

Exhibit No. 2Date 2/9/2015Bill No. SB 207**SB 207 – Just Another “Special” Immunity – Vote No**

What does "medically acceptable" mean? I don't see it in the definitions section, and it is not a medical legal term that I am aware of. Is it the same as the "standard of care" ? If so, why not just say it that way? If "medically acceptable" does not mean "standard of care", it needs to be defined or, some dozen or so doctors are going to be the subject of a series of appeals to the Montana Supreme Court to eventually define the term.

Who determines if a course of treatment is "medically acceptable"? Is this a fact question that a jury decides? Or is the bill designed for judges to make that decision, keeping the case from ever going to a jury?

Let me give you a brief scenario of how this bill would work:

Parents take their teen to ER, he presents with flu like symptoms (headache, fever, vomiting), neck ache and can't seem to stay awake. Doc charts that most likely flu, medically acceptable to prescribe the usual, fluids, rest, etc for treatment and hold off on further testing, and monitor symptoms. Parents find teen in bed next morning having seizure, to ER, permanent brain damage. Standard of care - what a reasonable doc would have done in similar circumstances - would have included a blood test to check for bacterial meningitis, as it can progress rapidly without immediate treatment.

Under this bill the doc cannot be held liable if he "selects, after discussion with the patient, patient's guardian, or patient's representative, if applicable, a medically acceptable course of treatment and includes in the medical record the health care provider's documented rationale." Page 2, lines 5-7

Is "medically acceptable" the same as "standard of care" or something else? Who determines that not ordering a blood test was medically acceptable? One other doctor agrees? one journal article? five journal articles? What makes it medically acceptable? Under SB 207, the physician alone determines if it is medically acceptable, simply by charting that it is so.

Page 2, lines 5-7 "the health care provider selects, after discussion with the patient, patient's guardian, or patient's representative, if applicable, a medically acceptable course of treatment and includes in the medical record the health care provider's documented rationale" - do you see anything in here that requires appropriate information to allow a patient to make an informed decision - like what are other possible courses of treatment? Shouldn't the patient get ALL the information, including other "medically acceptable" courses of treatment, allowing them to make their decision?

Because "medically acceptable" is not defined in this bill, or in the law. It will have to be defined by the courts - meaning more lawsuits.

Doctors already have a defense based on a well-documented judgment call that conforms with the standard of care. And no plaintiff lawyer takes cases where the judgment is even close, it just doesn't make legal or economic sense. This bill goes beyond the standard of care defense, and precludes a finding of negligence before such a defense is even raised.

There is no need for this bill. We have intelligent people who are ruled by fear, rather than reality. In the last year we have records for, 2013, we had 90 cases filed with the Medical Legal Panel, the lowest number since 1985. The Montana Medical Association in 2006 touted the 45 pieces of special protections enacted for health care providers, calling them "qualitatively better" than measures in most all states. SB 218 is just another special protection that limits the rights of Montanans harmed by malpractice.

Why do physicians order tests and procedures? One government agency found that when doctors ordered tests they almost always did so because of medical indications. Other reasons include, the desire to maintain a good doctor-patient relationship, caving into patient demands due to the influence of advertising by the medical industry, the simple availability of sophisticated technology, the desire for diagnostic certainty, the fear of missing a diagnosis that could harm a patient, and financial gain – a side effect of our traditional fee-for-service payment system.

We do know from a study reported in the October 2014 New England Journal of Medicine that tort reforms in Georgia, South Carolina and Texas did not decrease costs through a reduction in tests ordered in emergency rooms. After examining 3.8 million Medicare patient records from 1,166 hospital emergency departments from 1997 to 2011 – comparing care in these three states before and after they changed their emergency care standard to gross negligence with care in neighboring states that did not pass malpractice reform – researchers found that raising the legal standard for malpractice did not result in less expensive care.

We have absolutely no valid studies on medical decision making in Montana - at best we have anecdotal stories and self serving surveys. But we do know that Medicaid and Medicare, and private insurers, require that medical tests and procedures must be medically necessary. Truly defensive medicine – tests and procedures ordered not because they are medically necessary, but only to lessen liability exposure, is fraud.

Montana "Tort Reform" Measures In Effect & Not In Effect 2/9/2015 Related To Medical Malpractice - 1977 Through 2009¹ SB 207

Type Of Legislative Measures In Effect In Montana	
Tort Reform Measure - Statute, Case Law Or Court Rule	In Effect?
1. "Cap" On Non-Economic Damages - No Major Exceptions - Applies Per Claim	Yes
2. Statute of Limitations For Adults	Yes
3. Statute of Limitations For Minors Other Than Extending Limit Past Majority	Yes
4. Statute Of Repose - Time Beyond Which No Action Can Be Filed	Yes
5. Periodic Payment Of Future Damages	Yes
6. Collateral Source Offset - Duplicate Payment Of Damages	Yes
7. Comparative Negligence - Contribution - Joint And Several Liability	Yes
8. Mandatory Entry "Screening Panel" - Non-Binding Result Inadmissible At Trial	Yes
9. Mandatory Entry Mediation - Non-Binding Result Later Inadmissible	Yes
10. Voluntary Entry (Contractual), Binding Arbitration Contract <i>After</i> Incident	Yes
11. Voluntary Entry, Mediation <i>After</i> Event	Yes
12. No Statement of Damages In Complaint	Yes
13. Incident And Claims Data Reporting - To Board Of Medical Examiners	Yes
14. Report Of Incompetence Or Unprofessional Conduct - Immunity For Reporting	Yes
15. Peer Review Immunity	Yes
16. Punitive Damage Limits	Yes
17. Emotional/Mental Distress, Arising From Contract, No Recovery Of Damages	Yes
18. Vicarious Liability - <i>Respondeat Superior ("The Thing Speaks For Itself")</i> Yes	Yes
19. Products Liability - Strict (Automatic) Liability (Responsibility For Damages)	Yes
20. Notification of Intent To Sue (Pre-requisite To Suit - Claim Filing With Panel)	Yes
21. Counter-Suit Availability, Especially For Bad Faith Or Frivolous Lawsuit	Yes
22. Costs Of Court To Prevailing Party - Valid Or Frivolous Lawsuits	Yes
23. Attorney Fees For Frivolous Lawsuits	Yes
24. Wrongful Death Actions - Combined With Survival Actions - Brought At Same Time By Representative Of Estate - Duplicate Damages Eliminated	Yes
25. Limit On Liability - Immunity For Officers, Directors & Volunteers Of Non-Profit Corporations	Yes
26. Limit On Liability - Directors Of Certain Corporations	Yes

¹ Through 2011 Legislative Session. This inventory is current until Legislative changes in 2011 or after, if any. Of the available empirical scientific studies as to whether a specific tort reform measure has a downward or stabilizing effect on premiums, the rate of claims (frequency) or the payment on claims (severity), only the following meet that criteria, apart from measures that eliminate any liability and damages at all: Mandatory Pretrial Screening Panel; Modification Of Statutes Of Limitation; Ban On Naming Dollar Amounts In Initial Court "Complaint"; Limitations On Joint And Several Liability; Periodic Payment Of Future Damages; Offset Of Collateral Source Payment (Elimination Of Duplicate Payment Of Damages); Broad "Discovery" Of Medical Records For Claimants; Mandatory Risk Management Programs; Patient Compensation Funds; a "Cap" Or Other Limitations On Non-Economic Or Punitive Damages; Limits On Claimant Attorney "Contingency Fees". Except for Mandatory Risk Management Programs, A Patient Compensation Fund With A "Cap" On Maximum Liability, or Limits On Contingency Fees, each measure is present in Montana and each is qualitatively "better" than measures in almost all states. Any other measures may or may not have such an effect on the frequency and severity of claims and even if it does, the insurance carrier must pass through those benefits for it to affect premiums. See, regarding scientific reports: Research Report 18, *Effect Of Tort Reform Measures*, Montana Medical Legal Panel, December 10, 2002. A fully footnoted version of this document is available, describing legislative histories, the impact of case law for Montana Supreme Court cases through mid-2005 and other legislative details, including statute sections and bill numbers.

