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THE HEALTH CARE REFORM ACT OF 2010 AND MEDICAL MALPRACTICE LIABILITY: WORLDS IN COLLISION OR SHIPS PASSING IN THE NIGHT?

Thomas L. Hafemeister*
Joshua Hinckley Porter**

The Patient Protection and Affordable Care Act of 2010 tackles many health care-related issues, but medical malpractice liability reform is not one of them. Despite being a perennial target of health care reform—with accompanying assertions that a medical malpractice liability crisis is corrupting the delivery of health care in the United States—only three short sections that made little substantive change to existing law were devoted to it in a bill that eventually totaled over 900 pages in length. This Article describes what the bill did, what it failed to do, and its likely and perhaps unanticipated consequences for the ongoing medical malpractice liability reform debate.

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“The suppression of uncomfortable ideas may be common in . . . politics, but it is not the path to knowledge.”***

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*** CARL SAGAN, COSMOS 91 (1980) (commenting on the efforts of some scientists to suppress the ideas of Immanuel Velikovsky, the author of the controversial 1950 best-seller *Worlds in Collision*).

I. INTRODUCTION

THE Patient Protection and Affordable Care Act (PPACA),¹ enacted on March 23, 2010, to cheers and euphoria on one side of the political spectrum and doom, gloom, and predictions of apocalypse on the other, tackles many health care-related issues, but medical malpractice liability reform is not one of them.² Despite being a perennial target of health care reform—with accompanying assertions that a medical malpractice liability crisis is corrupting the delivery of health care in the United States³—only three short sections were devoted to it in a bill that eventually totaled over 900 pages in length, two of which made no substantive change to existing law while the third made only a minor change.⁴

This outcome was probably not surprising given the bitterly partisan fight that surrounded the PPACA's tortuous journey through Congress,⁵

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections at 42 U.S.C.).

2. See generally *id.*

3. See Timothy D. Lytton, Robert L. Rabin & Peter H. Schuck, *Tort as a Litigation Lottery: A Misconceived Metaphor*, 52 B.C. L. REV. 267, 268–69 (2011); see also Edward P. Richards & Thomas R. McLean, *Administrative Compensation for Medical Malpractice Injuries: Reconciling the Brave New World of Patient Safety and the Torts System*, 49 ST. LOUIS U. L.J. 73, 83 (2004) (“The aggregate effect of the[] false positive and false negative signals from the medical malpractice system is to convince physicians that medical malpractice claims are random events.”); Mark A. Rothstein, *Health Care Reform and Medical Malpractice Claims*, 38 J.L. MED. & ETHICS 871, 871 (2010) (“seemingly interminable debates about health care reform in the last few years”); David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2025 (2006).

It has also been noted that claims of a medical malpractice liability crisis have long been raised periodically and predate the American Civil War. Allen D. Spiegel & Florence Kavaler, *America's First Medical Malpractice Crisis, 1835-1865*, 22 J. COMMUNITY HEALTH 283, 283–85 (1997) (“Between 1800 and 1835, medical malpractice in the United States was virtually unknown. . . . Within the thirty year period from 1835–1865, medical malpractice lawsuits began to inundate the courts. . . . Dr. Frank H. Hamilton . . . , ‘a respected Buffalo (NY) surgeon . . . ,’ estimated that nine out of every ten physicians in western New York had been charged with malpractice by the mid-nineteenth century. . . . In 1860, a text on medical jurisprudence asserted: ‘There can hardly be found a place in the country, where the oldest physicians in it have not, at some periods in their lives, been actually sued or annoyingly threatened.’ . . . Even though America’s first medical malpractice crisis began to evolve more than 160 years ago, many of the factors that gave rise to it have remained constant over the years.”). It is possible, however, that this cyclic pattern has been altered by the recent national focus on health care reform in general. Allen Kachalia & Michelle M. Mello, *New Directions in Medical Liability Reform*, 364 NEW ENG. J. MED. 1564, 1564 (2011) (“As policymakers’ attention has shifted from winning passage of the health reform bill to determining how to implement and pay for it, medical liability reform has remained a focus because of its perceived potential to help ‘bend the health care cost curve.’”).

4. See PPACA §§ 6801, 10607, 10608. Arguably section 10608 did institute one substantive change, but it is relatively minor because it merely extends federal malpractice protections to the nonmedical personnel of free clinics. Randall R. Bovbjerg, *Will the Patient Protection and Affordable Care Act Address the Problems Associated with Medical Malpractice?*, TIMELY ANALYSIS OF IMMEDIATE HEALTH POL’Y ISSUES, Aug. 2010, at 1, available at <http://www.urban.org/uploadedpdf/412193-ppaca-medical-malpractice.pdf>.

5. David M. Herszenhorn & Robert Pear, *Health Vote Is Done, but Partisan Debate Rages On*, N.Y. TIMES, Mar. 23, 2010, at A19.

the sharply contested debate over the need for medical malpractice liability reform in general,⁶ and that positions on malpractice liability reform frequently break down along party lines, typically with Republicans supporting and Democrats opposing such reforms.⁷ Indeed, for a number of years now, the Republican Party leadership has routinely introduced medical malpractice reform bills in Congress, proposals that have been vigorously contested and thus far defeated by members of the Democratic Party.⁸

In the log-rolling that led up to the passage of the PPACA, there was some speculation that this partisan split might be bridged.⁹ For example, when President Barack Obama gave an invited presentation to the members of the American Medical Association, some construed his remarks as indicating a willingness to address medical malpractice reform in the PPACA.¹⁰ A similar gloss was applied by some to a speech he made to Congress a few months later urging passage of this bill.¹¹ Nonetheless,

6. See David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1086–87 (2006); Rothstein, *supra* note 3, at 871.

7. See Hyman & Silver, *supra* note 6, at 1086; Rothstein, *supra* note 3, at 871.

8. See Tanya Albert, *Medical Liability Crisis: Tort Reform Bill Goes to Congress*, AM. MED. NEWS (Feb. 24, 2003), <http://www.ama-assn.org/amednews/2003/02/24/gvl10224.htm>; see also *infra* note 33.

9. See Dan Gerstein, Op-Ed., *Obama's Masterful Health Care Maneuver: With His Speech Monday, The President Moves to Break the Trial Lawyers' Choke Hold on the Democratic Party*, FORBES.COM (June 17, 2009), <http://www.forbes.com/2009/06/16/obama-health-care-trial-lawyer-opinions-columnists-malpractice.html>.

10. See *President Obama's Speech to American Medical Association*, USA TODAY, June 15, 2009, at http://www.usatoday.com/news/washington/2009-06-15-obama-speech-text_N.htm. In the speech, President Obama said:

Now, I recognize that it will be hard to make some of these changes if doctors feel like they are constantly looking over their shoulder for fear of lawsuits. Some doctors may feel the need to order more tests and treatments to avoid being legally vulnerable. That's a real issue. And while I'm not advocating caps on malpractice awards which I believe can be unfair to people who've been wrongfully harmed, I do think we need to explore a range of ideas about how to put patient safety first, let doctors focus on practicing medicine, and encourage broader use of evidence-based guidelines. That's how we can scale back the excessive defensive medicine reinforcing our current system of more treatment rather than better care.

Id.; see also Gerstein, *supra* note 9.

