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Law in the Healthcare Crisis

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Law and the Healthcare Crisis: The Impact of Medical Malpractice and Payment Systems on Physician Compensation and Workload as Antecedents of Physician Shortages – Analysis, Implications, and Reform Solutions

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Abstract

The U.S. faces a healthcare crisis of monumental proportions with myriad facets including issues of access, quality, and affordability. Medical malpractice liability in this crisis is often alleged to play a role in this crisis through its impact on physician compensation and shortages. This study goes beyond the rhetorical arguments in exposing the root causes of the crisis to be the structure of healthcare delivery and physician compensation systems, in part using pooled data we develop. These systems greatly increase the cost of healthcare, lead to far too many medical errors, and skew the distribution of physicians across specialties, in part because the current compensation structure provides inappropriate treatment incentives. Rather than simplistic tort reform solutions such as direct caps on damages, we argue that the real answer to the healthcare crisis resides in new and evolving models of healthcare delivery and reimbursement that hold promise of improving the quality of care and decreasing the number of medical malpractice cases. At the same time, these new systems present new challenges for an already deficient regime for resolving malpractice claims which needs to be reformed to complement the new delivery and reimbursement systems. We propose pragmatic changes to the current malpractice regime predicated on five pillars: (1) mandated price and quality disclosure of healthcare services, (2) a focus on enterprise liability in which the medical entity responsible for care is the defendant as opposed to individual physicians, (3) mandated disclosure of medical errors to patients, (4) mandated, non-binding mediation the function of which is to avoid costly, protracted trials and long delays in patient compensation whenever possible, and (5) mandated disclosure of medical errors in settled cases. We argue that this approach will provide appropriate incentives to allow for needed systemic change that discourages under treatment and better serve the needs of tort victims.
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I. Introduction

The U.S. faces a healthcare crisis of monumental proportions with myriad facets including issues of access, quality, and affordability – the subject of much political rhetoric. Amidst the many facets of the crisis, and the rancor that attends it, are the problems of physician shortages in certain critical areas of practice, such as primary care, and the growing refusal of physicians to accept Medicare patients. Both problems are allegedly related to physician compensation, which, in turn, is linked to controversy involving medical malpractice insurance cost that supposedly causes physicians to shy away from certain medical specialties and has been heavily debated in recent years. In addition, physician shortages are also potentially related to Medicare

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1 See, e.g., John W. Hill, Arlen Langvardt & Anne Massey, Law, Information Technology, and Medical Errors: Toward a National Healthcare Information Network Approach to Improving Patient Care and Reducing Malpractice Costs, 2 J. L. TECH. & POL’Y 159, 159-165 (2007) (discussing problems with medical errors, healthcare cost, medical malpractice, and archaic health information systems).


3 Id.


5 Id.

6 Id.
fee-for-service (FFS) rules that are having a profound effect on physicians’ reimbursement for services and their career choices with respect to area of practice.7

There is little question that the United States is currently experiencing a crisis in healthcare quality, delivery, and cost. The healthcare industry is now the largest in the nation approaching 18% of gross domestic product8 and expected to reach 20% by 2016.9 Although much of the current debate about healthcare reform focuses on providing healthcare to the insured,10 two equally serious facets of the healthcare crisis are its high cost and unreliable quality.11 Healthcare spending continues to grow rapidly, and the industry is under enormous market pressure.12 One commentator has predicted Medicare will be insolvent by 2017.13 There is an

10 See, e.g., Paul McCloskey, Public-Minded Health IT, 2(6) GOV’T HEALTH IT, Nov. 2007, at 3 (noting also that “The presidential candidates have given short shrift to the notion that information technology is essential to curing the U.S. healthcare system.”).
“unconscionable error rate”\textsuperscript{14} that results in as many as 98,000 patient deaths per year,\textsuperscript{15} and research indicates large disparities in the quality of healthcare across different systems in the United States.\textsuperscript{16} Healthcare providers face pressures to improve healthcare delivery from multiple sources including the legal system and an aging population.\textsuperscript{17} A poorly organized healthcare delivery system continues to degrade the quality of care,\textsuperscript{18} cause unnecessary deaths, and waste billions.\textsuperscript{19} One source describes the efforts to improve the system as “unhurried,” “sluggish,” and “snail-paced.”\textsuperscript{20}

Appended to this crisis is a debate over medical malpractice costs that waxes and wanes periodically with physicians asserting various adverse effects on their practices resulting from malpractice costs.\textsuperscript{21} Among these assertions is that malpractice costs are so adversely affecting


\textsuperscript{14} Ahern, supra note 8.

\textsuperscript{15} A 1999 report of the Institute of Medicine settled on 44,000 to 98,000 as a reasonable estimate of the number of annual deaths in hospitals as a result of medical error. \textit{Inst. of Med., To Err Is Human} 26, 31 (1999), \textit{available at} http://www.nap.edu/openbook/0309068371/html/R1.html.


\textsuperscript{17} Don Tapscott, New Paradigm Learning Corporation, \textit{Business Intelligence for the Health Care Industry: Actionable Insights for Business Decision Makers} 1 (2008).

\textsuperscript{18} Sanford A. Garfield et al., \textit{Considerations for Diabetes Translational Research in Real-World Settings}, 26 \textit{Diabetes Care} 2670, 2671 (2003).


\textsuperscript{20} Bill Alpert, \textit{At Last, Digital Doctors}, \textit{Barron’s}, Feb. 13, 2006, at 43.

\textsuperscript{21} Hill, Langvardt & Massey, supra note 1, at 160-61.
the profitability of physician practices that physicians are being driven from practicing in some jurisdictions, thereby contributing to a problem of physician shortages in some locales and specialties. Although this debate and the volume of rancor it has generated has led some jurisdictions to enact tort reform measures, such as caps on malpractice awards designed to limit physicians’ legal liability, the issue of the real impact of malpractice liability on physician compensation as an antecedent of physician shortages remains an open one.

Also joined to the healthcare crisis is a furious debate over the role of Medicare to include its present and future cost to the government and therefore to taxpayers - and, of particular interest in this study, its role in physician reimbursement, in some physicians’ refusal to treat Medicare patients, and in emerging physicians’ choice of specialty. The U.S. Comptroller General has

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estimated that Medicare costs will grow from less than 10% of Gross Domestic Product currently to approximately 20% by the middle of the 21st century.29 Under the present fiscal regime, Medicare cash flow is projected to turn negative before 2010 and become increasingly so as figures are extrapolated into the future.30 Over the years, as pressure has mounted to control Medicare spending, Centers for Medicare & Medicaid Services (CMS) has moved to limit increases with some success.31 Despite this modest success, the Medicare trust fund is expected to be bankrupt by 2019 with some arguing the blame rests with the government subsidizing the supply of healthcare by paying providers directly and also with providers who have become adept at exploiting the system32 - thus setting up a seemingly inevitable collision between physician shortages on one hand and fiscal constraints on the other.

This study examines evidence regarding the respective influences of malpractice liability costs and Medicare reimbursement rules on physician compensation, workload, and shortages in critical specialties. Specifically, it explores, both logically and empirically, the association between malpractice insurance costs, physician compensation, and the quantity of care provided

http://bulletin.aarp.org/states/ks/articles/doctors_cant_afford_new_medicare_patients_reimbursement_rates_arent_k
keeping_pace_with_rising_costs_doctors_say.html.

28 Massachusetts Medical Society, supra note 23, at 2.


30 Id. at 24.

31 Thomas Bodenheimer, The Not-So-Sad History of Medicare Cost Containment As Told in One Chart, HEALTH

32 Graham, supra note 26.
over time and by specialty to draw conclusions about the evidentiary versus emotive impact of malpractice on physicians’ compensation as follows. Section II discusses the most important of the myriad facets of the healthcare crisis and explains how the current healthcare system came to be. Section III provides an assessment of the current medical malpractice liability landscape starting with a brief legal background and followed by an assessment of past, ongoing, and proposed tort reforms. Section IV describes the current third-party healthcare payment systems and how these systems operate. Section V analyzes evidence from various sources to include archival data on physicians’ compensation, malpractice insurance cost, and workload and draws conclusions about their effects on physician compensation, shortages of physicians, and quality of care. It also explores the issue of whether federal healthcare laws and regulation are skewing the distribution of physician specialties and draws conclusions about the flawed setting of Medicare reimbursement rates. We augment the extant evidence, much of which is anecdotal, with our own dataset consisting of pooled data drawn from three sources to help separate rhetoric from reality with respect to the impact of the legal system on physicians' compensation and shortages. Section VI discusses the smorgasbord of ongoing and proposed healthcare reforms and discusses the potential efficacy of each. In Section VII, we discuss the need for new healthcare delivery and payment systems, what forms these systems will likely take, and why we believe these new systems should embrace strategic cost management (SCM) concepts borrowed from the business research literature. Section VIII draws inferences from the evolving healthcare delivery and reimbursement systems for medical malpractice litigation. It then discusses the ideal characteristics of a modified medical malpractice regime and concludes with a pragmatic solution for how to create such a regime in response to the evolving models of healthcare delivery and reimbursement. Section IX summarizes our arguments and conclusions.
II. Major Facets and Origins of the Healthcare Crisis

As stated previously, the healthcare crisis is extraordinarily complex, costly, and seemingly intractable resulting in it receiving a great deal of attention by both politicians and commentators. Consequently, an appreciation of both the nature and origins of the crisis is a useful foundation for understanding the context of the subordinate issues of medical malpractice and Medicare reimbursement and how they affect physician compensation, workload, and shortages. Among the most important of the many facets of the healthcare crisis are (a) a grossly inefficient, antediluvian care delivery system, (b) an unacceptable rate of medical errors, and (c) an increasingly unaffordable cost of healthcare at the macro level that is exacerbated by a complex, convoluted payment system.33 The following subsections deal with efficiency, quality, and access/affordability issues before turning to a discussion of the origins of the crisis. We defer discussion of the reimbursement system to Section IV where we compare Medicare and Medicaid reimbursement with that of private insurance and discuss Medicare’s relationship to physician compensation.

*Healthcare Inefficiency*

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The U.S. healthcare system is extremely inefficient, a problem that becomes worse as healthcare grows as a percentage of gross domestic product (GDP).\textsuperscript{34} Aaron and Schwartz, in defining the efficient use of medical resources as obtained “when a given total expenditure cannot be reallocated to alternative kinds of care to achieve an improved medical outcome,” develop a taxonomy that identifies five types of efficiency: medical, distributional, production, insurance, and dynamic.\textsuperscript{35}

“Medical efficiency means that the mix of services should produce the greatest possible medical benefit.”\textsuperscript{36} This argues for a reasonable distribution of the types of resources based upon need, an end that is currently not met in light of such problems as critical physician shortages in some medical specialties\textsuperscript{37} and the overuse and misuse of emergency services.\textsuperscript{38} Major shortages of physicians are alleged to exist in many locales\textsuperscript{39} and some specialties, with 20\% of U.S. residents residing in medically underserved areas.\textsuperscript{40} There are growing problems in primary care where an adverse selection problem exists wherein medical students self-select to higher-paid

\textsuperscript{34} Krugman & Wells, \textit{supra} note 33, at 1.

\textsuperscript{35} AARON ET AL, \textit{supra} note 33, at 95.

\textsuperscript{36} Id.


\textsuperscript{39} Tilden, \textit{supra} note 37.

\textsuperscript{40} NEJM Article Examines U.S. Physician Shortage, \textit{MED. NEWS TODAY} (Apr. 21, 2008), \textit{available at} http://www.medicalnewstoday.com/articles/104699.php.
specialties instead of becoming primary care physicians (PCPs). Estimates developed by the Council for Graduate Education indicate a shortage of over 28,000 PCPs with inadequate private and public insurance reimbursement asserted as a cause. As primary care suffers from understaffing, emergency departments suffer from overuse with 90% of large hospitals at or over capacity and wait times having increased 33% in recent years.

Distributional efficiency is achieved when services are distributed among people to best satisfy the nation’s values and preferences. A healthcare system that permits disparities in care based upon wealth, income, race, age and/or gender implicitly sanctions inequalities that violate notions of fundamental fairness. Although such notions might suggest all persons are entitled to adequate care, this does not appear to be the case inasmuch as care funded through Medicaid, which insures the poor, has been deemed inferior to that funded by private health insurance. Further, evidence also suggests that blacks, women, and the elderly often receive inferior care on

41 See, e.g., Christine Hurley Deriso, Nationwide panel: Act Now to Avert Impending Health care Crisis, MED. C. GA. NEWS (Jul. 17, 2008), available at https://my.mcg.edu/portal/page/portal/News/archive/2008/Dr.%20Rahn%20to%20participate%20in%20July%20briefing%20on%20nation%92s%20heal.

