Legislators in D.C. Battle Over Damage Caps

BY JOYCE FRIEDEN
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The District of Columbia is the latest in a growing number of jurisdictions trying to combat rising malpractice insurance premiums among physicians, as legislators there battle over whether the best solution is damage caps or increased regulation of insurers.

D.C. Mayor Anthony Williams has proposed legislation that would limit noneconomic damages to $250,000 and expand the city's Good Samaritan law to provide immunity to all health professionals who provide free care.

Linda Cropp, chair of the District of Columbia City Council and a frequent political adversary of Mr. Williams, has introduced her own medical liability reform bill. Under Ms. Cropp's bill, the city's insurance commission would be required to approve all proposed liability premium increases that exceed a certain percentage, would allow the insurance commissioner to consider a malpractice insurer's current surplus as a factor in rate making, and would authorize refunds for physicians who have paid excessive insurance premiums.

Unlike Mr. Williams, Ms. Cropp said she believed that tort reform wasn't the answer. "The problem is the high [cost] of insurance," she said in a statement. "Payments to patients who sue doctors in the District have declined dramatically, even as doctors and politicians have blamed skyrocketing jury awards for driving up the cost of malpractice insurance and driving doctors out of business."

Ms. Cropp cited a recent analysis by the consumer watchdog group Public Citizen to back up her contention. That analysis found that insurer payouts in the city, when factored for inflation, dropped from $29 million in 2001 to $11 million in 2004, a reduction of more than 62%.

"Did the malpractice insurance rates paid by doctors drop commensurately?" Ms. Cropp said. "No, they did not."

But Victor G. Freeman, M.D., president of the Medical Society of the District of Columbia, disagreed with Ms. Cropp's approach. He said in an interview: Ms. Cropp "recognizes there is a crisis, and her solution is to make sure there is tighter regulation around medical liability rates in town. Unfortunately, I think she's been misled by Public Citizen and the trial lawyers, because she believes medical liability companies are making huge profits in the city at the expense of physicians."

Dr. Freeman suggested that Ms. Cropp might want to consider that NCRIC (formerly the National Capital Reciprocal Insurance Co.), the liability insurer for 80% of the District's physicians, lost $7 million last year. "If NCRIC wasn't losing money, other companies would come in and compete. They're staying out for one very clear reason: It's bad business to come into the District because of the high jury awards."

The study that Ms. Cropp referred to is one of several on malpractice insurance that recently have been published. A study of 27 states appearing in the online version of the journal Health Affairs found that counties in states that had a cap on noneconomic damages had 2.2% more physicians per capita than counties in states without a cap (Health Aff. [Millwood] May 2005:[Epub ahead of print]). The study used data from the years 1985-2000 and found that rural counties in states with a $250,000 cap had 5.4% more ob.gyns. per capita than did rural counties in states with a cap above $250,000.

Health Affairs also published an online study showing that malpractice payouts appear to be growing more slowly than previously thought (Health Aff. [Millwood] May 2005;[Epub ahead of print]). Using data from the National Practitioner Data Bank, Amitabh Chandra, Ph.D., of Dartmouth University, Hanover, N.H., and colleagues found that the average payment—including both settlements and judgments at trial—grew by 4% per year between 1991 and 2003, consistent with increases in other health care costs.

Another recent study found that the adoption of "direct" malpractice reforms—including reducing damage caps—resulted in a 3.3% increase in physician supply.

"Our results illuminate the mechanisms by which malpractice liability reduces growth in physician supply," wrote Daniel P. Kessler, Ph.D., of Stanford (Calif.) University, and colleagues (JAMA 2005;293:2618-25).

