

Will the Patient Protection and Affordable Care Act Address the Problems Associated with Medical Malpractice?

Timely Analysis of Immediate Health Policy Issues

August 2010

Randall R. Bovbjerg

Political battles over malpractice reform have recurred for 35 years, starting at the state level. Many states have enacted caps on awards and other tort reforms amid liability insurance crises proclaimed in the mid-1970s, mid-1980s, and early 2000s. Since the mid-1990s, Republicans have unsuccessfully sought similar malpractice limits at the federal level. Sharp run-ups in claims rates preceded the first two crises; the last seemed more driven by increases in awards and other costs, along with insurance market developments. Defensive medicine arose separately as a national policy issue in the late 1960s. At the time, medical liability was expanding from the very low level of the 1950s because of shifts in both tort doctrines and social culture.

The debates about problems and reforms are acrimonious, and arguments have become routinized. Conventional tort reform is a zero-sum game, much as lawsuits are—every gain for one side is a loss for the other. Meanwhile, neither patients nor caregivers are well served by the traditional liability regime.¹

The liability provisions of the Patient Protection and Affordability Act (PPACA)² did nothing to change this political dynamic or the underlying problems. The number of preventable injuries remains high, almost entirely compensated by health insurance rather than liability insurance. Some defensiveness persists, encouraging

Malpractice reforms could help curb health care spending and promote safety, but PPACA only offers small steps.

overutilization and hampering cost containment and many forms of safety promotion. Accountability for underperforming practitioners remains elusive, possibly to be improved by other parts of health reform. And liability processes continue to consume substantial time and resources to deliver compensation to a very small share of injured people.

This brief describes the relevant provisions of PPACA and lays out some alternative approaches to problems of medical injury and liability.

PPACA's Two Small Liability-Related Provisions

President Barack Obama, as recently as mid-2009, signaled willingness to trade some liability changes for medical providers' support of health reform.³ However, the partisan divide that emerged on health reform did not support such compromise. As enacted, PPACA contained only two, quite limited malpractice provisions. Section 10607 authorized malpractice demonstrations by states, and section 10608 extended federal malpractice protections to free clinics' nonmedical personnel.

The demonstration authority comes with many conditions that are much more limiting than the demonstrations grants already implemented by the Obama administration.⁴ Under PPACA, only states may be funded; funding levels are too low to backstop alternative compensation systems; even those funds are unappropriated; and any patient in a demonstration can, at any time, bring a conventional tort claim instead. The free-clinic provision extends the scope of the Federal Tort Claims Act (FTCA).⁵ The act had previously been modified to cover health professionals' volunteered services at free clinics, as well as care at federally qualified community health centers, as though the caregivers were federal employees, such as Veterans Administration physicians. The FTCA does not alter state rules of tort law, which govern any claims made; but claims resolution follows federal processes, any trials occur in federal courts, and payouts come from federal funds.

The Potential for Savings from Changes in Liability

Two key issues are what savings would accrue from reducing defensiveness and whether less fearful providers might cause more harm to



Robert Wood Johnson Foundation



patients. Taking the latter issue first, defensive medicine means activities undertaken or forgone more for legal defense than for patient benefit, so omitting defensive services almost by definition would not harm patients. Defenders of liability assert that any limit on tort liability reduces safety. This assertion sounds plausible but is not supported by what limited evidence exists, and health reform offers other platforms for promoting quality and safety.

How large might savings be? Probably about a half to a full percentage point of health spending, including cuts in defensive services as well as in malpractice premiums and litigation costs.⁶ The Congressional Budget Office (CBO) has estimated a 0.5 percent cut in spending from conventional tort reform.⁷ Savings could likely be larger—and more reliably achievable—if legal reform were combined with other incentives or controls to reduce overutilization of low-value services. Only part of the savings would occur within federal programs, and further changes might be needed to ensure savings accrued to public and prior payers rather than to providers.

The PPACA implementation period offers another opportunity to combine conventional or unconventional liability reforms with other approaches to bending the cost curve down and the safety-quality curve up.

