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By William M. Sage and David A. Hyman

Let’s Make A Deal: Trading Malpractice Reform For Health Reform

ABSTRACT Physician leadership is required to improve the efficiency and reliability of the US health care system, but many physicians remain lukewarm about the changes needed to attain these goals. Malpractice liability—a sore spot for decades—may exacerbate physician resistance. The politics of malpractice have become so lawyer-centric that recognizing the availability of broader gains from trade in tort reform is an important insight for health policy makers. To obtain relief from malpractice liability, physicians may be willing to accept other policy changes that more directly improve access to care and reduce costs. For example, the American Medical Association might broker an agreement between health reform proponents and physicians to enact federal legislation that limits malpractice liability and simultaneously restructures fee-for-service payment, heightens transparency regarding the quality and cost of health care services, and expands practice privileges for other health professionals. There are also reasons to believe that tort reform can make ongoing health care delivery reforms work better, in addition to buttressing health reform efforts that might otherwise fail politically.

Historically, malpractice policy evolved independently of health policy, with reform debates triggered by periodic “crises” in the cost and availability of malpractice insurance. Those crises were resolved through bare-knuckle political contests between physicians and trial lawyers. Occasional efforts to connect the two domains in a logical fashion failed, such as the Clinton administration’s attempt, as part of the 1993 health reform proposal, to shift malpractice risk from health care providers to managed care plans bearing “enterprise liability.”

More recently, during the 2009–10 congressional debate over health reform, malpractice reform was a logical olive branch with which to encourage Republicans to sign onto the Affordable Care Act (ACA). In a speech to Congress, President Barack Obama signaled his willingness to negotiate: “I don’t believe malpractice reform is a silver bullet, but I have talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs.” In the same breath, President Obama committed to funding a set of malpractice reform demonstration projects, emphasizing error disclosure and less adversarial dispute resolution, that had been recommended by the Institute of Medicine in 2002—unexpectedly reviving a report that had been roundly ignored since its release.

However, the olive branch was never fully extended. The Obama administration was unable to use malpractice reform to broaden support for the bill, in part because ideological resistance hardened among Republicans and in part because doing so would have offended the trial lawyer constituency that helps fund the Demo-
The ACA therefore punted on the subject of malpractice, ultimately including only two minor provisions. Section 6801 encouraged states “to develop and test alternatives to the civil litigation system,” and section 10607 authorized $50 million in grants to states for such alternatives. As one of us (Sage) accurately predicted before the 2008 election, although health reform “logically requires a planned system of accountability for error…the political maneuvering necessary to enact a universal coverage program will most likely sidestep tradeoffs between affordability and health care quality, avoid offending powerful corporate or trial lawyer lobbyists, and leave liability to the vagaries of courts and state legislatures.”

As the political challenges of implementing health reform became apparent, however, the ACA’s omission of tort reform attracted notice. Opponents of the ACA tend to be skeptical about the law’s potential, in the absence of restrictions on medical malpractice litigation, to reduce health care spending without imposing direct government controls on access to services or curtailing the personal liberties of ordinary Americans. Moreover, many physicians and medical associations continue to voice serious concerns over the law, which stokes the fears of the broader public.

These dynamics suggest that the time may be right to “make a deal,” offering federal tort reform as part of a comprehensive package of Medicaid reforms.9 Because it recruits new stakeholders and challenges jurisdictional assumptions, tying malpractice reform to health care cost savings as the ACA is implemented has political advantages. It may also provoke less strident opposition from the plaintiff’s bar because the deal is limited to medical care. As described below, moreover, the deal connects other, more powerful health care entities—plus manufacturers, insurance companies, and those with general business interests.

These efforts made malpractice reform a more plausible matter of federal concern, with connections to other legal areas of national economic import, such as securities litigation and product liability. Malpractice reform had long been a question of changing state courts, for which congressional intervention seemed inappropriate on both federalism and separation-of-powers grounds.

