Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NATIONAL PRACTITIONER DATA BANK: MALPRACTICE REPORTING REQUIREMENTS

Richard P. Kusserow
INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this study is to examine the impact of proposed changes to the malpractice reporting requirements for the National Practitioner Data Bank.

BACKGROUND

Since September 1, 1990, the National Practitioner Data Bank has received and maintained records of malpractice judgments and disciplinary actions against licensed health care practitioners. It provides hospitals and other health care entities with information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners.

Debate continues about the type of malpractice actions that should be reported to the Data Bank. Currently, all malpractice payments must be reported, regardless of amount. Some organizations feel that reports should be limited to payments above a certain floor--perhaps $30,000 or $50,000. Payments under this floor, they believe, most likely represent the efforts of practitioners or insurers to settle "nuisance suits," are not evidence of actual malpractice, and present an unnecessary burden for reporters. In contrast, some believe that the current reporting mandates should be extended to include all open malpractice claims. They argue that claims, though not in themselves evidence of malpractice, are more timely and therefore more useful than payments alone in assessing practitioners' records. (In practice, an open claim reporting requirement would almost certainly be accompanied by a *closed* claim reporting requirement to be fair to practitioners named in malpractice suits who were eventually exonerated.)

Congress instructed the Public Health Service (PHS) to prepare a report on the advisability of imposing a floor and of adding open claims to the Data Bank. The PHS requested Office of Inspector General (OIG) assistance in surveying two classes of interested parties: (1) licensing boards in States with reporting requirements similar to those under consideration for the Data Bank and (2) malpractice insurers. Our discussion is based on written responses to a mail survey from 62 malpractice insurers, telephone interviews with high-level officials of 6 State medical boards (3 of which require open claims reporting and 3 of which require paid claims reporting above a dollar threshold), and data we collected for a related study on the Data Bank.

FINDINGS

REQUIRING OPEN CLAIM REPORTS

Requiring that open malpractice claims be reported to the Data Bank could add over 125,000 hours to insurers' annual paperwork burden--an increase of at least 580 percent.

- For every claim insurers paid in the last year, they opened 3.56 claims and closed 2.23 claims without payment.

- An open claims reporting requirement could increase the insurance industry's annual reporting work load from just over 20,000 to almost 150,000 hours.

In the three States surveyed, reports of open malpractice claims do not in themselves usually signify violations of medical practice codes, but are somewhat useful to medical boards in the aggregate or as supplemental information.

- In Iowa, Texas, and New York, open claim reports rarely lead to disciplinary actions against physicians.

- In these States, open claim reports are used as supplemental information to a broader investigation or for research purposes.

IMPOSING A REPORTING FLOOR

A reporting floor would significantly reduce the number of reports forwarded to Data Bank queriers.

- A $50,000 floor would have eliminated nearly half of the malpractice reports sent to Data Bank queriers. A $30,000 floor would have eliminated 38 percent.

A reporting floor could affect the malpractice claim settlement process.

- Several insurers believe that a floor would make practitioners more receptive to settling small claims.

- Some insurers noted that the allocation of large payments among multiple practitioners could be manipulated to prevent reporting.

The experiences of the three surveyed States with reporting floors illustrate that floors have potential drawbacks.

- New Jersey recently repealed its floor in response to concerns about its impact.

- Ohio still has a reporting floor, but its medical board has found Data Bank reports of malpractice payments under the State floor worth investigating.

- Malpractice payments in California are often made for one dollar less than the State reporting floor.

CONCLUSION

Based on the information we received from malpractice insurers, State medical boards, and the Data Bank, we conclude that the potential drawbacks of reporting open claims or imposing a reporting floor outweigh the potential benefits.

The reporting of open claims would lead to a significant time and cost increase for the malpractice insurance industry. A requirement to that effect would be unpopular with insurers, and our interviews with State licensing boards suggest that open claim information on individual practitioners has limited utility.

A floor on malpractice payments would certainly ease the reporting burden for insurers and might reduce litigation costs by encouraging settlements. On the other hand, it could lead to distortion and misrepresentation in the settlement process and could prevent valuable information sharing.

We offer these findings to the Public Health Service as it summarizes its research and formulates its recommendations to Congress. However, because our inspection was limited in scope, we cannot offer a definitive recommendation as to whether or not to change the Data Bank reporting requirements. Additional information, such as the predictive value of open claims and small payments and the overall distribution of malpractice payment amounts, is needed to make such an assessment. We anticipate that PHS will consider such issues before making its recommendations to Congress.