11. See Jonathan Weisman & Janet Adamy, *President Makes His Pitch: Health Plan Cut to \$900 Billion with Tax on Premium Coverage; GOP Unmoved*, WALL STREET J., Sept. 10, 2009, at A1 (“President Barack Obama gave an emotional, sometimes contentious address to Congress on Wednesday, combining tough talk to opponents with olive branches on policy in a bid to break the impasse on revamping the health-care system. . . . The president pledged to tackle medical-malpractice lawsuits in an overture to Republicans.”). President Obama’s 2011 State of the Union address also included remarks that were viewed by some as supporting medical malpractice reform. David G. Savage, *Obama's Talk of Medical Malpractice Reform Surprises Both Sides*, L.A. TIMES, Jan. 28, 2011, <http://articles.latimes.com/2011/jan/28/nation/la-na-medical-malpractice-20110129> (“The president’s words breathed new life into the often discussed but never enacted Republican [medical malpractice reform] initiative.”); Elizabeth Stawicki, *Obama Opens Door to Medical Malpractice Reform*, MINN. PUB. RADIO NEWS, Jan. 26, 2011, <http://minnesota.publicradio.org/display/web/2011/01/26/tort-reform/>. But see Ticardo Alonso-Zaldivar, *Obama Budget, House Panel Address Medical Malpractice Reforms*, INS. J., Feb. 18, 2011, <http://www.insurancejournal.com/news/national/2011/02/18/186902.htm#>

the PPACA was ultimately passed along rigid party lines with no substantive attention given to the topic of medical malpractice liability reform.¹²

Currently, there are a series of legal challenges to the PPACA winding their way through the courts, driven primarily by elected Republican officials from various states, claiming, among other things, that the enactment of the PPACA by the Democratic majority exceeded the constitutional authority of the federal government.¹³ Ironically, the positions of the two political parties on this constitutional authority could be diametrically reversed should the Republicans ultimately regain power in both houses and succeed in passing a federal medical malpractice reform package, with Democratic officials then asserting that such an enactment exceeds the constitutional power of Congress.¹⁴

It is not the purpose of this Article, however, to offer opinions as to which political party holds the high ground in these debates. Rather, its goal is to evaluate the impact of the PPACA on medical malpractice liability reform, modest though it may be, and to note that the little attention it did give to the topic may ultimately further impede reconciliation between what already appear to be two relatively irreconcilable positions.

II. MEDICAL MALPRACTICE LIABILITY AND ITS COSTS

First, however, a few words about medical malpractice liability itself. It is routinely reported that “one of every 100 hospital patients suffers negligent treatment, and that as many as 98,000 die each year as a result,”¹⁵

(“Obama’s proposal also got a cool reception from congressional Republicans, who feel he has a record of promising more on malpractice than he delivers.”).

12. Herszenhorn & Pear, *supra* note 5, at A19; Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, N.Y. TIMES, Mar. 24, 2010, at A19.

13. Thus far, the two federal appellate courts that have ruled on the matter have split on whether the PPACA meets constitutional requirements. *Compare* Thomas More Law Ctr. v. Obama, No. 10-2388, 2011 WL 2556039, *16 (6th Cir. June 29, 2011) (upholding the PPACA) *with* Florida *ex rel.* Attorney Gen. v. U.S. Dep’t Health & Human Servs., Nos. 11-11021, 11-11067, 2011 WL 3519178, *83 (11th Cir. Aug. 12, 2011) (striking down the requirement that individuals purchase and maintain health insurance). *See also* T.R. Goldman, *Health Policy Brief: Legal Challenges to Health Reform*, HEALTH AFFAIRS (July 8, 2011), <http://www.rwjf.org/files/research/72585hahr201107.pdf>; Timothy Jost, *Appellate Court: Individual Mandate Falls But Rest of Affordable Care Act Survives*, HEALTH AFFAIRS BLOG (Aug. 15, 2011), <http://healthaffairs.org/blog/2011/08/15/appellate-court-individual-mandate-falls-but-rest-of-affordable-care-act-survives/>; William Sage, *The Legal Battle over Health Reform: Analyzing the 11th Circuit Opinions*, HEALTH AFFAIRS BLOG (Aug. 16, 2011), <http://healthaffairs.org/blog/2011/08/16/the-legal-battle-over-health-reform-analyzing-the-11th-circuit-opinions/>; Bara Vaida & Karl Eisenhower, *Scoreboard: Tracking Health Law Court Challenges*, KAISER HEALTH NEWS (Aug. 24, 2011), <http://www.kaiserhealthnews.org/Stories/2011/March/02/health-reform-law-court-case-status.aspx?> (“KHN is tracking the status of 26 federal lawsuits seeking to overturn the Patient Protection and Affordable Care Act.”).

14. *See generally* Betsy J. Grey, *The New Federalism Jurisprudence and National Tort Reform*, 59 WASH. & LEE L. REV. 475 (2002); Nim Razook, *A National Medical Malpractice Reform Act (and Why the Supreme Court May Prefer to Avoid It)*, 28 SETON HALL LEGIS. J. 99 (2003).

15. Kevin Sack, *Doctors Say ‘I’m Sorry’ Before ‘See You in Court’*, N.Y. TIMES, May 18, 2008, <http://www.nytimes.com/2008/05/18/us/18apology.html>; *see also* Carolyn M.

with the economic burden of preventable medical injuries set at \$17–\$29 billion per year.¹⁶ At the same time, the direct cost that health care providers incur from medical malpractice liability is asserted to be in the tens of billions of dollars each year, with two notable estimates being \$10 billion (combining indemnity payments and administrative expenses)¹⁷ and \$35 billion (combining malpractice insurance premiums with settlements, awards, and administrative costs not covered by insurance, an amount calculated to be about 2% of total health care expenditures).¹⁸ Whether or not these figures are accurate, they and other estimates have garnered a great deal of attention.¹⁹ In the twelve years since the Institute of Medicine released its sobering *To Err Is Human* report, which detailed America's grim track record on patient safety and preventable iatrogenic injuries, significant efforts have been made to improve the quality of the care patients receive and to address the causes of both medical malpractice and malpractice suits.²⁰ Indeed, despite continuing population

Clancy, *Patient Safety and Medical Liability Reform: Putting the Patient First*, PATIENT SAFETY & QUALITY HEALTHCARE, Sept.–Oct. 2010, at 6 (“More than 15 percent of patients receiving hospital care are harmed by the process of care they receive.”) (citing AGENCY FOR HEALTHCARE RESEARCH & QUALITY, NATIONAL HEALTHCARE QUALITY REPORT (2009)).

16. Michelle M. Mello, Amitabh Chandra, Atul A. Gawande & David M. Studdert, *National Costs of the Medical Liability System*, 29 HEALTH AFF. 1569, 1570 (2010); see also Clancy, *supra* note 15 (“Only 22 cents of every dollar spent settling a medical liability claim is spent on compensating patients Patients who are seriously harmed from the process of care often wait for years before receiving compensation.”).

17. *Id.* The authors further estimate that when the effects of using defensive medicine to avoid liability are taken into account, this amount rose to \$55.6 billion in 2008 dollars. *Id.*

18. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Senator Orrin G. Hatch (Oct. 9, 2009), http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf. Health care providers may also incur significant indirect and psychological costs. See *infra* note 97 and accompanying text.

19. See, e.g., Jennifer Arlen, *Contracting Over Liability: Medical Malpractice and the Cost of Choice*, 158 U. PA. L. REV. 957 (2010); Theodore R. LeBlang, *Medical Malpractice Crisis—Is There a Solution?*, 27 J. LEGAL MED. 1 (2006).