Fiscal politics given persistent deficits also enhances the case for federal intervention. If malpractice reform is scored by the Congressional Budget Office as generating substantial savings, it becomes a federal priority with potential bipartisan support. In 2011 the Congressional Budget Office estimated that a bill capping noneconomic damages at $250,000 would reduce national health spending by 0.5 percent (more than $10 billion annually).6 Health care cost growth and a sluggish economy have changed the politics of malpractice at the state level as well, where Medicaid increasingly dominates budget debates. Even liberal states now consider tort reform in connection with legislation to rein in health care spending. In 2011, for example, the Democratic governor of New York endorsed capping noneconomic damages in malpractice cases as part of a comprehensive package of Medicaid reforms.

Because it recruits new stakeholders and challenges jurisdictional assumptions, tying malpractice reform to health care cost savings as the ACA is implemented has political advantages. It may also provoke less strident opposition from the plaintiff’s bar because the deal is limited to medical care. As described below, moreover, the deal connects other, more powerful health care entities—plus manufacturers, insurance companies, and those with general business interests.

The Changing Politics Of Malpractice Reform
Malpractice policy has been mired for decades in a lawyer-centric political debate over whether personal injury litigation is good or bad for society. This political debate tends to ignore or caricature the health care system. Our proposed deal would change these dynamics and make the debate health care-centric.

The malpractice insurance crises of the 1970s and 1980s produced fierce but narrow fights over changes to state law involving the malpractice lawyers who filed lawsuits, the doctors who were offended by them, and the liability insurers who paid to resolve them. In the 2000s, as partisan rancor increased in Congress, medical malpractice became a poster child both for and against tort reform in the general economy. Democrats focused on the plight of those who are negligent-ly injured, which positioned them to receive campaign contributions from malpractice lawyers and from lawyers who usually sue large corporations. Republicans focused on risk and cost to industry, which positioned them to receive campaign contributions from physicians and other health care entities—plus manufacturers, insurance companies, and those with general business interests.

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and affordable for all physicians, including those participating in practice settings that many health reformers consider inefficient and of less verifiable quality.

What Physicians Might Exchange For Malpractice Reform
The fact that physicians and malpractice researchers differ in their conclusions regarding tort reform creates an opportunity for gains from trade. Physicians attach tremendous importance to tort reform, to which they ascribe a host of salutary consequences for themselves and for the health care system. Physicians also cite liability concerns as barriers to accepting change in other health policy domains.

By contrast, decades of scholarship and empirical research suggest that malpractice liability acts only at the margin of health policy, where in relatively small ways it may both protect patients from negligent care and induce inefficient health care spending. (See the online Appendix for a more detailed summary of research on the malpractice system.) Physicians’ clinical decisions, on the other hand, are responsible for roughly two-thirds of total health spending. Physicians determine the quantity and quality of medical services and heavily influence the price paid for them. Research has revealed that far more of this spending is wasteful than can reasonably be attributed to liability pressure alone.

In keeping with this understanding, we suggest using the strength of physicians’ belief in tort reform to facilitate the adoption and implementation of other measures more likely to improve access and efficiency, instead of using its direct effects to justify its enactment. If physicians value malpractice relief more than the public values retaining conventional tort remedies, Congress and the Obama administration might productively swap federal tort reform for health system improvements that require physician leadership or acquiescence either to be adopted or to be effective.

These measures typically involve changing the amount and method of provider compensation or the organization of care delivery. Examples include a quick transition to bundled, episodic payment for services; financial and information-al accountability for performance; participation in coordinated interdisciplinary care delivery models, such as medical homes and accountable care organizations; use of standardized, interoperable, and patient-accessible electronic health records with decision support capability; and acceptance of oversight bodies, such as the Independent Payment Advisory Board.

**PAYMENT REFORM**

At the federal level, payment policy is health policy. Medicare payment formulas are often more important than direct regulation in influencing the cost and quality of care. Reform of the Sustainable Growth Rate (SGR), sometimes referred to as the “doc fix,” is currently a federal legislative priority. Although the SGR was intended to limit growth in Medicare Part B expense to an affordable increment, massive reductions in physician payment that it threatened but never triggered made it into a sword of Damocles instead of an effective policy tool. Putting malpractice reform on the table in SGR negotiations might induce the AMA to accept modified reimbursement approaches that reduce costs, orient payment to performance, and reward team-based care.

