United States General Accounting Office

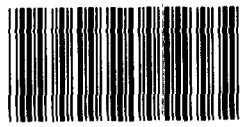
GAO

Report to the Honorable
Harry Reid, U.S. Senate

July 1992

PRACTITIONER DATA BANK

Information on Small Medical Malpractice Payments



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GAO/IMTEC-92-56

GAO

United States
General Accounting Office
Washington, D.C. 20548

Information Management and
Technology Division

B-248908

July 7, 1992

The Honorable Harry Reid
United States Senate

Dear Senator Reid:

This report responds to your request for information on small malpractice payments of less than $30,000 in the Department of Health and Human Services' (HHS) National Practitioner Data Bank. This data bank, which opened in September 1990, enables HHS to collect and release information on medical malpractice payments and adverse professional actions involving physicians, dentists, and other health care practitioners. In your request, you expressed concern that small payments are frequently considered meritless and implicate physicians who do not want to incur the expense of going to court to resolve disputes. As agreed with your office, our objectives were to (1) identify and analyze the range of malpractice payments reported to the data bank, and (2) report the views of key health care service and professional organizations on including small malpractice payments in the data bank. Details of our objectives, scope, and methodology are provided in appendix I.

Results in Brief

Reports of malpractice payments less than $30,000 constituted about 44 percent of the more than 15,000 malpractice reports received during the data bank's first year of operation. However, these reports accounted for only about 4 percent of the almost $2 billion in total reported payments. The percentage of small payment reports varied significantly by type of practitioner—dentists and pharmacists had 80 and 89 percent, respectively, of their reports under $30,000 while physicians had 36 percent of their reports under this threshold.

Many leading health care service and professional organizations believe that the requirement to report small payments is an unnecessary burden for data that may not be meaningful to users. However, some of these organizations are concerned that a single threshold may not be appropriate for each type of practitioner and that eliminating small payments could lead to manipulation of payment data to avoid reporting. Ongoing and completed HHS and HHS Office of Inspector General work offers insights on some of these issues.

Background

The Health Care Quality Improvement Act of 1986 (P.L. 99-660), as amended, authorized the Secretary of HHS to establish a data bank system to help ensure that unethical or incompetent practitioners do not compromise health care quality. This system, known as the National Practitioner Data Bank, was created to help meet a national need to restrict the ability of incompetent practitioners to move from state to state without disclosure or discovery of the practitioner's previous damaging or incompetent performance. The data bank contains information on adverse actions taken against a practitioner's license, clinical privileges, and professional society memberships, as well as information on malpractice payments resulting from judgments or settlements.

Health care entities, state medical and dental boards, and professional societies are all required by the Act to report adverse actions, such as license suspensions, taken against a practitioner. In addition, entities such as insurance companies and self-insured hospitals must report each malpractice payment at the time it is made. (App. II contains a copy of a malpractice payment report.)

Hospitals, group medical practices, professional societies, state licensing boards, and practitioners all have access to data bank information. The Act requires hospitals to query the data bank whenever they are (1) considering hiring or granting clinical privileges to a health care practitioner or (2) conducting reviews of health care practitioners, which occur every 2 years. Further, one of the Joint Commission on Accreditation of Healthcare Organizations' standards is that hospitals use judgment and settlement information in granting and renewing clinical privileges of their medical staff. Hospitals can comply with this standard by obtaining malpractice data from both the data bank and other sources, such as state data banks or insurance companies.

In December 1988, HHS' Health Resources and Services Administration awarded a 5-year, $15.8-million contract to the Unisys Corporation to establish and operate the National Practitioner Data Bank at the company's computer facility in Camarillo, California. As of August 31, 1991, the end of its first year of operation, the data bank contained 18,802 malpractice and adverse action reports, and had processed 838,573 queries.

In the autumn of 1991, pursuant to a requirement of the Act, HHS began studying whether a dollar threshold should be established under which reporting of small malpractice payments would not be required. As part of this study, HHS has collected position statements from major health care

