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MEDICAL LIABILITY AND HEALTH CARE REFORM

Leonard J. Nelson, III†
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ABSTRACT

We examine the impact of the Affordable Care Act (ACA) on medical liability and the controversy over whether federal medical

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reform including a damages cap could make a useful contribution to health care reform. By providing guaranteed access to health care insurance at community rates, the ACA could reduce the problem of under-compensation resulting from damages caps. However, it may also exacerbate the problem of under-claiming in the malpractice system, thereby reducing incentives to invest in loss prevention activities. Shifting losses from liability insurers to health insurers could further undermine the already weak deterrent effect of the medical liability system. Republicans in Congress and physician groups both pushed for the adoption of a federal damages cap as part of health care reform. Physician support for damages caps could be explained by concerns about the insurance cycle and the consequent instability of the market. Our own study presented here suggests that there is greater insurance market stability in states with caps on non-economic damages. Republicans in Congress argued that the enactment of damages caps would reduce aggregate health care costs. The Congressional Budget Office included savings from reduced health care utilization in its estimates of cost savings that would result from the enactment of a federal damages cap. But notwithstanding recent opinions offered by the CBO, it is not clear that caps will significantly reduce health care costs or that any savings will be passed on to consumers. The ACA included funding for state level demonstration projects for promising reforms such as offer and disclosure and health courts, but at this time the benefits of these reforms are also uncertain. There is a need for further studies on these issues.

INTRODUCTION

The passage of the Affordable Care Act (ACA) has ushered in a new era of health care in the United States. While the legislation remains controversial, its commitment to universal access is likely to have a significant and enduring impact on the health care system. There was a chance that alternative medical liability reforms (e.g., disclosure and offer, health courts, safe harbors) would be bundled with the health care reform as part of a bipartisan compromise, but it was not included in the final legislation. The ACA does, however, include funding for state-level demonstration projects that test malpractice reform alternatives. No doubt the failure to include medical

2 Michelle M. Mello & Troyen A. Brennan, The Role of Medical Liability Reform in Federal Health Care Reform, 361 NEW ENG. J. MED. 1, 1-2 (2009).
3 Patient Protection and Affordable Care Act, § 10607.
liability reform was due to the facts that there was not a malpractice insurance crisis at the time of passage, and that the prevailing view among Democrat legislators was that malpractice reform was "a Republican issue." \(^4\)

Although it was highly unlikely that health care reform legislation would include damages caps, they were much discussed during the debate. In fact, damages caps emerged as a primary component of Republican alternatives to the proposed Democratic health reform bill. And the notion that significant savings could result from the adoption of a federal cap on non-economic damages received some unlikely support during the debate. The Congressional Budget Office (CBO) found that the federal enactment of medical liability reform—including a cap on non-economic damages of $250,000—would reduce federal budget deficits by $54 billion over the period of 2009–2019. \(^5\) In making this calculation, CBO included savings from changed health care utilization, i.e., a reduction in defensive medicine, as a result of federal medical liability reform. \(^6\) This marked the first time that CBO included savings from decreased utilization of health care in its estimates of the cost savings from traditional medical liability reforms. \(^7\)

With the Democrats in control of the Senate, damage caps will not be enacted any time soon; they have consistently opposed attempts to enact a federal damages cap. The opposition to damages caps by Congressional Democrats is based on a legitimate policy disagreement with Republicans: Democrats view damages caps as unfairly penalizing the most severely injured victims of malpractice and unlikely to reduce health care costs significantly.

The divide between Republicans and Democrats on damages caps became even more apparent at the summit on health care reform convened by President Obama on February 25, 2010. In his opening statement, Senator Lamar Alexander (R-TN) identified federal enactment of traditional malpractice reform measures as a central plank of

\(^4\) Mello & Brennan, supra note 2, at 1.


the Republican health care reform proposal. Senator John McCain (R-AZ) pointed to the effectiveness of damages caps adopted in California and Texas in improving access and reducing health care costs. Senator McCain claimed that the adoption by Texas of a $250,000 cap on non-economic damages in 2003 dramatically reduced medical liability insurance premiums and increased the number of physicians moving to Texas. He also claimed that the reforms had reduced defensive medicine expenditures, noting that “defensive medicine increases annual medical costs by 10 percent.” Senator Tom Coburn (R-OK), a practicing physician, acknowledged that he had practiced defensive

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9 Senator McCain stated:

MCCAIN: And the—and the point is that we don’t have to go very far. There’s two examples right now of medical malpractice reform that is working. One’s called California, the other called—called Texas.

I won’t talk about California, because the Arizonans hate California, because they’ve stolen our water. But the fact is that Texas has established a $750,000 stack cap (ph) for non-economic damages, caps doctors at $250,000, hospitals at $250,000, and any additional institution $250,000, and patient’s harmed do—do a finding (ph) of medical malpractice are not subject to any limitations on recoveries for economic losses. And I hope you’ll examine it.

But the important aspect of what they’ve done in Texas is the following. Lawsuit filings are down. Medical cost—defensive medicine increases annual medical costs by 10 percent. They’ve saved 200 physicians—recruitment is up. In the last two years, 6,945 new physicians have been licensed, 65 percent increase from two years preceding their reforms, 31 percent increase in recruitment of rural emergency medicine physicians.

Amarillo lost 26 physicians in the two years preceding the legislation, has gained 37. The largest malpractice insurance company in the state slashed its premiums by 35 percent, saving doctors some $217 million over four years. There are now over 30 companies competing for business.

It’s already there. Now, all we have to do is enact this into legislation, and it’s already been proven. So I don’t think we have to experiment around.

The two states that have proven that you can enact medical malpractice reform and you can act great (ph) savings and provide health care providers with the incentives they need.

medicine and referred to the tort system as extortionate.\textsuperscript{10} House Minority Leader John Boehner (R-MI) went even further by identifying medical liability and defensive medicine as the “biggest cost driver” of health care cost inflation.\textsuperscript{11}

President Obama expressed disagreement with Rep. Boehner’s statement that malpractice was the major driver of health care cost inflation, noting that while the CBO estimated that enactment of a federal damages cap could save about $5 billion a year, this savings was a relatively insignificant amount in a system that spends $2 trillion annually. Nevertheless, he also noted his interest in medical liability reforms by calling for federal incentives for states “to experiment much more vigorously with ways to reduce frivolous lawsuits, to pursue settlements, to reduce defensive medicine.”\textsuperscript{12}

Senator Dick Durbin (D-IL), who as a practicing attorney had both defended and sued physicians, offered a rebuttal to the Republican’s arguments for adoption of a damages cap. He noted that while the CBO found that adoption of a damages cap could save $54 billion over ten years, it also found that it would reduce accountability and increase the number of patient deaths by 4,800 each year. He noted that a cap could result in under-compensation for the most severely injured victims of malpractice. He further noted that, according to the Kaiser Foundation, the number of malpractice claims had declined 50 percent nationwide in the past twenty years, and malpractice payouts had declined from $8 billion to $4 billion from 2003–2008.\textsuperscript{13} Henry Waxman also argued that while the California malpractice reforms had been in place in California since 1975, they had not solved the problem of health care cost increases, citing the recent attempt by Anthem to increase premiums for individual policies in California by 39 percent.\textsuperscript{14}


Following the bipartisan summit, President Obama announced that he would incorporate some Republican ideas into his health care reform proposal. This would include “medical liability reform” in the form of an additional $50 million for medical liability demonstration projects. Republican leaders quickly responded that these changes were cosmetic and would not affect their opposition to the President’s proposal for health care reform.\footnote{Ed Hornick, Obama Says White House Incorporating GOP Ideas into Health Plan, CNN (Mar. 3, 2010), http://edition.cnn.com/2010/POLITICS/03/03/health.care.gop.ideas/}

While damages caps remain popular with physicians and Republicans in Congress, Baker and others have argued that support for damages caps is largely based on myth rather than evidence.\footnote{See, e.g., Tom Baker, The Medical Malpractice Myth 1 (2005).} Indeed, there is a broad consensus among academic researchers that damages caps do not adequately address the shortcomings of the current medical liability system with respect to both its deterrence and compensation goals. While alternative tort reform measures are still largely untested, it is possible that some of these proposals could improve the medical liability system and make a positive contribution to improving the health care system.

Part I of this Article looks at the possible impact of health care reform on the medical liability system, concluding that while the ACA could reduce the problem of under-compensation resulting from damages caps, it could also undermine deterrence by exacerbating the problem of under-claiming by victims of malpractice and shifting losses from liability insurers to health insurers. The remainder of the Article focuses on the potential role of the adoption of federal medical liability reforms including a damages cap in improving medical liability systems and the delivery of health care. Part II discusses state responses to the medical liability crises and the push for enactment of a federal damages cap. In Part III we present our study on the relationship between damages caps and premium volatility concluding that there is greater insurance market stability in states with caps on non-economic damages. Part IV reviews studies surveying physicians on the prevalence of defensive medicine. In Part V, we conclude that it is not clear that federal medical liability reforms including a damages cap will significantly reduce health care costs or that any savings will be passed on to consumers. Part VI reviews studies on the impact of medical liability reform on access suggesting that it could have modest effects in terms of enhancing physician supply, reducing avoidance behavior by physicians, and increasing access to certain types of care. In Part VII, we discuss the impact of medical liability reform on pa-
tient safety, concluding that its effect, if any, on patient safety at the hospital level is uncertain at this time and that more research in this area is needed. Finally, Part VIII discusses two promising alternative medical liability reforms that may be tested in federally-funded demonstration projects: disclosure and offer and health courts.

I. THE POTENTIAL IMPACT OF HEALTH CARE REFORM ON MEDICAL LIABILITY

It is possible that the ACA will have a significant impact on the medical liability system. If health care reform is effective in reducing the growth of health care costs, this could have an impact on the level of damages awards. Baker has identified medical inflation as the most important factor influencing the rate of growth in loss payouts in medical malpractice cases. Similarly, Chandra et al. (2005) found that during the period 1991-2003, malpractice payments grew at a rate that was proportionate to health care spending. They also note: "medical costs, which contribute to the size of compensatory awards, may explain a sizable portion of payment growth . . ." In addition, by providing guaranteed access to health care insurance at community rates, the ACA could reduce the problem of under-compensation resulting from damages caps. It could also, however, exacerbate the problem of under-claiming in the malpractice system, thereby reducing incentives to invest in loss prevention activities. Moreover, shifting losses from liability insurers to health insurers could further undermine the already weak deterrent effect of the medical liability system.

The eventual elimination of medical underwriting in the individual and small group markets by the ACA could reduce the number of malpractice lawsuits. Beginning in 2014, there is a ban on the use of pre-existing condition limitations. Guaranteed issuance and renewal is required. Moreover, a regime of adjusted community rating will be imposed on insurers and the only permissible bases for rating are: age ratio, limited to a ratio of 3:1; rating area; family size; and tobacco

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17 Id. at 55.
19 Id. at W5-247
21 Id. at §1201(4), 124 Stat. at 156.
use, limited to a ratio of 1.5:1. Even if people are unemployed as a result of their injuries, they will have access to health insurance at relatively reasonable rates. Thus, there will always be a source of payment for future health care costs. This could reduce the propensity for those with iatrogenic injuries from suspected malpractice to file lawsuits in order to pay for future health care costs. But it may also exacerbate the problem of under-claiming for negligently-caused injuries that is already a widely acknowledged problem in the current system.

Moreover, many states have already eliminated or modified the collateral source rule. Accordingly, a plaintiff's recovery for past health care costs may be reduced by the amount of payments received from health insurers and the subrogation rights of health insurers that have already made payments may be eliminated. It is conceivable that this approach would be extended now that coverage is guaranteed at adjusted community rates. Future medical cost awards could be limited to the premium costs for a plan offering sufficient coverage. The policy question then would be whether or not the health insurer should be permitted to recover its actual medical costs from the liability insurer as they are incurred.

One of the criticisms of caps on non-economic damages is the likelihood that the cap could result in under-compensation for economic damages. This issue would seem less relevant in the era of health care reform. While caps on non-economic damages do not directly reduce recovery for future health care costs, caps do reduce the recovery for pain and suffering which may provide funds for the payment of the contingency fee. Particularly in high value cases, the imposition of the cap may result in the possibility that plaintiff will not have adequate funds available for the payment of future health care costs.

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22 Id. at §1201(4), 124 Stat. at 155.
23 Cf. Frank A. Sloan & Chee Ruey Hsieh, Injury, Liability and the Decision to File a Medical Malpractice Claim, 29 L. & Soc'y REV. 413, 426 (1995) (studying families in Florida that suffered adverse birth outcomes, and finding that families with health insurance were less likely to file claims).
costs. Proponents of caps could now argue that with the ready availability of health insurance at adjusted community rates, there is less reason to be concerned that the imposition of a cap would reduce the availability of funds to cover future economic losses such as health care costs.

This would be consistent with the approach taken in Canada—a common law jurisdiction with a fault-based medical malpractice regime and universal access to health care. In 1978, the Supreme Court of Canada in a trilogy of cases limited non-economic damages in personal injury cases to $100,000 (CAD). Subsequently, the court held that the cap should be adjusted for inflation. An attack on the cap based on the Charter of Rights was rejected by the British Columbia Court of Appeals in 2006 and leave to appeal to the Supreme Court of Canada denied. Similarly, in England, another fault-based common law jurisdiction with universal access, while there is not an actual cap, there are informal guidelines for the amount of damages available for pain, suffering and loss of amenities that are normally followed.

Notwithstanding these arguments, however, under the economic theory of tort law it may not be appropriate to shift the losses caused by physician negligence to health insurers from medical liability insurers. It would undermine the corrective justice aspect of tort law to require health care insurers rather than liability insurers to make good on these losses. In addition, the deterrent effect of the medical liability system is already relatively weak, and shifting losses for future health care costs to health insurers would further weaken it. Awarding damages for malpractice against negligent health care providers provides incentives for improvements in patient safety. Thus, deter-

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26 See Joni Hersch et al., An Empirical Assessment of Early Offer Reform for Medical Malpractice, 36 J. LEGAL STUD. s231, s233 (2007).
rence may be better served by retaining the collateral source rule and allowing subrogation by the health insurer.\textsuperscript{33}

Allowing plaintiffs to recover future health care costs from negligent providers will force medical liability insurers to pass along these costs to health care providers in the form of higher medical liability insurance premiums. This in turn should force health care providers to internalize the costs of their injury-producing activities. This may provide some additional incentives to concentrate their efforts on improving patient safety, thereby reducing the overall costs of injury. In addition, allowing plaintiffs in medical malpractice cases to recover for future health care costs and permitting subrogation by health insurers to recover those costs may reduce the costs of health insurance coverage.

Forcing health insurers rather than liability insurers to bear the cost of health care for victims of malpractice would also be inconsistent with the approach taken by the federal government in enforcing its rights to repayment of expenses incurred under the Medicare program.\textsuperscript{34} In the case of Medicare beneficiaries, the federal government has recently taken a more aggressive posture in seeking to recover payments for the expenses of health care made on behalf of Medicare beneficiaries from insurers and even attorneys.\textsuperscript{35}

Another way in which health care reform could impact medical liability is through its promotion of comparative effectiveness research (CER). The American Recovery and Reinvestment Act of 2009 created the Federal Coordinating Council for Comparative Effectiveness Research (FCCCER) to coordinate CER across federal agencies and provided funding for this research.\textsuperscript{36} In place of the FCCCER, the ACA creates a private, non-profit entity called the Patient-Centered Outcomes Research Institute to oversee federal CER and it provides a permanent funding stream.\textsuperscript{37} The expansion of CER could affect the standards of care for medical treatment, thereby influencing medical

\textsuperscript{33} Kenneth S. Reinker & David Rosenberg, Unlimited Subrogation: Improving Medical Malpractice Liability by Allowing Insurers to Take Charge, 36 J. LEGAL STUD. S261, S268 (2007).


liability. There is already a trend toward the replacement of the traditional customary care standard with a reasonable prudent physician standard that could rely more on evidence-based medicine. The increased emphasis on CER could accelerate this trend by focusing the attention of courts on what physicians should be doing as established by the body of CER. On the other hand, it could be argued that physician fear of malpractice risk and the concomitant defensive practices will trump the incentives for physicians to provide only evidence-based care absent enactment of legislation to provide a safe harbor for physicians who follow evidence-based practice guidelines. Thus safe harbor legislation could be combined with the growing body of CER to reduce physician fear of malpractice liability.

II. STATE RESPONSES TO MEDICAL LIABILITY CRISSES AND THE PUSH FOR A FEDERAL DAMAGES CAP

Damages caps have been popular with state legislatures and are the most prominent and widely debated tort reform measure. It is the only reform that has consistently been shown by empirical studies to be effective in reducing medical liability insurance premiums. But while a number of states have enacted damages caps, high courts in several states have declared damages caps unconstitutional under their state constitutions. Thus, in some instances legislative tort reform efforts at the state level have been frustrated by state courts and this has led to calls for a federal damages cap.

