ONLINE EXTRA

The Role of Supplemental Reforms in Taming MPL Costs

By Michael C. Stinson

In more recent times, some states have sought (to varying degrees of success) reforms that differ from all of the MICRA reforms, but which nonetheless may have a positive effect on the medical professional liability (MPL) system. These may work in conjunction with the MICRA-type reforms, or as stand-alone reforms. Among these are:

- **Certificates of merit.** Pre-litigation requirement to provide documented substantiation that an MPL claim is sufficiently valid to be pursued. The benefits of these laws depend largely on the qualifications required of the medical professional signing the certificate. Where enacted, certificates of merit help weed out those cases that otherwise are eventually dropped, withdrawn, or dismissed, but without having to go through the initial, and expensive, stages of litigation.

- **Apology protections.** Prohibition on the use of a healthcare provider’s expression of sympathy as evidence of negligence. Anecdotal evidence indicates this reform is more effective if it is sufficiently broad so as to include actual admissions of fault. Otherwise, the “apology” is subject to being misinterpreted as a declaration of fault and therefore admitted into evidence anyway. These laws are designed to improve provider-patient communication, which helps resolve MPL questions without resorting to litigation.

- **Expert witness reforms.** Requirements that anyone serving as an expert witness have certain minimum qualifications, usually along the lines of expertise in the same medical specialty as the defendant or specific knowledge of the treatments for the illness/injury in question. Such reforms ensure that “experts for hire” are less likely to be used, and that experts for either side actually have a true understanding of the underlying medical issues.

- **Pre-litigation screening panels.** States that have adopted this reform usually require a combination of individuals with legal or medical backgrounds to review a MPL claim before it may be taken to litigation. Some states allow evidence of the screening panel's decision to be entered into evidence in court, while others do not. Proponents believe the panels weed out meritless cases, not unlike certificate-of-merit requirements. It has been suggested by others, however, that such panels rarely prevent claims from being litigated, and thus frequently add to the costs of resolving such claims.
Alternative reforms

Efforts to enact MICRA-like reforms have slowed dramatically in the states, probably as a result of one of two situations:

1. There is a solid anti-MPL reform majority in the state legislature (New York State, for example).
2. Legislators are constitutionally prohibited from enacting reforms, such as caps on damages (Wyoming, for example).

As a result, some states have begun to consider other possible options to address ongoing MPL issues. These “alternative” reforms are largely, if not wholly, untested and frequently entail more questions than answers. Despite this, they have definite appeal, especially to those who may be frustrated by the lack of success in implementing proven reforms like MICRA in their own states. Perhaps the most prominent of these reforms are health courts, early offers programs, safe harbors, and patient compensation systems.

The concept of health courts is actually quite simple. Specialized courts overseen by judges with some degree of medical knowledge/training would handle all MPL cases, without a jury. The details of how such a court would operate vary from plan to plan. Some have suggested using expert witnesses that would be called by the court, instead of experts provided by the claimant or defendant. Others have recommended incorporating a specific damage scale for various injuries, in order to ensure that all similar claims receive equivalent awards.

One of the biggest problems with the health court approach, however, is that it focuses solely on the litigation side of the equation. Healthcare providers win the vast majority of claims that end up in court. Establishing a brand new court structure to deal with these claims may bring a level of efficiency to the process, but it would do little to cut down on the expense of trying such claims and nothing to address the numerous meritless claims that continue to consume vast resources, in both time and money. This may be the reason why no state, to date, has enacted a law that would put a health court in place.

Early offers programs, a variation of which was recently enacted in New Hampshire, use a stick-and-carrot approach to promote faster resolution of claims. Under such a system, if a negligence claim is filed, the defendant (and his/her insurer), would be given a specific time period for offering compensation for full economic damages and attorney fees. If no offer is made, the matter may proceed to court. If an offer is made and an agreement is reached, the matter would be considered resolved, and no further court action would be allowed. If the offer is made but the plaintiff rejects it, he may proceed to court but would do so facing a greater burden of proof and an increased standard of negligence than normally applies in an MPL claim.

This incentivizes defendants to make legitimate offers (since there is a guarantee that they will not have to pay noneconomic damages), and the plaintiff to accept, because winning a trial would be substantially more difficult than under the present system.