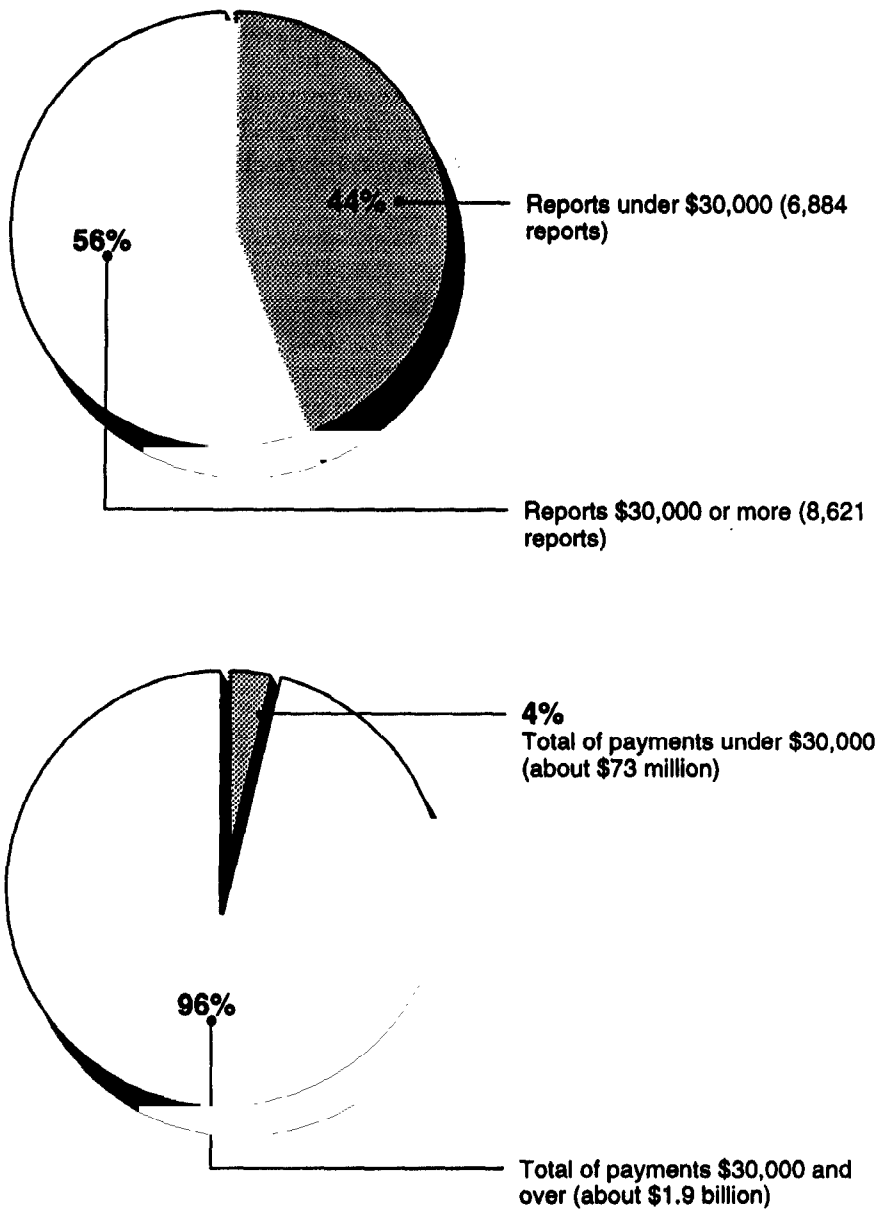
and professional organizations, is analyzing malpractice payments in the data bank, and contracted for analysis of malpractice data in state data bases. Further, the HHS Office of Inspector General surveyed organizations that report malpractice payments to the data bank to identify the potential impact of establishing a reporting threshold and is currently surveying users of the data bank. The HHS study and the Inspector General's users survey are expected to be completed later this summer.

Composition of Malpractice Payment Reports in the Data Bank

During its first year of operation, 15,505 malpractice payment reports were submitted to the data bank.[1] These reports represented almost $2 billion in total payments and ranged from $1 to approximately $4.7 million. As shown in figure 1, approximately 44 percent of the total number of malpractice reports were for payments under $30,000, while these reports represented only about 4 percent of the $2 billion in total reported malpractice payments.