The enactment of traditional malpractice reform legislation (including damages caps) by state legislatures has typically followed crises in the insurance market characterized by sudden spikes in rates and the withdrawal of insurers from the market. There have been three national liability insurance crises since 1974. The first crisis of the mid-1970s involved problems with both the affordability and availability of insurance.
bility of malpractice insurance coverage. By the late 1970s, the malpractice insurance crisis subsided, but by the mid-1980s there was a crisis of affordability across all lines of third party liability insurance coverage, including malpractice insurance. A third crisis occurred in the early 2000s. There was a spike in malpractice insurance premiums, and in December 2001, St. Paul, the largest malpractice insurer, stopped writing malpractice insurance. Subsequently, two other major insurers—PHICO and Frontier Insurance Group—withdrew from the medical liability insurance market. The third crisis had subsided by 2006.

There has been substantial disagreement about the causes of the three malpractice insurance crises. Consumer groups and trial lawyers have typically blamed investment losses by insurers. On the other hand, providers and insurers typically point to increases in loss payouts and litigation costs as the root causes of the crises. Recent studies, however, discount the notion that the crises have been caused by


45 Michelle M. Mello et al., The New Medical Malpractice Crisis, 348 NEW ENG. J. MED. 2281 (2003).

46 “[P]remiums for all physicians nationwide rose by 15 percent between 2000 and 2002-nearly twice as fast as total health care spending per person.” CONG. BUDGET OFFICE, ECONOMIC AND BUDGET ISSUE BRIEF: LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 1 (2004), available at http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf. Increases were even higher for some specialties: “22 percent for obstetricians/gynecologists and 33 percent for internists and general surgeons.” Id.

47 Patricia A. Danzon et al., The Crisis in Medical Malpractice Insurance, in BROOKINGS-WHARTON PAPERS ON FINANCIAL SERVICES 55 (Robert E. Litan & Richard Herring eds., 2004).


spikes in loss payouts. Baker rejects increased loss payouts as the cause and instead focused on the insurance underwriting cycle.\textsuperscript{51} He notes that insurers have periodically underestimated losses until actual loss experience has provoked a reaction from firms that have then overestimated predicted losses and increased reserves.\textsuperscript{52} This problem has been exacerbated by the time lag between the writing of coverage and the reporting of actual losses.\textsuperscript{53} But there is also some evidence that investment returns, in part, influence malpractice insurance premiums. Kilgore and colleagues (2006) found that, controlling for other factors, a 1% increase in the Dow Jones Industrial Average was associated with a 0.4% reduction in malpractice premiums.\textsuperscript{54}

The malpractice crisis of the mid-1970s resulted in significant state legislative activity beginning in 1975.\textsuperscript{55} Several states responded by passing medical liability reform legislation.\textsuperscript{56} The most popular reforms enacted during the 1970s included: damages caps, mandatory screening panels, tightened up statute of limitations, restrictions on \textit{ad damnum} clauses, collateral source rule modification or abrogation, restrictions on contingency fees, and clarification or limitation of the doctrine of informed consent.\textsuperscript{57} In order to address the lack of availability of coverage, some states created joint underwriting associations,\textsuperscript{58} and physician mutual insurers.\textsuperscript{59} A few states created patient compensation funds (PCFs) that were combined with caps on provider liability and total damages.\textsuperscript{60} In addition, physician mutual insurers were formed in many states.\textsuperscript{61}

\textsuperscript{51} Baker, \textit{supra} note 16, at 51-58
\textsuperscript{52} Id. at 53-54.
\textsuperscript{53} Id. at 52-53.
\textsuperscript{56} Sloan, \textit{supra} note 43.
\textsuperscript{57} See Grossman, \textit{supra} note 55, at 8-10.
\textsuperscript{58} Id. at 4. “Joint underwriting associations (JUAs) serve as residual market mechanisms for physicians who are unable to obtain coverage in the voluntary market.” Danzon et al., \textit{supra} note 47, at 56. Typically, insurers are required to participate in the medical JUA as a condition of writing other lines of insurance in the state. JUAs in many states provide “a cross-subsidy to physicians” by shifting their losses either to policy holders “in other personal lines” or allowing a tax write off for losses to insurers. \textit{DANZON, supra} note 43, at 112.
\textsuperscript{59} Grossman, \textit{supra} note 55, at 6.
In 1975, California enacted the Medical Injury Compensation Reform Act (MICRA), a package of bills that has become the "gold standard" for proponents of malpractice reform. MICRA capped non-economic damages at $250,000 with no adjustment for inflation. Other MICRA provisions included collateral source offset, periodic payout of future damages, limits on the contingency fees that may be charged by plaintiff's attorney, a statute of repose, mandatory advance notice of a claim, and binding arbitration.

63 CAL. CIV. CODE § 3333.2(b) (West 2011). Damages in a malpractice action may include compensatory and punitive elements. Compensatory damages (compensation for losses) include both economic (e.g., lost earnings and medical expenses) and non-economic components (e.g., pain and suffering). DANZON, supra note 43, at 34.
64 CAL. CIV. CODE § 3333.1 (West 2011). At common law, plaintiffs were permitted to recover damages even though the plaintiff has been reimbursed for those damages by a collateral source unrelated to the defendant. For example, a plaintiff could recover for medical expenses even if those expenses were covered by plaintiff's health insurer. The California statute modifies this common law rule by permitting the defendant to introduce evidence that the plaintiff was reimbursed for expenses by a collateral source. Id. Since the mid-1970s many jurisdictions have adopted statutes requiring the judge to offset the moneys from the collateral source or permitting evidence of reimbursement to be presented to the jury with evidence of the payment of premiums by the plaintiff. Randall R. Bovbjerg, Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card, 22 U.C. DAVIS L. REV. 499, 526 (1989).
65 CAL. CIV. PROC. CODE § 667.7 (West 2011). At common law, plaintiffs were entitled to receive a damages award as a lump sum including past damages and future damages discounted to present value. The California statute modifies this common law rule by mandating, upon the request of any party, the periodic payout of future damages that exceed $50,000. Under this law these future damages are to be paid out as they accrue. Id. Since the mid-1970s, several jurisdictions have passed statutes mandating or permitting periodic payout. Bovbjerg, supra note 64, at 527.
66 CAL. BUS. & PROF. CODE § 6146 (West 2010). This statute was adopted in 1975 and amended in 1987. Its current version provides for limits of 40% of the first $50,000 recovered; 33% and 1/3 of the next $50,000; 25% of the next $500,000, and 15% of any amount exceeding $600,000. Id. Since the mid-1970s, a number of jurisdictions have passed statutes imposing specific percentage limitations or providing for reasonableness review. Bovbjerg, supra note 64, at 522-23.
67 CAL. CIV. PROC. CODE § 340.5 (West 2011). A statute of repose places an absolute time limit on when an action must be filed regardless of whether plaintiff has discovered the injury. The California statute has a one year discovery rule coupled with a three year statute of repose than runs from the date of the injury with certain exceptions including fraud, intentional concealment, and presence of a foreign body with no therapeutic or diagnostic purpose in the plaintiff's body. Id. Several states have adopted this type of legislation typically with a three or four year statute of repose. Bovbjerg, supra note 64, at 524.
68 CAL. CIV. PROC. CODE § 364 (West 2011) requires ninety days advance notice of intent to file a medical malpractice claim.
the time of its enactment MICRA was relatively uncontroversial. Governor Jerry Brown, a Democrat, had called a special session of the legislature to deal with a perceived insurance crisis that had triggered a doctor’s strike in Northern California. The legislation enacted enjoyed bi-partisan support: most of the reforms were recommended by a committee chaired by Democrat Henry Waxman, then a member of the California Assembly, and embraced by Governor Brown. Subsequently, the California Supreme Court upheld the constitutionality of these reforms.

Other states also passed reforms during this period. For example, in 1975, Indiana and Louisiana adopted overall caps on damages coupled with a lower provider cap. To benefit from the cap, providers were required to obtain coverage up to the level of the provider cap or post a bond. Patient compensation funds were created in both states to provide insurance to cover the gap between the overall cap and the lower provider cap. The constitutionality of the Louisiana and Indiana damages caps were subsequently upheld by their respective state supreme courts.

Some damages cap passed during this era were declared unconstitutional by state courts. For example, in 1975, Illinois passed a package of reforms including an overall cap on damages in medical mal-

69 CAL. CIV. PROC. CODE § 1295 (West 2011) provides for the enforcement of pre-claim agreements to arbitrate that follow a specified format. Beginning in the mid-1970s, several states passed legislation endorsing voluntary pre-claim agreements to arbitrate. This legislation sometimes imposes special requirements to ensure that the plaintiff is aware that the right to jury trial is being given up. Bovbjerg, supra note 64, at 522; see also Rodriguez v. Superior Court, 98 Cal. Rptr. 3d 728 (Ct. App. 2009) (refusing to compel arbitration holding that health care provider could not establish that minor patient voluntarily waived right to jury trial where she died within statutory revocation period).


71 Id. at 45.


73 IND. CODE ANN. § 34-18-14-3 (West 2010).


75 Id. § 40:1299.42(A)(1).

76 See id. § 40:1299.42(B)(1)(a).

77 Williams v. Kushner, 549 So. 2d 294 (La. 1989) (upholding cap of $400,000 on liability of PCF but further holding that differential treatment of claims filed before September 1, 1984, violated equal protection, and declining to decide validity of $100,000 cap on provider liability).

practice cases of $500,000 that was subsequently declared unconstitutional.\(^7\) Similarly, caps on non-economic damages in malpractice cases enacted in Ohio (1975) and New Hampshire (1977) were later declared unconstitutional.\(^8\)

The mid-1980s crisis affected all lines of insurance, and many states passed tort reform legislation that applied to all types of personal injury claims.\(^9\) Tort reform measures were adopted in forty-one states in 1986.\(^10\) Many of the same tort reform measures were adopted in the 1970s and 1980s (e.g., damages caps, collateral source offset, periodic payout, etc.), but in the latter decade many of these reforms were applicable more generally to personal injury actions rather than being limited to medical liability actions.\(^11\) But some states adopted caps specific to medical malpractice in the mid-1980s that were declared unconstitutional. For example, in 1986, the State of Washington adopted a cap on non-economic damages in medical malpractice actions that was subsequently declared unconstitutional.\(^12\) In 1987 Alabama passed medical malpractice reforms including cap on non-economic damages in malpractice cases and an overall cap on damages in wrongful death malpractice cases that were subsequently declared unconstitutional by the state supreme court.\(^13\)


\(^11\) Bovbjerg, \textit{supra} note 64, at 538-39.


\(^13\) Smith v. Schulte, 671 So.2d 1334, 1344 (Ala. 1995) (declaring overall cap on wrongful death damages found in Ala. Code § 6-5-547 unconstitutional); Ray v. Anesthesia Assoc., 674 SO.2d 525, 526 (Ala. 1995) (declaring cap on wrongful death damages found in Alabama Code § 6-5-547 unconstitutional); Moore v. Mobile In-
A few states passed reform legislation that included damages caps in the mid-1990s despite the lack of a current crisis. For example, in the mid-1990s, the legislatures in both Illinois (1995) and Ohio (1996) attempted to impose caps in all personal injury actions after their respective state supreme courts had struck down caps in medical malpractice action, but both caps were subsequently struck down.\(^8\)

During the most recent malpractice crisis, the AMA identified eighteen states that were experiencing a crisis in medical liability insurance affordability and availability.\(^8\) Several states passed traditional malpractice reform measures in the 2000s,\(^8\) but some of these measures have already been declared unconstitutional. In 2005, the Illinois legislature again imposed a damages cap. This time it had a limit of $500,000 for individual defendants and $1 million for institutional defendants in malpractice actions, but this statute was declared unconstitutional by the state supreme court in 2010.\(^8\) In 2005, the Georgia legislature passed a $350,000 cap on non-economic damages in medical malpractice cases, but in 2010 the Supreme Court of Georgia invalidated this cap because it violated a state constitutional right to trial by jury.\(^9\)

Other caps have fared better. In 2002, the Ohio legislature again imposed a cap in medical malpractice actions.\(^9\) The Supreme Court of Ohio has not yet ruled on the constitutionality of this statute, but it did uphold a similar cap applicable in product liability and asbestos actions.\(^9\) In 2003, Texas adopted a damages cap on non-economic damages of $250,000 per claimant in actions brought against phys-
cians after a constitutional amendment was passed by the vote of the people to insulate the cap against constitutional challenge. The constitutional amendment was deemed necessary because the Texas Supreme court had held that an earlier cap violated the Texas Constitution. In 2009, Oklahoma adopted a cap of $400,000 on non-economic damages applicable in all personal injury cases. These limits do not apply in certain malpractice actions where the jury finds by clear and convincing evidence that the plaintiff suffered serious bodily injury, or that the harm was inflicted through grossly negligent, reckless, fraudulent, intentional or malicious acts.

Advocates of tort reform have been frustrated by the actions of state high courts and have focused their efforts on the enactment of a federal cap on damages. A federal cap would neither be subject to challenge under state constitutions nor vulnerable to federal constitutional challenges under existing precedents. During the early 2000s, President George W. Bush, Republicans in Congress, the AMA, and several other physician groups supported the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act (HEALTH Act). This proposed legislation was patterned after MICRA and included a $250,000 cap on non-economic damages. The House passed the HEALTH Act three years in a row (2003, 2004, 2005), but the legislation never made it through the Senate.

In 2003, Donald Palmisano, then President of the American Medical Association and a physician from Louisiana with a law degree, testified before Congress calling for the enactment of federal legislation patterned after MICRA including a $250,000 cap on non-

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93 TEX. CIV. PRAC. & REM. CODE § 74.301 (West 2011).
95 Lucas v. United States, 757 S.W.2d 687 (Tex. 1988).
96 23 OKLA. STAT. ANN. § 61.2(B) (West 2010).
97 Id. at § 61.2(C).
98 See e.g., Boyd v. Bulala, 877 F.2d 1191, 1195-96 (4th Cir. 1989) (upholding Virginia cap and rejecting federal due process, equal protection, separation of powers, and right to jury trial arguments); Lucas v. United States, 807 F.2d 414, 423 (5th Cir. 1986) (holding Texas damages cap does not violate federal equal protection clause).
101 Medical Liability Bill Passes House for Third Year in a Row: Inaction by Senate Stalls Pain and Suffering Award Caps, MED. & HEALTH, Aug. 8, 2005, at X.
economic damages. He testified that this legislation was necessary because many physicians could either no longer find or were unable to afford liability insurance and thus were closing their practices, retiring or reducing services.

In his testimony, Doctor Palmisano referred to two reports prepared by the United States Department of Health and Human Services in support of his claim that states with caps on non-economic damages had experienced only moderate increases in rates while states without such caps had experienced much larger increases. He argued that federal MICRA-style reforms were necessary because state courts had struck down many reforms as unconstitutional. He contended that the adoption of MICRA was responsible for keeping premium increases on medical liability insurance in California at moderate levels. And he urged congressional passage of legislation patterned after MICRA because of its effectiveness “especially at controlling non-economic damages.”

Physician specialty associations have also called for the adoption of MICRA-style reforms at the federal level. The American College of Obstetricians and Gynecologists (ACOG) claims that one in ten obstetricians and several hospitals have stopped delivering babies and cesarean sections have increased because of the cost of malpractice insurance. During the malpractice crisis of the early 2000s, the President of ACOG identified nine crisis states (FL, MS, NV, NJ, NY, PA, TX, WA, WV) where obstetricians were being forced to stop delivering babies because of unavailable or unaffordable malpractice insurance, and called for enactment of a federal damages cap as an appropriate remedy. Similarly, in 2003, the American College of Surgeons (ACS) endorsed the HEALTH Act, legislation that would

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103 Id. at 122.
105 Palmisano Statement, supra note 101, at 127.
impose a federal cap of $250,000 on non-economic damages in malpractice cases.108

III. PREMIUM VOLATILITY AND DAMAGES CAPS

The American Medical Association (AMA) supported the ACA even though the legislation did not include traditional medical liability reforms.109 But during the recent health care reform debate, physician groups contended that significant cost savings, quality improvements, and increased access could come from the federal adoption of traditional reforms including damages caps.110 Physician groups have traditionally identified tort reform as a policy priority and damages cap as the most important reform. A 2007 position paper issued by the AMA noted that “MICRA’s $250,000 cap on non-economic damages has been the cornerstone of organized medicine’s attempts to ensure a litigation system that does not hinder patient access to care.”111 Physician support for damages caps could be explained by concerns about the insurance cycle and the consequent instability of the market. Our own study presented here suggests that there is greater insurance market stability in states with caps on non-economic damages.

The enthusiastic support by physicians for damages caps is somewhat of a mystery. Since most physicians have insurance coverage that provides indemnification and the costs of defending claims, out-of-pocket costs are limited.112 Furthermore, medical liability insurance is not experience-rated so a claim does not result in an increase in premiums for the physician that is sued.113 Moreover, Thurston found that physicians are able to pass along medical liability insurance premium increases to third party payers.114 More recently, a

study by Pauly et al. (2006) found that increased medical liability insurance premiums did not reduce physician incomes, thereby supporting the notion that physicians are able to pass along those costs to employers, health insurers and consumers. And one study found that physician incomes actually increased during the malpractice crisis of the 1980s.

