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2005-06

(session year)

Assembly

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Some Research Identifies Defensive Medicine in Certain Clinical Situations

Most research that has attempted to measure defensive practices has examined physician practices under specific clinical situations.⁴¹ For example, based on clinical scenario surveys, records review, and a synthesis of prior research, a 1994 study concluded that the percentage of diagnostic procedures related to defensive medicine practices is higher in specific clinical situations, such as the management of head injuries in ERs and cesarean deliveries in childbirth, but lower when measured across multiple procedures.⁴² The same study also surveyed physicians about nine hypothetical clinical scenarios likely to encourage defensive medicine practices and found the share of physicians reporting taking at least one clinical action primarily out of concern about malpractice varied widely depending on the situation—from 5 percent for back pain to 29 percent for head trauma. A more recent 1999 study that used records review found that reduced malpractice premiums for OB/GYNs were related to a statistically significant but small decrease in the rate of cesarean sections performed for some groups of mothers, a procedure researchers believe to be influenced by physicians' concerns about malpractice liability.⁴³

Some studies have also concluded that certain tort reforms may reduce defensive medicine as evidenced by slower growth in health care expenditures; however, these studies have not fully considered the range of factors that can influence medical spending.⁴⁴ For example, a 1996 study using records review found that for a population of elderly Medicare patients treated for acute myocardial infarction or ischemic heart diseases, certain tort reforms led to reductions of 5 to 9 percent in hospital

⁴¹Researchers generally rely on two approaches to measure the extent of defensive medicine practices. They (1) use surveys to present a clinical scenario, ask physicians to choose a treatment and provide a rationale for their decision, and may also examine the variation in survey responses across groups facing different amounts of malpractice pressure, or (2) review clinical or other records to compare actual treatment approaches and health care expenditures across groups of physicians facing different amounts of malpractice pressure.

⁴²U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-602 (Washington, D.C.: U.S. Government Printing Office, 1994).

⁴³Lisa Dubay, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics*, vol. 18, no. 4 (1999): 491-522.

⁴⁴Researchers have found that physician practice patterns and health care spending can vary greatly across geographic regions for many reasons. See Jonathan Skinner and John E. Wennberg, "How Much Is Enough? Efficiency and Medicare Spending in the Last Six Months of Life," working paper #6513, National Bureau of Economic Research (Cambridge, Mass.: April 1998).

expenditures.⁴⁵ However, this study did not control for other factors that can affect hospital costs, such as the extent of managed care penetration in different areas. When controlling for managed care penetration in a 2000 follow-up study, the same researchers found that the reductions in hospital expenditures attributable to direct tort reforms dropped to about 4 percent.⁴⁶ Moreover, preliminary findings from a 2003 study that replicated and expanded the scope of these studies to include Medicare patients treated for a broader set of conditions failed to find any impact of state tort laws on medical spending.⁴⁷ Appendix III summarizes the methods, findings, and limitations of published studies examining defensive medicine.

Studies Cannot Be Generalized to Reliably Estimate Defensive Medicine Prevalence and Costs

Although available research suggests that defensive medicine may be practiced in specific clinical situations, the findings are limited and cannot be generalized to estimate the prevalence and costs of defensive medicine nationwide. Because the studies focused on specific clinical circumstances and populations, even slight changes in these scenarios could yield significant changes in the degree of defensive medicine practices identified. Consequently, reports that use the results of these studies to estimate defensive medicine practices and costs nationally are not reliable. For example, recent reports by the U.S. Department of Health and Human Services (HHS) applied the 5 to 9 percent hospital cost savings estimate for Medicare heart patients to total national health care spending to estimate the total defensive medicine savings that could result if federal

⁴⁵The researchers found that direct reforms (such as caps on damage awards, abolition of punitive damages, and collateral-source rule reforms) were associated with reduced medical expenditures, while indirect reforms (such as caps on contingency fees, mandatory payment of damages through periodic installments, joint and several liability reform, and patient compensation funds) were not. Daniel P. Kessler and Mark B. McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, vol. 111, no. 2 (1996): 353-90.

⁴⁶Kessler and McClellan, "Medical Liability, Managed Care, and Defensive Medicine."

⁴⁷U.S. Congress, Congressional Budget Office (CBO), *Cost Estimate: H.R. 5 – Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003* (March 2003). CBO characterizes results relating to its analysis of defensive medicine practices as preliminary.

tort reforms were enacted.⁴⁸ Because the 5 to 9 percent savings only applies to hospital costs for elderly patients treated for two types of heart disease, the savings cannot be generalized across all services, populations, and health conditions.

States with Certain Noneconomic Damage Caps Had Lower Recent Growth in Malpractice Premium Rates and Claims Payments

Premium rates reported for the physician specialties of general surgery, internal medicine, and OB/GYN—the only specialties for which data were available—were relatively stable on average in most states from the mid- to late 1990s and then began to rise, but more slowly among states with certain noneconomic damage caps.⁴⁹ Malpractice claims payments against all physicians between 1996 and 2002 also tended to be lower and grew less rapidly on average in states with these damage caps than in states with limited reforms; however, these averages obscured wide variation between states in any given year and for individual states from year to year. Like the premium rate data, these claims payment data do not depict the experience of all providers; they exclude institutional providers such as hospitals and nursing homes, for which comprehensive data were not available. Moreover, differences in both premiums and claims payments are also affected by multiple factors in addition to damage caps, and we could not determine the extent to which differences among states were attributable to the damage caps or to additional factors.