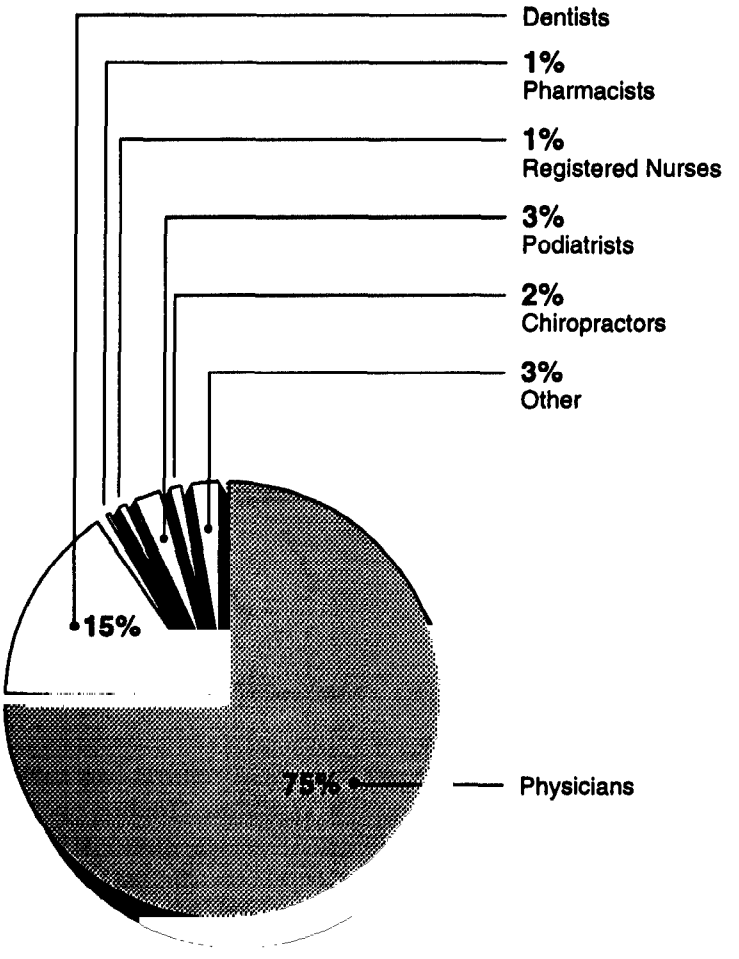
[1]This amount does not include 457 reports that either contained missing payment data, were voided, or whose accuracy was disputed by a practitioner.

Figure 1: Number and Total Dollar Value of Small Malpractice Payment Reports Compared to All Malpractice Reports



The majority of malpractice reports—75 percent—involved physicians, 15 percent involved dentists, and the remaining 10 percent involved other licensed practitioners. Figure 2 provides a summary of malpractice reports by practitioner.

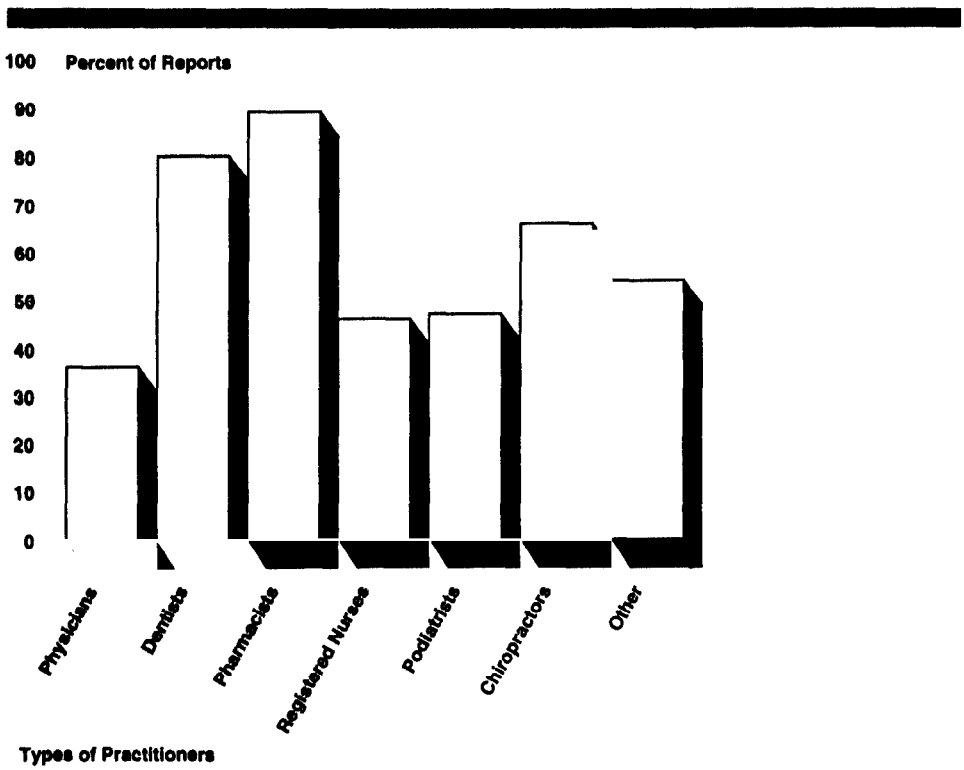
Figure 2: Malpractice Reports by Type of Practitioner



Of the 15,505 reports with usable payment data, 230 had missing or nonvalid practitioner licensure types.

