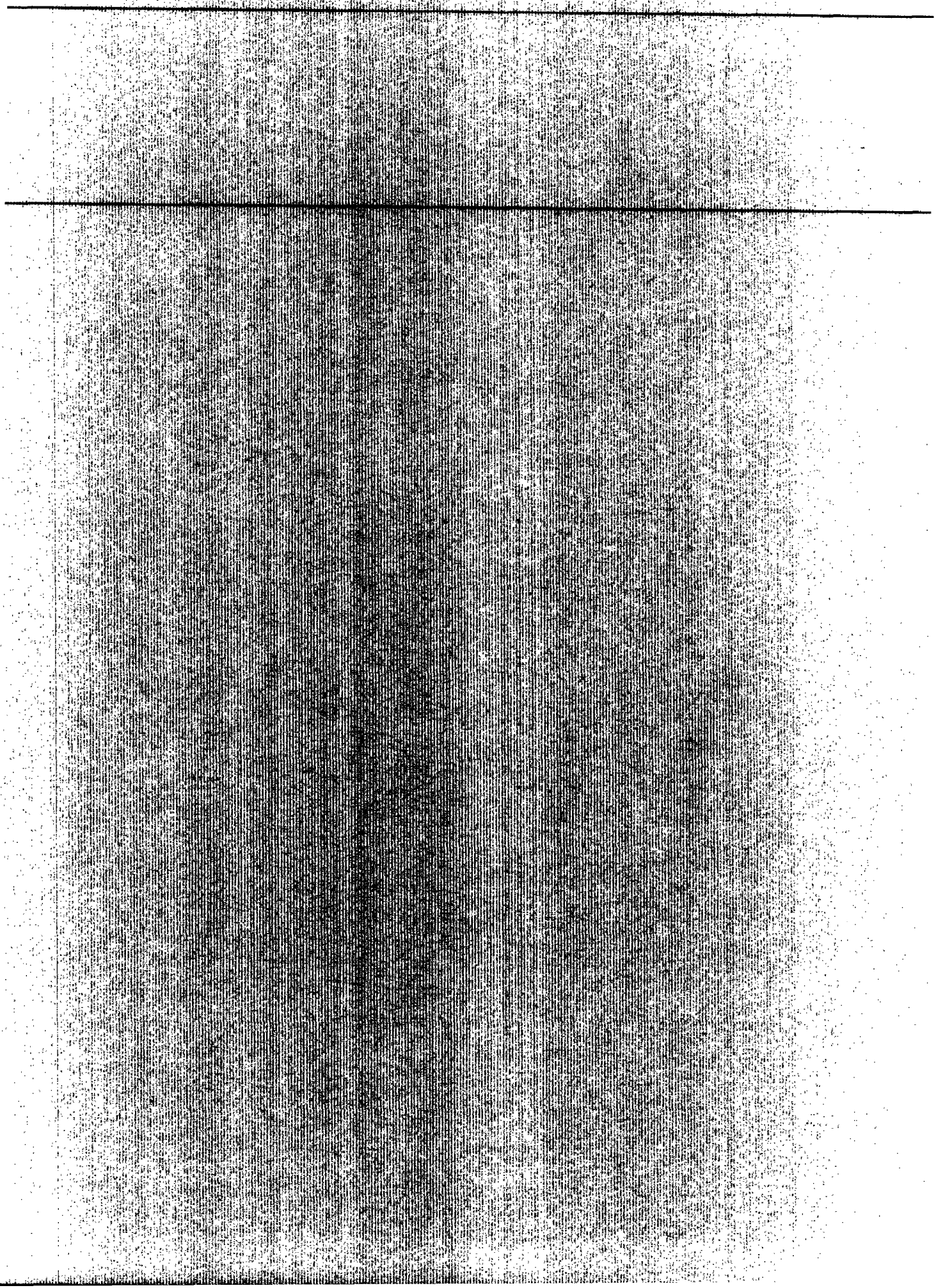

GAO

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General Accounting Office
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Human Resources Division

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December 27, 1990

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Willis D. Gradison, Jr.
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Nancy L. Johnson
House of Representatives

The Honorable Sander M. Levin
House of Representatives

The present methods for resolving medical malpractice claims in the United States are neither efficient nor equitable. Claims take a long time to be resolved; awards and settlements are unpredictable; and legal costs are high.[1] Malpractice claims are heard primarily in the state courts, and a plaintiff must establish that the injury was the fault of the health care provider. Concerns about the present methods have inspired various proposals for alternative approaches to resolving claims. These proposals include both fault-based and no-fault-based approaches. Some of these alternative approaches are as yet untested; states have implemented others.

This report responds to your request that we review one of the fault-based alternatives—the Michigan Medical Malpractice Arbitration Program. As agreed with your staffs, we assessed the Michigan program to determine (1) the extent of hospital, health care provider, and patient participation,[2] (2) the arbitration alternative's effect on medical malpractice claims resolution, and (3) whether arbitration contributed to

[1]Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55, Apr. 22, 1987). Medical Malpractice: A Framework for Action (GAO/HRD-87-73, May 20, 1987). Medical Malpractice: A Continuing Problem With Far-Reaching Implications (GAO/T-HRD-90-24, Apr. 26, 1990).

[2]Under Michigan's Medical Malpractice Arbitration Act of 1975, which established the program, "hospital" means a person, partnership, or corporation lawfully engaged in the operation of a hospital, clinic, health maintenance organization, or sanitarium. "Health care provider" means a person, partnership, or corporation lawfully engaged in the practice of medicine, surgery, dentistry, podiatry, optometry, chiropractic, or nursing, or a person dispensing drugs or medicines.

reducing medical malpractice insurance costs. As further agreed, we focused our malpractice claims resolution analysis on data for 1987 and 1988—the most current data available at the time of our review.

Other alternative claims resolution approaches will be discussed in a separate report. We are reviewing various approaches to respond to the mandate of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239).[3]

Background

The arbitration program, established by Michigan's Medical Malpractice Arbitration Act of 1975, resolves claims through a voluntary binding arbitration process, rather than through a court trial (litigation).[4] The Michigan legislature established the arbitration program because they 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.