42 Coile, supra note 4.

43 Deriso, supra note 41.

44 Liebenrood & Pond, supra note 38.

45 AARON ET AL, supra note 33, at 95.

46 See, e.g., id at 97.

Consequently, it does not appear that a reasonable level of distributional efficiency is being achieved by the U.S. healthcare system.

Insurance efficiency is achieved when people are protected from risks that cause the greatest financial burdens and distress. In the United States, neither public nor private insurance seems to be functioning particularly well in that both have been the subject of complaints by patients, healthcare providers (HCPs), and insurers themselves. Patients sue insurance companies for

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49 AARON ET AL, supra note 33, at 95.

claims denial, physicians and private insurance companies feud over reimbursement, and governments discipline insurance companies for unfair claims practices and fraud. Some lawmakers allege insurance companies fail to provide insurance to a broad enough base of patients, while some physicians accuse insurance companies of attempting to coerce physicians into doing business with them. Others say insurers use unfair practices prompting lawmakers to force insurers to define contractual terms such as “medical necessity.” In the public sector of health insurance, physicians are said to be turning away Medicare and Medicaid patients because of low reimbursement rates. Medicaid has encountered both funding and quality

SACRAMENTO BUS. J. (Aug. 25, 2008), available at,

51 See, e.g., Blue Cross of California Settles another Policy Cancellation Suit, supra note 50.

52 See, e.g., Gold, supra note 50.

53 See, e.g., Newman, supra note 50; and Massachusetts Attorney General Sues Low-Cost Health Insurer Alleging Unfair Practices, supra note 50.

54 With Few Details Known, WellCare FBI Raid Could Have Effect on MA Program Funding, 17(38) HEALTH PLAN WEEK (Oct. 29, 2007), at 1, 6.


58 Semenza, supra note 27.
challenges, and during the period 2003-2006 some states ended their financing arrangements for supplemental payments. Attempts to meld private plans with Medicare have met with limited success, and states’ attempts to institute premium subsidy programs for the low-income uninsured have encountered administrative difficulties. Consequently, it seems apparent that insurance efficiency is lacking in the U.S. healthcare system.

Production efficiency implies that a given quantity of healthcare should be provided with the fewest possible resources. Credible estimates, however, suggest that as much as 5% of GDP is wasted healthcare spending. Private insurance administrative costs have been estimated to be in the range of 25% of the healthcare costs for which they pay versus comparable figure of 3%


63 AARON ET AL, supra note 33, at 95.

64 Len Nichols, Health Affairs Blog (Aug. 26, 2008) (comments re: Jack Hadley et al., Covering the Insured in 2008: Current Costs, Sources of Payment, and Incremental Costs, 27(5) HEALTH AFFAIRS (Aug.25, 2008), available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.5.w399).
for Medicare.\(^65\) Healthcare costs are said to be unnecessarily reducing take-home pay for many.\(^66\) Insured consumers are insulated by third-party payers from knowing healthcare costs and are therefore unable to make efficient cost/benefit decisions.\(^67\) David Walker, Comptroller General of the United States, projects that public healthcare spending will bankrupt the nation by 2040\(^68\) and “[t]he cost of health insurance continues its 20-year reign as the number one problem for small business owners.”\(^69\) Although much of the focus of attention in the healthcare crisis is on the uninsured and underinsured, a surprising number of citizens in the U.S. have more health coverage than they need and pay more than is necessary for insurance.\(^70\) Insurers are said to find it difficult to define standard-of-care measurements to appropriately price their products.\(^71\)

\(^{65}\) Carl Mercurio, Another Call for Medicare for All, Corporate Research Group Weblog (Sep. 3, 2008), available at http://blog.corporateresearchgroup.com/.


\(^{67}\) Manos, supra note 9.


\(^{69}\) Malorye Allison, Reform Plans NEWS, REFORMPLANS.COM (Jun. 27, 2008) (copy on file with authors).


These production inefficiencies are said to be a major contributor to what has been described as a “perfect storm of negative economic trends.”

Dynamic efficiency requires that incentives for technological change properly encourage scientific advance and the emergence of cost-effective technologies. Despite the enormous strides that have been made in medical technologies for diagnosing and treating illnesses, as well as the enormous potential of technological change for improving both the cost and quality of healthcare, such change in terms of healthcare administration, clinical process improvement, and medical error proofing remain all too primitive. HCPs have been slow in adopting even relatively basic technologies, such as electronic medical records, and adoption rates of other technologies have been less than desirable due to systemic inefficiencies that fail to reward such

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73 AARON ET AL, supra note 33, at 95

74 See, e.g., JOHN GROUT, MISTAKE-PROOFING THE DESIGN OF HEALTH CARE PROCESSES, AGENCY FOR HEALTHCARE RES. & QUAL., U.S. DEPT. HEALTH & HUM. SERVS., AHRQ PUBLISHING NO. 07-0020, 1 (May 2007) (for a treatise on the potential of mistake-proofing processes stemming from operations research to greatly reduce medical errors; Hill, Langvardt & Massey, supra note 1, at 194-7, 204-10 (explicating the unrealized benefits associated with a national health information network); Volker Pfahlert & Hamid Emminger, *Future Prospects In Medical Diagnostics*, J. MED. ENGINEERING & TECH., May/June 2003, at 109, 109-12 (describing the potential benefits of technology in improving physicians’ diagnoses); Joseph Conn, *Upgrading to Health 2.0: What Will the Next Generation of Web Enterprises look Like?* 37(49) MODERN HEALTHCARE, 32, at 33 (Dec. 10. 2007) (noting the potential for web-based software to deal with matters such as the myriad insurance reimbursements rules with which HCPs must deal); *Futurist: I.T. Key to Productivity*, 15(12) HEALTHDATAMANAGEMENT.COM (Dec. 2007) (stating that information technology offers the best prospect for eliminating waste in healthcare.

progress. Consequently, it appears obvious that the potential benefits of dynamic efficiencies go unrealized to a significant extent in the U.S. healthcare system.

**Healthcare Quality**

Quality problems are pervasive within the U.S. healthcare system despite the expenditure of a higher percentage of GDP on healthcare than any of the industrialized country. It has been estimated that more than 250 Americans die each day due to medical errors. A landmark study in 1999 by the Institute of Medicine (IOM) titled “To Err Is Human” shocked many with its estimate of up to 98,000 deaths from medical errors annually. A subsequent report by the IOM in 2006 declared quality problems so serious that, on average, a hospital patient is subjected to at least one medication error per day. Both systemic and anecdotal examples of catastrophic medical errors abound with evidence that the incidence of errors is increasing. Perhaps one

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76 [RICHMOND & FEIN](http://www.annals.org/cgi/reprint/144/10/742.pdf), supra note 33, at 91-3.


79 Id.

of the most glaring indications of underlying systemic problems is that the United States, despite its higher healthcare expenditures, has a higher infant mortality rate than any other industrialized nation.\textsuperscript{82} A “national report card” on American healthcare issued by the Rand Corporation concluded that virtually everyone in the United States is at risk of receiving poor healthcare.\textsuperscript{83} An estimated 4% of all patients entering hospitals experience some type of adverse incident, approximately half of which are preventable, and 25% of which are due to negligence.\textsuperscript{84}

An understanding of the reasons for these quality problems begins with an understanding of the current structure of the U.S. healthcare industry. This structure might be analogized to a rural Indiana road that wanders through hills and dales on a seemingly not-implausible path until suddenly making an illogical ninety-degree turn – illogical, that is, from a topographical perspective, unless one considers that the secondary road was preceded by a dirt road that

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\item RICHMOND & FEIN, \textit{supra} note 33, at 93.


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evolved from a wagon trail that circumvented a 19th century cornfield. And so it is that a former life-sciences executive compared the current state of the healthcare industry as one of paved-over cart paths— a system that was never designed but rather evolved. This has led to an anomaly in which not only do the great innovations in medical diagnostics and treatment of the past half century go unmatched by the architecture of the healthcare delivery system, but these innovations are actually contributing to what has been termed a contrarian paradox in which ever-improving medical science extends patient longevity, thereby necessitating more healthcare and placing more demands upon the system. This paradox is likely to be exacerbated by the advent of molecular medicine that holds promise of greatly expanding life spans. That science places such strains upon the art of medical practice is not a travesty per se; it seems lamentable

85 Interview with Ronald W. Dollens, former President and CEO, Guidant Corp., and past Chairman, Healthcare Leadership Council, in Bloomington, IN (Feb. 1, 2006) (notes on file with authors) (noting that fundamental process change is a prerequisite for healthcare improvement).

86 Brad Broberg, Medical Errors Going Under the Microscope, PUGET SOUND BUS. J. (Oct. 26, 2007), available at http://www.bizjournals.com/seattle/stories/2007/10/29/focus1.html (quoting Dr. David Flum, Assistant Professor of Surgery, University of Washington: “What we call the health care system is really not a system yet.”)


88 John W. Hill, Arlen Langvardt & Jonathon Rinehart et al., Bottom-Up or Top-Down? Removing the Privacy Law Obstacles to Healthcare Reform in the National Healthcare Crisis, 84 IND. L. J. SUPP. 23, 25.

89 See generally, COPING WITH METHUSELAH: THE IMPACT OF MOLECULAR BIOLOGY ON MEDICINE AND SOCIETY (Henry J. Aaron & William B. Schwartz, eds., 2004) for an analysis of arguments and counterarguments regarding the potential social and economic effects of innovations in molecular medicine.

90 See, e.g., Krugman & Wells, supra note 33, at 1 (noting that costs are an important sign of progress and that new technology has been a principal culprit in these rising costs).
only in its contribution to the problems associated with a structurally weak healthcare delivery system.

The organizational structure of U.S. healthcare is an overarching contributor to healthcare quality problems in that its systems are very complex in terms of their constituent elements with dual lines of authority for clinical and administrative staff and powerful subcultures that often clash leaving one to wonder who precisely has the ultimate responsibility of reducing healthcare errors in a given HCP. By far and large, healthcare processes are unconnected to one another in any real-time fashion and care is delivered unevenly. If the error rates in intensive care units were acceptable in the airline and banking industries, for example, the result would be two dangerous landings per day at O’Hare International Airport and 32,000 checks deducted from the wrong accounts every hour. In the era of total-quality-management and six-sigma thinking in

91 R. Nat Natarajan & Amanda Hoffmeister, Do No Harm: Can Health Care Live Up to It? (undated working paper), http://www.tntech.edu/mayberry/2001N-DoNoHarm.htm (noting that it is important to distinguish between active errors, which occur at the frontline provider level, and latent errors which are systemic and removed from the direct control of individuals – with the implication that error prevention must focus on the entire system).

92 See Hill, Langvardt & Massey, supra note 1, 197-204. “Many medical errors are traced to gaps in the flows of necessary information.” Sidney Taurel, Chairman & CEO, Eli Lilly & Co., Remarks at the Indiana University Kelley School of Business Annual Business Conference, “The Health Care Conundrum: A Call for Leadership,” Indianapolis, IN (March 8, 2006) (hereinafter “Health Care Conundrum Conference”) (notes on file with authors). A lack of understanding of patterns of error resulting from shared information is often the culprit in causing medical errors as opposed to purely individual human mistakes. Tom Murphy, Clarian Plans Training Center.

93 Ahern, supra note 8.

94 Id.
many business organizations that strive to limit errors to 3.4 defects per million opportunities, high U.S. healthcare error rates, especially when one considers what is at risk, seem absurdly unconscionable, but nonetheless persistent. Yet, adoption rates for new information technologies that hold promise of reducing errors are slow, and involving physicians in implementing quality improvement tools in healthcare has proven difficult- in part because fear of legal liability inhibits disclosure of mistakes, and, in part, because of physician narcissism which resists system checks on decisions.


96 Blackford Middleton et al., Accelerating U.S. EHR Adoption: How to Get There From Here; Recommendations Based on the 2004 ACMI Retreat, 12 J. AM. MED. INFORMATICS ASS’N 13, 14-15 (2005).