Premium Growth Was Lower in States with Noneconomic Damage Caps Than in States with Limited Reforms

The average medical malpractice premium rates across the three specialties reported by MLM (general surgery, internal medicine, and OB/GYN) remained relatively stable during the mid- to late-1990s. From 1996 to 2000, average premium rates for all states changed little, as did average premium rates for states with certain caps on noneconomic damages and states with limited reforms, increasing or decreasing

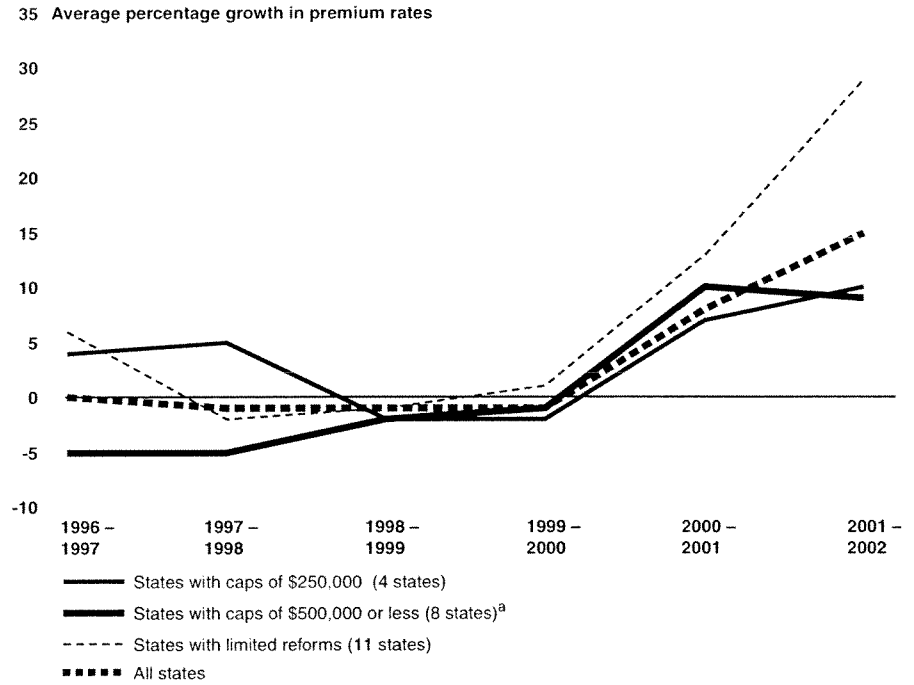
⁴⁸HHS, Office of the Assistant Secretary for Planning and Evaluation, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System* (Washington, D.C.: July 24, 2002), <http://aspe.hhs.gov/daltcp/reports/litrefm.htm> (downloaded June 9, 2003); and *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care* (Washington, D.C.: Mar. 3, 2003), <http://aspe.hhs.gov/daltcp/reports/medliab.htm> (downloaded June 9, 2003).

⁴⁹Noneconomic damages compensate for harm that is not easily quantifiable, such as pain and suffering.

annually by no more than about 5 percentage points on average.⁵⁰ After 2000, premium rates began to rise across most states on average, but more slowly among the states with certain noneconomic damage caps. In particular, from 2001 to 2002, the average rates of increase in the states with noneconomic damage caps of \$250,000 and \$500,000 or less were 10 and 9 percent, respectively, compared to 29 percent in the states with limited reforms. (See fig. 5.)

⁵⁰We focused our analysis on those states with noneconomic damage caps as a key tort reform because such caps are included in proposed federal tort reform legislation and because published research generally finds these caps to have a greater impact on medical malpractice premium rates and claims payments than some other tort reform measures. See appendix II for details on our classification of states by tort reforms.

Figure 5: Premium Rates for Three Physician Specialties Rose After 2000, but to a Lesser Extent in States with Noneconomic Damage Caps



Source: MLM.

Notes: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

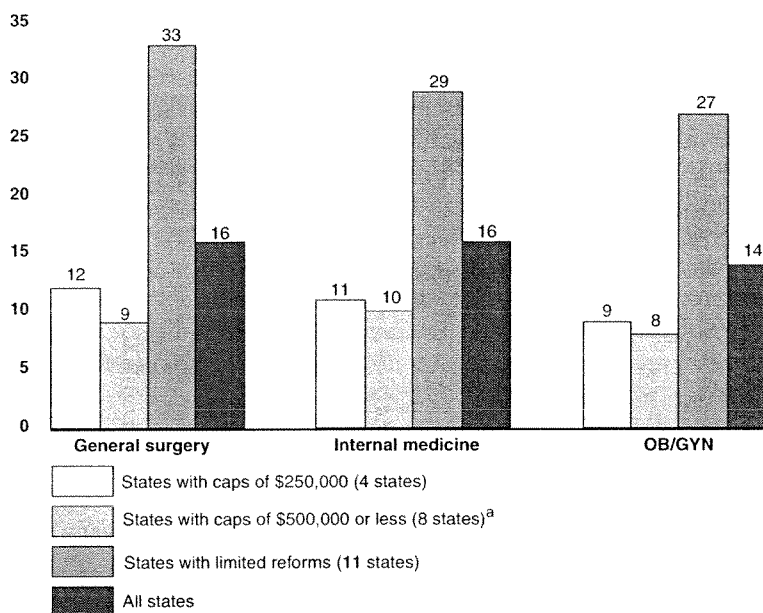
Premiums are adjusted for inflation to 2002 dollars.

^aThis category excludes states with caps of \$250,000.

The recent increases in premium rates were also lower for each reported physician specialty in the states with these noneconomic damage caps. From 2001 to 2002, the average rates of premium growth for each specialty in the states with these noneconomic damage caps were consistently lower than the growth rates in the limited reform states. (See fig. 6.)

Figure 6: Recent Premium Growth Was Lower for Three Physician Specialties in States with Noneconomic Damage Caps

40 Average percentage growth in premium rates, 2001-2002



Source: MLM.

Note: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

Premiums are adjusted for inflation to 2002 dollars.

^aThis category excludes states with caps of \$250,000.

In addition to including rates for only three specialties, premium rates reported by MLM are subject to other limitations. First, because MLM relies on a voluntary survey, its data do not include all insurers that provide coverage in each state. Certain companies that may have a large market share in a particular state may not be included. MLM estimates that its 2002 survey may exclude about one-third of the total malpractice insurance market nationwide. Second, insurers that do report rates have not consistently done so across all the years, or have not consistently reported premiums in different geographic areas within each state. We generally excluded data from insurers that did not consistently report premium rates across most of the years studied. Third, premium rates do not reflect discounts, premium offsets, or rebates that may effectively reduce the actual premium rate, or surcharges that are assessed in certain

states for physician participation in mandatory state-funded insurance programs. These surcharges can range from a small amount to more than the base premium rate.