The Michigan act requires that at or near the time of treatment, hospitals insured by companies licensed to write malpractice insurance in Michigan must offer patients the opportunity to sign agreements to arbitrate any future dispute, controversy, or issue arising out of the care or treatment provided. At these hospitals, all personnel—including health care providers practicing there—must also have future claims arbitrated if the patient accepts the hospital's offer. Although they are not required to do so, self-insured hospitals and health care providers engaged in private practice may also offer patients arbitration agreements.

Patient participation in Michigan's program is voluntary. Arbitration agreements that patients sign with hospitals generally cover a single admission and may be revoked within 60 days of discharge. Agreements signed with physicians and other health care providers (including hospitals for outpatient treatment) cover treatment over a 1-year period, but

[3]Public Law 101-239 requires GAO to study alternative resolution procedures for malpractice claims involving services provided through Medicare. The act states that the study must examine the feasibility of establishing no-fault payment procedures or using mandatory arbitration to resolve malpractice claims.

[4]Arbitration is a fault-based alternative to the use of the courts in resolving medical malpractice claims. It involves submitting a dispute between parties to persons, selected by law or agreement, for resolution. The use of arbitration may be voluntary or compulsory, and the arbitration decisions may be nonbinding or binding. Arbitration panels operate with less formality than courts, but the legal principles applicable to the courts govern the decisions in that liability is established only upon finding that the injury was due to the health care provider's negligence or fault.

may be revoked within 60 days of signing. Patients who do not sign agreements when first offered may later request arbitration if a malpractice claim arises. Those who sign and do not revoke arbitration agreements within the permitted time frame relinquish their right to a court trial.

A three-member arbitration panel, rather than a judge or jury, hears the case and makes the decisions on provider fault and patient compensation. The panel consists of a health care provider, an attorney, and a lay person. All parties to a dispute participate in panel selection and have up to 6 months to complete discovery.[5] Plaintiffs and defendants may be represented before the panel by an attorney. Panel decisions are based on a majority ruling and are binding on all claimants and defendants. Unlike court decisions, which have many bases for appeal, panel decisions can be appealed only for the following reasons: (1) either a claimant or a defendant alleges fraud, (2) the panel exceeded its authority, or (3) the conduct of the hearing prejudiced the rights of a claimant or a defendant.

An 18-member advisory committee appointed by the Michigan Insurance Bureau provides policy guidance and oversight for the arbitration program. Until recently, the American Arbitration Association administered the program under contract with the bureau.[6] Annual assessments on insurance carriers licensed to write medical malpractice insurance in Michigan provide the contract funds. The assessments, based primarily on the volume of premiums written, totaled about $373,000 in fiscal year 1990.

Over the years, various aspects of the program have been challenged in state courts. For example, some have claimed that the Michigan act is unconstitutional because it (1) requires a health care provider to be on the panel and (2) deprives plaintiffs of the right to a court trial. The Michigan Supreme Court upheld the act with regard to both issues. Appendix I summarizes the issues and court decisions on the major legal challenges to Michigan's program.

Results in Brief

Few hospitals, health care providers, and patients have chosen to participate in Michigan's voluntary arbitration program. During the 13-year

[5]Discovery is a prehearing procedure to obtain information from the opposing party.

[6]Effective October 1, 1990, Arbitration Services, Inc., became the program administrator.

period between November 1976 and November 1989, plaintiffs filed about 800 claims for arbitration compared to an estimated 20,000 claims in which litigation was initiated. Because of the low participation, it is difficult to determine the program's overall effect on the state's medical malpractice claims resolution. However, for the claims we reviewed, arbitration had a positive effect on the timeliness of claims resolution. In 1987 and 1988, for example, the median time to resolve 65 arbitrated claims was less than that for 438 litigated claims.

Perhaps because of the low participation in the program, malpractice insurance premiums in the state have continued to increase since the legislature enacted the arbitration program, although at a decreasing rate since 1986. In contrast, national data indicate a decline in premium rates since about 1988. The primary insurers writing medical malpractice insurance for Michigan believe that the arbitration program has not contributed to reducing malpractice insurance costs or to slowing down the rate of increase. In addition, they believe that because of low participation, the arbitration program is not a significant factor in establishing insurance rates.

Representatives of medical, legal, insurance, and consumer interest groups believe program participation could be increased by providing economic incentives to patients and including arbitration agreements in health insurance plans.

Methodology

As the program administrator, the American Arbitration Association had maintained data on award payments[7] and processing times for all claims filed for arbitration since the program began. Since 1983, the Michigan Insurance Bureau required insurers to report data on award and settlement payments, processing times, defense costs, and severity of injury from closed litigated medical malpractice claims. However, some of these data were missing on some closed claims reports submitted. Because comparable data elements were not available for the entire time frame of the program for arbitrated and litigated claims, we focused our analysis on 1987 and 1988. For these years we reviewed the 65 claims closed through arbitration and the 471 resolved through litigation.

[7]Payment data maintained include awards made by arbitration panels and settlements on claims closed before a panel decision.

Initial data for this 2-year comparison were obtained from the bureau's records. To validate data and obtain missing data, we contacted defense attorneys and insurance carriers. GAO's Chief Medical Advisor reviewed the claims for which severity of injury had not been coded and classified the injuries using the insurance bureau's nine severity categories.

To identify characteristics of patients who signed arbitration agreements, we analyzed an automated data file containing information on the 3,296 patients discharged during July and August 1988 from a major Michigan hospital that offered arbitration.

We also met with 11 interest groups representing physicians, attorneys, hospital administrators, insurance carriers, and consumers familiar with Michigan's program. Using an interview guide, we obtained their views on the arbitration program, identified factors influencing participation, and discussed the program's effect on reducing medical malpractice insurance costs. Appendix II identifies the interest groups and organizations we interviewed.

We reviewed Michigan's Medical Malpractice Act and related program guidance, statistics on program participation, national and state malpractice insurance cost reports, and state court decisions pertaining to the program.

We conducted our review from September 1989 to June 1990 in accordance with generally accepted government auditing standards.