97 Natarajan & Hoffmeister, supra note 90.

For the most part, HCPs have historically been able to directly externalize a majority of the costs of poor quality, so economic incentives to improve quality have been largely dependent upon the threat ex post of malpractice litigation which, as discussed subsequently, has been neither very effective in compensating plaintiffs for their losses nor in providing adequate economic incentives to improve healthcare quality. There is, however, some evidence that this cost externalization may be coming to an end as more private insurers and federal and state governments refuse to pay for errors.

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100 See, supra note 98, at 126; Hill, Langvardt & Massey, supra note 1, at 186-7.

At the consumer level, a lack of transparency makes it difficult for health consumers to make rational cost/benefit selections among HCP and other healthcare alternatives.\(^\text{102}\) Contrary to most markets in which price and quality indicators are reasonably transparent,\(^\text{103}\) in the complex healthcare market structure it is difficult to discern precise linkages between the inputs to care and its outcomes.\(^\text{104}\) Since healthcare bills are most often paid by a third party, HCPs typically do not disclose prices, and in many cases patients have little reason to care about prices.\(^\text{105}\) Consequently, HCPs do not compete on price, and, because there is no price competition, there is little quality competition as well - factors which have a profound effect on the cost and quality of healthcare.\(^\text{106}\) Moreover, HCPs typically think of those they treat as passive patients rather than savvy consumers.\(^\text{107}\) Healthcare consumers are therefore currently disempowered by the

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\(^{103}\) Id.

\(^{104}\) Herrick & Goodman, *supra* note 102.

\(^{105}\) *Id.* (noting “The biggest obstacle to quality transparency is a tax system that favors third-party insurance over individual self-insurance. For a middle-income employee [third-party insured], government is effectively paying almost half the cost of health insurance.”) The reason for this is that employer—paid health insurance for employees is exempt from federal income tax thereby providing a government subsidy to employer-based healthcare plans. KENNETH R. WING, *LAW AND THE PUBLIC’S HEALTH* 290 (6th ed. 2003); J. STUART SHOWALTER, *THE LAW OF HEALTHCARE ADMINISTRATION* 139 (4th ed. 2004).

\(^{106}\) *Id.*

\(^{107}\) Deloitte Center for Health Solutions, *2008 Survey of Health Care Consumers*, at 20, available at [http://www.deloitte.com/dtt/article/0,1002,cid%3D193730%26pv%3DY,00.html](http://www.deloitte.com/dtt/article/0,1002,cid%3D193730%26pv%3DY,00.html).
Consumers’ attitudes toward healthcare quality are more influenced by personal experiences than any educated view of the system, and, as a consequence, vary widely. Even gaining access to their own medical records is often problematic for patients.

There is substantial evidence, however, that the lack of transparency is changing, albeit not without resistance from entrenched interests within the healthcare community. A healthcare consumerist movement is gathering strength nationally because much of the public has a deep yearning to exercise more control over their health and sees healthcare information as the path that leads to better health. This is translating into a desire by patients to exert more control over treatment and have greater access to information about healthcare availability,

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109 Deloitte Center for Health Solutions, *supra* note 107, at 6.


111 Deloitte Center for Health Solutions, *supra* note 107, at 20.


quality, and cost\textsuperscript{114} in order to make their own decisions about their healthcare.\textsuperscript{115} This desire, in turn, is attracting the interest of both the private sector and the government as exemplified by the recent advent of Google Health, which links consumers to healthcare information,\textsuperscript{116} and the fact that both the federal government and a number of states have pushed for healthcare quality measures and reporting.\textsuperscript{117} Under pressure from patients,\textsuperscript{118} HCPs are beginning to provide patients with more data,\textsuperscript{119} and medical researchers are beginning to examine to how best accomplish this.\textsuperscript{120} These steps toward quality transparency seem modest, however, in light of the massive quality issues plaguing the healthcare system.\textsuperscript{121}

\textsuperscript{114} Deloitte Center for Health Solutions, \textit{supra} note 107, at 20.

\textsuperscript{115} \textit{Id.}


\textsuperscript{118} \textit{Patients Urge Doctors to Get Connected}, 19(24) FOR THE RECORD (Nov. 11, 2007), at 35.


\textsuperscript{121} See, e.g., Ahern, \textit{supra} note 8.
Healthcare Affordability and Access

There are several indicators that healthcare affordability and access are major facets of the healthcare crisis. “Skyrocketing costs” are said to burden the nation’s economy. A recent survey of U.S. patients indicated that, because of affordability constraints within the past two years, 40% of patients did not fill a prescription, 34% did not see a physician when ill, and 33% did not obtain a recommended test or follow up. Retail, walk-in clinics - staffed with nurse practitioners supported by computer diagnostic and treatment protocols and offering transparent pricing - are growing in popularity. Growth in healthcare spending is said to represent the greatest fiscal challenge for state and local governments. The demands placed on emergency departments (EDs), which provide medical care to 44 million low-income Americans and, by federal law, must treat all comers regardless of their ability to pay, are becoming so swamped with patients that nearly 4,000 EDs are operating at critical capacity. Questions of patients being denied ED treatment illegally are said to be an indication of the stresses EDs are facing.

122 Todres, supra note 84, at 692.
124 Herrick & Goodman, supra note 102.
125 Leopold, supra note 66.
126 Liebenrood & Pond, supra note 38.
stresses exacerbated by private clinics referring poor Medicaid patients to higher-priced, affiliated EDs. Over the past few years, lifetime benefits from private insurers have failed to keep pace with healthcare cost inflation due to an increase in the number of seven-figure claims. With healthcare costs having increased by nearly 10% in 2008, problems of affordability are likely to become even greater. A telling sign of the healthcare cost burden is the growth of medical tourism wherein people who have never left the United States before are traveling out of the country to obtain affordable medical procedures.

Timely access to healthcare is obviously enormously important to many Americans given evidence that even slowing access to healthcare can affect mortality. This is especially true for many of the nation’s uninsured and underinsured who struggle to pay medical costs and do

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129 *Patients Hit Benefit Maximums, but Care Charges, Cost-Shifting Is Heart of the Problem*, AIS HEALTH.COM (Sep. 5, 2008), available at http://www.aishealth.com/Bnow/hbd090508.html (arguing that hospital billing practices result in great disparities for the same services depending upon which type of payer is billed and that many services are over billed.


133 Joshi, *supra* note 2, at A02.
not have the same access to preventive medical care that the fully insured receive.134 One in 
three working-age adults in the United States without health insurance has a chronic disease that 
goes untreated.135 A portion of the problem with uninsured and underinsured can be traced to a 
decline of employer-based health insurance as indicated by a reduction of the percentage of 
jobs offering plans for employees from 69% in 2000 to 60% in 2006.136 Employer 
healthcare insurance premiums rose 73% during the period 2000 to 2005,137 and deductibles have 
nearly doubled over the past decade.138 Bills unpaid by the uninsured plague hospitals as the 
number of uninsured under age 65 grew from 39.6 million to 46.1 million over a recent five-year 
period.139

134 Government: Health Care Improves, but Prevention Remains Missed Opportunity, USA TODAY (Jan. 1, 2007), 
Cancer Patients Diagnosed Later, FierceHealthcare (Jun. 12, 2007), available at 
http://www.fiercehealthcare.com/story/study-uninsured-cancer-patients-diagnosed-later/2007-06-12 (reporting on a 
study indicating that later cancer diagnoses are the result of uninsured and underinsured patients not having the same 
access to healthcare as those fully insured).


136 Jon Gabel et al., Health Benefits in 2005: Premium Increases Slow Down, Coverage Continue to Erode, 24(5) 
Health Affairs 1273, 1273 (2005), available at http://content.healthaffairs.org/cgi/content/full/24/5/1273.

137 Id.

138 Herrick & Goodman, supra note 102.

139 Todd Pack, Unpaid Bills to Keep Sapping Hospital Profits in ’07, Analysts Say, TENNESSEAN (Jan. 1, 2007), 
Complicating the access/affordability problem is the treatment of illegal immigrants only approximately 22% of whom have health insurance.\textsuperscript{140} Although researchers disagree about the healthcare cost impact of illegal immigrants, many hospitals argue that it is a serious issue.\textsuperscript{141} It is estimated that in the year 2000 American taxpayers paid $1.1 billion in healthcare costs for illegal immigrants between the ages of 18 and 64.\textsuperscript{142} As a result, the federal government initiated a controversial program to pay hospitals for care provided to illegal immigrants.\textsuperscript{143} Among illegal immigrants, only those with medical emergencies, pregnant women, and some children have a legal right to receive healthcare, and, after administering care, hospitals are supposed to transfer patients requiring longer-term, acute care to long-term-acute-care (LTAC) hospitals.\textsuperscript{144} Unfortunately, it is often impossible to make such arrangements because LTAC hospitals will not accept the patients for financial reasons, and this has led to both extreme costs for the HCP initially treating \textit{in extremis} illegal immigrants and occasional horror stories about attempts to

\begin{itemize}
  \item \textsuperscript{142} \textit{Debate Continues on Illegal Immigrant Health Costs}, supra note 140.
  \item \textsuperscript{143} Pear, supra note 141.
return the immigrants to their home countries because of the financial drain on the HCP stuck with the patient.145

In summary, the foregoing discussion suggests that the U.S. healthcare system is plagued by intractable problems involving poor efficiency, quality, and access/affordability. To understand how these massive problems of efficiency, quality, and affordability came to be, it is helpful to review briefly some of the history of the origins of the healthcare crisis. Such a review is especially instructive with respect to understanding issues related to physician compensation and shortages, which are dealt with in subsequent sections. The following subsection provides a brief sketch of some of the more important historical events that have lead to the healthcare crisis and the current structure, culture, and political and economic interests that characterize the system.

**Origins of the Healthcare Crisis**

If anyone wished to attribute credit for the structure of the current system, to a large extent attribution should go to the architectural firm of Economic Self-interest, Politics & Regulation. Medicine in the United States has long been fraught with financial – and therefore political - self-interest, and past healthcare reform efforts have been impeded by the unwillingness of politicians to confront insurance and other lobbies. Some modern-day medical historians refer to an “early recognition of the economic benefits of guild-like behavior” in which “‘quality standards’ are used to provide a rationale for the restriction of supply.” Such behavior found its amalgamated manifestation in the American Medical Association (AMA), which traditionally devoted “its attention and efforts to what it discerned were the economic interests of its members.” Thus, from the early 20th century, organized economic self-interest became a subset of the private enterprise focus – one unique to the United States among first-world countries - that is a central tenet of U.S. healthcare - and one that has manifested itself continually to this day in various ways including a culture of protectionist thinking within the physician community.

Parallel to this private-enterprise focus – and plausibly, in part, because of it - was a narrow focus of medical school and school of public health curricula on the improvement and expansion of medicine and medical facilities as opposed to any substantive attention to the design of

146 See generally, RICHMOND & FEIN, supra note 33.
147 Krugman & Wells, supra note 33, at 1.
148 RICHMOND & FEIN, supra note 33, at 11.
149 Id. at 12-13.
150 Krugman & Wells, supra note 33, at 5.
151 See, e.g., RICHMOND & FEIN, supra note 33, at 234-239.
152 Id., at 13.
healthcare systems. Not all physicians engaged in this head-in-the-sand behavior with respect to healthcare delivery systems, however, as evidenced by the 1937 “Committee of 430” consisting of distinguished physicians who embraced the principles that healthcare is a direct concern of government, a national health policy is needed, economic need and healthcare are not necessarily synonymous, and that healthcare must involve various levels of government in addition to the medical community – positions adamantly opposed by the AMA which was becoming increasingly doctrinaire.

The private-enterprise focus of healthcare delivery became a precursor to a litany of major evolutions that have combined to create the schizophrenic nature of U.S. healthcare today, which is neither public nor private, but rather a misshapen fusion of both. One of the most significant of these evolutions was the advent of private health insurance companies, the effects of which on the healthcare system and attempts to reform it have been profound. For example, because private health insurance pays for a considerable amount of the healthcare resources consumed, there is effectively no limit on healthcare spending in the United States – a

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153 Richmond & Fein, supra note 33, at 17 (noting “...few innovative or exploratory programs in delivering medical care” have existed historically).

