

January 1992

MEDICAL MALPRACTICE

Alternatives to Litigation



Human Resources Division

B-242223

January 10, 1992

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

Critics say the litigation system for resolving medical malpractice claims is flawed. Claims take a long time to be resolved; legal costs are high; and settlements and awards are unpredictable. In addition, many legitimate claims may never reach the courts. Frustrated by the litigation system and its impact on the costs of medical malpractice insurance, several states have enacted legislation that establishes alternatives to litigation.

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) requires that GAO review these alternatives. In December 1990, we reported on Michigan's voluntary arbitration program for medical malpractice.¹ In this report, we describe voluntary arbitration, as well as other alternatives available in other states and from two health maintenance organizations (HMOs) in the private sector—including mandatory arbitration, no-fault programs, and assessing compliance with approved standards of care. This last alternative is a unique approach being tested in one state.

Background

Generally, a medical malpractice claim filed for litigation is based on tort law. A tort is a wrongful act or omission (not based on a contract) that causes injury to another person. Tort law provides a framework for compensating the damages that an injured person incurs through medical malpractice.² Most malpractice litigation is based on negligence. The threat of litigation alone may discourage negligence and other substandard medical care.

¹Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program (GAO/HRD-91-38, Dec. 27, 1990).

²An injured person can seek compensation for both economic and noneconomic damages. Economic losses include medical bills, rehabilitation costs, and lost income. Noneconomic losses include pain, suffering, anguish, and marital losses.

nuisance claims and, because of its nonpublic nature, protect those at fault. No-fault supporters believe this alternative has some of the same advantages as arbitration. Critics charge that if determination of fault is eliminated, there would be no deterrent to medical negligence; in addition, the overall cost of malpractice may increase if filing claims becomes easier.

Results in Brief

Fifteen states have specific statutes on medical malpractice arbitration. However, only Michigan (1) has a method to make patients aware of the arbitration option and (2) established a program to implement its statute's requirements. But even in Michigan, relatively few malpractice claims have been filed for arbitration compared with litigation. We previously reported that there was little likelihood use of the program would increase because it is voluntary and lacks incentives. Arbitration appears to be seldom used in the other 14 states.

Virginia and Florida enacted statutes authorizing no-fault programs to resolve certain birth-related injury claims. Although less than 4 years old, the programs have had some success. For example, one of Virginia's largest malpractice insurers resumed writing new policies for obstetrical coverage because the state enacted its program. While fewer claims than expected have been filed, program officials suggested several reasons for this, including the fact that the time from injury to claim filing typically takes several years for the type of injuries that the programs target.

As a condition of enrollment, at least two HMOs in the private sector mandate the use of arbitration to resolve malpractice claims. Over 6 million enrollees accepted the mandatory arbitration provision at these HMOs. The HMOs would not provide detailed data on their claims experience. They told us, however, that they believe this alternative is successful because it results in faster claims resolution, lower defense costs, and more predictable and equitable decisions.

Maine has initiated a demonstration project to test a unique approach that may improve patient care while protecting some physicians from litigation. Maine established standards of care in four specialties—anesesthesiology, emergency medicine, obstetrics and gynecology, and radiology. If physicians follow the standards, there may be no basis for litigation. Physicians participating in the demonstration can begin to use the standards in 1992. Maine officials expect the legality of the approach to be challenged. Insurers are concerned that if the approach

Fifteen States Have Statutes for Arbitration of Medical Malpractice Claims

Fifteen states have statutes specifically covering voluntary arbitration of medical malpractice claims. As shown in table 1, almost three-quarters of these statutes were enacted during or shortly after the medical malpractice crisis of the mid-1970s. Some of these statutes include a general framework for arbitration; others are more specific in their requirements. Information on some of the requirements of arbitration statutes for medical malpractice can be found in appendix II.

Table 1: States With Medical Malpractice Arbitration Statutes and Year Enacted

State	Year enacted
Alabama	1975
Alaska	1976
California	1975
Colorado	1988
Florida	1985
Georgia	1978
Illinois	1976
Louisiana	1975
Michigan	1975
New York	1986
Ohio	1975
South Dakota	1976
Utah	1985
Vermont	1975
Virginia	1976

Source: American Medical Association.

Of the states with medical malpractice statutes, only Michigan (1) has a method to make patients aware of the arbitration option and (2) established a program to implement the statute's requirements. In appendix III, more details are given on how medical malpractice arbitration works in Michigan. While arbitration is possible under statutes in the other 14 states, none has a state-level program to assure that this alternative is offered to patients or to provide guidance, oversight, and documentation of arbitration activities.

From the beginning of Michigan's program through March 1991, 882 claims were filed for arbitration.⁴ In appendix IV, disposition of these claims is shown. We previously reported that there appeared to be little potential for increasing participation because the program is voluntary

⁴An estimated 20,000 medical malpractice claims were filed for litigation in Michigan since the arbitration program began.

afford the premiums; in some instances, such physicians stopped delivering babies. In addition, some insurers stopped writing new policies until the states did something to reduce the uncertainty and unpredictability of the risk associated with delivering seriously injured babies. These programs, although recently enacted, appear to have had some effect. For example, officials at one of Virginia's largest medical malpractice insurers said that although the insurer stopped writing new policies for obstetrical malpractice coverage in 1986, it resumed this coverage because the state enacted its program.

