



HEALTH CARE 2009

## The Role of Medical Liability Reform in Federal Health Care Reform

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Although enthusiasm for health care reform is resounding in Washington these days, the specific shape reform will take and the compromises that will have to be made along the way are opaque.

Currently, much of the discussion centers on possibilities for insurance mandates, a public insurance plan modeled after Medicare, and the methods that will be used to control costs.<sup>1</sup> Many other issues will have to be addressed, including physician payment reform, the future of Medicare Advantage, providers' participation in public programs, the role of expansions of Medicaid, and of course, the funding mechanism for any increase in government expenditures. A further question is whether the reform package should include reforms to the medical liability system, which is often blamed for contributing to rising health care costs.

Medical liability reform has garnered relatively little attention in the past two congressional sessions — in striking contrast to its prominence in previous federal health policy debates. The ebbing of the recent malpractice insurance “crisis” may have undercut momentum for liability reform, but a more important explanation relates to the politics of the issue. Tort reform has long been a Republican issue; Democrats have been suspicious of reform proposals and, perhaps, mindful of the heavy support they have received from the trial bar. With the turnover of the House (in 2007) and the Senate (in 2009) to Democratic control,

liability reform has been submerged. The question now is whether health care reform changes the political calculations around the issue.

There are at least three reasons why government champions of health care reform might consider bundling medical liability reform in the same package. First, one piece of conventional wisdom that is shared by those on both sides of the political aisle is that “defensive medicine” spurred by concern about malpractice liability is a substantial driver of the escalation of health care costs. These costs are notoriously difficult to estimate, and analysts disagree about the magnitude of their contribution to overall health expenditures.<sup>2</sup> But trimming even 1% of total health care spending would save around \$22 billion per year — not a trivial amount, particularly in lean times.

Second, health care reformers understand that they will have to garner physician support for an omnibus bill that will no doubt create a more stringent financial environment for health care providers. Expansions of public insurance programs, including models generating stiffer market competition between public and private health plans, will entail changes in the payer mix that are unfavorable for providers and exert continued downward pressure on reimbursement rates. What can reformers offer physicians as a *quid pro quo*? The answer is malpractice reform. Most physicians find the litigation system unfair, financially and psychologically burdensome, and unhelpful in promoting safety and quality. They would welcome relief of some sort.

Third, bundling tort and health care reform may help to attract support from congressional Republicans for a health care reform package. Many key Republicans agree with physicians about the problems with the tort system and have worked hard in the past to develop proposals for medical liability reform. A bundling strategy would offer them the chance to advance their agenda in exchange for helping the President achieve his vision of bipartisan health care reform legislation.

What kinds of malpractice reforms might be candidates for bundling? The warhorse of federal tort reform efforts in the past has been caps on noneconomic damage awards. However, in the current political environment, the chances are nearly nil that tort reform of this sort could pass

— it is anathema to most House Democrats. The realistic contenders are more moderate measures that address physicians' complaints about the unfairness of court decisions that appear to be out of step with medical expertise (see table).

Two potential approaches are outlined in the widely read 2008 white paper on health care reform by Senator Max Baucus (D-MT), the Patients' Choice Act introduced in May by a group of Senate and House Republicans led by Senator Tom Coburn (R-OK), and the Fair and Reliable Medical Justice Act, which Baucus and Senator Michael Enzi (R-WY) cosponsored in each of the past two congressional sessions.<sup>2,3</sup> The first approach calls for state experimentation with innovative programs adopted by liability in-