154 Richmond & Fein, supra note 33, at 18-9.

155 Krugman & Wells, supra note 33, at 3 (stating that “The U.S. health care system is more privatized than that of any other advanced country, but nearly half of total health care spending nonetheless comes from the government.”)

156 See, e.g., Id. at 234-9.

157 Richmond & Fein, supra note 33, at 236.
phenomenon that has contributed to a proliferation of costly medical innovations.\textsuperscript{158} This, obviously, has both good and bad aspects – good from the standpoint of improved medical capabilities and bad from a cost perspective. By shielding patients from much of the cost of their healthcare once they become ill, private insurance encourages patients to seek as more care that they might if forced to bear the full cost.\textsuperscript{159} Private insurance also reduces the concerns of biomedical investigators regarding the costs of new treatments being developed.\textsuperscript{160} Thus, although plausible medical innovations hold the promise of revolutionizing some areas of medical care, development of these innovations is not independent of the revenues they are expected to generate which, in turn, is a function of insurance.\textsuperscript{161}

Another evolution of U.S. healthcare’s private-enterprise focus – one adjunct to private insurance - is that of employer-funded health insurance, an institution peculiar to the United States.\textsuperscript{162} As an adjunct to private health insurance companies, the effects of employer-based health insurance on the healthcare system have also proved substantial, in part, because treating health insurance as a fringe benefit of employment logically further insulates consumers of healthcare services from having to make cost/benefit decisions about their care.\textsuperscript{163} In recent

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\textsuperscript{159} AARON AL. \textit{supra} note 33, at 2.

\textsuperscript{160} \textit{Id.} at 3.

\textsuperscript{161} Garber & Goldman, \textit{supra} note 158, at 114.

\textsuperscript{162} Krugman & Wells, \textit{supra} note 33, at 2.

\textsuperscript{163} See Herrick & Goodman, \textit{supra} note 102 (discussing the lack of price transparency in healthcare markets due, in part, to employer-funded insurance).
\end{footnotes}
years, as the costs of healthcare began to climb dramatically, some have begun to actively seek employment with companies providing generous healthcare insurance.\footnote{Krugman & Wells, supra note 33, at 2.} As noted in the previous subsection, however, rapidly rising premiums have resulted in the curtailment of many of the benefits of employer-funded healthcare plans.\footnote{See supra text accompanying notes 135-7.}

From a political perspective, one of the greatest impacts of the private insurance market is its lobbying efforts, which have exerted a substantial influence in inhibiting attempts at healthcare reforms and attempting to contour changes in healthcare to preserve or enhance its interests.\footnote{See RICHMOND & FEIN, supra note 33, at 228.} So effective are the insurance industry’s lobbying and advertising efforts that it has been, at least in part, successful in inculcating the notion that, if unhindered by excessive government regulation, private insurance can resolve many of the troublesome social issues associated with healthcare.\footnote{Id.} One of the problems associated with this argument, however, rests with the information asymmetry in the healthcare markets to which we previously alluded. As a result of this asymmetry in which HCPs have far more information about healthcare and its pricing than do patients, HCPs and insurance battle it out largely absent influence exerted by consumers as would be the case in a fully competitive market.\footnote{Id., at 229.}

A difficulty with a system of private health insurance is that it does not serve the needs of large segments of the population well.\footnote{See, generally, Krugman & Wells, supra note 33.} One of those segments consists of retired persons who

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\item[\footnoteref{164}] Krugman & Wells, supra note 33, at 2.
\item[\footnoteref{165}] See supra text accompanying notes 135-7.
\item[\footnoteref{166}] See RICHMOND & FEIN, supra note 33, at 228.
\item[\footnoteref{167}] Id.
\item[\footnoteref{168}] Id., at 229.
\item[\footnoteref{169}] See, generally, Krugman & Wells, supra note 33.
\end{itemize}
\end{footnotesize}
no longer enjoy the benefits of employer-funded health insurance if they ever did.\textsuperscript{170} Elderly persons have a much greater likelihood of experiencing high-cost medical events and therefore have a great need for insurance, but they also represent the type of client insurance companies would prefer to avoid.\textsuperscript{171} As a result, Medicare came into being in 1966 as a program primarily designed to insure the aged.\textsuperscript{172}

Even with the combination of private health insurance and Medicare, however, there was still a large group of uninsured comprised of those too poor to afford private insurance and those too young to qualify for Medicare.\textsuperscript{173} Medicaid burst onto the scene in what has been termed a “historical accident” in which the AMA, which opposed Medicare out of fears of socialized medicine, was caught in the paradoxical situation of having criticized Medicare for not covering the poor only to have this criticism deflected by President Johnson by the proposed creation of Medicaid.\textsuperscript{174} Today, Medicaid covers almost as many people as does Medicare,\textsuperscript{175} and is the cause of significant cost consternation for state governments.\textsuperscript{176} Unlike Medicare, which is totally federally funded, Medicaid is both state and federally funded.\textsuperscript{177} Also unlike Medicare

\begin{itemize}
\item \textsuperscript{170} See RICHMOND & FEIN, \textit{supra} note 33, at 236.
\item \textsuperscript{171} Krugman & Wells, \textit{supra} note 33, at 3.
\item \textsuperscript{172} RICHMOND & FEIN, \textit{supra} note 33, at 49 (noting that Medicare also provides insurance for the disabled).
\item \textsuperscript{173} Krugman & Wells, \textit{supra} note 33, at 3.
\item \textsuperscript{174} Id., at 3 (calling Medicaid a “masterful piece of political jiu jitsu”).
\item \textsuperscript{175} Id.
\item \textsuperscript{176} Krugman & Wells, \textit{supra} note 33, at 3.
\item \textsuperscript{177} RICHMOND & FEIN, \textit{supra} note 33, at 130.
\end{itemize}
with its “beneficiaries,” Medicaid patients are termed “recipients” reflecting its welfare mantle.\textsuperscript{178}

Interspersed among the aforementioned events were various attempts to reform the healthcare system, all of which engendered significant opposition from vested interests and none of which met with much success.\textsuperscript{179} One of the most significant made health maintenance organizations (HMOs) its centerpiece. The HMO concept was born in the 1973 HMO legislation under pressure to expand healthcare coverage and was built upon the notions that group enrollment means a reduction in administrative costs and health is best maintained on a preventative basis. In some respects, HMOs were a compromise to physician opposition to prepaid group practices. Under the HMO concept, a group of HCPs would deliver all healthcare services covered under the HMO plan for a predetermined monthly premium. HMOs revolutionized the manner in which insurance companies participated in that, for the first time, they became involved with care decisions instead of just payments. Unfortunately, HMOs provided incentives to deny care and to do less than necessary or desirable, and neither patients nor physicians are pleased with the results. Moreover, HMOs do not provide a solution for meeting the needs of the uninsured.\textsuperscript{180}

All the various past attempts at healthcare reform, no doubt strongly swayed by the insurance lobby, were influenced into retaining private insurance as a principal basis for risk spreading as

\textsuperscript{178} Id. at 236.

\textsuperscript{179} See, generally, Richmond & Fein, \textit{supra} note 33 for a reasonably detailed, albeit not very well organized, treatise of the history of healthcare reform and the reasons for failure of each past initiative.

\textsuperscript{180} See, \textit{id.} at 63-69 for an explication of the rise and fall of HMOs as the answer to healthcare reform.
opposed to shifting the entire function to government.181 Further, the AMA has long strongly opposed any systematic planning for the delivery of healthcare.182 Nonetheless, over the years a growing body of uninsured and underinsured has greatly intensified the debate over the efficacy of a single-payer system versus the current hybrid.183 Today, the debate has invaded virtually every household as politicians bloviate continuously on television regarding healthcare reform with promises to make healthcare available for virtually everyone. Yet, as one leading healthcare commentator has noted in critiquing both major political parties’ proposed reform plans:

What is clear is that the system-wide cost of universal healthcare coverage does not begin to reveal the tidal shifts in spending that all plans necessary to achieve that goal entail. Nor does it hint at the redistribution among providers that would result from measures such as those proposed in different forms by both candidates to promote generic drugs or malpractice reform . . . . Achieving universal coverage is mostly about income redistribution-among politically and economically powerful payers and providers with stakes that dwarf those measured by the added system-wide cost of insuring everyone.184

From the foregoing, several points seem obvious. The healthcare crisis is one of - if not the - greatest challenges the country is likely to face in the 21st century, and the complexity, political and economic interests, and past failures at reform make the task of real reform formidable. Simple solutions are unworkable. Only with a clearer and more detailed understanding of the various participants’ roles and interests can efficacious solutions be forged.

III. The Medical Malpractice Environment and Its Alleged Role in the Healthcare Crisis

181 Id. at 76.

182 Id.

183 See, generally, Krugman & Wells, supra note 33.

With the foregoing background on the healthcare crisis and its history, we now turn to an examination of medical malpractice liability and its alleged role in the crisis. This examination provides a foundation for the examination of the impact of changes in malpractice insurance costs on physician compensation dealt with in Section V. This section discusses the nature of medical malpractice, whether a runaway medical malpractice liability problem exists, medical malpractice insurance, and recent attempts at malpractice reform.

**The Nature of Medical Malpractice**

Medical malpractice cases against physicians usually take the form of negligence claims in which the following question proves critical: Did the physician meet the standard of reasonable care? This standard requires the physician to have exercised the degree of care that a reasonable provider of ordinary prudence would have exercised under the circumstances. If the physician

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185 In this background discussion, we address only the basic legal issues that arise in malpractice cases against physicians because those cases are the ones directly relevant to the issues addressed in this article. Although not discussed here, malpractice cases may also be brought against nurses, other medical professionals, hospitals, medical clinics, and other similarly situated parties. *E.g.*, JAMES WALKER SMITH, HOSPITAL LIABILITY §§ 3.01, 3.02, 3.03[1], 4.02[1], 11.02[2]-[3] (rev. ed. 2005); WING, supra note 105, at 295-96; SHOWALTER, supra note 105 at 40-41, 129-33.

186 SMITH, supra note 185, § 4.02[1]; WING, supra note 105, at 290; and SHOWALTER, supra note 105, at 40-3. The reasonable care focus means that malpractice cases against physicians nearly always are negligence-based. *Id.* at 39; WING, supra note 105, at 287-90. Malpractice cases very seldom rest on allegations of intentional or reckless wrongdoing on the part of a healthcare provider. *E.g.*, John C.P. Goldberg, The Constitutional Status of Tort Law: *Due Process and the Right to a Law for the Redress of Wrongs*, 115 YALE L.J. 524, 621 (2005). Breach-of-contract claims against physicians are relatively few and far between because physicians typically do not guarantee that a certain outcome will result from a medical procedure or treatment. *See* SMITH, supra note 185, § 4.02[2].
failed to measure up to the reasonable care standard in the treatment she provided or did not provide, and if that failure caused or helped to cause harm to the patient, the physician faces liability. Thus, a patient who experiences an undesirable outcome as a result of medical care

187 In some jurisdictions, the defendant physician's action (or inaction) is to be compared with the action or inaction of the hypothetical reasonable physician in the same locality. E.g., Leazer v. Keifer, 821 P.2d 957, 960 (Idaho 1991). Other jurisdictions broaden the inquiry somewhat by measuring the defendant physician’s treatment decisions against those of the hypothetical reasonable physician in the same community or a similar community, e.g., Purtill v. Hess, 489 N.E.2d 867, 874 (Ill. 1986), or by considering what a reasonable physician in the same state would have done. E.g., Vasquez v. Markin, 731 P.2d 510, 517 (Wash. App. 1986). Other jurisdictions take a broader view by employing what amounts to a national standard of reasonable. E.g., Hall v. Hilburn, 466 So. 2d 856 (Miss. 1985). The trend appears to be in the direction of statewide or national standards, especially if the defendant physician is a board-certified specialist. See SHOWALTER, supra note 105, at 41. When the defendant is a specialist, her treatment decisions should be compared with those of reasonable physicians in her specialty, as opposed to reasonable physicians generally. E.g., Riggins v. Mauriello, 603 A.2d 827 (Del. 1992).