20. NANCY BERLINGER, AFTER HARM: MEDICAL ERROR AND THE ETHICS OF FORGIVENESS 11 (2005); see also MICHAEL D. GREENBERG, AMELIA M. HAVILAND, J. SCOTT ASHWOOD & REGAN MAIN, IS BETTER PATIENT SAFETY ASSOCIATED WITH LESS MALPRACTICE ACTIVITY: EVIDENCE FROM CALIFORNIA 1–19 (2010) (showing a significant correlation between the frequency of adverse events and malpractice claims); Barry R. Furrow, *Regulating Patient Safety: The Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1727, 1727 (2011); Ronen Avraham, Op-Ed, *A Market Solution for Malpractice*, N.Y. TIMES, Mar. 29, 2011, at A31 (“It’s been a year since health care reform was signed into law, and since then both Republicans and Democrats have been trying to address one item it left out: medical malpractice reform. In last month’s budget proposal, the Obama administration offered a solution: a plan to encourage evidence-based medicine by limiting the malpractice liability of doctors who follow clinical practice guidelines—in effect, granting them immunity. . . . [But] Mr. Obama’s proposal to limit the liability of doctors who follow these flawed guidelines . . . is clearly not the way to better care.”); News Release, U.S. Dep’t Health & Human Servs., Partnership for Patients to Improve Care and Lower Costs for Americans (Apr. 12, 2011), <http://www.hhs.gov/news/press/2011pres/04/20110412a.html> (proclaiming a “[n]ew partnership between Administration, the private sector, hospitals and doctors to make care safer, potentially save up to \$50 billion” with “leaders from across the nation pledg[ing] their commitment to this new initiative” and “HHS announc[ing] it would invest up to \$1 billion in federal funding, made available under the Affordable Care Act”); U.S. Dep’t Health & Human Servs., Report to

growth and the increasing number of medical procedures performed, the absolute number of medical malpractice claims filed has dropped substantially since the report was released.²¹ Numerous studies have investigated the needs of injured patients and the reasons they file lawsuits against their health care providers, with efforts made at all levels of the health care system, from private institutions to state laws, to address the concerns of both patients and providers, often with an emphasis on avoiding recourse to the courts.²²

Nevertheless, the cost of physicians' malpractice insurance premiums rose significantly in the first half of the last decade despite purported improvements in the quality of care they delivered and either static or decreased levels of awards in malpractice suits.²³ Whatever the reason for

Congress: National Strategy for Quality Improvement in Health Care (Mar. 2011), <http://www.healthcare.gov/center/reports/quality03212011a.html#es> (“[T]he implementation of this Strategy will lead to a measurable improvement in outcomes of care, and in the overall health of the American people.”).

21. Rothstein, *supra* note 3, at 873 (“All of the available data clearly suggest the number of cases filed has dropped significantly in the last decade. One source is data from certain states that maintain the number of state medical malpractice filings. For example, in Pennsylvania, case filings declined from 2,632 in 2000 to 1,533 in 2009. Another source is the National Practitioner Data Bank, which compiles the number of medical malpractice payments made each year. From 2000 to 2009, the number of payments made on behalf of physicians declined from 15,447 to 10,772. . . . Indeed, a leading insurance industry publication stated: ‘Overall, the most significant trend in [medical professional liability insurance] results over the five years through 2008 is the ongoing downward slope in the frequency of claims.’”); see also Bobby Kerlik, *Malpractice Lawsuits in Pennsylvania Continue to Decline*, PITTSBURGH TRIBUNE-REV., May 22, 2011, http://www.pittsburghlive.com/x/pittsburghtrib/email/s_738354.html?s_icmp=et (“The number of medical malpractice cases filed against Pennsylvania doctors and hospitals dropped in 2010, the sixth consecutive annual decline.”). Further, a recent empirical study purports to show that most medical malpractice claims are abandoned by the plaintiffs that brought them. Dwight Golann, *Dropped Medical Malpractice Claims: Their Surprising Frequency, Apparent Causes, and Potential Remedies*, 30 HEALTH AFFAIRS 1343, 1343 (2011).

22. Paul J. Barringer, David M. Studdert, Allen B. Kachalia & Michelle M. Mello, *Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again*, 33 J. HEALTH POL’Y & L. 725, 725 (2008); Richards & McLean, *supra* note 3, at 74; Albert L. Strunk & John T. Queenan, *Beyond Negligence: Administrative Compensation for Adverse Medical Outcomes*, 115 OBSTETRICS & GYNECOLOGY 896, 896 (2010); Amy Widman, *Liability and the Health Care Bill: An “Alternative” Perspective*, 1 CAL. L. REV. CIRCUIT 57, 59 (2010); Michelle M. Mello & Allen Kachalia, *Evaluation of Options for Medical Malpractice System Reform: A Report to the Medicare Payment Advisory Commission (MedPAC)* (Apr. 2010), http://www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf; Gale Scott, *Med Mal Cases Get Expert Hearings: Bronx System Uses Judges, Not Juries, Streamlines Costly Process*, CRAIN’S N.Y. BUSINESS, Aug. 22, 2010, <http://www.crainsnewyork.com/article/20100822/SUB/308229981>.

For an exploration of the reasons that patients sue their health care providers, see Rothstein, *supra* note 3, at 872. State laws permitting physicians to issue apologies to patients who suffer negative outcomes, without fear that those statements will be used against them in court as an admission of fault, are an example of an attempt to provide patients with what they often desire (candidness and concern from their health care providers), while obviating the need for them to sue their health care provider to get it. Sack, *supra* note 15; American Medical Ass’n, Advocacy Resource Center, *I’m Sorry Laws: Summary of State Laws* (July 2007), http://www.physicianspractice.com/all/p2files/images/publication/charts/11_2007_TheLaw_Chart1.pdf.

23. J. ROBERT HUNTER, GILLIAN CASSELL-STIGA & JOANNE DOROSHOW, AMERICANS FOR INSURANCE REFORM, TRUE RISK: MEDICAL LIABILITY, MALPRACTICE INSUR-

these rate increases, they generated, as they have previously,²⁴ the perception among health care providers of a malpractice liability crisis fueled by the litigiousness of patients (driven by greedy plaintiffs' lawyers) and outsized awards made by juries.²⁵ As has also happened in the past,²⁶ this perceived crisis triggered renewed calls for tort reform to limit medical malpractice suits, which in turn, it was believed, would ultimately reduce the malpractice premiums of health care providers.²⁷

But such calls for reform are not the only consequences of a perceived medical malpractice liability crisis.²⁸ It is frequently asserted that physicians, out of fear of potential liability, engage in what has come to be known as "defensive medicine"—orders for tests and treatment that are of dubious medical value yet are thought to protect physicians from future lawsuits by defusing arguments that they acted negligently in failing to order a given procedure.²⁹ Proponents of malpractice liability reform often contend that significant savings in health care expenditures could

ANCE AND HEALTH CARE 14 (2009), available at <http://www.centerjd.org/air/TrueRiskF.pdf> (graph).

24. BARRY R. FURROW ET AL., *HEALTH LAW* 346 (2d ed. 2000) ("The most visible manifestation of the malpractice crisis in the 1970s and again in the 1980s was the size of increase in premiums for malpractice insurance purchased by health care professionals and institutions.").

25. See, e.g., Richard G. Roberts, *Understanding the Physician Liability Insurance Crisis*, *FAM. PRAC. MGMT.*, Oct. 2002, at 47 (2002) ("The most important factor in rising medical liability premiums appears to be the size of the awards.").

26. FURROW ET AL., *supra* note 24, at 349–50 ("The response to the perceived 'crisis' in malpractice litigation and insurance availability . . . has been twofold. First, the availability of insurance has been enhanced by changes in the structure of the insurance industry. Second, provider lobbies and insurers have lobbied with substantial success at the state level for legislation to impede the ability of plaintiffs to bring tort suits; to restrict the size of awards; and to more clearly delineate the standard of care required. It was hoped . . . that state legislation . . . would thereby obviate the crisis in availability and affordability in malpractice insurance.").