Nonetheless, there are now several studies showing that caps either reduce medical liability insurance premiums, or slow the rate of increase in medical liability insurance premiums. Thus, caps under some circumstances could reduce physician costs by reducing the cost of medical liability insurance. Where prices of medical services do not adjust to these changes or demand is sufficiently elastic, physician incomes could increase.

In addition to malpractice insurance premiums and the stress that arises while defending a lawsuit, physicians are also concerned about the effect of malpractice lawsuits on their reputations. This problem has undoubtedly been exacerbated by the requirement that judgments against and settlements on behalf of physicians be reported to the National Practitioner Data Bank. Lawthers et al. (1992) found that physicians over-predict their likelihood of being sued. Thus it may be legitimate for them to focus on reforms that indirectly reduce the number of claims by reducing the levels of recovery for

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115 Mark Pauly et al., Who Pays? The Incidence of High Malpractice Premiums, 9 F. HEALTH ECON. & POL’Y, 2006 at 1, 8.
117 Nelson, Morrisey & Kilgore, supra note 41.
119 Peters, supra note 24, at 256-57 (citing Sara C. Charles et al., Sued and Nonsued Physicians’ Self-Reported Reactions to Malpractice Litigation, 142 AM. J. PSYCHIATRY 437, 438 (1985)).
121 Peters, supra note 24, at 256 (citing Teresa M. Waters et al., Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims, 40 INQUIRY 283, 283 (2003)). Physicians are concerned about reports to the National Practitioner Data Bank because hospitals are required to query it about malpractice payments for new applicants for staff privileges and on a periodic basis for existing members of the medical staff. Laura-Mae Baldwin et al., Hospital Peer Review and the National Practitioner Data Bank, 281 JAMA 349, 349 (1999).
In this regard, there is evidence of a slight reduction in claim frequency due to direct reforms such as damages caps. And Waters et al. (2007) found that caps on non-economic damages were associated with fewer paid claims and lower per physician payments.

Physicians may also be more concerned about sudden spikes in premiums and volatility in the medical liability insurance market than they are about continuous moderate increases in premium levels over time. This attitude would be consistent with the ability to pass on higher malpractice insurance premiums, but only with a time lag between the increase in rates and the pass through of these costs. If so, physicians would suffer income losses until the higher premium costs are reflected in higher charges to payers. In this regard, it appears that a damages cap coupled with creation of a state patient compensation fund may be an effective means of reducing volatility in the medical liability insurance market even if it is not effective in reducing claim frequency and overall loss payouts.

In a comparative study of the medical liability systems in Alabama, Louisiana and Mississippi, Nelson et al. (2008) found that medical liability insurance premium levels in Louisiana, a jurisdiction with a patient compensation fund and damages caps, were substantially higher than in Alabama, and that Louisiana had a more plaintiff-friendly malpractice environment in terms of the total value of paid claims and the number of paid claims than either Alabama or Mississippi. Nonetheless, the study concluded that Louisiana had established a stable medical liability insurance system that was generally supported by providers and insurers. While premiums in Louisiana were substantially higher than those in Alabama, and comparable to those in Mississippi, they were not as volatile. During the period examined (1991–2004), Louisiana had a damages cap in place. Alabama had caps that were passed in 1987, but they were held unconstitutional by the Supreme Court of Alabama.

Daniel P. Kessler & Mark. B. McClellan, The Effects of Malpractice Pressure and Liability Reforms on Physicians’ Perceptions of Medical Care, 60 LAW & CONTEMP. PROBS. 81 (1997).
Teresa M. Waters et al., Impact of State Tort Reforms on Physician Malpractice Payments, 26 HEALTH AFF. 500, 504 (2007).
Id. at 147-48.
in 1991 (non-economic damages) and 1995 (wrongful death).

Mississippi did not have a cap on non-economic damages until 2002, and that was passed in response to a spike in premium levels.

The continuing support of physicians for the Louisiana malpractice system suggests that physicians may be more concerned with the stability of premium levels than with the actual cost of premiums. The most significant components of the Louisiana malpractice reforms are the caps on damages and the Louisiana Patient Compensation Fund (LPCF). The Louisiana cap limits the liability of “qualified health care providers” for injuries resulting from malpractice to $100,000. Health care providers may become “qualified” by filing proof that they are covered by a policy of malpractice liability insurance in an amount of at least $100,000 per claim, or if self-insured, depositing $125,000 with the fund or otherwise arranging for a letter of credit or other security.

“Qualified health care providers” must also pay a surcharge assessed by the Louisiana Insurance Rating Commission. Damages recoverable in malpractice actions against “qualified health care providers” are capped at a total of $500,000 plus interest and costs, with the liability of the individual health provider being capped at $100,000. These caps were set in 1975 and have not been increased for inflation. In 1984, however, the statute was amended to exclude future health care expenses. Thus plaintiffs are now entitled to recover for future health care costs without regard to the cap.

The damages available to a successful plaintiff in an action against a “qualified health care provider” are paid both by the provider’s insurer and the LPCF. No “qualified health care provider” can be held liable for more than $100,000 plus interest. Thus, any judgment in excess of the total liability for qualified health care providers of $100,000 is to be paid out of the LPCF. Future medical costs, which are not subject to the $500,000 cap, are also to be paid out of


131 Miss. Code Ann. § 11-1-60 (West 2010).
132 Nelson, Morrisey & Kilgore, supra note 126, at 117.
134 Id. § 40:1299.42(A)(1).
135 Id. § 40:1299.42(A)(2); Id. § 40:1299.44(2)(A).
136 Id. §40:1299.42(B)(1).
137 Id. §40:1299.42(B)(2).
138 Id. §40:1299.42(B)(3)(a).
the LPCF.\textsuperscript{141} Louisiana does not recognize punitive damages as an available common law remedy.\textsuperscript{142}

Arguably, it is the low cap on provider’s liability and the cap on total damages coupled with the LPCF that has led to a relatively stable medical liability insurance market in Louisiana. Sloan et al. (2005) noted that one of the main motivations in creating patient compensation funds was “providing physicians and hospitals with affordable and reliable medical malpractice insurance coverage by covering losses at the higher end of the distribution of losses, thereby reducing volatility...”\textsuperscript{143} Based on a qualitative evaluation, they found that properly designed patient compensation funds may be an effective means of reducing volatility and combating periodic insurance crises.\textsuperscript{144}

It is generally assumed that there is a strong link between the conditions in the medical liability insurance market and physician support of damages caps. It is not, however, clear whether this support for damages caps is more a function of higher absolute premium levels, concern about the probability of lawsuits, or premium volatility. Concerns about premium volatility could explain physician support for damages caps. Baker has attributed most of the volatility in the medical liability insurance market to an underwriting cycle in which insurers periodically underestimate potential losses until actual losses force them to raise their premium rates.\textsuperscript{145} A time lag between a sudden spike in medical liability insurance premium levels and the ability of physicians to pass on those increased costs could energize physicians to support the enactment of damages caps in the belief that this will reduce market volatility and return stability to the system. If this sudden spike is accompanied by the exit of insurers from the market, then

\begin{footnotesize}
\textsuperscript{141} Id. § 40:1299.42(B)(1). The cap on Patient Compensation Fund liability established by § 40:1299.42(B) excludes from its scope “future medical care and related benefits” as provided in § 40:40:1299.43. Under § 40:1299.43, if a court determines that a claimant is in need of “future medical care and related benefits,” defined as “all reasonable medical, surgical, hospitalization, physical rehabilitation, and custodial services and includes drugs, prosthetic devices, and other similar materials reasonably necessary in the provision of such services, after the date of the injury,” then damages are recoverable from the Patient Compensation without regard to the cap. In addition, the legislature is supposed to appropriate sufficient monies to pay claims in excess of the $500,000 limit for future medical care.

\textsuperscript{142} Louis Guirola & Thomas L. Carpenter, Jr., Punitive Damages in Mississippi: What Has Happened, What is Happening and What is Coming Next, 73 MISS. L.J. 135, 137 & n.11 (2003).


\textsuperscript{144} Id. at 271.

\textsuperscript{145} BAKER, supra note 16, at 51-58.
\end{footnotesize}
physician support for damages caps would be tied to the malpractice insurance underwriting cycle.

There is a dearth of empirical studies establishing that damages caps have been effective in taming the volatility of the insurance underwriting cycle, but there are studies finding that caps reduce losses by insurers. Using financial data from the National Association of Insurance Commissioner files for medical liability insurers (1984–1991), Born and Viscusi (2005) found that caps on non-economic damages reduced insurers’ loss ratios and incurred losses.\textsuperscript{146} Focusing on loss ratios—the ratio of losses incurred to premiums earned—they found that the enactment of reforms typically follow a surge in loss ratios.\textsuperscript{147} And they found that caps on non-economic damages increased insurer profitability by reducing loss ratios 10 to 13 percent.\textsuperscript{148} Born et al. (2010) found that caps on non-economic damages reduced insurer’s ultimate losses and increased insurer’s income.\textsuperscript{149}

On the other hand, it does not appear that the medical malpractice crises of the mid-1980s and the 2000s resulted from sudden spikes in loss payouts.\textsuperscript{150} Indeed, Chandra et al. (2005) concluded that medical liability loss payouts (judgments and settlements) had “not risen significantly” from 1991 to 2003 when viewed “as a fraction of national health care spending.”\textsuperscript{151} They found the increase in loss payouts during this period could largely be explained by increased medical costs, and concluded there was only a weak relationship between loss payouts and increased medical liability insurance premiums.\textsuperscript{152} And a study of closed claims in Texas by Black et al. (2005) concluded that the medical liability insurance crisis in that jurisdiction was not caused by a spike in loss payouts.\textsuperscript{153} They concluded that malpractice reforms will probably not prevent future crises.\textsuperscript{154}

Nonetheless, supporters of damages caps point to success in California as a basis for their support of damages caps. The AMA touts the relative stability of the California insurance market since the en-

\textsuperscript{147} \textit{Id.} at 28.
\textsuperscript{148} \textit{Id.} at 38-39.
\textsuperscript{149} Patricia Born et al., \textit{The Effects of Tort Reform on Medical Malpractice Insurer's Ultimate Losses}, 76 J. Risk & Ins. 197, 216 (2009).
\textsuperscript{150} BAKER, supra note 16, at 51.
\textsuperscript{151} Chandra et al., \textit{supra} note 18, at W5-247.
\textsuperscript{152} \textit{Id.}
\textsuperscript{154} \textit{Id.}
actment of MICRA in 1975 as proof of the efficacy of caps. But according to opponents of caps, this stability has resulted not from MICRA, but from the passage of Proposition 103 in 1988, a measure that included a rollback on premiums, and a mechanism for consumers to challenge rate increases. Nonetheless, it is clear that the MICRA cap has resulted in reductions in damage awards. Rand (2004) found that from 1995–1999 California jury verdict awards in malpractice cases were reduced 30 percent due to the imposition of the MICRA cap, with the cap being imposed in 45% of the cases reviewed.

Rand (2004) also found that as a result of MICRA’s limits on contingency fees, MICRA reduced plaintiff’s attorney fees by 60%. Indeed, these limits reduced incentives for attorneys to bring malpractice claims, which in turn could have reduced the number of claims filed. From 2003–2008, the total number of annual paid claims in California declined from 1,312 to 901. It is not clear, however, that the decline in the number of claims is due to the effect of MICRA. For example, it could be due to improvements in patient safety. Using California physician malpractice claims and patient safety data from 2001–2005, Rand (2010) found a correlation between a reduction in potential adverse patient safety incidents and fewer malpractice claims at the county level. The study noted that since MICRA had been in place since the mid-1970s, the decline in claims could not be explained by “the impact of tort reform within the state.” Nonetheless, since the California damages cap has no inflation factor and has not been increased since its adoption in 1975, it becomes more stringent

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158 Id. at 48.


161 Id. at 5.
over time. This ratcheting down effect could provide at least a partial explanation for the continuing decrease in the number of claims.

Proponents of damages caps also point to Texas as an example of the success of caps in stabilizing the medical liability insurance market. In 2003, the Texas legislature capped non-economic damages in medical malpractice actions at $250,000 in actions against individual physicians, with an aggregate cap of up to $500,000 per claimant in actions involving more than one institutional provider. In 2005, several Texas medical liability insurers announced rate cuts for 2006. For several of these companies, this was the second round of rate cuts following enactment of the damages cap. Hyman, Black, Silver and Sage (2009) found that the Texas caps significantly reduced verdicts, payouts and settlements. And from 2003 to 2008, the total number of annual paid claims in Texas plunged from 1,067 to 464.

Table 1 provides some initial evidence that the presence of damage caps on non-economic damages is associated with greater premium stability. Data on malpractice insurance premiums for internal medicine, general surgery, and obstetrics/gynecology by state were obtained from the Medical Liability Monitor for the period 1991 through 2004. During this period nineteen states had damage caps in place for the entire period and twenty-two states did not. The remaining nine states had caps in place for part of the period.

163 TEX CIV. PRAC. & REM. CODE § 74.301 (West 2011).
165 Id.
Table 1

Premiums and Volatility Measures by Damage Cap Status

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<tr>
<th></th>
<th>Internal Medicine</th>
<th>General Surgery</th>
<th>Obstetrics/Gynecology</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Never Cap</td>
<td>Always Cap</td>
<td>Never Cap</td>
</tr>
<tr>
<td><strong>PREMIUM LEVELS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Premium 1991</td>
<td>$7,510</td>
<td>$8,432</td>
<td>$31,195</td>
</tr>
<tr>
<td>Mean Premium 2004</td>
<td>$11,708</td>
<td>$12,768</td>
<td>$41,912</td>
</tr>
<tr>
<td>% Change 1991-2004</td>
<td>55.9%</td>
<td>51.4%</td>
<td>34.4%</td>
</tr>
<tr>
<td><strong>VARIATION IN LEVELS</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Coefficient of Variation</td>
<td>.306</td>
<td>.238</td>
<td>.287</td>
</tr>
<tr>
<td><strong>PREMIUM GROWTH</strong></td>
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<td></td>
</tr>
<tr>
<td>Mean Annual % Change</td>
<td>7.3%</td>
<td>5.9%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Std. Dev. Of % Change</td>
<td>22.3</td>
<td>15.4</td>
<td>31.9</td>
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### IV. THE PROBLEM OF DEFENSIVE MEDICINE

Defensive medicine may both increase health care costs and reduce access. It is generally recognized that there are two types of defensive medicine: positive (assurance behavior) and negative (avoidance behavior).\(^{168}\) Positive defensive medicine has an impact on costs because it involves ordering extra diagnostic tests or performing additional procedures in order to reduce the risk of being sued for malpractice.\(^{169}\) Negative defensive medicine reduces access because it

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\(^{169}\) *Id.* at 2609, 2616.
involves avoiding certain classes of patients, refusing to perform certain procedures, or leaving practice altogether.\footnote{id at 2609, 2613.}

The definition of defensive medicine has been debated. In its 1994 report, OTA defined defensive medicine as:

\[\ldots\text{when doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice liability. When physicians do extra tests or procedures primarily to reduce malpractice liability, they are practicing positive defensive medicine. When they avoid certain patients or procedures, they are practicing negative defensive medicine.}\footnote{Office of Tech. Assessment, Defensive Medicine and Medical Malpractice 36 (1994), available at \url{http://www.princeton.edu/~ota/disk1/949405/9405.pdf}.} \]

On the other hand, Sloan & Shadle (2009), using a law and economics approach, defined defensive medicine as "only care for which expected cost exceeds expected benefits."\footnote{Frank A. Sloan & John H. Shadle, Is There Empirical Evidence for "Defensive Medicine"? A Reassessment, 28 J. Health Econ. 481, 481 (2009).}

Several studies of the prevalence of defensive medicine have relied on surveys.\footnote{Cong. Budget Office, Background Paper, Medical Malpractice Tort Limits and Health Care Spending 8 (April 2006), available at \url{http://www.cbo.gov/ftpdocs/71xx/doc7174/04-28-MedicalMalpractice.pdf}.} While recognizing the shortcomings of physician surveys, Kessler & McClellan (1997) found that survey results could be a helpful measure of actual defensive practices.\footnote{Kessler & McClellan, supra note 124, at 106.} As noted by the CBO (2006), however, there are problems with interpreting survey results: physicians report both positive (additional tests and procedures) and negative (avoiding procedures and patients) defensive medicine so that it is difficult to determine the net effect on utilization; surveys typically have a low response rates so there may be a response bias (i.e., those with more negative feelings about the malpractice system are more likely to respond); and the types of questions asked may substantially affect results (i.e., if you ask physicians whether malpractice concerns have affected their practice they will usually respond affirmatively, while more open-ended questions with clinical scenarios are less likely to elicit a response indicating malpractice fears as a reason for ordering additional tests).\footnote{See Cong. Budget Office, supra note 173, at 9-12.}

A 2005 study used a survey instrument to examine the prevalence of defensive medicine in the then volatile Pennsylvania malpractice
environment. The study concluded that defensive medicine was “highly prevalent” among high risk physicians in Pennsylvania (i.e., those in specialties with the highest medical liability insurance premiums) and had “potentially serious implications for cost, access, and both technical and interpersonal quality of care.” That study attempted to address concerns about the difficulty of interpreting survey results through careful design of the questionnaire and the use of aggressive follow up techniques to ensure a high response rate. They also sought to improve upon earlier surveys by focusing on physicians from multiple specialties in a volatile malpractice environment. Initially, they identified six high risk specialties impacted by high medical liability insurance rates: “emergency medicine, general surgery, neurosurgery, obstetrics/gynecology, orthopedic surgery, and radiology…”

The questionnaire asked about both positive defensive medicine (assurance behaviors: ordering more tests or prescribing more medically indicated, unnecessary specialist referrals, or suggesting unnecessary invasive procedures) and negative defensive medicine (avoidance behaviors: avoiding certain procedures or high risk patients).