Type Of Legislative Measures In Effect In Montana	
Tort Reform Measure - Statute, Case Law Or Court Rule (continued)	In Effect?
27. Special Good Samaritan Law - Limits On Liability (No Ordinary Negligence) - Emergency Care For Assistance Rendered To Patient Of Direct-Entry Midwife By Licensed Physician, Nurse Or Hospital – Care Rendered With Or Without Compensation	Yes
28. Special Good Samaritan Law - Limits On Liability (No Ordinary Negligence) – Medical Practitioners, Including Licensed Physicians, And Dental Hygienists - Care Rendered Voluntarily & No Compensation – At Any Site – Patient Of Clinic, Patient Referred To Clinic Or Patient In A Community-Based Program To Provide Access To Health Care Services For Uninsured Persons	Yes
29. Special Good Samaritan Law - Limits On Liability (No Ordinary Negligence) - Governor Declared Authorized Disaster Or Emergency Medicine - For Assistance Rendered To Patient By “Health Care Professional” Where Normal Capacity Of Medical Resources Is Exceeded – Care Rendered With Or Without Compensation	Yes
30. General Good Samaritan Law – Limits On Liability (No Ordinary Negligence) – Any Person Including Licensed Physicians - Care Rendered Voluntarily & No Compensation - At The Scene Of An Accident Or Emergency	Yes
31. Advance Payment Of Damages, Fact And Amount, Not Admission & Not Admissible At Trial	Yes
32. Authorization For Physician-Owned Carriers	Yes
33. Committee Immunity For Peer Review - Confidentiality Of Data	Yes
34. Locality Rule - Standard Of Care	Yes
35. Limits On Pre-Judgment Interest	Yes
36. Inadmissibility In Court - Evidence Of Expressions Of Apology, Sympathy	Yes
37. No liability - Act or omission of other providers not within employment or control	Yes
38. Joint Underwriting Association - For Emergency Insurance Carrier	Yes
39. Incident And Claims Data Reporting – To Insurance Commissioner	Yes
40. Expert Witness Qualifications	Yes
41. Damage Limits - Loss Of Chance Doctrine Modification	Yes
42. Limit On Liability - "Captain Of The Ship" Doctrine Modification	Yes
43. No Liability - Acts Or Omissions Of "Ostensible" Agent	Yes
44. Panel Results Additionally Not Admissible In Bad Faith Action	Yes
45. Emergency Room Limits On Liability - Care To Patient Of Direct-Entry Midwife; Or Care Without Compensation As To Patient Of A Clinic, Patient Referred To A Clinic Or Patient In A Community-Based Program To Provide Access To Health Care Services For Uninsured Persons; Or Care Under Disaster Or Emergency Medicine	Yes

Type Of Legislative Measures NOT In Effect In Montana	
Tort Reform Measures – Not Enacted In Montana	In Effect?
1. Patient Compensation Fund For Excess Insurance Coverage	No
2. Cost Bond Before Filing In District Court	No
3. Certificate Of Merit By Physician, Prior To Lawsuit, Good Cause To Sue Exists	No
4. "No Fault" Administration Mechanism For Resolution Of Dispute	No
5. Mandatory Entry, Binding Arbitration	No
6. Attorney Fees To Prevailing Party	No

MONTANA MEDICAL LEGAL PANEL				
NUMBER AND RATE OF FILED MEDICAL MALPRACTICE CLAIMS				
ANNUAL DATA				
Panel Claim Filing Year	Number Of Claims Filed At The Panel¹	Number Of Hearings	Number Of Health Care Providers²	Number Of Claims As A Percentage Of Montana Health Care Providers
1984	104	88	1,260	8.3%
1985	80	76	1,266	6.3%
1986	124	92	1,226	10.1%
1987	97	95	1,226	7.9%
1988	101	71	1,795	5.6%
1989	110	90	1,806	6.1%
1990	102	109	1,808	5.6%
1991	85	75	1,765	4.8%
1992	101	68	1,947	5.2%
1993	121	90	1,983	6.1%
1994	121	106	2,073	5.8%
1995	150	106	2,122	7.1%
1996	139	128	2,143	6.5%
1997	143	110	2,148	6.7%
1998	146	131	2,189	6.7%
1999	149	134	2,230	6.7%
2000	145	141	2,272	6.4%
2001	139	112	2,416	5.8%
2002	149	124	2,414	6.2%
2003	170	132	2,547	6.7%
2004	153	127	2,558	6.0%
2005	175	162	2,623	6.7%
2006	130	125	2,618	5.0%
2007	136	107	2,738	5.0%
2008	110	98	2,783	4.0%
2009	122	93	2,905	4.2%
2010	100	98	3,015	3.3%
2011	94	78	3,215	2.9%
2012	108	81	3,215	3.4%
2013	90	75	3,367	2.7%
Total	3,694	3,122		

¹Number Of Claims Filed At The Panel represents: Claims deemed complete.
²Montana Health Care Providers include: Physicians, Podiatrists, Dentists, Facilities and Hospitals.

<http://montanamedicallegalpanel.org/janda/inner.php?PageID=312>

Summary - Claims Basis - Claims Filed



MONTANA MEDICAL LEGAL PANEL

**NUMBER & RATE OF MEDICAL MALPRACTICE CLAIMS FILED
AT THE PANEL**

PART 2: MEDICAL MALPRACTICE, HEALTH CARE COSTS AND "DEFENSIVE MEDICINE"

❖ **NUMEROUS STUDIES HAVE DEBUNKED THE NOTION THAT HEALTH CARE COSTS CAN BE SAVED BY STRIPPING AWAY PATIENTS' LEGAL RIGHTS; "TORT REFORM" HAS NO IMPACT ON SO-CALLED DEFENSIVE MEDICINE.**

"The Effect of Malpractice Reform on Emergency Department Care," RAND Corporation Adjunct Natural Scientist Daniel A. Waxman, M.D., Ph.D., et al., 2014.

After examining 3.8 million Medicare patient records from 1,166 hospital emergency departments from 1997 to 2011 – comparing care in three states before and after they changed their emergency care standard to gross negligence with care in neighboring states that did not pass malpractice reform – researchers found that raising the legal standard for malpractice did not result in less expensive care.¹³⁵

As explained in an October 15, 2014 RAND press release, the study "examined whether physicians ordered an advanced imaging study (CT or MRI scan), whether the patient was hospitalized after the emergency visit and total charges for the visit. Advanced imaging and hospitalization are among the most costly consequences of an emergency room visit, and physicians themselves have identified them as common defensive medicine practices."¹³⁶ The researchers discovered that "malpractice reform laws had no effect on the use of imaging or on the rate of hospitalization following emergency visits. For two of the states, Texas and South Carolina, the law did not appear to cause any reduction in charges. Relative to neighboring states, Georgia saw a small drop of 3.6 percent in average emergency room charges following its 2005 reform."¹³⁷

"Our findings suggest that malpractice reform may have less effect on costs than has been projected by conventional wisdom," said Dr. Daniel A. Waxman, the study's lead author. "Physicians say they order unnecessary tests strictly out of fear of being sued, but our results suggest the story is more complicated. ... This study suggests that even when the risk of being sued for malpractice decreases, the path of least resistance still may favor resource-intensive care, at least in hospital emergency departments...."¹³⁸

"Do Doctors Practice Defensive Medicine, Revisited," Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2014.