27. See Opinion, *The Malpractice Insurance Crisis*, *N.Y. TIMES*, Jan. 17, 2003, <http://www.nytimes.com/2003/01/17/opinion/the-malpractice-insurance-crisis.html?scp=1&sq=The%20Malpractice%20Insurance%20Crisis&st=cse>. But see Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 *DEPAUL L. REV.* 393, 394–95 (2005). These calls for reform ultimately led to the enactment of numerous associated state measures, which in turn resulted in a series of lawsuits challenging these measures. See, e.g., *Estate of McCall v. United States*, 642 F.3d 944, 953 (11th Cir. 2011) (holding Florida's statutory cap on non-economic damages in medical malpractice cases does not violate equal protection or the Takings Clause of the federal or state constitution); *Lebron v. Gottlieb Mem'l Hosp.*, 930 N.E.2d 895, 914 (Ill. 2010) (striking down a 2005 Illinois medical malpractice law that limited the non-economic damages available to victims of medical malpractice); *MacDonald v. City Hosp., Inc.*, No. 35543, 2011 WL 2517201 (W. Va. June 22, 2011) (ruling West Virginia law that limits non-economic damage awards in medical malpractice cases does not violate the state constitution); see also Thomas Kaplan, *Lessons for Albany on Malpractice Limits*, *N.Y. TIMES*, Mar. 24, 2011, at A22 ("As New York lawmakers strive to complete the state budget . . . , one of the most contentious battles involves whether to include a cap on medical malpractice payments But other states that have similar caps in place offer cautionary evidence about the big savings for health care providers that such limits are believed to produce.").

28. See Mello et al., *supra* note 16, at 1569 (recognizing the connection between medical malpractice liability and defensive medicine).

29. A common definition of defensive medicine is "when doctors order tests, procedures, or visits, or avoid certain high-risk patients or procedures, primarily (but not solely) because of concern about malpractice liability." Mello et al., *supra* note 16, at 1572 (citing

be obtained if physicians did not feel obligated to order these unnecessary procedures to protect themselves from liability.³⁰ While estimates vary widely, researchers at Harvard University recently placed the cost of defensive medicine at \$45.6 billion per year (based on the year 2008), or roughly 2% of the nation's health care spending.³¹

III. THE FEDERAL RESPONSE

Yet despite the vigorous continuing debate over medical malpractice liability, the PPACA did not take a position on the issue.³² Instead, section 6801 simply expresses the "sense of the Senate" (and thus not the House at that time)³³ that "health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance" and that:

[s]tates should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court[,]

while recommending that "Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims."³⁴ Section 10607 of the PPACA goes on to establish such a program, providing federal grants to support state demonstration projects

U.S. CONG., OFFICE OF TECH. ASSESSMENT, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, OTA-H-602 (1994), available at <http://biotech.law.lsu.edu/policy/9405.pdf>.

30. See *President Obama's Speech to American Medical Association*, *supra* note 10.

31. Mello et al., *supra* note 16, at 1574. At the same time, these conclusions and the impact of medical malpractice liability reform have been sharply contested. See Aaron Carroll, *Meme-Busting: Tort Reform = Cost Control*, WASH. POST, June 2, 2011, http://www.washingtonpost.com/blogs/ezra-klein/post/meme-busting-tort-reform-cost-control/2011/06/02/AGpb0DHH_blog.html?referrer=emailink ("it's not the solution to our high health-care spending").

32. See generally PPACA, Pub. L. No. 111-148, § 6801, 124 Stat. 119-1025 (2010) (codified as amended in scattered sections of 42 U.S.C.).

33. The Democratic Party held a majority in the House of Representatives when the PPACA was enacted. In the following Congressional election of 2010, the Republican Party gained a majority and promptly introduced a bill to reform medical malpractice liability nationally, which included provisions to place a three-year statute of limitations on malpractice lawsuits, a cap on non-economic damages, and a limit on punitive damages. Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, H.R. 5, 112th Cong. (2011). The Democrat-controlled Senate, however, has signaled its unwillingness to pass this bill (assuming it can survive some Republican opposition to it in the House), notwithstanding that its previously stated "sense of the Senate" could be construed to suggest amenability to such legislation. See Alexander Bolton, *Senate Democrats Skeptical on Malpractice Reform*, THE HILL: HEALTHWATCH, Jan. 26, 2011, <http://thehill.com/blogs/healthwatch/other/140255-senate-democrats-greet-call-for-medical-malpractice-reform-with-skepticism>; Brett Coughlin, *House Judiciary Approves Tort Reform*, POLITICO, Feb. 16, 2011, <http://www.politico.com/news/stories/0211/49703.html>; Savage, *supra* note 11.

34. PPACA, Pub. L. No. 111-148, § 6801, 124 Stat. 119-1025 (2010) (codified as amended in scattered sections of 42 U.S.C.).

intended to test the effectiveness of alternatives to the current medical tort litigation system.³⁵ Whether one considers these modest provisions to be a step in the right direction toward making rational and empirically driven changes to the existing litigation system or a wasted opportunity to enact needed national reform, they are certainly nothing like the sweeping overhaul of other parts of the nation's health care system that can be found elsewhere in the bill.³⁶

To say that the PPACA adopted a minimalist approach when it came to the topic of malpractice liability reform is not to suggest that the current administration is wholly uninterested in addressing the matter (although skeptics may disagree).³⁷ In his September 2009 address to Congress previously noted,³⁸ as the debate over health care reform was taking center stage in Congress, President Obama signaled at least some willingness to address medical malpractice reform when he stated:

I don't believe malpractice reform is a silver bullet, but I've talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs. So I'm proposing that we move forward on a range of ideas about how to put patient safety first and let doctors focus on practicing medicine. . . . I'm directing my Secretary of Health and Human Services to move forward on [a demonstration projects] initiative today.³⁹

The directive that the President gave to the Secretary of the Department of Health and Human Services (DHHS) resulted in the establishment of the Patient Safety and Medical Liability Initiative, a program administered by the DHHS and the Agency for Healthcare Research and Quality to provide grants for the planning and demonstration of a variety of proposed means for improving patient safety and reducing medical liability costs.⁴⁰ While the criteria and funding for these grants were desig-

35. *Id.* § 10607 (“Each State desiring a grant . . . shall develop an alternative to current tort litigation that allows . . . for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations,” and that “allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and . . . promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved . . . by organizations that engage in efforts to improve patient safety and the quality of health care.”).

36. *See, e.g., id.* § 1501 (requiring individuals to maintain minimum essential insurance coverage).

37. *See* Barack Obama, President of the U.S., Overhauling Health Care: Address to a Joint Session of Congress (Sept. 9, 2009), *available at* <http://www.presidentialrhetoric.com/speeches/09.09.09.html> (recognizing the need to address medical malpractice liability reform).

38. *See* Weisman & Adamy, *supra* note 11 and accompanying text.