Both sides, however, have objections to this concept. Defendants are concerned that the narrow time frame for responding to a claim would “force” them to make offers on non-meritorious claims in order to avoid going to court. Plaintiff attorneys have vigorously opposed such programs, contending that they fail to compensate victims adequately, because they do not allow for large non-economic damage awards.
The idea of creating medical "safe harbors" has gained popularity in recent years, and continues to pick up steam as the likes of Peter Orszag, former director of the Office of Management and Budget in the Obama Administration, promote it. In fact, Orszag has said that the lack of a safe harbors provision in the Patient Protection and Affordable Care Act as one of the great failings of the new law. According to this concept, treatment protocols (developed by government entities or medical specialty societies, depending on one's preference) would create "best practices" for healthcare services, and providers would be able to use proof that they abided by said "best practices" as evidence that they were not negligent in their care of a patient.

While superficially appealing, this approach could lead to significant problems if it was not developed very carefully. For starters, the adoption of best practices could result in "cookbook" medicine, with healthcare providers encouraged to follow a specified treatment plan, without regard to whether that plan was in their patient's best interest, because doing so would guarantee protection from a liability suit.

In addition, medicine is a rapidly changing field, and it would be difficult for any entity to approve new safe harbors quickly enough to keep up with medical advances. Thus, doctors could actually be discouraged from using new, effective treatments and technologies because doing so would not provide adequate legal protections.

Finally, the implementation of "safe harbor" protections could lead to new MPL claims: personal injury lawyers could cite the failure to adhere to the provisions in a given safe harbor as evidence of de facto negligence – regardless of the legitimacy of the provider's rationale for seeking an alternative course of treatment.

In short, safe harbors could just as easily end up as a sword against the provider's interest as a shield.

The newest concept promoted as an alternative reform is that of a "patient compensation system." Modeled after the workers' compensation system (but at the same time distinctly different from it, according to the proposal's advocates), such a system would create an administrative mechanism for compensating individuals who have suffered a suboptimal medical outcome. No longer requiring that negligence be the determining factor in deciding if payment was due, this plan would compensate everyone who experienced an adverse outcome, without regard to whether the outcome was the fault of any healthcare provider. Supporters of this plan claim it would be much more efficient, and that it would save significant funds because defensive medicine would be all but eliminated with such a program in place.

Ignoring the fact that the savings claimed for this system are astronomically higher than what prior research has estimated, the plan still has a major financial flaw. Supporters claim it will pay a significantly higher number of claims than are now paid, and pay those "victims" substantially more money than they would get under the current system of litigation. Given that relatively few of the currently filed claims actually result in a payment to the claimant, it seems highly suspect that paying more money to even more claimants could result in a less costly system.

Even if one believed that the savings in defensive medicine expenditures resulting from a patient compensation system would actually develop, note that these savings would not automatically accrue to the compensation fund. Money not spent on tests and treatments would be just that—money not spent. It would not suddenly become available for paying claims without some additional effort to extract it from the system, via new taxes or fees on the healthcare community.
The future of state reforms

Going forward, it seems unlikely that a dramatic uptick in traditional reform efforts will sweep the states, barring one or both of these events comes about: a new, severe MPL crisis in which premiums rise substantially or insurers drop out of the market, or a sudden and dramatic political swing in states that do not have effective reforms at this point. Most of the states that have a political environment favorable to true tort reforms already have such legislation in place (or have had it nullified by the courts),\(^6\) Those states on the other end of the spectrum are unlikely to enact such reforms; they have already neglected to do so through no less than three major MPL crises.

More likely is legislation that tinkers around the edges of the MPL issue, as states with reforms already in place seek additional measures to improve their liability environment, and states without such reforms attempt to improve their MPL system without risking the political wrath of the personal injury bar. For this reason,, some of the supplemental reforms discussed here may prove to be the most appealing to state legislators in the years ahead.

References


5. While the main group advocating for this change, Patients for Fair Compensation, claims up to $650 billion per year is spent on defensive medicine (see http://www.patientsforfaircompensation.org/problem-solution/), another actuarial analysis (see PricewaterhouseCoopers Health Research Institute, "The price of excess, Identifying waste in healthcare spending," 2010, available at http://pwchealth.com/cgi-local/hregister.cgi/reg/waste.pdf) finds the amount to be only $210 billion, and noted MPL researchers found the amount to be less than $56 billion (see Michelle M. Mello, et al., "National Costs of the Medical Liability System," Health Affairs, September 2010 at 1569).

6. Alabama, Georgia, Illinois, Missouri, New Hampshire, Oregon, and Washington have all had duly enacted caps on damages ruled as unconstitutional by their state supreme courts. To learn more, see PIAA, “State Enactments of Selected Health Care Liability Reforms” (June 5, 2014), available at https://www.piaa.us/docs/GR/State_Enactments_with_Citations.pdf.

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