The authors examined health care spending trends in nine states that enacted caps during the last "hard" insurance market (2002 to 2005)¹³⁹ and compared these data to other "control" states. They found that "damage caps have no significant impact on Medicare Part A

(hospital) spending, but lead to 4-5% *higher* Medicare Part B (physician) spending” [emphasis in the original].¹⁴⁰ As the researchers note:

“Damage caps have long been seen by health policy researchers and policymakers as a way to control healthcare costs. We find, in contrast, no evidence that adoption of damage caps or other changes in med mal risk will reduce healthcare spending. Instead, we find evidence that states which adopted during the third wave of med mal reforms have *higher* post-cap Medicare Part B spending...” [emphasis in the original].¹⁴¹

“[O]ne policy conclusion is straightforward: There is no evidence that limiting med mal lawsuits will bend the healthcare cost curve, except perhaps in the wrong direction. Policymakers seeking a way to address rising healthcare spending should look elsewhere.”¹⁴²

“The Relationship Between Tort Reform and Medical Utilization” Health Watch USA Chair Kevin T. Kavanagh, M.D., M.S. et al., 2013.

“The comparison of the Dartmouth Atlas Medicare Reimbursement Data with Malpractice Reform State Rankings, which are used by the PRI [Pacific Research Institute], did not support the hypothesis that defensive medicine is a driver of rising health-care costs. Additionally, comparing Medicare reimbursements, premedical and postmedical tort reform, we found no consistent effect on health-care expenditures. Together, these data indicate that medical tort reform seems to have little to no effect on overall Medicare cost savings.”¹⁴³

“Will Tort Reform Bend the Cost Curve? Evidence from Texas,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2012.

In June 2012, the *Journal of Empirical Legal Studies* published a groundbreaking study, which concluded that limiting injured patients’ legal rights will not reduce overall health-care spending.¹⁴⁴ Professor Black and his co-authors – David A. Hyman, University of Illinois College of Law; Myungho Paik, Northwestern University Law School; and Charles Silver, University of Texas Law School – examined Medicare spending after Texas enacted severe “tort reform” in medical malpractice cases, including “caps” on compensation for injured patients, and found no evidence of a decline in health-care utilization. Among the report’s key findings:

Texas’s “Tort Reforms” Did Not Reduce Health-Care Spending Or Spending Trends.

- “A major exogenous shock to med mal risk from the reforms had no material impact on Medicare spending (in effect, health-care quantity), no matter how we slice the data.”¹⁴⁵
- “We find no evidence that overall health-care spending, physician spending, or imaging and lab spending declined more in counties with higher med mal risk.”¹⁴⁶

- “We also find no overall decline in Texas Medicare spending relative to control states, nor an overall association between spending (or spending trends) and med mal risk.”¹⁴⁷
- “If anything, we find some evidence, well short of definitive, that physician spending rose after reform in larger, high-risk counties.”¹⁴⁸
- “Our data are limited to Medicare, but med mal reform seems even less likely to influence treatment intensity for the privately insured, since most private insurers exercise greater oversight over treatment decisions than does Medicare.”¹⁴⁹
- “The further one gets from the time of reform, the less reliable will be any effort to have confidence in a causal link between tort reform and health-care spending.”¹⁵⁰

Limiting Patients’ Rights Will Have Little Impact On Health-Care Spending.

- “Our results, combined with those from other studies, let us place some bounds on the likely impact of tort reform on spending. We believe a ‘credible interval’ for the most likely effect of major tort reform on health-care spending runs from 0 percent to about a 2 percent decline for states that currently lack caps on non-econ or total damages.”¹⁵¹
- “Zero to one percent of health-care spending is \$0 to \$30 billion per year. The upper end of this range is more than small change, but we believe that claims that tort reform can meaningfully bend the health-care cost curve, or save hundreds of billions of dollars in annual spending, are not plausible, based on the available research.”¹⁵²
- “Higher spending cannot be ruled out; indeed, our study finds some evidence suggesting higher spending after reform.”¹⁵³

There Are Many Reasons Why “Tort Reform” Doesn’t Lower Health-Care Spending.

- “One possibility is that there may not be much ‘pure’ defensive medicine – medical treatments driven solely by liability risk. If liability is only one of a number of factors that influence clinical decisions, even a large reduction in med mal risk might have little impact on health-care spending.”¹⁵⁴
- “Lower med mal risk could lead some doctors to practice less defensive medicine, yet make other doctors more willing to offer aggressive medical treatment that is profitable to the doctor but of doubtful value to the patient.”¹⁵⁵
- “There could be savings in some areas of medical practice (cardiac care, perhaps), yet higher costs in other areas. The physician tendency toward more aggressive treatment as med mal risk declines might be stronger in urban areas, with more

sophisticated physicians. This could explain the hints we find of higher physician spending in these areas.”¹⁵⁶

- “[I]f the major, highly publicized Texas reforms, followed by a major drop in insurance premiums, did little to persuade doctors to practice less defensively, it is unclear what would do so, other than complete abolition of med mal liability. To date, no one has proposed going that far.”¹⁵⁷

Countless Explanations Exist As To Why U.S. Health Care Costs Are Out Of Control.

- “One is physician incentives to provide profitable services....A second is a political system that has thus far been unwilling to impose, for the publicly financed portion of health-care spending, the types of limits on spending that are routine in many other countries.”¹⁵⁸
- Moreover, “[p]olitically convenient myths are hard to kill. The myth that defensive medicine is an important driver of health-care costs is convenient to politicians who claim to want to control costs, but are unwilling to take the unpopular (with physicians or the elderly) steps needed to do so. It is convenient for health-care providers, who prefer lower liability risk. It is also convenient for members of the public, who find it easy to blame lawyers and the legal system for problems that have more complex and difficult roots, and call for stronger responses.”¹⁵⁹

“The Empirical Effects of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“Tort reform” provides little in the way of health care savings: “One recent summary concludes that the ‘accumulation of recent evidence finding zero or small effects suggests that it is time for policymakers to abandon the hope that tort reform can be a major element in healthcare cost control’ (Paik 2012, 175).”¹⁶⁰

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

“In over 30 years, medical malpractice premiums and claims have never been greater than 1% of our nation’s health care costs.”¹⁶¹

CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (“Tort Reform”), Congressional Budget Office, 2009

The Congressional Budget Office (CBO), in its October 2009 analysis (in the form of a 7-page letter to Senator Orin Hatch),¹⁶² found that even if the country enacted an entire menu of extreme tort restrictions, it could go no farther than to find an extremely small percentage of health care savings, about 0.5%, “far lower than advocates have estimated.”¹⁶³ This includes even smaller health care savings – “0.3 percent from slightly

less utilization of health care services¹⁶⁴ or “defensive medicine.” CBO ignored factors that would not only lower this already small figure but also likely *increase* costs:

- “CBO acknowledged but did not consider in its cost calculations the fact that these kinds of extreme “tort reforms” would weaken the deterrent potential of the tort system, with accompanying increases in cost and physician utilization inherent in caring for newly maimed patients and for care.”¹⁶⁵
- “There will be new burdens on Medicaid because if someone is brain damaged, mutilated or rendered paraplegic as a result of the medical negligence but cannot obtain compensation from the culpable party through the tort system (which is the impact of capping even non-economic damages), he or she may be forced to turn elsewhere for compensation, particularly Medicaid. None of these increased Medicaid costs are considered.”¹⁶⁶
- “Whenever there is a successful medical malpractice lawsuit, Medicare and Medicaid can both claim either liens or subrogation interests in whatever the patient recovers, reimbursing the government for some of the patients’ health care expenditures. Without the lawsuit, Medicare and Medicaid will lose funds that the government would otherwise be able to recoup. Again, none of these lost funds are factored in by the CBO.”¹⁶⁷
- “CBO arrived at its numbers by plugging selective studies into CBO’s internal econometric models that no one ever sees. When Senator Jay Rockefeller (D-WV) asked CBO for a “complete empirical analysis of the cost savings associated with medical malpractice reforms,” CBO’s response was another seven-page letter. No empirical analysis, no econometric models and no data were provided.”¹⁶⁸

***The Truth About Torts: Defensive Medicine and the Unsupported Case for Medical Malpractice Reform,* Center for Progressive Reform, 2012.**

“The evidence reveals that ‘defensive medicine’ is largely a myth, proffered by interests intent on limiting citizen access to the courts for deserving cases, leaving severely injured patients with no other recourse for obtaining the corrective justice they deserve. These changes would limit the deterrent effect of civil litigation and diminish the regulatory backstop that the civil justice system provides to the professional licensing system, leading to more medical errors.