"The estimated effect of direct reforms was greater among physicians who practice in nongroup settings. … This is consistent with the lesser ability of smaller practices to spread liability insurance costs among many physicians, cushion premium volatility with high patient volume, or share risk with hospitals or other health care institutions." ■

Doctors to CMS: One National Provider Identifier Only, Please

BY NELLIE BRISTOL
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WASHINGTON — The Centers for Medicare and Medicaid Services will review national provider identifier protocols that now require separate numbers for each covered entity. The requirement could mean some physicians who are also part of group practices and other arrangements would have multiple NPI numbers.

At a meeting of the Practicing Physicians Advisory Council, members brought the issue to the attention of CMS's director of program integrity, Kimberly Brandt. "The goal here was to have less numbers, not more. So I appreciate your point, and it's a very good one. And that's something I will definitely look into," Ms. Brandt said.

PPAC member Barbara McAneny, M.D., an oncologist from Albuquerque, suggested the review as part of a draft recommendation approved by the council. The recommendation suggests CMS clarify which current provider numbers would be replaced by the NPI number and which entities would need their own numbers.

Dr. McAneny also suggested CMS "put pressure" on other groups, including state licensure boards, "to eliminate some of the numbers and not to just add them on and add them on and add them on … "

NPI enrollment began May 2 and continues through May 2007, when all providers will be required to use the system for standard electronic health care transactions. "With national standards and identifiers in place for electronic claims and other transactions, health care providers will be able to submit transactions to any health plan in the United States," CMS Administrator Mark McClellan, M.D., said in a May letter to health care providers. "Health plans will be able to send standard transactions such as remittance advices and referral authorization to health care providers."

VIVIAN E. LEE

PPAC member Dr. Geraldine O'Shea applied for her national provider identifier number during a break at a recent council meeting.

As a requirement of the Health Insurance Portability and Accountability Act, many health plans—including Medicare, Medicaid, private health insurance issuers, and health care clearinghouses—must use NPIs in standard transactions by May 2007. Small health plans have an additional year to comply. The number is intended to replace current numbers, including the unique physician identification number (UPIN).

Ms. Brandt told the advisory council that CMS is conducting a "massive outreach effort" to inform providers of the change and encourages them to apply for an NPI. Applications can be made electronically or through the mail.

To demonstrate the process of getting an NPI, PPAC Chairman Ronald Castellanos, M.D., got his number at the council's meeting, in a process that took approximately 8 minutes.

"I'm not bleeding," Dr. Castellanos said when asked how painful the process was.

CMS is encouraging health plans to devise a transition plan for a system that accepts both the UPIN and NPI until the May 2007 compliance deadline. Ms. Bryant said that although a few health plans already have systems developed, most do not—including Medicare, which she said will not have the "capacity to be fully changed over" until 2007.

"We need the next year and a half to finish getting our claims-processing system completely converted over, and then we'll begin the phase-out I would say about 6-8 months ahead" of the May 2007 deadline, she said.

CMS is recommending that members of groups not sign up individually now but wait until fall, when "batch enumeration" systems will be in place to accept group applications. ■

NPI Directory Hits Security Roadblock

Security concerns are currently keeping CMS from developing a directory of all NPI numbers for all health providers and covered entities, but one may be developed in the future, Ms. Brandt told PPAC members.

"We may get to a point where we have a directory, but right at the moment, we don't have a [list] like the unique physician identification number directory in the works," she said.

Instead, the agency is planning to publish in the Federal Register in October a notice on how NPIs can be obtained from other health care providers and covered entities.

PPAC members at the council meeting encouraged Ms. Brandt to look into a directory for referring physicians, even if it's a subscriber service.

"I would strongly advocate that you [develop a directory] even if there's a subscription fee because one of the more problematic things when you bill for a consult is to try to track down Dr. Jones' [UPIN], and it's a significant hurdle and a big burden on the practice," said surgeon Anthony Senagore, M.D., of the Cleveland Clinic Foundation.

Ms. Brandt noted that an encrypted or password-accessed system would be necessary, given that "people have been able to get access to [the UPIN director] who shouldn't have been able to get access to it." Council members' recommendation for a subscription fee or encryption is "a good one," she said.