MINNESOTA SENATE

RESEARCH REPORT

THE MEDICAL MALPRACTICE SYSTEM

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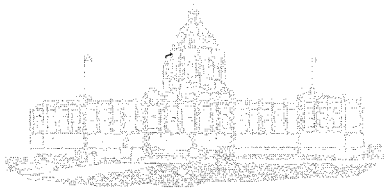

Senate Counsel & Research

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INTRODUCTION

MEDICAL MALPRACTICE INSURANCE

Medical malpractice insurance is a liability coverage. The insurance pays for damages due to mistakes of omission or commission made during medical practice. Because of its expense, this is a less than popular coverage with doctors.

Medical malpractice insurance is an optional coverage -- although for a doctor to go without insurance usually means losing hospital privileges, and exposure to financial risks. It is said that a few doctors do forego medical malpractice coverage when faced with potential premiums in excess of $30,000 per year.

Rather than dropping coverage, many doctors or clinics that are worried about high premiums forego certain practices, such as delivering babies. Across the United States, there have been recurrent shortages of specialists such as obstetricians or anesthesiologists due to the cost and unavailability of medical malpractice insurance. By eliminating some of the more legally risky elements of medical practice, premiums can be lowered. However, the availability of medical care is also lowered.

Critics have suggested the existence of other problems. Do lawyers take too much in fees, and do they foster a litigious system that favors neither patient nor doctor? Do insurance companies profit by exorbitant rates for this coverage? Is there a better way for everybody? If not a better way for everybody, is there a better way for practitioners who work with low-income and charity patients?

The genesis of the current debate over this coverage lies in human fallibility. People make mistakes, and patients who suffer the damages need and deserve compensation. But most agree that the law and the insurance coverage should not damage the entire medical system in its effort to help the injured person. Reform suggestions are an attempt to strike a balance between the damaged patient, the allegedly at-fault medical provider, and the entire medical system.

This report briefly outlines the workings of the medical malpractice system and a number of potential reforms. The reform ideas are taken from the literature, from other states, and from experts in the field. While some analysis of these ideas is attempted, most of the reforms are presented in outline.

MEDICAL MALPRACTICE COVERAGE

Medical malpractice is an optional liability coverage. In Minnesota, there are two insurers which dominate the medical malpractice insurance market: the St. Paul Companies and the Midwest Medical Insurance Company (MMIC).

The St. Paul Companies is a major supplier of malpractice insurance in the United States, providing this coverage in 43 states. The MMIC started as a physicians' mutual and is now a stock company controlled by doctors, providing coverage in three states. MMIC has more than 50 percent of the Minnesota market, and the St. Paul Companies has much of the remainder.

Insurance policies for medical malpractice are sold on a claims-made basis. A claims-made policy covers only those claims made during the term of coverage. This kind of policy replaced the earlier occurrence policy, which covered for any act of malpractice that happened during the term of coverage, even if reported in later years.

As a result of the claims-made policies, physicians are covered for reported claims and must buy a tail policy to cover them after they retire, for claims arising from earlier practice.

According to a 1987 Minnesota Department of Commerce study, policy limits on coverage range from $100,000 per occurrence, $300,000 aggregate (63.3% of the market) to $200,000/$400,000 (20.4%) and higher levels, such as $10,000,000/$10,000,000.

Efforts to reform medical malpractice have a history in Minnesota. Joint Underwriting Associations (JUAs) were formed to provide coverage to those who were unable to buy insurance in the private market. Minnesota's JUA was established in 1976 (Minnesota Statutes, Chapter 62F). Other changes were made, including some tort reforms, in 1986.

In 1987, the Department of Commerce issued a study of claims in the medical malpractice field. The study found that the overall loss ratio for this line of insurance was 71.8 percent. The Department concluded that "the insurers have consistently and significantly over-reserved." The study found that some costs, such as defense costs, had fallen, and others had not risen significantly. Fewer than one-half of one percent of claimants received a jury award.

As a result of this study, rate regulatory actions were started to lower premiums charged by malpractice insurers. The St. Paul Companies was the initial target of this effort. The medical malpractice insurers disputed the facts in the Commerce study and were prepared to fight the Department's actions in court. However, a settlement was reached.

The St. Paul Companies has lowered premiums for medical malpractice insurance, not only in Minnesota but nationally. There were market and economic reasons for these actions. The Department of Commerce at this point appears to be satisfied with premium levels.