As to both types of behavior, respondents acknowledging that they engaged in the behavior were asked to provide more specific information about their most recent act. Respondents were also questioned about whether they had reduced or eliminated high-risk aspects of their practice in the last three years or planned to do so in the next two years in response to the costs of medical liability insurance.

There was an overall response rate of 65% to the questionnaire. Most of the respondents (93%) reported they engaged in defensive medicine. Fifty-nine percent reported ordering excessive diagnostic tests, 52% reported unnecessary specialist referrals, one-third reported excessive prescribing, and one-third reported suggesting unnecessary invasive procedures. As to assurance behavior, among emergency room physicians, neurosurgeons, and orthopedic surgeons, the most commonly reported defensive act was ordering unnecessary imaging studies.

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176 Studdert et al., supra note 168.
177 Id. at 2610.
178 Id.
179 Id.
180 Id.
181 Id.
182 Id. at 2612.
183 Id.
184 Id.
185 Id.
186 Id.
Among obstetricians/gynecologists, the most common defensive practice was unnecessary referrals. Concerns about cancer detection was a commonly reported motivating factor across specialties that led to increased utilization of diagnostic imaging, specialist referrals, and suggesting invasive procedures. Thirty-nine percent of respondents reported avoidance behaviors in the form of refusing to care for high-risk patients. And one-third reported avoiding certain procedures or interventions. Mello (2005) concluded that, based on the survey of Pennsylvania physicians, the supply of surgeons and other specialists would likely decrease in the next two years and that physicians were avoiding providing high risk services in response to increased costs of medical liability insurance.

In 2008, the Massachusetts Medical Society released the results of a statewide survey of practicing physicians in eight specialties (anesthesiology, emergency medicine, family medicine, general surgery, internal medicine, neurological surgery, obstetrics/gynecology, and orthopedic surgery) on the prevalence of defensive medicine. Eighty-three percent of the respondents reported they practiced defensive medicine. The commonly reported assurance behaviors related to diagnostic imaging ordered for defensive purposes: 22% of X-rays; 28% of CT scans; 27% of MRIs; and 24% of ultrasounds. In addition, 28% of specialty referrals, 18% of laboratory tests ordered, and 13% of hospital admissions were motivated by liability concerns. On avoidance behaviors, 38% reported reducing the number of high risk services and procedures and 28% reported reducing the number of high risk patients seen. Based on the survey results, the report concluded that “the total cost of defensive medicine in Massachusetts accounts for billions of dollars. But there were problems with this survey:

The response rate for the survey was too low (23.6 percent) for the results to be considered generalizable, the validity and
reliability of the self-report measures had not been established, and the authors acknowledged that confirmation from more objective measures (such as medical record review) were warranted to uphold the validity of the survey results.196

The American College of Obstetricians and Gynecologists (ACOG) does periodic surveys of its members on professional liability issues including defensive medicine practices. In ACOG (2009),197 of those who reported making obstetrical practice changes because of concerns about liability insurance: “19.5% reported increasing the number of cesarean deliveries and 19.5% indicated they stopped performing or offering VBACs [vaginal birth after cesarean section]... 21.4% decreased the number of high-risk obstetric patients, 10.4% decreased the number of total deliveries, and 6.5% stopped practicing obstetrics altogether.”198 In addition, of those who reported making obstetrical practice changes out of fear of being sued for malpractice: “30.2% decreased the number of high-risk obstetric patients, 29.1% reported increasing the number of cesarean deliveries, ... 25.9% stopped offering and performing VBACs [vaginal births after cesareans] ... 13.9% decreased the number of total deliveries, and 8.0% stopped practicing...”199

As to those who reported gynecological practice changes because of concerns about liability insurance, ACOG (2009) found: “11.0% decreased gynecologic surgical procedures ... 4.5% stopped performing major gynecologic surgery, and 1.8% stopped performing all surgery.”200 And as to those who reported gynecological practice changes due to fear of being sued for malpractice, 14.7% decreased gynecologic surgical procedures, 5.2% stopped performing major gynecologic surgery, and 2.0% stopped performing all surgery.”201 Notwithstanding the responses to ACOG (2009), however, it seems unlikely that the increased cesarean rates and decrease in VBAC were driven entirely by liability concerns. For example, reimbursement policies could be a factor in the observed rate of increase in cesarean sections because doctors are paid more for cesarean sections than VBACs. The

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198 Id. at 2.
199 Id. at 3.
200 Id.
201 Id.
decrease in VBAC could also be influenced by concerns about the risks to the mother.202

Reyes (2010), utilizing the results of a 2003 ACOG survey, found that short term rising liability insurance premiums led to practice reductions, but longer term rises led to greater specialization: while some physicians focused more on obstetrics, others focused more on gynecological surgery.203

In a separate national survey of primary care physicians, nonsurgical specialists, surgical specialists, and other specialist respondents reported ordering more tests and procedures than needed due to fear of malpractice suits.204 Over 90% of respondents also agreed that additional medical liability reforms were needed to decrease overutilization of diagnostic tests.205

In addition to surveys, there have been several empirical studies on the prevalence of defensive medicine. Most of these have focused on heart disease or maternity care. More recent studies have revisited the earlier work, and explored imaging and physician services more generally. A few recent studies have examined expenditures or overall utilization and made inferences about defensive medicine. These studies yield mixed results as to the magnitude and generalizability of any findings but have led the CBO to revise its view of the evidence of defensive medicine. These studies will be discussed in the next section.

V. THE IMPACT OF A FEDERAL DAMAGES CAP ON COSTS

As noted supra, Republicans have argued that a federal damages cap could reduce health care costs. And, as discussed infra, the CBO included savings from reduced health care utilization in its estimates of cost savings for the federal government that would result from the enactment of a federal damages cap. Nonetheless, at this time it is not clear that a cap will significantly reduce health care costs or that any savings would result to consumers as result of federal medical liability reform.

202 Cf. Y. Tony Yang et al., Relationship Between Malpractice Litigation Pressure and Rates of Cesarean Section and Vaginal Birth After Cesarean Section, 47 MED. CARE, 234, 238 (2009).
204 Bishop et al., supra note 39.
205 Id.
The stated goals of proponents of health care reform were to reduce costs, increase access, and improve quality. It will, however, be difficult to accomplish these goals simultaneously. Some health policy analysts have referred to an "iron triangle" of health care, with three vertices: cost, access and quality. "In equilibrium, increasing the performance of the health care system along any one of these dimensions can compromise one or both of the other dimensions, regardless of the amount that is spent on health care."208

The potential impact of the ACA on health care costs is a controversial topic. Initially, CBO estimated that enactment of the health care portions of this legislation would decrease the federal deficit by $124 billion between 2010 and 2019. But if combined with the legislation that reverses the cut in payment rates for physician services under Medicare, CBO estimated that enactment of the ACA would add $59 billion to the deficit during that same period. In May 2010, the CBO estimated that the ACA would increase discretionary spending by $115 billion between 2010 and 2019. The CBO later noted that while Medicare costs will continue to increase, some provisions of the ACA have the potential to reduce outlays by decreasing payment rates for some providers and limiting per enrollee expenditures.

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The chief actuary of the Centers for Medicare Services estimated that the ACA would increase overall federal spending by $251 billion over the 2010–2019 period, but net Medicare spending would be reduced by $575 billion. Overall national health expenditures were estimated to increase by $311 billion during 2010–2019 due to the coverage expansion under the ACA.\(^{214}\) In a May 2010 presentation to the Institute of Medicine, Douglas Elmendorf, Director of the CBO, noted: "Rising health costs will put tremendous pressure on the federal budget during the next few decades and beyond. In CBO’s judgment, the health legislation enacted earlier this year does not substantially diminish that pressure."\(^{215}\) During the debate over reform the Obama administration claimed (based on research compiled by the Dartmouth Atlas Project)\(^{216}\) that $700 billion of wasteful spending could be saved without adversely affecting health outcomes.\(^{217}\) But significant questions have now been raised about the magnitude of these potential cost savings.\(^{218}\)

If, however, additional health care cost savings could be achieved by the adoption of medical liability reforms, including a federal damages cap, it could be justified as long as there were no significant adverse effects on patient safety. There is a continuing debate as to


[W]e estimate that overall national health expenditures under the health reform act would increase by a total of $311 billion . . . during calendar years 2010-2019, principally reflecting the net impact of (i) greater utilization of health care services by individuals becoming newly covered (or having complete coverage), (ii) lower prices paid to health providers for the subset of those individuals who become covered by Medicaid, (but with net Medicaid costs from provisions other than the coverage expansion), and (iii) lower payments and payment updates for Medicare services. Although several provisions would help to reduce health care cost growth, their impact would be more than offset through 2019 by the higher health care expenditures resulting from the coverage expansions.

Id.


\(^{218}\) Reed Abelson & Gardiner Harris, Study Cited for Health-Cost Cuts Overstated Its Upside, Critics Say, N.Y. TIMES, June 3, 2010, at A1, A20.
MEDICAL LIABILITY AND HEALTH CARE REFORM

overall costs of defensive medicine and the potential impact of tort reform on those costs. Reductions in health care costs by the implementation of medical liability reform could come through reductions in medical liability insurance premiums and/or reductions in defensive medicine. There are now several research studies suggesting that damages caps will reduce medical liability insurance premiums, but establishing a link between traditional tort reforms and reductions in health care utilization has been more elusive. There have been a number of government and industry-sponsored reports that have looked at the impact of tort reform on health care costs. There have also been a number of empirical studies on the impact of tort reforms on defensive medicine. Although some of these studies have shown a link between direct reforms such as damages caps and reductions in the practice of defensive medicine, other studies have found no significant effect.

A 1994 study on defensive medicine by the Office of Technology Assessment (OTA) found that while traditional tort reforms (i.e., damages caps and collateral source modification) could reduce malpractice insurance premiums, their impacts on defensive medicine were “largely unknown” and “likely to be small.” Moreover, to the extent that they could reduce defensive medicine, OTA (1994) notes that tort reforms could do so without distinguishing between “medically appropriate” defensive practices and “wasteful” or “very costly” practices.

As to the potential savings from the effect of tort reform, government agencies have been in disagreement. A 2002 study issued by the Department of Health and Human Services estimated that a cap on non-economic damages could save the federal government between $25.3 billion and $44.3 billion in direct costs. But a 2003 study by the GAO concluded: “Although available research suggests that de-


220 Compare Daniel P. Kessler & Mark B. McClellan, Malpractice Law and Health Care Reform: Optimal Liability in an Era of Managed Care, 84 J. PUB. ECON. 175 (2002), with Sloan & Shadle, supra note 172.


222 Id. at 2, 13.

Defensive medicine may be practiced in specific clinical situations, the findings are limited and cannot be generalized to estimate the prevalence and costs of defensive medicine nationwide.  

A 2006 report prepared by Price Waterhouse Coopers for America's Health Insurance Plans (AHIP) looked at “cost drivers” that contributed to the 8.8% increase in health insurance premiums from 2004 to 2005. It found that 10 percent of health care spending was attributable to litigation costs and defensive medicine, “that more intensive diagnostic testing contributed eight tenths of a percentage point to premium increases in 2005,” and that defensive medicine contributed to those costs. It suggested that 30 percent of each health care dollar was spent on “poor quality” care and of that 30 percent, 2 percent was attributable to direct litigation costs and 8 percent to defensive medicine.

A. Empirical Studies on the Impact of Tort Reforms on Defensive Medicine

There have been a number of empirical studies on the impact of tort reforms on defensive medicine with conflicting results. The most influential of the early work was undertaken by Kessler & McClellan (1996). They note: “Our study is the first to use exogenous [i.e., independent] variation in tort laws not related to potential idiosyncrasies of providers or small geographic areas to assess the behavioral effects of malpractice pressure.” Kessler & McClellan (1996) examined the effects of “direct” and “indirect” malpractice tort reforms on Medicare hospital spending on behalf of beneficiaries with acute myocardial infarction (AMI) or new ischemic heart disease (IHD) in 1984, 1987 and 1990. They also examined health outcomes measured as one year post admission mortality or readmission for AMI or IHD. Direct reforms included the implementation of a damages cap, abolition of punitive damages, elimination of mandatory pre-judgment interest, or the abrogation or modification of the collateral source rule. Indirect reforms included such changes as limitations on plaintiff at-
attorney contingency fees, mandatory periodic payments, joint and several liability and patient compensation funds. Direct reforms were found to reduce one year Medicare hospital payments by 5 to 9%. Indirect reforms reduced payments by 1.8%.

Because Kessler & McClellan found no statistically significant effects on health outcomes, they concluded that direct reforms reduced defensive medicine and improved social welfare. In a follow-up study, Kessler & McClellan (2002) found that direct reforms reduced medical expenditures for Medicare patients with serious heart disease (AMI and IHD) without significantly affecting health outcomes. They also found that "malpractice pressure" had a greater effect on diagnostic procedures than treatments.

Although Kessler & McClellan’s results have largely been accepted, controversy remains regarding the generalizability of their findings to overall health care spending. For example, Baker criticized their attempt to extrapolate those findings into a potential overall savings from direct reforms of $50 billion per year nationwide. Further undermining the generalizability of the findings of Kessler & McClellan, Baicker & Chandra (2004) found little evidence of changes in treatment patterns for several different treatment protocols for Medicare enrollees, or for overall expenses in Medicare program due to increases in liability insurance premiums.

More recently Sloan & Shadle (2009) have revisited the Kessler & McClellan work using 1985–2000 Medicare claims data linked to the National Long-Term Care Survey data. Their principal contributions were to examine ambulatory as well as hospital payments by Medicare. Sloan & Shadle extended the Kessler & McClellan work by examining a longer time period, 1985 through 2000, and importantly by including ambulatory services and clinical conditions in addition to heart disease. This is important because much of the alleged defensive medicine is said to be undertaken by physicians in non-hospital settings. Finally, Sloan & Shadle control for the health conditions of the patients in the study, which they argue Kessler and McClellan may not have done as effectively. Sloan & Shadle found that direct reforms had no statistically significant effect on the broader measure of Medi-

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232 Id. at 952.
233 Kessler & McClellan, supra note 229, at 387-388 discussed in BAKER, supra note 16, at 128-130.
care spending, although the effect on AMI was similar to that found by Kessler & McClellan. However, there were no statistically meaningful effects of direct reforms on breast cancer, diabetes or stroke cases. There were also no meaningful effects on mortality. Thus, Sloan & Shadle concluded that the Kessler & McClellan results are not generalizable. As they say, "Our results indicate that KM's findings do not generalize to other reasons for hospital admission. They conclude that "it seems inappropriate to conclude that tort reforms implemented to date succeed in reducing non-beneficial care as their proponents would have it."235

Several studies have focused on the impact of malpractice risk on cesarean deliveries, a procedure that has been considered particularly sensitive to malpractice risk, with mixed results. Localio et al. (1993), using New York state hospital claims data for 1984, found that cesarean delivery rates increased with malpractice risk.236 Tussing & Wojtowycz (1997) looking at New York hospital discharge records for 1986 found that malpractice risk was associated with increased use of Electronic Fetal Monitoring, diagnoses of fetal distress, and use of cesarean sections thereby increasing costs, but could not determine whether or not defensive medicine was "good or bad in this instance."237 In the first study using national birth certificate data, Dubay et al. (1999) found that obstetricians reacted to malpractice claims risk by performing more cesarean sections and that this effect was greater for women from lower socioeconomic groups.238 Murthy et al. (2007) found that higher rates of primary cesarean delivery were associated with higher medical liability insurance premiums for Illinois obstetricians-gynecologists.239 On the other hand, Baicker & Chandra (2004) found little evidence that cesarean rates had increased in response to higher malpractice premiums.240 And in a study using national data from the National Practitioner Data Bank and the Natali-

235 Sloan & Shadle, supra note 172, at 490.
236 A. Russell Localio et al., Relationship Between Malpractice Claims and Cesarean Delivery, 269 JAMA 366 (1993). This study used five measures of malpractice risk: "(1) relative premium levels; (2) perceived risk by geographic area as revealed in a physician survey; (3) claims against hospitals, regardless of specialty; (4) claims against the hospital obstetric staff taken as a group; and (5) claims against individual physicians." Id. at 368.
237 A. Dale Tussing & Martha A. Wojtowycz, Malpractice, Defensive Medicine, and Obstetric Behavior, 35 MED. CARE 172, 186-88 (1997).
238 Lisa Dubay et al., The Impact of Malpractice Fears on Cesarean Rates, 18 J. HEALTH ECON. 491, 519 (1999).
240 Baicker & Chandra, supra note 234, at 18.
ty Detail File, Kim (2007) found that cesarean rates were not sensitive to malpractice risk.\textsuperscript{241} Dranove & Watanabe (2010) using micro-data found a short term hospital-wide upsurge in cesarean rates among physicians contacted about malpractice suits against them or their colleagues and an upsurge in the use of cesareans by the responsible physician, but these effects quickly disappeared.\textsuperscript{242}

Some studies have focused on the impact of tort reforms on obstetrical practices. Dubay et al. (1999), using Zuckerman et al. (1990),\textsuperscript{243} found that a cap on total damages would reduce malpractice premiums in the long run for obstetricians by 58%. Dubay et al. concluded that a cap “would result in a 0.48 percentage point decline in the rate of cesarean sections (from 15.18\% to 14.71\%) . . . or 3\% of the approximately 540,000 primary cesareans performed every year.”\textsuperscript{244} They estimated that a cap on total damages would reduce total obstetrical charges by “US $73.7 million or 0.27\% of the US $27.6 billion (1996) in obstetrical charges for women at risk of a primary cesarean section.”\textsuperscript{245}

Currie & Macleod (2008) estimated that joint and several liability (JSL) reforms reduced preventable complications of labor and delivery by 6\%, and damages caps increased complications by 13\%.\textsuperscript{246} By way of explanation of these findings, they note:

Intuitively, if many doctors are performing procedures in marginal cases not because of fear of liability but because the procedures are more profitable and less time-consuming than the alternatives, then these doctors may be more likely to perform these procedures when they are less fearful of liability. On the other hand, under JSL reform, doctors are held more accountable for their own actions (and are less likely to be held liable for the torts committed by others). This results in more care being taken and fewer procedures, which results in the testable prediction that the effect of damage caps upon


\textsuperscript{242} David Dranove & Yasutora Watanabe, \textit{Influence and Deterrence: How Obstetricians Respond to Litigation Against Themselves or Colleagues}, 12 Am. L. & ECON. REV. 69, 91-92 (2010).