Other studies have found a relationship between direct tort reforms that include noneconomic damage caps and lower rates of growth in premiums.⁵¹ For example, in a recent analysis of malpractice premiums in states with and without certain medical malpractice tort limitations, the Congressional Budget Office (CBO) estimated that certain caps on damage awards in combination with other elements of proposed federal tort reform legislation would effectively reduce malpractice premiums on average by 25 to 30 percent over the 10-year period from 2004 through 2013.⁵² A 1997 study that assessed physician-reported malpractice premiums from 1984 through 1993 found that direct reforms, including caps on damage awards, lowered the growth in malpractice premiums within 3 years of their enactment by approximately 8 percent.⁵³

Average Claims Payments and Growth Lower in States with Noneconomic Damage Caps Than in States with Limited Reforms

Average per capita payments for claims against all physicians tended to be lower on average in states with noneconomic damage caps than in states with limited reforms.⁵⁴ From 1996 through 2002, the average per capita payments were \$10 for states with these damage caps compared with \$17 for states with limited reforms. Within these averages, however, were wide variations among states. For example, in 2002 the per capita claims payments among states with these caps ranged from \$4 to \$16, compared with \$3 to \$33 among states with limited reforms. In addition, two states among those with limited reforms had consistently higher average claims payments, raising the overall average among this group of states.⁵⁵ Absent

⁵¹Direct reforms are limits on amounts that can be recovered in a malpractice action including: caps on noneconomic or total damages, abolition of punitive damages, collateral source rule reforms, and abolition of mandatory prejudgment interest.

⁵²CBO, *Cost Estimate: H.R. 5*.

⁵³Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," *Law and Contemporary Problems*, vol. 670, no. 1 (1997): 81-106.

⁵⁴Per capita claims payments are the total claims payments in each state divided by the state population.

the claims experience of these two states, the average claims payment for states with limited reforms from 1996 through 2002 would decrease to \$11, only slightly higher than the \$10 in states with these damage caps.

Average growth in per capita claims payments for all physicians was also lower among the states with caps on noneconomic damages than among the states with limited reforms. From 1996 through 2002 average per capita claims payments grew by 5 and 6 percent in the states with noneconomic damage caps of \$250,000 and \$500,000 or less, respectively, compared to 10 percent in the states with limited reforms. However, the growth in these payments also varied widely among states in any given year and within individual states from year to year. For example, from 2001 to 2002, the average growth in claims payments on an individual state basis ranged from a 68 percent decrease in the District of Columbia to a 70 percent increase in Wyoming. Within the same state, growth rates fluctuated widely from year to year. For example, Mississippi experienced an 18 percent decrease in claims payments from 1999 to 2000, followed by a 61 percent increase in 2001, and a 5 percent decrease in 2002.

The claims payment data reported to NPDB that we analyzed contain certain limitations. The data include malpractice claims against licensed physicians, and not against other institutional providers such as hospitals and nursing homes, thus limiting the overall completeness of the data across all providers. In addition, as we have previously reported, certain claims payments may be underreported to NPDB. When physicians are not specifically named in a malpractice settlement, the related claims payments may not be reported.⁵⁶ Nevertheless, because insurers must report payment of claims against physicians subject to federal law and not varying state laws, NPDB data are useful in comparing trends across states. Other sources of claims payment data are subject to limitations of

⁵⁵Average per capita claims payments among states with limited tort reforms were highest in the District of Columbia and Pennsylvania in each year from 1996 through 2002. For example, in 2002, average claims payments were \$27 and \$33 for the District of Columbia and Pennsylvania, respectively, compared to from \$3 to \$18 in the remaining states with limited tort reforms.

⁵⁶See U.S. General Accounting Office, *National Practitioner Data Bank: Major Improvements Needed to Enhance Data Bank's Reliability*, GAO-01-130 (Washington, D.C.: Nov. 17, 2000).

completeness or comparability.⁵⁷ See appendix II for more information on the limitations of NPDB and other claims data sources.

For states that have adopted certain tort reforms, especially caps on noneconomic damages, other studies have also found associations with lower claims payments. In its recent analysis of malpractice premiums and claims payments in states with various medical malpractice tort limitations, CBO found that caps on damage awards result in lower malpractice costs.⁵⁸ Another study based on claims data in 19 states showed that direct reforms were associated with a smaller percentage of claims resolved with some compensation to plaintiffs and reduced claim frequency.⁵⁹ In contrast, other researchers who have examined the effect of indirect tort reforms on malpractice costs have found mixed results.⁶⁰ One study found that indirect reforms did not reduce malpractice cost indicators, while another found that a greater number of reforms (both direct and indirect) were associated with lower malpractice costs.⁶¹ These studies have also relied on claims data that have limitations in terms of their completeness and comparability.

⁵⁷For example, the National Association of Insurance Commissioners (NAIC) maintains data on claims costs reported by malpractice insurers; however, NAIC officials told us that reporting requirements are dictated by state law. As a result, certain types of insurers are exempted from reporting in certain states (such as insurers operating in a single state, certain physician mutual companies, or—in all states—self-insured groups), thus limiting the usefulness of the data for making state-level comparisons.

⁵⁸CBO, *Cost Estimate: H.R. 5*.

⁵⁹See Daniel P. Kessler and Mark B. McClellan, “How Liability Law Affects Medical Productivity,” *Journal of Health Economics*, vol. 21, no. 6 (2002): 931-55.

⁶⁰Indirect reforms are changes in laws that do not directly specify limits on amounts that can be recovered in a malpractice action; rather, they may indirectly affect recoverable amounts, such as by limiting attorneys’ contingency fees or allowing periodic rather than lump sum payments of awards.

⁶¹Kessler and McClellan, “The Effects of Malpractice Pressure and Liability Reforms on Physicians’ Perceptions of Medical Care” and Stephen Foreman, Pennsylvania Medical Society Health Services Research Institute, *[Premium] Deceit: A Critique of a Center For Justice and Democracy Study by J. Robert Hunter and Joanne Doroshov* (Harrisburg, Pa.: Jan. 8, 2003).