Voluntary Hospital, Health Care Provider, and Patient Participation Is Low

Few hospitals, health care providers, or patients choose to participate in the arbitration program. Under Michigan law, hospitals insured by companies licensed to write malpractice insurance in the state must offer arbitration agreements. Program participation is voluntary for the remaining hospitals and for physicians engaged in private practice. Statewide data on program participation levels for these groups are not available. However, Michigan Insurance Bureau and State Medical Society officials believe few hospitals or health care providers voluntarily choose to offer patients the opportunity to sign agreements to arbitrate future claims. This limits patient exposure to the program. In addition, when arbitration agreements are offered, few patients appear to choose to sign them or to actually arbitrate claims. Since the arbitration program was established, about 800 claims have been filed for arbitration, compared to about 20,000 claims in which litigation was initiated.

About Half of Michigan Hospitals Are Not Required to Participate

Many hospitals are not required to participate in the arbitration program. At the time of our review, 272 hospitals were licensed to operate in the state. Of these, about half were insured by companies licensed to write medical malpractice insurance in Michigan and, according to Michigan law, were required to offer arbitration agreements to patients. Statewide data on the voluntary participation of the remaining hospitals are not available. However, officials of the Michigan Insurance Bureau believe that few of these hospitals are voluntarily offering arbitration agreements.

Some hospitals see no apparent benefits to participating in the program. Interest group representatives cited the program's implementation and administration costs as the major factors affecting hospital administrators' decisions not to participate. While the arbitration program costs may not be large when compared to a hospital's total operating costs, several group representatives stated that generally, hospitals are not willing to incur any additional costs if they do not foresee an economic benefit. They emphasized that most hospitals are reluctant to devote resources to train personnel in offering the agreement and to establish and maintain additional records on these patients.

Few Physicians Participate Voluntarily

Michigan law does not require the 16,000 to 18,000 physicians engaged in private practice to offer patients arbitration agreements. The number of physicians voluntarily participating in the arbitration program is unknown, but officials at the Michigan State Medical Society believe that few physicians offer arbitration agreements to their patients.

Physician groups told us there are several reasons why physicians may not want to offer patients the opportunity to sign arbitration agreements. Arbitration agreements are to be offered to patients at or near the time of treatment. Discussing the possibility of malpractice with patients at this time may reduce their confidence in the physicians' competence. Discussing the possibility of malpractice also creates an uncomfortable situation for both the physician and the patient. Further, representatives of several groups pointed out that at the time of treatment, patients may be under emotional stress and unable to make informed decisions on whether to sign.

Few Patients Choose Arbitration

Few patients choose arbitration over litigation. The actual number of patients signing an arbitration agreement when it is offered is not known. At one major Michigan hospital, 3,296 discharged patients were

offered arbitration agreements during July and August 1988. Fifteen percent (482) of them signed an agreement. While a typical patient discharged was black, male, 65 years or older, and admitted for an emergency procedure, a typical patient signing an arbitration agreement was white, male, 51 to 64 years old, and admitted for an elective procedure. Appendix III shows the characteristics of patients who signed arbitration agreements.

Few medical malpractice claims have been arbitrated since the program was implemented. A total of 811 malpractice claims were filed for arbitration in the 13 years from November 1976 through November 1989. The number filed annually ranged from 19 in 1977 to 93 in 1984.[8] Fifty-eight claims were filed in 1988. Appendix IV shows the number of claims filed for resolution through the arbitration program by year. Although the actual numbers are unknown, Michigan attorney groups and insurance carriers estimate that litigation was initiated in about 20,000 claims since the arbitration program began. Many of the claims filed for arbitration were settled, withdrawn, or administratively closed.[9] As shown in table 1, of the 811 claims filed, arbitration panels decided 247, or about 30 percent.[10]

Table 1: Disposition of Claims Filed With Michigan's Medical Malpractice Arbitration Program From November 1976 Through November 1989

	Claims	
Disposition	**Number**	**Percent**
Withdrawn or administratively closed without hearings	198	25
Settled without hearings	310	38
Panel decisions[a]	247	30
Open	56	7
Totals	**811**	**100**

[a]59 for plaintiff with payment and 188 for defendant.

Several factors may contribute to low patient participation. Representatives of 8 of the 11 interest groups said that the lack of an appeal process contributes to low participation because patients who are dissatisfied with panel decisions generally have no further recourse.

[8]This comparison does not include the two claims filed in November and December 1976.

[9]Claims were administratively closed when there was a lack of progress or when the claim was suspended pending a supreme court determination of constitutionality questions.

[10]Of medical malpractice claims in which litigation was initiated in Michigan, an estimated 90 percent were withdrawn or settled and about 10 percent went to trial.

Further, many patients may believe the presence of a health care provider on the three-member panel creates a built-in bias favoring the defendant in a malpractice claim.

Attorneys' advice was another factor identified as influencing patients' decisions. Although not all patients contact attorneys, when they do, officials at interest groups representing both plaintiff and defense attorneys said that plaintiff attorneys often advise their clients either not to sign arbitration agreements or to revoke signed agreements. Patients may enter into arbitration agreements before they have full knowledge of the ramifications or complexities of their injuries, according to plaintiff attorney representatives. Attorney interest groups also indicated that individuals may be given insufficient or inaccurate information about arbitration at the time of offering.

Arbitration May Improve Timeliness of Claims Resolution

The small number of claims arbitrated makes it difficult to determine the program's effect on medical malpractice claims resolution in Michigan. While it appears that the arbitration alternative may have a positive effect on the timeliness of claims resolution when compared to litigation, the overall effect on patients is unclear.

Compared to litigated claims, claims arbitrated during 1987 and 1988 took less time and resulted in lower award payments. The percentages of claims resolved in the patients' favor were about 18 and 22 percent for litigated and arbitrated claims, respectively. Although arbitrated claims were resolved more quickly than litigated claims, there was little difference in insurance companies' costs to defend the claims. Analyses of awards paid, resolution times, and defense costs for arbitrated and litigated claims closed in 1987 and 1988 showed that

- arbitrated claims had a median payment of $43,120 compared to $69,500 for litigated claims;[11]
- the median time from claim filing to claim closing was 19 months for arbitrated claims compared to 35 months for litigated claims; and

[11]Excludes claims where payment was $0. Median payment amounts are based on 14 paid arbitrated and 85 paid litigated claims.