188 WING, supra note 105, at 292-93; SHOWALTER, supra note 105, at 51. The causation requirement has two components—actual cause and proximate cause—with proof of both parts being required. Actual cause is present if the defendant’s failure to use reasonable care was the “but for” cause of the plaintiff’s harm or was at least a substantial factor in the production of that harm. Id. at 51. Although jurisdictions differ in their proximate cause tests, proximate cause usually exists if the plaintiff’s harm was a foreseeable consequence of the defendant’s breach or was a natural and probable consequence thereof. WING, supra note 105, at 292-93. If actual cause exists in a medical malpractice case, proximate cause is likely to exist as well. See id.

189 E.g., WING, supra note 105, at 292. A malpractice claim based on supposed professional negligence obligates the plaintiff to establish these elements: a duty on the part of the defendant, a breach of that duty, and a causation link between the breach and the harm experienced by the plaintiff. E.g. id. The duty element will nearly always be present in the physician-patient relationship and will take the form of the reasonable care standard discussed above. See supra text accompanying notes 185 & 186. The outcome of the case will then depend upon whether the breach of duty and causation elements are established See, e.g., WING, supra note 105, at 291-92.
provided by his physician does not have a meritorious malpractice claim if a reasonable
physician in the same situation would have acted as the defendant physician did. Liability will
attach only if the treatment provided (or not provided) by the defendant reflected a lack of due
care and the requisite causation link is present. Of course, as physicians and their insurers
note, the lack of ultimate liability to a patient in a given case is just that: a lack of liability. There
is no guarantee that the physician will not be sued even when there was no failure to use
reasonable care, if the patient who experienced a bad outcome as a result of medical treatment
believes he has a plausible chance of proving a lack of due care.

Suppose the plaintiff establishes that the defendant physician’s breach of duty caused him to
take experience harm. In that event, the harmed plaintiff will be entitled to compensatory damages

\[190\] E.g., WING, supra note 105, at 291-93. Proving a failure to use reasonable care will normally require expert
testimony. SHOWALTER, supra note 105, at 45-47. Negligence-based malpractice cases against physicians may
reset on various specific ways in which the physicians failed to use reasonable care. For instance, a defendant
surgeon’s performance of a procedure may not have reflected the minimum level of skill a reasonable surgeon
would have displayed, or a physician may have ordered a mode of treatment that a reasonable physician would have
deprecated to order under the circumstances. See, e.g., Estadiari v. United States, 810 F. Supp. 1 (D.D.C. 1992);
Riggins v. Maurillo, 603 A.2d 827 (Del. 1992). Perhaps the physician prescribed an improper medication. See,
e.g., Incollingo v. Ewing, 282 A.2d 206 (Pa. 1971). See also SMITH, supra note 185, § 10.08 (discussing physician's
liability for issuance of improper medication order). A physician’s negligent failure to act may also trigger liability.
For instance, if a reasonable physician would have diagnosed his patient’s severe illness in time to help her but the
defendant physician failed to make a timely diagnosis, the defendant may face liability. See, e.g., Jones v. Speed,
1985).

\[191\] See Hill, Langvardt & Massey, supra note 1, at 165-68 for a discussion of the reasonable care standard.
which are meant to make him economically “whole” without furnishing a windfall. Two varieties of compensatory damages—special damages and general damages—come into play here. Special damages compensate the plaintiff for losses that have a clear economic character and may be quantified with relatively little difficulty. Medical bills and lost earnings stemming from the defendant physician’s malpractice serve as typical examples. Such damages are often designated by the alternate name economic damages because of the obvious economic nature of the expenses and losses for which they compensate.

General damages, on the other hand, compensate the patient for proven harms such as pain and suffering, emotional distress, and loss of quality of life - harms to which the jury must assign a dollar value even though that value is less readily ascertainable than the harms compensated for by special damages. The nature, duration, and severity of the harm suffered by the plaintiff influence the amount of general damages, which, accordingly, may be modest or large depending

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193 E.g., Sharkey, supra note 24, at 398.
194 E.g., id.
195 E.g., id. In malpractice cases concerning the wrongful death of a patient, the financial support lost by financially dependent heirs may constitute an item of special damages. Id.
196 Id.; Showalter, supra note 105, at 53.
upon what the evidence reasonably supports. The potential for a large award of general damages—often referred to as non-economic damages because the harms for which they compensate are less tangible than the expenses and losses addressed by special damages - provides a key reason that tort reform proponents have often targeted non-economic damages in their reform proposals.

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198 See Priest, supra note 192, at 10; Sharkey, supra note 24, at 403; Vidmar, supra note 197, at 1224-25; Goldberg, supra note 186, at 621.

199 Sharkey, supra note 24, at 398; Vidmar, supra note 197, at 1225. Successful plaintiffs in medical malpractice cases cannot normally expect an award of punitive damages in addition to their special and general damages awards. Id. at 415-6; NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS 169-71 (1995). Punitive damages normally apply only when the defendant's conduct was flagrantly wrongful and far worse in culpability than the mere failure to use reasonable care that is present in negligence cases. CASS R. SUNSTEIN ET AL., PUNITIVE DAMAGES: HOW JURIES DECIDE 75 (2002). The punishment and deterrence rationales supporting punitive damages do not fit the defendant who simply failed to exercise due care. See RESTATEMENT (SECOND) OF TORTS § 908 cmt. b (1979). For punitive damages to be appropriate, the defendant's wrongdoing must typically have been intentional and egregious or to have involved an apparent willful indifference to a known danger. Id. § 908(2); SUNSTEIN ET AL., supra, at 75. Medical errors on which malpractice liability tends to be based are negligent mistakes, rather than the sorts of actions or inactions concerning which punitive damages assessments seem appropriate. See Sharkey, supra note 24, at 393, 415-16; Brandon Van Grack, Recent Development: The Medical Malpractice Liability Limitation Bill, 42 HARV. J. ON LEGIS. 299, 306 (2005).

200 See Sharkey, supra note 24, at 402-03, 404-05; Vidmar, supra note 197, at 1225-26; David A. Hyman & Charles Silver, The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?, 90 CORNELL L. REV. 893, 895, 899, 927 (2005). Tort reform efforts will be addressed later in this article. See infra text accompanying notes 235-85.
A malpractice lawsuit against a physician means that his or her professional liability insurer provides counsel to defend against the case. The insurer later pays the plaintiff a settlement amount if there is an agreed resolution of the dispute and pays the damages awarded if the case goes to trial and the physician is held liable. Have recent years’ applications of the liability and damages rules discussed earlier led to excessive and too-frequent payouts by insurers and therefore to malpractice insurance that is unreasonably expensive? Have the risks of tort liability and the costs of malpractice insurance had the effect of forcing physicians out of the practice of medicine or at least out of their preferred specialty, thus creating problems of physician shortages in certain areas? Some physicians who believe in the existence of a malpractice liability and insurance crisis have offered affirmative answers to these questions, and have joined malpractice insurers in calling for legal reform as a supposed mechanism for alleviating the crisis. Later in this section we will examine the tort reform measures undertaken in some

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201 E.g., SMITH, supra note 185, §§ 3.01 n.13, 5.01[6]; William P. Gunnar, Is There an Acceptable Answer to Rising Medical Malpractice Premiums?, 13 ANNALS HEALTH L. 465, 470, 479-80, 482-83 (2004). The insurer’s obligation to pay is restricted, of course, to the dollar amounts set forth in the policy limits. If there is no settlement and the physician is not held liable, the insurer makes no payment to the plaintiff but has still incurred the costs of defending against the case.

202 See, e.g., Gunnar, supra note 201, at 465-66, 470-71, 473-74. Interestingly, law firms are not immune from the high costs of healthcare with some firms having experienced as much as 20% annual increases in the cost of providing healthcare for their employees. Karen Sloan, Law Firms Wrestle with Health Care Costs, 31(15) NAT’L L. J. (Dec. 8, 2008) 1, 1, 10.

203 See. id.; Geoffrey Christopher Rapp, Doctors, Duties, Death, and Data: A Critical Review of the Empirical Literature on Medical Malpractice and Tort Reform, 26 N. ILL. U.L. REV. 439, 440 (2006); Edward J. Kionka, Things to Do (or Not) to Address the Medical Malpractice Insurance Problem, 26 N. ILL. L. REV. 469, 470-72 (2006); Joseph B. Treaster & Joel Brinkley, Behind Those Medical Malpractice Rates, N.Y. TIMES, Feb. 22, 2005,
states in response to the asserted crisis and earlier, similar interludes in which liability insurance premiums were seen as having reached too-high levels. Here, however, we examine the assertions of a crisis by addressing the following questions. Is the medical profession experiencing runaway malpractice liability? Has such liability has produced prohibitively expensive malpractice insurance premiums? How effective have efforts been at curbing the alleged medical malpractice liability crisis?

**Has Medical Malpractice Liability Acquired Runaway Status?**

Determining whether malpractice liability has acquired runaway status requires consideration of the amount of malpractice litigation, the frequency with which payouts are made to plaintiffs, and the dollar amounts of those payouts. Potential defendants may naturally be inclined to argue that too many malpractice cases are filed, whereas potential plaintiffs and those aligned with their interests may regard the number of filed cases as too low. Whatever the "correct" number of filed cases should be, recent studies indicate that the amount of malpractice litigation


204 See Hill, Langvardt & Massey, supra note 1, at 175-77 for a discussion of malpractice insurance costs. Reform efforts urged or undertaken thus far have centered around altering the liability and damages rules that apply to malpractice cases rather than advocating a reform effort geared toward reducing medical errors and thereby lessening the number of instances in which malpractice cases are pursued. Id., at 181-84.

205 See Gunnar, supra note 201, at 476-77; Kionka, supra note 203, at 470-72. This disagreement seems fundamentally a political and philosophical one in which beliefs are strongly held and neither side's invocation of supposed supporting evidence (whether anecdotal or statistical) is likely to convince the other. See Gunnar, supra note 105, at 466; Kionka, supra note 203, at 473-74.
has been generally stable during the past two decades. Further, most patients injured by medical errors never file claims. Concerning the related question of whether plaintiffs win malpractice cases too often, studies show that plaintiffs win malpractice trials approximately 25\% of the time. This is a far lower winning percentage than plaintiffs manage in other tort cases.

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207 David M. Studdert et al., Claims, Errors, and Compensation Payments in Medical Malpractice Litigation, 354 NEW ENG. J. MED. 2024, 2025 (2006); Hyman & Silver, supra note 200, at 976; Michael J. Saks et al., A Multiattribute Utility Analysis of Legal System Responses to Medical Injuries, 54 DEPAUL L. REV. 277, 277-78 (2005). Studies dealing with patients harmed by medical errors indicate that the percentage of such patients who sue is as low as 3 to 6 percent. Sharkey, supra note 24, at 399 n.26. Other studies suggest that this percentage is 10 to 14 percent, see Vidmar, supra note 197, at 1226-27, but in any event, the harmed patient who institutes litigation is the exception, not the rule. See id. at 1227-28. Studies indicate that physicians tend to overestimate by a considerable degree the actual risk of being sued. See e.g., Gunnar, supra note 201, at 476.


What victorious plaintiffs recover in damages is the next issue to be addressed in considering evidence for the existence of runaway liability. A Department of Justice study revealed that plaintiffs who won malpractice trials in 2001 recovered a median damages award of $431,000, as compared with the 1992 median verdict of $253,000. When adjusted for inflation and recent years’ significant increases in the costs of medical care—costs that would be reflected in the economic damages portion of the awards—the more recent median figure represents a fairly modest increase. There is no denying, however, that when a plaintiff wins a malpractice case,


210 Thomas H. Cohen, U.S. DEPT OF JUSTICE, NCJ No. 206240, CIVIL JUSTICE SURVEY OF STATE COURTS, 2001: TORT TRIALS AND VERDICTS IN LARGE COUNTIES, 2001, at 9 (2004). Other studies have yielded similar figures. Based on verdict information compiled by the National Center for State Courts concerning 46 of the nation’s 75 most populous counties, the median verdicts for 1992, 1996, and 2001 were $251,600, $324,601, and $529,034, respectively. Sharkey, supra note 24, at 446-451.

211 Vidmar, supra note 197, at 1240; Sharkey, supra note 24, at 481, 484-87; Kenneth C. Chessick and Matthew D. Robinson, Medical Negligence Litigation Is Not the Problem, 26 N. ILL. L. REV. 563, 569-70 (2006). See Amitabh Chandra et al., The Growth of Physician Medical Malpractice Payments: Evidence From the National Practitioner Data Bank, HEALTH AFF., May 31, 2005, at W5-240, W5-243, W5-247 (web exclusive), at http://content.healthaffairs.org. Recall, too, that any median figure for damages awarded takes into account only those cases in which the plaintiff prevails. It does not take into account the 75 percent of malpractice trials in which the plaintiff loses. See sources cited at supra note 77. Of course, the defendants and their insurers will still incur significant defense costs in these cases. E.g., Vidmar, supra note 197, at 1234.
the damages award can be quite large. Very large verdicts attract media attention and the watchful eye of those who favor reform measures such as caps on damages.

