Medical Liability Reform

Michael Clayton

ACAAI and AAAAI Joint Task Force on Health Care Reform
June 2013

As enthusiasm for health care reform increased in Washington leading up to passage of the Affordable Care Act (ACA) in 2010, there was a sense of cautious optimism that medical liability reform would be part of the package to help garner support from physicians and Republicans and further trim health care costs. However, no liability reform measures survived the final bill, and since Democrats, who tend to oppose tort reforms assumed control of health committees in Congress and many states during 2008, the chances of passing traditional tort reform seemed to diminish.

The final ACA legislation did authorize $50 million for states and health care systems to investigate new approaches to malpractice compensation and patient safety, supplementing the $23 million that the Agency for Healthcare Research and Quality (AHRQ) awarded in 2010 for projects to test these new ideas (1). With these federal initiatives, the focus of reform evolved from the traditional one of reducing insurance costs for health care providers to targeting both liability cost control and patient-safety improvement. Newer metrics were developed to study the performance of liability reform including monitoring overhead costs, physician supply, quality of care, claims frequency, indemnity costs, and defensive medicine, amongst others. Increasingly, the emphasis in research shifted to measures of how the liability system affects clinical care.

A primary reason for this change in focus was the perception that the current system treats both patients and physicians unfairly. The present system is difficult for many injured patients to access, takes an unreasonable amount of time and expense to deliver compensation, and often results in very different outcomes for patients with similar injuries (2). Less than 22 cents of every settlement dollar is spent on compensating the patient (3). From the physician perspective, many claims are without merit. 64% of claims closing in 2010 were dropped, withdrawn or dismissed. Less than 10 % were decided by a trial verdict, and 90% of these were won by the physician defendant (4). The high cost of medical liability insurance has lead to staffing shortages and changes in physician practice patterns in many states. Medical liability premiums in Connecticut, New Jersey and Pennsylvania nearly tripled in cost between 2000 and 2004.

Proposed Medical Liability Reforms

1. Full disclosure/early offer programs. Four of the seven currently funded AHRQ grants are for projects investigating the disclosure-and-offer approach championed by the University of Michigan Health System. These programs involve full disclosure of medical errors combined with early offers of compensation. There is considerable variability, but most programs involve a careful explanation of what occurred and why it occurred as well as information about how the institution plans to prevent a reoccurrence of such an error in the future. When appropriate, the disclosure might be accompanied by an “apology”. In most programs, the patient is afforded the opportunity to seek legal counsel to ensure that the offer is fair. 29 states have enacted legislation to prevent the presentation of an apology in a State court following the occurrence of an unanticipated outcome.
2. Certificate of merit. These programs are geared to stop claims in their early stages. In some states, the plaintiff must present an affidavit that the case was reviewed by a

medical expert and that the expert believes there is a basis for the claim. As of 2009, 25 states required certificates of merit in medical malpractice claims. In Florida, a defendant rejecting a claim must also submit a written opinion of a medical expert that there is a lack of reasonable grounds for a medical malpractice suit.

3. Tort reforms. These measures include caps on damage awards, periodic interim payment rules, joint and several liability reform, and collateral source rule reform. As of 2011, about half of the states have enacted caps on non-economic damages, and six states cap total damages. Periodic interim payment initiatives permit claims to be paid over a period of time rather than all at once. Joint and several liability reform laws weaken the joint and several liability principle that calls for losing defendants to pay all the damage despite their level of fault. The collateral source offset rule permits total damages payable in a malpractice tort to be reduced by all or part of the amount received by other sources of payment.
4. Screening panels. Pre-trial panels consisting of medical experts review potential liability cases before they proceed to court. Approximately 20 states have pre-trial litigation screening panels.
5. Health courts. With this model, compensation decisions are based on an "avoidability" standard rather than a negligence standard and compensation is determined by specially trained judges rather than juries. This is essentially a "no-fault" approach in a setting other than a judicial court. In other countries, this model has been more acceptable to physicians, compensates a larger percentage of injured patients, generates lower overhead costs, and provides better information about patient-safety lapses than the tort system (3).
6. Liability safe harbors for the practice of evidence-based medicine. In 2009, the AMA adopted principles related to liability safe harbors for physicians when they practice in accord with evidence-based (EBM) guidelines. This is a concept that is gaining increased traction in the health system reform debate. Participating physicians who follow EBM guidelines receive liability protection for diagnosis and treatment in compliance with the guidelines. These protections could include civil immunity related to the claims, an affirmative defense to the claims, and a higher burden of proof for plaintiffs. There would be no presumption of negligence if a physician does not adhere to the guidelines. Admissibility of a guideline by a plaintiff would be prohibited if not introduced by the physician first.

At this point, it is difficult to know the best approach to medical liability reform. With the exception of damage caps, there is very little data to show that any of the potential reforms listed above will control insurance costs, let alone impact the overall quality of care and patient safety. The AHRQ projects will not test the full range of proposals, and by design will be limited in the strength of evidence that they provide. They may provide a good starting point, however as we move forward in designing a more just and efficient system to fairly compensate injured patients, minimize administrative waste and improve quality of care.

1. 42 U.S.C. 280g-15 Section 399V-4 (2010).
2. Kachalia, A, Mello, MM. New directions in medical liability reform. N Engl J Med 2011; 364:1564-1572
3. Rubin, P, Shepherd,J. Tort reform and accidental deaths. Journal of Law and Economics, v.50, No.2, May 2007, 221-238
4. Guardado, Jose R. Medical professional liability insurance indemnity and expense payments, claim disposition, and policy limits, 2001-2010. Policy
Research Perspectives 2011-3. (Chicago, Il: American Medical Association, November 2011).