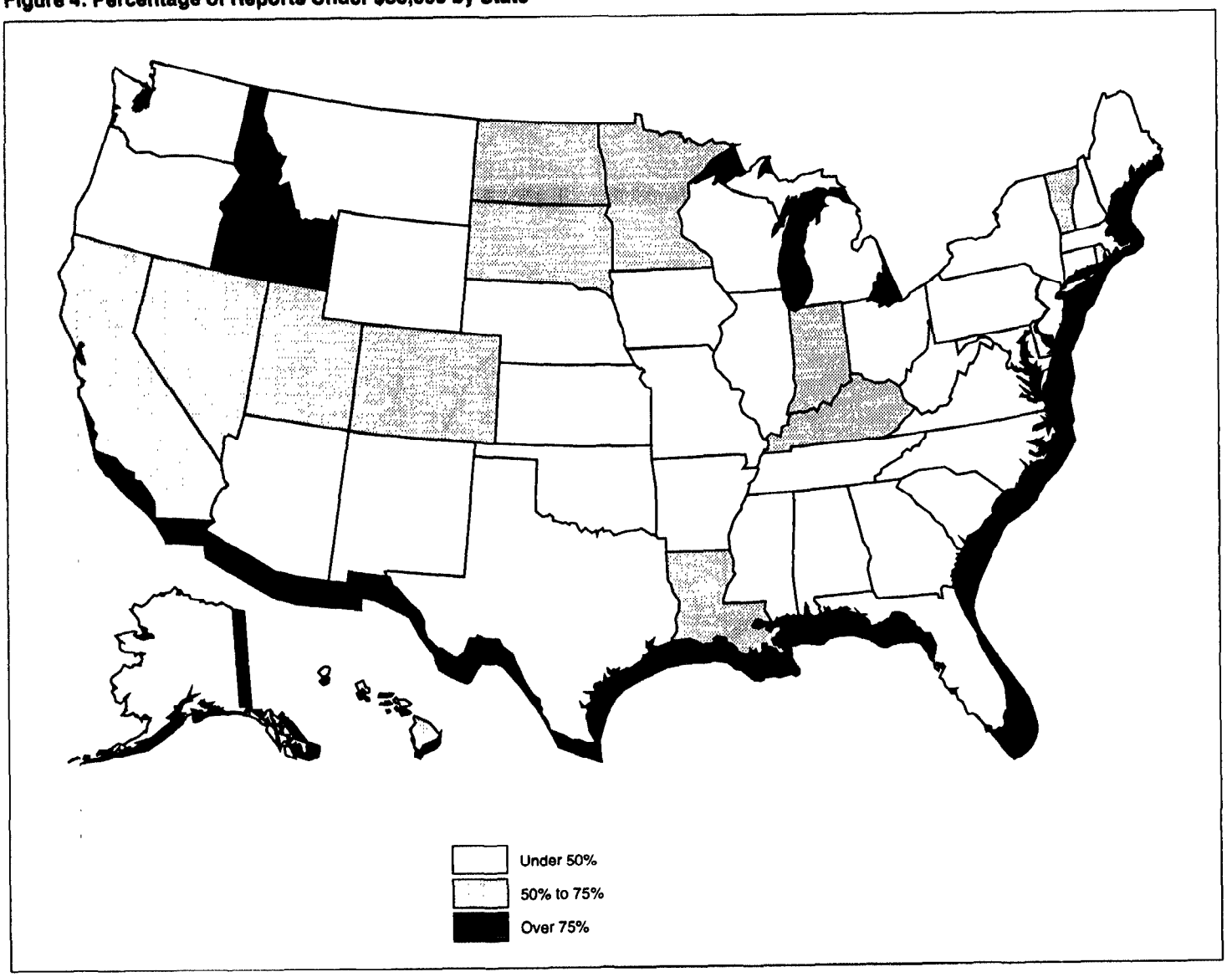
The percentage of malpractice reports under $30,000 varied significantly by type of practitioner, as shown in figure 3. While physicians had 36 percent of their reports under $30,000, dentists and pharmacists had 80 and 89 percent, respectively, below this threshold.