39. Obama, *supra* note 37.

40. Memorandum from the White House to the Secretary of Health & Human Services, Demonstration Grants for the Development, Implementation, and Evaluation of Alternatives to the Current Medical Liability System (Sept. 17, 2009), *available at* http://www.whitehouse.gov/the_press_office/Presidential-Memorandum-Concerning-Medical-Liability-Reform; *see also* U.S. Dep't of Health & Human Servs., *The HHS Patient Safety and Medical Liability Initiative*, HHS.GOV, http://www.hhs.gov/news/press/2010pres/06/patient_safety_and_medical_liability_initiative.htm (last visited Aug. 29, 2011).

nated administratively and were not linked to the soon to be enacted PPACA, they do in a number of ways parallel the provisions found in the PPACA and therefore provide a useful source for analysis, highlighting both the potential of the PPACA provisions and their limitations.⁴¹

IV. PATIENT SAFETY AND MEDICAL LIABILITY INITIATIVE DEMONSTRATION FUNDING

The Department of Health and Human Services (DHHS) and the Agency for Healthcare Research and Quality (AHRQ) announced the first grants to be made under the Patient Safety and Medical Liability Initiative (PSMLI) on June 11, 2010.⁴² An amount of \$19,652,522 was divided among seven grant recipients authorized to implement demonstration projects, while \$3,566,892 was allocated to thirteen planning projects.⁴³ The four announced goals of this funding are to: (1) “[p]ut patient safety first and work to reduce preventable injuries”; (2) “[p]rovide better communication between doctors and their patients”; (3) “[e]nsure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits”; and (4) “[r]educe liability premiums.”⁴⁴

In justifying these goals, the DHHS declared that “[t]oo many patients experience significant challenges with health care quality and patient safety, and many injured patients are not well-served by the current medical liability system.”⁴⁵ It further cited the following mixture of patient-focused and physician-focused “background facts” on patient safety and medical liability: (1) “[a]ccording to the Institute of Medicine (IOM) report *To Err Is Human*, between 44,000 and 98,000 patients die each year from medical errors”; (2) “[p]atients who are seriously harmed from medical errors often wait too long for compensation”; (3) “[m]any experts believe fear of liability is a substantial barrier to the development of transparent and effective patient safety initiatives in hospitals and other settings”; (4) “[m]any doctors believe that medical liability concerns lead to ‘defensive medicine,’ which in turn may contribute to higher costs”; (5) “[m]any physicians continue to struggle to pay their medical malpractice premiums, which vary tremendously by specialty and by state[, as t]he cost of insurance continues to be one of the highest practice expenses for some specialties”; and (6) “[f]ears of medical malpractice claims may lead to altered practices, restricted emergency coverage, and limited or discontinued high-risk procedures.”⁴⁶ The DHHS added, “[t]he evidence regarding the impact of prior efforts to reduce the occurrence of lawsuits

41. See PPACA § 10607(a), (c).

42. Press Release, U.S. Dep’t of Health & Human Servs., HHS Announces Patient Safety and Medical Liability Demonstration Projects (June 11, 2010), available at <http://www.hhs.gov/news/press/2010pres/06/2010061a.html>.

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

and improve patient safety is mixed. In particular, evidence regarding the impact of specific medical liability reforms on health care quality and patient safety is almost nonexistent; these grants will address that essential gap.”⁴⁷

As described by the DHHS, “[t]he *planning grants* give States and health systems the opportunity to create detailed plans for patient safety and medical liability reform” and “represent a variety of models that meet one or more of the patient safety and medical liability reform goals, including [eleven] that are intended to reduce preventable medical injuries in a variety of ways,” while the *demonstration projects* “support the implementation and evaluation of evidence-based patient safety and medical liability projects” and “include a variety of models that meet one or more of the patient safety and medical liability reform initiative goals.”⁴⁸

Both state government entities and private health care systems are eligible to apply for funding under the PSMLI.⁴⁹ A second round of demonstration project funding was announced in November of 2010, and the AHRQ is currently accepting proposals for review.⁵⁰

Of the seven currently funded demonstration projects, three attempt to address the costs of the medical malpractice liability system directly by changing what occurs following an adverse medical event but prior to traditional litigation, while the other four attempt to do so indirectly by improving the quality of care that patients receive in order to reduce the number of adverse events and, by extension, the number of lawsuits that flow from them.⁵¹ Since this Article is concerned primarily with how re-

47. *Id.*

48. *Id.* (emphasis added).

49. *Medical Liability Reform and Patient Safety Demonstration Projects (R18): RFA-HS-10-021*, NAT'L INSTITUTES HEALTH, <http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-10-021.html> (last visited Aug. 17, 2011).

50. *Medical Liability Reform and Patient Safety Demonstration Projects (R18): PAR-11-025*, NAT'L INSTITUTES HEALTH, <http://grants.nih.gov/grants/guide/pa-files/PAR-11-025.html> (last visited Aug. 17, 2011).

51. See Agency for Healthcare Research & Quality, *Medical Liability Reform and Patient Safety: Demonstration Grants*, AHRQ.GOV (June 2010), <http://www.ahrq.gov/qual/liability/demogrants.htm> (providing brief summaries of the goals of each of the seven funded projects, including to: (1) “fill the evidence gap regarding the impact on patient safety and litigation rates of programs that feature improved communication with patients, transparency, disclosure of adverse events, early offers of compensation, and learning from mistakes” (University of Illinois at Chicago); (2) “improve perinatal (the period prior to and just after birth) patient safety and demonstrate the relationship between improved patient safety and a reduction in the number of malpractice claims” (Fairview Health Services in Minneapolis); (3) “use . . . a disclosure and compensation model, which informs injured patients and families promptly and makes efforts to provide prompt compensation” (University of Texas Health Science Center); (4) “establish a uniform, evidence-based obstetrics practice model based on the idea that eliminating variation in obstetrics practice will translate to improved patient safety” (Ascension Health System in St. Louis); (5) establish “communication training for health care workers and a collaboration between hospitals and a malpractice insurer to improve adverse event analysis, disclosure, and compensation” (University of Washington); (6) “protect obstetrical and/or surgery patients from injuries caused by providers’ mistakes and reduce the cost of medical malpractice through the use of an expanded and enhanced Judge-Directed Negotiation Program currently used

forms targeting the litigation process can improve the medical malpractice liability system, the three projects that deal with litigation most directly deserve a brief mention.

One grant, made to the New York State Unified Court System (principal investigator, Judy Kluger), funds a program to implement a new early disclosure and settlement model in five academic medical centers in New York City and to expand and enhance an existing Judge-Directed Negotiation Program.⁵² Another grant, made to the University of Illinois at Chicago (principal investigator, Timothy McDonald), supports an evaluation of the effectiveness of a comprehensive process for responding to patient harm events known as the “Seven Pillars” (the long-term objectives of which are “to improve patient safety and mitigate medical liability risk through improved communication with patients and families, disclosure and early offer when patients suffer preventable harm, and by learning from mistakes to prevent future harms”) and to determine the feasibility of implementing this process at other hospitals in the Chicago area.⁵³ The third grant was awarded to the University of Texas Health Science Center (principal investigator, Eric J. Thomas) to fund a project studying best practices within a disclosure and compensation system to determine how best to utilize such systems to promote patient safety and dispute resolution.⁵⁴

Notably, all three of these funded demonstration projects address “disclosure and compensation” in one way or another, although none of them target litigation per se.⁵⁵ In a nutshell, disclosure and compensation systems are intended to quickly identify, investigate, and respond to medical errors when they occur; fully disclose to the patient what the investigating facility believes occurred; and make an offer of compensation to the patient for any injuries suffered as a result of medical error.⁵⁶ Proponents of such systems identify numerous benefits that might accrue from their use, including faster dispute resolution, reduced court and attorney costs for both sides, financial support for injured patients when they need it most instead of only after years of litigation, and one of the things pa-

in New York’s courts, coupled with a new hospital early disclosure and settlement model” (New York State Unified Court System); and (7) “engage clinicians, patients, malpractice insurers, and the State public health agency to ensure more timely resolution of medical errors that occur in outpatient practices and improve communication in all aspects of care” (Massachusetts State Department of Public Health)).

52. Agency for Healthcare Research & Quality, *Grant Number HS19505-01*, AHRQ.gov, http://gold.ahrq.gov/projectsearch/grant_summary.jsp?grant=R18+HS19505-01 (last visited Aug. 17, 2011).

53. Agency for Healthcare Research & Quality, *Grant Number HS19565-01*, AHRQ.gov, http://gold.ahrq.gov/projectsearch/grant_summary.jsp?grant=R18+HS19565-01 (last visited Aug. 17, 2011).