The General Accounting Office (GAO) in 1986 issued a study of the medical malpractice system. The title of the study is appropriate: Medical Malpractice: No Agreement on the Problems or Solution. This study concluded that "GAO found no agreement among the major interest groups surveyed regarding the problems, their severity, their solutions, or the proper role of states or the federal government. There was also no consensus among the interest groups that any of the reforms implemented in response to the situation experienced in the mid-1970's has had a major effect."

Critics of the medical malpractice field find different areas of fault. Insurers are blamed for high premiums. Lawyers are blamed for litigious blockage of the system. Doctors and other practitioners are blamed for hurting their patients. There have been numerous criticisms but, to date, no all-encompassing solution. The GAO's conclusions still hold.

CRITICISMS OF THE CURRENT SYSTEM

Critics say that the current malpractice system is often unable to substantially help the injured person. Doctors have noted that, under the current system, too many physicians are unwilling to learn from their mistakes. Nearly every critic, no matter what background, complains about the high costs of the medical malpractice system.

Cost. The American Medical Association estimates that malpractice insurance premiums were $5.6 billion in 1990 and that $15 billion in defensive medicine was ordered by doctors that year, out of $675 billion in health care spending.

The cost of medical malpractice is thought by some Maryland physicians to be a factor keeping some physicians in that state from participating in Medicaid and Medicare. National studies are inconclusive on this point. In recent years, premiums have stabilized, yet critics feel that too much is spent on malpractice and that malpractice has an expensive and distorting effect on the health care system.

If medical malpractice were cheaper, only some of the criticisms would go away. The legal system would still be criticized as time-consuming and unwieldy. There would still be concerns that the injured patient may not be adequately compensated. But cost is a major concern, and not just to doctors. If too many doctors forego delivering babies due to cost, the community is hurt.

Doctors. "Somehow silence has become oddly moral when a wrong has been done." This is a comment by a doctor who has felt the pressure not to tell -- the pressure not to inform on incompetent practitioners. Is it right for a doctor, nurse, or clinic administrator to stay quiet -- not to cover up or condone, but merely to stay quiet?

"Mistakes should be reported to persons in positions of authority. Boards of licensure and boards of discipline are widely thought to exercise very weak supervision over the profession. The doctor who has neglected his education should be required to remedy this deficiency to the satisfaction of the appropriate authorities. If he will not or cannot do this, his right to treat patients should be withdrawn."

The various panels that receive and investigate complaints about the quality of care given by specific practitioners have been criticized nationally as paper tigers. The number of license revocations is not high. Some claim that this is due to the expertise of the American medical community. Others fear that medical people are staying quiet about mistakes from fear of a punitive medical malpractice system. One mistake can cost a doctor a great deal.

Insurers. A few insurance companies tend to dominate the medical malpractice field. The cost of such insurance is high, and has become a determinative factor in some practices.

"In a survey of doctors, medico-legal risk and malpractice litigation were an overwhelming concern of all survey respondents, but more so among those who preferred not to treat the trauma patient." Some claim that there are specialties -- trauma, obstetrics, anesthesiology -- that are understaffed due to malpractice insurance costs. Although the evidence of such shortages is inconclusive, some locales have experienced acute service delivery problems.

Is the cost of delivering medical malpractice insurance too high? There have been complaints about the cost of premiums, but insurers claim that the biggest cost factors are out of their control -- a litigious system and medical errors.

Some studies of the profitability of the medical malpractice insurance industry have not found profits to be exorbitant when compared to other lines. The Department of Commerce has worked with some success to lower medical malpractice rates.

Lawyers. Is it right for a lawyer to take one-third of the settlement for a patient who has suffered? Lawyers have made substantial profits from the medical malpractice field, and the tort system is not universally admired. On the other hand, lawyers have served to expose the malpractice of many doctors who would never have been found out. And contingent fees allow some cases to be taken that would otherwise not be.

Patients. Despite the large sums spent on the system, injured people reportedly receive less than half of what is spent. "The rest is fed into the grinder of insurance overhead, attorney fees, expert witnesses, court costs, and the administrative costs of processing a claim."

OTHER STATES

Several states have enacted some sort of medical malpractice legislation in the past few years. Here are some of the enactments:

Arizona required the courts to change their rules for expert witnesses, early mediation, settlement practices, and other elements of tort reform.

Colorado allowed the awarding of punitive damages in an arbitration proceeding, and limited the awards for injuries to an infant during labor when specified causes contribute to the condition of the infant.

