WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Task Force on Medical Malpractice (ATF-MM)

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- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Appointments* ... *Appt*
- **

- *Clearinghouse Rules* ... *CRule*
- **

- *Committee Hearings* ... *CH*
- **

- *Committee Reports* ... *CR*
- **

- *Executive Sessions* ... *ES*
- **

- *Hearing Records* ... *HR*
- **

- *Miscellaneous* ... *Misc*
- **05hr_ATF-MM_Misc_pt15b**

- *Record of Comm. Proceedings* ... *RCP*
- **

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

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

[a]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.)

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

		Tort reforms in place as of 1995[a]				
Extent of malpractice problems	State	Noneconomic damage cap of $250,000	Noneconomic damage cap of $500,000 or less[b]	Other tort reforms	Limited tort reforms[c]	Average annual premium rate increase, 2001–2002 (percentage change)
States with reported problems[d]	Florida[e]			X[f]		23
	Mississippi				X	45
	Nevada				X	28
	Pennsylvania				X	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.

[a]States 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.

[b]This category excludes states with caps of $250,000.

[c]States had no damage caps or collateral source reform.

[d]Problem status based on the American Medical Association (AMA) classification of "crisis" state as of April 2003.

[e]Florida 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.

[f]Florida and Minnesota enacted mandatory collateral source offsets that directly reduced expected malpractice awards.

[g]West 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,

[1]Limitations 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.

[2]Medicare 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).

[3]Population 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 cap[4]) 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.)

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

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[j]	
		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.

[a]In 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.

[b]States had a noneconomic or total damage cap above $500,000, any punitive damage cap, or collateral source reform.

[c]States had no damage caps or collateral source reform.

[d]Caps may be increased or removed under special circumstances.

[e]Louisiana'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.

[f]Missouri's cap is indexed to inflation and was $500,000 in 1997, increasing to $547,000 by 2002.

[g]Florida 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.

[h]Kansas enacted a noneconomic damage cap of $250,000 in 1988, but these damages are recoverable by each party from all defendants.

[i]A noneconomic damage cap is limited to wrongful death cases.

[j]Damage 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.

[5]MLM 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.

[6]Where 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-

[7]NPDB, 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))

[8]NPDB 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.

[9]See 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.

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

[11]NAIC 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.

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.

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

[b]Frank 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.

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

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

[e]Lisa 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.

[f]Daniel P. Kessler and Mark B. McClellan, "Medical Liability, Managed Care, and Defensive Medicine," working paper #7537, National Bureau of Economic Research (Cambridge, Mass.: 2000).

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

[h]U.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

Randy DiRosa, (312) 220-7671

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