When the programs were first implemented, program officials in both states expected about 40 claims to be filed under each program annually. The actual number filed has been much lower. As of October 1991, 21 claims had been filed—2 in Virginia and 19 in Florida. One Virginia claim was determined to be ineligible, and a decision is pending on the second. Twelve of the Florida claims were determined to be eligible, with initial payments totaling about \$1.5 million.

Program officials believe the claims volume has been much lower than expected because

- the programs are targeted at a very small, narrowly defined population;
- attorneys may be waiting to see whether the programs will withstand constitutional challenges before filing claims;⁸ and
- the time from injury to claims filing typically takes several years for the injuries that the programs target.

In an earlier report, we found that on average, more time elapsed between the injury and claim for obstetrics-related medical care than for injuries from all types of medical care.⁹ The average length of time from the injury to claim filing was about 16 months for all claims. By comparison, obstetrics-related claims are filed, on average, about 2 years after the injury. About 25 percent of all claims filed more than 3 years after the injury were obstetrics related.

⁸The Virginia supreme court recently upheld the constitutionality of the Virginia act in *King v. Va. Birth-Related Neurological Injury Compensation Program*, ___ Va. ___, 1991 Va. LEXIS 151 (November 8, 1991). The constitutionality of mandatory assessments of physicians under the Florida law is pending before the Florida supreme court. *McGibony v. Florida Birth-Related Neurological Injury Compensation Plan*, 564 So. 2d 177; (Fla. 1990); *juris. accepted sub nom. Coy v. Florida Birth-Related Neurological Injury Compensation Plan*, 573 So. 2d 3 (Fla. 1990).

⁹*Medical Malpractice: Characteristics of Claims Closed in 1984* (GAO/HRD-87-55, Apr. 22, 1987).

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.¹¹

Mandatory arbitration has been successful, HMO officials believe: arbitration offers several advantages, including faster claims resolution, lower defense costs, and more predictable and equitable results. According to a Kaiser official, arbitration takes about 19 months, compared with 33 months for litigation. Arbitration costs are less, officials at both HMOs believe, primarily because of lower defense costs. Arbitration hearings require about 2 to 4 days, compared with several weeks for litigation. Further, mandatory arbitration reduces the likelihood of excessive awards.

Maine Is Testing a Unique Approach

Maine is testing a unique approach for resolving malpractice claims by eliminating the need to litigate to establish the standard of care. Through Maine's Medical Liability Demonstration Project—enacted by Maine's legislature in 1990 and amended in 1991¹²—medical specialty advisory committees representing four specialties—anesthesiology, emergency medicine, obstetrics and gynecology, and radiology—have established practice parameters and risk management protocols.¹³

The parameters could have the effect of giving physicians "immunity from litigation," Maine officials believe, because there would be no basis for litigation if a physician can demonstrate compliance with the standards. The initiation of the test depended on the willingness of at least 50 percent of the physicians in each of the four specialty areas to participate. Maine officials told us in October 1991 that they had achieved the required participation levels in two specialties and expected to have the required levels for the remaining two specialties by

¹¹*Madden v. Kaiser Found. Hosp.*, 552 P.2d 1178 (Cal. 1976).

¹²The project was enacted on April 24, 1990, Me. Rev. Stat. Ann. tit. 24, §2971 (Supp. 1991), and amended on June 17, 1991 (1991 Me. Laws C. 319).

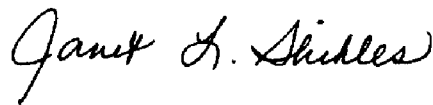
¹³Practice parameters define appropriate treatment methods. (Practice parameters are also known as practice standards, protocols, algorithms, guidelines, indicators, and preferred practice patterns. See Rebecca Rhine Gschwend, "Medical Specialty Societies and the Development of Practice Policies," *Quality Review Bulletin* (Feb. 1990), p. 58.) The risk management protocols establish standards of practice designed to avoid malpractice claims and increase the defensibility of claims that are pursued. Within the Maine project, practice parameters and risk management protocols are indistinguishable.

and no damages recovered. The Maine project shifts the focus to the question of compliance with the approved standard. Therefore, when physicians can demonstrate early and convincingly that they have complied with the standard, they may avoid litigation.

The practice parameters for the four specialties have been established. The parameters have the force and effect of state law and establish the legal standard of care for malpractice claims that will be brought against participating physicians beginning January 1, 1992. However, there are legal issues surrounding this legislation that will probably be litigated in the courts, including whether restricting the use of parameters to physicians in law suits is constitutional and whether expert witnesses can challenge the practice parameters. Maine officials expect that these issues will be decided ultimately by the state supreme court. Malpractice insurers are concerned that if the use of practice parameters 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.

We are sending copies of this report to the Secretary of Health and Human Services 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 VII.



Janet L. Shikles
Director, Health Financing
and Policy Issues

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**Appendix I
Interest Groups and Organizations in States
With Medical Malpractice Arbitration
Statutes That GAO Interviewed**

Michigan

Information taken from an earlier GAO report.¹ Current statistics on number of claims filed for arbitration in Michigan provided by Arbitration Services, Inc., Detroit, Michigan.