Mississippi lowered the statute of limitations for children's malpractice cases to two years.

Texas required a premium discount by insurers for physicians with a caseload of more than 10 percent charity patients and for obstetricians. Also required that juries be instructed that a bad medical outcome does not necessarily justify a finding of negligence. Required that expert witnesses be practicing physicians. Established a rate appeals proceeding.

Other states considered eliminating joint and several liability, eliminating punitive damages, strengthening standards for misconduct, and other provisions. Wisconsin considered lowering its cap on noneconomic damages from $1 million to $250,000. Alaska considered collapsing the number of physician categories that an insurer could use in underwriting to four classes.

Maine considered a comprehensive act to limit physician error and to lower the medical malpractice costs of rural obstetricians.

In general, states have considered incremental reforms that changed the tort system and the insurance system.

REFORMS: INCREMENTAL APPROACHES

The medical malpractice issue has been attacked on several fronts simultaneously: improvements in medical practice, insurance reforms, tort reforms. These approaches represent an incremental push toward lower rates. A radical approach would change the

entire system; but many radical approaches are risky, unproven, and may not be politically possible. If an incremental approach is selected, initiatives from one of these areas could be emphasized, or a coordinated package of reforms could be presented.

The Health Practitioner

One way to reduce malpractice is to have better doctors, nurses, and providers. Yet, as a practical matter, even the best practitioners will make occasional mistakes. Most would agree that doctors should be encouraged to report these mistakes and efforts made to learn from the mistakes. And when a practitioner is prone to make many mistakes, that person's license to practice should be in jeopardy.

Should clinic and hospital administrators be required by law to report instances of professional misconduct? How about medical department heads? The current child abuse statutes require certain people, such as school principals, to report any knowledge of an abuse that has occurred. It is a criminal offense not to report such an abuse. Yet the people in charge of clinics, hospitals, and medical practices have less of a legal obligation to report malpractice to the licensing and disciplinary boards.

Boards of Licensure

In 1986, insurers were required by the Legislature to report all settled malpractice claims to health practitioner boards. In September 1990, a federal data bank began providing data on settlements, producing a steady stream of information for the boards.

Boards with reporting requirement:

- Board of Chiropractic Examiners
- State Board of Medical Practice
- Board of Nursing
- Office of Social Work and Mental Health Boards
- Board of Podiatric Medicine

Boards without reporting requirement:

- Board of Dentistry
- Nursing Home Administrators
- Board of Optometry
- Board of Pharmacy
- Board of Psychology

It would be possible to extend insurer reporting requirements to all boards. However, the National Practitioner Data Bank has been reporting on settled malpractice claims to some of the boards.

The Minnesota Board of Medical Practice had been receiving quarterly reports from insurers on settled malpractice claims. Now the federal center sends reports in a continuous stream. Of the approximately 1200 reports against about 700 different physicians received in the last year, about 180 were from the federal center.

The Board of Medical Practice treats a settled malpractice claim in exactly the same manner it treats other reports about physicians. The reports are used as part of an investigation that seeks to determine if a physician has a pattern of practice that is below community standards. One event is not enough -- a pattern of practice is needed before action is taken.

The Board of Dentistry does not receive information from insurers, but does get some reports from the National Practitioner Data Bank. However, the Dentistry Board feels that reports from insurers would be helpful.

Other boards are less busy with respect to malpractice claims. For example, the Minnesota Board of Nursing receives no reports from insurers, but believes that the number of nurses involved in such claims is small.

It has been suggested in the past that the Attorney General's Office is too understaffed to adequately process all of these complaints. According to the director of one board, the quality of field investigations of complaints has been high, but a backlog has existed. However, a change made in 1991 has started to address this problem. In 1991, the Attorney General was given the flexibility to increase staff if the boards would pay for the increase. The boards of licensure had the money and have now allowed the Attorney General to increase its complement. This has started to clear up the backlog. It is unclear yet whether more changes will be needed.

Insurers

Changes in the way insurance is sold have already occurred. One was the creation of physician mutuals, to provide a direct source of insurance for doctors, run by doctors. The MMIC is an example of such an insurer and has more than 50 percent of the Minnesota market.

Another reform was the creation of Joint Underwriting Associations. Minnesota's JUA was established in 1976. These organizations provide coverage for practitioners unable to obtain coverage through ordinary methods.