Factors Other Than Caps on Noneconomic Damages Also Affect Premiums and Claims Payments Trends

Differences in malpractice premiums and claims payments across states are influenced by several factors other than noneconomic damage caps. First, the manner in which damage caps are administered can influence the ability of the cap to restrain claims and thus premium costs. Some states permit injured parties to collect damages only up to the specified level of the cap regardless of the number of defendants, while other states permit injured parties to collect the full cap amount from each defendant named in a suit. Malpractice insurers told us that imposing a separate cap on amounts recovered from each of several defendants increases total claims payouts, which can hinder the effectiveness of the cap in constraining premium growth. Second, tort reforms unrelated to caps can also affect premium and claims costs. For example, California tort reform measures not only include a \$250,000 cap but also allow other collateral sources to be considered when determining how much an insurer must pay in damages and allow periodic payment of damages rather than requiring payment in a lump sum, among other measures. Malpractice insurers told us that these provisions in addition to the cap have helped to constrain premium growth in that state. In Minnesota, which has no caps on damages but has relatively low growth in premium rates and claims payments, trial attorneys maintain that prescreening requirements reduce claim costs and premiums by preventing some meritless claims from going to trial. Third, state laws and regulations unrelated to tort reform, such as premium rate regulations, vary widely and can influence premium rates. Some states such as Minnesota and Mississippi tend not to regulate rates, while others, such as California, require state approval of the premium rates charged by insurers.⁶² Finally, insurers' premium pricing decisions are affected by their losses on medical malpractice claims and income from investments, and other market conditions such as the level of market competition among insurers and their respective market shares.⁶³ We could not determine the extent to which differences in premium rates and claims payments across states were attributed only to damage caps or also to these additional factors.

⁶²In 1988, California passed Proposition 103, which in part required greater state oversight and approval of premium rate increases.

⁶³For more information on the factors that influence malpractice premium rates, see GAO-03-702.

External Comments and Our Evaluation

We received comments on a draft of this report from three independent health policy researchers and from AMA. Each of the researchers has expertise in malpractice-related issues and has conducted and published research on the effects of malpractice pressures on the health care system, and two of the three are physicians. The independent researchers generally concurred with our findings and provided technical comments, which we incorporated as appropriate.

In its written comments, AMA questioned our finding that rising malpractice premiums have not contributed to widespread health care access problems, expressing concern that the scope of our work limited our ability to fully identify the extent to which malpractice-related pressures are affecting consumers' access to health care. We disagree with AMA, as explained below. However, in response to AMA and the other reviewers' comments, we clarified the report's discussion of the scope of work and methods used to assess health care access issues. AMA's comments fell into four general areas: completeness of evidence examined, measures used to assess access problems, time lags in available data, and the cost and impact of defensive medicine.

Completeness of Evidence Examined

AMA questioned our finding that access problems were not widespread based on our work in 5 states, whereas it has identified 18 states "in a full-blown liability crisis." It further cited results from its own recent physician survey on professional liability as evidence that medical liability concerns are causing physicians to limit their practices. The report clearly states the scope of our work and does not attempt to generalize our findings beyond the 5 states with reported problems that we reviewed. However, these 5 states were among the most visible and often-cited examples of "crisis" states by AMA and other provider groups. We believe that our finding that malpractice-related concerns contributed to localized but not widespread access problems in these states provides relevant and important insight into the overall problem. With respect to AMA's reference to evidence available from its own survey, our report notes that the low response rate of 10 percent to its survey precludes the ability to reliably generalize the survey results to all physicians.

AMA suggested that we withhold release of the report until we contacted state and national medical and specialty associations to obtain more complete and accurate information about access to care problems and it provided contacts for associations in each of the five states with reported problems and for four national specialty associations. We made these contacts throughout the course of our work, and the information these

associations provided formed the basis for many of our findings. As the draft report noted, we contacted state medical, hospital, and nursing home association representatives in each of the five states with reported problems. We also contacted nine national medical and specialty associations, including three of the four AMA cited, which were specified in the draft report. In response to AMA's comments, we added an appendix to specify the names of each national and state provider association we contacted during the course of our work.

AMA commented that we failed to account for the two clinical areas of patient care in which impairment of access has been the most egregious: obstetrical and ER services. It attributed its concern to our acknowledgment in the report that we were unable to use Medicare claims data to investigate reported concerns about these services. Because of the recognized limitations of Medicare claims data for these and other services, we used other methods to explore whether malpractice-related pressures had affected access to ER on-call surgical services and newborn deliveries and indeed found—and reported—evidence of access problems for these services in localized areas. In response to AMA and technical comments from the other reviewers, we clarified the report's discussion of our methodology for this issue.

Measures Used to Assess Access Problems

AMA commented that using aggregated data on physician supply to draw conclusions about access to care is problematic. It said that physicians tend to hold multiple state licenses and typically retain their licenses when they relocate their practices, thus potentially obscuring the supply of practicing physicians, and overall counts of physicians can obscure the impact of changes for different specialties and different jurisdictions. We agree that measuring changes in physician supply—especially changes due to malpractice-related issues—and the related effects on access to care is problematic. Sharing AMA's concerns, during the course of our work we obtained available data reported by state medical licensing agencies for newly licensed physicians and for physicians practicing in the state whenever possible rather than for all licensed physicians and contrasted those data with reports of departing physicians. As noted in the draft report, although we reported physician supply and practice changes at the state level, the number of recent departures attributed specifically to malpractice concerns was relatively small and usually not concentrated in particular locales. Also as noted in the draft report, we further explored reports of specialty-specific problems, such as orthopedic surgeons in Pennsylvania and OB/GYNs in Nevada. For example, we analyzed rates of all procedures performed by orthopedic surgeons in Pennsylvania and

found them to be growing, and called a random sample of OB/GYN practices in Clark County, Nevada, and on that basis determined that obstetrical care was readily available. Moreover, our Medicare claims analysis of certain high-risk services was specialty-specific. For example, to assess assertions by orthopedic surgeons that they have reduced the provision of spinal surgeries and joint revisions and repairs, our analysis was limited to only those services performed by orthopedic surgeons.

Time Lags in Available Data

AMA commented that our analysis of Medicare claims data as of June 2002 does not capture the current experience of physician decisions to curtail certain services or to retire or relocate their practices, the impact of which takes time to develop. We agree it is challenging to identify data that are sufficiently current and reliable to describe the effects of reported problems. However, we reported that premium increases began about 2000, and others have found that premiums began increasing as early as the late 1990s. We therefore believe that analyzing Medicare claims data through June 2002 provides important insights into at least 2 years of this most recent period of rising premiums. Moreover, we augmented our Medicare claims analysis with more recent qualitative data, such as interviews in late 2002 and early 2003, with national and state provider associations and local providers in areas where access problems were reported to exist.