54. Agency for Healthcare Research & Quality, *Grant Number HS19561-01*, AHRQ.gov, http://gold.ahrq.gov/projectsearch/grant_summary.jsp?grant=R18+HS19561-01 (last visited Aug. 17, 2011).

55. See *Grant Number HS19505-01*, *supra* note 52; *Grant Number HS19561-01*, *supra* note 54; *Grant Number HS19565-01*, *supra* note 53.

56. David A. Hyman, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 943 (2005).

tients want the most: honesty and openness from their health care providers.⁵⁷

While preliminary results from the small set of implemented disclosure and compensation systems may show some promise,⁵⁸ opponents caution that there is a risk that cost savings will be realized at the expense of fairness and justice.⁵⁹ First, because the investigations into whether or not a patient's injury was due to medical error are carried out by the institution that would be responsible for compensating them, the institution may be either consciously or unconsciously biased in favor of finding that no error occurred.⁶⁰ Second, asking patients to accept an offer just a short time after they have been injured—before they have had a chance to consult with an attorney, conduct their own investigation, or even recover (physically and emotionally) from their injury—may serve to pressure uninformed patients into accepting inadequate offers.⁶¹ Third, concern has been expressed that this approach may be “extremely punitive toward patients who do not accept the settlement provided.”⁶²

Another frequently cited alternative model to traditional medical malpractice litigation is that of “health courts,”⁶³ an approach that is the focus of the New York grant's Judge-Directed Negotiation Program.⁶⁴ This model is driven by the notion that because medicine is a highly specialized field, medical malpractice cases should be handled by judges who have received special training relevant to medicine-related lawsuits so as to be better able to evaluate the merits of these cases.⁶⁵ Judge-Directed Negotiation goes one step further, having those same judges make concerted attempts to bring the parties to the table and then mediate negotiations between them outside of court.⁶⁶ As pioneered by Bronx Judge

57. Richard C. Boothman, Amy C. Blackwell, Darrell A. Campbell, Jr., Elaine Comiskey & Susan Anderson, *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 159 (2009); Allen Kachalia, Samuel R. Kaufman, Richard Boothman, Susan Anderson, Kathleen Welch, Sanjay Saint & Mary A.M. Rogers, *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS INTERNAL MED. 213, 219 (2010).

58. Kachalia et al., *supra* note 57, at 219.

59. Widman, *supra* note 22, at 64; Joanne Doroshov, *Analysis of HHS Patient Safety and Medical Liability Initiative Demonstration Grant Proposal for New York State*, CENTER FOR JUSTICE & DEMOCRACY (2010), <http://www.centerjd.org/archieves/issues-facts/HH-SNYMedMalDemoGrantAnalysis.pdf>.

60. See Widman, *supra* note 22, at 63–64.

61. *Id.* at 64; see also Joanne Doroshov, *supra* note 59 (“There is little doubt that an uninformed patient, particularly one who is catastrophically injured, will be pressured by the hospital to resolve their case for a fraction of what they need or deserve, particularly when it comes to future medical expenses. . . . [N]o lay person will ever be capable of making a reasoned decision as to what they may need, such as in the case of a brain-injured newborn, without the assistance of counsel or their own expert.”).

62. Widman, *supra* note 22, at 64.

63. Paul Barringer, *Health Courts: A Better Approach to Malpractice Reform*, 14 BNA'S HEALTH L. REP. 877 (2005); Michelle M. Mello, David M. Studdert, Allen B. Kachalia & Troyen A. Brennan, “Health Courts” and Accountability for Patient Safety, 84 MILBANK Q. 459, 460 (2006); Scott, *supra* note 22.

64. Scott, *supra* note 22.

65. *Id.*

66. *Id.*

Douglas McKeon and the New York City Health and Hospitals Corporation, Judge-Directed Negotiation has been reported to increase the rate at which medical malpractice cases settle, decrease the average time it takes to resolve cases, and reduce the overall cost of those cases.⁶⁷ Among the criticisms levied at health courts in general are that “the modest benefits likely to be produced . . . are more than matched by the risks of bias and overreaching that these courts would also present,”⁶⁸ that they raise constitutional concerns,⁶⁹ that they incorporate an inevitable slide toward a limitation on awards,⁷⁰ and that they do not improve patient safety.⁷¹ With regard to the Judge-Directed Negotiation approach specifically, concern might be expressed that a judge involved in both the mediation and subsequent adjudication would be biased by what he or she learned during mediation, notwithstanding that this information would not be admissible at the adjudication hearing.⁷²

As might be inferred, these demonstration projects, as well as the thirteen funded planning grants,⁷³ are unlikely to bring closure to the debate on the role and impact of medical malpractice liability and related proposed reforms. This is in part because they do not address medical malpractice litigation per se but rather focus on steps that obviate the need

67. Barringer, *supra* note 63, at 877; Mello et al., *supra* note 63, at 460; William Glaberson, *To Curb Malpractice Costs, Judges Jump in Early*, N.Y. TIMES, June 12, 2011, at A1 (“Under a \$3 million federal grant, the city courts are now expanding the [judge-directed negotiation] program beyond the Bronx, where it started in cases against city hospitals, to courts in Brooklyn and Manhattan, as well as to cases against private hospitals. It is to begin in Buffalo courts in the fall [of 2011].”).

68. Philip J. Peters, Jr., *Health Courts?*, 88 B.U. L. REV. 227, 227–28 (2008) (arguing that health courts should not be introduced without the accompanying implementation of hospital enterprise liability, which is “the doctrinal change most likely to improve patient safety”).

69. Widman, *supra* note 22, at 61 (“Health court proponents point to worker’s compensation and no-fault auto insurance as models for such a program. However, there is a significant constitutional difference between those programs and the proposed health courts: the standard of liability. Those alternatives share a strict liability theory, which sharply contrasts with the health court model’s avoidability theory. The difference is vital to the constitutionality of such programs because the general maxim is that the legislature may not remove a right from the jury without offering a quid pro quo. Strict liability is the quid, and without it, these pilot programs are vulnerable to constitutional attacks at both the state and federal levels.”).

70. *Id.*

71. *Id.* at 62.

72. *See, e.g.*, FED. R. EVID. 408(a)(2).

73. Although space constraints preclude their discussion here, the planning grants funded under the PSMLI reflect approaches that are similar to those of the demonstration grants. A description of the planning grants can be found at Agency for Healthcare Research & Quality, *Medical Liability Reform and Patient Safety: Planning Grants*, AHRQ.GOV, <http://www.ahrq.gov/qual/liability/planninggrants.htm> (June 2010) (these planning grants “represent a variety of models that meet one or more of the patient safety and medical liability reform goals, including [eleven] that are intended to reduce preventable medical injuries in a variety of ways,” which include “[s]upporting the development of a ‘safe harbor’ for physicians who can prove they followed State-endorsed evidence-based care guidelines,” “[p]romoting shared decision making,” “[s]upporting early disclosure and offer models, which inform injured patients and families promptly, and make efforts to provide prompt compensation,” and “[p]romoting transparency and enhanced communication between providers and patients when avoidable injuries occur.”).

for it, and because their results are likely to reflect local efforts and conditions that may not be generalizable to other jurisdictions.⁷⁴ Further, if these projects were funded without the aid of the PPACA, the question remains: what does the PPACA contribute to this ongoing discourse?