...

“What is perhaps most striking about the CBO letter, though, is the rare departure from years of careful analysis. The CBO’s past work found small savings from civil justice restrictions and declared the evidence on ‘defensive medicine’ to be ‘weak or inconclusive’ and “at best ambiguous.’ Another CBO report, in 2004, described the limits of Kessler and McClellan’s 1996 Medicare research by concluding, ‘those studies

were conducted on a restricted sample of patients, whose treatment and behavior cannot be generalized to the population as a whole.’ In fact, just ten months before its letter to Senator Hatch, the CBO concluded that there is insufficient evidence that civil justice restrictions would reduce health care costs. The past work speaks for itself. Little changed in the research on defensive medicine in the years between CBO’s prior analyses and its letter to Senator Hatch.”¹⁶⁹

"Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions," Columbia University Mailman School of Public Health Clinical Professor Fred Hyde, M.D., 2011.¹⁷⁰

- “‘Defensive medicine’ by all accounts has become such a myth, a combination of surveys of interested parties and the ‘imagination’ that those parties are avoiding – or believe they are avoiding – liability through alteration of their medical practices.”
- “The cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care.”
- Medical liability “acts as a guardian against under treatment, the primary concern which should now be facing policy-makers.”
- “If tort reform reduces or even eliminates sanctions associated with negligent care and activity, adverse events themselves may increase, and by a number far greater than .2, .3 or .7% of the American health care bill.”
- “The implicit hypothesis would appear to be the following: That, in contravention of good medical judgment, the basic rules of Medicare (payment only for services that are medically necessary), threats of the potential for False Claim Act (prescribing, referring, where medically unnecessary), physicians will, as a group, act in ways which are possibly contrary to the interests of their patients, certainly contrary to reimbursement and related rules, under a theory that excessive or unnecessary prescribing and referring will insulate them from medical liability. There are many more cases concerning incompetence in credentialing and privileging, negligent referral, unnecessary radiation, etc., to provide at least a counter hypothesis.”
- “[A]s reaffirmed in the CBO studies, and as reflected in the literature generally, all estimates of the ‘indirect’ costs of professional liability, including, for example, the cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care. Controversies involving Senators, the CBO in 2009 appear entirely to reflect the difference between .2 and .5% of health costs.”
- “The import of the phrase ‘defensive medicine’ is in its ‘political’ or strategic use: ‘Defensive medicine has mainly been invoked as an argument for tort reform in the years between malpractice crises when other pressures for legal change have ebbed.’ The methods used to study the existence, prevalence and impact of defensive medicine have been, primarily, survey of those (practicing physicians) who may be perceived as having

a position or stance in the political discussion, in addition to having access to information necessary to answer the questions posed above.”

- “Survey-type findings led to a conclusion that defensive medicine was significant among physicians in Pennsylvania who pay the most for liability insurance. In later studies (Mello [footnote omitted]), however, some of the same authors have cast doubt on the survey as an objectively verifiable means of establishing the presence, quantity or scope of defensive medicine.”
- “The fee for service system both empowers and encourages physicians to practice very low risk medicine. Health care reform may change financial incentives toward doing fewer rather than more tests and procedures. If that happens, concerns about malpractice liability may act to check potential tendencies to provide too few services.”
- “If most claims result from errors, and most errors result in injuries, and most injuries resulting from such errors result in compensation (73%), what is at stake in limiting access to the courts? If access is limited, it would be in recognition that the basic principle of civil justice, having a remedy available to enforce a right, is void.”

Defensive Medicine and Medical Malpractice, Office of Technology Assessment, 1994.

The congressional office found that less than 8 percent of all diagnostic procedures were likely to be caused primarily by liability concerns. According to its analysis, most physicians who “order aggressive diagnostic procedures...do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability.” The effects of “tort reform” on defensive medicine “are likely to be small.”¹⁷¹

❖ **STUDIES ESTABLISHING "DEFENSIVE MEDICINE" DEPEND ALMOST ENTIRELY ON UNTRUSTWORTHY PHYSICIAN SURVEYS, OFTEN CONCEIVED BY LOBBY GROUPS PUSHING "TORT REFORM."**

Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care, General Accountability Office, 2003.

The General Accountability Office (GAO) condemned the use of "defensive medicine" physician surveys as being inaccurate and misleading.¹⁷² The GAO also noted that those who produced and cited such surveys "could not provide additional data demonstrating the extent and costs associated with defensive medicine."¹⁷³ And, "some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures"¹⁷⁴ and "according to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit."¹⁷⁵

"Critique of February 2011 AAOS 'Defensive Medicine' Survey," Columbia University Mailman School of Public Health Clinical Professor Fred Hyde, M.D., 2011.

In a widely-reported recent "survey" of 56¹⁷⁶ or 72¹⁷⁷ Pennsylvania orthopedic surgeons, respondents claim that 19.7 percent of the imaging tests they ordered were for defensive purposes – *i.e.* to avoid being sued. This supposedly amounts to 34.8 percent of total imaging costs because "the most common test was an MRI, an imaging test which costs more than a regular X-ray."¹⁷⁸ Professor Hyde reviewed this study for CJ&D and found:

- "In searching for the actual paper containing these findings, it turns out that there is no paper, much less one peer reviewed prior to publication. Instead, this was a podium presentation by a medical student, accompanied by a faculty supervisor."¹⁷⁹
- "The methodology, according to news and public relations reports, was this: to ask the ordering doctor whether or not he or she was ordering a test for reasons having to do with 'defensive medicine.'"¹⁸⁰
- "However, the issues are not straightforward. For example, a moderator of the presentation suggested other possible explanations for the MRI exams. He noted that MRIs and other imaging studies are frequently ordered 'unnecessarily' for reasons *other than malpractice avoidance*.
 - "The moderator noted that many MRIs are required by insurers before those insurers will authorize an arthroscopy (a minimally invasive surgical procedure in which an examination and treatment of damage of the interior of a joint is performed using an arthroscope, an endoscope inserted into the joint through a small incision).