The Cost and Impact of Defensive Medicine

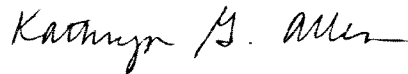
AMA commented that while specific estimates of defensive medicine costs have not been conclusive, the vast majority of peer-reviewed research indicates that those costs are enormous, in the tens of billions of dollars per year. To support this point, AMA cited three recent government studies. As our report notes, the peer-reviewed literature attempts to quantify the extent and sometimes the cost of defensive medicine under narrowly defined clinical circumstances that cannot be generalized more broadly. Two of the three government studies that AMA cited are examples of what we believe to be overgeneralizations of prior study results. We cite one of these by way of example in our report. The third government study AMA cited does not address the cost of defensive medicine but instead explicitly notes the difficulty of estimating such costs and the speculative nature of existing estimates.

AMA also commented that our draft report ignored the impact of defensive medicine costs in terms of patient access, expressing the view that these costs are ultimately reflected in rising health insurance premiums that contribute substantially to the number of uninsured. Our draft report

noted that, because of the absence of data to reliably measure overall malpractice-related costs—such as the combined cost of malpractice insurance premiums, litigation, and defensive medicine practices—we did not assess the indirect impact on access to care that may result from any added costs that malpractice pressures impose on the health care system. In response to AMA’s comment, we moved our discussion of this point to the report’s Results in Brief.

As agreed with your offices, unless you publicly announce this report’s contents earlier, we plan no further distribution until 30 days after its issue date. At that time, we will send copies to other interested congressional committees and Members of Congress. We will also make copies available to others on request. In addition, this report is available at no charge at the GAO Web site at <http://www.gao.gov>.

Please call me at (202) 512-7118 or Randy DiRosa at (312) 220-7671 if you have any questions. Other major contributors are listed in appendix IV.



Kathryn G. Allen
Director, Health Care—Medicaid
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Appendix I: National and State Provider Associations Contacted

During the course of our work, we contacted a number of national and state health care provider associations in order to identify the actions health care providers have taken in response to malpractice pressures and the localized effects of any reported actions on consumers' access to health care.

National Provider Associations

American Academy of Neurology
 American Association of Neurological Surgeons
 American Association of Orthopaedic Surgeons
 American College of Emergency Physicians
 American College of Obstetricians and Gynecologists
 American College of Radiology
 American Health Care Association
 American Hospital Association
 American Medical Association

State Provider Associations

Table 2: State Provider Associations GAO Contacted

State	Provider association
California	California Association of Health Facilities
	California Healthcare Association
	California Medical Association
Colorado ^a	Colorado Health and Hospital Association
Florida	Florida Health Care Association
	Florida Hospital Association
	Florida Medical Association
Minnesota	Minnesota Health and Housing Alliance
	Minnesota Hospital Association
	Minnesota Medical Association
Mississippi	Mississippi Health Care Association
	Mississippi Hospital Association
	Mississippi State Medical Association
Montana	Association of Montana Health Care Providers
	Montana Medical Association

Appendix I: National and State Provider Associations Contacted

State	Provider association
Nevada	Nevada Health Care Association
	Nevada Hospital Association
	Nevada State Medical Association
Pennsylvania	The Hospital & Healthsystem Association of Pennsylvania
	Pennsylvania Health Care Association
	Pennsylvania Medical Society
West Virginia	West Virginia Health Care Association
	West Virginia Hospital Association
	West Virginia State Medical Association

*We also contacted officials from the Colorado Medical Society and the Colorado Health Care Association, but they did not respond to our request for an interview.

Appendix II: Scope and Methodology

In response to concerns about rising malpractice premiums, we examined how health care provider responses to rising premiums have affected access to health care, what is known about how rising premiums and fear of litigation cause health care providers to practice defensive medicine, and how rates of growth in malpractice premiums and claims payments compare across states with varying levels of tort reform laws.

Consumers' Access to Health Care

To evaluate how actions taken by physicians in response to malpractice premium increases have affected consumers' access to health care, we focused our review at the state level because reliable national data concerning physician responses to malpractice pressures were not available. We selected nine states that encompass a range of premium pricing and tort reform environments. Five of the states—Florida, Mississippi, Nevada, Pennsylvania, and West Virginia—are among those cited as “crisis” or “problem” states by the American Medical Association (AMA) and other health care provider organizations based on such factors as higher than average increases in malpractice insurance premium rates, reported difficulties obtaining malpractice coverage, and reported actions taken by providers in response to their concerns about rising premiums and malpractice litigation. Four of the states—California, Colorado, Minnesota, and Montana—are not cited by provider groups as experiencing malpractice-related problems. (See table 3.)

Appendix II: Scope and Methodology

Table 3: Tort Reforms and Average Rates of Premium Increases in Nine States

Extent of malpractice problems	State	Tort reforms in place as of 1995 ^a			Average annual premium rate increase, 2001–2002 (percentage change)
		Noneconomic damage cap of \$250,000	Noneconomic damage cap of \$500,000 or less ^b	Other tort reforms	
States with reported problems ^d	Florida ^e			X ^f	23
	Mississippi				45
	Nevada				28
	Pennsylvania				35
	West Virginia			X ^g	12
States without reported problems	California	X		X	6
	Colorado	X		X	8
	Minnesota			X ^f	5
	Montana	X		X	10

Sources: National Conference of State Legislatures (NCSL) and Medical Liability Monitor (MLM).

Notes: GAO analysis of state tort reforms obtained from the NCSL “State Medical Liability Laws Table” (Oct. 16, 2002) and independently confirmed in selected instances.

Premium increases are based on base rates reported by MLM for specialties of general surgery, internal medicine, and obstetrics/gynecology (OB/GYN). Premiums are in 2002 dollars.

^aStates are categorized based on tort reforms enacted as of 1995 because research indicates any impact reforms may have on premium rates or claims payments would follow the implementation of tort reforms by at least 1 year. Mississippi, Nevada, and West Virginia have recently enacted varying tort reforms.

^bThis category excludes states with caps of \$250,000.

^cStates had no damage caps or collateral source reform.

^dProblem status based on the American Medical Association (AMA) classification of “crisis” state as of April 2003.

^eFlorida enacted a noneconomic damage cap of \$250,000 in 1988, but the cap was limited to cases involving arbitration; noneconomic damage limits may increase if the plaintiff or defendant refuses to arbitrate.

^fFlorida and Minnesota enacted mandatory collateral source offsets that directly reduced expected malpractice awards.