- insurers' median defense costs were $17,509 for arbitrated claims compared to $17,798 for litigated claims.[12]

Appendix V provides more detailed information for these data elements for claims closed during 1987 and 1988. Appendix VI shows data on award payments and resolution times for all arbitrated claims closed from November 1976 to November 1989.

Several interest groups suggested that patients with less severe injuries choose arbitration over litigation. As shown in table 2, there appears to be little difference between the two resolution types in how claims were distributed among the severity of injury categories.[13]

Table 2: Severity of Injury for Arbitrated and Litigated Claims Closed During 1987 and 1988

	Arbitrated claims		Litigated claims	
Severity of injury	**Number**	**Percent**	**Number**	**Percent**
Emotional only	1	2	13	3
Temporary insignificant	2	3	25	5
Temporary minor	16	25	75	16
Temporary major	2	3	28	6
Permanent minor	15	23	85	18
Permanent significant	14	22	78	17
Permanent major	2	3	46	10
Permanent grave	0	0	10	2
Death	8	12	108	23
Data not available	5	8	3	1
Totals	**65**	**101[a]**	**471**	**101[a]**

[a]Does not add to 100 percent due to rounding.

We also attempted to examine the difference in award payments between arbitrated and litigated claims relative to the severity of injury. However, we could not make a meaningful comparison of the size of

[12]Lawyers handling malpractice cases for plaintiffs usually do so on a contingency fee basis—the lawyer is compensated only if an award or settlement results in payment to the plaintiff. Generally, the attorney will get a percentage of the award. For claims with no award or settlement, the plaintiff must still pay for other expenses, such as court costs and the attorney's expenses for obtaining evidence.

[13]We tested this relationship using a Spearman's Rank Order correlation test. This test is appropriate when measuring the degree of association between two ordinal measures. In this case, we compared the degree of severity of injury between two types of claims resolution—arbitration and litigation. A high level of correlation between these two groups would indicate little difference in how claims were distributed among the different categories of injury severity, even though there were more litigated than arbitrated claims. We obtained a correlation coefficient of 0.83, which suggests that the severity of patients' injuries has little effect on whether they choose arbitration or litigation.

award within severity categories because only 14 arbitrated claims were paid.

Michigan Medical Malpractice Insurance Costs Continue to Increase

Malpractice insurance costs in Michigan have continued to increase, although the state legislature believed that voluntary arbitration would decrease insurance costs because claims would be resolved more quickly with lower award payments and defense costs.[14] As discussed above, arbitrated claims were resolved faster with lower payment amounts. However, perhaps because the number of claims arbitrated has been small, malpractice insurance costs have not decreased.

Representatives of insurance carriers in Michigan believed that the state's arbitration program has not contributed to reducing malpractice insurance costs or to slowing down the rate of increase. They also said the arbitration program is not a significant factor in establishing insurance rates because too few claims have been arbitrated. Over the program's life through 1986, malpractice insurance premiums in Michigan continued to increase, paralleling trends for the nation and adjacent states. However, data for the nation and adjacent states show a decline in premium rates since about 1988, while Michigan rates have continued to increase, although at a slower rate since 1986. Appendix VII shows data on rates of change in malpractice insurance premiums for Michigan compared to the nation and Ohio and Illinois from 1979 through 1989.

Suggestions Made for Increasing Participation

Interest groups were not optimistic that future program participation would increase significantly unless changes were made. Several groups made the following suggestions for increasing participation in Michigan's program: (1) provide economic incentives to individuals in the form of health care premium reductions and (2) incorporate in health care plans agreements to arbitrate any disputes arising from health care services provided under the plan.

Several groups believed that arbitration program participation would increase if patients were provided some type of economic incentive to take part. According to officials at one major insurance carrier, reducing

[14]Medical malpractice insurance costs are influenced by several factors, including the number of claims filed, the amount of awards, the time required to resolve claims, and the costs associated with defending claims. Factors that also affect malpractice insurance premiums include administrative expenses, marketing costs, investment income, taxes, profits, extent of state regulation, and amount of competition in the market.

individuals' health care plan premiums would be the incentive needed to increase patient participation.

Incorporating mandatory arbitration agreements as part of individuals' health care plans would significantly increase program participation by both patients and health care providers, according to groups representing physicians. By selecting the health care contract that included arbitration, patients would have a better understanding of the arbitration agreement and would be less threatened by it.

Conclusions

Because arbitration program participation has been low, we cannot determine whether arbitration has improved malpractice dispute resolution or has contributed to reducing medical malpractice insurance costs in Michigan. A meaningful determination cannot be made until program participation is significantly increased. We do not see any immediate potential for increased program participation because of the voluntary nature of the program and the lack of incentives for patients to participate.

We discussed the contents of this report with Michigan officials and incorporated their comments where appropriate. As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Michigan Insurance Bureau, the American Arbitration Association, Arbitration Services, Inc., and other interested parties, and we will make copies available to others on request.

Please call me on (202) 275-5451 if you or your staffs have any questions about this report. Other major contributors are listed in appendix VIII.

Janet L. Shikles

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Director, Health Financing
and Policy Issues

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Major Legal Challenges to Michigan's Medical Malpractice Arbitration Program

To avoid arbitration, plaintiffs (patients) challenged the enforceability of signed arbitration agreements. As a result, Michigan's Medical Malpractice Arbitration Act, Mich. Stat. Ann. § 27A.5040 (1988), was the subject of numerous suits in Michigan state courts. Generally, these challenges fall into three broad categories: (1) constitutional issues, (2) contractual issues, and (3) statutory construction issues.

Constitutional Issues

Plaintiffs and their attorneys raised two major constitutional issues. First, they questioned whether including a health care professional on the arbitration panel—which is required by the act—violates the patient's constitutional right to due process. Second, they questioned whether the patient's waiver of a right of access to the courts when signing an arbitration agreement must be "voluntary, knowing, and intelligent," as the U.S. Supreme Court decided when dealing with waiver of rights in criminal proceedings.