What Liability and Safety Reforms Have Promise, and Do They Qualify for Demonstration Grants?⁸

Early disclosure with compensation seems to have the broadest appeal among reforms, in great measure because it requires no change in law and combines claims resolution with

the promise of improved patient safety. The idea is to disclose adverse events promptly to patients, offering reasonable compensation where mistakes have occurred. The approach seeks to reduce patients' desire to litigate and increase information for safety improvement. A few pioneering VA and academic medical centers have taken this approach and report being able to resolve their cases much faster and at lower cost than before. Demonstrations are desirable to improve understanding of such impacts and to show whether providers without unified management of hospital and physician care can replicate this model. The administration's grant program is funding such demonstrations,⁹ but they do not qualify for PPACA support.

The safe harbor approach seemed to have been endorsed by President Obama but never received serious legislative attention. A safe harbor rewards adherence to evidence-based guidelines by making it a presumptive defense to a claim that care was negligent because some different or additional service did not occur. Guidelines could start with any branch of care seen as high in defensiveness or low in safety. Implementation challenges are substantial, as individual circumstances will lead to exceptions. Because this approach would require legislative changes to liability rules, it does not qualify for PPACA demonstration grants. Aggregate enforcement through payment or participation rules may be a more reliable way to implement guidelines, apart from case-by-case use as a malpractice defense.

Making more even-handed changes to tort rules or processes is another promising idea. For example, flat caps on awards are arguably inequitable,

but the lack of any consistent standards in traditional law leads to both horizontal and vertical inequities in awards. Flat caps could be replaced with actuarially equivalent sliding scales for pain and suffering. These could still improve the predictability of awards and avoid outlandish verdicts, thus reducing defensiveness; and they would also improve the consistency and proportionality of payouts to injured patients. Because they change legal rules, such arrangements would not qualify as demonstrations.

Administrative compensation in lieu of tort is a longstanding proposal for comprehensive liability reform that has recently been rebranded as "health courts." Like workers' compensation or vaccine compensation funds, such approaches would replace the traditional tort system with insurance coverage designed to pay for more injuries, faster, cheaper, and more consistently. By emphasizing neutral medical expertise and avoiding courtroom battles of experts, the approach is meant to make practitioners less defensive. Given its limited precedents in the United States, demonstrations are needed, but full replacements of the conventional legal system seem ineligible for demonstration funding under PPACA or the administration's grant program.

Improving future compensation and care for permanent severe injuries is little discussed as a liability reform but is a worthy goal. It would address the other reason besides allowances for pain and suffering that raise liability awards above the limits of physicians' liability coverage and make them fearful of bankruptcy. Proposals have been made, but not implemented, for more efficient coordination and management of ongoing care across payers.

Demonstration support is appropriate because both market and social program incentives for such management are weak. Again, demonstration funding appears unlikely under the current rules.

More enterprise responsibility in health care would make health care more like nonhealth sectors of the economy. There, individual professionals are rarely sued; their employers are responsible and act to reduce defensiveness and improve safety. Health reform offers ways to expand such approaches, notably through accountable care organizations. ACOs remain largely conceptual, but demonstrations might be feasible in due course. This approach does not fit the PPACA criteria.

What Other Changes Might Be Considered Going Forward?

Two points deserve mention here. First, given the restrictiveness of the enacted PPACA framework for demonstrations, the administration's grants process at the Agency for Healthcare Research and Quality seems preferable for stimulating innovative and useful proposals. Its procurement has already engendered much interest in planning and demonstrating reforms. As yet, the agency lacks ongoing funds to support initiatives whose planning shows the most promise. Shifting any available

PPACA demonstration funding to this preexisting process would enable productive follow-through on the administration's initial investments and perhaps also allow additional start-ups.

Second, the recent health reform debates failed to alter the hardened political postures on liability reform. The Democrats who had to pass PPACA without bipartisan support continued to see liability reform as a takeaway from injured patients and a giveaway to doctors—the familiar zero-sum game. Liability reforms would seem more acceptable if they achieved value not only for doctors but also for patients, by strengthening health reform. Thus, some limits on tort liability could help fund the abolition of health coverage limits. Health insurance covers more injury costs and does more to promote health than any liability coverage can. It also provides a platform for improving patient safety. PPACA faces a large challenge in maintaining affordability going forward, and trading liability changes for other changes could help.

The free-clinic liability provision provides a good example of such a trade-off. Potential defendants got free liability coverage and an altered tort process with features appealing to defendants, including no jury trials, no punitive awards, and limits on attorneys' fees. Why? Because, to get these benefits, they have to give back

something of value—free care for largely disadvantaged patients.