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INTRODUCTION

PURPOSE

The purpose of this study is to examine the impact of proposed changes to the malpractice reporting requirements for the National Practitioner Data Bank.

BACKGROUND

The National Practitioner Data Bank maintains records of malpractice judgments and disciplinary actions against licensed health care practitioners. It was established by Title IV of the Health Care Quality Improvement Act of 1986,[1] and has been in operation since September 1, 1990. The Data Bank provides hospitals and other health care entities with information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. It is intended to be an important (but not the only) tool in the practitioner assessment process. The Data Bank is funded by user fees and Federal outlays. It is administered by Unisys Corporation under contract to the Health Resources and Services Administration (HRSA) of the Public Health Service (PHS).

State licensing boards, hospitals and other health care entities, and professional societies submit reports of adverse actions against practitioners to the Data Bank.[2] These groups must report actions against physicians and dentists and may report actions against other licensed practitioners. Malpractice insurers must report payments made on behalf of all licensed practitioners.

Data Bank records may be released only to authorized entities, including hospitals and other health care entities, State licensing boards, professional societies, and, under specified conditions, plaintiffs' attorneys in malpractice suits. Also, practitioners may request their own records. Only hospitals are required by law to query the Data Bank. They must request records for practitioners wishing to obtain clinical privileges and, every two years, for all practitioners on staff.

Debate continues about the type of malpractice actions that should be reported to the Data Bank. Currently, all malpractice payments must be reported, regardless of amount. Some observers feel that reports should be limited to payments above a certain floor. The American Medical Association (AMA) has suggested a $30,000 floor, and the Physicians Insurance Association of America (PIAA) has proposed one of $50,000.[3] Payments under this floor, they believe, most likely represent the efforts of practitioners or insurers to settle "nuisance suits." Such payments, they claim, are not evidence of actual malpractice and present an unnecessary burden for reporters.

In contrast, some believe that the current reporting mandates should be extended to include all open malpractice claims. They argue that claims, though not in themselves evidence of malpractice, are more timely and therefore more useful than payments

alone in assessing practitioners' records. (In practice, an open claim reporting requirement would almost certainly be accompanied by a *closed* claim reporting requirement. In other words, each claim would be reported at least twice--once at opening, once at closing, and perhaps at other key junctures in between. An open claim reporting requirement without a closed claim reporting requirement would be unfair to practitioners named in malpractice suits who were eventually exonerated.)

Congress instructed PHS to prepare a report on the advisability of imposing a floor and of adding open claims to the Data Bank. The PHS requested OIG assistance in surveying two classes of interested parties: (1) licensing boards in States with reporting requirements similar to those under consideration for the Data Bank and (2) malpractice insurers. Specifically, PHS asked (1) what the current reporting burden on malpractice insurers is and how it would be affected by a change in reporting requirements, and (2) what lessons can be learned from States that currently require open claim reporting or have had reporting floors.

METHODOLOGY

To assess the potential change in reporting burden for insurers, we mailed questionnaires to 220 companies which are authorized to report malpractice payments to the Data Bank. We describe our methods for selecting these companies in appendix A. We received 81 responses, 19 of which we disregarded because they came from companies that had paid fewer than 5 malpractice claims over a recent 12-month period. We believe that these 19 companies would not have sufficient experience in reporting to the Data Bank to provide accurate estimates of the associated reporting burden. The remaining 62 insurers account for about 90 percent of the country's malpractice claim activity.[4]

To learn from States' experiences with alternative reporting requirements, we conducted telephone interviews with high-level officials from medical licensing boards in six States. Using the Federation of State Medical Boards' *Exchange*[5] and brief confirmation telephone calls to State boards, we identified 15 boards that receive reports of open claims and 7 boards that receive reports only on payments above a specified floor.[6] From the list of boards receiving open claim reports we chose Iowa, New York, and Texas on the basis of State size and geographic diversity. From the list of boards in States with reporting floors, we chose California, New Jersey, and Ohio because their floors were the highest (and therefore closest to the floors suggested for the Data Bank).

We also analyzed Data Bank records that we obtained for a related study.[7] These records consisted of all Data Bank matches through March 19, 1992.[8]

Our review was conducted in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

REQUIRING OPEN CLAIM REPORTS

Requiring that open malpractice claims be reported to the Data Bank could add over 125,000 hours to insurers' annual paperwork burden--an increase of at least 580 percent.