A third area for reform is rate regulation. Minnesota has not recently strengthened the statutory rate regulation of medical malpractice insurers, but the 1987 claims study

conducted under the direction of Minnesota Commissioner of Commerce Michael Hatch was used to leverage rates downward. There are currently fewer problems with rates in Minnesota, as they have been fairly steady in recent years.

A fourth idea is some sort of underwriting reform. One such is a collapse of current medical specialty underwriting categories into a small number of classes. One drawback is that some doctors from specialties with lower premiums would see their rates rise to subsidize others.

The Legal Option

(**Note:** Kathleen Pontius of Senate Counsel contributed to this discussion.)

Two major options for legal reform dominate most of the literature. First, there are proposals for limits on awards. Second, there are proposals for changes in the legal process.

In 1986, Minnesota legislated a number of changes in the tort-liability system. Although some of these changes were aimed directly at medical liabilities, general tort reforms are also helpful to the medical profession. For example, in 1988 the joint and several liability rule was amended, so that a person whose fault is 15 percent or less is liable for no more than four times the person's percentage of fault.

The medical profession has always been a major proponent of tort liability changes. Doctors and other medical professionals are often viewed as attractive "deep pocket" defendants and are considered particularly vulnerable to civil liability. Juries may have a tendency to award larger verdicts, assuming that the doctor is insured or can afford it. On the other hand, opponents of major changes in medical malpractice liability argue that most claims are legitimate and that many people who may be entitled to a recovery do not even sue.

The Legislature has already adopted provisions that are intended to help prevent frivolous lawsuits against medical practitioners. For example, as part of the 1986 law, procedural protections were established which require the plaintiff in a medical malpractice case to have an affidavit from an expert witness certifying that the claim is legitimate and identifying expert witnesses who will testify at trial. Suits that do not meet these requirements within 180 days will be dismissed.

In addition, the law that suspends the running of the statute of limitations for lawsuits involving injuries to minors was modified so that the suspension may not exceed more than seven years in medical malpractice cases. As a result, if a minor was injured at birth, a lawsuit would have to be commenced before the minor reached the age of nine (seven years plus the two-year statute of limitations). Previously, the minor could have brought a suit until the age of 19 or 20. The 1986 law also provided that a party who

brings a malpractice action waives any medical privilege with respect to the health care providers who treated or cared for the individual after the alleged malpractice.

In 1990, Minnesota repealed the 1986 cap that was imposed on damages for "intangible loss" (which was defined as embarrassment, emotional distress, and loss of consortium, but did not include pain and suffering). This was based on a recommendation of the Injury Compensation Study Commission, which proposed the change because the statute was ineffective and applied to only a very small category of cases. In addition, the commission disliked caps, believing that review and reduction of damages by trial judges is the best way to address excessive awards. However, tort reform advocates still wish to see caps enacted, and several states have enacted caps that apply only to medical malpractice cases.

Independent researchers point to three types of limits which may be effective in reducing malpractice awards: ceilings on awards for pain and suffering; shortening the time during which claims may be made; allowing defendants to tell juries about any awards a plaintiff may have already received from insurers or other sources.

The American Medical Association has published a plan for reform. The AMA plan: (1) prefers arbitration instead of courts; (2) caps non-economic damages; (3) combines complaint filing and provider discipline into one office.

The Minnesota Medical Association, in its package for universal health coverage, calls for caps on the sizes of awards for pain, suffering, and punitive damages in malpractice cases.

In California, a $250,000 ceiling on payments for "noneconomic losses" such as pain and suffering has been established. It is given some credit in slowing the rise in the state's medical insurance premiums, but there is little evidence that this is passed along as a savings to patients.

In New York, a medical negligence case must be reviewed by a panel, consisting of a lawyer, doctor, and judge, before it can proceed to trial. The panel renders an opinion which if unanimous can be introduced at trial. It cannot dismiss cases or give awards. This has not reduced the number of trials . . . malpractice lawyers often try to discredit the panel. But the panel has worked to streamline the legal process.

According to an insurance industry journal, "Law interests are cool to the idea of limiting medical malpractice litigation, as it can be construed as a financial boundary to their practice." This is clearly an industry point of view. Lawyers prefer to talk about preserving access to the courts for all those injured or potentially injured.

On the national level, Senator Peter Domenici of New Mexico has sponsored a plan -- The Medical Injury Compensation Fairness Act of 1991: a binding arbitration system, mandatory for certain federal programs, encouraged for the private sector. There are also bills from Senator Orrin Hatch and others, with ideas such as pre-litigation screening

panels and free coverage for medical malpractice claims against community or migrant health centers.