Composition of Arbitration Panel

The issue of the constitutionality of the panel composition caused a split in the appellate courts of Michigan. The Michigan Supreme Court resolved this issue in 1984. In the cases comprising Morris v. Metriyakool, 418 Mich. 423, 344 N.W.2d 736 (1984), plaintiffs argued that the composition of the arbitration panel presented too high a probability of bias to be constitutionally tolerable. Plaintiffs believed that the medical member of the arbitration panel has such an interest in the outcome that there is too great a risk that this member will not be impartial. Plaintiffs also alleged that many doctors had an "anti-plaintiff" attitude.

Plaintiffs submitted affidavits of malpractice insurance underwriters stating that hospital administrators and physicians would have a direct and substantial interest in the outcome of arbitrated cases because the cost and availability of medical malpractice insurance would be affected. Also, half of the committee that selects the pool of arbitration panel candidates consists of malpractice insurance carriers and health care providers, who have a direct interest in reducing the number and size of malpractice awards. Plaintiffs believed that failing to inform

patients of the panel composition and selection process for the candidate pool violated their right to due process.[1]

In Morris, the Michigan Supreme Court found that the panel composition did not violate the federal and state constitutions because the plaintiffs showed no actual bias by a particular arbitration panel. Nor did the plaintiffs show that medical professionals had a direct or substantial interest in the outcome of the controversy. The court was looking for an economic or monetary interest that would create a probability of unfairness. Plaintiffs failed to prove that the panel would not act with honesty and integrity.

The decision in Morris was not unanimous. Of the six judges participating in the case, five agreed that the act was constitutional. However, three judges reached that result because they found that the act met the basic requirements of due process. Two other judges reached the result that the act was constitutional because the arbitration agreements did not involve "state action" as required by the due process clause of the 14th Amendment to the Constitution. These judges believe that the court was required to determine whether private action—arbitration pursuant to the act—rose to the level of state action so as to make the due process clause applicable. They found that it did not. The sixth judge dissented, finding that the act was unconstitutional because it deprived plaintiffs of a fair hearing before an impartial decisionmaker.

Waiver of Right to Trial by Judge or Jury—Burden of Proof

The Michigan Supreme Court also addressed whether arbitration deprives plaintiffs of the right to a jury trial and access to courts. A patient contractually agrees to arbitrate any claims against health care providers by signing an arbitration agreement. The agreement precludes access to the court system for trial and severely limits appeal rights. The issue raised the question of who must prove that the arbitration agreement (with its consequent waiver of the right to a trial by judge or jury) was made "voluntarily, knowingly, and intelligently." The plaintiffs argued that a waiver cannot be "voluntarily, knowingly, and intelligently" made when the agreement does not highlight the waiver, fails to disclose the composition of the arbitration panel, and fails to disclose that the attitudes of health care providers may be biased.

[1]The 14th Amendment to the U.S. Constitution states, "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." The Michigan Constitution provides, "No person shall be . . . deprived of life, liberty or property, without due process of law." Const. 1963, art. 1, § 17.

A Michigan appellate court held in Moore v. Fragatos, 116 Mich. App. 179, 321 N.W.2d 781 (1982), that to be a "knowing" waiver, the patient must be informed that (1) by signing the agreement he or she gives up the right to a court trial by a jury or judge, (2) the arbitration panel is composed of an attorney, a layman, and a health care provider or administrator, and (3) doctors and hospital administrators on panels have an incentive to minimize the number and size of malpractice awards because the awards directly affect their insurance rates. The Moore court and other Michigan appellate courts derived their standard of a "voluntary, knowing and intelligent" waiver from U.S. Supreme Court cases dealing with waiver of rights in criminal proceedings. See, e.g., Brady v. United States, 397 U.S. 742 (1970); Miranda v. Arizona, 384 U.S. 436 (1966).

This issue was settled by the Michigan Supreme Court in McKinstry v. Valley Ob-Gyn Clinic, P.C., 428 Mich. 167, 405 N.W.2d 88 (1987). The court declined to "infuse constitutional concerns equivalent to those in a criminal proceeding into a civil litigant's contractual choice-of-forum decision." Thus, the court found that signing an arbitration agreement, which has the effect of waiving a court trial, does not deprive the patient of a fundamental constitutional right. The court noted that the act contains safeguards to ensure fairness—the patient must be given an information booklet and a copy of the agreement, there is a 60-day revocation period, and boldface type in the agreement explains that medical treatment does not depend on an arbitration agreement.

The Michigan Supreme Court also held in Morris that the burden of avoiding the arbitration agreements rests with those who would avoid them—primarily the patients. Thus, to avoid arbitration, a plaintiff bears the burden of proving that there is a legitimate ground for invalidating the contract. Contract law principles apply even though the contract itself involves the waiving of a constitutional right.

Because of the statutory presumption of validity in the act, an agreement is presumed valid if the act's requirements are met. The Michigan courts closely examine whether the arbitration agreements are executed in strict compliance with the act. For example, failure to provide the patient with a copy of the arbitration agreement or with an information booklet will allow the arbitration agreement to fail. McKain v. Moore, 172 Mich. App. 243, 431 N.W.2d 470 (1988).

Contractual Issues

Some patients tried to avoid enforcement of the arbitration agreements by arguing that the agreements are adhesion contracts or are unconscionable and therefore enforcement is against public policy.

Adhesion contracts imply a grave inequality of bargaining power. They are characterized by standard printed forms prepared by one party that are presented to a second party without the opportunity for bargaining. Usually, the desired product or service cannot be obtained except by signing the form agreement. In Morris, the Michigan Supreme Court found that arbitration agreements were not adhesion contracts because patients can rescind the agreements within a certain period and can obtain the service whether or not they sign.

The court also decided whether arbitration agreements are unconscionable in Morris. Unconscionability in contracts generally means an absence of meaningful choice in which the contract terms unreasonably favor one party.[2] Plaintiffs argued that the arbitration agreements were unconscionable because they did not explicitly state that patients waive a right to a jury trial when they sign the agreement. By not specifically stating this fact, the plaintiffs believed that health care providers were in effect fraudulently concealing the fact from the patients. Plaintiffs also argued that the arbitration agreements were unconscionable because they failed to disclose the (1) composition of the panel, (2) attitudes of physicians, (3) fact that the medical member may be intrinsically biased against plaintiffs, and (4) reasonable probability that malpractice rates are affected by awards in medical malpractice cases.