- For every claim insurers paid in the past year, they opened 3.56 claims and closed 2.23 claims without payment.

The 61 insurers who responded to our survey question paid a combined total of 14,648 claims on behalf of individual licensed practitioners during a recent 12-month period.[9] At the same time, they opened files on a combined total of 52,105 claims. This yields an opened-to-paid-claims ratio of 3.56:1.[10] The ratio was higher for physicians than for other types of practitioners: 3.83 for physicians, 2.66 for dentists, and 2.73 for other practitioners. Also during this 12-month period, insurers closed 32,693 claims without payment. For closed claims the unpaid-to-paid ratio was 2.23 overall, 2.48 for physicians, 1.25 for dentists, and 1.74 for other practitioners.[11]

- An open claims reporting requirement could increase the insurance industry's annual reporting work load from just over 20,000 to almost 150,000 hours.

Over its first 447 days of operation, the Data Bank received 19,897 malpractice payment reports.[12] This is equivalent to 16,247 reports per year. At 3.56 opened claims per paid claim, an open/closed claim reporting requirement would add 57,839 reports of open claims and 36,231 reports of unpaid closed claims annually. This increase of 94,070 reports would bring the annual total to 110,317 reports.

Insurers told us they require an average of 80 minutes to complete each Data Bank malpractice report form. On average, they require 40 minutes for gathering information, 22 minutes for typing and mailing the form, and 17 minutes for reviewing and correcting the verification documents sent back to them by the Data Bank.[13] At 80 minutes per form, 16,247 reports would take 21,663 hours to complete. In contrast, 110,317 reports would require 147,089 hours.[14] The 125,426 hour difference represents a 579 percent increase.[15]

In the three States surveyed, reports of open malpractice claims do not in themselves usually signify violations of medical practice codes, but are somewhat useful to medical boards in the aggregate or as supplemental information.

- In Iowa, Texas, and New York, open claim reports rarely lead to disciplinary actions against physicians.

The Iowa board received 181 open claim reports in 1990. Of those, 51 (28 percent) were referred to the board's Discipline Committee for further investigation. None of

those referrals ended in disciplinary action. An official there told us, however, that in previous years there have been disciplinary actions taken in cases that arose from malpractice claim reports.

The Texas board began about 130 investigations based on open claim reports from September 1990 through August 1991. Seven or eight of these (6 percent) resulted in disciplinary actions.[16]

The New York board reported that no open claim reports resulted in disciplinary actions because they are not used to open investigations. The official we interviewed noted, however, that many doctors against whom actions were taken did have "significant" malpractice claim histories.

- In these States, open claim reports are used as supplemental information to a broader investigation or for research purposes.

The Iowa State Board of Medical Examiners follows up on each open claim report it receives from the State's insurance commission. Once it has received a more complete description of the event, it can choose to pursue or drop the investigation. The board official we interviewed believes that open claim reports have a role in protecting the public but acknowledges that most reports are without merit. He predicts that the board will have to adopt a screening mechanism to weed out open claim reports that are not worth pursuing at all. He feels it is too early in the Data Bank's life to recommend whether to add an open claim reporting requirement.

The New York State Board of Professional Medical Conduct has the authority to begin investigations of physicians against whom several malpractice claims have been opened. In practice, however, it does not. Instead, it adds reports of open claims to its comprehensive research-oriented data base. When the board initiates an investigation on other grounds, it retrieves the subject physician's claims history from the data base to create a more complete historical file. A high-level board official did not recommend that the Data Bank begin collecting open claim information because (1) open claims are not necessarily indicative of poor practice, and (2) the Data Bank might not be able to accommodate the additional influx of information.

The Texas State Board of Medical Examiners is likely to begin an investigation whenever three or more claims are opened against a physician in a five-year period. It also uses open claim reports for research purposes. Although the board official we interviewed finds the open claim reports useful enough as supplementary information to justify the effort of collecting and storing them, she considers them "not terribly useful . . . about a 4 on a scale of 1 to 10." She feels that an open claim requirement for the Data Bank is unnecessary because doctors are generally required to report their malpractice claims histories to hospitals anyway. She believes that doctors who lie about their histories are likely to be discovered through sources other than the Data Bank.