\textsuperscript{244} Dubay et al., \textit{supra} note 238, at 518.

\textsuperscript{245} \textit{Id.} at 519.

\textsuperscript{246} Currie & MacLeod, \textit{supra} note 123, at 821.
procedure use should be the opposite of the effect of reform of JSL. 247

Using a fixed effects analysis, Yang et al. (2009) found a positive association between malpractice premium levels and total cesarean and primary (first time) cesarean rates, and a negative association between malpractice premium levels and VBAC rates. 248 Caps on non-economic damages and pretrial screening panels were associated with lower cesarean delivery rates and higher VBAC rates. 249 But they also found that these effects were modest relative to recent changes in practice patterns, suggesting that other factors are driving the shift away from VBAC. 250

B. CBO Estimates on the Impact of Federal Enactment of Tort Reforms on Aggregate Health Care Costs

During the debate over health care reform, it was contended by Republicans and physician groups that the federal enactment of tort reforms—particularly a cap on damages—could result in significant savings in aggregate health care costs. The AMA based its support of the federal damages cap on arguments that the cap will reduce the costs of health care. 251 Republicans in Congress claimed that federal enactment of traditional tort reforms including a $250,000 cap on non-economic damages would result in significant savings. However, the effect of damages caps on aggregate health care costs remains uncertain.

In 2003, the Congressional Budget Office (CBO), at the request of the House Energy and Commerce Committee, estimated the potential savings that could result from federal enactment of traditional tort reform measures, including a cap of $250,000 on non-economic damages. 252 CBO estimated that if these reforms were adopted, “premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent lower than what they would be under current law.” 253 It also found that the proposed legislation would reduce direct

247 Id. at 797.
248 Yang et al., supra note 202.
249 Id. at 239.
250 Id. at 240.
253 Id. at 4.
federal spending on health care programs by $14.9 billion for 2004–2013 due to reductions in malpractice insurance premiums.\textsuperscript{254}

CBO (2003) further acknowledged that the impact on health insurance premiums would be much smaller because “[m]alpractice costs account for a very small fraction of total health care spending.”\textsuperscript{255} As to the effect on health care utilization, CBO’s estimate did not include potential savings from reductions in defensive medicine. It noted that estimating this effect would be difficult and that most studies estimating the magnitude of spending due to defensive medicine were “speculative.” The 2003 CBO report referred to empirical studies finding reductions in health care spending due to tort reforms that focused on Medicare hospital spending on patients treated for heart disease and Caesarean sections. But its own study “found no effect of tort controls on medical spending in an analysis that considered a broader set of ailments.”\textsuperscript{256}

In 2004, CBO looked at the effects of tort reform throughout the States.\textsuperscript{257} It examined nine studies on the effects of tort reform and concluded: “[e]vidence from several of the studies suggests that different tort reform initiatives affect the number of lawsuits filed, the value of insurance claims, and the value of insurance payouts for damages.”\textsuperscript{258} Specifically, as to medical malpractice, it noted that “[a]lthough statistical evidence was scant,” there was some support for the proposition that caps on non-economic damages and mandatory collateral source offset “reduced some medical malpractice costs.”\textsuperscript{259} While noting that tort reform could potentially reduce defensive medicine and enhance efficiency,\textsuperscript{260} it reiterated that in its 2003 study CBO found no evidence that tort reforms reduced medical spending when it applied the same methods used by Kessler and McClellan to a broader set of ailments.\textsuperscript{261}

In 2006, CBO (2006) again looked at the effect of federal enactment of traditional tort reforms on health care spending.\textsuperscript{262} It found that while there was “some evidence of links between tort limits and health care spending, the results are inconsistent and depend on the

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\textsuperscript{254} \textit{Id.} at 6. \\
\textsuperscript{255} \textit{Id.} at 4-5. \\
\textsuperscript{256} \textit{Id.} at 5. \\
\textsuperscript{258} \textit{Id.} at 11. \\
\textsuperscript{259} \textit{Id.} at 16. \\
\textsuperscript{260} \textit{Id.} at 18. \\
\textsuperscript{261} \textit{Id.} at 19. \\
\textsuperscript{262} \textit{Cong. Budget Office, supra} note 173, at 1.
\end{flushright}
particular relationships and specifications tested."

It also noted "the difficulty of disentangling any effects of tort limits from other factors that affect levels of spending. . . ." In this study, CBO looked at both the impact of tort reform on both overall health care spending per capita and Medicare spending per beneficiary. It found that while eliminating joint and several liability increased per capita health care spending, the impact of the package of tort reforms would be "near zero." As to the impact on Medicare spending per beneficiary, CBO found that while "[i]mposing a cap on non-economic damages is associated with reductions . . . the estimated effect of that tort limit falls and become statistically insignificant when controls are added that capture the effects of the implementation of Medicare's prospective payment system (PPS) for hospitals."  

During the recent health care reform debate, the CBO estimated, in response to a request from Senator Orrin Hatch (R-UT), that federal enactment of traditional malpractice reform measures (cap on non-economic damages of $250,000; cap on punitive damages of $500,000 or 2x economic damages; collateral source rule modification; shortened statute of limitations; and replacement of joint and several liability) would reduce medical liability insurance premiums by 10 percent. It further estimated that direct costs incurred by providers for medical liability (including premiums as well as settlements, awards, and administrative costs not covered by insurance) would be $35 billion in 2009, amounting to "2 percent of total health care expenditures."  

It thus concludes that "lowering premiums for medical liability insurance by 10 percent would reduce total national health care expenditures by 0.2 percent."  

In contrast with its earlier reluctance to provide an estimate of significant health care savings flowing from tort reforms due to reductions in defensive medicine, CBO estimated that federal enactment of traditional tort reforms would result in "an additional indirect reduction of 0.3 percent from slightly less utilization of health care services." CBO did, however, note one anomaly in the research: while physicians may reduce the volume and intensity of services in re-
sponse to damages caps, they might increase volume and intensity in response to reform of joint and several liability reforms.\footnote{Id. at 3.}

In terms of total health care spending, CBO found that federal enactment of traditional tort reforms "would reduce total national health care spending by about 0.5 percent (about $11 billion in 2009)."\footnote{Id.} As to the impact on the federal budget, CBO found: "enactment of such a package of proposals would reduce mandatory spending for Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits program by roughly $41 billion over the next ten years. . . ."\footnote{Id. at 4.}

CBO also found a potential positive impact on federal tax revenues in the amount of $13 billion over the next ten years that would result from a reduction in tax-sheltered health care spending and a shift to taxable compensation.\footnote{Id. at 5.} Thus CBO estimated that the federal enactment of a package of traditional tort reforms would reduce the federal budget deficit by about $54 billion during 2010–2019.

After publication of CBO's letter to Senator Hatch, Senator Rockefeller submitted some follow-up questions to CBO concerning "how recent empirical analysis affected CBO's analysis, why CBO's latest estimates of the budgetary effects of tort reform are larger than . . . previous estimates, and whether tort reform would have a negative impact on patients' health."\footnote{Rockefeller Letter, supra note 6.} In response, CBO noted that while earlier studies did not provide adequate support for the hypothesis that tort reform will reduce health care utilization, more recent studies did provide sufficient support.\footnote{Id. at 2.}

In the letter to Senator Rockefeller, CBO noted that it had increased its estimate of the effect of tort reform on lowering malpractice costs ("malpractice insurance premiums, and settlements, awards and administrative costs not covered by insurance") from 6 percent to 10 percent.\footnote{Id.} It stated that its estimate of savings from tort reform "now incorporate a slight reduction in the utilization of health care attributable to changes in the practice patterns of providers."\footnote{Id. at 4.}

As noted supra, CBO has estimated that significant savings could be realized in the Medicare program from the enactment of a federal damages cap because of reductions in defensive medicine. In making
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this estimate, however, it does not appear that CBO took into account the impact of ACA’s changes to the Medicare program. One major purpose of the health care reform legislation is to transition Medicare from a traditional fee-for-service program to a quality-based reimbursement system that rewards efficiency.

There are several provisions in the health care legislation that are intended to encourage development of new models of health care delivery (e.g., accountable care organizations). There is funding for comparative effectiveness research that presages a greater emphasis on evidence-based medicine. There are also programs to encourage the development of new payment methods (e.g., payment bundling).

Some studies that have looked at defensive medicine have concluded that managed care is a substitute for tort reform, and that defensive medicine can be reduced either by tort reform measures or by the use of managed care techniques to limit utilization. Indeed, Avraham et al. (2009), a study relied on by CBO, found that defensive medicine was reduced in PPOs rather than HMOs by the enactment of damages caps and collateral source modification. The CBO projected larger effects of federal tort reform on Medicare expenditures owing to its reliance on fee-for-service reimbursement. The Medicare program, with its traditional fee-for-service methodology, has largely been free of controls on utilization. Thus it seems that CBO, in estimating the potential impact of a federal damages cap, should have also considered the potential impact on utilization arising from the transition away from a fee-for-service approach in Medicare.

CBO also responded to an inquiry from Rep. Bruce L. Braley (D-IA) about its letter to Senator Hatch. In its letter to Rep. Braley, CBO commented on the effects of tort reform on medical liability insurance premiums and health care spending. As to the impact on medical liability insurance premiums, CBO again cited several recent studies as well as their own analysis finding that tort reform low-

280 Id. § 6301, 124 Stat. at 727.
281 Id. §3023, 124 Stat. at 399.
283 Rockefeller Letter, supra note 6, at 2.
284 Braley Letter, supra note 7.
ers medical liability insurance premiums. It notes that these recent studies “are the best ones for identifying the effects of tort reform on malpractice insurance premiums because they use data for many states and control for the relevant characteristics of states’ health care markets that may affect malpractice premiums.”

As to the impact of traditional tort reforms on health care spending, CBO reiterated that it “concluded that the weight of empirical evidence now demonstrates a link between tort reform and the use of health care services.” Noting that, at the time of its 2006 study, it had concluded that “there was not sufficient evidence to incorporate in its budget estimates an effect of tort reform on health care utilization . . . [m]ore-recent studies have provided further support for the hypothesis that tort reform would slightly reduce the use of health care . . .” But CBO also acknowledged that “estimates of the budgetary effects of tort reform are unavoidably uncertain . . . [and accordingly] the agency consistently strives to produce estimates that lie in the middle of the distribution of plausible outcomes based upon available knowledge.”

In concluding that tort reform will reduce health care utilization and costs, the CBO primarily relied on four studies: Lakdawalla & Seabury (2009), Avraham et al. (2009), Sloan & Shadle (2009), and Baicker et al. (2007).

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286 Cong. Budget Office, supra note 173.
287 Braley Letter, supra note 7, at 3.
288 Id. at 4.
289 Id. at 5.
290 Id. at 4.
292 Avraham et al., supra note 282.
293 Sloan & Shadle, supra note 172.
294 Katherine Baicker et al., Malpractice Liability Costs and the Practice of Medicine in the Medicare Program, 26 Health Aff. 841 (2007).
Table 2
Studies Relied Upon by CBO

Lakdawalla & Seabury (2009)

- Malpractice measured as jury verdict data 1985-1999 from 2 states and 4 cities.
- Hospital and county fixed effects regressions with alternative lagged jury awards as the independent variable
- Analogous modeling of county death rates.

Findings:
- 10% higher noneconomic damage awards associated with 0.2 to 0.8% higher hospital costs, 0.8 to 1.2% higher Medicare Part A spending and 0.3 to 0.6% higher Part B spending.
- “In absolute terms, this is rather a modest effect...” (page 21) but does suggest a reduction in defensive medicine.
- Doubling malpractice costs associated with a 2% reduction in total death rate; the effect was large for those <65.
- While “malpractice liability leads to modest reductions in patient mortality; the value of these more than likely exceeds the cost impacts of malpractice liability.”
- “Policies that reduce expected malpractice costs are unlikely to have a major impact on health care spending for the average patient and are also unlikely to be cost effective...”
- “on balance, reducing malpractice costs is more likely to harm than improve social welfare.”

Avraham, Dafny & Schanzenbach (2009)

- 1998 – 2006 data from 813 employers contained in a data maintained by a large unnamed benefits consulting firm.
- Malpractice reforms measured by Northwestern University compendium.
- Separate analyses for self-insured and purchased plans.
- Models use plan and year fixed effects.

Findings:
- Caps on non-economic damages, collateral source reform, and joint and several liability reduce self-insured ESHI premiums by 1 to 2 percent each
- Caps on punitive damages reduce premiums by 2 to 3% but caps on non-economic damages increase premiums for purchased plans.
- Premium reductions among self-insured plans driven by PPOs.
Sloan & Shadle (2009)

- 1985-2000 National Long Term Care Survey linked to Medicare claims data for 38,566 beneficiaries
- Examine Medicare expenditures: total, inpatient and ambulatory, as well as spending for AMI, stroke, breast cancer and diabetes.
- Examine one year survival rates.
- Include state and year fixed effects and patient level measures of health status.

Findings:

- Direct reforms (caps, abolition of pds, elimination of pre-judgment interest, collateral source offset) do not significantly reduce payments for Medicare-covered services. Do find that AMI expenditures are 17% lower and almost statistically significant. No effects on other measures of spending.
- Indirect reforms (limitations on contingency fees, mandatory periodic payout, joint and several liability reform, and PCFs) reduced Medicare payments for any hospitalization by 9.4% but had no effects on any clinical category of costs.
- The reforms had no statistically meaningful effects of survival.
- "assertions that tort reforms will reduce [the] waste of scarce resources seems, at best, highly premature."

Baicker, Fisher & Chandra (2007)

- Examine level and growth in mean dollar value of (1) Medicare expenditures per beneficiary, (2) per beneficiary spending for major components of care, (3) rates of use of specific physician services.
- Malpractice payments reported in the National Practitioner Data Bank, and malpractice premiums from Medical Liability Monitor.
- Two time periods, but no trend data.
- State variables but no fixed effects.

Findings:

- No statistically significant effect on total spending.
- 10 percent increase in average malpractice payments per physician within a state was associated with a 1.0 percent increase in Medicare Part B services, a 1.0 percent increase in "minor procedures," and a 2.2 percent increase in the imaging component of these services.
- The average 60% increase in average malpractice premiums between 2000 and 2003 is associated with an increase of Medicare spending of about $16.5 billion.

295 Sloan & Shadle, supra note 172, at 490.
The CBO conclusion, however, appears to be over-reaching. Consider each study in turn. The Lakdawalla & Seabury (2009) study does find that higher malpractice payouts are associated with greater hospital and Medicare spending. However, they also find that the higher payouts are associated with lower mortality. Thus, the cost savings are not an unmixed blessing. Indeed, the authors conclude that "... on balance, reducing malpractice costs is more likely to harm than improve social welfare." Other than in the very narrow sense of health care spending, it seems a bit of an oversimplification to add this study to the "reduces costs" column.

As discussed supra, the Sloan & Shadle (2009) study revisits and expands upon the classic work by Kessler & McClellan (1996). In essence, Sloan & Shadle confirm the Kessler & McClellan results as they relate to direct malpractice reforms on Medicare expenditures for heart disease. However, they did not find analogous results for stroke, breast cancer, or diabetes, nor did they find an overall effect on Medicare Part A and Part B spending. Thus, they must be interpreted as finding modest and non-generalizable results of tort reform.

