Affordable Care and Medical Malpractice--How Two Broken Health Care Systems Will Only Get Worse Without Better Compromise

Heather N Seigler, Whittier College
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HEATHER NICOLE SEIGLER

ABSTRACT

When the Affordable Care Act was initially proposed, critics initially attacked the idea as “socialist,” damaging to small businesses, a proponent of big government, etc. Supporters have celebrated the Affordable Care Act’s passing and further celebrated when the United States Supreme Court upheld the constitutionality of the Affordable Care Act in a landmark decision last term. While attention has been placed on the general fears regarding the consequences of government healthcare and its effect on the medical field (both founded and unfounded), insufficient attention has been paid to how the Affordable Care Act will affect the legal community. In this Article, light will be shed on what the Affordable Care Act planned to do regarding medical malpractice and what the final draft actually placed into law. To do so, the initial Affordable Care Act proposal will be examined, followed by the three main proponents of medical malpractice, the problems associated with those branches of medical malpractice, and what the Affordable Care Act “does” to fix them. I conclude that the Affordable Care Act as initially proposed would have effectively curtailed the medical malpractice industry’s problems, but as signed into law effectively does nothing to effectuate real change. In addition, I offer recommendations on how future laws can address the holes regarding medical malpractice that the Affordable Care Act left behind.

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* Graduate Teaching Fellow & Adjunct Professor, Whittier Law School; J.D. Whittier Law School; B.A. Columbia University
TABLE OF CONTENTS

I. INTRODUCTION .................................................................................................................. 1

II. PATIENT PROTECTION AND AFFORDABLE CARE ACT
    “OBAMACARE”—AN EXAMINATION OF THE LAW ITSELF .............................................. 4
        A. Background—Passing the Law ............................................................................. 8
        B. The Law in Effect .............................................................................................. 11
        C. Backlash ........................................................................................................... 15

III. MEDICAL MALPRACTICE—MEDICAL CARE, TORT LAW, AND LIABILITY INSURANCE:
    A BREAKDOWN OF THE HOW THE THREE-PRONG SYSTEM BROKE DOWN .................. 18
        A. History .............................................................................................................. 19
        B. The Blame Game .............................................................................................. 23
            1. Blaming Liability Insurance ....................................................................... 23
            2. Blaming the Medical Prong ...................................................................... 23
            3. Blaming the Legal System ....................................................................... 23
        C. Summing Up the Blame Game ....................................................................... 25

IV. ANALYSIS: HOW THE PPACA AND MEDICAL MALPRACTICE INFLUENCE EACH OTHER
    AND WHY THE PPACA MISSED A PRIME OPPORTUNITY TO PROVIDE EFFECTIVE MEDICAL
    MALPRACTICE REFORM .................................................................................................. 32
        A. The PPACA & Medical Malpractice .................................................................. 19
        B. The Missed Opportunity to Create More Positive change in Health Care & Medical Malpractice ................................................................. 23

VI. CONCLUSION .................................................................................................................. 40
I. INTRODUCTION

Now, finally, many in this chamber -- particularly on the Republican side of the aisle -- have long insisted that reforming our medical malpractice laws can help bring down the cost of health care. . . . 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. (Applause.) 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. (Applause.) I know that the Bush administration considered authorizing demonstration projects in individual states to test these ideas. I think it's a good idea, and I'm directing my Secretary of Health and Human Services to move forward on this initiative today. (Applause.)

The Patient Protection and Affordable Care Act (hereinafter: PPACA) was supposed to be either the answer to the country’s costly health care needs or simply “downright evil.” The media broadcast “Obamacare” in several different, uneven lights by running with stories of town hall meetings protesting the plan’s “death panels” and

1 Remarks by the President To a Joint Session of Congress on Health Care, Office of the Press Secretary, (Sept. 9, 2009) available at: http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/.


“health rationing” while doing human-interest pieces on people with pre-existing conditions who desperately needed health insurance. Perhaps as a result of the media onslaught of both fear and praise, along with both political parties’ resounding inability to compromise effectively, the PPACA went through various drafts, ultimately producing a watered-down bill that would pass through Congress. The PPACA President Obama signed on March 23, 2010 was a mere shadow of what it was intended to be.

The focus has been on how the PPACA will impact the individual, small businesses, or the health care community in general. Almost no scrutiny has focused on what impact the PPACA will have on the legal community. Medical malpractice insurance and litigation continues to produce great cost for doctors and patients alike. The medical malpractice system is just as broken as the health care system and the PPACA meekly attempts to fix it through encouraging and paying for the creation of state-run committees that will create pilot alternative dispute resolution systems. This article will shed light on the PPACA’s lack of a solution for the legal side of medicine, where it

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6 Id.


8 Ceci Connolly, Decision Makers Differ on How To Mend Broken Health System, Washington Post, Nation (June 9, 2009).

9 Watered down, at least with respect to medical malpractice.

10 Gerald E. Harmon, Malpractice Lawsuits Raise Health Care Costs For All, The Herald (Rock Hill, SC) (January 15, 2005) (stating that medical malpractice “added $50 billion dollars each year to the federal health care system”).

11 The PPACA, Pub. L. No. 111-148, Sec. §§ 6801, 10607
was originally claimed that it would do wonders to fix the broken medical malpractice system.¹²

This article first will introduce the two broken health-related systems. Then the article will take a comprehensive look at the various drafts of the PPACA, how the bill changed as it progressed through Congress, and what the bill, as signed, will do. Then it will breakdown the three tiers of the medical malpractice system to explain how the system is broken. Finally, an analysis of how the PPACA and medical malpractice influence each other and how the PPACA could have been better designed to cure the ills of the two broken health care systems will conclude this article.