^gWest Virginia enacted a \$1 million cap on noneconomic damages.

In each of the nine states we reviewed, we contacted or interviewed officials from associations representing physicians, hospitals, and nursing homes to more specifically identify the actions physicians have taken in response to malpractice pressures and the localized effects of any reported actions on access to services. (See app. I for a complete list of the provider organizations we contacted at the state and national levels.) Such actions were reported only in the five states with reported problems. In these five states we obtained and reviewed the evidence upon which the reports were based. Evidence of physician departures, retirements, practice closures, and reduced availability of certain hospital-based services consisted of survey results, information compiled and quantified by provider groups, and unquantified anecdotal reports collected by provider groups. Although we did not attempt to confirm each report cited by state provider groups, we judgmentally targeted follow-up contacts with local providers where the reports suggested potentially acute consumer access problems or where multiple reports were concentrated in a geographic area. With the local providers we contacted directly, including representatives of physician practices, clinics, and hospitals, we discussed the reports provided by the state provider groups and explored the resulting implications for consumers' access to health care. In total, we contacted 49 hospitals and 61 clinics and physician practices in the five states. From these contacts we identified examples of access problems that were related to providers' concerns about malpractice-related pressures as well as examples of provider actions that did not appear to affect consumer access or were not substantiated.

We separately examined evidence of specific high-risk services that providers reportedly reduced in response to concerns about malpractice pressures. Such evidence consisted of results from surveys conducted by national and state-level medical, hospital, and specialty associations that identified the high-risk procedures physicians reported reducing or eliminating in response to malpractice pressures. High-risk services commonly identified in these surveys included spinal surgeries, joint revisions and repairs, mammograms, physician services in nursing homes, emergency room services, and obstetrics. We analyzed Medicare utilization data to assess whether reported reductions in three of these high-risk services—spinal surgery, joint revisions and repairs, and mammograms—have had a measurable effect on consumers' access to

these services.¹ To calculate service utilization rates per thousand fee-for-service Medicare beneficiaries enrolled in part B, we used Medicare part B physician claims data from January 1997 through June 2002 and the Medicare denominator files from 1997 through 2001.² For 2002, we estimated each state's part B fee-for-service beneficiary count by adjusting the 2001 count by the change in the 65 and older population between 2001 and 2002 and the change in Medicare beneficiaries enrolled in part B managed care plans between January 1 and July 1, 2002.³

Defensive Medicine Practices

To assess what is known about how rising premiums and fear of litigation cause health care providers to practice defensive medicine, we reviewed studies that examined the prevalence and costs of defensive medicine and the potential impact of tort reform laws on mitigating these costs that were published in 1994 or later, generally in peer-reviewed journals, or were conducted by government research organizations. We identified these studies by searching databases including MEDLINE, Econlit, Expanded Academic ASAP, and ProQuest; and through contacts with experts and affected parties. Several studies published prior to 1994 were reviewed by the Office of Technology Assessment (OTA) in its comprehensive 1994 report on defensive medicine, which we included in our review. In addition, we also explored the issue with medical provider organizations and examined the results of several recent surveys, including those conducted by national health care provider organizations,

¹Limitations to Medicare data precluded an assessment of trends for physician services provided in nursing homes, emergency room services, and obstetrics services. Utilization rates of services provided in nursing homes per Medicare beneficiary could not be completed because Medicare data do not identify the beneficiaries that reside in these facilities. Emergency room services could not be analyzed because it is not possible to accurately count emergency room services in the part B physician claims data. Obstetrics services could not be analyzed because Medicare beneficiaries are mostly elderly, so the counts of females of childbearing age are not representative of the general population.

²Medicare part B claims for these specific services were identified by the five-digit procedure codes specified in the Centers for Medicare & Medicaid Services' (CMS) Health Care Common Procedure Coding System (HCPCS).

³Population data were obtained from the U.S. Bureau of the Census. Medicare enrollment data were obtained from the Medicare Denominator File. The Medicare Denominator File contains data on all Medicare beneficiaries entitled to benefits in a given year and includes information on the programs in which they participate. The changes in Medicare enrollment in managed care programs were reported in CMS's *MMCC Monthly Summary Report on Medicare Managed Care Plans*. See HHS, CMS, *Medicare Managed Care Contract (MMCC) Plans - Monthly Summary Report* (Baltimore, Md.: Jan. 1, 2002 and July 1, 2002), <http://www.cms.hhs.gov/healthplans/statistics/mmcc/> (downloaded Apr. 16, 2003).

in which providers were asked about their own defensive medicine practices.

Malpractice Premium Rate and Claims Payments Growth

To assess the growth in medical malpractice premium rates and claims payments across states, we compared trends in states with tort reforms that include noneconomic damage caps (4 states with a \$250,000 cap and 8 states with a \$500,000 or less cap⁴) to the 11 states (including the District of Columbia) with limited reforms and the average for all states. We focused our analysis on those states with noneconomic damage caps as a key tort reform because such caps are included in proposed federal tort reform legislation and because published research generally reports that such caps have a greater impact on medical malpractice premium rates and claims payments than some other types of tort reform measures. We did not separately assess trends in the 28 states with various other tort reforms because of the wide range of often dissimilar and incomparable tort reforms that are included among these states. Because research suggests that any impact of tort reforms on premiums or claims can be expected to follow the implementation of the reforms by at least 1 year, we grouped states into their respective categories based on reforms that had been enacted no later than 1995 and reviewed premium rate and claims payment data for the period 1996 through 2002. We relied upon a summary of state tort reforms compiled by the National Conference of State Legislatures (NCSL) to place states within the reform categories and reviewed the information with respect to the 9 study states for accuracy in February 2003. (See table 4.)

⁴The eight states with a \$500,000 or less cap do not include the four states with a \$250,000 cap.