V. PATIENT PROTECTION AND AFFORDABLE CARE ACT DEMONSTRATION FUNDING

The answer is, not very much. Like the PSMLI before it, the PPACA provides for grants to support demonstration projects with the goal of improving patient safety and reducing the costs of the medical liability system, but it differs in several critical ways that are likely to impair the value of this funding.⁷⁵ First, whereas grants under the PSMLI can be sought by both states and private health care systems, the PPACA provides that only states may apply for its grant funding,⁷⁶ potentially limiting the number of applicants and testing grounds for malpractice reform ideas. Second, and of particular importance, the requirements that proposals must meet to receive funding are more restrictive under the PPACA, meaning that many of the leading ideas for malpractice reform are not eligible for funding.⁷⁷

Restricting funding only to states is significant in that it automatically forecloses many otherwise capable applicants from testing ideas for improving patient safety and reforming the way they handle malpractice liability.⁷⁸ Notably, only 1,092 out of a total 5,795 hospitals in the United States are run by state governments, leaving over 80% of these potential testing grounds for reform unable to independently pursue funding under the PPACA.⁷⁹ Two out of the seven currently funded demonstration grants under the PSMLI were made to private organizations, as were seven of the thirteen planning grants, none of which would have been able to directly receive a grant under the PPACA.⁸⁰ While the states may solicit input from and involve private health care systems in their demonstration projects,⁸¹ states may also channel or limit these contributions because of political agendas or ideological differences in how they believe these issues should be approached.

The types of institutions eligible to apply for funding under the PPACA, however, is not the only restriction that will make it difficult for the federal money promised by the Act to support serious, effective

74. See generally *Medical Liability Reform and Patient Safety: Demonstration Grants*, *supra* note 51.

75. PPACA, Pub. L. No. 111-148, § 10607(c)(1), 124 Stat. 119-1025 (2010) (codified as amended in scattered sections of 42 U.S.C.).

76. *Id.* § 10607(a).

77. Bovbjerg, *supra* note 4, at 1.

78. See *Medical Liability Reform and Patient Safety: Demonstration Grants*, *supra* note 51 (indicating that seven private institutions received planning grants under the PSMLI).

79. Am. Hosp. Ass'n, *Fast Facts on U.S. Hospitals*, AHA.ORG, <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html> (last updated Dec. 7, 2010).

80. See *supra* text accompanying notes 43, 51.

81. See PPACA § 10607(j).

changes in the medical liability system. Like the PSMLI, the PPACA sets out a list of criteria that projects must meet to receive funding, but its list is more extensive and demanding.⁸² The requirements for a project to be eligible for funding under the PPACA are that it:

- (A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;
- (B) encourages the efficient resolution of disputes;
- (C) encourages the disclosure of health care errors;
- (D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;
- (E) improves access to liability insurance;
- (F) fully informs patients about the differences in the alternative and current tort litigation;
- (G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;
- (H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and
- (I) would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.⁸³

To require one project to satisfy all of these criteria may be unrealistic and prohibitive. What differentiates the criteria most starkly from the requirements of the PSMLI, however, are items (H) and (I).⁸⁴ By prohibiting any demonstration that would require a change in state law, the PPACA may not be able to fund studies of options that involve procedures that are not available under existing law. Safe harbor protections, for example, that would provide predictable liability protection to physicians who adhere to specific evidence-based practices will be unavailable for testing if such programs would require a change in existing state liability rules.⁸⁵ Similarly, funding would not appear to be available for administrative compensation systems that would attempt to enhance the predictability and consistency of awards for injury by making the medical tort process more like the workers' compensation process because such a system would inevitably involve substantial changes in patients' rights to bring traditional medical malpractice lawsuits.⁸⁶

82. *Id.* § 10607(c).

83. *Id.*

84. Compare PPACA § 10607(c), with *Medical Liability Reform and Patient Demonstration Projects (R18): RFA-HS-10-021*, *supra* note 49 (lacking the same restrictions that are present in the PPACA).

85. Bovbjerg, *supra* note 4, at 2. It should be noted, however, that reliance on evidence-based guidelines has itself garnered criticism. See Widman, *supra* note 22, at 65-67.

86. *Id.* As another example, a "health court" focused project like the Judge-Directed Negotiation model being studied under an existing PSMLI demonstration grant, see *supra* notes 52-54 and accompanying text, would likely require a change in state law to adapt the existing court structure in many, if not most, jurisdictions and thus be precluded from study

Further, beyond these limitations on the funding of demonstration grants, some have argued that because the PPACA does so little to directly address malpractice and malpractice litigation-related concerns, its enactment will actually result in an increase in the number of malpractice cases and related costs as its provisions come into effect.⁸⁷ As more patient encounters occur per year as a result of more insured people seeking medical attention, as a matter of course, the total number of adverse events may increase, resulting in a greater number of medical malpractice suits.⁸⁸ In addition, because the number of available physicians will remain constant while the number of patients able to obtain medical care will increase, this may result in the time and energy of doctors being stretched to cover more patients, possibly resulting in an increased number of mistakes on the part of physicians.⁸⁹ Alternatively, patients may simply have to wait longer to see a physician, a pattern that has already been observed for Medicaid patients,⁹⁰ but with the result that when pa-

under the PPACA. Similarly, a proposal to study a fiduciary duty approach in lieu of, or as a supplement to, a more traditional medical malpractice model would not be available in those states that have not explicitly embraced the fiduciary duty doctrine in this context. See generally Thomas L. Hafemeister & Sarah P. Bryan, *Beware Those Bearing Gifts: Physicians' Fiduciary Duty to Avoid Pharmaceutical Marketing*, 57 U. KAN. L. REV. 491 (2009); Thomas L. Hafemeister & Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians to "Just Say No" if an "Informed" Patient Demands Services that Are Not Medically Indicated*, 39 SETON HALL L. REV. 335 (2009); Thomas L. Hafemeister & Selina Spinos, *Lean On Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient*, 86 WASH. U. L. REV. 1167 (2009). Even the "early offer" approach, which has been widely discussed as a possible alternative to the prevailing way in which medical malpractice lawsuits are processed, could not be studied because it would involve, among other things, a change in the burden of proof at trial. See generally Joni Hersch, Jeffrey O'Connell & W. Kip Viscusi, *An Empirical Assessment of Early Offer Reform for Medical Malpractice*, 36 J. LEGAL STUD. S231 (2007); Jeffrey O'Connell, *The Large Cost Savings and Other Advantages of an Early Offer "Crimtorts" Approach to Medical Malpractice Claims*, 17 WIDENER L. J. 835 (2008). For a discussion of prominently noted alternatives to the existing medical malpractice liability system, most of which would necessitate a change in state law and thus be ineligible for funding under the PPACA, see generally Anne Underwood, *Prescriptions: Experiments in Tort Reform*, N.Y. TIMES (Oct. 13, 2009), <http://prescriptions.blogs.nytimes.com/2009/10/13/experiments-in-tort-reform/>.

87. Rothstein, *supra* note 3, at 871 ("When fully implemented, PPACA will increase the number of individuals with health care coverage by approximately 32 million. As a result, there will be many millions of additional patient encounters each year. If the rate of adverse events arguably attributable to medical malpractice remains constant, then it might be assumed that the total number of medical malpractice claims will increase.")

88. *Id.*

89. *Id.* Physicians could refuse to see more patients, but it is probably likely that at least some physicians, driven either by their perceived ethical responsibilities to patients in need or their desire to maximize their revenue, will significantly increase the number of patients they see.

