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HEALTH POLICY BULLETIN

FOCUS: THE MEDICAID MYTH

Sharing significance with the program's low levels of reimbursement in creating obstacles to care for Medicaid patients is the Medicaid myth—that Medicaid patients sue physicians and hospitals more often than do other patients because they are encouraged by unscrupulous attorneys to view lawsuits as a relatively painless way to "get rich quick." Despite an increasing body of evidence to the contrary, the Medicaid myth endures and prevails among health care providers. Two recent studies, which focus on obstetrical malpractice claims, suggest strongly that Medicaid patients, if anything, sue physicians less often or at the same rate as their representation in the general population.

The most recent study, conducted for the state of Maryland's Medicaid program, examined all malpractice claims filed in 1985 and 1986; the claims were examined for final disposition and patient payment source through 1989. The total number of claims filed was 1,037; 132 claims were filed by persons enrolled in Medicaid *at the time of filing,* while 84 claims were filed by persons receiving Medicaid *before or at the time the alleged incident occurred.* The percentage of malpractice claims represented by the 132 claims filed by persons enrolled in Medicaid at the time of the filing (12.7 percent) tracked very closely the percentage of the state's population enrolled in the Medicaid program (11 percent). If the analysis is limited to the 84 persons enrolled in the program before or at the time the alleged incident of malpractice occurred, the number of claims generated by Medicaid recipients (8.1 percent) falls about 36 percent below their representation in the general population (11 percent).

The vast majority of malpractice claims were filed by patients who were not Medicaid recipients but patients covered by private-pay, commercial insurance, Blue Cross and Blue Shield of Maryland, or some other arrangement. When the total number of obstetrical claims (100 for 1985–86) and the total number of hospital discharges for obstetrical services (345,548) is compared to the number of claims filed by Medicaid patients (21 for 1985–86) and to the number of Medicaid patients who were obstetrical discharges in the same period (71,862), the ratio of claims to patients is exactly the same for both groups: 21 percent.

There were some significant differences between claims filed by Medicaid and non-Medicaid patients. First, Medicaid patient's claims tended to be for minor or moderate injuries, while those filed by other patients were generally for temporary or fatal injuries. Second, more Medicaid claims were settled privately than through the state's formal hearing mechanism (only 19 of 206 formal hearings involved Medicaid patients). The median award for Medicaid claimants resolved through the hearing process was $80,000, while the median award for non-Medicaid claims was $58,000. (The largest claim of $4,350,000 was a non-Medicaid claim.) Cases appealed to the court system resulted in one Medicaid claim of $2 million and seven non-Medicaid claims that ranged from less than $10,000 to $5 million. The authors of the study concluded that physicians who cite the "litigious nature" of Medicaid patients as their reason for not accepting such patients do not necessarily reduce their exposure to malpractice litigation.

Implicit in the discussion of the "litigious nature" of Medicaid patients are two assumptions that are rarely voiced. The first is that most such patients are minorities and are more likely to be black than white, Asian-American, Hispanic, or Native American; the second assumption is that poor minorities are more likely to perceive a malpractice suit as an easy road to riches.

The American College of Obstetricians and Gynecologists in northern California conducted a study of Medi-Cal patients. (Medi-Cal is the California Medicaid program.) The study's principal finding was that white patients were more likely to sue than any other ethnic or racial group. The study covered 84 closed obstetrical claims for the years 1985–87 that occurred in twenty counties in northern California; although many of the counties are rural, urban areas such as Sacramento and San Francisco were also included.

Racial and ethnic data were available for 78 of the 84 claims. White women accounted for 55 of the claims; only 16 were filed by Medi-Cal recipients; the remaining 39 were filed by white women who were privately insured. Six claims were filed by Hispanic women, four of whom were Medi-Cal recipients, while the other two were privately insured. The only black plaintiff was privately insured. Of the 16 women in the category "other," only 3 were Medi-Cal recipients; the remainder were privately insured. The authors of the study noted that these numbers were very much below the ratio of total births by each group, that is, Hispanic, black, Asian, and other women represent 64 percent of Medi-Cal births but only 30 percent of Medi-Cal malpractice suits, while white women account for 36 percent of births but 70 percent of claims. When the claims were examined by the age of the mother, teenage Medi-Cal recipients giving birth (20 percent of the Medi-Cal births) accounted for 31 percent of the Medi-Cal complaints, while privately insured teenagers filed 5 percent of the suits brought by private-pay patients.