Figure 3: Percentage of Reports Under $30,000 by Type of Practitioner



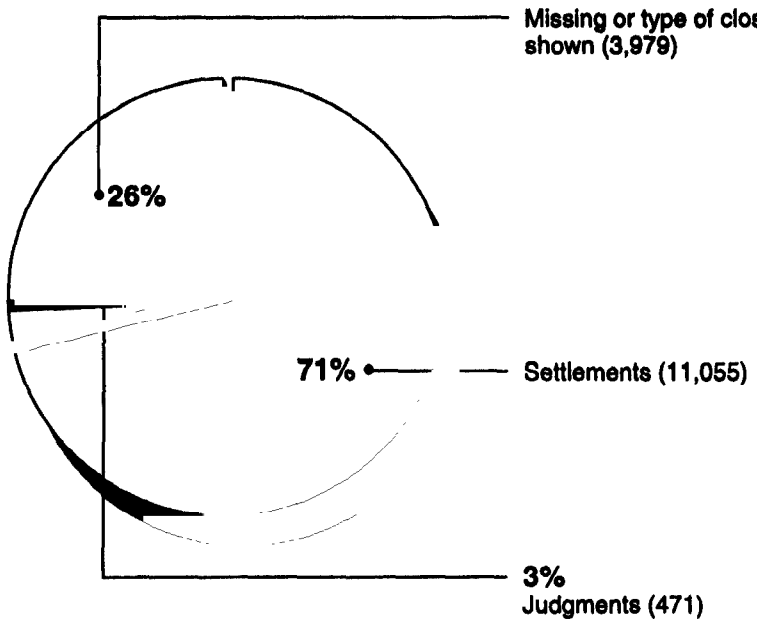
The percentage of reports less than $30,000 also varied by state. As figure 4 shows, in one state (Idaho) over 75 percent of the reports were less than $30,000; in 13 states, small payment reports comprised between 50 to 75 percent of total reports; and in the remaining states, small payment reports comprised less than 50 percent of total reports.

Figure 4: Percentage of Reports Under $30,000 by State



As figure 5 shows, approximately 71 percent of the reported payments for all malpractice reports were the result of settlements between parties while 3 percent were the result of court judgments. Settlements represented about $1.5 billion in total payments and judgments $120 million. The type of closure was not indicated on the remaining 26 percent of the reports.

Figure 5: Malpractice Reports by Type of Closure



Type of closure for reports under $30,000 was generally representative of the above overall composition—approximately 68 percent were settlements and 2 percent were judgments.

Many Leading Health Organizations View Small Payment Reports As Burdensome and Not Meaningful

In response to HHS' invitation, 14 of the nation's leading health care service and professional organizations submitted position statements on whether the reporting of small malpractice payments to the data bank should be discontinued.[2] HHS is using these statements in its ongoing study of small malpractice reports.

[2]Each of these organizations has a representative on the Data Bank's Executive Committee, which serves as an advisory group to HHS' contractor on data bank operations.

Nine of the 14 organizations submitting position statements supported establishing a dollar threshold for malpractice reports. A major reason provided by these organizations was their belief that reporting small malpractice payments imposes an unnecessary cost burden on organizations for data that may not be meaningful to users. These organizations contended that small payments result primarily from the settlement of nuisance claims that lack merit but would be too expensive to fight in court.

Of the remaining five organizations, three were against establishing a threshold and two did not take a position on the issue. Those against the threshold expressed concerns that a single threshold may not be appropriate for each type of practitioner and geographic location, and thresholds could result in organizations manipulating payment data to avoid reporting. Appendix III identifies the 14 organizations that provided position statements and their reasons for these positions.

HHS Work Provides Information on Organizations' Views on Small Payments

Ongoing and completed HHS and HHS Office of Inspector General work provides further insights on the organizations' concerns. Specifically, the work provides additional information on the (1) reasonableness of the burden of reporting small malpractice payments, (2) usefulness of small malpractice data, (3) extent to which multiple small malpractice payments are a predictor of future malpractice problems, (4) appropriateness of a single threshold, and (5) magnitude of potential avoidance reporting if a threshold were implemented. On the basis of its completed work, the Inspector General concluded that the potential drawbacks of imposing a reporting threshold outweighed the potential benefits, but did not make any recommendations because it stated that its work was limited in scope.

To estimate the burden on organizations of reporting small malpractice payments, the HHS Inspector General conducted a survey of 62 malpractice insurers and 6 licensing boards. On the basis of this survey, the Inspector General estimated that the cost to insurers to complete and submit all malpractice reports to the data bank is a total of 21,663 hours annually. Using this estimate, if a $30,000 reporting threshold had been in effect for the data bank's first year, the reporting burden would have been reduced by about 44 percent or 9,500 hours. Unisys, HHS' contractor for operating the data bank, estimated that annual costs could be reduced by $44,400 for salaries and benefits, and $5,160 for supplies and computer expenses, if a threshold of $30,000 were established. This estimate was based on Unisys'

determination that malpractice payment reports constitute less than 3 percent of the data bank's total volume of transactions.