New York

Medical Society of the State of New York
New York State Trial Lawyers Association
Medical Liability Mutual Insurance Company

Ohio

Ohio State Medical Association
Ohio Academy of Trial Lawyers
Physicians Insurance Exchange-Mutual
Ohio Hospital Insurance Company
Physicians Insurance Company of Ohio

South Dakota

South Dakota State Medical Association
South Dakota Trial Lawyers Association
Physicians Insurance Company

Utah

Utah State Medical Association
Utah Trial Lawyers Association
Utah Medical Insurance Association

Vermont

Vermont State Medical Society
Vermont Association of Trial Lawyers
Physicians Insurance Company

Virginia

Medical Society of Virginia
Virginia Trial Lawyers Association
Physicians Insurance Company
Virginia Medical Protective
Virginia Alternative Dispute Resolution Center

¹Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program (GAO/HRD-91-38, Dec. 27, 1990).

**Appendix II
Requirements of Arbitration Statutes for
Medical Malpractice**

Table II.1: Arbitration Panel Members as Specified in State Medical Malpractice Arbitration Statutes

State	Number	Panel members
Alabama	3	^a
Alaska	3	^a
California	^a	^a
Colorado	^a	^a
Florida	3	One member must be an administrative hearing officer who serves as chief arbitrator
Georgia	3	^a
Illinois	3 ^b	^a
Louisiana	^a	^a
Michigan	3	Members are an attorney who serves as the chairperson, a physician or hospital representative, and a layperson
New York	3	Members are an attorney who serves as the chairperson and two unspecified members
Ohio	3	Only one member may be a physician or representative of a hospital
South Dakota	3 or 5 ^c	^d
Utah	3	^e
Vermont	3	Members are a judicial referee, ^f a member of the same profession as the defendant, and a layperson
Virginia	^a	^a

^aNot specified.

^bThere will be three panel members unless the parties agree that a single arbitrator will conduct the arbitration

^cThe arbitration panel will consist of three members when damages sought in a claim do not exceed \$10,000. If damages are over \$10,000, the panel will consist of five members. In all cases, if there is more than one plaintiff or defendant, a five-member panel will be appointed, regardless of the damage amount.

^dThe president of the state bar, the medical association, and the hospital association each select 15 panelists from their professions to serve on the panel. Each member selected serves a 3-year term.

^eThe panel consists of one member who is (1) appointed from a list of attorneys provided by the commissioners of the Utah State Bar and acts as the chairperson, (2) appointed from a list provided by the professional association representing the same area of practice as the defendant or, in claims only against hospitals, one member who is currently in hospital administration (from a list provided by the Utah Hospital Association), and (3) a lay panelist, not a lawyer, doctor, hospital employee, or other health care provider.

^fMay be any district or superior court judge or attorney.

Apart from the number of panel members, most state medical malpractice arbitration statutes do not have requirements for panel members. However, seven address the issue to varying degrees, as shown in table II.1. Michigan, Utah, and Vermont statutes contain the most specific requirements—primarily, they require that a legal, medical, and lay representative be on the panel.

**Appendix II
Requirements of Arbitration Statutes for
Medical Malpractice**

**Table II.2: Arbitration Panel Selection
Method as Specified in State Medical
Malpractice Arbitration Statutes**

State	Arbitration panel selection method
Alabama	The plaintiff and defendant each choose an arbitrator; these arbitrators then select the third panel member ^a
Alaska	The plaintiff and defendant each choose an arbitrator; they also mutually agree on the third member who serves as the chairperson
California	^b
Colorado	^b
Florida	The plaintiff and defendant each choose an arbitrator; the Division of Administrative Hearings chooses the third, an administrative hearing officer, who serves as chief arbitrator
Georgia	The plaintiff and defendant each choose an arbitrator; these arbitrators then select the third panel member ^c
Illinois	The plaintiff and defendant each choose an arbitrator; these arbitrators then select the third panel member and if they cannot agree, the court will appoint a third arbitrator ^d
Louisiana	^e
Michigan	The plaintiff and defendant must agree on all three arbitrators ^f
New York	The panel chairperson, an attorney, serves a fixed term; the other two arbitrators are selected from a pool of candidates, and the first two mutually agreed-to candidates are invited to serve ^g
Ohio	"Model Agreement" in the statute specifies that the plaintiff and defendant each choose an arbitrator; these arbitrators then select the third panel member
South Dakota	In the case of a three-member panel, the plaintiff and defendant each choose an arbitrator; these arbitrators then select the third panel member; if the two arbitrators cannot decide within 15 days, the presiding judge of the circuit court will appoint a third arbitrator ^h
Utah	The Utah Department of Commerce chooses two arbitrators who then must agree to the third arbitrator
Vermont	The court administrator chooses one arbitrator, the judicial referee; the remaining two are drawn by lot, and parties have a limited number of challenges to those drawn, similar to jury selection procedures
Virginia	^b

^aIf unable to agree within 30 days, the third arbitrator will be selected by a judge of a court of record in the county in which the arbitration is pending.