II. PATIENT PROTECTION AND AFFORDABLE CARE ACT
“OBAMACARE”—AN EXAMINATION OF THE LAW ITSELF

A. BACKGROUND—PASSING THE LAW

President Obama signed the PPACA into law on March 23, 2010.¹³ Much debate went into the PPACA’s passing. President Obama placed great emphasis on health care reform early on in his campaign¹⁴ and once elected, President Obama made health care reform one of his top priorities.¹⁵ The Obama Administration outlined its health care goals generally, providing principles to define what health care reform should do, leaving the details to Congress.¹⁶

¹² Remarks by the President To a Joint Session of Congress on Health Care, Office of the Press Secretary, (Sept. 9, 2009) available at: http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/.

¹³ Sheryl Gay Stolberg and Robert Pear, Obama signs Health Care Overhaul Bill, With a Flourish, N.Y. Times (March 23, 2010).


¹⁶ Id.
President Obama’s health care reform plans outlined the main goals of: incorporating those excluded from insurance coverage due to pre-existing conditions, holding insurance companies more accountable, lowering health care costs, guaranteeing more health care choices, and enhancing the quality of health care for all Americans.\(^ {17}\) In a speech made on September 9, 2009\(^ {18}\) President Obama covered the basics of his plan.\(^ {19}\) The speech laid the foundation for Congress to work from. Over the course of ten years the health overhaul would: cost around $900 billion, tax high-value insurance plans, cut Medicare costs, dedicate $630 billion over ten years to a Health Reform Reserve fund, require businesses with 50 employees or more to offer coverage or pay a fee, support sliding-scale subsidies for low-income families, prevent insurers from denying coverage to people with pre-existing conditions, stop insurers from dropping the sick, limit premium variation, and small businesses and people without access to affordable insurance would gain access to a new Health Insurance Exchange.\(^ {20}\) Illegal immigrants would not have access to the exchange.\(^ {21}\) Taking the framework President Obama created, Congress went to work.

Three congressional committees emerged with health care reform plans.\(^ {22}\) The House Tri-Committee Plan produced “America’s
Affordable Health Choices Act” in mid-July of 2009. In early July, the Senate Health, Education, Labor, and Pensions (HELP) Committee released a draft of the “Affordable Health Choices Act.” By mid-September the Senate Finance Committee introduced the “America’s Health Future Act.” Each Act focused on individual mandates—requiring everyone to purchase health insurance, “Play-or-Pay Provisions” which required firms with annual payrolls of more than $250,000 to offer insurance to their employees or pay a government fee, insurance subsidies on a sliding scale, and various other similar reforms. These plans took the Obama Administration’s optimistic framework and created proposals that Capitol Hill could work with. By virtue of President Obama’s very basic plan, the bills proposed varying details, as well as added elements President Obama initially did not propose. For example, President Obama initially did not advocate for an individual mandate, nor did he describe a specific benefit package that should be offered by insurance companies.

By November 2009 the House of Representatives passed the Affordable Health Care for America Act, and by Christmas 2009 the

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24 Id.

25 Id.

26 For a comprehensive breakdown of the different congressional plans, see The Kaiser Family Foundation, Side by Side Comparison of Major Health Care Reform Proposals, Focus on Health Reform, available at: http://www.kff.org/healthreform/upload/healthreform_sbs_full.pdf


28 Id.
Senate passed the PPACA. The House’s bill was considered more liberal as it included a public option, more generous benefits, and higher taxes. It was also estimated to cost around $1.2 trillion. The Senate bill was less expensive ($871 billion), had a detailed plan for how it would be funded and increased the number of employees necessary for employers to provide coverage from President Obama’s fifty to two hundred. It further separated from President Obama’s initial plan by dropping plans for a Health Insurance Exchange and government directly operated health plan, opting for contracting out to nonprofits instead.

After the election of Scott Brown in Massachusetts threatened the Democrat’s super majority, President Obama successfully plotted a legislative approach that would allow the Senate to pass the PPACA by reconciliation—allowing the bill to pass by simple majority and push through a second bill containing “fixes” to the first bill. The second bill, the Health Care and Education Affordability Reconciliation Act removed several special deals created to gain

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30 Id.


32 Id.

33 Id.


votes,\textsuperscript{36} reduced and delayed taxes on generous employee health plans, increased taxes on health care industries, and included student loan reforms.\textsuperscript{37} The House passed the PPACA, and both the House and the Senate passed the Health Care and Education Affordability Reconciliation Act, making it possible for President Obama to sign the PPACA into law on March 23, 2010.\textsuperscript{38}