The court in Morris rejected all these arguments. It also found that the essence of the agreement is arbitration and that no ordinary person signing the agreement could reasonably expect a jury trial.

Statutory Construction Issues

The Michigan courts also interpreted several of the act's provisions, including clauses addressing (1) revocation, (2) minor children, and (3) emergency care. These are discussed below.

Revocation Clause

Under the act, a patient may revoke an agreement to arbitrate within 60 days after discharge from a hospital or within 60 days of signing an

[2]An unconscionable bargain has been defined as one "such as no man in his senses and not under delusion would make on the one hand, and as no honest and fair man would accept on the other." Earl of Chesterfield v. Janssen, 2 Ves. Sr. 125, 155, 28 Eng. Rep. 82 (1750), as quoted in Hume v. United States, 132 U.S. 406, 411 (1889).

agreement with a health care provider. Mich. Stat. Ann. §§ 27A.5041(3), 27A.5042(3). Revocation and the 60-day period in which it is permitted have been the subject of numerous suits.

Some cases interpreted when the 60-day revocation period begins. For example, a patient's death in a hospital does not mean that he or she was "discharged" within the meaning of the statute. Appellate courts have not consistently interpreted when the 60-day period begins for representatives of the deceased. In DiPonio v. Henry Ford Hosp., 109 Mich. App. 243, 311 N.W.2d 754 (1981), the court held that the 60-day period does not begin until the appointed representative discovers the arbitration agreement—a so-called "discovery" rule. But in Boiko v. Henry Ford Hosp., 110 Mich. App. 514, 313 N.W.2d 344 (1981), a legal representative of a patient who died while undergoing medical treatment has 60 days from the date of appointment as representative to revoke any arbitration agreements. This is called the "disability" standard because it follows the disability standard found in the Michigan statute of limitations.

In one case, a comatose patient's spouse filed a malpractice action against the health care provider. The court held that the filing of the suit was notice of revocation and that it was filed even before the 60-day period began. The 60-day period runs from the date the "disability" of the comatose patient was removed—when the patient is capable of making a knowledgeable decision. Amwake v. Mercy-Memorial Hosp., 92 Mich. App. 546, 285 N.W.2d 369 (1979). In another case, a court interpreted the term "legal representative" to mean the husband of a comatose wife, even though he was not formally appointed by a court. Edwards v. St. Mary's Hosp., 135 Mich. App. 753, 356 N.W.2d 255 (1984).

In another case, Brintley v. Hutzel Hosp., 181 Mich. App. 566, 450 N.W.2d 79 (1989), an appellate court found an arbitration agreement between a hospital and a patient invalid because the revocation notice said revocation was permitted within 60 days of execution of the agreement, not within 60 days of the date of discharge from the hospital, as the act states.

The Michigan appellate courts also found that arbitration agreements are enforceable even if the patient is only semiliterate or does not fully understand the agreement. Horn v. Cooke, 118 Mich. App. 740, 325 N.W.2d 558 (1982). In addition, the agreement is enforceable if the

patient fails to read it. Feinberg v. Straith Clinic, 151 Mich. App. 204, 390 N.W.2d 697 (1986).

Minor Children Clause

Also challenged was the provision binding minor children to an arbitration agreement executed by their parents or legal guardians. Mich. Stat. Ann. § 27A.5046(2). In McKinstry, the issue was whether a mother could sign an arbitration agreement on behalf of an unborn child. The Michigan Supreme Court noted that although the provision departed from the common law rule that a parent has no authority to waive, release, or compromise claims by or against a child, common law may be changed by statute. An appellate court also found that the provision did not violate the equal protection clause of the constitution because age is not a "suspect classification"[3] and the plaintiff did not meet the burden of showing that the classification was arbitrary with no reasonable justification. Crown v. Shafadeh, 157 Mich. App. 177, 403 N.W.2d 465 (1986).

Emergency Care Clause

The act provides that "A person receiving emergency health care or treatment may be offered the option to arbitrate but shall be offered the option after the emergency care or treatment is completed." Mich. Stat. Ann. § 27A.5042(1). The Michigan courts have voided agreements where the emergency treatment was not provided before the arbitration agreement was presented for signature. May v. St. Luke's Hosp., 139 Mich. App. 452, 363 N.W.2d 6 (1984).

The fact that the care is provided in the emergency room does not necessarily mean that the emergency room exception applies. McKain v. Moore, 172 Mich. App. 243, 431 N.W.2d 470 (1988), interpreted the meaning of "emergency" care or treatment. In McKain, the patient came to a hospital emergency room complaining of shoulder pain. Allegedly the patient was presented with and signed an arbitration agreement before the hospital provided care. The shoulder was X-rayed and the emergency room physician diagnosed a pulled shoulder. The following day, another hospital physician reviewed the X-rays, diagnosed a defect

[3]In equal protection cases, different tests are applied depending on the facts of the case. If the interest is "fundamental" or the classification "suspect," the courts apply a strict scrutiny test requiring the state to show a "compelling" interest which justifies the classification. This is a heavy burden of justification. If the classification does not involve a suspect classification or fundamental interest, a "rational basis test" is usually used. There the burden is on the person challenging the classification to show it is without reasonable justification. 16B C.J.S. Constitutional Law §§ 714-16 (1985). A classification will stand unless it is shown to be "essentially arbitrary." Manistee Bank & Trust Co. v. McGowan, 394 Mich. 655, 668, 232 N.W.2d 636, 649 (1975).

or malignancy in the shoulder, and recommended that follow-up testing be done. The hospital did not notify the patient. The patient subsequently died of osteosarcoma—a generally malignant bone tumor.

The Michigan appellate court found the statutory phrase "emergency health care or treatment" ambiguous and interpreted it to mean treatment in which a delay would "endanger the life or health of a patient." Id. at 475. The court found that delaying this patient's treatment for the time needed to read an arbitration agreement and to decide whether to accept or reject it would not have endangered the patient's life or health. Thus, the court found that the patient did not receive emergency medical treatment within the meaning of the act and the emergency exception did not apply. The arbitration agreement was upheld. However, the court determined that the arbitration agreement did not cover medical action (or lack thereof) after the patient's discharge. Thus, the arbitration agreement did not include the health care provider's actions after the treatment date.