IMPOSING A REPORTING FLOOR

A reporting floor would significantly reduce the number of reports forwarded to Data Bank queriers.

- A $50,000 floor would have eliminated nearly half of the malpractice reports sent to Data Bank queriers. A $30,000 floor would have eliminated 38 percent.

When a hospital, licensing board, or other health care entity requests information on a certain practitioner from the Data Bank, and that practitioner has been reported to the Data Bank, it is referred to as a "match." As of March 19, 1992, there had been a total of 20,954 matches, 16,962 of which involved single malpractice payment reports.[17]

The average amount of malpractice payments involved in a match was $132,358, but most matches involved payments far below this mean. Had the Data Bank adopted AMA's suggested floor of $30,000, 37.9 percent of the malpractice matches would not have occurred because the malpractice payments would not have been reported. The PIAA's proposed floor of $50,000 would have eliminated another 8.9 percent of malpractice matches.

The usefulness to queriers of matches on small payment reports or any other type of report is not yet known. We intend to address this question in a forthcoming report.

A reporting floor could affect the malpractice claim settlement process.

- Several insurers believe that a floor would make practitioners more receptive to settling small claims.

Small malpractice claims can often cost more to litigate than to pay outright.[18] For this reason, it can be in an insurer's interest to settle small claims even when it believes it could win in court. Doctors, however, may have an incentive not to settle because settlements as well as judgments are reported to the Data Bank. Doctors may fear that Data Bank queriers will interpret any report as a blemish on the doctor's record, and that queriers may not distinguish between claims that were settled for convenience as opposed to cause. Several insurers commented that doctors would be more willing to settle small claims if the Data Bank had a floor and the claims did not have to be reported.[19]

- Some insurers noted that the allocation of large payments among multiple practitioners could be manipulated to prevent reporting.

We asked insurers whether a floor for the Data Bank would affect the way they allocated payment amounts in cases where multiple practitioners were found liable for damages. Thirty-nine of the 55 respondents said "no" and another 3 said "probably not." But we also received several affirmative responses. The first two following

comments came from companies with over 2,000 insured physicians each, and the third from a company that insures 3,500 registered nurses:

> Yes. When more than one practitioner is involved, we will be under pressure to have payments under the floor amount instead of true allocations.
>
> Yes. Many physicians refuse to settle a case if it means that their name will be reported to yet another agency (in this case, the NPDB). Therefore, if a settlement opportunity exists among multiple defendants, and that settlement can be divided so that none of the defendants' names would be reported (even if one defendant health care provider is more culpable than another), it is likely that the larger than floor dollar amount settlement would occur but not be reported to the Data Bank. [emphasis in original]
>
> Possibly. If the amount is combined, and there is no definitive split between the facility and the practitioner, the decision probably would be made to allocate to the practitioner only that amount below the floor.

The experiences of the three surveyed States with reporting floors illustrate that floors have potential drawbacks.

The impact of State-imposed reporting floors varies from State to State. Even in States with reporting floors, licensing boards are now notified of all their licensee's malpractice payments, regardless of amount. Copies of all malpractice payment reports submitted by insurers to the Data Bank are automatically forwarded to the appropriate boards. The information contained in Data Bank reports, however, may not be equivalent to the information contained in State-mandated reports.

- New Jersey recently repealed its floor in response to concerns about its impact.

The New Jersey State Board of Medical Examiners had a $25,000 reporting floor from July 1983 to January 1990. As part of a broad malpractice reform movement that year, the floor was eliminated for two reasons. First, the board found that many doctors were settling claims for $24,999, which indicated that the settlement amount had more to do with the floor than the true value of damages involved. Second, the board was concerned that it would not find out about incompetent physicians who had many judgments or settlements for amounts less than the floor.

No reports of malpractice payments have led to investigations or disciplinary actions against New Jersey physicians in the past year. The board official we spoke with believes that malpractice information is useful only as a supplement to a broader case file. Nevertheless, he advises against a floor for the Data Bank, saying that it is important to collect a full set of information.

- Ohio still has a reporting floor, but its medical board has found Data Bank reports of malpractice payments under the floor worth investigating.

The Ohio legislature granted authority for the Ohio State Medical Board to collect reports of malpractice payments over $25,000 in early 1987. This followed a survey of Ohio insurers that determined that payments under $25,000 often represented settlements designed to avoid litigation costs.

