JOINT ECONOMIC COMMITTEE POLICY BRIEF

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MEDICAL MALPRACTICE REFORM: PERSPECTIVES ON RECENT FINDINGS BY THE GAO

The U.S. General Accounting Office (GAO) released a study in August 2003 on medical malpractice which has been cited in several press accounts as providing evidence that there is no medical malpractice crisis, and hence, no need for the medical malpractice reform now in Congress (H.R. 5 and S. 11).[1] This policy brief offers some perspectives on the GAO report.

GAO Findings on Medical Malpractice and Effectiveness of Reforms

The GAO report never actually concludes that there is no evidence of a medical malpractice problem. Rather, the GAO report states that it was unable to substantiate anecdotal reports that medical malpractice problems resulted widespread impediments to the access of health care, a finding consistent with an analysis GAO did of Medicare claims data. However, the same GAO report also includes evidence both that malpractice insurance premiums are rapidly escalating and that caps on non-economic damage awards appear effective at slowing such growth rates.

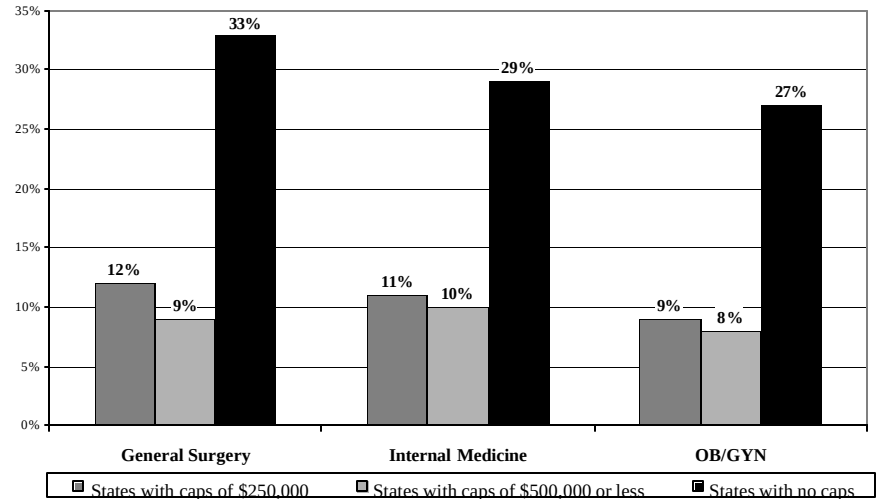
Notwithstanding the more reported elements of the GAO report, the report provides some strong evidence in favor of medical malpractice reform. Not only did malpractice premiums begin to shoot up dramatically starting in 2000, but the problem was significantly worse in those states that lacked caps on noneconomic damages. According to the GAO report:

> After 2000, premium rates began to rise across most states on average, but more slowly among the states with certain noneconomic damage caps. In particular, from 2001 to 2002, the average rates of increase in the states with noneconomic damage caps of $250,000 and $500,000 or less were 10 and 9 percent, respectively, compared to 29 percent in the states with limited reforms.[2]

For example, GAO reports that during 2001 and 2002, premiums for General Surgery physicians rose an average of 12 percent in states with non-economic damage caps of $250,000, and by 9 percent in states with caps of $500,000 or less (Figure 1).[3] However, for states with no

[1] U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (August 2003).
[2] *Ibid.*, 31.
[3] GAO's list of eight states with a cap of $500,000 or less does not include the four states with a cap of $250,000. The analysis further counts 11 states plus the District of Columbia with no cap and no collateral benefit offset rule.

Figure 1. Malpractice Premium Growth Rates, 2001-2002



Source: U.S. General Accounting Office.

caps, the average premium growth rate was a whopping 33 percent. A similar pattern is evident for Internal Medicine OB/GYN physicians.

In addition, GAO compared average medical malpractice payments per capita, and found that states with non-economic damage caps had lower payouts than states without caps. For 1996-2002, states with caps averaged $10 in per capita payments, versus $17 for states without caps. Growth rates in per capita payments showed a similar pattern. Over the same period, per capita claims payments grew by an average of 5 percent in states with a non-economic damage cap of $250,000, and by 6 percent in states with a cap of $500,000 or less. By comparison, states with no caps experienced growth of 10 percent.

Methodological Issues

The GAO report reached three conclusions that seem to undermine the case for medical malpractice reform. With regard to the findings that received so much media attention, readers should bear in mind the methodological underpinnings of the conclusions.

First, GAO was unable to substantiate anecdotal reports of widespread impediments to the health care access. GAO's research approach was to follow-up on some of the problems reported by state health care provider groups (e.g., Florida Medical Association). However, GAO only examined five of the 18 states that have been identified as being in a "full-blown" medical malpractice crisis. Within those five states, GAO did not attempt to verify all reported problems, just those that it deemed as potentially acute or concentrated. Even the GAO acknowledges that the report "does not attempt to generalize our findings beyond the 5 states with reported problems that we reviewed."[4]

An additional problem with this finding is that GAO seems inclined to cast its empirical findings in a light unfavorable to reform. For example, when GAO did find evidence of problems, the study attributes the cause to other factors, noting, for instance, that problems "often occurred in rural locations, where maintaining an adequate number of physicians may have been a long-standing problem."[5] Elsewhere, even though 53 percent (26 of 49) of the hospitals it contacted "confirmed a reduction in surgeons available to provide on-call coverage

[4] *Ibid*., 38.
[5] *Ibid*., 5.

for the ER," GAO minimized the importance by emphasizing that 11 of those reporting such a decrease found ways to maintain the full range of ER services.[6] However, that finding still means that close to one-third (15 of 49) of hospitals have *not* been able to maintain the full range ER services. In other words, medical malpractice pressures caused nearly one-third of contacted hospitals to reduce the range of ER services. Moreover, the GAO report argues that hospitals and other providers have averted the full impact of malpractice-related pressures by taking certain actions, such providing physicians with partial premium subsidies. However, GAO fails to note that while some actions have been taken to reduce such pressures, they are not long-term fixes to the problem of high malpractice premiums.

Second, GAO analyzed Medicare data to see if there was any evidence of a reduction in "risky" procedures due to the medical malpractice crisis. GAO concludes that "our review of Medicare claims data did not identify any major reductions in the utilization of certain services" considered to be high risk.[7] However, this assessment is undermined by the fact that any analysis of Medicare data will necessarily exclude obstetrics, a field that has been one of the key problem areas for medical malpractice insurance.

Finally, GAO dismissed evidence of the widespread occurrence of defensive medicine. The primary basis for this conclusion is a review of selected research. In the review, the GAO cites seven studies on defensive medicine. Although five of the seven clearly indicate that doctors practice defensive medicine, GAO dismisses all simply by saying that none is generalizable, even though some of the research is quite sound. GAO's rejection of such evidence seems premature given the abundance of evidence (both survey and analytical) that defensive medicine results in a substantial amount of health care expenditures.

Conclusion

The GAO report, quite simply, cannot be relied upon as the primary basis for deciding the fate of medical malpractice reform. The bottom line is that GAO is not an organization ideally suited to general diagnoses of policy issues like tort reform. Rather, GAO is better at specific, quantifiable tasks, such as audits of government agencies and evaluations of accounting systems.

The GAO report is not a comprehensive study of medical malpractice problems. Instead, it is a report that on one hand fails to back up anecdotal reports of problems, yet simultaneously documents other evidence that there is a medical malpractice problem. Moreover, the GAO report also finds evidence that tort reforms like those in H.R. 5 and S. 11 may be effective at controlling premium growth.

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[6] *Ibid*., 16.
[7] *Ibid*., 5.