- "The insurers require the imaging study in an attempt to protect against fraud. Orthopedic surgeons believe the MRI study prior to arthroscopy to be unnecessary; this was affirmed by a show of hands in the audience for the San Diego presentation."¹⁸¹
- o "No mention was made of the potential for fraudulent billing if the MRI studies ordered were not for the benefit of the patient. If the box checked 'defensive' were accompanied by a box that indicated 'no bill to be rendered' or 'bill referring physician' this would undoubtedly have been included in the report. It would be a reasonable assumption that, to the contrary, a bill was rendered to the patient or to the insurance company for the MRIs as ordered. Were the physicians really uninterested in the results of the MRI tests, and willing to risk sanction? Or did they 'check the box' to 'show support' without realizing that it might indicate a potentially fraudulent act?"¹⁸²
- o "Appearing in Pennsylvania especially, this study should be regarded primarily as an advocacy position. This advocacy presentation has received disproportionate attention due to its timing in the context of current proposals before the Congress, not because of the credibility of the survey. The difficulty facing physicians especially in Pennsylvania concerning the cost and availability of malpractice insurance are well known, but are due to insurance issues, and not to causes directly related to tort law."¹⁸³

❖ DEFENSIVE MEDICINE IS MEDICARE FRAUD.

A doctor who bills Medicare or Medicaid for tests and procedures done for a personal purpose – *e.g.*, possible lawsuit protection – as opposed to what is medically necessary for a patient, is committing fraud under federal and state Medicare/Medicaid programs.

- The Medicare law states: “It shall be the obligation of any health care practitioner and any other person...who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act...will be provided economically and only when, and to the extent, medically necessary.”¹⁸⁴ “[N]o payment may be made under part A or part B for any expenses incurred for items or services...which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”¹⁸⁵
- Providers cannot be paid and/or participate in the Medicare program unless they comply with these provisions, and they impliedly certify compliance with these provisions when they file claims. Thus, if they are not in compliance, the certifications and the claims are false. Providers who do not comply and/or file false claims can be excluded from the Medicare program.¹⁸⁶
- Perhaps more importantly, the Medicare claim form (Form 1500) requires providers to expressly certify that “the services shown on the form were medically indicated and necessary for the health of the patient.”¹⁸⁷ If the services are, to the doctor’s knowledge, not medically necessary, the claim is false.

❖ THE REAL REASONS DOCTORS MAY ORDER TOO MANY TESTS AND PROCEDURES: WORKLOAD AND REVENUE.

"Impact of Attending Physician Workload on Patient Care: A Survey of Hospitalists,"
Johns Hopkins Assistant Professor of Medicine Henry J. Michtalik, M.D., M.P.H.,
M.H.S., et al., 2013.

In a survey of hospital attending doctors published in *JAMA Internal Medicine*, 22 percent of physicians reported that workload led them to "order potentially unnecessary tests, procedures, consultations, or radiographs due to not having the time to assess the patient adequately in person."¹⁸⁸ In other words, a heavy workload, not fear of lawsuits, caused them to order extra tests, etc.

"Exclusive: Medicare on drugs: 24,000 tests for 145 patients," Reuters, May 29, 2014.

- "Medicare paid medical providers \$457 million in 2012 for 16 million tests to detect everything from prescription narcotics to cocaine and heroin, according to the Reuters analysis. 'In some parts of the country every doctor and his cousin is hanging out a shingle to do (addiction) treatment. There's a tailor-made opportunity for ordering a profusion of tests instead of one,' said Bill Mahon, former executive director of the National Health Care Anti-Fraud Association. 'It's like turning on a spigot of money,' he said."¹⁸⁹

"Doctors Overlook Lucrative Procedures When Naming Unwise Treatments,"
Chicago Tribune and Kaiser Health News, April 14, 2014.

- "The medical profession has historically been reluctant to condemn unwarranted but often lucrative tests and treatments that can rack up costs to patients but not improve their health and can sometimes hurt them."¹⁹⁰
- In 2012, "medical specialty societies began publishing lists of at least five services that both doctors and patients should consider skeptically. ... Yet some of the largest medical associations selected rare services or ones that are done by practitioners in other fields and will not affect their earnings. 'They were willing to throw someone else's services into the arena, but not their own,' said Dr. Nancy Morden, a researcher at the Dartmouth Institute for Health Policy & Clinical Practice in New Hampshire."¹⁹¹
- The American College of Cardiology "did not tackle what studies suggest is the most frequent type of overtreatment in the field: inserting small mesh tubes called stents to prop open arteries of patients who are not suffering heart attacks, rather than first prescribing medicine or encouraging a healthier lifestyle. As many as one out of eight of these stent procedures should not have been performed, according to a study in

Circulation, the journal of the American Heart Association. At hospitals where stenting was most overused, 59 percent of stents were inappropriate, the study found.¹⁹²

- “Dr. Augusto Sarmiento, a former president of the academy and retired chairman of orthopedics at the University of Miami Miller Medical School, said there were more significant overused procedures the academy omitted, including replacing hips and knees when the patient’s pain is minimal and can be managed with medicine. In addition, Sarmiento said too many surgeons operate on simple fractured collarbones, inserting metal plates, rather than letting the injury heal with the help of a sling.”¹⁹³

“Patients’ Costs Skyrocket; Specialists’ Incomes Soar,” *New York Times*, January 19, 2014.

- “Doctors’ charges – and the incentives they reflect – are a major factor in the nation’s \$2.7 trillion medical bill. Payments to doctors in the United States, who make far more than their counterparts in other developed countries, account for 20 percent of American health care expenses, second only to hospital costs.”¹⁹⁴
- “Many specialists have become particularly adept at the business of medicine by becoming more entrepreneurial, protecting their turf through aggressive lobbying by their medical societies, and most of all, increasing revenues by offering new procedures – or doing more of lucrative ones.”¹⁹⁵
- “In addition, salary figures often understate physician earning power since they often do not include revenue from business activities: fees for blood or pathology tests at a lab that the doctor owns or ‘facility’ charges at an ambulatory surgery center where the physician is an investor, for example.”¹⁹⁶

“What’s the deal with health care credit cards? Four things you should know” and “CFPB Orders GE CareCredit to Refund \$34.1 Million for Deceptive Health-Care Credit Card Enrollment,” U.S. Consumer Financial Protection Bureau, 2013 and 2014.

- “Recently, many patients facing medical procedures have seen their health care providers suggest deferred interest rate credit cards as a payment option. Unfortunately, health care providers don’t always explain how these deferred interest credit cards work. ...Case in point: GE CareCredit cards.”¹⁹⁷
- “CareCredit offers personal lines of credit for health-care services, including dental, cosmetic, vision, and veterinary care. Doctors, dentists and other medical providers and their office staff, such as office managers and receptionists, are the primary sellers of the product, offering it as a payment option for their patients. The product is sold by more than 175,000 enrolled providers across the country. There are about 4 million active CareCredit cardholders.”¹⁹⁸

- In December 2013, the Consumer Financial Protection Bureau ordered GE Capital Retail Bank and its subsidiary, CareCredit, to “refund up to \$34.1 million to potentially more than 1 million consumers who were victims of deceptive credit card enrollment tactics. At doctors’ and dentists’ offices around the country, consumers were signed up for CareCredit credit cards they thought were interest free, but were actually accruing interest that kicked in if the full balance was not paid at the end of a promotional period. According to the CFPB order, since January 2009, consumers who signed up for the credit card frequently received an inadequate explanation of the terms. Many consumers, most of whom were enrolled while waiting for health-care treatment, incurred substantial debt because they did not understand how they could have avoided deferred interest, penalties, and fees.”

Darshak Sanghavi, M.D., Chief of Pediatric Cardiology at the University of Massachusetts Medical School, 2013.

“Studies show that doctors order a lot of questionable testing and treatment even when malpractice risks are very low.”¹⁹⁹

“Deaths Linked to Cardiac Stents Rise as Overuse Seen,” *Bloomberg News*, 2013.