Conclusive information is not available on the usefulness of small malpractice payments data. The HHS Inspector General is surveying about 100 hospitals and other entities that requested and received reports on practitioner malpractice payments. To the extent that reports sent to these hospitals contained small malpractice payments, the study will collect information on the hospitals' experiences in using such data. However, the Inspector General's study was not specifically designed to evaluate the usefulness of small malpractice payments data. To support the position statement it sent to HHS, the Department of Defense analyzed its data on (1) malpractice payments and (2) internal determinations of whether Defense's standard of care was met. Defense found that its standard of care was not met in 46 percent of the cases with malpractice payments of $30,000 or less compared to 63 percent of those cases with payments of more than $30,000.

As part of its ongoing work, HHS also contracted with researchers to conduct studies of malpractice data bases in three states to determine if data on multiple small payments are a predictor of future malpractice problems. In two of the three malpractice data bases reviewed, the studies found that practitioners with small payments were more likely to have larger payments later. For example, the review for New Jersey disclosed that (1) physicians with small payments in the first 5 years had twice as much chance of having a payment in the second 5 years as compared to those with no payments, and (2) physicians with both small and large payments in the first 5 years had a higher probability of a subsequent large payment compared to those with only a large payment in the first 5 years.

Regarding the appropriateness of a single threshold, some of the organizations' position statements noted that malpractice reporting thresholds vary by geographic area. For example, most state medical boards for physicians require all malpractice payments to be reported to them, but six use a threshold varying from $1,000 to $30,000. According to the American Association of Dental Examiners, about half of their state boards require the submission of malpractice reports for their review, but only a few use a threshold.

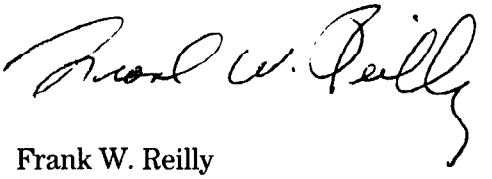
On avoidance reporting, the HHS Inspector General found that some states had many cases settled for $1 under the state's reporting threshold. For example, in California about 10 percent of the malpractice payments were

$1 less than the state's reporting threshold. New Jersey previously had a $25,000 threshold but eliminated it because the state medical board (1) found that many claims were being settled for $24,999 and (2) was concerned that it would not identify incompetent physicians who had many judgments or settlements for amounts less than the threshold. In response to the HHS Inspector General survey, some insurers stated that payments may be divided among multiple practitioners to avoid reporting to malpractice data banks. Malpractice payments for one practitioner can also be divided. For example, one practitioner had 211 reports in the National Practitioner Data Bank, each for less than $1,000, yet they were all the result of one class action settlement of $197,195.

We conducted our review from December 1991 through June 1992, in accordance with generally accepted government auditing standards. The views of HHS officials, including the Director of the Bureau of Health Professionals, other senior HHS Health Resources and Services Administration officials responsible for the data bank, and Office of Inspector General officials, were sought during the course of our work and their comments have been incorporated where appropriate. These officials generally agreed with the information presented in the report. Therefore, we did not obtain written agency comments on a draft of this report.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the date of this letter. At that time, we will send copies to the Secretary of Health and Human Services, the Director, Office of Management and Budget; and interested congressional committees. Copies will also be made available to others upon request. Please contact me at (202) 512-6408 if you have any questions concerning this report. The major contributors to this report are listed in appendix IV.

Sincerely yours,



Frank W. Reilly
Director
Human Resources Information Systems

Contents

Figures

Abbreviations

GAO	General Accounting Office
HHS	Department of Health and Human Services
IMTEC	Information Management and Technology Division

Objectives, Scope, and Methodology

In response to the request of Senator Harry Reid, we obtained information on small malpractice payments of less than $30,000 in the National Practitioner Data Bank. Our specific objectives were to (1) identify and analyze the range of malpractice payments reported to the data bank, and (2) report the views of key health care service and professional organizations on including small malpractice payments in the data bank.

To identify the range of payments, we obtained and analyzed an automated file containing malpractice reports recorded in the data bank during its first year of operation ending August 31, 1991. Our analysis was limited to first-year data because information on the total amount of malpractice settlements was readily available for this time period only. The data bank can routinely provide data only on the individual payment amount and not the total amount, but at HHS' request Unisys had previously prepared a special file containing both these amounts for reports recorded during the first year.

We tested the integrity and accuracy of the malpractice payment file by examining the computer programs used to extract the information from the data bank files and testing a sample of data from the special file. We tested a random sample of 50 cases by comparing the special file's data to the data on the original reports submitted to the data bank. This comparison focused on the recorded data for payment amounts, type of practitioner, state, type of closure, designation of single or multiple payments, and number of practitioners involved in the payment. Test results for this sample did not disclose any errors in excess of 5 percent; therefore, we did not test additional cases. After completing these tests, we tabulated the data on the special file by major information category including size of payment, type of practitioner, state, and type of closure.