### B. The Law in Effect

The PPACA’s policies will slowly take effect over the course of five years (and beyond).\textsuperscript{39} Several reforms took effect almost immediately in 2010: patients with pre-existing medical conditions were entered into a temporary high-risk pool to provide coverage, dependents up to age 26 were allowed to stay on their parent’s policies, lifetime limitations on the dollar value of coverage were banned, tax credits were given to small businesses, retirees not qualifying for Medicare were enrolled in a reinsurance program under their previous employers, and a program for reporting and evaluating insurance plan premiums was put into place.\textsuperscript{40} Both Medicare and Medicaid were adjusted to be more inclusive and less expensive, and

\begin{itemize}
\item \textsuperscript{36} The PPACA originally included the “Cornhusker Kickback” and the “Gator-aid” which would pay for Nebraska’s Medicaid expansion and protect Florida’s Medicare Advantage program from cuts, respectively. Jake Tapper and Karen Travers, Obama Makes Final Health Care Push, Calls for Up or Down Vote in Congress, ABC World News (March 3, 2010), available at: http://abcnews.go.com/Politics/health-care-reform-obama-democrats-reconciliation-rules-bill/story?id=9995953;
\item \textsuperscript{37} Theda Skocpol and Vanessa Williamson, Obama and the Transformation of U.S. Public Policy: The Struggle to Reform Health Care, 2 Ariz. St. L.J. 1203, 1229, Arizona State Journal (2010-2011).
\item \textsuperscript{38} Scott Wilson, Obama Signs Health-Care Reform Bill, Washington Post, (March 24, 2010).
\item \textsuperscript{39} Focus on Health Reform, Health Reform Implementation Timeline, Kaiser Family Foundation, available at: http://www.kff.org/healthreform/upload/8060.pdf.
\item \textsuperscript{40} Id.
\end{itemize}
to pay for it all taxes were increased for non-profit hospitals, indoor tanning salons, and transactions “lacking economic substance.”

In 2011 similar changes were made. Further changes to Medicare and Medicaid implemented in 2011, including changes to provide discounts on brand-name prescriptions, provide 10% bonuses to primary care physicians and general surgeons working in shortage areas, and establish community-based attendant support services for people with disabilities. To date, more than half of PPACA law has been implemented. Over the next four years, further changes to Medicare, Medicaid, taxes, insurance reforms, and the individual mandate will be implemented to continue making health care more affordable and more inclusive to the indigent and those with illnesses that cost more than their insurance (or lack there of) would cover without the implementation of the PPACA.

C. BACKLASH

The 2010 elections changed the layout of Congress, allowing Republicans to gain momentum toward repealing or defunding parts of the PPACA. On February 2, 2011, the opposition went as far as an unsuccessful attempt to repeal the PPACA through Senate vote. On the conservative side, sentiments such as: “America will never become

41 Id.


45 While Senate Democrats were successful in protecting the bill, the vote was only the beginning of a long line of political and legal/constitutional challenges. David M. Herszenhorn, Senate Rejects Repeal of Health Care Law, NY Times (February 2, 2011).
the nation it can be if we’re saddled with ‘Obamacare,’”46 “[t]he ultimate arrogance . . . is Obamacare,”47 and “The controversial law takes health-care reform in the completely wrong direction toward higher costs, higher taxes, higher spending, and higher deficits. Real reform begins with repealing this monstrosity and putting federal spending on health care on a sustainable path.”48 In 2010, For supporters of the PPACA, the future felt:

very uncertain . . . . I wouldn’t give much more than a 50-50 chance that all of the critical components of the Affordable Care Act will be alive and well . . . . Court decisions, defunding efforts or actual repeal of some major provisions could eviscerate the dreams of universal coverage and restrained cost growth.”49

After the law’s signage, several lawsuits were filed challenging the constitutionality of the individual insurance mandate of the PPACA.50 Congress Democrats insisted: “the requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do no exclude coverage of preexisting conditions can be sold.”51 However, the “essential” individual mandate requirement was not initially part of

46 Rep. Steve King Congressman of Iowa is leading the charge to repeal the PPACA. Id.
47 Michelle Bachman has been courting voters through out the country in an attempt to gain momentum for the Republican nomination. Mike Glover, Republicans Court Voters in Iowa, Associated Press (March 27, 2011).
49 Urban Institute President Robert Resichaur released his statement on the anniversary of the PPACA’s signing, voicing his concern that the PPACA will be rendered ineffective. Happy Anniversary?, The Hotline,
50 Patrick Leahy, Senate Judiciary Committee Chairman, Constitutionality of Health Care Law, (February 2, 2011), available at 2011 WLNR 2091548 (discussing political and legal challenges to the PPACA).
President Obama’s basic outline of goals, and almost provided the PPACA’s opponents with the argument they needed to allow the Supreme Court to declare the PPACA unconstitutional. This is an example of where the PPACA changed from its initial drafting and from what it was intended to be—this time on the insurance side, rather than the medical malpractice element. However, the PPACA ultimately prevailed upon Supreme Court review.

III. MEDICAL MALPRACTICE—MEDICAL CARE, TORT LAW, AND LIABILITY INSURANCE: A BREAKDOWN OF THE HOW THE THREE-PRONG SYSTEM BROKE DOWN

The medical malpractice system is three-pronged, incorporating medical care, tort law, and liability insurance. With increasing and complex medical advances and technologies, combined with an increasingly litigious patient demographic, the liability system has gotten out of control.

A. HISTORY


53 Id.


Medical malpractice litigation was almost non-existent for the first 500 years of the United States\(^{57}\), which begs the question: how did it appear?

Medical Malpractice, as a concept, can be traced as far back as Blackstone’s *Commentaries on the Laws of England*, but was rarely something that would come up in a claim before the 1840s.\(^{58}\) In the nineteenth century America’s increasing awareness of their personal ability to stay healthy and fit (rather than health being a divine gift), along with increasing medical advertising of success stories, led to the common suit claiming a doctor was at fault for undesirable outcomes.\(^{59}\) However, by 1850 medical malpractice litigation was established\(^{60}\) and from there, the medical malpractice suit became more and more commonplace.