- For the nearly 350,000 elective-surgery patients in stable condition who have cardiac stents implanted each year, “overuse, death, injury and fraud have accompanied the devices’ use as a go-to treatment....”²⁰⁰ This was the finding of a *Bloomberg News* investigation, which examined “thousands of pages of court documents and regulatory filings, interviews with 37 cardiologists and 33 heart patients or their survivors, and more than a dozen medical studies.”²⁰¹ According to the report, “These sources point to stent practices that underscore the waste and patient vulnerability in a U.S. health care system that rewards doctors based on volume of procedures rather than quality of care. Cardiologists get paid less than \$250 to talk to patients about stents’ risks and alternative measures, and an average of four times that fee for putting in a stent.”²⁰²
- “‘Stenting belongs to one of the bleakest chapters in the history of Western medicine,’” University of North Carolina at Chapel Hill’s Professor Nortin Hadler told *Bloomberg News*.²⁰³ “Cardiologists ‘are marching on’ because ‘the interventional cardiology industry has a cash flow comparable to the GDP of many countries’ and doesn’t want to lose it, he said.”²⁰⁴ Former Assistant U.S. Attorney Jamie Bennett echoed these sentiments: “‘There is a huge financial incentive to increase the number of these procedures....The cases we have seen to date are just the tip of the iceberg.’” As of September 26, 2013, “[a]t least five hospitals have reached settlements with the Justice Department over allegations that they paid illegal kickbacks to doctors for patient referrals to their cath labs.”²⁰⁵

Spinal Devices Supplies by Physician-Owned Distributors: Overview of Prevalence and Use, Office of Inspector General, U.S. Department of Health and Human Services, 2013.

Responding to a congressional request to investigate the growth of physician-owned distributorships for spinal fusion equipment (screws, rods and plates) and their impacts on Medicare beneficiaries and federal health care programs, OIG studied Medicare billings and found that “financial incentives for doctors may be driving some of the rapid rise in spinal fusion surgery.”²⁰⁶ Among the data uncovered, as reported by the *Washington Post*:

- “Nearly one in five spinal fusions sampled in the study involved equipment purchased from distributors that were co-owned by physicians”;
- “Six months after a hospital began to purchase spinal devices from a physician-owned distributorship, the number of spinal fusions performed jumped 21 percent on average, more than twice as fast as at other hospitals”;
- “Doctors who are investors in such companies stand to benefit when more spinal fusions are performed”; and
- “The average hospital performed 62 spinal fusion surgeries per 1,000 surgical patients before beginning to purchase devices from the physician-owned companies; that figure climbed to 75 spinal surgeries per 1,000 surgical patients afterward.”

After reviewing the study, Sen. Orrin G. Hatch (R-Utah), the ranking member of the Senate Finance Committee, which had requested the investigation, said, “With this report, HHS’s inspector general has produced data that clearly demonstrate a direct correlation between the perverse financial incentives created by physician-owned distributorships and the rise in these highly invasive spinal surgeries....Given the impact of these surgeries on seniors and their health, the structure of these entities needs to be further scrutinized.”²⁰⁷

Medicare: Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrant Scrutiny, U.S. Government Accountability Office, 2013.

The report, requested by bipartisan leaders in Congress, found that doctors whose practices offered IMRT – an intensive form of prostate cancer treatment that usually costs over \$31,000 – were more likely to refer patients for IMRT therapy than less expensive treatments.²⁰⁸ More specifically,²⁰⁹

- “The number of Medicare prostate cancer-related intensity-modulated radiation therapy (IMRT) services performed by self-referring groups increased rapidly, while declining for non-self-referring groups from 2006 to 2010.”
- “Over this period, the number of prostate cancer-related IMRT services performed by self-referring groups increased from about 80,000 to 366,000. Consistent with that

growth, expenditures associated with these services and the number of self-referring groups also increased.”

- “Providers substantially increased the percentage of their prostate cancer patients they referred for IMRT after they began to self-refer. Providers that began self-referring in 2008 or 2009 – referred to as switchers – referred 54 percent of their patients who were diagnosed with prostate cancer in 2009 for IMRT, compared to 37 percent of their patients diagnosed in 2007. In contrast, providers who did not begin to self-refer – that is, non-self-referrers and providers who self-referred the entire period – experienced much smaller changes over the same period.”
- “Among all providers who referred a Medicare beneficiary diagnosed with prostate cancer in 2009, those that self-referred were 53 percent more likely to refer their patients for IMRT and less likely to refer them for other treatments, especially a radical prostatectomy or brachytherapy. Compared to IMRT, those treatments are less costly and often considered equally appropriate but have different risks and side effects.”
- “Factors such as age, geographic location, and patient health did not explain the large differences between self-referring and non-self-referring providers. These analyses suggest that financial incentives for self-referring providers – specifically those in limited specialty groups – were likely a major factor driving the increase in the percentage of prostate cancer patients referred for IMRT.”
- “Medicare providers are generally not required to disclose that they self-refer IMRT services, and the Department of Health and Human Services (HHS) lacks the authority to establish such a requirement. Thus, beneficiaries may not be aware that their provider has a financial interest in recommending IMRT over alternative treatments that may be equally effective, have different risks and side effects, and are less expensive for Medicare and beneficiaries.”
- “To the extent that providers’ financial interests are shaping treatment decisions, some patients may end up on a treatment course that does not best meet their individual needs. Second, because IMRT costs more than most other treatments, the higher use of IMRT by self-referring providers results in higher costs for Medicare and beneficiaries. To the extent that treatment decisions are driven by providers’ financial interest and not by patient preference, these increased costs are difficult to justify.”

**“Urologists' Use of Intensity-Modulated Radiation Therapy for Prostate Cancer,”
Georgetown University Public Policy Institute Economist and Professor Jean M.
Mitchell, PhD., 2013.**

According to a comprehensive study financed by the American Society for Radiation Oncology (ASTRO) and published in the *New England Journal of Medicine*, doctors who have a financial interest in [intensity-modulated radiation therapy] IMRT are twice as likely to recommend it despite the absence of strong evidence that it would be better than

less costly options.²¹⁰ As reported by *Reuters*, “Federal law prohibits what is known as self-referral, when doctors send patients for tests or treatment from which the physician stands to gain financially, but makes an exception for ‘in house’ services.”²¹¹ Yet, “urologists are taking advantage of a loophole in federal law that doesn’t make it a conflict of interest for the doctors to benefit from such an arrangement,” the study’s author told *Reuters*.²¹² ASTRO’s Chairwoman agreed, saying in a news release that the “study provides clear, indisputable evidence that many men are receiving unnecessary radiation therapy for their prostate cancer due to self-referral,” adding that “[w]e must end physician self-referral for radiation therapy and protect patients from this type of abuse.”²¹³

Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer, U.S. Government Accountability Office, 2013.

- “Self-referred anatomic pathology services increased at a faster rate than non-self-referred services from 2004 to 2010. During this period, the number of self-referred anatomic pathology services more than doubled, growing from 1.06 million services to about 2.26 million services, while non-self-referred services grew about 38 percent, from about 5.64 million services to about 7.77 million services.”
- “Similarly, the growth rate of expenditures for self-referred anatomic pathology services was higher than for non-self-referred services. Three provider specialties – dermatology, gastroenterology, and urology – accounted for 90 percent of referrals for self-referred anatomic pathology services in 2010.”
- “Referrals for anatomic pathology services by dermatologists, gastroenterologists, and urologists substantially increased the year after they began to self-refer. Providers that began self-referring in 2009 – referred to as switchers – had increases in anatomic pathology services that ranged on average from 14.0 percent to 58.5 percent in 2010 compared to 2008, the year before they began self-referring, across these provider specialties. In comparison, increases in anatomic pathology referrals for providers who continued to self-refer or never self-referred services during this period were much lower. Thus, the increase in anatomic pathology referrals for switchers was not due to a general increase in use of these services among all providers.”
- “GAO’s examination of all providers that referred an anatomic pathology service in 2010 showed that self-referring providers of the specialties we examined referred more services on average than non-self-referring providers. Differences in referral for these services generally persisted after accounting for geography and patient characteristics such as health status and diagnosis. These analyses suggest that financial incentives for self-referring providers were likely a major factor driving the increase in referrals.”
- “GAO estimates that in 2010, self-referring providers likely referred over 918,000 more anatomic pathology services than if they had performed biopsy procedures at the same rate as and referred the same number of services per biopsy procedure as non-self-referring providers. These additional referrals for anatomic pathology services cost

Medicare about \$69 million. To the extent that these additional referrals were unnecessary, avoiding them could result in savings to Medicare and beneficiaries, as they share in the cost of services.”