To obtain the views of key health care service and professional organizations, we collected the position statements of organizations that have representatives on the National Practitioner Data Bank's Executive Committee. These organizations represent the interests of health care professionals, state licensing boards, insurance companies, and health care public interest groups. Where appropriate, we contacted the organizations' representatives to clarify their position statements.

We also obtained and analyzed the initial results of studies being conducted by HHS and the HHS Inspector General concerning the perceived reporting burden and the potential usefulness of data on small malpractice payments. The HHS studies are being conducted by contractors who analyzed

malpractice data bases in Florida, Maryland, and New Jersey.[1] We did not attempt to test or otherwise validate the results of these studies. We reviewed the HHS Inspector General's report National Practitioner Data Bank: Malpractice Reporting Requirements (OEI-01-90-00521, April 1992), which contained the results of a survey of (1) 62 malpractice insurers to identify the burden associated with preparing malpractice reports and (2) six state medical boards to identify states' experiences with reporting thresholds. We also reviewed the questionnaire that the Inspector General planned to use in its survey of hospitals to identify how they have used data bank information.

We conducted our work at HHS' Health Resources and Services Administration in Rockville, Maryland, and Unisys' computer facility in Camarillo, California, from December 1991 to June 1992. The views of HHS officials, including the Director of the Bureau of Health Professionals, other senior officials who are responsible for the data bank, and HHS Office of Inspector General officials, were sought during the course of our work and their comments have been incorporated where appropriate. These officials generally agreed with the information presented in the report. Therefore, we did not obtain written agency comments on a draft of this report.

[1]HHS contracted with the Urban Institute to analyze Florida data, the Johns Hopkins University to analyze Maryland data, and the Rand Corporation to analyze New Jersey data.

Malpractice Report Filed With the Data Bank

National Practitioner Data Bank
P.O. Box 6048
Camarillo, CA 93011-6048

MEDICAL MALPRACTICE PAYMENT REPORT

OMB NO. 0915-0126
EXP. DATE 3/31/91

FOR DATA BANK USE ONLY — Document Number of Previous Report (To be entered by Reporting Entity only when submitting a "Correction or Addition" or "Void Previous Report.")

SECTION A — REPORTING ENTITY INFORMATION

1. Data Bank ID (16) | 4. Type of Report: ☐ Initial Report ☐ Correction or Addition ☐ Void Previous Report
3. Relationship of Entity to the Practitioner: ☐ Insurance Company ☐ Self-Insured Individual ☐ Self-Insured Organization
4. Entity Name (40)
5. Street Address (40)
6. City (28) | 7. State (2) | 8. Zip Code (5 or 9)

SECTION B — PRACTITIONER INFORMATION — Add'l Info (See Instructions) ☐

9. Practitioner Name: Last (25) | First (15) | Middle (15) | Suffix (3)
10. Other Name Used: Last (25) | First (15) | Middle (15) | Suffix (3)
11. Organization Name (40)
12. Work Address (40)
13. City (28) | 14. State (2) | 15. Zip Code (5 or 9) | 16. Country (if not U.S.) (10)
17. Home Address (40)
18. City (28) | 19. State (2) | 20. Zip Code (5 or 9) | 21. Country (if not U.S.) (10)
22.a. License Number (16) | 22.b. State of Licensure (2) | 22.c. Field of Licensure (3)
23. Date of Birth (mm/dd/yy) | 24. Social Security Number (U.S.) (9) | 25. Federal DEA No. (12)
26.a. Professional School Attended (40) | 26.b. Year of Graduation (4)
27.a. Hospital Affiliation (40) | 27.b. City (28) | 27.c. State (2)

SECTION C — PAYMENT INFORMATION — Add'l Info (See Instructions) ☐

28. Act(s) or Omission(s) Code(s) (3): a. b.
29. Date(s) of Act(s) or Omission(s): a. b.
30. Payment Date (mm/dd/yy) | 31. Amount Paid: a. b. | 32. ☐ Single Payment ☐ Multiple Payments | 33. Number of Practitioners on Whose Behalf Payment Was Made
34. Payment Made for: ☐ Judgment, if any ☐ Settlement, if any | 35. Date of Judgment or Settlement, if any (mm/dd/yy) | 36. Adjudicative Body Case Number, if applicable
37. Adjudicative Body Name, if applicable (80)
38. Description of the acts or omissions and injuries or illnesses upon which the action or claim was based (600 - see instructions)
39. Description and total amount of judgment or settlement and any conditions attached thereto, including terms of payment (600)

SECTION D — CERTIFICATION

I certify that the reporting entity or individual identified in Section A of this report is authorized, under the provisions of P.L. 99-660, as amended, and as specified in 45 CFR Part 60, to provide this information to the National Practitioner Data Bank. I further certify that the reporting entity or individual has authorized me to submit this report to the Data Bank and that the information provided is true and complete.