Since the 1960s, the medical malpractice system has experienced several crises.\(^{61}\) In response to each crisis, insurers, doctors, and state policy makers have attempted to create laws and policies to ease the “crises.”\(^{62}\) When new treatments and technological medical breakthroughs were made in the 1960s and 70s, people began to expect more from medicine, making the legal climate more conducive to medical malpractice claims.\(^{63}\)

Many scholars, including doctors and lawyers entrenched in the system themselves, have tried to theorize specifically where and when the blame belongs for the breakdown of the system. No one can

\(^{57}\) James C. Mohr, PhD, American Medical Malpractice Litigation in Historical Perspective, 283 JAMA 1731 (2000).

\(^{58}\) Id.

\(^{59}\) Id.

\(^{60}\) Id.

\(^{61}\) See The Reform of Medical Malpractice Law: Historical Perspectives, 55 Am. J. Econ & Soc. 257.


\(^{63}\) Id.
seem to pick one theory. Some feel that contingent fees and overly sympathetic juries led to the rise of medical malpractice suits due to the ever-increasing amounts juries would award.\textsuperscript{64} Others believe that the system, in which insurance companies pay for the liability of the tortfeasor, creates a system where there is little to no deterrence.\textsuperscript{65} Still others feel that the insurance itself is the problem because of the ever-increasing expense it creates.\textsuperscript{66} President Obama himself has stated that defensive medicine has a hand in the rising costs of medical malpractice and health care itself.\textsuperscript{67} No one can seem to agree on where to pinpoint the source of the medical malpractice crisis, therefore this article will breakdown how each prong of the system affects the other and why each system creates problems.

B. THE BLAME GAME

All three systems have their problems.\textsuperscript{68} However, each branch has side-tracked attention by playing what’s commonly called “The Blame Game.”\textsuperscript{69} Every branch will explain that another branch’s issues are what’s causing its own problems, or at least overshadowing its own.

\textsuperscript{64} See id.

\textsuperscript{65} See Gary T. Schwarz, The Ethics and the Economics of Tort Liability Insurance, 75 Cornell L. Rev. 313 (1990)

\textsuperscript{66} See William M. Sage, Medical Malpractice Insurance and the Emperor’s Clothes, 4 DePaul L. Rev. 463 (2005).

\textsuperscript{67} Remarks by the President To a Joint Session of Congress on Health Care, Office of the Press Secretary, (Sept. 9, 2009) available at: http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/ (“I’ve talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs.”).

\textsuperscript{68} See cites 65-67.

\textsuperscript{69} The blame game is a colloquial term for passing blame onto someone or something else, even where there is fault to be had on your side. For further example, a google search on February 21, 2013 of “the Blame Game” brings up the lyrics to a Kanye West song about a couple blaming each other for their problems, Obama blaming “partisan recklessness” for a sequester standoff. Obama blames ‘Partisan Recklessness’ for sequester standoff—as it happened. The Guardian.co.uk. (February 19, 2013).
I. Blaming Liability Insurance—Lowering Premiums

Today, most health care providers need to buy professional liability insurance. While some are quick to blame insurance companies and high premiums for the breakdown of the medical malpractice industry, the fact of the matter is the medical malpractice insurance industry is in trouble. Since the 1990s, insurers in many states have reported increasing losses on medical malpractice claims.

In response to the crises starting in the 1960s and 1970s, physicians began to create their own insurance companies. In the 1980s, state regulatory commissions would not allow premium increases, resulting in many insurance companies seizing their medical malpractice insurance business all together. With limited insurance companies and state-set premium maximums, the medical malpractice insurance industry became both competitive and fruitless. By the 2000s, crisis in the medical malpractice insurance industry was commonplace: insurance companies who made money in the 90s kept premium rates low and reduced capital reserves to invest, leading to insurers losing money when winning claims began to get increasingly


73 See History §

74 Id.

75 Id.

76 Id.
outrageous winnings.\textsuperscript{77} This cycle led to a drastic increase in premiums.\textsuperscript{78}

In every crisis, the main indicator was the unavailability of liability insurance and/or the inability to pay for it. Insurance premiums have to respond to litigation, therefore, when litigation grows, according to supply and demand, so should insurance premiums.\textsuperscript{79} Based on the history of the crises indicated above, the increasing premiums are a symptom of the medical malpractice breakdown, not the cause.

2. BLAMING THE MEDICAL PRONG—REDUCING MEDICAL ERROR

To establish a claim, a plaintiff must show that he sustained damages during the course of medical treatment, that the treatment violated the standard of due care, and that the injury was caused by the negligent treatment.\textsuperscript{80} Therefore, the frequency of claims filed depends on the frequency of injury and the standard of care applied.\textsuperscript{81} Rather than capping jury awards, those who blame the medical prong of the medical malpractice system, say the solution lies in reducing medical errors.\textsuperscript{82}

With an increased awareness of insurance and litigation costs, comes fear of mistakes and fear of liability.\textsuperscript{83} Physicians often feel

\textsuperscript{77} Find Source regarding most recent high-dollar medical malpractice pay out.

\textsuperscript{78} William M. Sage, Medical Malpractice Insurance and the Emperor's Clothes, 54 DePaul L. Rev. 463, 464-467 (Winter 2005).