90. See Lisa Kim Bach, *Medicaid Patients Left Without Care*, LAS VEGAS REV.-J., Mar. 23, 2008, at 1B, available at <http://www.lvrj.com/news/16936926.html>; Dan Diamond, *New Year, but Same Old Budget Challenges*, CAL. HEALTHLINE, Jan. 12, 2011, <http://www.californiahealthline.org/road-to-reform/2011/new-year-but-same-old-budget-challenges.aspx>; Kevin Sack, *As Medicaid Payments Shrink, Patients Are Abandoned*, N.Y. TIMES, Mar. 16, 2010, at A1; Kevin Sack & Robert Pear, *States Consider Medicaid Cuts as Use Grows*, N.Y. TIMES, Feb. 19, 2010, at A1; Shawn Tully, *Health Care Reform Can't Work Without More Doctors*, CNN MONEY, Apr. 6, 2011, http://money.cnn.com/2011/04/06/news/doctor_shortage_healthcare.fortune/index.htm ("[President Obama's plan] aims to vastly increase health care coverage while effectively freezing the ranks of the already-busy

tients are able to see a physician their medical state will have deteriorated to the point where it is more difficult and complicated to treat, resulting in more treatment-related adverse events and malpractice litigation.⁹¹

VI. CONCLUSION

No doubt the proponents of the PPACA were unwilling to incorporate medical malpractice litigation reform into the bill lest its divisive nature destroy the fragile support necessary to enact this legislation, but because they avoided tackling medical malpractice liability in the debate over the PPACA, the topic was essentially swept under the rug.⁹² Although for all practical purposes they succeeded in keeping medical malpractice reform out of the bill,⁹³ the underlying fracture associated with this type of litigation remains. Indeed, this unresolved tension could ultimately undercut the success of the PPACA, as the Act's attempts to control escalating health care costs may be undermined if the practice of defensive medicine, propelled by fears of malpractice liability, continues unabated.⁹⁴

The debate about medical malpractice liability will undoubtedly resurface,⁹⁵ though perhaps in a context that the proponents of the PPACA will find disadvantageous. The PPACA and the PSMLI demonstration funding criteria and the awarded grants focus on how to dissuade injured

providers needed to furnish all those extra [services] . . . Medicare and Medicaid patients will increasingly face long waits to see a doctor, if they can find a physician to treat them at all.”).

91. Others argue that even if more patients are receiving medical care under the PPACA (which is a benefit that may well outweigh the cost of any increase in medical malpractice), other provisions of the Act will have the effect of reducing the total number of malpractice suits. For example, one reason patients may sue for malpractice is concern over their ability to pay ongoing medical costs. However, if the PPACA's provisions expand the availability of insurance, remove lifetime caps on benefits, and eliminate disqualifications from coverage based on preexisting conditions, far more injured patients will be able to rely on insurance to cover their medical costs instead of awards won through the unpredictable course of litigation, and thus they will not feel pressure to sue because of a fear that needed insurance benefits will not be available to them. Rothstein, *supra* note 3, at 871.

92. See generally PPACA, Pub. L. No. 111-148, § 6801, 124 Stat. 119-1025 (2010) (codified as amended in scattered sections of 42 U.S.C.).

93. *Id.*

94. See Mello et al., *supra* note 16, at 1574 (recognizing the extensive cost of defensive medicine).

95. Indeed, if anything, this debate has continued unchecked. See Emily Ramshaw, *State's Tort Reform Makes Lawyers Wary of Taking on Patients*, N.Y. TIMES, Dec. 19, 2010, at A39A; see also Walt Bogdanich & Kristina Rebelo, *A Pinpoint Beam Strays Invisibly, Harming Instead of Healing*, N.Y. TIMES, Dec. 29, 2010, at A1; Amy Goldstein, *GOP Lacks Clear Health Plan*, WASH. POST, Jan. 16, 2011, at A03; *Loser Pays, Everyone Wins: Texas Pushes the British Rule on Tort Reform*, WALL ST. J., Dec. 15, 2010, at A20; Press Release, 24-7PressRelease, “SAFE HARBOR” FOR DOCTORS, CAPS, HEALTH COURTS AND OTHER PANACEAS ARE NOT THE ANSWER TO RISING HEALTH CARE COSTS (JAN. 18, 2011), available at <http://www.24-7pressrelease.com/press-release/safe-harbor-for-doctors-caps-health-courts-and-other-panaceas-are-not-the-answer-to-rising-health-care-costs-191524.php>.

patients from pursuing medical malpractice claims in court.⁹⁶ These efforts may in turn provide support and momentum for calls that an avoidance of the legal system should be the emphasis of future medical malpractice liability reform. Indeed, avoiding litigation is a high priority for members of the medical profession because litigation tends to be unpleasant and distracting, it may cause them to pay increased medical malpractice premiums, and it can stigmatize and jeopardize a physician's reputation and status.⁹⁷

These funding criteria and grants, however, do virtually nothing to address what happens when disclosure and compensation systems fail,⁹⁸ which they will almost inevitably do in some cases when the parties can not agree on a resolution. Also, in these relatively informal discussions, patients may be at risk of not fully understanding their situation and options, or they may be unable to effectively advocate on their own behalf. Further, these largely private negotiations, unlike the public forum of litigation, may fail to reduce the likelihood of future patient harm. By emphasizing the deleterious impact of medical malpractice litigation on physicians,⁹⁹ the funding criteria and resulting demonstration projects of the PPACA and the PSMLI generally fail to ensure that patients who have been harmed by medical malpractice, through no fault of their own, will be adequately compensated and that future medical malpractice will be deterred.

Finally, by directing that demonstration grants be awarded based on restrictive criteria¹⁰⁰ that prevent funding from being devoted to proposals that would explore more substantial, creative alternatives to the status quo, the more difficult and potentially troubling questions related to medical malpractice liability reform tend to be avoided and alternative solutions remain untested. The focus adopted by the PPACA and the PSMLI will instead promote the likelihood that avoiding litigation will be

96. See *Medical Liability Reform and Patient Safety: Demonstration Grants*, *supra* note 51 (emphasizing that the seven awarded demonstration grants meet the initiative's goal of "[p]romoting early disclosures and settlement, through a court-directed alternative dispute resolution model"); *Medical Liability Reform and Patient Safety Demonstration Projects (R18): RFA-HS-10-021*, *supra* note 49 (stressing that one of the purposes of the funding is to reduce "the incidence of frivolous lawsuits and liability premiums").

97. See Roberts, *supra* note 25, at 47 (noting the problem of increasing medical malpractice premiums); see also Anupam B. Jena, Seth Seabury, Darius Lakdawalla & Amitabh Chandra, *Malpractice Risk According to Physician Specialty*, 365 *NEW ENG. J. MED.* 629, 634–35 (2011) ("[P]hysicians consistently report concern over malpractice and the intense pressure to practice defensive medicine Physicians can insure against indemnity payments through malpractice insurance, but they cannot insure against the indirect costs of litigation, such as time, stress, added work, and reputational damage.").

98. See generally *Medical Liability Reform and Patient Safety: Demonstration Grants*, *supra* note 51 (showing the awarded grants' failure to address situations when disclosure and compensation systems fail).

99. See PPACA, Pub. L. No. 111-148, § 10607(c), 124 Stat. 119-1025 (2010) (codified as amended in scattered sections of 42 U.S.C.); *Medical Liability Reform and Patient Safety Demonstration Projects (R18): RFA-HS-10-021*, *supra* note 49.

100. PPACA § 10607(c)(2).

the center of future medical malpractice liability reform debate, or it will at least enhance the likelihood that the opposing sides in this debate will continue to largely talk past one another.¹⁰¹

101. As evidence that these two sides can find common ground, see Amy Jeter, *Deal Would Raise Caps on Malpractice Suits in Va.*, THE VIRGINIAN-PILOT, Jan. 11, 2011, <http://hamptonroads.com/2011/01/deal-would-raise-cap-malpractice-suits-va>; Anita Kumar, *Bill Would Raise Medical Malpractice Awards in Va.*, VA. POLITICS, Dec. 3, 2010, http://voices.washingtonpost.com/virginiapolitics/2010/12/post_711.html.

Casenotes