The Avraham et al. (2009) study examines the effects of malpractice reform laws on the premiums paid by large employers. They find that non-economic damage caps, together with collateral source and joint and several liability reforms each reduced premiums by 1 to 2 percent. Although they observed similar effects for self-insured and purchased plans, their results were statistically significant only for self-insured plans. The reforms had similarly sized effects on purchased plans, but the level of statistical confidence in these estimates was such that they may be due to chance. Thus, the results are applicable only to self-insured plans offered by large employers.

Moreover, the self-insured result in Avraham et al. (2009) was driven entirely by preferred provider organization (PPO) type plans. Morrisey (2007) reports that nearly 70 percent of workers in PPOs are in self-insured plans and that 60 percent of workers are in PPOs. This suggests that a 2 percent premium savings would apply, at most, to approximately 42 percent of workers. Even this is an overstatement in as much as Avraham et al. (2009) were unable to examine the effects of tort reform on plans offered by small employers. Because such plans tend not to be self-insured, the effect on small employers would likely be much smaller than that found for large self-insured plans. Indeed, their focus on large self-insured employers may explain why their results differ from Morrisey et al. (2008), a study that found

\[296\] Michael A. Morrisey, Health Insurance 70 (2008).
\[297\] Id. at 16.
no effect of malpractice reforms on employer health insurance premiums, but included small as well as large employers and did not make distinctions between self-insured and purchased plans. 298

Finally, the Baicker et al. (2007) study finds that a 10 percent increase in average malpractice settlement payments per physician was associated with a 1.0 percent increase in Medicare Part B spending, with analogous increases in “minor procedures” and, particularly, increases in imaging procedures. This is suggestive of defensive medicine and has the advantage of examining physician out-of-hospital behaviors, which have been identified in physician surveys as prime examples of defensive medicine. However, in many ways, this is the weakest of the four new studies. It focused exclusively on two short time windows, 1991–93 and 1999–2001, rather than the fifteen years of trend data employed in the other new studies. Under this methodology, the effects of other intervening factors may be inappropriately attributed to the malpractice environment. With this approach the authors are unable to use the fixed effects statistical techniques used by the other studies. Baicker and colleagues argue that a fixed effects approach may absorb variation that is rightly attributable to the malpractice reforms. If so, the fixed effects models will underestimate the true effects. On the other hand, failure to adequately control for other factors, which fixed effects purports to do, can lead to over-estimates of the true effect. Thus, while fixed-effects estimates may understate the effects of malpractice reforms, Baicker and her colleagues may have over-estimated the magnitude of the effects.

In short, the new studies greatly add to our knowledge of the existence and magnitude of defensive medicine in response to medical malpractice fears. However, they don’t move us very much in drawing a simple conclusion about the overall effect of defensive medicine on the costs of medical care. Yes, there is now more and better evidence that defensive medicine exists. But there is also more and better evidence that malpractice reforms have at best a small and limited impact on health care costs.

VI. THE IMPACT OF MEDICAL LIABILITY REFORM ON ACCESS

While health care reform will provide insurance coverage for millions of persons, it could also exacerbate the shortage of primary care

physicians. While shortages could be alleviated by expanding training programs and the roles of physician extenders such as nurse practitioners, it is likely that access to health care services will be compromised. Tort reformers have contended that liability pressure puts further strain on physician supply. Based on currently available studies, medical liability reforms appear to have modest effects on enhancing physician supply, reducing avoidance behavior by physicians, and increasing access to certain types of care.

A 2003 study by Hellinger & Encinosa (2003) found that states with damages caps had 12 percent more physicians than states without caps, and that states with relatively higher caps were less likely to have more physicians than states with lower caps. This study has been criticized, however, because it did not control for other factors that could have differed across states and influence physician supply. Encinosa & Hellinger (2005) found that counties in states with damages caps had 2.2 percent more physicians than states without caps and rural counties in states with caps had 3.2 percent more physicians than similar counties in states without damages caps. This study used a fixed effects model that reduced the influence of other factors on their findings.

Kessler et al. (2005) found direct reforms including caps on non-economic damages increased physician supply by 3.3% after controlling for state differences. Matsa (2007) found that most residents of states were not affected by improved physician supply as a result of reforms, but that caps did increase the number of specialists in more isolated rural areas by 10–12 percent. He concluded that reform had
an impact on supply in the most rural areas because these physicians faced higher uninsured costs and greater elasticity in demand for medical services.\textsuperscript{307} He predicted that the adoption of a national cap would result in an increase of 13 percent more specialist physicians in the most rural areas.\textsuperscript{308}

Texas is often advanced as an example of the beneficent effects on damages caps of physician supply. In 2003, Texas adopted a $250,000 per claimant cap on non-economic damages in malpractice actions against physicians.\textsuperscript{309} By 2006, there had been a significant increase in the numbers of physicians moving to Texas from other jurisdictions.\textsuperscript{310} Nonetheless, trial lawyers still claim that the situation has not improved in rural areas in Texas.\textsuperscript{311} Even after the adoption of the cap, the Texas Department of State Health Services noted a continuing problem with the supply of primary care physicians in rural areas.\textsuperscript{312}

Arguably, malpractice reform could also reduce avoidance behavior and increase access to certain types of care. In the first national study on the effects of malpractice premiums on prenatal care, Dubay et al. (2001) found that a decrease in malpractice premiums due to tort reform was associated with a 3 to 5.9% reduction in the late initiation of prenatal care for black women and a 2.2 to 4.7% reduction for white women.\textsuperscript{313} Dranove & Gron (2005), using data from Florida between 2000 and 2003, a time when it was designated a malpractice crisis state by the AMA because of spikes in premium levels, found increased travel times for patients undergoing craniotomies, but not

\textsuperscript{307} Id. at 177.
\textsuperscript{308} Id.
\textsuperscript{309} TEX. CIV. PRAC. & REM. § 74.301 (West 2010).
\textsuperscript{310} John Donnelly, Malpractice Curbs Hailed, Faulted: Texas Law Draws Doctors, Frustrates Some Claimants, BOS. GLOBE (Nov. 26, 2007), http://www.boston.com/news/nation/articles/2007/11/26/malpractice_curbs_hailed_fa ulted/. The article states: “The Texas Medical Board received around 2,400 license applications a year before 2003, when voters passed Proposition 12, the ballot initiative limiting malpractice awards. In fiscal years 2006 and 2007, the board received slightly more than 4,000 applications each year.” Id.
\textsuperscript{313} Lisa Dubay et al., Medical Malpractice Liability and Its Effect on Prenatal Care Utilization and Infant Health, 20 J. HEALTH ECON. 591, 591, 605 (2001).
for women undergoing high-risk deliveries. They also found decreased activity levels for high volume neurosurgeons, and increased exit of low volume obstetricians.

VII. THE IMPACT OF MEDICAL LIABILITY REFORM ON PATIENT SAFETY

Traditional tort reforms were not designed to enhance patient safety. Instead, they were adopted to ensure access to liability insurance for providers and protect them from the volatility of the medical liability insurance market. Intuitively, it seems that medical liability reforms could undermine the deterrent effect of tort law and endanger patients. But the effect, if any, of medical liability reforms on patient safety at the hospital level is uncertain at this time.

It has been generally acknowledged that the design of effective systems to enhance patient safety requires that providers candidly acknowledge their errors and learn from their mistakes. Nevertheless, it has been argued that the fear of litigation by providers could impede the collection of the information necessary for improving patient safety. In the late 1990s, as part of its accreditation standards, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) adopted its sentinel event policy to encourage reporting of errors by hospitals so that information could be shared to facilitate improvements in patient safety, but there was resistance to reporting from providers based on a lingering concern that the information reported could end up being subject to discovery by plaintiffs' attorneys.

In response to these concerns, the Patient Safety and Quality Improvement Act of 2005 created Patient Safety Organizations to collect and analyze confidential patient safety data from health care provid-

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315 Id.


ers. It also created a federal legal privilege restricting access in civil and criminal proceedings to this information. But Hyman and Silver (2005) found that no "rigorous evidence show[s] that fear of malpractice lawsuits discourages error reporting. . ." They further argued that damages could undermine incentives for preventing errors. Moreover, there seems to be increased receptivity to the disclosure of harmful medical errors to patients in the belief that disclosure will actually reduce the number of malpractice claims.

In the 1970s, medical malpractice was thought by many to be an infrequent phenomenon and the professionalism of physicians guaranteed a high quality of health care. It is now clear though that there is a large pool of unintentional injuries experienced by patients as result of receiving medical treatment, and a significant portion of these injuries result from negligence. There have been three major studies in the United States on the rates of negligent injuries. A 1974 study of a representative sample of patient admission records in selected California hospitals found injuries from adverse events occurred in 4.6 percent of admissions, and 17 percent of these adverse events were caused by negligence. The Harvard Malpractice Study of New York hospital records for 1984 found injuries from adverse events in 3.7 percent of admissions, and 27.6 percent of these injuries were caused by negligence including a larger proportion of the more severe injuries. The Utah and Colorado Medical Malpractice Study (UTCOS) reviewed hospital discharge records for 1992 and found an injury rate of 2.9 %, and 32.6 percent of these injuries in Utah and 27.4 percent in Colorado were caused by negligence.

321 Id. at 989.
322 See Thomas H. Gallagher et al., Disclosing Harmful Medical Errors to Patients, 356 NEW ENG. J. MED. 2713 (2007).
325 DANZON, supra note 43, at 20.
326 Id.
327 Brennan et al., supra note 32, at 370.
328 Id.
329 Eric J. Thomas et al., Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado, 38 MED. CARE 261, 262 (2000).
330 Id. at 265.
While there are pockets of high quality health care available in the United States, the quality of care actually received by most Americans is less than optimal. In a 2001 report, the Institute of Medicine found significant shortcomings in the quality of health care received by many Americans, particularly those suffering from chronic conditions, and called for a restructuring of the health care system. The report noted: “During the last decade alone, more than 70 publications in leading peer-reviewed journals have documented serious quality shortcomings.” One important aspect of quality care is patient safety, but the link between the medical liability climate and patient safety is somewhat murky. A Rand Corporation study found that adults received only about half of the recommended care for various acute and chronic care conditions as well as preventive care. Of the twelve communities studied, the RAND study found that the highest quality health care was being delivered in Seattle, Washington, located in a state identified at that time by the AMA as a malpractice crisis state. It also found health care quality higher in communities in six crisis states than in California and Indiana, two states with damages caps in place since 1975 that were not identified as crisis states.

On the other hand, Mello et al. (2004) surveyed Pennsylvania physicians in high-liability risk specialties finding that physician angst about medical liability issues could have an impact on the interpersonal quality of care. This study reported that “specialists who felt heavily financially burdened by malpractice insurance costs were least likely to report satisfaction with their practice.” Some survey respondents indicated liability concerns had eroded their clinical autonomy and attributed their reduced ability to provide quality care to their patients to the increased volume of patients and reductions in administrative support as necessitated by the increasing cost of medical liability insurance.

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332 Id. at 3.
333 Eve A. Kerr et al., Profiling the Quality of Care In Twelve Communities: Results From the CQI Study, 23 Health Aff. 247, 247 (2004); Elizabeth A. McGlynn et al., The Quality of Health Care Delivered to Adults in the United States, 348 New Eng. J. Med. 2635, 2641 (2003).
335 Kerr et al., supra note 333, at 251; AMA and Consumer Group Debate Tort Reform Efforts, supra note 334, at 81.
336 Michelle M. Mello et al., Caring For Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care, 23 Health Aff. 42 (2004)
337 Id. at 48.
338 Id. at 49-51.
While avoiding the controversy over malpractice reform, a series of reports from the Institute of Medicine (IOM) have highlighted the problems of patient safety and quality. To Err is Human: Building a Safer Health Care System (2000), the landmark report issued by the Institute of Medicine (IOM), estimated there were between 44,000 and 98,000 hospital patient deaths annually due to preventable adverse events. IOM (2002) called for federally-funded state-level medical liability demonstration projects focused on patient safety. It recommended two options for participating states: (1) a provider-based early offer of settlement coupled with federal reinsurance and state-enacted caps on non-economic damages “for identifiable classes of avoidable injuries,” and (2) state administrative systems for claims resolution that would grant immunity to providers from tort liability in exchange for their participation.

IOM (2004) also recommended: (1) the creation of a national health information system, (2) the establishment of comprehensive patient safety programs in all health care settings operated by trained personnel in a culture of patient safety that would focus on analysis of adverse events and near misses, and (3) an improved system for reporting medical errors. It opined that “patient safety is indistinguishable from the quality of care” and called for the creation of a new health care delivery system “that is capable of preventing errors from occurring in the first place, while at the same time incorporating lessons learned from any errors that do occur.”

IOM (2007) found that hospital patients were subject to an average of one medication error each day with a significant variation in error rates across facilities. The report also found that there were annually at least 1.5 million “adverse drug events” (ADEs)—serious


343 Id. at 5.

medication errors—in nursing homes, outpatient settings, and hospitals excluding failure to prescribe medically indicated drugs.\textsuperscript{345}

A number of public and private patient safety initiatives followed the release of \textit{To Err is Human}.\textsuperscript{346} The Leapfrog Group, an employer consortium, developed patient safety initiatives (“three leaps”): “Computerized Prescriber Order Entry,” “ICU Physician Staffing,” and “Evidence Based Hospital Referrals” (limiting referrals only to hospitals that meet certain volume criteria).\textsuperscript{347} In 2002, JCAHO established the National Patient Safety Goals Program “to help accredited organizations address specific areas of concern in regards to patient safety.”\textsuperscript{348} Also in 2002, JCAHO, together with the Center for Medicare and Medicaid Services (CMS), launched the Speakup Program, “a national program to urge patients to take a role in preventing health care errors by becoming active, involved and informed participants on the health care team . . .”\textsuperscript{349} In 2003, JCAHO adopted the “Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery.”\textsuperscript{350}

In 2002, in reaction to increasing concerns about patient safety, the Agency for Healthcare Research and Quality (AHRQ) developed a list of twelve Patient Safety Indicators (PSIs).\textsuperscript{351} The definition of patient safety used by AHRQ, borrowed from \textit{To Err is Human}, was: “freedom from accidental injury caused by medical care, which translates to medical errors.”\textsuperscript{352} The initial twelve PSIs focused on events with a high likelihood of being caused by a medical error, such as foreign objects left in the body.\textsuperscript{353} The list was later expanded to twenty PSIs that focused “on potentially preventable instances of

\begin{itemize}
\item \textsuperscript{345} \textit{Id.} at 4-5.
\item \textsuperscript{346} Drew E. Altman et al., \textit{Improving Patient Safety—Five Years after the IOM Report}, 351 NEW ENGL. J. MED. 2041, 2041 (2004).
\item \textsuperscript{348} \textit{Facts About Patient Safety}, THE JOINT COMM’N (Jan. 18, 2011), http://www.jointcommission.org/assets/1/18/Patient_Safety_1_14_11.pdf.
\item \textsuperscript{349} \textit{Id.}
\item \textsuperscript{350} \textit{Id.}
\item \textsuperscript{351} Marlene R. Miller et al., \textit{Patient Safety Indicators: Using Administrative Data to Identify Potential Patient Safety Concerns}, 36 HEALTH SERV. RES. 110, 121 (2001).
\item \textsuperscript{352} \textit{Id.} at 112.
\item \textsuperscript{353} Patrick S. Romano et al., \textit{A National Profile of Patient Safety in U.S. Hospitals}, 22 HEALTH AFF. 154, 154 (2003).
\end{itemize}
harm to patients, such as surgical complications and other iatrogenic events.”

These twenty PSIs were defined as “measures that screen for potential problems that patients experience resulting from exposure to the health care system, and that are likely amenable to prevention by changes at the level of the system.”

PSIs relate to “inpatient care, and the adverse events that have either a high likelihood or at least a reasonable possibility of being iatrogenic.”

Using PSIs, Romano et al. (2003) found that in 2000, 1.12 million potential patient safety events occurred in nonfederal acute care hospitals. They also found, however, that the incidence of most PSIs had declined since 1995 “with the notable exception of postoperative medical complications, decubitus ulcer, and infection due to medical care.”

Although originally intended for use as quality improvement tools and screening mechanisms, PSIs have increasingly been used for public reporting to compare hospitals and pay-for-performance rewards for hospitals with high levels of safety. Rivard et al. (2006) found that PSIs could be a useful quality improvement tool at the organizational level when used with other data to make system changes to improve patient safety. Isaac & Jha (2008), however, found poor or inverse relationships between PSIs and other quality measures thereby suggesting a need for further validation.