Appendix II: Scope and Methodology

Table 4: State Tort Reform Categories, Based on Reforms in Place as of 1995

Noneconomic damage cap of \$250,000 (4 states)	Noneconomic damage cap of \$500,000 or less ^a (8 states)	Other reforms ^{a,b} (28 states)	Limited reforms ^c (11 states)
California	Hawaii ^d	Alabama	Arkansas
Colorado ^d	Louisiana ^e	Alaska	District of Columbia
Montana	Massachusetts ^d	Arizona	Kentucky
Utah	Michigan ^d	Connecticut	Mississippi
	Missouri ^f	Delaware	Nevada
	North Dakota	Florida ^g	Ohio
	South Dakota	Georgia	Oklahoma
	Wisconsin	Idaho	Pennsylvania
		Illinois	South Carolina
		Indiana	Vermont
		Iowa	Wyoming
		Kansas ^h	
		Maine ⁱ	
		Maryland ^d	
		Minnesota	
		Nebraska	
		New Hampshire ⁱ	
		New Jersey	
		New Mexico ^j	
		New York	
		North Carolina	
		Oregon	
		Rhode Island	
		Tennessee	
		Texas	
		Virginia	
		Washington	
		West Virginia	

Source: NCSL.

Notes: GAO analysis of summary data compiled by NCSL (Oct. 16, 2002). We independently reviewed selected sections for accuracy.

^aIn states with patient compensation funds (PCF), the fund cap, rather than the per provider cap, is considered under these criteria. PCFs are either voluntary or mandatory state-sponsored funds that provide insurance coverage for health care providers beyond that guaranteed by the provider's medical liability insurance policy.

^bStates had a noneconomic or total damage cap above \$500,000, any punitive damage cap, or collateral source reform.

^cStates had no damage caps or collateral source reform.

^dCaps may be increased or removed under special circumstances.

^eLouisiana's PCF cap is subject to a total cap of \$500,000 for all claims of malpractice. Amounts awarded for future medical expenses are paid from the state fund and not by individual providers, and those amounts are not subject to the \$500,000 limit.

^fMissouri's cap is indexed to inflation and was \$500,000 in 1997, increasing to \$547,000 by 2002.

^gFlorida enacted a noneconomic damage cap of \$250,000 in 1988, but the cap was limited to cases involving arbitration; noneconomic damage limits may increase if the plaintiff or defendant refuses to arbitrate.

^hKansas enacted a noneconomic damage cap of \$250,000 in 1988, but these damages are recoverable by each party from all defendants.

ⁱA noneconomic damage cap is limited to wrongful death cases.

^jDamage cap increased beyond \$500,000 during 1995.

To assess the growth in medical malpractice premiums, we analyzed state-level malpractice premium rates for the specialties of general surgery, internal medicine, and obstetrics/gynecology (OB/GYN) reported by insurers to the Medical Liability Monitor (MLM) from 1996 to 2002.⁵ Our analysis does not capture the experience of other physician specialties and other types of medical providers such as hospitals and nursing homes. MLM reports base premium rates that do not reflect discounts or rebates that may effectively reduce the actual premium rates charged. We generally excluded data from insurers that did not consistently report premium rates across most of the years studied. We also excluded surcharges for contributions to state patient compensation funds (PCF) because these were inconsistently reported across states and years.⁶ We adjusted rates for inflation using the urban consumer price index. We calculated a composite average premium across all three specialties, as well as specialty-specific average premiums, for each year. We then analyzed growth rates in these average premiums from 1996 through 2002 across all states.

⁵MLM is a private research organization that annually surveys professional liability insurance carriers in 50 states to obtain their base premium rates for the specialties of internal medicine, general surgery, and OB/GYN.

⁶Where physicians participate in PCFs, they typically pay an annual surcharge for participation in the fund, an assessment for payments made out of the fund, or both. These surcharges can range from a small percentage of the base premium to nearly as much, and in some instances, more than the base premium.

To assess the growth in medical malpractice claims payments, we analyzed state level claims payment data from the National Practitioner Data Bank (NPDB) from 1996 to 2002, which had been adjusted to 2002 dollars.⁷ We calculated average per capita claims payments and their growth rates for each state across this time frame. Assuming a 1-year lag to allow the reforms to affect these indicators, we calculated overall averages of these indicators from 1996 to 2002, and used these averages to compare average per capita payments and their rates of growth across the reform categories.

The NPDB claims data we analyzed contain notable limitations. First, they include malpractice claims against licensed physicians only, and not against institutional providers such as hospitals and nursing homes.⁸ Secondly, as we have previously reported, NPDB claims may be underreported. When physicians are not specifically named in a malpractice judgment or settlement, the related claims are not reported to the data bank, and certain self-insured and managed care plans may be underreported as well.⁹ The extent to which this underreporting occurs is not known. Finally, NPDB data do not capture legal and other administrative costs associated with malpractice claims.

We examined other sources of information on claims payments, and found none to be a comprehensive data source for each state that captures malpractice claims costs from all segments of the malpractice insurance market—commercial insurers, physician-mutual companies, and self-

⁷NPDB, established by the Health Care Quality Improvement Act of 1986, is maintained by the Secretary of Health and Human Services and is a nationwide source of information on physicians and other licensed health care practitioners who have been party to a medical malpractice settlement or judgment. Insurers are required by law to report payments made on behalf of these providers in settlement or satisfaction of a judgment in a malpractice action, and are subject to civil penalties for noncompliance. Pub. L. No. 99-660, tit. IV, 100 Stat. 3743, 3784 (codified at 42 U.S.C. §§ 11101-11152 (2000))

⁸NPDB reports payments for claims against all licensed practitioners, including, physicians, nurses, and dentists; however, we analyzed payments only for claims against physicians. The consulting firm of Tillinghast-Towers Perrin estimates that total malpractice claims costs (including payments and defense and administrative costs) in 2001 were approximately \$21 billion. See Tillinghast-Towers Perrin, *U.S. Tort Costs: 2002 Update – Trends and Findings on the Costs of the U.S. Tort System*, <http://www.tillinghast.com/tillinghast/> (downloaded June 9, 2003). Payments reported for physician claims in the NPDB database for the same year (excluding associated defense/administrative costs) represent about 20 percent of these total costs.

⁹See GAO-01-130.

insured and other groups. For example, data reported to the National Association of Insurance Commissioners (NAIC) have been used in other research; however, data are not reported consistently across states and exclude payments from certain insurers. According to NAIC officials, the laws that dictate reporting requirements differ by state, and not all insurers are required to report in every state. They also stated that exempted insurers can include those operating in a single state and certain physician mutual companies.¹⁰ In all states, self-insured groups, which represent a substantial proportion of the medical malpractice insurance market, are exempted from reporting.¹¹ Similarly, the Insurance Services Office (ISO) is a private organization providing state-level price advisory information to state insurance regulators. However, ISO does not operate in all states, nor does it uniformly collect data on hospital claims, or claims from physician mutual companies, and represents only 25 to 30 percent of the total medical malpractice market. Physician Insurers Association of America is an association of physician mutual companies; however, it does not share proprietary state-level claims data. Jury Verdict Research is a private research organization that collects data from several different sources, including attorneys and media reports, among others. Some have criticized the accuracy of this data set for several reasons, including a varied and unsystematic data collection process and because large verdict awards may be more likely to be included than smaller verdict awards.