"Physician Self-Referral: Frequency of Negative Findings at MR Imaging of the Knee as a Marker of Appropriate Utilization," Duke University Medical Center Radiology Fellow Matthew P. Lungren, M.D. et al., 2013.

After reviewing 700 referrals for knee M.R.I.s made by two physician groups (one with a financial interest in the machine, the other without), researchers found that “patients are more likely to have magnetic resonance imaging scans that indicate nothing is wrong if they are referred by a doctor who owns the machine. The scientists conclude that doctors with a financial interest in the machines may be more likely to order M.R.I.s even when clinical findings suggest they are unnecessary.”²¹⁴

"Patients Mired in Costly Credit From Doctors," *New York Times*, October 13, 2013.

- “In dentists’ and doctors’ offices, hearing aid centers and pain clinics, American health care is forging a lucrative alliance with American finance. A growing number of health care professionals are urging patients to pay for treatment not covered by their insurance plans with credit cards and lines of credit that can be arranged quickly in the provider’s office. The cards and loans, which were first marketed about a decade ago for cosmetic surgery and other elective procedures, are now proliferating among older Americans, who often face large out-of-pocket expenses for basic care that is not covered by Medicare or private insurance.”²¹⁵
- “While medical credit cards resemble other credit cards, there is a critical difference: they are usually marketed by caregivers to patients, often at vulnerable times, such as when those patients are in pain or when their providers have recommended care they cannot readily afford.”²¹⁶
- “Many of these cards initially charge no interest for a promotional period, typically six to 18 months, an attractive feature for people worried about whether they can afford care. But if the debt is not paid in full when that time is up, costly rates — usually 25 to 30 percent — kick in, the review by *The Times* found. If payments are late, patients face additional fees and, in most cases, their rates increase automatically. The higher rates are often retroactive, meaning that they are applied to patients’ original balances, rather than to the amount they still owe....For patients, the financial consequences can be dire.”²¹⁷
- “A review by *The New York Times* of dozens of customer contracts for medical cards and lines of credit, as well as of hundreds of court filings in connection with civil lawsuits brought by state authorities and others, shows how perilous such financial arrangements can be for patients — and how advantageous they can be for health care providers.”²¹⁸

- “Doctors, dentists and others have a financial incentive to recommend the financing because it encourages patients to opt for procedures and products that they might otherwise forgo because they are not covered by insurance. It also ensures that providers are paid upfront – a fact that financial services companies promote in marketing material to providers.”²¹⁹
- “[A]ttorneys general in a several states have filed lawsuits claiming that other dentists and professionals have misled patients about the financial terms of the cards, employed high-pressure sales tactics, overcharged for treatments and billed for unauthorized work.”²²⁰

“A.G. Schneiderman Issues Consumer Alert On Potential Dangers Of Medical Credit Cards,” Office of New York State Attorney General Eric Schneiderman, 2013.

In November, Schneiderman warned that increasing numbers of health care professionals are urging patients to use medical credit cards to pay for treatments not covered by their insurance plans because medical providers reap the benefits. As the N.Y. Attorney General explained, “Doctors, dentists and other providers have a financial incentive to recommend the financing because it encourages patients to opt for procedures and products they may not need. It also ensures that providers are fully paid upfront even for an ongoing course of treatment – a fact that financial services companies promote in marketing material to providers.”²²¹

Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions, U.S. Government Accountability Office, 2012.

- “From 2004 through 2010, the number of self-referred and non-self-referred advanced imaging services – magnetic resonance imaging (MRI) and computed tomography (CT) services – both increased, with the larger increase among self-referred services. For example, the number of self-referred MRI services increased over this period by more than 80 percent, compared with an increase of 12 percent for non-self-referred MRI services. Likewise, the growth rate of expenditures for self-referred MRI and CT services was also higher than for non-self-referred MRI and CT services.”
- “GAO’s analysis showed that providers’ referrals of MRI and CT services substantially increased the year after they began to self-refer – that is, they purchased or leased imaging equipment, or joined a group practice that already self-referred. Providers that began self-referring in 2009 – referred to as switchers – increased MRI and CT referrals on average by about 67 percent in 2010 compared to 2008. In the case of MRIs, the average number of referrals switchers made increased from 25.1 in 2008 to 42.0 in 2010. In contrast, the average number of referrals made by providers who remained self-referrers or non-self-referrers declined during this period. This comparison suggests that the increase in the average number of referrals for switchers was not due to a general increase in the use of imaging services among all providers.”

- “GAO’s examination of all providers that referred an MRI or CT service in 2010 showed that self-referring providers referred about two times as many of these services as providers who did not self-refer. Differences persisted after accounting for practice size, specialty, geography, or patient characteristics. These two analyses suggest that financial incentives for self-referring providers were likely a major factor driving the increase in referrals.”
- “GAO estimates that in 2010, providers who self-referred likely made 400,000 more referrals for advanced imaging services than they would have if they were not self-referring. These additional referrals cost Medicare about \$109 million.”
- “To the extent that these additional referrals were unnecessary, they pose unacceptable risks for beneficiaries, particularly in the case of CT services, which involve the use of ionizing radiation that has been linked to an increased risk of developing cancer.”²²²

“Hospital Chain Inquiry Cited Unnecessary Cardiac Work,” *New York Times*, August 7, 2012.

- “[U]nnecessary – even dangerous – procedures were taking place at some HCA hospitals, driving up costs and increasing profits.”
- “HCA, the largest for-profit hospital chain in the United States with 163 facilities, had uncovered evidence as far back as 2002 and as recently as late 2010 showing that some cardiologists at several of its hospitals in Florida were unable to justify many of the procedures they were performing. ... In some cases, the doctors made misleading statements in medical records that made it appear the procedures were necessary, according to internal reports.”
- “[T]he documents suggest that the problems at HCA went beyond a rogue doctor or two...”
- “Cardiology is a lucrative business for HCA, and the profits from testing and performing heart surgeries played a critical role in the company’s bottom line in recent years.”²²³

“For-profit hospitals performing more C-sections,” *California Watch*, 2010.

An investigative team recently looked at C-Section rates in California, which has had a \$250,000 cap on damages since 1975. It found that from 2005-2007:²²⁴

- “[W]omen are at least 17 percent more likely to have a cesarean section at a for-profit hospital than at one that operates as a non-profit. A surgical birth can bring in twice the revenue of a vaginal delivery.”

- “[S]ome hospitals appear to be performing more C-sections for non-medical reasons – including an individual doctor’s level of patience and the staffing schedules in maternity wards, according to interviews with health professionals.”
- “In California, hospitals can increase their revenues by 82 percent on average by performing a C-section instead of a vaginal birth....”²²⁵

“The Cost of Dying: End-of-Life Care,” 60 Minutes, 2010.