Miscellaneous Provisions

Michigan courts also examined some of the act's miscellaneous provisions. One issue examined was whether independent doctors who enter into arbitration agreements with hospitals are also covered by agreements between the hospitals and the patients. Mich. Stat. Ann. §§ 27A.5042(1), 27A.5041(1). When the Michigan Supreme Court confronted this question in Kukowski v. Piskin, 415 Mich. 31, 327 N.W.2d 832 (1982), reh'g denied, 417 Mich. 1103 (1983), the justices split evenly. Subsequently, lower courts have generally found that the arbitration agreements between patients and hospitals include independent physicians, even though the patient receives no notice as to which doctors have agreements with the hospital. Harte v. Sinai Hosp. of Detroit, 144 Mich. App. 659, 375 N.W.2d 782 (1985); Marciniak v. Amid, 162 Mich. App. 71, 412 N.W.2d 248 (1987).

Arbitration agreements have been found to include ordinary negligence and not just medical malpractice. For example, the arbitration agreement covers a patient falling out of a bed. Nemzin v. Sinai Hosp., 143 Mich. App. 798, 372 N.W.2d 667 (1985).

In interpreting the statutory provision pertaining to judgments, a Michigan appellate panel held that a prevailing party is entitled to interest from the date of the panel's judgment, not from the filing date, as is permitted for cases filed with the courts. Morgan v. Kamil, 144 Mich. App. 171, 375 N.W.2d 378 (1985).

It has also been held that whether the arbitration agreement was executed according to the act is a question for the courts, not for the arbitration panel. May v. St. Luke's Hosp., 139 Mich. App. 452, 363 N.W.2d 6 (1984). In the recent case of Campbell v. St. John Hosp., 434 Mich. 608, 455 N.W.2d 695 (1990), the Michigan Supreme Court reaffirmed this principle by finding that an agreement to arbitrate does not deprive a circuit court of jurisdiction to resolve a controversy. The arbitration agreement narrows a party's legal rights to pursue a particular claim in a particular forum. As a procedural matter, the supreme court has held that in the first response to the complaint, a health care provider must state that an arbitration agreement exists. If it is not done, either because the health care provider is unaware of its existence or for any other reason, the court will not later enforce the arbitration agreement. The health care provider waived his or her right to insist on adherence to the arbitration agreement by not asserting it at the proper time.

Interest Groups and Organizations GAO Interviewed

Consumer Group	American Association of Retired Persons
Insurance Carriers	Michigan Hospital Association Insurance Company Michigan Physicians Mutual Liability Company Physicians Insurance Company of Michigan
Hospital Organizations	Michigan Hospital Association Michigan Society of Hospital Risk Management
Legal Groups	Association of Defense Trial Counsel Michigan Trial Lawyers Association State Bar of Michigan
Physician Organizations	Michigan Association of Osteopathic Physicians and Surgeons Michigan State Medical Society

Characteristics of Patients Who Signed Arbitration Agreements and Were Discharged From a Major Michigan Hospital During July and August 1988

	Patients			
	Discharged		Signed arbitration agreements	
Characteristics	Number	Percent	Number	Percent
Race				
Black	1,782	54	188	39
White	1,491	45	289	60
Other	23	[a]	5	1
Sex				
Male	1,697	52	299	62
Female	1,599	48	183	38
Age[b]				
25 years or younger	257	8	29	6
26 to 50 years	1,031	31	150	31
51 to 64 years	855	26	158	33
65 years or older	1,152	35	145	30
Admission type				
Emergency	1,756	53	134	28
Elective	1,206	37	255	53
Readmission	299	9	90	19
Other	35	1	3	[a]
Totals	**3,296**	**100**[c]	**482**	**100**

[a]Less than 1 percent.

[b]Data missing for one discharged patient who did not sign an arbitration agreement.

[c]Discharged patient percentage for race does not add to 100 percent due to rounding.

Number of Claims Filed for Resolution Through Michigan's Medical Malpractice Arbitration Program by Year

Year	Claims	
	Number	Cumulative total
1976[a]	2	2
1977	19	21
1978	54	75
1979	86	161
1980	86	247
1981	75	322
1982	62	384
1983	31	415
1984	93	508
1985	67	575
1986	76	651
1987	57	708
1988	58	766
1989[b]	45	811
Total	**811**	

[a]The first claim was filed on November 30.

[b]Through November.

Comparison of Award Payments, Resolution Times, and Costs to Defend for Arbitrated and Litigated Claims Closed During 1987 and 1988

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

	Number of claims		Award payments[a]			
					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

[a]Excludes claims where payment was $0.

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

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

[a]Represents months from claim filing to claim closing.

[b]Does not include 33 litigated claims for which data were missing and could not be obtained.

[c]Michigan statute established a 6-month discovery period for arbitrated claims.

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

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

[a]Defense costs represent the costs reported by defense attorneys and insurance companies at the time the claim was closed.

[b]Does not include 12 arbitrated and 9 litigated claims for which data were missing and could not be obtained.

Award Payments and Resolution Times for All Claims Arbitrated From November 1976 to November 1989

Table VI.1: Award Payments for Arbitrated Claims

Number of claims		Award payments[a]			
				Range	
Total	Paid	Median	Average	Lowest	Highest
247	59	$22,998	$106,198	$250	$1,700,000

[a]Excludes claims where payment was $0.