Romano et al. (2009) examined the criterion validity of selected surgical PSIs using clinical data from V.A. hospitals. They found moderate sensitivities and high specificity, but concluded that there should be further validity

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355 ld.
356 ld. at 2.
357 Romano et al., supra note 353, at 157.
358 ld. at 163.
359 Patrick S. Romano et al., Validity of Selected AHRQ Patient Safety Indicators Based on VA National Surgical Quality Improvement Program Data, 44 HEALTH SERV. RES. 182, 183 (2009).
362 Romano et al., supra note 359.
testing before most of the PSIs are used to publicly compare hospitals.\textsuperscript{363}

Health care providers should have strong incentives to make investments in improved patient safety. As noted, supra, Rand (2010) found that reductions in the number of PSIs resulted in a decline in medical malpractice claims.\textsuperscript{364} In addition, significant savings to the health care system could result from a decrease in the rate of preventable injuries. IOM (2000) estimated the annual costs of preventable medical errors at $17 to 29 billion annually.\textsuperscript{365} The Leapfrog Group (2004) estimated that universal adoption of its “three leaps” could result in a substantial number of injuries prevented and lives saved.\textsuperscript{366} Zhan & Miller (2003) “use[d] the PSIs and administrative data to assess excess length of stay (LOS), charges, and deaths attributable to medical injuries during hospitalization” in 994 acute-care hospitals in twenty-eight states for 2000.\textsuperscript{367} They found that, for the types of medical injuries studied, preventable errors may result in $4.6 billion in excess national health care costs annually.\textsuperscript{368} IOM (2007) noted: “Assuming conservatively an annual incidence of 400,000 in-hospital preventable ADEs, each incurring extra hospital costs of $5,857, yields an annual cost of $2.3 billion in 1993 dollars or $3.5 billion in 2006 dollars.”\textsuperscript{369} At least 25\% of these ADEs were preventable, according to IOM (2007).\textsuperscript{370} Milliman (2010), a study commissioned by the Society of Health Care Actuaries, found that the costs of medical errors for 2008 were $19.5 billion.\textsuperscript{371} In addition, these errors resulted in 2,500 excess deaths and 10 million excess missed workdays.

Patient safety advocates have tried to make the case that hospitals should view patient safety activities that reduce health care costs and medical liability exposure as a cost effective strategy. But Mello et al.

\begin{footnotes}
\item[\textsuperscript{363}] Id. at 199.
\item[\textsuperscript{364}] GREENBERG ET AL., supra note 160.
\item[\textsuperscript{365}] INST. OF MED., supra note 340, at 27.
\item[\textsuperscript{367}] Chunlui Zhan & Marlene R. Miller, Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization, 290 JAMA 1868, 1869 (2003).
\item[\textsuperscript{368}] Id. at 1872.
\item[\textsuperscript{369}] COMM. ON IDENTIFYING & PREVENTING MEDICATION ERRORS, supra note 344, at 5.
\item[\textsuperscript{370}] Id. at 6.
\end{footnotes}
using records from hospitals in Utah and Colorado found that, on average, hospitals were able to externalize “78 percent of the costs of all injuries, and 70 percent of the costs of negligent injuries . . . .”\textsuperscript{373} They further concluded that the deterrent effects of tort law were undermined by the relatively small number of negligently injured patients that were compensated for their injuries.\textsuperscript{374}

Will the passage of traditional malpractice reform legislation further dilute the incentives for providers to invest in patient safety improvements? Commentators have noted the weakness of deterrence in the current medical liability system.\textsuperscript{375} And it has been argued that traditional tort reforms could further weaken deterrence thereby increasing injuries related to medical errors. But in its response to Senator Hatch, the CBO noted that “[t]here is less evidence of the effect of tort reform on people’s health . . . than about its effects on health care spending—because many studies of malpractice costs do not examine health outcomes.”\textsuperscript{376} It further noted that the evidence of recent studies was mixed: Lakdawalla & Seabury (2009) found that a 10 percent reduction in medical malpractice costs would result in an increased overall mortality rate of 0.2 percent while Kessler & McClellan (1996 and 2002) and Sloan & Shadle (2009) found “no significant adverse outcomes for patients’ health.”\textsuperscript{377} Klick & Stratmann (2003) found that collateral source reform resulted in a statistically significant increase in infant mortality rates.\textsuperscript{378} Shepherd (2008) found that caps on non-economic damages and punitive damages were associated with decreases in accidental death rates, while caps on total damages and collateral source reforms were associated with increases in the rate of accidental death.\textsuperscript{379}

In a follow-up letter to Senator Rockefeller, CBO noted that these mixed results may be due to the “complicated relationship between malpractice claims and medical errors.”\textsuperscript{380} In this regard it noted the findings of the Harvard Medical Practice Study that a majority of hos-

\textsuperscript{374} \textit{Id.} at 853.
\textsuperscript{375} Mello & Brennan, supra note 339, at 1615-16.
\textsuperscript{376} Hatch Letter, supra note 5.
\textsuperscript{377} \textit{Id.}
\textsuperscript{380} Rockefeller Letter, supra note 6, at 6.
hospital patients who suffered negligently-caused injuries never filed
claims, while a substantial portion of filed claims did not stem from
negligently inflicted injuries.\(^{381}\) And in a subsequent letter to Repre-
sentative Braley, CBO noted: “the limited evidence currently availa-
ble about the effects of tort reform on health outcomes is much more
mixed than the larger collection of evidence currently available about
the effects of tort reform on health care spending.”\(^{382}\) Thus the effect,
if any, of the enactment of malpractice reform legislation on the rate
of PSIs at the hospital level is unknown at this time. Clearly, this is an
area where more research is needed.

**VIII. ALTERNATIVE MEDICAL LIABILITY REFORM PROPOSALS**

The AMA has supported federal funding for state demonstration
projects to test alternative approaches to malpractice reform.\(^ {383}\)

During a June 15, 2009, speech to the AMA, the audience cheered
President Obama’s statement that medical liability reform should be
included in health care reform, but roundly booed his statement that
he did not support damages caps.\(^ {384}\) Nonetheless, the outgoing Presi-
dent of the AMA announced she was “thrilled” that the President was
willing to talk to the group about including medical liability reform in
health care reform.\(^ {385}\) She was probably heartened by the President’s
acknowledgment that defensive medicine has contributed to the high
cost of health care.\(^ {386}\) President Obama’s statement supporting med-
cal liability reform at the AMA convention was undoubtedly motivat-
ed in part by a desire to defuse physician opposition to his health care
reform efforts.\(^ {387}\)

\(^{381}\) Id.

\(^{382}\) Braley Letter, supra note 7, at 3.

\(^{383}\) Health System Reform Insight, AM. MED. ASS’N (Jun. 24, 2010),
http://www.ama-assn.org/ama/pub/health-system-reform/resources/insight/june-

\(^{384}\) Carrie Budoff Brown, Obama Talks Up Liability Reform, POLITICO (June

\(^{385}\) Id.

\(^{386}\) Text of Obama’s Speech to the AMA, WALL ST. J. HEALTH BLOG (June
before-the-ama/.

\(^{387}\) Alex Nussbaum, Malpractice Lawsuits are “Red Herring” in Obama
Plan, BLOOMBERG (June 16, 2009),
to Chandra et al., supra note 18).
While President Obama has not supported a federal cap on damages,\textsuperscript{388} he has supported alternative tort reform measures. In a meeting with the incoming President of the AMA and a series of meetings with Senate Democrats in the spring of 2009, President Obama indicated his interest in legislation that would create a safe harbor for doctors that follow evidence-based professional practice guidelines.\textsuperscript{389} In 2006, he also co-sponsored legislation with Hillary Clinton that would have encouraged health care providers to report medical errors, disclose them to patients, provide an apology, and agree to negotiate compensation while preserving a patient’s right to sue.\textsuperscript{390} Although it has not yet been established that disclosure-and-offer programs and safe harbors for adherence to evidence-based guidelines will reduce medical liability insurance costs,\textsuperscript{391} the AMA has supported both of these reform proposals.\textsuperscript{392}

President Obama later announced that he was directing the Secretary of Health and Human Services to move forward on funding medical liability demonstration projects in the states during a September 9, 2009, address to Congress.\textsuperscript{393} The House Bill included a provision that excluded certain guidelines developed under the legislation from being used to establish the standard of care in malpractice actions, coupled with a savings clause for state malpractice actions.\textsuperscript{394} It also included an incentive payment program for states to adopt effective alternatives to the current medical liability system, but further provid-

\begin{footnotes}
\item[391] Mello & Brennan, supra note 2, at 2-3.
\item[392] Letter from AMA and other Groups to President Barack Obama (June 1, 2009), available at http://www.ama-assn.org/ama/pub/upload/mm/31/stakeholders-to-obama.pdf. An addendum to the letter from the AMA states:

Physicians who adhere to evidenced based best practice guidelines are not protected from lawsuits in our current liability system. Congress needs to enact liability protections for physicians who adhere to best practice guidelines and fund state demonstration projects to test alternative reforms such as health courts, administrative compensation systems and early offer initiatives.

\textit{Id.}
\item[394] Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 261 (2009).
\end{footnotes}
ed that those incentive payments were not available for states that cap damages.\textsuperscript{395}

The ACA includes a "Sense of the Senate" that "States should be encouraged to develop and test alternatives to the existing civil litigation system . . . while preserving an individual's right to seek redress in court. . . ."\textsuperscript{396} It also provides funding for state demonstration projects of "alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers. . . ."\textsuperscript{397}

Physician groups have supported alternative reforms as add-ons to damages caps. While it has continued to advocate for MICRA-style reforms, the AMA has recognized that alternative reforms such as health courts, use of court-appointed expert witnesses, restrictions on expert witnesses hired by parties, and health claim ombudsman/pre-trial screening panels could be a valuable add-on to a damages cap.\textsuperscript{398} James Rohack, the President of the AMA, recently praised federal funding for alternative malpractice demonstration projects under the ACA.\textsuperscript{399}

In 1988, the AMA/Specialty Society Medical Liability Project, a coalition composed of the AMA and thirty-one specialty societies, proposed that states adopt legislation authorizing a new state agency or a revamped medical disciplinary board to establish a fault-based administrative compensation scheme that would replace the current tort system.\textsuperscript{400} The proponents of the fault-based administrative system argued that "[t]he current tort system precludes many patients with relatively small damage claims from receiving any compensation for injuries caused by medical negligence."\textsuperscript{401} They noted that victims of malpractice do not receive equal treatment in cases where compensation was provided; some victims were overcompensated and others

\textsuperscript{395} Id. at § 2531(a)(4)(B).
\textsuperscript{397} Id. at § 10607.
\textsuperscript{400} Kirk B. Johnson et al., A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims, 42 VAND. L. REV. 1365 (1989).
\textsuperscript{401} Id. at 1367.
were undercompensated.\textsuperscript{402} They argued that reliance on juries is an inefficient and unreliable method for deciding malpractice cases.\textsuperscript{403}

Under the fault-based administrative system proposal, malpractice claims were to be decided through an "administrative adjudicatory process."\textsuperscript{404} An attorney was to be provided at state expense for those whose claims were deemed meritorious after an initial review process.\textsuperscript{405} The proposal also included such traditional tort reform measures as a cap on non-economic damages, collateral source rule modification, and the periodic payout of future damages. It proposed a liberalized fault standard (the reasonable prudent physician standard rather than the state’s customary standard). Yet the standard could have easily evolved into a no-fault system because the state agency was to be given rulemaking authority to include, after a five-year moratorium, the authority to promulgate more specific liability guidelines.\textsuperscript{406} Thus the state agency could adopt a schedule of compensable events (e.g., Accelerated Compensation Events (ACEs))\textsuperscript{407} that would obviate the need for proving fault.

The AMA stopped promoting its fault-based administrative system, probably because of the increasing certitude that its adoption would result in a significant increase in the number of claims.\textsuperscript{408} But some physician groups now support a similar reform: the creation of specialized tribunals known as health or medical courts to adjudicate malpractice claims.\textsuperscript{409}

ACOG has supported proposed legislation in New York State to adopt a no-fault compensation scheme for birth-related neurological injuries that is a variant of schemes adopted in Virginia and Florida.\textsuperscript{410}

\begin{thebibliography}{9}
\bibitem{402} \textit{Id.} at 1367-69.
\bibitem{403} \textit{Id.} at 1370-71.
\bibitem{404} \textit{Id.} at 1379.
\bibitem{405} \textit{Id.} at 1381.
\bibitem{406} \textit{Id.} at 1384-85.
\bibitem{407} See, e.g., Laurence R. Tancredi & Randall R. Bovbjerg, \textit{Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test}, \textit{54 L. & CONTEMP. PROBS.} 147 (1991). ACEs are medically caused injuries that are usually preventable by the exercise of good care. Experts have developed several lists of ACEs. \textit{Id.} at 149. ACEs could be used as the basis for compensating those who have suffered a listed injury "without individualized fault finding." \textit{Id.} at 151.
\bibitem{408} \textsc{Mark A. Hall et al.}, \textit{Medical Liability and Treatment Relationships} 392 (2008).
\bibitem{409} \textit{Id.}
\bibitem{409} \textit{Richard L. Berkowitz et al.}, \textit{A Proposed Model for Managing Cases of Neurologically Impaired Infants}, \textit{113 OBSTETRICS & GYNECOLOGY} 683, 685 (2009). The Virginia and Florida programs are described in Mello, et al., \textit{Adjudicating Severe Birth Injury Claims in Florida: The Experience of a Lanmark Experiment in Personal Injury Compensation}, \textit{34 AM. J. L. & MED.} 493 (2008), as follows:
\end{thebibliography}
This proposal was distinguished from Virginia and Florida versions by its broader scope, the inability to opt-out, and its requirement that negligence be determined and, if found reported, to licensing officials and the National Practitioner Data Bank.\textsuperscript{411} There is also a requirement that de-identified information on cases determined to be caused by negligence be disseminated for teaching purposes.\textsuperscript{412}

The National Medical Association (NMA), a group primarily comprising African American physicians, has also endorsed traditional tort reform measures, noting that: “frivolous lawsuits and skyrocketing malpractice insurance premiums are driving America’s physicians out of business. In the minority community this is likely to translate into an exacerbation of healthcare disparities.”\textsuperscript{413} The NMA has endorsed federal legislation imposing caps on non-economic damages, “reforming the process by which insurance companies set the premiums paid for malpractice insurance coverage,” but it has also called for the adoption of health courts as a solution to these problems.\textsuperscript{414}

There is also great interest in alternative reforms among academic researchers that would connect malpractice reforms with overall health policy concerns and integrate improved patient safety with liability protection.\textsuperscript{415} Baker proposed a “blueprint” for state reforms, “the Patient Protection and Healthcare Responsibility Act,” that includes the following evidence-based reforms: mandatory disclosure of possible “adverse health-care event[s],” incentives for at-fault providers to apologize and offer restitution, a no-fault compensation scheme for “moderate” injuries, and enterprise liability.\textsuperscript{416} Baker has suggest-

These programs carve out a category of adverse events within a defined clinical area (obstetrics and neonatology) that carry a rebuttable presumption of compensability. Compensation is awarded based on the nature of the outcome and a finding that the outcome is causally linked to the birth process (rather than on the basis of a finding or negligence or avoidability). Unless certain conditions are met, patients who experience these events while under the care of providers who participate in the systems must seek compensation through a non-judicial process.

\textit{Id.} at 497.
\textsuperscript{411} Berkowtiz et al., supra note 410, at 685-86.
\textsuperscript{412} \textit{Id.} at 685.
\textsuperscript{413} \textit{Where the NMA Stands, NAT’L MED. ASS’N, http://nmanet.org/index.php?/HealthPol_sub/where_the_nma_stands/} (last visited Feb. 15, 2011).
\textsuperscript{414} \textit{Id.}
\textsuperscript{416} \textit{BAKER, supra note 16, at 157-65.}
ed the following goals for medical liability reformers: "reducing patient injuries, improving the accuracy of medical malpractice claiming, improving patient compensation, and reducing the disruption that the insurance cycle imposes on doctors."\(^{417}\)

Traditional tort reforms have been more focused on reducing liability insurance costs for providers and stabilizing insurance markets rather than deterring negligence and providing fair compensation for the victims of malpractice. Sage (2004) noted the apparent disconnect between traditional medical liability reform proposals such as damages caps and the need to approach medical liability from a health policy perspective.\(^{418}\) He called for states to consider reforms that would speed resolution of claims, shift to a first party from a third party basis, and "link liability risk management with clinical quality improvement at the institutional level."\(^{419}\) He also called for federal support for state demonstration projects that would include federal subsidies for reinsurance and the implementation of an administrative compensation system in the Medicare program to compensate for "avoidable injuries."\(^{420}\)

In addition, a 2004 IOM Report called for experimentation with alternatives to traditional tort reform measures that would both enhance patient safety and stabilize the medical liability insurance market.\(^{421}\) The report called for federal and state support for demonstration projects that would utilize one of two options. Under the first option the federal government would provide reinsurance and technical support for demonstration projects that would require providers to identify avoidable injuries and promptly compensate injured patients for net economic losses and limited non-economic damages based on caps set by state law.\(^{422}\) Under the second option, the state would require that all health care providers participate in a statewide administrative claims system that would provide recovery for avoidable injuries. The providers would be granted immunity from tort liability. Providers would be required to identify victims of avoidable injuries and disclose these to the patients. And injured patients could recover net economic losses and non-economic losses subject to a cap.\(^{423}\)

\(^{417}\) Id. at 158.
\(^{418}\) Sage, supra note 324, at 10.
\(^{419}\) Id. at 19.
\(^{420}\) Id. at 18-20.
\(^{421}\) INST. OF MED., supra note 341, at 81-90.
\(^{422}\) Id. at 87.
\(^{423}\) Id. at 88.
In this section we will examine two proposals for alternative reforms that seem promising: disclosure and offer, and health courts. These options do not necessarily require specific legislation and could be implemented at the institutional level. Indeed, some providers and insurers have already initiated disclosure and offer programs. There is increased interest in such reforms by institutional providers, particularly in light of the fact that damages caps have been declared unconstitutional by several state high courts and federal enactment of caps seems very unlikely in the foreseeable future.