In the State's fiscal year ending August 31, 1991, the board investigated 18 percent of reports it received on malpractice payments over the floor. It also investigated 9 percent of reports it received on malpractice payments *under* the floor, which it received as copies of reports to the Data Bank. Two reports of payments over the floor led to disciplinary action, compared with none as yet for payments under the floor. Despite the low number of disciplinary actions, the board official we spoke with is convinced that malpractice information is useful and worth collecting, regardless of payment amount. The fact that investigations had been started as a result of Data Bank reports of small payments led him to advise against a floor for the Data Bank. He was confident that the investigations would eventually lead to disciplinary actions.

- Malpractice payments in California are frequently made for one dollar less than the State reporting floor.

The reporting floor in California is $30,000. Through March 19, 1992, 1,816 lump-sum malpractice payments by California physicians were involved in one or more matches between Data Bank reports and queries. Of those 1,816 payments, 176 (9.7 percent) were for exactly $29,999. Another 21 were for amounts between $29,000 and $29,990. Only 17, however, were for exactly $30,000. Clearly, part of the malpractice claim settlement process in California involves avoiding reports to the State medical board.

Whether a claim is settled for $29,999 or $30,000, however, is not of great concern to the medical board. We interviewed a high-ranking official of the California Board of Medical Quality Assurance who considers all malpractice information minimally useful, especially information on small payments. The board formally investigated 40 percent of all complaints and referrals it received in the last year, but only 11.5 percent of the malpractice payments (all of which were for amounts of $30,000 or more). Because he believes that reports of small malpractice payments are of little use and create unnecessary processing work, the official recommended that the Data Bank adopt a reporting floor.

At least two factors minimize the utility of small malpractice payment reports to the California medical board. First, the board's computer system does not keep complete records of malpractice payments. Second, the board is unable to use the copies of Data Bank reports on payments less than $30,000 because the reports do not include the patient's name. Without patient names, the board has great difficulty obtaining detailed information on the incident leading to the malpractice payment.

CONCLUSION

Based on the information we received from malpractice insurers, State medical boards, and the Data Bank, we conclude that the potential drawbacks of reporting open claims or imposing a reporting floor outweigh the potential benefits.

The reporting of open claims would lead to a significant time and cost increase for the malpractice insurance industry. A requirement to that effect would be unpopular with insurers, and our interviews with State licensing boards suggest that open claim information on individual practitioners is only somewhat useful.

The best argument for including open claim reports is that it could make the Data Bank a highly valuable research tool. The existence of a nationwide data base of malpractice claim activity could be helpful to malpractice researchers and policy makers. The Data Bank's authorizing legislation indicates that Data Bank information "is intended to be used solely with respect to activities in the furtherance of the quality of health care."[20] Whether this mandate would include medical malpractice research and whether the benefits of such research could justify the costs of collecting open claim information are unresolved questions.[21]

A floor on malpractice payments would certainly ease the reporting burden for insurers and might reduce litigation costs by encouraging settlements. On the other hand, it could lead to distortion and misrepresentation in the settlement process and could prevent valuable information sharing. The experience in New Jersey and California and the comments of three large insurers indicate that reporting floors can have unintentional effects on settlement amounts. Also, a floor would significantly reduce the frequency of Data Bank matches. Until it is known whether these matches on small payments are useful to queriers, an attempt to eliminate them would seem premature.

We offer these findings to the Public Health Service as it summarizes its research and formulates its recommendations to Congress. However, because our inspection was limited in scope, we cannot offer a definitive recommendation as to whether or not to change the Data Bank reporting requirements. Additional information, such as the predictive value of open claims and small payments and the overall distribution of malpractice payment amounts, is needed to make such an assessment. We anticipate that PHS will consider such issues before making its recommendations to Congress.

APPENDIX A

METHODOLOGY

Survey of Malpractice Insurers

We selected the nation's 20 largest malpractice insurance writers as listed in *Healthweek* magazine, October 21, 1991 for our survey. We then obtained from the Health Resources and Services Administration a list of all non-Federal entities that were authorized to report malpractice payments to the National Practitioner Data Bank--1,056 companies or public agencies in all. We selected 100 companies at random from this list, discarding from the sample any companies located outside U.S. territory or whose parent organization was represented in the top 20. We mailed questionnaires to all 120 companies on November 21, 1991. Because our response rate was inadequate as we neared the due date of December 20, 1991, we selected another 100 companies at random. This time, in addition to the disqualification criteria above, we excluded companies whose titles contained the words "guaranty" or "re-insurance." We learned from our first sample that such companies usually do not write malpractice insurance for individual practitioners. We mailed questionnaires to this second group of 100 on December 18, 1991.