\textsuperscript{79} Id. at 470.


\textsuperscript{81} Patricia Danzon, The Frequency and Severity of Medical Malpractice Claims, 27 J. of Law and Econ. 115, 121 (1984).

\textsuperscript{82} Hillary Rodham Clinton and Barack Obama, Making Patient Safety the Centerpiece of Medical Liability Reform, 354 New England Journal of Medicine 2205, (May 6, 2006).

\textsuperscript{83} Addressing the new Health Care Crisis: Reforming the Medical Litigation System To Improve the Quality of Health Care, U.S. Department of
forced to engage in defensive medicine by performing tests and providing treatments that they would not ordinarily perform to protect themselves from suits.\textsuperscript{84} Politicians believe the practice of defensive medicine is one of the primary cost-increasing problems of medical malpractice. Defensive medicine has been on the minds of politicians and doctors for years. According to a 2006 Senate Committee, established by Hillary Rodham Clinton, the solution to the medical liability crisis was four-tier: “reduce the rates of preventable patient injury, promote open communication between physicians and patients, ensure patients access to fair compensation for legitimate medical injuries, and reduce liability insurance premiums for health care providers.”\textsuperscript{85} According to her report, reducing medical error and promoting patient safety was paramount among her four objectives.\textsuperscript{86}

More recently, President Obama stated that he has “talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs.”\textsuperscript{87} One Journal of the American Medical Association article claimed: “It has never been safer to have a baby and never more dangerous to be an obstetrician.”\textsuperscript{88} It is difficult to keep track of the costs defensive medicine causes, however defensive medicine does become more prevalent when physicians perceive a higher malpractice risk.\textsuperscript{89} Congressman Tom Price, a Republican from Georgia, stated on the Republican website America Speaking

\textsuperscript{84} Id. at *7.

\textsuperscript{85} Id.

\textsuperscript{86} Id.

\textsuperscript{87} Remarks by the President To a Joint Session of Congress on Health Care, Office of the Press Secretary, (Sept. 9, 2009) available at: http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/.

\textsuperscript{88} Alastair MacLennan et al., \textit{Who Will Deliver Our Grandchildren?}, 294 JAMA 1688, 1688-90 (Oct. 5, 2005).

Out, that defensive medicine could be costing as much as: “an astounding $650 billion each year. That’s 26 percent of all money spent on health care.”\textsuperscript{90} With mindsets like these, the risk is certainly perceived as high.

In a 1990 survey of 31,000 medical records, Harvard Medical Practice went through multiple rounds of evaluating the records to conclude that doctors were injuring one of every 225 patients, and that only four percent of those patients sued.\textsuperscript{91} Another study, done in 2008, indicated that medical malpractice related costs to health care amount to an estimated $55.6 billion annually, providing for 2.4 percent of the total health care spending in the United States.\textsuperscript{92} Of the $55.6 billion medical malpractice costs annually, $44 billion comes from defensive medicine.\textsuperscript{93} That amounts to defensive medicine amounting to merely 1.9 percent of health care costs annually. While the perceived risk may be in the minds of doctors and those who blame defensive medicine for rising costs, the data indicates that the risk is truly only in their minds.

The criticism of defensive medicine is ineffective when it comes to cost, however, where Hillary Rodham Clinton et. al get it right is the fact that the health care system needs to be tailored to patient safety and health, not avoiding litigation.\textsuperscript{94}


\textsuperscript{91} Ezra Klein, The Medical Malpractice Myth: Forget Tort Reform. The Democrats Have a Better Diagnosis, Slate, Medical Examiner Section, (July 11, 2006) available at: http://www.slate.com/id/2145400/.

\textsuperscript{92} Michelle M. Mello, Amitabh Chandra, Atul A. Gawande, and David M. Studdert, National Costs of the Medical Liability System, 29 Health Aff. J. 1569 (Sept. 2010).

\textsuperscript{93} Id.

\textsuperscript{94} Hillary Rodham Clinton and Barack Obama, Making Patient Safety the Centerpiece of Medical Liability Reform, 354 New England Journal of Medicine 2205, (May 6, 2006).
3. BLAMING THE LEGAL SYSTEM—TORT REFORM

The Conservative solution to health care reform is tort reform. Politicians have used many means to create tort reform in medical malpractice litigation. By erecting barriers to bringing suit through statutes of limitation and attorney contingency-fee reform, creating barriers to reaching trial through pretrial screening panels, limiting the amount plaintiffs may take as an award, and altering the way damages are paid (joint and several liability, periodic payment), the belief was medical malpractice spending can be limited. Of those possible solutions, the only mildly efficient measure was caps on damages.

Placing caps on medical malpractice suit payments has been attempted in several states to fix the broken system. Tort reform advocates maintain that the out-of-control liability system created sharp premium increases for medical malpractice insurance. When the number of claims and the size of payments continued to steadily climb, the medical malpractice insurers had no choice but to increase premiums. Therefore, the root of it all was the liability system. One way to curtail the liability system was to limit the amount a claimant could receive in a medical malpractice case. The theory was that by creating such a cap on the amount a medical malpractice claim could yield frivolous lawsuits would be curtailed and spending would decrease.

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97 For a great summary of the inefficiencies of contingency fee limits, joint and several liability, altered damages payments see Id. at *7.

98 Kathryn Zeiler, Medical Malpractice Liability Crisis or Patient Compensation Crisis?, 59 DePaul L. Rev, 675, 678 (Winter 2010).