#### Advantages and Disadvantages of Potential Medical Liability Reforms.

Reform	Advantages	Disadvantages
Disclosure-and-offer programs	<ul style="list-style-type: none"> <li>Would promote transparency regarding medical errors</li> <li>Are reportedly effective at the institutional level in reducing volume and costs of lawsuits</li> <li>Would reduce length and adversarial nature of claiming process</li> <li>Are unlikely to be opposed by patients' groups because patients' participation would be voluntary</li> </ul>	<ul style="list-style-type: none"> <li>Might be opposed by trial attorneys because their role would be somewhat reduced</li> <li>Involve risk for health care providers because patients would be told of medical errors and might choose to sue</li> <li>Evidence base for effectiveness in reducing costs consists solely of programs' self-reports</li> </ul>
Administrative or specialized tribunals	<ul style="list-style-type: none"> <li>Would improve predictability of litigation outcomes through greater use of decision guidelines and expertise</li> <li>Would replace "battles of the experts" with use of neutral experts or expert adjudicators</li> <li>Might promote physicians' uptake of comparative-effectiveness research and adherence to practice guidelines</li> <li>Might reduce length and adversarial nature of litigation process</li> <li>Would probably reduce costs if guidelines for damages awards were adopted</li> </ul>	<ul style="list-style-type: none"> <li>Would probably be opposed by trial attorneys because their role would be reduced</li> <li>Might be opposed by patients' groups because access to court would be restricted and awards might be lower</li> <li>Might face fights over constitutionality</li> <li>Evidence base for effectiveness in reducing costs is small</li> </ul>
"Safe harbors" for adherence to evidence-based practices	<ul style="list-style-type: none"> <li>Would promote physicians' uptake of comparative-effectiveness research and practice of evidence-based care</li> <li>Might streamline adjudication of some cases</li> <li>Might control costs by reducing the proportion of cases in which plaintiffs prevailed</li> </ul>	<ul style="list-style-type: none"> <li>State-level experiments showed that cases in which physicians could invoke safe harbors were infrequent</li> <li>Unclear how many lawsuits would be prevented</li> <li>Would not affect size of damages awards</li> </ul>

surers, sometimes called disclosure-and-offer programs, in which health care providers disclose unanticipated outcomes of care to patients and make prompt offers of compensation in appropriate cases. Patients do not waive their right to sue by accepting the offer, but reportedly, few go on to file lawsuits. While he was a senator, President Barack Obama cosponsored legislation to promote this approach.<sup>4</sup> These programs appear promising, though they have never been formally evaluated.

The second approach is to shift the adjudication of medical malpractice claims to a new kind of tribunal — either an administrative panel that would award damages on the basis of judgments by neutral experts about the avoidability of the injury or specialized judicial courts presided over by judges with medical expertise. This approach is attractive on its merits; it would address several fundamental problems with the current system, in which juries make decisions with scant guidance on complex scientific issues and what constitutes reasonable damages awards.

A third approach would be to create a federal “safe harbor,” retaining the current process of adjudication but insulating physicians from liability if they adhered to evidence-based medical practices. For example, legislation introduced by Senator Ron Wyden (D-OR) in February would create a rebuttable presumption that care was not negligent if the physician followed accepted clinical practice guidelines.<sup>5</sup> Similarly, physicians could be given immunity or a favorable presumption

if they practiced in accordance with findings of credible comparative-effectiveness research (CER).

Part of the appeal of the second and third approaches is their resonance with Washington’s current interest in CER. The American Recovery and Reinvestment Act of 2009 allocated \$1.1 billion for CER; however, it granted the Federal Coordinating Council for Comparative Effectiveness Research no authority to implement changes to insurance coverage or reimbursement on the basis of CER findings. Because safe harbors and special tribunals led by medical experts would give physicians a legal incentive to practice evidence-based medicine, liability reform could be an effective way to foster the uptake of CER findings. As politically difficult as tort reform can be, it is probably more tractable than limiting coverage or reimbursement to the most cost-effective treatments — or even to the most clinically effective therapies. In addition, physicians and hospitals will complain, with reason, if they practice in accordance with CER findings yet are found liable for malpractice.

The three reform approaches are not mutually exclusive and indeed could complement one another. All face a common legal hurdle: federalism. The fact that medical malpractice law has traditionally been controlled by the states complicates attempts to impose a federal structure on it. However, there are at least two ways Congress could surmount the federalism obstacle: declare its intent to completely preempt state regulation of the field — a drastic step — or simply condi-

tion states’ receipt of federal health funds or “bonus payments” on their willingness to adopt changes to their tort systems.

At present, few policymakers are openly discussing the pros and cons of bundling liability reform and health care reform. The overture to the exquisite oratorio of lawmaking calls for each player to press the key positions its constituents demand. But within a few months, we predict that many will be looking for compromises. Quite a few already recognize the potential political advantages of bundling, and the President himself is on record as stating that liability reform must be part of health care reform. If liability reform proves to be an enticing sweetener for a health care reform compromise, it could become part of the package.

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