As of our cutoff date of January 27, 1992, we had received 81 completed surveys, 17 of which were from top 20 firms. We eliminated 19 respondents from the data base because they reported closing fewer than 5 claims with payment over a recent 12-month period. We decided that these insurers did not have enough experience with Data Bank reporting to make reasonable estimates of the burden it imposes. (One respondent that was unable to report the number of claims paid was kept in the data base because it insured nearly 5,000 physicians and 2,800 dentists. We believe that a company with so many insureds would have enough experience with the Data Bank to provide informed responses.) Together, the remaining 62 firms insured the following number of licensed health care practitioners:[1]

Physicians:	254,000
Dentists:	88,500
Other:	125,000
TOTAL:	467,500

[1]Numbers have been rounded to the nearest 500 because several firms reported approximations rather than exact counts. The number for other practitioners is extremely conservative and consists largely of chiropractors and podiatrists insured by firms who were able to provide an exact or approximate count. Many respondents insure hospitals and all licensed health practitioners who work there. These firms usually did not have a separate file for each hospital-based practitioner insured, and therefore were not able to give us even an approximate count.

A total of 14,648 claims were paid by the 61 firms with such data available for the 12-month period. Based on the Data Bank's first 447 calendar days of experience, it receives 16,247 paid claim reports per year. Therefore, the insurers in our survey represent about 90 percent of the malpractice claim activity in this country.

We made some adjustments to the written responses to improve logical consistency. For example, we ensured that the respondents' estimates of the total time required to complete a Data Bank report was equal to the sum of the times they reported as required for each step in the process.

Virtually all of the figures reported to us as the number of claims opened, closed, and paid appeared to be actual counts rather than estimates--very few ended in one or two zeroes. We therefore treated each response in these categories as an exact amount.

APPENDIX B

NOTES

1. P.L. 99-660, Sections 401-432.

2. Adverse actions include license revocation, suspension, and probation; clinical privilege revocation, suspension, reduction, restriction, and voluntary surrender; and professional society membership revocation, suspension, and denial; as well as other categories.

3. Letter from the Chairman of the PIAA Data Sharing Project to the Director of the Bureau of Health Professions, HRSA, February 25, 1991.

4. One of the 62 included insurers did not report the number of paid claims because it was unable to break down closed claims into paid and unpaid. This insurer was included in our analysis because of the large number of practitioners it insured and claims it opened. We believe it must have paid at least 5 claims over the 12-month period used for reporting.

5. The Federation of State Medical Boards of the United States, Inc. *The Exchange: Section 3, Physician Licensing Boards and Physician Discipline*, 1989-1990 ed., pp. 34-35.

6. Boards collecting open claim reports are in Arizona, Arkansas, Delaware, Iowa, Kansas, Maine, Maryland, Michigan, Missouri, Montana, New Hampshire, New York, Oregon, Texas, and Wyoming. Boards that recently had or still have reporting floors are in California, Louisiana, Nevada, New Jersey, Ohio, Tennessee, and Washington. Since the Data Bank opened, these boards have also received copies of Data Bank reports on *all* claims paid by their licensees regardless of amount.

   There may be discrepancies between State statutes and State practices. The lists of States above are based solely on telephone conversations with State board staff and the *Exchange*.

7. Office of Inspector General, *National Practitioner Data Bank: Profile of Matches*, OEI-01-90-00522, in press.

8. A match occurs when a request for information from the Data Bank identifies a practitioner for whom a report is on file with the Data Bank.

9. As stated above, 1 of the 62 insurers was unable to separate paid claims from unpaid closed claims and was excluded in the computation of this statistic.

The 12-month period varied from insurer to insurer. One of the 62 did not report which period was used. All but 6 of the remaining 61 insurers included all or part of calendar year 1991 in their responses. The 12-month period began in December 1990 or January 1991 for 37 insurers.

10. Malpractice claims generally take years to close, so probably few if any of the 52,640 opened claims were among the 14,648 paid claims. Our analyses assume no change from year to year in the rate of claim openings or the likelihood of claims closing with payment. If (as some have suggested) the existence of the Data Bank has discouraged settlements, then even fewer than 14,648 payments will eventually result from the 52,640 claims opened during the 12-month period used.