WARNING: Any person who knowingly makes a false statement or misrepresentation to the National Practitioner Data Bank is subject to a fine and imprisonment under Federal statute

40. Printed Name of Authorized Representative/Self-Insured Individual (40)
41. Title of Authorized Representative (40)
42. Telephone Number (15) ( ) ext. | 43. Signature Date (mm/dd/yy) | 44. Signature of Authorized Representative/Self-Insured Individual

SECTION E — SELF INSURED INDIVIDUAL NOTARIZATION

The individual named in Section A and further identified in Section B of this form has appeared before me in person on the _____ day of _____, 19____ and is known to me to be that individual. My notary seal appears in the lower right hand corner of this form.

45. Printed Name of Notary | 46. Date Commission Expires (mm/dd/yy)
47. Signature of Notary | 48. Notary Number

WHITE-DATA BANK YELLOW-STATE LICENSING BOARD PINK-REPORTING ENTITY

HRSA-529 (1/90)

Summary of Health Care and Professional Organizations' Positions on Reporting Threshold

Organization	Represents	Position	Reasons for Position
American Hospital Association	5,500 hospitals and over 50,000 personal members	Supports a $50,000 threshold	Reporting small malpractice payments is an unnecessary expense, a disincentive for physicians to settle claims, of questionable merit, and may not be useful for identifying physician incompetence.
American Osteopathic Hospital Association	140 osteopathic hospitals that include over 30,000 practicing doctors of osteopathy	Supports a $30,000 threshold	Establishing a threshold would reduce costs and eliminate the reporting of nuisance suits; small malpractice payments provide little additional knowledge for peer review.
American Insurance Association	250 insurers	Supports a threshold in the range of $35,000 to $50,000	A threshold would cut the reporting burden in half and may eliminate claims of marginal interests to peer review bodies.
Physician Insurers Association of America	44 physician-owned and medical society sponsored insurance companies	Supports a $50,000 threshold	A threshold would reduce the reporting and processing burden and eliminate reports of questionable value; the organization determined that 54 percent of its paid claims were under $50,000 but represented only 7.6 percent of payments.
American Medical Association	297,000 physicians	Supports a threshold of not less than $30,000	Small claims and nuisance suits are of questionable use for peer review; a threshold would lessen administrative costs.
American Dental Association	140,495 dentists and other members	Supports a threshold of undetermined amount	Unjustified to characterize settlements forced by insurers as malpractice; small claims represent fee refunds for patient dissatisfaction, not malpractice; dissatisfied patients can resolve disputes through dental society peer review.
Federation of State Medical Boards	Primarily state medical boards	Supports a $30,000 threshold	The large volume of small payments has limited utility.
Council of Medical Specialty Societies	24 societies with over 330,000 physicians	Supports a $50,000 threshold	Establishing a threshold would reduce work load and the reporting of nuisance claims.
American Association of Dental Examiners	Primarily state dental boards	Tentatively supports a $25,000 threshold	Small payments are a significant administrative burden and the data are of questionable use.
National Council of State Boards of Nursing, Inc.	Primarily state nursing boards	No formal position taken but comments provided by Director for Public Policy	Small nuisance claims are due to poor outcome rather than physician incompetence; however, multiple small incidents may be more indicative of problems than a single serious error.
Risk Management Foundation of the Harvard Medical Institutions Inc.	Harvard medical institutions and physicians	Clearer definition of data bank's purpose needed to decide on utility of threshold	Data on all claims have a role in peer review and credentialing; costs and benefits of the data bank providing this information compared with other available means should be considered.

(continued)

Organization	Represents	Position	Reasons for Position
Department of Defense Health Affairs	Military health care quality assurance services	Does not support a threshold	All payment data are necessary for evaluating health risks; a threshold is difficult to define and might influence litigation activities.
Public Citizen Health Research Group	Consumer health research group	Does not support a threshold	Not possible to set a reasonable single threshold for all areas of medicine or all geographical locations; reporting all payments reduces reporting-avoidance maneuvers.
American College of Obstetricians and Gynecologists	Over 31,000 physicians specializing in women's health care	Does not support a threshold	Small payments are not nuisance suits but reflect the amount of damage; payment amounts vary by geographic location; a threshold might influence litigation activities; all malpractice data should be available for policy decisions.

Major Contributors to This Report

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