99 Id.
In 1975, California adopted the Medical Injury Compensation Reform Act. This legislation put caps on the amount an attorney could require on a contingency basis and created a noneconomic damages cap. Several other states have created similar tort reforms. Currently, in California, Montana, Kansas, and Texas, noneconomic damages are capped at $250,000. In New Mexico, Louisiana, Nebraska, and Indiana have total damages caps in place, limiting the total award a medical malpractice claim can receive. Washington, Oregon, Arizona, Wyoming, Minnesota, Iowa, Arkansas, Alabama, Tennessee, Kentucky, North Carolina, Pennsylvania, New Jersey, New York, Connecticut, Delaware, Rhode Island, Vermont, New Hampshire, and Maine have no damages cap in place. The remaining states have noneconomic damages caps between $250,000 and above.

The problem with the caps is that they have not been very effective in stopping frivolous lawsuits—lawyers and courts systems were doing that on their own. In a 2006 study, 1,452 medical malpractice claims were reviewed. Of these claims, 90% involved physical injury, 63% of those injuries were due to medical error while 37% had insufficient evidence to prove error. Of the claims that did not involve error, 72% did not receive compensation and when they

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101 Claudia H. Williams and Michelle M. Mello, What is a Medical Malpractice Crisis, and Are We in One?, Robert Wood Johnson Foundation Synthesis Project, (May 2006) (Figure 2) available at: http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_policybrief.pdf.

102 Id.

103 Id.

104 Id.


106 Id.
did, the payments were lower than average.\textsuperscript{107} The cost of litigating those claims averaged $52,521 per claim, amounting for, on average, more than half of the compensation paid to plaintiffs.

The benefit damage caps do have within the medical malpractice three-prongs is that in the states where more stringent caps are in place, physicians pay lower premiums.\textsuperscript{108} However, as stated above, the insurance premiums, while an unfortunately expensive part of the system, is not the root of the medical malpractice crisis, it is simply an indicator that the system is in crisis.

\textbf{C. Summing Up the Blame-Game}

Medical malpractice insurance premiums, defensive medicine, and the court system are each individually blamed for the problems in the medical malpractice system. Insurance premiums indicate when the medical malpractice system is in crisis, and thus, are a symptom not a cause. Defensive medicine might be a contributor to rising costs, however, the effect it has is minor. Finally, tort reform has not done much to limit frivolous lawsuits and spending, but it has eased some of the insurance premium expense in states where damage caps are in place.

Perhaps if all three prongs took the blame and each system was overhauled the medical malpractice system would not constantly be in crisis. To start, the three different industries need to start keeping better records to provide better evidence of just how much malpractice insurance needs to cost, how much defensive medicine actually goes on and what it costs, and what tort reform can do to have a more positive impact in the legal and medical communities. From those records, a better analysis of where solutions are needed, and what they should be, can be made.

\textsuperscript{107} Id.

IV. ANALYSIS: HOW THE PPACA AND MEDICAL MALPRACTICE INFLUENCE EACH OTHER AND WHY THE PPACA MISSED A PRIME OPPORTUNITY TO PROVIDE EFFECTIVE MEDICAL MALPRACTICE REFORM

A. THE PPACA AND MEDICAL MALPRACTICE

When the PPACA went through various committees, incarnations, and drafts, Congress utilized President Obama’s list of guidelines and proposed various ideas that touched on, and sometimes expanded, President Obama’s goals.\[109\] For example, the individual mandate that Congress recently described as “essential” to health care reform\[110\] was not initially mentioned or outlined by President Obama.\[111\] President Obama retroactively provided support for the individual mandate.\[112\]

An essential difference between the different plans was the attention to medical malpractice reform needed. In the Patients’ Choice Act of 2009 the cost containment plans would create independent expert panels or state “health courts” to review cases and render decisions, provide bonuses to states that enact medical malpractice reforms and limit malpractice lawsuit rewards.\[113\] The National Health Insurance Act would have created a cost control mechanism that included an analysis of the impact on medical malpractice claims and liability insurance on health care costs.\[114\] From these failed bills, it is clear that medical malpractice reform was

\[109\] See Section II regarding the differences between the House and Senate bills.


\[112\] Id.


\[114\] Id.
contemplated within Congress, however, the only medical malpractice measure to end up in the PPACA was a five-year grant to the states to develop, implement, and evaluate alternatives to current tort litigations.\(^\text{115}\)

The implementation of medical malpractice five year grants to states to develop, implement, and evaluate alternatives to current tort litigations,\(^\text{116}\) cited “the sense of the Senate that – (1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance.”\(^\text{117}\) These grants “encourage” development and testing of alternatives to existing civil litigation systems and tell Congress to “consider” establishing State demonstration programs to evaluate alternatives to resolving medical malpractice claims.\(^\text{118}\) This grant system will allow the Secretary of State to authorize award demonstration grants over five years to states who implement programs that test and evaluate potential changes to the medical malpractice litigation system. To qualify for this grant, the State’s program must meet a laundry list of conditions:

(1) Requirements—Each State desiring a grant under subsection (a) shall develop an alternative to current tort litigation that –

(A) allows for the resolution of dispute over injuries allegedly caused by health care providers or health care organizations; and

(B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved under subparagraph (A) by organizations that engage in

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\(^{116}\) Id.

\(^{117}\) The PPACA, Pub. L. No. 111-148, Sec. 6801.