11. Overall ratios are based on 61 insurers. Practitioner-specific ratios are based on 51 physician insurers, 23 dentist insurers, and 27 other practitioner insurers.

12. Unisys Corporation, Cumulative Data Bank Statistics Summary, presented to the Data Bank Executive Committee on December 5, 1991, p. 1. This number excludes initial reports that were later voided. The 447 days are calendar days, not work days, and span from September 1, 1990, to November 22, 1991.

13. All time estimates are weighted averages. Individual estimates were weighted in proportion to the number of payments made during the reporting period. The sum of the average times required for each step in reporting is one minute less than the average time required for all steps combined. This difference most likely reflects the fact that 61 respondents estimated total time required but only 56 reported time required for each intermediate step.

14. In fact, the percentage increase in the work load resulting from a Data Bank open claim reporting requirement could be even greater, for two reasons.

    First, not all of the current 21,000 hour burden is solely attributable to the Data Bank. Malpractice insurers have to report payments to most State licensing boards as well as to the Data Bank. Insurers in our survey estimated that, on average, 12 minutes of the time required to report a paid claim to the Data Bank also goes toward satisfying State reporting requirements (this average is weighted in proportion to the number of claims paid by each insurer and is based on 59 responses). Therefore, it could be said that the current Data Bank reporting burden is only 18,413 hours (16,247 * 68 ÷ 60). The 147,089 hours imposed by an open claim reporting requirement would therefore be an increase of 128,676 hours, or 699 percent. (Of course, in the States that currently require open claim reporting there would be some overlap with Data Bank reporting. Therefore, the 147,089 hour estimate is slightly high. There are far fewer States requiring open claim reporting, however, than paid claim reporting.)

Second, open claims may take even longer to report than paid claims. The insurers estimated that open claims would require an average of 96 minutes to report (this average is weighted in proportion to the number of claims opened by each insurer and is based on 51 responses). If this estimate is accurate, and if unpaid closed claims took as long to report as paid claims, then an open claims reporting requirement would increase the work load to 159,263 hours (57,839 open claims at 96 minutes each, plus 36,231 unpaid claims at 80 minutes each [assuming no overlap with State reporting requirements], plus 16,247 paid claims at 68 minutes each). This is an increase of 765 percent. Again, the increase could be somewhat lower for those insurers whose State reporting requirements overlapped with Data Bank requirements.

15. Not surprisingly, there is virtually no support among insurers for an open claims reporting requirement. Fifty-eight of the 62 insurers in our survey were opposed to such a requirement. They objected to the burden it would impose on them and said that open claim information would be of little use to Data Bank users.

16. The board's information system does not distinguish between open and closed claim reports. The figures presented in the text are based on the Assistant Director for Investigation's estimates that 50 percent of the 261 claim reports resulting in investigations are open claim reports, and that 4 percent of the 371 disciplinary actions resulted from cases initiated through the malpractice claim reporting system.

17. For a more complete description of the types of practitioners, queriers, and reporters who were involved in matches, see Office of Inspector General, *National Practitioner Data Bank: Profile of Matches*, OEI-01-90-00522, in press.

    Of the 18,521 total malpractice matches, 1,559 involved reports of the first in a series of multiple payments. For those matches, we were unable to determine the full amount of payment, and we excluded them from our analysis.

18. U.S. General Accounting Office, *Medical Malpractice: Characteristics of Claims Closed in 1984*, HRD-87-55, April 1987, p. 22.

19. Eleven insurers made a comment to this effect as their primary or only reason for supporting a floor in response to one particular question. A number of other insurers made similar comments elsewhere in their written response.

    In response to our invitation for comments on the prospect of a floor for malpractice reporting to the Data Bank, 37 of the 62 insurers in our analysis expressed a clear opinion. All but 1 of the 37 were in favor. Several reasons were given in support of a floor, the most common being that it would relieve the burden on insurers, that small payments do not necessarily indicate poor care, and that it would encourage doctors to settle small claims.

20. Health Care Quality Improvement Act of 1986, section 427(b)(3).

21. Although research is not mentioned specifically as a purpose of the Data Bank in the authorizing legislation, HRSA plans to release information to the public "in a form which does not permit the identification of any particular health care entity, physician, dentist, or other health care practitioner" (*56 Federal Register* 13389). This type of release is not yet underway.