Through the SGR or independently, Congress might exchange malpractice reform for physicians’ acceptance of oversight and participation in new payment and delivery systems. Tort reform might apply generally or might be limited to participating physicians. The ACA initiated pilot programs and demonstration projects testing bundled payment and payment for value, but political obstacles exist to continuing and expanding them. Similarly, the Independent Payment Advisory Board has proved to be controversial, and continued AMA opposition could sound its death knell.

Changing the rules for both malpractice liability and physician payment has other plausible benefits. The cost of malpractice insurance has been explicitly incorporated into Medicare’s physician-payment methodology since the early 1990s. Malpractice liability therefore reinforces reliance on fee-for-service physician payment. At the same time, fee-for-service payment facilitates the practice of defensive medicine and
Malpractice reform also seems to make physicians and other health professionals more comfortable revealing errors, apologizing to patients, and offering compensation without litigation. Over the past decade, a movement favoring prompt disclosure and honest discussion of medical errors with patients and families has helped physicians appreciate the ethical implications of malpractice policy. For example, many of the demonstration projects funded by the Agency for Healthcare Research and Quality in association with health reform emphasize improved communication and early resolution of potential claims.

Experience with the National Practitioner Data Bank exemplifies how physicians’ fears of liability and concern over their personal and professional reputations feed off each other, often with perverse consequences for health policy. Created in 1986, the National Practitioner Data Bank requires federal reporting of payments on malpractice claims against physicians and adverse actions involving medical licenses and practice privileges. Physicians worry greatly that a data bank report will affect the likelihood that liability insurers will sell them affordable malpractice coverage and the willingness of hospitals and health insurers to grant them privileges or network affiliations. As a result, they are less likely to be forthcoming about medical errors and less willing to settle disputes over care, which has led some patient advocates to question the National Practitioner Data Bank’s utility.

Nonphysician and Interdisciplinary Practice As millions of people newly or better insured by the ACA seek services, the need for high-quality, cost-effective primary care will become even more acute. In exchange for malpractice relief, the AMA could be asked to set aside its objections to the provision of basic clinical services by other trained health professionals.

Better coordination of care and payment for services based on error-free value received should make medical care safer.

These services would be provided both in interdisciplinary, community-based settings, such as patient-centered medical homes, which are specifically endorsed by the ACA, and by advanced-practice nurses, pharmacists, and other nonphysician professionals in independent practice. In the case of nursing, little if any empirical evidence supports continuing current scope-of-practice limitations or payment differentials.

Thus, nonphysician and interdisciplinary primary care practice offers a largely unexploited pathway for the improvement of access to care—which can be opened up with the deal we propose. This is not just pie in the sky: Florida recently brokered a scope-of-practice deal for optometrists in connection with physician malpractice reform. Instead of engaging in trench warfare over contested professional turf state by state, nonphysician health professionals could gain national rights to practice from federal policy makers, which would complement ongoing efforts to liberalize Medicare and Medicaid payment policy for those professionals.

Other Implications For Malpractice Policy Because we focus mainly on quid pro quo benefits to health reform of reducing malpractice litigation, our proposal does not depend on large beneficial effects coming from tort reform itself. If health reform proceeds as intended, however, the need for traditional liability protections may shift as well.

For example, better coordination of care and payment for services based on error-free value received should make medical care safer. If the ACA succeeds in expanding coverage while making health care prices less arbitrary and cost growth less relentless, it could also dampen demand for malpractice litigation. One of us (Sage) has argued that universal coverage should be viewed as a powerful tort reform because solid
health insurance would pay many of the costs for which patients typically seek compensation through malpractice litigation.18

As the health care delivery system changes post ACA, federal tort reform might also help reduce uncertainty regarding the potential for accountable care organizations and other new institutional actors, many with deep pockets, to incur excessive liability. This issue arose in the 1990s, when public fear that health care maintenance organizations would ration care in pursuit of profit made juries more likely to impute malicious intent, assign liability, and award punitive damages. A similar dynamic led vaccine manufacturers to insist on federal indemnification and an administrative compensation system before they would take steps to develop a vaccine against swine flu in the 1970s.