\(^{118}\) Id. at §§ 6801, 10607
efforts to improve patient safety and the quality of health care.

(2) Alternative to Current Tort Litigation—Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)—

(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.119

119 Id. at § 10607
In addition to the substantive requirements of the program, the State must identify the source from which claims under the alternative dispute resolution plan would be paid, the scope of jurisdiction the plan would have, and the means to identify patients of when they are receiving health care that falls under the alternative malpractice claim resolution.\textsuperscript{120} States will receive preferential treatment for a grant if the program utilizes several different legal and health professionals and experts in mandating and researching the system, promotes patient safety and helps reduce medical error, and improves access to liability insurance.\textsuperscript{121} The PPACA then sets up a review panel in order to review grant proposals, and allocate funds.\textsuperscript{122}

While Section 10607 of the PPACA does account for each prong of the medical malpractice system by asking the grant committees to consider programs that promote patient safety and reduce medical error (the Medical prong), creates alternative dispute resolution (the legal prong) and helps reduce medical error (the malpractice insurance prong), it does nothing to actually change anything. The PPACA merely pays the States to consider making changes to their plans, and does not require any patient or doctor to opt in to whatever plan is proposed by the grant-funded committee. The PPACA missed the opportunity to revamp the court system with the Patients’ Choice Act’s “health courts” and control costs and maintain a real analysis of just how much the medical malpractice system costs the country’s health care with The National Health Insurance Act. It should have taken the cues from those proposals to actually create solutions to problems, not merely contemplate the solutions.

The PPACA likely included medical malpractice reform because conservative politicians often believe tort reform will provide the means for health care reform, where liberal politicians believe trending toward a more socialized health care plan will provide the best means for health care reform.\textsuperscript{123} When it comes to bridging the

\textsuperscript{120} Id.
\textsuperscript{121} Id.
\textsuperscript{122} Id.
\textsuperscript{123} Bill Bradley, Tax Reform’s Lesson for Health Care Reform, N.Y. Times, Op-Ed (August 29, 2009).
gap between conservatives desiring tort reform and liberals desiring universal health care, the solution seems simple: combine universal health care with medical malpractice reform.\textsuperscript{124} While the PPACA attempted to create such a solution, it failed on both accounts.

B. THE PPACA MISSED OPPORTUNITY TO CREATE MORE POSITIVE CHANGES IN HEALTH CARE AND MEDICAL MALPRACTICE BECAUSE BUREAUCRATIC RED TAPE GOT IN THE WAY

The problem is, as President Obama stated, the best means to change the health care system is not to completely change it, but to “fix what’s broken and build on what works.”\textsuperscript{125} As pointed out in the New England Journal of Medicine in 2005, there are many questions associated with a total health care re-haul—what role should the government take? Should there be health plans? How much should it cost? What mechanisms of accountability are built in the system to ensure resources are used well? There are no answers that come immediately to mind.\textsuperscript{126} When there have been answers, they have been deemed too complicated.

For example, in 1992, Hillary Rodham Clinton led the President’s Task Force on Health Care Reform, which sounded a lot like the initial Obama Administration-outlined goals of the PPACA.\textsuperscript{127} The Task Force presented the 1300 page, extremely detailed, Health Security Act in October of 1993.\textsuperscript{128} The government would make it

\begin{itemize}
  \item \textsuperscript{124} Id.
  \item \textsuperscript{125} Archived Update on Health Reform June 15, 2009—Fix What’s Broken, Build on What Works, HealthReform.Gov (June 15, 2009), \url{http://www.healthreform.gov/video/weeklyvideoarchive20090615.html} (accessed April 1, 2011).
  \item \textsuperscript{126} Richard Kronick, Financing Health Care-Finding the Money is Hard and Spending it Well is Even Harder, 352 New Eng. J. Med. 1252 (March 24, 2005).
  \item \textsuperscript{128} Susan J. Stayn, Securing Access To Care in Health Maintenance Organizations: Toward A Uniform Model of Grievance and Appeal Procedures, 94 Colum. L. Rev. 1674, 1674 (June 1994).
\end{itemize}
mandatory for all citizens to have health insurance, and would create a means for people to get it. The new system would provide health care to all citizens and lawful residents of the United States, who would receive health security cards. Under this system, Medicaid would have been folded into the new health care insurance system and the government would contract with a number of health plans to create community-rated premiums based on the least expensive plans in the region. The system would have guaranteed the affordability of health care, regardless of malpractice costs, because it would be completely governmentalized. However, when the true extent of the plan came out (a complete overhaul of the healthcare system), the Task Force came to an end. It was deemed too complicated.

The failure of such a thoroughly researched, well-thought out plan is the perfect example of just how much modern politics gets in the way of real change. The best healthcare reform plan, which was strategically created to effect change from the 20th through the 21st century and beyond, was deemed too complicated and doomed to stall on the committee floor. Was it fear of the unknown? Was it fear that an overhaul of the system would be extremely expensive and even after all of the expense it might fail? The reality was the Health Security Act would not have passed through the House and Senate. The questions regarding the Act’s potential to succeed or fail were barely even considered. The complete overhaul the Task Force called for was too extreme for those hesitant to vote for a bill that would so completely change the healthcare system. Without gaining support from those on the fence then and now any bill with similar

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129 *Id.*

130 *Id.* at 4

131 *Id.* at 4-8


134 FIND CITE
weight and magnitude is also doomed to fail. Simply put, extreme change seems impossible when the potential change has to better the country is not considered before a bill’s popularity is.