¹⁰We found that exempted companies are disproportionately represented in states with limited reforms.

¹¹NAIC claims data represented slightly over a third of the total malpractice claim costs reported by Tillinghast-Towers Perrin. See *Tillinghast-Towers Perrin* <http://www.tillinghast.com/tillinghast/>.

Appendix III: Summary of Selected Research Designed to Measure Defensive Medicine Prevalence and Costs

Table 5 summarizes the scope, methods, results, and limitations of studies that examined the prevalence and costs of defensive medicine practices or the potential impact of tort reform laws on mitigating defensive medicine costs. Studies were published in 1994 or later, generally in peer-reviewed journals, or were conducted by government research organizations.

Table 5: Summary of Selected Research Designed to Measure Defensive Medicine Prevalence and Costs

Study	Scope	Method	Results	Limitations
OTA, 1994 ^a	Physicians from three national specialty societies (1993 data), physicians from New Jersey (1993 data), and cesarean deliveries in New York State (1984 data) and Washington State (1989 data).	Physician clinical scenario surveys, records reviews, and synthesis of prior research.	Among other findings, defensive medicine causes less than 8 percent of diagnostic procedures and varies significantly by clinical situation.	Physician clinical scenario surveys were designed to elicit defensive medicine practices among physicians; hence, they may overestimate the rate at which defensive medicine is actually practiced.
Sloan and others, 1995 ^b and 1997 ^c	Births in Florida in 1987.	Survey of mothers and records reviews.	An increased threat of malpractice litigation is not associated with improved birth outcomes, and malpractice pressures generally had no impact on delivery method (cesarean vs. vaginal).	Results cannot be generalized, as study only assessed practice patterns in one state in 1 year.
Kessler and McClellan, 1996 ^d	Medicare beneficiaries treated for a new heart attack or new ischemic heart disease (1984, 1987, and 1990 data).	Records reviews.	Direct tort reforms enacted by states between 1985 and 1990 reduced hospital expenditures for Medicare patients with a new heart attack or new ischemic heart disease by 5 to 9 percent, respectively; indirect reforms had no effect. Among states adopting direct reforms prior to 1985, no consistent effect was found.	Results cannot be generalized to all patients and procedures, and certain other factors that can influence practice patterns and health care expenditures (such as the prevalence of managed care in an area) were not controlled for.
Dubay, Kaestner, and Waidmann, 1999 ^e	Births in the United States from 1990 to 1992.	Records reviews.	A \$10,000 reduction in malpractice premiums could result in a 1.4 to 2.4 percent decline in the cesarean section rate for some mothers. Researchers concluded a total cap on damages would reduce the number of cesarean sections by 3 percent and total obstetrical charges by 0.27 percent.	Results are limited to only certain socioeconomic groups of mothers.

**Appendix III: Summary of Selected Research
Designed to Measure Defensive Medicine
Prevalence and Costs**

Study	Scope	Method	Results	Limitations
Kessler and McClellan, 2000 ^f	Medicare beneficiaries treated for a new heart attack or new ischemic heart disease (1984-94 data). Study attempted to control for the influence of managed care.	Records reviews.	When controlling for the influence of managed care, direct tort reforms reduced hospital expenditures for Medicare patients with a new heart attack or new ischemic heart disease by about 4 percent.	Results cannot be generalized to all patients and procedures, and certain other factors that can influence practice patterns and health care expenditures (such as the supply of cardiac specialists in an area) were not controlled for.
Kessler and McClellan, 2002 ^g	Medicare beneficiaries treated for a new heart attack or new ischemic heart disease (1984-94 data). Study attempted to identify the mechanisms through which reforms affect the behavior of health care providers.	Records reviews.	Direct tort reforms reduced malpractice pressure and hospital expenditures for Medicare patients with a new heart attack or new ischemic heart disease; indirect reforms increased malpractice pressure in some cases.	Findings cannot be generalized to all patients and procedure, and certain other factors that can influence practice patterns and health care expenditures (such as the prevalence of managed care in an area) were not controlled for.
CBO, 2003 ^h	Medicare beneficiaries diagnosed with a broader set of ailments than considered in previous research (1989-99 data).	Records reviews and expenditure analysis.	No effect of tort controls on medical expenditures or per capita health spending.	Results cannot be generalized to all patients and procedures.

Sources: As noted below.

Note: Researchers generally rely on two approaches to measure the extent of defensive medicine practices. They (1) use surveys to present a clinical scenario, ask physicians to choose a treatment and provide a rationale for their decision, and may also examine the variation in survey responses across groups facing different amounts of malpractice pressure, or (2) review clinical or other records to compare actual treatment approaches and health care expenditures across groups of physicians facing different amounts of malpractice pressure.

^fU.S. Congress, OTA, *Defensive Medicine and Medical Malpractice*, OTA-H-602 (Washington, D.C.: U.S. Government Printing Office, 1994).

^gFrank A. Sloan and others, "Effects of the Threat of Medical Malpractice Litigation and Other Factors on Birth Outcomes," *Medical Care*, vol. 33, no. 7 (1995): 700-14.

^hFrank A. Sloan and others, "Tort Liability and Obstetricians' Care Levels," *International Review of Law and Economics*, vol. 17, no. 2 (1997): 245-60.

ⁱDaniel P. Kessler and Mark B. McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, vol. 111, no. 2 (1996): 353-90.

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**Appendix III: Summary of Selected Research
Designed to Measure Defensive Medicine
Prevalence and Costs**

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²Daniel P. Kessler and Mark B. McClellan, "How Liability Law Affects Medical Productivity," *Journal of Health Economics*, vol. 21, no. 6 (2002): 931-55.

³U.S. Congress, CBO, *Cost Estimate: H.R. 5 – Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003* (March 2003).

Appendix IV: GAO Contacts and Staff Acknowledgments

GAO Contact

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