^bNot specified.

^cIf the arbitrators are unable to agree on the third member, the judge authorizing the arbitration or the judge's successor will appoint that panel member.

^dIf a single arbitrator is used, all parties must agree to the selection; otherwise, the arbitrator will be appointed by the court.

^eIf an arbitration contract contains a provision that permits a physician, dentist, or medical institution to appoint one or more arbitrators, then the contract will also provide that the patient has the right to appoint an equal number of arbitrators. There can be no restrictions in the agreement as to whom the patient can appoint as an arbitrator. If the agreement provides for one or more neutral arbitrators and if the selected arbitrators cannot agree, the neutral arbitrators will be appointed by the court.

^fIf three panel members cannot be selected by mutual agreement, the administering organization will

Voluntary Arbitration of Medical Malpractice Claims in Michigan

Michigan's Medical Malpractice Arbitration Act of 1975 requires that at or near the time of treatment, hospitals insured by companies licensed to write malpractice insurance in the state must offer patients the opportunity to sign agreements;¹ these include arbitrating any future dispute, controversy, or issue arising out of the care or treatment provided. About half of the hospitals in the state meet this requirement and must offer arbitration agreements to patients. All personnel at these hospitals—including health care providers practicing there²—must also have future disputes arbitrated if a patient accepts the hospital's offer. However, self-insured hospitals and health care providers in private practice are not required to offer arbitration agreements to their patients. Further, none of the patients are required to accept arbitration agreements when offered.

Michigan's Medical Malpractice Arbitration Program is administered by Arbitration Services, Inc., under contract with the Michigan Insurance Bureau. Contract funds come from annual assessments of insurance carriers licensed to write medical malpractice insurance in Michigan. The assessments, based primarily on the volume of premiums written, totaled about \$373,000 in fiscal year 1990. An 18-member advisory committee, appointed by the bureau, gives policy guidance and oversees the program.

A three-member arbitration panel 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 layperson. Panel decisions are based on a majority ruling and are binding on all plaintiffs and defendants. Unlike court decisions, which have many bases for appeal, panel decisions can be appealed only for the following reasons: (1) either a plaintiff or a defendant alleges fraud, (2) the panel exceeded its authority, or (3) the conduct of the hearing prejudiced the rights of a plaintiff or a defendant.

Over the years, various aspects of the program have been challenged in state courts. Plaintiffs challenged Michigan's statute, raising two constitutional issues concerning whether (1) requiring a health care professional on an arbitration panel violates the right to due process and

¹Under Michigan's statute, "hospital" means a person, partnership, or corporation lawfully engaged in the operation of a hospital, clinic, HMO, or sanitarium.

²"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.

Disposition, Award Payments, and Resolution Times for All Claims Arbitrated Under Michigan's Medical Malpractice Arbitration Program (Nov. 1976 Through Mar. 1991)

Table IV.1: Disposition of Arbitrated Claims

Disposition	Claims	
	Number	Percent
Withdrawn or administratively closed without hearings	222	25
Settled without hearings	331	38
Panel decisions ^a	272	31
Open	57	6
Total	882	100

^aThrough March 1991, there were 272 panel decisions, resulting in 70 paid claims for the plaintiffs. However, complete claims data were not available for 2 claims.

Table IV.2: Award Payments for Arbitrated Claims

Number of claims	Award payments ^a				
	Paid	Median	Average	Range	
Total				Lowest	Highest
270 ^b	68 ^b	\$23,999	\$98,725	\$250	\$1,700,000

^aExcludes claims where payment was \$0.

^bThrough March 1991, there were 272 panel decisions, resulting in 70 paid claims for the plaintiffs. However, complete claims data were not available for 2 claims. Analyses represent those claims for which complete data were available.

Table IV.3: Resolution Times for Arbitrated Claims

Number of claims	Months to resolve ^a			
	Median	Average	Range	
			Lowest	Highest
270 ^b	17	23	3	114

^aRepresents months from claim filing to claim closing.

^bThrough March 1991, there were 272 panel decisions. However, complete claims data were not available for 2 claims. Analyses represent those claims for which complete data were available.

Appendix V
Description of the No-Fault Programs for
Birth-Related Neurological Injuries in
Virginia and Florida

In both programs, physicians voluntarily choose to participate for an annual fee of \$5,000. By participating, program officials said, physicians are protected from what could be the most costly malpractice cases. Among obstetricians and gynecologists, about 75 percent in Virginia and Florida participate. In addition, all licensed nonparticipating physicians are assessed \$250 annually to help fund the programs.⁴

Hospital assessments vary by state. Like physicians, Virginia hospitals can choose to participate. About 51 percent of the state's hospitals participate and pay \$50 for each delivery—up to a maximum of \$150,000 a year. Program participation protects hospitals from court verdicts that could exceed their malpractice insurance limits. In Florida, all private hospitals are taxed to help fund the program, but public and teaching hospitals are exempt. About half of Florida's hospitals are private and are assessed \$50 for each delivery with no maximum annual limit.