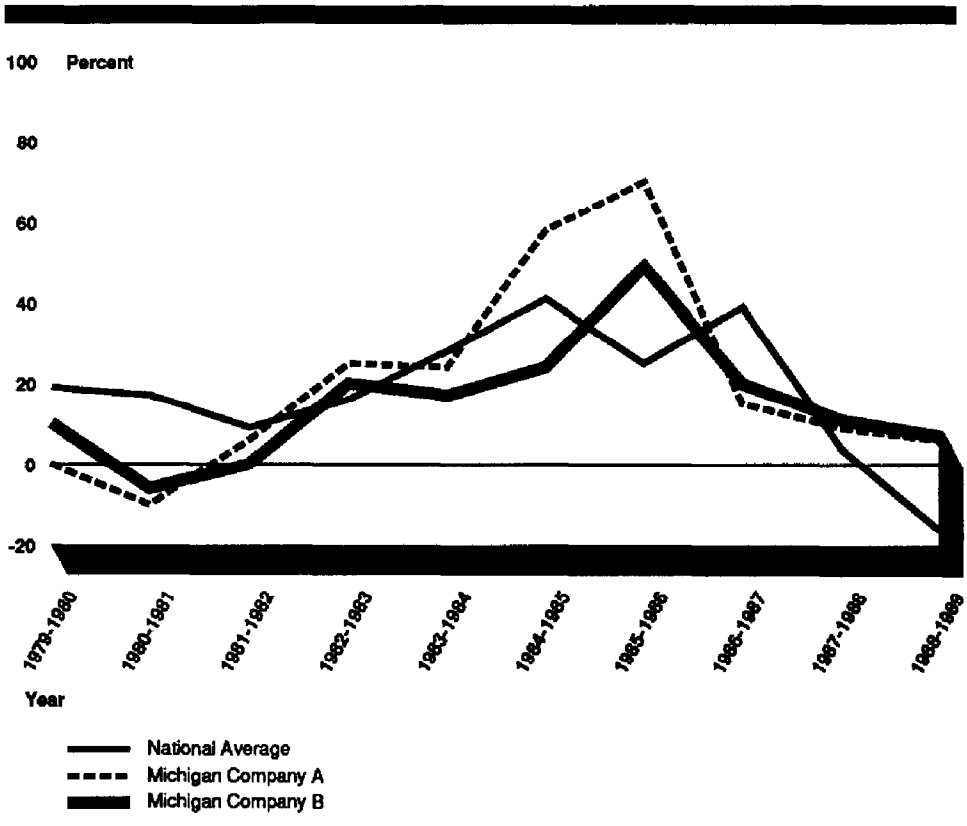
Table VI.2: Resolution Times for Arbitrated Claims

	Months to resolve[a]			
			Range	
Number of claims	Median	Average	Lowest	Highest
247	18	24	3	114

[a]Represents months from claim filing to claim closing.

Yearly Rate of Change in Medical Malpractice Insurance Premiums From 1979 Through 1989

Figure VII.1: Rates of Change in Michigan Compared With National Average

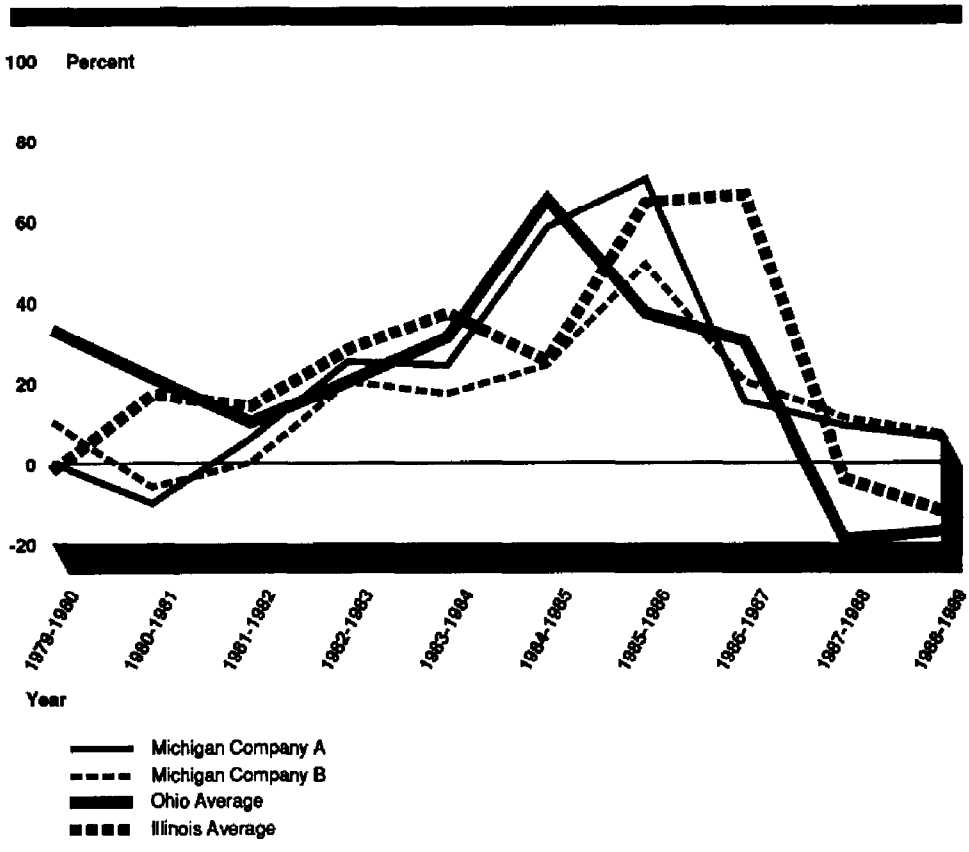


Notes: Two of the three primary medical malpractice insurers in Michigan provided data. Michigan Company A data represent changes in insurance rates for physicians and ancillary medical personnel, and Michigan Company B data represent physicians and dentists.

The national average is for physicians and surgeons insured by the nation's leading medical malpractice insurer.

During 1985, Michigan Company B reported rate changes of 48 percent and 24 percent. The 24-percent rate change is reflected in this figure.

Figure VII.2: Rates of Change in Michigan Compared With Two Adjacent States



Notes: Two of the three primary medical malpractice insurers in Michigan provided data. Michigan Company A data represent changes in insurance rates for physicians and ancillary medical personnel, and Michigan Company B data represent physicians and dentists.

Ohio and Illinois data are for physicians and surgeons insured by the nation's leading medical malpractice insurer.

During 1985, Michigan Company B reported rate changes of 48 percent and 24 percent. The 24-percent rate change is reflected in this figure.

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