Focusing exclusively on trends in dollar amounts of plaintiffs’ verdicts does not provide a complete understanding of monetary compensation issues in malpractice cases, however. When plaintiffs receive payment in such cases, it is predominantly through settlement rather than a jury verdict. Approximately 25% of pursued malpractice claims result in settlement agreements under which the plaintiff receives payment from the defendant, usually through the defendant's insurer. Far more cases - 60% or more - are either dismissed at a pre-trial stage or are dropped

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212 See Vidmar, supra note 197, at 1240-42. The obstacles to obtaining any award of damages--let alone a large award--in malpractice cases are considerable, however. See id. at 1229-39. The potential for large verdicts is as it should be, some commentators contend, because they see the liability system as furnishing necessary incentives for healthcare providers to improve the quality of their services. See, e.g., Hyman & Silver, supra note 200, at 917, 991; Chessick & Robertson, supra note 211, at 574, 585.

213 See, e.g., Lohr, supra note 208; Treaster & Brinkley, supra note 203.

214 Chandra et al., supra note 211, at W5-240, W5-246-W5-247. According to Chandra et al.’s study of malpractice payments made to injured patients, only 4 percent of the payments stemmed from jury verdicts, with the other 96 percent resulting from settlement agreements. Id. This study relied on figures obtained from the National Practitioner Data Bank, to which malpractice payments made on behalf of physicians must be reported in accordance with federal law. Id. at W5-241. See Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-52 (2005). Other estimates similarly indicate that settlements much more frequently account for payments to patients in malpractice cases than do trial verdicts. See, e.g., Vidmar, supra note 197, at 1245-46 (when malpractice payments are made, settlements are the reason approximately 97 percent of the time).

by the claimant after the defendant and the defendant's insurer refuse to settle with the claimant. In the end, not quite 30% of pursued claims result in payment to the patient.

With settlement payments occurring much more frequently than payments pursuant to trial verdicts, it becomes important to consider verdict and settlement amounts together in order to obtain a more complete perspective on how payments have trended. Recent studies of malpractice payments by way of settlements and verdicts in Texas, Florida, and throughout the United States have revealed mean and median dollar amounts lower than the median verdict amount revealed by the previously noted Justice Department study. Moreover,

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216 See Gunnar, supra note 201, at 477; Vidmar, supra note 197, at 1228, 1246-47, 1250-51.

217 This estimate takes into account the roughly 25 percent of claims in which payment is made under a settlement agreement. See Gunnar, supra note 201, at 477. It then factors in plaintiffs' likely one-fourth success rate, see supra text accompanying note 77, in the 7 to 10 percent of claims that proceed to trial. See Vidmar, supra note 197, at 1228.

218 A study conducted by Professors Black, Silver, Hyman, and Sage (hereinafter "Texas Study") focused on a Texas Department of Insurance database that dealt with malpractice claims from 1988 through 2002. Black et al., supra note 203.

219 In what will be referred to hereinafter as the “Florida Study,” Professor Vidmar and his co-authors studied malpractice payments by insurers in tried and settled cases in Florida from 1990 through 2003. Vidmar et al., supra note 206.

220 In what will be referred to hereinafter as the "NPDB Study", Professor Chandra and his co-authors took into account more than 184,000 malpractice payments, as reported to the National Practitioner Data Bank. Chandra et al., supra note 211.

221 The Texas Study revealed that when converted to 1988 dollars, mean payments per large claim (those exceeding $25,000 in 1988 dollars) went from $300,000 in 1988 to $401,000 in 1990 and then back down to $347,000 in 2002. Black et al., supra note 203, at 238. Because mean figures can be influenced by extremely large or very small payments, median figures are therefore a useful alternative way of examining payment trends. Vidmar et al., supra
similar to the quantity of malpractice litigation as previously noted, malpractice litigation payouts have remained generally stable over time when adjusted for inflation and increases in the costs of obtaining medical treatment. Consequently, allegations of runaway malpractice liability seem questionable, at least on average, across those jurisdictions for which data are generally available. This does not preclude, however, difficulties with liability within specific jurisdictions and/or medical specialties.

*Has Medical Malpractice Liability Produced Unaffordable Malpractice Insurance Costs?*

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note 199, at 337. In the Texas Study, median payments for 1988, 1990, and 2002 were $120,000, $145,000, and $132,000, respectively (again in 1988 dollars). Black et al., *supra* note 203, at 238. The Florida Study revealed that mean payments (converted to 2003 dollars) went from $177,000 in 1990 to $300,000 in 2003. Vidmar et al., *supra* note 206, at 336, Table 6. Median payments for 1990 and 2003 were $49,000 and $150,000, respectively. *Id.* The NPDB study demonstrated that the average payment increased from $173,000 in 1991 to $263,000 in 2003. Chandra et al., *supra* note 211, at W5-242, W5-243 & Exhibit 1. The increase over the full period translated into an average annual average annual growth rate of 4 percent. *Id.* at W5-243.

222 See *supra* text accompanying notes 79-80.

223 See Black et al., *supra* note 203, at 209, 238. The authors of the Texas Study characterized this stability as "remarkable given that health-care costs account for a significant fraction of the harm from medical malpractice, and these costs rose significantly faster than overall prices" from 1988 through 2002. *Id.* at 238-39. In the Florida Study, the rate of increase was greater than that revealed in the Texas Study. Compare Vidmar et al., *supra* note 206, at 336 & Table 6, 337 (Florida numbers) with Black et al., *supra* note 203, at 209, 238 (Texas numbers). The authors of the Florida Study noted that the very significant rise in costs of medical care was a likely contributing factor in the upward trend in malpractice payment amounts. Vidmar et al., *supra* note 206, at 338, 344. According to the NPDB Study's authors, the malpractice payment growth rate during the studied period was proportionate to increases in national healthcare spending—suggesting that rising costs of medical treatment would help explain the increase in malpractice payment amounts. Chandra et al., *supra* note 211, at W5-243, W5-245 & Exhibit 3, W5-247.
The perceived medical malpractice crisis has a further dimension whose causes are debated: the expensive nature of malpractice insurance and the consequences that may flow when insurance effectively becomes unaffordable. Critics of the liability and damages rules applicable to malpractice cases typically argue, as do the liability insurers themselves, that significant increases in the amounts of insurance premiums are the direct result of too many large awards of damages in favor of plaintiffs. Curtailing awards of damages in terms of frequency and amount would supposedly enable insurers to bring premiums down from their

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224 See Gunnar, supra note 201, at 466, 470-71, 473-75; Kionka, supra note 203, at 472-73; Van Grack, supra note 199, at 299. An American Medical Association report classified 20 states as supposedly experiencing a "full-blown medical liability crisis"--with numerous other states showing signs of such a problem--because of very substantial increases in the amounts of malpractice insurance premiums. AM. MED. ASS'N, AMERICA'S MEDICAL LIABILITY CRISIS: A NATIONAL VIEW (2004), http://www.ama-assn.org/ama/noindex/category/11871.html.

225 During the past few years, malpractice premium amounts in a significant number of states have increased dramatically--especially for specialties perceived as high-risk in nature. Sharkey, supra note 24, at 408. In some states, specialties such as obstetrics and gynecology, neurosurgery, and general surgery have been hit with rate hikes of 19 to 56 percent over one to two years. Gunnar, supra note 201, at 471. Malpractice premiums are set according to the physician's specialty, the geographic location of his or her practice, and his or her years in practice. They are not individual experience-rated--i.e., they do not vary depending upon whether the insurer has or has not had to pay out sums because of malpractice claims against the individual physician. Id. at 471; Hyman & Silver, supra note 200, at 981; Daniel P. Kessler et al., Impact of Malpractice Reforms on the Supply of Physician Services, 293 JAMA 2618, 2624 (2005); William L. Sage, Understanding the First Malpractice Crisis of the 21st Century, in HEALTH LAW HANDBOOK 1, 21 (Alice Gosfield ed., 2003). Roughly 54 percent of paid malpractice claims since 1990 have been based on medical errors committed by approximately 5 percent of physicians. Gunnar, supra note 201, at 471-72.
allegedly lofty heights\textsuperscript{226} and would alter a blame-focused environment in which physicians feel compelled to engage in so-called "defensive medicine."\textsuperscript{227} Plaintiffs' attorneys and other commentators concede the existence of overly high liability insurance premiums, but place most of the blame on the insurance companies. Those who hold this view regard huge premiums as less a result of insurers' financial exposure and more an attempt by insurers to make up for the

\textsuperscript{226}E.g., Vidmar, supra note 197 at 1218-19 (noting this argument). See Treaster & Brinkley, supra note 203 (quoting January 2005 speech by President Bush, in which he commented on spikes in malpractice insurance premiums, asserted that high premiums "don't start in an examining room or an operating room [but] in a courtroom," and blamed the "skyrocketing" costs of "junk lawsuits" against physicians and hospitals). But see Black et al., supra note 203, at 210, 221, 223, 249, 252 (concluding that malpractice claims outcomes in Texas from 1988 through 2002 would not have caused the insurance premium hikes that led Texas to enact a package of tort reforms); id. at 252 (observing that "runaway med mal litigation' makes a poor poster child for the cause of tort reform"); Chandra et al., supra note 211, W5-247 (expressing doubt that recent years' considerable hikes in malpractice insurance premiums could be credibly attributed to large jury verdicts or to increases in average amounts of malpractice payments).

\textsuperscript{227}"Defensive medicine" may be defined as departing from sound medical practice--perhaps by ordering needless, costly tests and procedures--because of a fear of potential liability. David M. Studdert et al., Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, 293 JAMA 2609, 2609 (2005). Commentators have noted the defensive medicine concerns raised by critics of existing malpractice liability rules. See, e.g., Gunnar, supra note 201, at 466, 476-77. See also Studdert et al., supra note 227, at 2609, 2612, 2615, 2616-17 (concluding that vast majority of Pennsylvania physicians who participated in study believed they had engaged in defensive medicine). Other commentators regard the defensive medicine argument as exaggerated and unpersuasive. See, e.g., Chessick & Robinson, supra note 211, at 570, 574; Hyman & Silver, supra note 200, at 937-38.
loss of income they had become used to receiving when investment yields were better in previous years.\textsuperscript{228}

Regardless of the cause or causes of the high insurance premiums, it is a serious problem if premiums reach a level at which physicians wonder how long they can continue to take the substantial financial "hit."\textsuperscript{229} If the costs of liability insurance become too great, some physicians may face the dilemma of deciding whether to relocate, scale back their practices, or even leave practice altogether.\textsuperscript{230} During the 2004 election campaign and in speeches since then,

\begin{itemize}
\item \textsuperscript{228} See, \textit{e.g.}, Gunnar, \textit{supra} note 201, at 482-83; Kionka, \textit{supra} note 203, at 514; Bryan A. Liang & LiLan Ren, \textit{Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare}, 30 \textit{AM. J. L. \\& MED.} 501, 517, 519-20 (2004); Van Grack, \textit{supra} note 199, at 314-16. \textit{See also U.S. GEN. ACCOUNTING OFFICE (GAO), Pub. No. GAO-03-0702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (2003), available at http://www.gao.gov/cgi-bin/getrpt?GAO-03-72 (concluding recent years' steep hikes in premiums resulted from various causes, including insurers' losses on claims, insurers' losses on investment income, some insurers' decisions to get out of the malpractice insurance business, and a rise in reinsurance rates); Anderson, \textit{supra} note 84 (citing study indicating that premium increases in recent years were 21 times the increases in amounts paid out on claims); Tom Baker, \textit{Medical Malpractice and the Insurance Underwriting Cycle}, 54 \textit{DEPAUL L. REV.} 393, 393-400 (2005) (explaining role of insurance underwriting cycle in periodic large increases in malpractice premiums).}
\item \textsuperscript{229} Kionka, \textit{supra} note 203, at 473-74; Vidmar, \textit{supra} note 197, at 1218. Efforts to achieve savings in insurance premiums have made self-insurance in organizations and risk-retention groups more common than they once were, but a meaningful group size is necessary in order to make such options viable alternatives to conventional malpractice insurance. \textit{See} Shefali An and, \textit{Doctors' Creed: Insure Thyself}, \textit{WALL ST. J.}, Aug. 17, 2005, at C1.
\item \textsuperscript{230} See Gunnar, \textit{supra} note 201, at 471, 473-76; Sharkey, \textit{supra} note 24, at 410-12; Liang & Ren, \textit{supra} note 228, at 501-02, 514-15. According to studies, physicians have made such decisions often enough in 18 states that those states face physician supply shortages and problems with patients' access to medical care. Gunnar, \textit{supra} note 201, at 473. \textit{But see id.} at 467, 474 (indicating that lowered Medicare and Medicaid payments to physicians may also have
President Bush referred repeatedly to anecdotal evidence of instances in which high insurance premiums presumably forced obstetricians, cardiologists, neurosurgeons, and other specialists to decide to relocate, scale back, or retire. Commentators disagree on whether the anecdotal evidence has been confirmed by statistical evidence of a broader physician supply problem, or whether the seriousness of the supposed problem is less than as billed.

played role in decisions by physicians to alter their practices or discontinue practicing); Marc A. Rodwin et al., *Malpractice Premiums and Physicians' Income: Perceptions of a Crisis Conflict With Empirical Evidence*, 25 HEALTH AFF. 750, 757 (2006) (concluding that recent years' income loss by physicians stemmed mainly from declining revenue and increases in other practice expenses instead of from increases in malpractice premiums).