The Virginia supreme court recently upheld the constitutionality of the Virginia act.⁵ The court found that removing these obstetrical claims from the tort system did not violate the prohibition against enacting legislation for a special class rather than the public in general. It also found that the mandatory assessments do not violate the equal protection or due process clauses of the constitution. The constitutionality of mandatory assessments of physicians under the Florida law is pending before the Florida supreme court.⁶

Additional characteristics of the programs are shown in table V.1.

⁴Some physicians are exempt from the assessment. In both Virginia and Florida, retired physicians, physicians enrolled in postgraduate medical education programs, and physicians employed by the states are generally exempt. Florida also exempts, in certain circumstances, physicians employed by the Department of Veterans Affairs, physicians who are part of the Armed Forces, or physicians who are not compensated for their medical services.

⁵King v. Va. Birth-Related Neurological Injury Compensation Program, ___ Va. ___, 1991 Va. LEXIS 151 (November 8, 1991).

⁶McGibony v. Florida Birth-Related Neurological Injury Compensation Plan, 564 So. 2d 177; (Fla. 1990); *juris. accepted sub nom. Coy v. Florida Birth-Related Neurological Injury Compensation Plan*, 573 So. 2d 3 (Fla. 1990).

Comparison of Selected Characteristics of Mandatory Arbitration in Two HMOs

Selected characteristic	Mandatory arbitration programs	
	Ross-Loos	Kaiser
Location	Southern California	California Colorado Hawaii Oregon Washington
Arbitration panel: Number of members	3	3
Members ^a	^b	^b
Selection method	Plaintiff and defendant each choose an arbitrator; these arbitrators then select the third panel member	Plaintiff and defendant each choose an arbitrator; these arbitrators then select the third panel member
Length of hearing	3 to 4 days	2 to 3 days
Filing fee	None	\$150
Limits on damages:		
Economic	None	None
Noneconomic	\$250,000	\$250,000

^aAlthough not specified, the Ross-Loos panels generally consist of two attorneys and one judge; the Kaiser panels generally consist of three attorneys.

^bNot specified.

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Major Contributors to This Report

Human Resources
Division,
Washington, D.C.

Susan D. Kladiva, Assistant Director (202) 426-1357
Joseph A. Petko, Assignment Manager

Office of the General
Counsel,
Washington, D.C.

Susan A. Poling, Senior Attorney

Detroit Regional Office

Norman L. Psenski, Evaluator-in-Charge
Donna Bright Howard, Evaluator

Appendix V
Description of the No-Fault Programs for
Birth-Related Neurological Injuries in
Virginia and Florida

Table V.1: Additional Characteristics of
No-Fault Birth-Related Injury Programs

Selected characteristic	No-fault birth-related injury programs	
	Virginia	Florida
Date enacted	November 1987	February 1988
Date implemented	January 1988	January 1989
Participation:		
Physicians ^a	400	589
Hospitals ^b	37	111
Claims filed ^c	2	19
Compensated items	^d	^e
Value of fund ^f	\$36 million	\$74 million
Additional funding sources:		
State	Not specified	\$20 million ^g
Insurance carriers ^h	.25 percent of prior year's premiums	.25 percent of prior year's premiums
Statute of limitations	10 years from birth	7 years from birth

^aEstimates for participating obstetricians and gynecologists as of March 1991.

^bHospitals participating in Virginia as of March 1991. Florida hospitals at which participating physicians delivered babies during calendar year 1990.

^cClaims filed under the two programs as of October 1991.

^dVirginia provides compensation for (1) actual medically necessary and reasonable expenses: medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel; (2) loss of earnings from the ages of 18 to 65 in the amount of 50 percent of the average weekly wage in Virginia for workers in the private, nonfarm sector; and (3) reasonable expenses associated with filing the claim, including reasonable attorney's fees.

^eFlorida provides compensation for (1) actual expenses for medically necessary and reasonable medical and hospital, habilitative and training, residential, and custodial care and service; medically necessary drugs, special equipment, and facilities; and related travel; (2) the parents or legal guardians of the injured infant in an amount not to exceed \$100,000, and (3) reasonable expenses incurred in connection with filing the claim, including reasonable attorney's fees.

^fValue of the fund as of October 1991.

^gAs of October 1991, the state contributed \$20 million of the \$40 million it committed to the program.

^hFunding deficits can be covered by yearly assessments on malpractice liability writers in the two states—up to .25 percent of the previous year's net direct premiums written in Virginia and Florida. In 1989, Virginia assessed liability writers .1 percent of their 1988 net direct premiums written. Florida has not exercised this option.

Description of the No-Fault Programs for Birth-Related Neurological Injuries in Virginia and Florida

Virginia and Florida enacted statutes that authorize no-fault programs for resolving claims involving birth-related neurological injuries. Both statutes define birth-related neurological injury. Virginia's definition is as follows:

'Birth-related neurological injury' means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled. In order to constitute a 'birth-related neurological injury' within the meaning of this chapter, such disability shall cause the infant to be permanently in need of assistance in all activities of daily living. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality, degenerative neurological disease, or maternal substance abuse.¹

Florida uses the following definition:

'Birth-related neurological injury' means injury to the brain or spinal cord of a live infant weighing at least 2,500 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.²

The two no-fault programs include similar features. State statutes established specific organizations to administer both programs.³ For approved claims that meet the programs' definitions, the programs provide total coverage of medical expenses and other expenses, such as custodial care and special equipment for the life of the injured infant. However, these expenses must be offset by other means of compensation, such as private health insurance or benefits payable under federal laws. Both programs receive funding through assessments on physicians and hospitals. Although funding mechanisms are similar, differences exist. For example, Florida also contributes state funds to support the program.