What Kind Of Malpractice Reform?
We suggest that federal tort reform follow familiar state law models. State tort reforms vary in their details, but the most popular model among physicians is California’s Medical Injury Compensation Reform Act (MICRA) of 1975, which imposed a flat cap of $250,000 on noneconomic damages. MICRA also limited lawyers’ contingent fees; shortened the statute of limitations for bringing cases; and allowed amounts available to plaintiffs from collateral sources, such as health insurance, to be offset from damages.

By making this recommendation, we indicate our willingness to forgo the comprehensive improvements to medical liability that we and other health policy academics have long supported. Malpractice scholars tend to eschew MICRA-style reforms as blunt instruments designed mainly to stabilize markets for physicians’ malpractice insurance and instead recommend more balanced approaches that prioritize safe care and fair dispute resolution.21

We believe that a short window of opportunity has opened for major changes to health care delivery, and that the perfect would be the enemy of the good. Over the years, academics have designed many superior alternatives to the existing malpractice system, only to have them go nowhere because of politics. It seems more important for the country to make comprehensive improvements to the health care system in a timely fashion than to pursue a longer-term and more speculative agenda of stand-alone malpractice reform, however well conceived.

Moreover, malpractice reform will not reclaim physician support for health reform if the change strays too far from the familiar. In 1993 the Clinton administration’s attempt to secure physicians’ goodwill by endorsing enterprise liability was instead roundly condemned by the medical profession. Perhaps this was because holding health plans accountable for patient injury seemed to imply that physicians would lose control over medical decisions. One prominent doctor even publicly decried the violation of his “constitutional right to be sued.”1

In the months preceding the ACA’s passage, it appeared that offers of federal malpractice relief might again inadvertently prescribe cures that physicians regarded as worse than the disease. For example, a proposal was floated to shield physicians from liability if they comply with clinical practice guidelines, which might have been interpreted by physicians as further eroding their clinical discretion. Another proposal to deem physicians to be federal employees so that the government might pay their malpractice costs under the Federal Tort Claim Act might have seemed a harbinger of “socialized medicine.” Basing malpractice reform on the MICRA model has a lower risk of backfiring.

Closing The Deal
We propose a simple exchange. Physicians receive MICRA-style tort reform at the federal level. In return, physicians accept changes in law and policy governing health care financing and delivery that are likely to reduce waste, increase efficiency, and promote access to care.

The parties to any agreement and the specific vehicle for memorializing it might vary according to the circumstances, but federal legislation would be required—and the AMA is a logical bargaining representative for the medical profession. As with any bill that spans jurisdictions, congressional committee assignments and similar procedural complexities would need to be addressed, as would other realities of federal and interest-group politics.

To those who might ask whether malpractice reform is needed to support health system change that seems inevitable, we observe that health care providers and the consultants who
advise them often focus on the liability risks of altering their behavior. We also note that the malpractice insurance crises that recur periodically have a way of panicking physicians and distracting policy makers, increasing the payoff from early intervention. To those who might ask whether the case for malpractice reform is so compelling as not to require a deal at all, we respond that it is not—or it would have happened already. Because physicians and informed policy makers attach different valuations to malpractice reform, there is the opportunity for a mutually beneficial exchange.

An old joke asks how many psychiatrists it takes to change a light bulb. Answer: The light bulb has to want to change. Malpractice liability is not a major cause of what ails the health care system, but it is a barrier to change. Health care reform cannot succeed without the willing participation of physicians in payment reform and delivery system transformation, and addressing physicians’ liability concerns can help secure that cooperation. The ACA’s omission of malpractice reform was politically determined, not carefully reasoned. Instead of simply accepting that outcome, let’s make a deal.

NOTES

11 To access the Appendix, click on the Appendix link in the box to the right of the article online.