232 See Kessler et al., supra note 225, at 2620-21, 2623, 2624 (study finding physician supply growth exceeded national growth rate in states that had implemented malpractice reform measures, but acknowledging that factors other than malpractice climate could help explain results); *Doctors Gravitate to States With Malpractice Limits*, N.Y. TIMES, May 31, 2005, http://online.wsj.com/article_print/0,,SB111758299333547628,00.html (reporting on study indicating significant increases in numbers of physicians in states having damages caps); Gunnar, supra note 201, at 467, 471, 473-76 (discussing states with physician supply problems that may be related to malpractice concerns, but appearing to acknowledge that other factors may be part of explanation). See also U.S. GEN. ACCOUNTING OFFICE (GAO), Rep. No. GAO-03-836, *MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTHCARE* 3, 12-21 (2003) (hereinafter "GAO-03-836") (concluding that reports of relocating physicians often not confirmed and did not severely restrict medical care access except in regard to emergency services and obstetrical care in rural areas, but that those access problems were longstanding ones resulting from factors other than malpractice insurance costs).
The amount of public attention devoted to the malpractice crisis of recent years seems to match the amount devoted to similar perceived crises during the past three decades. At varying times during the 1970s and 1980s, premiums for malpractice insurance and other liability insurance became uncomfortably large. Then, as now, healthcare providers, other businesses, and insurers cited tort litigation generally, and malpractice cases specifically, as the culprits, with contrary explanations offered by those who sought to lay the blame at insurers’ feet. Then, as now, calls for tort reform—and especially medical malpractice reform—have been issued and sometimes heeded. The following subsection addresses these attempts and their effectiveness.

**How Effective Have Been Attempts to Reform the Medical Malpractice Tort System?**

Over the past three decades, as it has become clear that the medical liability system is “broken,” the search for how to fix it has generated a variety of tort reform proposals. The majority of these proposals are considered “conventional tort reform[s]” enacted by states rather than the federal government. Further, most attempts to create federal measures are rejected and ultimately fail. Although some conventional tort reforms appear to be effective in the limited capacities of reducing litigation and stabilizing insurance markets, patients, already underserved by the tort system, have arguably been made worse off, and the ultimate goal of a

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233 See Gunnar, supra note 201, at 484; Liang & Ren, supra note 228, at 504; Vidmar et al., supra note 206, at 315.

234 Gunnar, supra note 201, at 484; Vidmar et al., supra note 206, at 315-16; Kionka, supra note 203, at 479.

235 Hill, Langvardt & Massey, supra note 1, at 177.

236 Id. (For example, the $250,000 non-economic damages cap called for by President Bush in 2006).
just malpractice system cannot be reached by these measures alone – a more comprehensive reform is required.237

Conventional tort reform proposals fall within three major families: (1) limiting access to courts; (2) modifying liability rules in an effort to reduce both the frequency of claims and the size of payouts; and (3) directly addressing the size of awards.238 Attempts at the former include laws requiring the use of medical review panels, shortening statutes of limitations, and enacting statutes of repose.239 Medical review panels have been adopted by states with reasonable frequency.240 A common review panel procedure calls for malpractice claims to be submitted to a review panel comprised mostly, if not entirely, of physicians before the claims go to court.241 While review panels operate as a check on unmeritorious cases, it is both time-consuming and costly242 and has been criticized because panels comprised largely of physicians may be reluctant to rule against other members of their profession.243

Modifications of liability rules include such actions as elimination of joint-and-several liability, imposing higher standards for proving breaches of informed consent, and elimination of the doctrine of *res ipsa loquitur.*244 States that have eliminated joint-and-several liability allow


238 *Id.* at 288.

239 *Id.* at 288 Table 1.


241 *Id.*

242 *Id.* at 179.

243 *Id.*

244 Studdert et al, *supra* note 237, at 288 Table 1.
plaintiffs to recover from multiple defendants only in proportion to their respective contributions in causing injury.\(^{245}\) In theory, this could reduce the amount of malpractice litigation and stabilize insurance markets; additionally, it could have a positive effect on physician retention.\(^{246}\) Evidence is lacking, however, regarding the full consequences of abolishing joint and several liability.\(^{247}\)

Perhaps the most prominent tort reform measures focus on limiting the size of awards. Laws that cap damages, limit attorney fees, mandate collateral source offsets, and require periodic payments are often used for medical malpractice reform.\(^{248}\) Legislative caps on medical malpractice damages have been adopted and remain in effect in nearly 30 states.\(^{249}\) Caps on damages almost always apply to non-economic damages—restricting awards for intangible harms such as pain and suffering and mental anguish;\(^{250}\) however, a few states have capped total

\(^{245}\) Id. at 288.

\(^{246}\) Hill, Langvardt & Massey, supra note 1, at 185.

\(^{247}\) Id. also see Liang & Ren, supra note 228, at 505-13 (discussing components in packages of malpractice reform measures enacted in various states); cf. Kessler et al., supra note 225, at 2619-20 (classifying elimination of joint and several liability as an indirect reform measure, and stressing the important effect that direct measures like caps on damages have on the supply of physicians). Even if positive premium-reduction or physician-retention effects could be documented, the apparent fairness of tying a particular defendant's damages exposure to that defendant's degree of responsibility for causing the plaintiff's harm may be undercut by the potential unfairness to certain harmed plaintiffs when the collection options afforded by joint and several liability are taken away. Hill, Langvardt & Massey, supra note 1, at n. .

\(^{248}\) Studdert et al, supra note 237, at 288 Table 1.

\(^{249}\) Hill, Langvardt & Massey, supra note 1, at 177 (citing Sharkey, supra note 24, 412-3).

\(^{250}\) Id. at 177.
compensatory damages.\footnote{251} In some states, caps on damages have lowered average awards and decreased malpractice insurance premiums, while caps appear to have little or no affect on premiums in other states.\footnote{252} However, caps on damages cannot reach the real objective of reformation of the malpractice system; they only address the problem of some plaintiffs being awarded too much money.\footnote{253} Moreover, caps “raise fundamental fairness concerns by having their greatest adverse impact on plaintiffs who experienced the most severe harms as a result of malpractice.”\footnote{254}

Although such conventional proposals as the foregoing represent the most frequently encountered restructuring of the medical malpractice system, alone they do little to achieve the goal of reducing “litigation by decreasing patient injury, by encouraging open communication and disclosure among patients and providers, and by assuring prompt and fair compensation when safety systems fail.”\footnote{255} In order to remedy fundamental failings of the malpractice system, more sweeping reforms are needed, and proposals to improve the medical liability system center on three broad approaches: (1) creation of alternative mechanisms for compensating injured patients.

\footnote{251} \textit{Id. (citing} Sharkey, supra note 24, at 414).

\footnote{252} \textit{Id.} at 181. “Moreover, when states that have imposed damages caps have witnessed lowered premiums, it has not been clear whether the real reason was the damages cap or direct insurance rate regulation.” \textit{Id.}

\footnote{253} \textit{Id.} at 182.

\footnote{254} \textit{Id.} at 186.

patients; (2) resolving disputes through a so-called “no-fault” administrative system; and (3) shifting liability from individuals to organizations (enterprise liability). 256

Alternative, theoretical mechanisms for resolving medical malpractice disputes include measurements such as private settlement immediately after an adverse event occurred, structured mediation, administrative law hearings, and medical courts. 257 Some maintain that the way to improve “patient safety and accountability would be to require individual physicians or provider organizations to ‘earn’ their way into alternative dispute resolution.” 258 In order to be a part of the system, HCPs would first have to meet “specified standards and other performance thresholds.” 259 Specially designed health courts would have special knowledge regarding the assessment of scientific evidence and medical practices, and would incorporate reliance on expert guidelines for compensation of avoidable events. 260 Under the health court system, damages would be awarded based on predetermined classes of events and their avoidability. 261 However, the constitutionality of health courts is controversial. 262 Implications for due process,

256 Id. (Citing Studdert, supra note 237).
257 Id. at 32.
258 Id.
259 Id.
260 Id. at 33.
261 Id.
262 See generally Amy Widman, Why Health Courts are Unconstitutional, 27 Pace L. Rev. 55 (2006). Widman’s arguments center around the fact that “[m]edical malpractice is not a separate body of law; it is part and parcel of ordinary tort law that has been enshrined in the common law since the beginning of our civil justice system.” Id. at 86-7.
equal protection, the right to jury, and open access to courts give rise to strong arguments against health courts.  

Another alternative mechanism to dispute resolution that has drawn attention among academics is the use of private contracts to replace tort liability. Proponents argue that contract law “would allow patients to agree in advance with their providers or health plans to submit to specified procedures, such as arbitration, in the event of an injury.” Some scholars argue that the “most forthright and sensible way to deal with the liability crisis is to remove the minimum constraints on liability set by law and allow parties to cut their own deals.” However, contracting by individual patients would lead to high transaction costs of service-by-service contracting, and “conflicts among contracts could occur with care from multiple providers.” Furthermore, individual patients clearly have a negotiating disadvantage relative to medical providers because of knowledge asymmetries.

263 See Id. at 81-8.
264 Studdert et al, supra note 237, at 289.
265 Id.
266 Richard A. Epstein, Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice, 54 DePaul L. Rev. 503, at 509 (2005). For other proponent’s arguments for private contract, see generally Id.; also see generally CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (AEI 1995).
268 See generally id. at 20-1 (For more details on the perceived pros and cons of private contracting).
A no-fault administrative system approach would remove negligence as the basis of eligibility for compensation. Because no-fault implies absence of responsibility, strict liability may be a better term to explain the shift in determinate factors for compensation. Rather than a determination of negligence, a determination of avoidability could be used as the basis of compensation. Some administrative body could have the power to determine compensation for all medical-injury claims, possibly providing a no-trial resolution process. Classes of adverse events that fall under the category of preventable clinical outcomes could be adjudicated by the administrative body on a fast track that speeds compensation. Concerns with no-fault systems include such matters as standards of avoidability more permissive than that of negligence and avoidability criteria leading to a larger pool of injuries eligible for compensation thereby raising cost concerns. No-fault proponents argue that savings in other areas could offset such cost increases, including administrative and legal expenses.

269 \textit{JOINT COMMISSION}, supra note 255, at 31.

270 \textit{Id.} But see contra Amy Widman, supra note 262, at 60-1 (2006) (discussing the results of Sweden’s avoidability standards demonstrates that an avoidability standard creates a higher standard for compensation than no-fault.)

271 \textit{Id.}

272 \textit{Id.}

273 Studdert et al, supra note 237, at 189. “For example, bleeding after a limited colectomy that necessitates reoperation, greater resection of the bowel, and ileostomy would always be considered avoidable, but determining whether this event was caused by negligence would require careful review of the facts of the surgery.” \textit{Id.}

274 \textit{Id.}

275 \textit{Id.} (citing generally Studdert et al, Can the United States afford a “no-fault” system of compensation for medical injury?, 60 LAW & CONTEMP. PROBS. 1 (1997)).