¹The Virginia Birth-Related Neurological Injury Compensation Act, Va. Code Ann. § 38.2-5001 (1990).

²The Florida Birth-Related Neurological Injury Compensation Plan, Fla. Stat. Ann. § 766.302 (West. Supp. 1991).

³The Virginia program is administered by the Birth-Related Neurological Injury Compensation Board. The Florida program is administered by the Birth-Related Neurological Injury Compensation Association.

**Appendix III
Voluntary Arbitration of Medical Malpractice
Claims in Michigan**

(2) arbitration deprives plaintiffs of the right to a jury trial. The Michigan supreme court upheld the act's constitutionality on both challenges.³

³Morris v. Metriyakool, 418 Mich. 423, 344 N.W.2d 736 (Mich. 1984) and McKinstry v. Valley Ob-Gyn Clinic, P.C., 428 Mich. 167, 405 N.W.2d 88 (Mich. 1987).

**Appendix II
Requirements of Arbitration Statutes for
Medical Malpractice**

appoint the remainder of the panel.

⁹If a complete panel is not selected by mutual agreement, the arbitration administrator will appoint the remaining associate arbitrators

¹⁰The same procedures generally apply to a five-member panel. Multiple plaintiffs and defendants must agree on panel selections

Revocation of Agreements

Sometimes, health care providers offer patients the opportunity to sign agreements to arbitrate medical malpractice claims at or near the time of treatment. Medical malpractice arbitration statutes that address revocation of these agreements vary as to the time periods during which patients, after having signed them, can revoke them. In some states, the arbitration statutes address voluntary binding arbitration in the context of litigation. The parties, through their counsel, may mutually agree to submit a claim to binding arbitration. These agreements are not generally revokable. The time periods during which the agreement to arbitrate can be revoked are shown in table II.3.

**Table II.3: Arbitration Agreement
Revocation Period as Specified in State
Medical Malpractice Arbitration Statutes**

State	Revocation period
Alabama	Agreement is irrevokable and made only after the claim is known
Alaska	30 days from signing by patient only; health care provider may not revoke
California	30 days from signing
Colorado	90 days from signing or discharge
Florida	Not specified; however, parties' agreement to binding arbitration is not generally revokable
Georgia	Not specified; however, parties' agreement to binding arbitration is not generally revokable
Illinois	60 days from signing or discharge
Louisiana	Both parties may revoke within 30 days, but care provided during agreement is subject to the agreement
Michigan	60 days from signing or discharge
New York	Both parties may revoke, but care provided under agreement is subject to the agreement
Ohio	60 days from treatment or discharge
South Dakota	Both parties may revoke as to future services at any time
Utah	Not specified; however, parties' agreement that prelitigation hearing will be binding arbitration is not generally revokable
Vermont	Agreement can be made only after nature and existence of claim are known; once chosen, this agreement may only be revoked with written consent of all parties
Virginia	60 days from termination of treatment

**Appendix II
Requirements of Arbitration Statutes for
Medical Malpractice**

Almost every state medical malpractice arbitration statute includes the method for selecting arbitration panel members. As shown in table II.2, all but three of the state statutes specify a panel selection method. The method is not addressed in the California, Colorado, and Virginia statutes. In most cases, the plaintiff and defendant are involved in the selection process. The most common method requires the plaintiff and defendant to select an arbitrator; then, these two arbitrators select the third panel member.

Requirements of Arbitration Statutes for Medical Malpractice

Fifteen states have statutes authorizing arbitration to resolve medical malpractice claims. These statutes were enacted between 1975 and 1988. The arbitration requirements of these statutes vary by state. Some statutes establish how claims will be arbitrated; others provide a general framework for arbitration. Specific requirements most often addressed in the medical malpractice arbitration statutes include the composition of the arbitration panels and revocation of arbitration agreements.

Arbitration Panels

The number of panel members required by the states' medical malpractice arbitration statutes is fairly consistent. As shown in table II.1, of the 15 states, 11 have statutes specifying the size of the arbitration panels; 4 states—California, Colorado, Louisiana, and Virginia—do not have such statutes. One statute authorizes an arbitration panel of five members, but three is the most common size specified.

Interest Groups and Organizations in States With Medical Malpractice Arbitration Statutes That GAO Interviewed

Alabama

Alabama State Medical Association
Alabama Trial Lawyers Association
Mutual Assurance Incorporated

Alaska

Alaska State Medical Association
Alaska Trial Lawyers Association
Medical Indemnity Corporation

California

California Medical Association
California Trial Lawyers Association
Cooperative of American Physicians, Inc. .