President Obama was more fortunate to be elected in a time when healthcare reform was a popular hot-button issue. However, the lofty goals of PPACA were also stalled by bureaucratic red tape. In committees, and throughout the process of passing the PPACA, President Obama’s best laid plans were weeded out. Thus, the PPACA failed to create universal health care. It failed to even make an optional federal government-run insurance, even though it was part of President Obama’s initial plan, and part of earlier drafts. The PPACA also failed to create any kind of medical malpractice reform at all. Instead the states were tasked to consider creating alternative dispute resolution programs that would be prototypical and optional for doctors and patients to utilize. On both accounts, as President Obama even stated: “nothing in our plan requires you to change what you have.” While these words were meant to be encouraging to people who were scared of or against health care reform, the fact of the matter is President Obama admitted that his plan had the potential to change everything by creating a government-run, inclusive insurance program (as indicated in his outlined plans and earlier drafts), and yet ended up changing nothing substantial.

The inherent weakness of the PPACA was that the bureaucratic drafting process compromised it. President Obama established his

135 See Part II. A.


137 See above analysis regarding The PPACA, Pub. L. No. 111-148, Sec. §§ 6801, 10607.

138 Remarks by the President To a Joint Session of Congress on Health Care, Office of the Press Secretary, (Sept. 9, 2009) available at: http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/.

139 See above regarding the drafts of the PPACA
vision, and that vision was slowly eroded due to the political moderation process required to get it to pass.

The contemporary form of moderation, however, simply assumes government growth (i.e., intervention), which occurs under both parties, and instead concerns itself with balancing the regulatory interests of various campaign contributors. The interests of the insurance companies are moderated by the interests of the drug manufacturers, which in turn are moderated by the interests of the trial lawyers and perhaps even by the interests of organized labor, and in this way the locus of competition is transported from the marketplace to the legislature. The result is that mediocre trusts secure the blessing of government sanction even as they avoid any obligation to serve the public good. Prices stay high, producers fail to innovate, and social inequities remain in place.\(^\text{140}\)

The real change in the PPACA, as a whole and specific to medical malpractice, was lost to moderation. Now that the Supreme Court has ruled that the PPACA’s individual mandate is constitutional, health care reform on this grand a scale will likely not face further political upheaval for quite some time.\(^\text{141}\) This means that further initiative is necessary to address the legal side of medical malpractice.

Unfortunately, the current climate in Congress is not conducive to improving upon the PPACA. Democrats have divided over the necessity of the individual mandate.\(^\text{142}\) When the PPACA was initially deemed invalid in Florida v. Department of Health and Human


Affordable Care and Medical Malpractice—How Two Broken Health Care Systems Will Only Get Worse Without Better Compromise—
2/21/13 Draft

Services, Moderate Democrats proposed alternatives to the individual mandate, while more liberal Democrats held on strong to the “essential” individual mandate element of the PPACA\textsuperscript{143} despite its potential unconstitutionality.\textsuperscript{144} Meanwhile, the Whitehouse has had problems with GOP governors who have been slow to implement the PPACA, and critical of its funding and constitutionality.\textsuperscript{145} With internal Democratic turmoil, and increasing eagerness to repeal the PPACA within the Republican Party, it looks like healthcare reform may have hit another stalemate and medical malpractice reform will continue to go unlooked.

V. CONCLUSION

Some believe that medical malpractice reform is an inefficient way to protect patients from negligent care and reduce the cost of health care overall;\textsuperscript{146} the fact is that since the 1960s medical malpractice has been “in crisis.” Since then, health care has continued to become more and more expensive across the board. Politicians have attempted to step in to find a solution to both medical malpractice litigation and rising health care costs, however all of these solutions have been inadequate. The PPACA proposes more of the same—politicians stepping in with pilot program type ideas for programs that might ease the current medical malpractice crisis. The problem with what the PPACA proposes is that it encourages more bureaucracy—which historically resulted in watered down, ineffective medical malpractice reform and health care reform. If history continues to

\textsuperscript{143} Id.; Manu Raju, A New Dem Threat To Health Care Law, Politico (February 7, 2011) available at: http://dyn.politico.com/printstory.cfm?uuid=02B1096D-BEB5-F43B-FC7406A0FD1F32CB.

\textsuperscript{144} For a good analysis of the PPACA and the probability of the Supreme Court declaring the individual mandate unconstitutional see Laurence H. Tribe, On Health Care, Justice Will Prevail, N.Y. Times, Op-Ed (Feb. 7, 2011).

\textsuperscript{145} Sam Stein, Health Care Showdown: Obama Administration Calls Out GOP Governors, Huffington Post (Feb. 7, 2011).

\textsuperscript{146} James J. Mongan, Timothy G. Ferris, Thomas H. Lee, Options for Slowing the Growth of Health Care Costs, 358 New Eng. J. Med. 1509 (stating that “the direct costs of malpractice premiums and estimated cost of defensive medicine are not major factors in overall health care spending.”)
repeat itself, the PPACA committees created by the medical malpractice grants will continue to create programs that provide minor changes to a system that needs a complete overhaul or the programs that effect change will be deemed too complicated or too extreme. Where the PPACA as a whole, as well as the history behind it, is on point to spur change is the sentiment behind it. If patient care and overall health become the primary focus of our government health care system, the hope is, there will be fewer medical mistakes, less litigation, and less expense.