The same principle could be applied elsewhere. For example, the FTCA could be extended to promote full participation in Medicaid or to reduce resistance to evidence-based medicine, case management, or other health insurance initiatives that reduce cost or enhance value. It is more challenging to seek out productive interactions between liability and health reform than to rehash familiar positions for or against tort reforms. But seeking out such synergies has the potential to be much more helpful to all patients and premium payers.

Summary

Neither patients nor caregivers are well served by the traditional regime of medical liability. Yet debates about liability reform have become nonproductive battles between pro-defendant and pro-plaintiff forces. Health reform did nothing to alter that political dynamic, nor the underlying problems of preventable injury and defensive medicine. Patients as a whole could benefit if conventional tort limits were traded for better-value care as health reform is implemented or if broader reforms of liability could be demonstrated successful. The pre-existing demonstration mechanisms of the Agency for Healthcare Research and Quality better serve this purpose than do PPACA's very limited provisions on demonstrations.

Notes

¹ For a brief summary, see R. R. Bovbjerg and R. A. Berenson, “Surmounting Myths and Mindsets in Medical Malpractice” (Washington, DC: Urban Institute, 2005), <http://www.urban.org/url.cfm?ID=411227> (provides extensive references).

² The Patient Protection and Affordable Care Act, Public Law 111-148, 124 Stat. 119-1025, March 23, 2010, <http://www.gpo.gov>. The key liability provisions appear in Title X, Subtitle F.

³ B. Obama, “Obama Addresses Physicians at AMA Meeting: Transcript of President Obama’s Remarks,” annual meeting of the AMA House of Delegates (Chicago, IL, 2009), <http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/2009-annual-meeting/speeches/president-obama-speech.shtml>.

⁴ Agency for Healthcare Research and Quality, *Medical Liability Reform and Patient Safety: Demonstration and Planning Grants* (Rockville, MD: Agency for Healthcare Research and Quality, 2009), <http://www.ahrq.gov/qual/liability/>.

⁵ Health Resources and Services Administration, “The Health Center Program: Federal Tort Claims Act,” <http://bphc.hrsa.gov/ftca/>.

⁶ R. A. Berenson, J. Holahan, L. J. Blumberg, R. R. Bovbjerg, T. Waidmann, A. Cook, and A. Williams, “How We Can Pay for Health Care Reform” (Princeton, NJ: Robert Wood Johnson Foundation, 2009), <http://www.rwjf.org/files/research/46492full.pdf>.

⁷ In October 2009, the CBO reduced its prior estimate of malpractice premium savings, one source on which the July report from Berenson et al. had relied. The CBO also made a lower estimate of defensive savings than did the Berenson et al. paper because it reasoned that better managed care was already reducing excessive services. Another difference between the two estimates was that CBO made no allowance for effects resulting from the interactions between liability and other reforms that address overutilization.

⁸ More about the approaches discussed here can be found in R. R. Bovbjerg and T. B. Metzloff, eds., “The Medical Malpractice System and Emerging Reforms,” *Law and Contemporary Problems* 54, no. 2(1991): 1–223; J. M. Corrigan, A. Greiner, and S. M. Erickson, eds., “Liability: Patient-Centered and Safety-Focused, Nonjudicial Compensation,” in *Fostering Rapid Advances in Health Care: Learning from System Demonstrations* (Washington, DC: National Academies Press, 2002); Bovbjerg and Berenson, “Surmounting Myths,” 2005; R. R. Bovbjerg and L. R. Tancredi, “Liability Reform Should Make Patients Safer: ‘Avoidable Classes of Events’ Are a Key Improvement,” *Journal of Law, Medicine & Ethics* 33, no. 3(2005): 478–500; and F. J. Hellinger and W.E. Encinosa, “Review of Reforms to Our Medical Liability System” (Rockville, MD: Agency for Healthcare Research and Quality, 2010), <http://www.ahrq.gov/qual/liability/reforms.htm>.

⁹ *Medical Liability Reform and Patient Safety: Demonstration Grants*. June 2010. Rockville, MD: Agency for Healthcare Research and Quality. <http://www.ahrq.gov/qual/liability/demogrants.htm>.

The views expressed are those of the author and should not be attributed to the Robert Wood Johnson Foundation, or the Urban Institute, its trustees, or its funders.

About the Author and Acknowledgments

Randall R. Bovbjerg is a senior fellow in the Health Policy Center of the Urban Institute. This research was funded by the Robert Wood Johnson Foundation.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation’s largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 35 years, the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.