The biggest difference between Medi-Cal and private-pay patients who sued was in the reasons for the suit: The Medi-Cal patients tended to sue for injuries and conditions like toxemia, tubal pregnancies, and maternal infections, while private-pay patients sued for fetal distress and genetic abnormalities. The authors of the California study found that, overall, Medi-Cal

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patients and private-pay patients sue in proportion to their representation in the population, a conclusion also reached by the Maryland study.

Attempts to gather data on suits in Michigan by payment source have not been very successful. The Michigan Insurance Bureau in its 1989 report found that its data were inconclusive on the issue of Medicaid patient malpractice suits. It is likely that the agency's current report will reach a similar conclusion. Esther Reagan, spokesperson, Medical Services Administration, Michigan Department of Social Services, said "Nothing in the way of a separate study has been done by DSS. Most of our responses [to the Medicaid myth] are based on anecdotal information from attorneys and physicians who say that Medicaid clients are not as litigious as the general population."

FOCUS: SENATE HEALTH HEARINGS

The Joint Senate Committee on Affordable Health Care held its first hearing on September 10. The co-chairs, senators Wartner and Pridnia, as well as other members of the committee made brief opening statements reflecting their philosophies. Senator Pridnia said, "Most would agree that government-sponsored programs are not noted for cost effectiveness," while Senator Kelly observed that "the principal responsibility [of the committee] was to design a system that provides access to quality care." Approximately 22 people testified on the bills that were on the agenda (SBs 413–419, SBs 430–431, and SB 432).

The bills providing for basic or "barebones" policies (SBs 413–414 would allow commercial insurers and Blue Cross and Blue Shield of Michigan [BCBSM] to sell policies without state-mandated coverages) drew the most discussion. The substitutes for both bills increased the proposed premium from $100 to $120 a month for a family.

Definitions were also a problem; as drafted, the bills provide only for emergency care. The confusion over the difference between emergency and basic care led to what Senator Schwarz, the only practicing physician in the legislature, said was a "definitional thicket." He also said he would not vote for a bill that did not provide basic coverage. Senator De Grow noted that such a policy would provide coverage for emergency surgery, not elective surgery.

Frank Venuto, testifying for the Golden Rule Insurance Company, said that a basic policy at a cost of $125 per month in Lansing (higher-rate areas would pay $165 monthly, while lower-rate areas could pay $100 a month) would have high deductibles, copayment requirements with the insured paying at least 20 percent of the bill, and limits such as $25,000 per covered illness episode with a lifetime limit of $50,000. Venuto also said his company would need the same kind of rate negotiation privileges that BCBSM currently has with hospitals and that such a policy would be medically underwritten.

Senator Koivisto inquired about copays on maternity coverage and preexisting conditions. He said, "Let's have no illusions about coverage. We need to explain from the beginning." Senator Wartner admitted, "This is not a great policy—not a Cadillac policy." Marguerite Shearer, M.D., Chairperson, Legislative Policy Committee, Michigan State Medical Society, said that "what is a basic package is a social decision that should not be made by physicians only."

The proposed capital pass-through diversion bill (SB 419), which would take some of the BCBSM capital payments to hospitals to fund the Michigan Caring Program, was opposed by Spencer Johnson, President, Michigan Hospital Association. Johnson proposed instead that the estimated $40–45 million to fund the Michigan Caring Program could be found by increasing beer, wine, and liquor taxes. Senator Pridnia asked if the potential savings produced by medical liability and certificate of need reform would make the diversion "palatable" to Johnson. Johnson reiterated his support for a "broad social approach." "Providers," he noted, "cannot solve all of the problems in the health care system."

Cathy Virskus, Director, Legislative Policy, Michigan Department of Public Health, testified that the department supported the package, particularly liability reform (which was not on the day's agenda). Her remarks drew a response from a shocked Senator Kelly. "Why," he wondered, "with all the public health problems the MDPH is facing, is the department concentrating on liability reform? How about improving the quality of care for people in the system?" Virskus responded that "access is equally important with quality," and that liability spills over into access.

Paul Shaheen, Executive Director, Michigan Council for Maternal and Child Health, commented that increasing access will increase costs. He urged the committee to priortize services: "If you are talking about healthy young families, you need to emphasize prevention and ambulatory care services," he pointed out. While willing to let insurers make cuts in benefits, he recommended strongly that the proposed benefit cuts be made in acute care, not preventive care. Shaheen drew the biggest laugh of the long afternoon when he said that "sin taxes should be used [to fund the Michigan Caring Program] before the Tigers get them!"

OF INTEREST

The legislature returned on September 11. Both houses will be preoccupied with the FY 1991–92 budget appropriations bills for the remainder of the month.

—Frances L. Faverman, Editor