A. Disclosure and Offer

Although physicians, hospitals and liability insurers have traditionally been reluctant to disclose medical injuries for fear of stirring up additional claims, the ethical obligation of providers to disclose negligently inflicted injuries is widely acknowledged. Within the profession there is “increasing receptivity” to full disclosure. The AMA Code of Medical Ethics recognizes the obligation of a physician to inform the patient about an injury caused by the physician’s negligence. Since 2001, JCAHO has required institutional providers to inform patients of “unanticipated outcomes.” And in 2006, the National Quality Forum endorsed a safe practice requiring timely disclosure of “serious unanticipated outcomes” to patients. The latter is particularly significant because “the 29 large health care purchasing coalitions in the Leapfrog Group use the NQF safe practices as standards in their pay-for-performance programs.”
Proponents of disclosure and offer have argued that the information from disclosure can be used to enhance patient safety. They contend that apologizing to the patient also has salutary effects: it benefits the patient emotionally, mitigates the harm, and preserves the physician-patient relationship. And it has been argued by the “Sorry Works! Coalition” that disclosure and apology will reduce the frequency of malpractice claims and litigation costs. Nonetheless, physicians may still be unwilling to apologize because of fear that the apology could be admissible in a lawsuit. To combat that concern, thirty-five states have now enacted apology laws to encourage disclosure of negligently inflicted injuries by precluding at least some statements of apology from being admissible in court. A few states have coupled inadmissibility provisions with a disclosure and/or reporting mandate.

There is, however, an emerging consensus that disclosure and apology alone are insufficient and should be accompanied by an offer to compensate the negligently injured patients injured. In 2006, Sena-

432 McDonnell & Guenther, supra note 426.
433 Id.
435 McDonnell & Guenther, supra note 426.

State governments have pursued a greater range and volume of disclosure-related legislation. Seven states—Nevada, Florida, New Jersey, Pennsylvania, Oregon, Vermont, and California—have mandated that institutions disclose serious unanticipated outcomes to patients. Pennsylvania’s 2002 law was the first and arguably stands as the sternest. It requires hospitals to notify patients in writing within 7 days after a “serious event.” To counteract concerns about litigation exposure, the law includes a provision prohibiting the use of such communications as evidence of liability for the disclosed event. Interest in adopting this type of legal protection has been widespread and is not limited to states with disclosure mandates. At least 34 states have adopted “apology laws” that protect specific information conveyed in disclosures, most commonly apologies or other expressions of regret.

Id. at 2715 (citations omitted).
437 NEV. REV. STAT. ANN. § 439.855 (West 2003) (patient involved to be given notice of sentinel event); N.J. STAT. ANN. § 26:2H-12.25 (2004) (reporting mandate for “serious preventable adverse events”; patient disclosure mandate for “serious preventable adverse events” related to allergic reactions); 40 PA. CONS. STAT. ANN. § 1303.308 (2002) (health care worker required to report a “serious event or incident” to facility; facility required to inform patient or family of a “serious event.”)); McDonnell & Guenther, supra note 426, at 812 (citing FLA. STAT. ANN. § 395.1051 (2003) (patient disclosure mandate for adverse events causing “serious harm”).
tors Barack Obama and Hillary Clinton proposed federal legislation that would have provided grants and technical assistance for providers that adopted disclosure and offer programs. But disclosure and offer is not a new idea. Professor Jeffrey O’Connell has long supported legislation to provide incentives for providers to offer a prompt tender for economic damages. Under the current version, the provider could, within 180 days after a claim is filed, offer an injured patient periodic payments to cover net economic losses as accrued, including medical expenses, lost wages and rehabilitation expenses incurred due to the injury not otherwise covered by insurance. If the offer is rejected by the patient, then the case would be tried under a gross negligence standard and the patient would be required to prove fault beyond a reasonable doubt.

In an empirical study focusing on closed claims in Florida and Texas between 1998 and 2002, Hersch et al. (2007) found that early offer could accelerate payment of claims by two years and reduce overall insurer and litigation costs by $100,000 to $200,000 per claim. But in their own empirical study, Black et al. (2009) take issue with this finding and conclude that the savings are overstated: while early offer would significantly reduce payouts in cases with low economic damages, it would not significantly affect payouts in other cases. They find that there would be even less of an impact in states with damages caps. In a reply, Hersch et al. (2010) question the methodology used by Black et al. (2009) and reassert their original findings. The debate is continued in Black et al. (2010). But regardless of the impact of early offer on costs, O’Connell has identified

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441 Id. at 289.
442 Hersch et al., supra note 26, at s256.
443 Bernard Black et al., The Effects of “Early Offers” in Medical Malpractice Cases: Evidence from Texas, 6 J. EMPIRICAL LEGAL STUD. 723, 758-59 (2009).
444 Id. at 738-39.
445 Joni Hersch et al., Reply to the “Effects of ‘Early Offers’ in Medical Malpractice Cases: Evidence from Texas,” 7 J. EMPIRICAL LEGAL STUD. 164 (2010).
446 Bernard Black et al., O’Connell Early Settlement Offers: Toward Realistic Numbers and Two-Sided Offers, 7 J. EMPIRICAL LEGAL STUD. 379 (2010).
a significant advantage that early offer has over damages caps: "... unlike with caps, claimants who received an early offer would be guaranteed prompt payment of their economic losses, plus their attorneys' fees."\(^{447}\)

Unlike early offer, an institutional or insurer initiated disclosure and offer protocol does not require legislation. Proponents of disclosure and offer approaches point to successful implementation of such protocols by University of Michigan Health System, the Lexington, Kentucky, Veterans Affairs (V.A.) Hospital, and the 3Rs program operated by COPIC Insurance, a Colorado physician-directed medical liability insurer.\(^{448}\) Proponents of disclosure and offer have argued that it will reduce the number of malpractice claims and the costs to the health care system. But Studdert et al. (2007) found, using a Monte Carlo simulation model, that due to under-claiming in the current system, widespread use of disclosure is likely to trigger additional malpractice claiming by negligently injured patients.\(^{449}\) Boothman et al. (2010), however, argue that the concerns voiced by Studdert et al. (2007) have been refuted by the experience of the University of Michigan Health System.\(^{450}\) They report that implementation of the Michigan disclosure and offer protocol has resulted in a significant decrease in the number of claims and a reduction in litigation costs.\(^{451}\) In addition, the University of Illinois at Chicago Medical Center, using a protocol similar to the Michigan protocol, reports no increase in claims or loss payouts due to full disclosure.\(^{452}\)

The Michigan program is based on three principles:

1. Compensate quickly and fairly when unreasonable medical care causes injury.

2. Defend medically reasonable care vigorously.

3. Reduce patient injuries (and therefore claims) by learning from patients’ experiences.\(^{453}\)

\(^{447}\) O'Connell, supra note 440, at 289 (emphasis in original).

\(^{448}\) Mello & Gallagher, supra note 425, at 1354.


\(^{450}\) Boothman et al., supra note 436, at 159.

\(^{451}\) Id. at 143-44.

\(^{452}\) Timothy McDonald et al., Responding to Patient Safety Incidents: The "Seven Pillars," 19 QUALITY & SAFETY HEALTH CARE e11, at 4 (2010), available at http://qualitysafety.bmj.com/content/19/6/1.31.full.pdf.

\(^{453}\) Boothman et al., supra note 436, at 139.
The basis for compensation under the Michigan program is a determination that the patient has received unreasonable treatment. This determination is made after an in-depth investigation by the risk management department. This is followed by a committee review of the risk management department’s determination that focuses on two questions: “(1) Was the care at issue reasonable under the circumstances? and (2) Did the care adversely impact the patient’s outcome?”

The Lexington V.A. program has also been touted as a success. Since 1995, the Department of Veteran Affairs has required all its facilities to notify patients when they have experienced a negligently inflicted iatrogenic injury, but the Lexington V.A. Hospital has followed this policy since 1987. Kraman & Hamm (1999) found that “[d]espite following a policy that seems to be designed to maximize malpractice claims, the Lexington facility’s liability payments have been moderate and are comparable to those of similar facilities.” They believe that these results were due to a dampening of the patient’s desire for revenge.

Another program that has been widely discussed is COPIC’s 3Rs Program. It uses the following principles: “Recognize Unanticipated Event;” “Respond Soon After Event;” and “Resolve Related Issues.” The 3Rs program was initiated in 2000 and is a no fault system. Participation by the physician is voluntary. The program is administered by the insurer’s risk management department rather than the claims department and is considered a “first party supplemental benefit” rather than a “third party insurance payment.” It provides up to $25,000 for out-of-pocket damages and up to $5,000 for loss of time. The process is initiated with an incident report by the physician, but there is no attempt to determine whether the injury was negligently inflicted. Death cases and cases involving egregious neglig-
gence are excluded from the program.\textsuperscript{464} It does not require the patient to waive the right to sue in order to receive compensation, but the program is not available if the patient has retained an attorney, filed a written demand for compensation, or initiated a court proceeding.\textsuperscript{465} It does require the physician to disclose the injury and apologize to the patient.\textsuperscript{466}

A March 2004 report by issued by COPIC on the 3Rs program boasted: “As one can see, 3Rs cases—where payments average $1,820—appear to be an effective use of funds. In addition numerous anecdotes of patient gratitude and physician satisfaction have been received.”\textsuperscript{467} Quinn & Eichler (2008) report that from the inception of the program until October 1, 2007, 1,110 patients had received payments with the average payment being $5,258.\textsuperscript{468} They believe that open disclosure was instrumental in resolving some cases without payment.\textsuperscript{469} They also report positive feedback from physicians and patients that have participated in the program and that COPIC is “well pleased” with its results.\textsuperscript{470} It seems that the sole focus of the COPIC 3Rs program is to reduce loss payouts. While a strong business case could be made for the adoption of the program, it would not seem to do much for improving the fairness of compensation or deterring negligence.

As noted by Mello and Gallagher (2010), the COPIC and Michigan programs take quite different approaches: the COPIC model offers a low level of reimbursement for loss of time and out-of-pocket expenses without investigation of provider negligence or waiver of a right to sue, while the Michigan program offers higher levels of reimbursement for all traditional damages components in cases of unreasonable care and patients who accept the offer waive their right to sue.\textsuperscript{471} And while the Michigan and V.A. programs provide opportunities to improve patient safety by identifying preventable injuries due to negligence, the COPIC program makes no attempt to identify neg-

\textsuperscript{464} Id. at 710.
\textsuperscript{465} Id.
\textsuperscript{466} Id. at 713.
\textsuperscript{468} Quinn & Eichler, supra note 460, at 714.
\textsuperscript{469} Id.
\textsuperscript{470} Id. at 716-18.
\textsuperscript{471} Mello & Gallagher, supra note 425, at 1354.
ligent events and thus probably makes less of a contribution to improvements in patient safety. 472

B. Health Courts

Recently, there has been a great deal of interest in the creation of health courts that would replace judicial resolution of claims with an administrative compensation scheme. In 2005, legislation with widespread bipartisan support was introduced in both houses of Congress to authorize federally funded health court demonstration projects. 473 In 2006, Common Good, a non-partisan coalition that focuses on advocacy of legal reforms, proposed the creation of a system of federal health courts to supplant state courts in adjudicating medical malpractice disputes, 474 but the constitutionality of this proposal has been questioned. 475 While the ABA has rejected mandatory health courts as an option, such a proposal has been endorsed by the AMA as a “promising” approach. 477 In 2008, Common Good, recognizing the unfavorable political environment for federally mandated health courts, proposed an approach based on contract and utilizing the Federal Arbitration Act. 478

As with the disclosure and offer proposal, health courts are not a new type of proposal. There have been several such proposals since the 1970s, including the AMA’s 1988 fault-based administrative

472 Boothman et al., supra note 436, at 148.
compensation scheme, discussed supra. The current proposal was
developed by Common Good, working in conjunction with the Har-
vard School of Public Health.\textsuperscript{479} As they describe it:

A \textit{health court} is a system of administrative compensation for
medical injuries. It has five core features. First, injury compen-
sation decisions are made outside the regular court system
by specially trained judges. Second, compensation decisions
are based on a standard of care that is broader than the negli-
gence standard (but does not approach strict liability).
‘Avoidability’ or ‘preventability’ of the injury is the touch-
stone. To obtain compensation, claimants must show that the
injury would not have occurred if best practices had been fol-
lowed or an optimal system of care had been in place, but
they need not show that care fell below the standard expected
of a reasonable practitioner. Third, compensation criteria are
based on evidence; that is, they are grounded in experts’ in-
terpretations of the leading scientific literature. To the maxi-
imum extent feasible, compensation decisions are guided by ex
\textit{ante} determinations about the preventability of common med-
ical adverse events. Fourth, this knowledge, coupled with
precedent, is converted to decision aids that allow fast-track
compensation decisions for certain types of injury. Fifth and
finally, ex \textit{ante} guidelines also inform decisions about how
much for economic and noneconomic damages should be
paid.\textsuperscript{480}

Proponents of health courts claim that they would be, on balance,
beneficial to patients, noting that health courts are more procedurally
fair, patients would be more likely to get a favorable result, compen-
sation is faster, the pool of compensable events is expanded, caps are
replaced with more flexible scheduled recoveries, disclosure of ad-
verse events is required, and patients with small claims benefit be-
cause attorneys are not required.\textsuperscript{481} They also contend that insurers
and providers will benefit. There will be greater fairness and con-
sistency in decisions, and the courts will offer a better opportunity for
cost control measures.\textsuperscript{482} They contend that the greatest benefits will
be: (1) the improvements in patient safety due to increased candor and

\begin{footnotesize}
\begin{itemize}
\item[479] Michelle M. Mello et al., "Health Courts" and Accountability for Patient
\item[480] Id. at 460-61.
\item[481] Id. at 468.
\item[482] Id. at 469-70.
\end{itemize}
\end{footnotesize}
transparency in confronting errors resulting from the shift from the stigmatizing negligence standard to the avoidability standard, (2) an increase in the number of legitimate claims in the system, (3) clearer ex ante standards, (4) and fairer decisions. They argue that hospitals would have increased incentives to enhance safety because payments into the system would be based on the frequency of avoidable injuries experienced in the hospital. And state level scrutiny would also be enhanced because the health court system would provide a central repository of information that could be used by researchers and a state patient safety office to improve patient safety. Eventually, data from the states could be integrated into a national database. Proponents of health courts have recognized that establishing the link between health courts and improvements in patient safety is critical to the success of the proposal.

While the Common Good proposal seems to be an improvement over the earlier AMA proposal, it is nonetheless disappointing to those who have advocated a shift to no-fault and enterprise liability. The proposal has also been controversial among academicians. Peters foresees only marginal improvements in the accuracy of decision making and fairness of outcomes. He believes that health courts are likely to exacerbate current problems such as under-claiming (for legitimate claims) and over-claiming (for baseless claims). He believes that the level of procedural protections provided to patients in health courts is inadequate and should be strengthened. And he is skeptical about the purported improvements in patient safety and foresees little change in the willingness of physicians to disclose errors as a result of implementation of health courts. Baker has characterized health courts as ‘part of the same ‘doctor knows best’ approach to malpractice that has produced the error-ridden system that we have today. It’s an effort to neutralize malpractice litigation, the institution that deserves almost all the credit for bringing medical malpractice to light.’ Even health court proponents recognize that their potential

483 id. at 473-74.
484 id. at 475.
485 id. at 476-78.
486 id. at 482-83.
488 Peters, supra note 24, at 236.
489 id. at 251-52.
490 id. at 258.
491 id. at 268.
492 id. at 270-78.
493 Kristin Eliasberg, Malpractice Fix, BOS. GLOBE, Aug. 21, 2005, at E1.
benefits are uncertain and have recommended a series of small scale demonstrations to test their effectiveness.494

CONCLUSION

By providing guaranteed access to health care insurance at community rates, the ACA could reduce the problem of undercompensation resulting from damages caps, but it could also weaken deterrence by exacerbating the problem of under-claiming in the current medical liability system, and shifting losses from liability insurers to health insurers. At this time, it is uncertain whether damages caps will be enacted at the federal level. While some Republicans in Congress will continue to press for adoption of a federal damages cap,495 there is a new development in the Republican party: some tea party activists believe that a federal damages caps would violate the Tenth Amendment.496 Caps disadvantage the most severely injured patients in return for the promise of lower health care costs for all.497 But notwithstanding recent opinions offered by the CBO, it is not clear that caps will significantly reduce health care costs or that any savings will be passed on to consumers. Moreover, the impact of damages caps on access to physicians and patient safety is unclear. The benefits of alternative reforms such as disclosure and offer and health courts are also uncertain. Perhaps we will know more after several demonstration projects are conducted.

494 Mello et al., supra note 479, at 487.