Colorado

Colorado Medical Society
Colorado Trial Lawyers Association
Physicians Insurance Company

Florida

Florida Medical Association, Inc.
Florida Trial Lawyers Association
Physicians Insurance Company
Physicians Protective Trust Fund
Florida State Division of Administrative Hearings

Georgia

Medical Association of Georgia
Georgia Trial Lawyers Association
MAG Mutual Insurance Company

Illinois

Illinois State Medical Society
Illinois Trial Lawyers Association
Illinois State Medical Inter-Insurance Exchange

Louisiana

Louisiana State Medical Society
Louisiana Trial Lawyers Association
State of Louisiana Risk Management
Louisiana Medical Protective
Louisiana Medical Mutual Insurance Company

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Abbreviations

HMO health maintenance organization

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December 31, 1991. The parameters will be available as a legal defense against medical malpractice suits for 5 years, beginning January 1, 1992, for participating physicians.

An official of the Maine Medical Association indicated that the project grew out of discussions of a coalition of business, labor, insurance, and health interests, all concerned about alarming increases in the cost of health insurance. The coalition was especially concerned about defensive medicine, which was identified as one of the factors leading to increased health care costs.¹⁴ The coalition believed that physicians are motivated by the unfavorable liability climate, but cannot be expected to change their practice patterns unless given some protection from litigation. Defensive medicine could be reduced and, ultimately, health care costs as well if (1) practice parameters 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 parameters.

Establishing the standard of care is an essential element of proving medical negligence during litigation. Failure to meet the standard, which is usually established through medical expert testimony, could be the basis for a finding of medical negligence. For example, an anesthesia-related malpractice claim involving a catastrophic injury—such as permanent brain damage or death resulting from lack of oxygen to the brain—might allege that the anesthesiologist had failed to adequately monitor the level of oxygen in the blood. In such a case, how frequently and in what way the anesthesiologist should have monitored the patient would be the essential factors in establishing the physician's negligence. In the area of anesthesia, Maine's practice parameters establish appropriate methodologies for anesthesia care before, during, and after surgery, including the assessment of patient oxygen levels.

Only participating physicians may introduce the practice parameters, and they will be able to use compliance with them as an affirmative defense in any malpractice litigation during the project. The Maine statute does not permit a plaintiff to introduce the parameters at any phase in the litigation process. An affirmative defense in this context means that when a physician follows the practice parameters, the physician has met the standard of care and thus there can be no negligence

¹⁴Defensive medicine is generally regarded as the performance of diagnostic tests and medical procedures motivated by a physician's fear of a medical malpractice lawsuit rather than by medical necessity.

Mandatory Arbitration Used by Some Private Sector HMOs

In entering into contracts for medical services with patients, some HMOs mandate the use of arbitration with binding decisions for medical malpractice disputes. Two such HMOs, Ross-Loos and Kaiser Permanente, require about 6.5 million subscribers—1 million for Ross-Loos and 5.5 million for Kaiser—to arbitrate claims arising from care received through their health care plans. Ross-Loos, located in southern California, includes arbitration in all its contracts. Kaiser plans enroll about 6.5 million people in 16 states. While Kaiser includes mandatory arbitration in health care contracts in only 5 states, these plans cover about 85 percent of the total enrollees.¹⁰ All enrollees in the Ross-Loos and Kaiser health care plans, regardless of the source of payment for the coverage—Medicare, Medicaid, and federal and nonfederal employee health benefit programs—are required to use arbitration if it is included in the health care contract.

The HMOs implemented this alternative for different reasons. When Ross-Loos began including mandatory arbitration in its contracts in the mid-1940s, medical malpractice was not a major concern. The HMO wanted to establish an on-going relationship with its members and believed that resolving disputes through arbitration would be less adversarial and more private than using the courts. Kaiser incorporated arbitration in the early 1970s as medical malpractice claims and costs were rising in California. Kaiser incorporated mandatory arbitration with the help of Ross-Loos. Therefore, arbitration in the two HMOs incorporates essentially the same features. In appendix VI, selected characteristics of arbitration at Ross-Loos and Kaiser are compared.

We requested details on the HMOs' claims experience, but HMO officials did not provide the data. However, HMO officials indicated that a majority of the claims filed for arbitration are either closed without payment or settled before a hearing is held. For their enrollment of 1 million beneficiaries, Ross-Loos officials estimated, an average of 50 malpractice claims are filed each year. On average, the officials estimated, between 6 and 12 claims are resolved annually by arbitration hearings, and decisions generally favor health care providers. Between 1985 and 1989, Kaiser officials indicated, 5.5 million Kaiser enrollees covered by mandatory arbitration filed about 3,890 claims, an average of about 778 annually; about 440 of these claims were resolved by arbitration hearings, and decisions favored health care providers about 48 percent of the time.

¹⁰Kaiser Permanente requires plan subscribers to arbitrate medical malpractice claims in California, Colorado, Hawaii, Oregon, and Washington.

and lacks participation incentives. In the other 14 states with malpractice arbitration statutes, interest group representatives indicated that arbitration appears to be seldom used.

Because the medical malpractice arbitration statutes are not widely used, there has been little litigation concerning the validity of the statutes. Michigan's program has the widest use and has also had the most legal challenges, but the Michigan supreme court has upheld the constitutionality of the statute.