- “Last year, Medicare paid \$55 billion just for doctor and hospital bills during the last two months of patients’ lives. That’s more than the budget for the Department of Homeland Security, or the Department of Education. And it has been estimated that 20 to 30 percent of these medical expenses may have had no meaningful impact.”
- “[T]here are other incentives that affect the cost and the care patients receive. Among them: the fact that most doctors get paid based on the number of patients that they see, and most hospitals get paid for the patients they admit... ‘So, the more M.R.I. machines you have, the more people are gonna get M.R.I. tests?’ [Steve] Kroft asked. ‘Absolutely,’ [Dr. Elliott Fisher, a researcher at the Dartmouth Institute for Health Policy] said.”²²⁶

“Doctors Reap Benefits By Doing Own Tests,” Washington Post, 2009.

The paper obtained Wellmark Blue Cross and Blue Shield documents, which showed that in 2005, doctors at a medical clinic on the Iowa-Illinois border were ordering eight or nine CT scans a month in August and September of 2005. But after those doctors bought their own CT scanner, within seven months, those numbers ballooned by 700 percent. The *Post* did a similar analysis of the Wellmark data for doctors in the region and found that after CT scanners were purchased, the number of scans they ordered was triple that of other area doctors who hadn’t purchased such equipment. The paper also cited consistent data from the GAO and MedPac. Jean M. Mitchell, a professor for public policy and a health economist at Georgetown University, suggested that getting rid of profit-driven medicine like this “could reduce the nation’s health care bill by as much as a quarter.”²²⁷

“The Cost Conundrum: What a Texas town can teach us about health care,” New Yorker, 2009.

The following exchange took place with a group of doctors and author, Dr. Atul Gawande:²²⁸

“It’s malpractice,” a family physician who had practiced here for thirty-three years said.

“McAllen is legal hell,” the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.

That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn't lawsuits go down?

"Practically to zero," the cardiologist admitted.

"Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures.

¹¹⁹ *Ibid.*

¹²⁰ *Ibid.*

¹²¹ *Ibid.*

¹²² David M. Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," 354 *N Engl J Med* 2024, 2025, 2031 (2006), <http://www.hsph.harvard.edu/faculty/michelle-mello/files/litigation.pdf>.

¹²³ *Id.* at 2027-2028.

¹²⁴ *Id.* at 2026.

¹²⁵ *Id.* at 2031.

¹²⁶ [http://www.ajog.org/article/S0002-9378\(14\)00434-7/fulltext](http://www.ajog.org/article/S0002-9378(14)00434-7/fulltext);

<http://insurancenewsnet.com/oarticle/2014/06/10/obstetric-malpractice-claims-dip-when-hospitals-stress-patient-safety-a-515885.html>.

¹²⁷ Bernard S. Black and Zenon Zabinski, "The Association between Patient Safety Indicators and Medical Malpractice Risk: Evidence from Texas," January 20, 2013, at 3, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1884630.

¹²⁸ *Ibid.*

¹²⁹ *Ibid.*

¹³⁰ Michael D. Greenberg et al., *Is Better Patient Safety Associated with Less Malpractice Activity? Evidence from California*, Rand Corporation (2010) at x, http://rand.org/pubs/technical_reports/2010/RAND_TR824.

¹³¹ *Ibid.*

¹³² *Id.* at 15.

¹³³ *Id.* at 15-16.

¹³⁴ *Id.* at 19.

¹³⁵ RAND Corporation, "Making It More Difficult to Sue Physicians for Malpractice May Not Reduce 'Defensive Medicine,'" October 15, 2014, <http://www.rand.org/news/press/2014/10/15.html>, discussing Daniel A. Waxman et al., "The Effect of Malpractice Reform on Emergency Department Care," 371 *N. Engl. J. Med.* 1518, October 16, 2014, <http://www.nejm.org/doi/full/10.1056/NEJMs1313308>.

¹³⁶ RAND Corporation, "Making It More Difficult to Sue Physicians for Malpractice May Not Reduce 'Defensive Medicine,'" October 15, 2014, <http://www.rand.org/news/press/2014/10/15.html>.

¹³⁷ *Ibid.*

¹³⁸ *Ibid.*

¹³⁹ Florida, Georgia, Illinois, Mississippi, Nevada, Ohio, Oklahoma, South Carolina and Texas.

¹⁴⁰ Bernard S. Black, David A. Hyman and Myungho Paik, "Do Doctors Practice Defensive Medicine, Revisited," Northwestern University Law & Economics Research Paper No. 13-20; Illinois Program in Law, Behavior and Social Science Paper No. LBSS14-21 (October 2014) at 2, <http://ssrn.com/abstract=2110656>.

¹⁴¹ *Id.* at 26.

¹⁴² *Id.* at 27.

¹⁴³ Lindsay E. Calderon, Kevin T. Kavanagh and Daniel M. Saman, "The Relationship Between Tort Reform and Medical Utilization," *Journal of Patient Safety* (2013), http://journals.lww.com/journalpatientsafety/Abstract/publishahead/The_Relationship_Between_Tort_Reform_and_Medical_Utilization.aspx.

¹⁴⁴ Myungho Paik et al., "Will Tort Reform Bend the Cost Curve? Evidence from Texas," *Journal of Empirical Legal Studies* (June 2012), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1635882.

¹⁴⁵ *Id.* at 209.

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.*

¹⁴⁸ *Ibid.*

¹⁴⁹ *Ibid.*

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.*

¹⁵² *Ibid.*

¹⁵³ *Ibid.*

¹⁵⁴ *Id.* at 210.

¹⁵⁵ *Ibid.*

¹⁵⁶ *Ibid.*

¹⁵⁷ *Ibid.*

¹⁵⁸ *Ibid.*

¹⁵⁹ *Id.* at 210-11.

¹⁶⁰ Theodore Eisenberg, "The Empirical Effects of Tort Reform," *Research Handbook on the Economics of Torts*, Forthcoming; Cornell Legal Studies Research Paper No. 12-26, April 1, 2012, at 19, <http://ssrn.com/abstract=2032740>.

¹⁶¹ Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009) at 2, www.insurance-reform.org/studies/TrueRiskF.pdf.

¹⁶² Congressional Budget Office, "CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ('Tort Reform')," October 9, 2009, <http://www.cbo.gov/publication/41334>.

¹⁶³ Alexander C. Hart, "Medical malpractice reform savings would be small, report says," *Los Angeles Times*, October 10, 2009, <http://articles.latimes.com/2009/oct/10/nation/na-malpractice10>.

¹⁶⁴ Congressional Budget Office, "CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ('Tort Reform')," October 9, 2009, at 4, <http://www.cbo.gov/publication/41334>.

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¹⁸⁰ *Ibid.*

¹⁸¹ *Id.* at 1-2.

¹⁸² *Id.* at 2.

¹⁸³ *Ibid.* (citation omitted). According to Hyde, "Malpractice insurance has been an extremely difficult issue for Pennsylvania physicians and hospitals in the time period (1994 to present) since the Office of Technology Assessment dismissed 'defensive medicine' as a minor, even illusory issue. That is, in part, because physicians and hospitals indulged in the self-insurance business, through the now insolvent MII and Hospital Association of Pennsylvania misadventures. Commercial insurers often avoid markets where 'home grown' and 'provider owned' insurance is their competitor. As a result of these insurance problems, Pennsylvania has compelled a variety of taxes and insurance surcharge premiums for purposes of providing affordable malpractice insurance coverage. Quite aside from the limitations of studies in this area, the controversies stemming from insurance problems facing

Pennsylvania physicians and hospitals – some self-inflicted – would color and may overshadow any attempt to generalize findings from that state.” *Id.* at 2.

¹⁸⁴ 42 U.S.C. § 1320c-5(a)(1).

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