RADICAL REFORM: THE NEO NO-FAULT SYSTEM

"One way to minimize losses is to admit mistakes and offer credible compensation."

Incremental reforms such as those discussed above have been criticized as at best a stop-gap measure. The GAO found no evidence that 1970's reforms such as pre-screening panels and caps on awards had any effect on costs. Medical people worry that caps on awards may only slightly lower costs and not increase the efficiency of the legal system. Lawyers worry that tort reforms might come at the expense of a person's day in court.

Proponents of a "neo no-fault" system argue that a true reform must be systemic. They argue that reforms should encourage the defendant to make an offer early and to make an offer that is reasonable rather than strategic. The offer should be for actual economic loss.

One no-fault proposal works as follows:

> A provider facing a claim in which there has been no wanton or reckless conduct has the option to make an offer within 180 days after the plaintiff files suit. Payment of the claim would be periodic as loss accrues, or a lump sum with court approval.
>
> Covered losses would include medical expenses and wage losses not met from some other source. No double dipping by patients is allowed, and only a small attorney's fee (15% maximum) is acceptable.
>
> If no offer is forthcoming from the defendant within 180 days, the normal tort suit may proceed.

If the offer is made and refused, the plaintiff would be required to meet certain tort restrictions:

> A threshold requirement of wanton or willful conduct by the provider.
>
> No noneconomic losses unless these losses greatly outstrip the economic losses (4 to 1 or more).

If the plaintiff presses on, and eventually gains from the court less than the original offer, the plaintiff must pay the defendant's court costs and the plaintiff's attorney is jointly and severally liable for these amounts.

This proposal retains the current private sector insurance market, but substitutes a system in which a real offer can be made up front before litigation can proceed. One variation of this proposal would require both sides to make an initial offer and submit the offers to arbitration.

One strength of these proposals is that they do not place the entire career of the doctor at jeopardy. A mistake can be admitted early, in the context of an offer; and if that offer is valid, a rejection will cost the plaintiff.

TARGETED PROGRAMS

Senator Hank Brown, (R) Colorado, has sponsored a bill in Congress to provide free coverage for medical malpractice claims against community or migrant health centers. Brown argues that "limited funds force centers to perform budget balancing acts that pit health care delivery against malpractice insurance costs." The federal government currently covers about half of the cost of this insurance for these centers -- Brown's bill would use the existing federal expenditures to establish self-insurance by clinics.

Senator Brown's bill depends upon spending the federal contribution to establish a self-insurance pool. Rather than spend the federal money every year for premiums, the money would be invested and used to offset claims. These centers can self-insure already; the key to Senator Brown's approach is the federal government's large financial contribution.

In 1990, Senator Michael Freeman sponsored Senate File 1835 which, among other provisions, required Minnesota's medical malpractice insurers to offer a premium discount to physicians who worked for the community.

For a doctor to be eligible, at least 20 percent of projected patient encounters had to be with patients in a community clinic or public health clinic; patients whose care was paid for by Medicare, medical assistance, general assistance medical care, the children's health plan, or a county indigent medical program; or low-income patients for whom the physician charges no fee or a substantially lower than usual fee.

The amount of discount would be set and approved by the Commissioner of Commerce, who also would verify the doctor's qualifications.

These approaches leave the medical malpractice system substantially alone, but carve out one particularly deserving group of doctors for lower rates, or for free insurance. The premiums of all other doctors would rise, to offset these lower rates.

The argument for these bills is that certain doctors are serving the community and it is in the community's interest to remove obstacles to this service. Arguments against these reforms suggest that if the system is screwed up, why buy off the suffering of a few doctors when a total reform is needed?

CONCLUSION

Medical malpractice reform is either incremental or revolutionary. Incremental reforms offer a choice -- there are three menus of incremental reforms, affecting the doctors, the lawyers, and the insurers. Revolutionary reform, such as the no-fault proposal, requires a radical restructuring of the market.

The alternative to reform is a targeted approach, which selects out some doctors as more worthy of lower premiums, due to some measure of their contribution to the state.

What works? The GAO is skeptical about many of the discussed reforms. Some such reforms do lower costs, but do not make the legal system more effective. Some tort reforms may appear to be helpful, but no real data has been gathered to prove their worth.

Any change in the medical malpractice system will offend at least one of the groups which make their living off malpractice. The trick is to help the injured patient while improving the system. And the problem with reforming the system is that no one agrees on the nature of the problem.