Two States Recently Enacted No-Fault Programs

Virginia and Florida recently enacted statutes that authorize no-fault programs for resolving claims.^{5,6} The programs apply to one narrowly focused group—neurologically injured infants. For approved claims, the programs provide total coverage of medical expenses and other expenses, such as custodial care and special equipment for the life of the injured infant. Physicians voluntarily choose to participate in both states' programs. Virginia hospitals can also choose to participate; all private hospitals in Florida are taxed to help provide funds. In appendix V, birth-related neurological injuries are defined and no-fault programs are described in more detail.

In both states, claims involving neurologically injured infants must be resolved through no-fault programs if (1) the health care provider participates in the program and (2) the related injury meets the neurological injury definitions for the programs.⁷ Officials in these states believe the no-fault programs offer families incentives to participate. Families with these infants can receive payments as early as 30 days from claim filing. In addition, families can maintain a positive relationship with the health care provider because there is no need to prove negligence when initiating a claim.

Both states, within the last 4 years, enacted no-fault programs because of rising malpractice insurance premiums. Prior to enactment, many physicians, especially those involved in obstetrical care, could no longer

⁵The Virginia Birth-Related Neurological Injury Compensation Act, Va. Code Ann. § 38.2-5000 (1990 & Supp. 1991) (effective Jan. 1, 1988).

⁶The Florida Birth-Related Neurological Injury Compensation Plan, Fla. Stat. Ann. § 766.303 (West, Supp. 1991) (effective Jan. 1, 1989).

⁷In Virginia, claims are eligible for the no-fault program if either the physician or hospital participates. In Florida, the physician must participate for a claimant to recover under the program.

is found to be unconstitutional, they may be held liable retrospectively for claims arising from care provided by the physicians who used it.

Methodology

We identified states with statutes authorizing specific alternatives to litigation: voluntary arbitration, no-fault programs, and a unique approach that involves establishing standards of care in four physician specialties. We reviewed each of the statutes and state supreme court decisions interpreting these alternatives.

Using an interview guide, we conducted telephone interviews with officials of interest groups representing attorneys and physicians and with officials of insurance carriers in the 15 states with voluntary medical malpractice arbitration statutes.³ In appendix I, the interest groups and organizations interviewed are shown. We sought to identify the (1) statute objectives and the extent to which they were achieved, (2) implementation status, (3) claims filed, and (4) factors affecting use. We also met with officials in the two states with medical malpractice no-fault programs—Florida and Virginia—and in the one state implementing a unique approach—Maine.

Further, to obtain program and claims-related data on the use of mandatory arbitration from two HMOs in the private sector, we met with California officials from the Ross-Loos Medical Group in Pasadena and Kaiser Permanente in Oakland. Ross-Loos is the nation's oldest HMO; Kaiser is the largest. Officials of these HMOs considered detailed claims experience data to be proprietary, but they gave us general information on objectives and requirements of arbitration, use of arbitration for resolving malpractice claims, and claims experience.

We carried out our review between July 1990 and October 1991 in accordance with generally accepted government auditing standards.

³Various states have enacted statutes in response to concerns over the availability of medical malpractice insurance and have used different terms to describe their systems. The only states analyzed for the purposes of this study were those with medical malpractice arbitration statutes specifying that once arbitration is elected, it must be used instead of litigation. These arbitration decisions are binding. Some states have enacted statutes that call their decisionmaking panels "arbitration panels," but these panels are primarily pretrial screening devices and we did not include them in our review. In addition, we did not examine general arbitration statutes.

In the courts, recovering damages for negligence is a multistep process. As part of the process, the attorney for the injured person (the plaintiff) must establish, usually through expert witness testimony, the standard of care to which the health care provider is accountable. The attorney must also prove that the provider failed to meet that standard, causing an injury resulting in damage or loss. If a plaintiff proves that the provider's negligence or fault caused the injury, the plaintiff is entitled to recover damages. The uncertainty associated with how a judge or jury may decide a claim often affects plaintiffs', providers', and insurers' decisions about whether to settle or go to trial. Most claims are withdrawn or settled before the court reaches a verdict.

During the mid-1970s, malpractice insurance costs increased rapidly, in part because of the rising number of claims filed for litigation and the size of settlements and awards. As a result, insurance became unaffordable or unavailable for many health care providers, creating a medical malpractice "crisis." Almost all states responded to the crisis by changing tort laws to reduce the amount of litigation and damages paid. Some also enacted legislation so that alternatives to litigation could be used.

Arbitration is one alternative to litigation. Under most states' general arbitration statutes, medical malpractice claims can be resolved. During the 1970s, however, states began to enact specific statutes authorizing medical malpractice arbitration. Under arbitration, neutral third parties or panels resolve disputes. These decisionmakers usually operate with less formality than the courts, but 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, as a condition of enrollment in the health care plan, some HMOs have mandated that subscribers use arbitration to resolve claims.

No-fault programs, another alternative, 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.

Both the arbitration and no-fault alternatives contain positive and negative features. Arbitration supporters believe that this alternative offers faster resolution, reduced costs, and more predictable and equitable results. Critics, however, say arbitration may also encourage small or