276 \textit{Id.}
Moreover, proponents “emphasize the prospect of fairer, more efficient compensation”, but serious doubts remain about such matters as the willingness of insurance companies to provide malpractice coverage under a no-fault system.

Finally, a shift from individual physician liability to enterprise liability could be a successful means of improving medical quality oversight. In an enterprise liability model, the enterprise “assumes primary responsibility for any claim brought against an affiliated clinician and covers affiliates' liability costs at rates that vary from year to year according to the enterprise's overall injury experience.” Enterprise liability would create a new and strong incentive to foster a culture of patient safety, and to identify and redesign vulnerable systems in the health care organization. Traditional problems with the enterprise liability approach are that hospitals sometimes have little control over many activities that contribute to errors because practitioners often have multiple hospital affiliations, diagnoses often occur outside of the hospital, and physicians often resent being treated as employees rather than independent contractors. Perhaps the most often discussed hurdle to a holistic enterprise liability framework is that of

277 Id.
278 Richard A. Epstein, Redesigning the Medical Malpractice System: Commentary: Contractual Principle versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice, 54 DEPAUL L. REV. 503, 520-1.
279 John V. Jacobi & Nicole Huberfeld, Quality Control, Enterprise Liability, and Disintermediation in Managed Care, 29 J.L. MED. & ETHICS 305 (2001).
280 Studdert et al, supra note 237, at 290.
281 JOINT COMMISSION, supra note 255, at 32.
ERISA— the preemption provision of which has been widely interpreted to afford health plans immunity from against tort action for the negligent management of health plans.283 Others argue, however, that the rationales for vicarious liability under an enterprise liability concept are, “….if anything, more robust today than they were one hundred years ago.”284

In summary, the medical malpractice system has stimulated a national debate and discussion of both conventional and conceptual reforms. There have been mixed results regarding whether runaway liability exists, whether insurance rates are prohibitively high, and the effectiveness of conventional reforms which discourage HCPs from openly discussing and learning from errors and fail to foster an effective safety culture.285 Conceptual reforms such as medical courts raise concerns about constitutionality, and it seems doubtful many of these will be found legally and politically acceptable in the foreseeable future given the strength of past resistance. As discussed in Section VIII, however, some form of comprehensive medical malpractice system reform is needed to promote a more just culture for injured patients and to encourage appropriate behaviors consistent with the evolving new models of health delivery and payment discussed in Section VII.

IV. Third-Party-Payer Reimbursement of Physicians


284 Epstein, supra note 283, at 585.

285 Bovbjerg & Raymond, supra note 267, at 22. “Meanwhile, none of the traditional approaches to reform, including award its, or collateral source rule reform aim to break this cycle because they all primarily seek to help medical professionals and their liability insurers rather than patients and patient safety improvements.
Inasmuch as physicians’ revenue comes largely from third-party payers, there is little question that private insurance and Medicare/Medicaid reimbursement have a profound effect on physician compensation and, ultimately, on shortages of physicians in the less-well-compensated specialties. During the period 1995-2003, physician’s average net income from medical practice declined about 7% in real dollars in contrast to an approximately equal increase for other types of professionals. In primary care the decrease was 10.2%. Physician shortages are asserted to be particularly acute in primary care because private and public reimbursement does not compensate PCPs for many activities their jobs require. Medicare’s alleged contribution to this problem results from the combination of bias in the reimbursement system that favors procedural medicine over cognitive medicine. Additionally, laws governing Medicare fee

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288 Tu & Ginsburg, supra note 287.

289 Id.


The reason there’s a real threat of a shortage of primary care physicians is that they are paid much less than other physicians . . . . Their incomes are lower than surgeons and other specialists, and a lot of what primary care physicians do is not compensated. The time they spend coordinating care on the phone, talking to social workers, and talking to specialists about care provided to the same patient just does not get compensated.)

291 Tu & Ginsburg, supra note 287.
increases and volume growth are such that the system generates fee cuts for individual services once spending targets are exceeded absent Congressional intervention.\textsuperscript{292}

While physician compensation overall has decreased, the amount of time physicians spend treating patients and the volume of services provided have supposedly increased as a result of restructuring of practices in ways that reduce the amount of time physicians spend on matters other than patient care, and growth in the number of tests and procedures available.\textsuperscript{293} Consequently, the volume of patients treated does not appear to be the culprit in diminished physician compensation. Rather, declining reimbursement rates in real dollar terms relative to practice costs appear to be to blame.\textsuperscript{294} When it comes to reimbursement, physicians are said to be currently dealing with too many healthcare plans which are unnecessarily complicated and have little consistency. Physicians are unable to be familiar with the myriad protocols and regulations of each plan, and the reimbursement formularies are cumbersome and change frequently.\textsuperscript{295} The following subsections discuss the primary sources of physician compensation.

\textsuperscript{292} Christopher Hogan, Current Structure of Medicare Physician Reimbursement, Direct Research, LLC presentation, Feb. 25, 2008, available at http://www.dhmh.state.md.us/hcar/pdf/feb08/0208HoganStructure_of_Payment.pdf; and Medicare, available at http://www.wikinvest.com/concept/Medicare (noting the 10.1\% cut that was slated to take effect on July 1, 2008 had it not been for Congressional intervention).

\textsuperscript{293} Tu & Ginsburg, supra note 287 (noting that some specialties have seen increases in net income despite declining fees due to productivity for procedures having grown rapidly).

\textsuperscript{294} Id.

\textsuperscript{295} AIS’ S HEALTH BUSINESS DAILY (Nov. 25, 2008), available at http://www.aishealth.com/Bnow/hbd112508.html (quoting Toni Brayer, MD, Chief of Staff at California Pacific Medical Center and former president of the San Francisco Medical Society).
reimbursement as a foundation for exploring their effects on physician compensation and shortages in the subsequent section.

Private Insurance Reimbursement

The problems associated with private health insurance would seem to present yet another of the numerous conundrums associated with U.S. healthcare in that private insurance is essentially a risk-spreading arrangement to protect against the risk of low-probability, high-cost events such as a house catching fire. To operate effectively as for-profit entities, private insurance companies obviously must control the risks associated with coverage which creates incentives to exclude the high-risk prospective insured or charge them very high premiums. In the case of health insurance, however, assuming reasonable longevity, it stands to reason that a relatively large number of the privately insured will likely experience some high-cost medical event providing disincentives for private insurance to cover the aged and giving rise to the need for public insurance. Moreover, many privately insured patients are insured under group policies which require scant or no prescreening. This creates incentives for healthcare insurance companies to insure and then deny coverage when costly medical events do arise; and, indeed, this practice has not been all that infrequent as evidenced by recent lawsuit settlements involving

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296 Krugman & Wells, supra note 33, at 2.

297 The majority of persons insured by private insurers are covered under employer-based policies. The employees’ share of the cost (called “co-payments”) has been in creasing over time. Michael Chernew, Private Insurance System, U. Mich. Presentation, available at www.med.umich.edu/csp/Course%20materials/Fall%202005/Chernew_Private%20Insurance%20System.ppt.
large-scale coverage denials.\textsuperscript{298} Physicians and insurance companies are often at odds over definitions of what constitutes a medical necessity under private insurance and at least one state, 


Connecticut, has fostered legislation to shift the burden of proving a lack of medical necessity to the insurer as opposed to physicians and patients.\textsuperscript{299}

The multi-payer healthcare market that is unique to the United States\textsuperscript{300} permits larger HCPs to practice price discrimination wherein different prices are charged by private insurance companies depending upon the relative bargaining power of the HCPs and/or payers.\textsuperscript{301} Private insurance companies are said to have higher administrative costs than government insurance,\textsuperscript{302}

\begin{itemize}
  \item \textsuperscript{300} Krugman & Wells, supra note 33, at 4.
  \item \textsuperscript{301} Wirtz, supra note 286. For their part, insurance companies have enjoyed some immunity from federal antitrust laws through the McCarran-Ferguson Act of 1945 which expressly exempted the “business of insurance” from such laws to the extent that insurance was regulated by state law and did not involve “acts of boycott, coercion, or intimidation.” The Supreme Court has interrupted the “business of insurance” narrowly, however, to include only to activities involving agreements between the insurance company and policyholder and directly involved the underwriting of risks. See Wing, supra note 105, at 242-3 (citing Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979); Union Life Insurance Co. v. Pireno, 458 U.S. 119 (1982)).
  \item \textsuperscript{302} One estimate places private insurance company overhead between 15\% and 20\% of overhead. Research and Policy Committee of the Committee for Economic Development, Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System (2007), at 36, available at http://www.ced.org/docs/report_healthcare200710.pdf. CMS estimates private insurance administrative costs have averaged about 12\% of premiums over the past 40 years whereas Medicare’s percentage was about 3\% in 2003. However, despite single-payer health reform advocates touting of Medicare’s low administrative cost rate, it is difficult to make comparisons with private health plans because Medicare does not include a cost of capital in its estimates of spending. Adding the costs of Medicare’s share of the federal debt service cost would cause Medicare’s administrative cost arte to grow to just under 10\%, still below that of private insurers but not dramatically so. Jeff Lemieux, Perspective: Administrative Costs of Private Health Insurance Plans, Center for Policy and Research,

303 Wirtz, supra note 286.

304 Kevin Hayes & Christopher Hogan, Medicare Physician Payment Rates Compared to Rates Paid by the Average Private payer, 1999-2001, Direct Research, LLC Study Conducted for the Medicare Payment Advisory Commission No. 03-6 (Aug. 2003), available at www.medpac.gov/publication/contractor_reports/Aug03_PhysPayRates(cont)Rpt.pdf (noting that Medicare payments fees were in the 60-70% during the period 1989-1997 but averaged closer to 80% during the period 1999-2001. These higher reimbursement rates have been funded by rapidly rising premiums for family coverage which are doubling every ten years. Joseph Paduda, How Does Physician Income Drop while Costs Increase? Weblog Managed Care Matters (Jun. 22, 206), available at http://www.joepaduda.com/archives/000572.html. Employer-based health insurance is said to be pricing itself out of reach. Private health insurance premiums are increasing at a faster rate than insured’s incomes. Employers have coped with rising employee-healthcare costs by imposing more restrictions on eligibility and increasing employee contributions. RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, QUALITY, supra note 302, at 2, 12. Premiums have increased so much in recent years that some states have instituted premium subsidy plans through which low-income residents who would otherwise presumably be uninsured are able to purchase individual, private health insurance. Janet B. Mitchell, et al., Premium Subsidy Programs: Who Enrolls, and How Do They Fare? 24(5) HEALTH AFFAIRS 1344, 1344-5 (2005). During the period 2000-2007, employment-based health insurance premiums increased by 100% compared to a 21% cumulative wage growth over the same period, and health insurance is the fastest growing cost component for employers. National Coalition on Health Care, Health Insurance Costs (2008), available at http://www.nchc.org/facts/cost.html. Private health insurance premiums are rising faster than incomes. RESEARCH
contrast, Medicare is said to reimburse physicians at rates so low as to create low and sometimes negative margins for HCPs.\textsuperscript{305}

An examination of the cumulative growth per enrollee payments for physician and clinical services indicates that the rate for private insurers has paralleled that of Medicare over most of the period 1970-1990 except for a period during the late 1980s when the rates diverged somewhat with private payments growing at a faster rate.\textsuperscript{306} There is, however, evidence of a diminishing difference between Medicare and private insurer rates during the latter 1990s,\textsuperscript{307} and the gap between Medicare rates and private insurance rates private payers’ reimbursement

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\textsuperscript{306} Christina Boccuti & Marilyn Moon, \textit{Comparing Medicare and Private Insurers: Growth rates In Spending Over Three Decades}, 22(2) HEALTH AFFAIRS (Mar./Apr. 2003), 230, 235 (noting that the cumulative growth rate per enrollee account for differences in payers’ spending relative to previous spending trends thereby allowing for a more comprehensive perspective over time).

\textsuperscript{307} Hayes & Hogan, \textit{supra} note 304.
further declined from 143% of Medicare’s rate in 1997 to 123% in 2003. Private insurance companies thus impact physician compensation in a manner somewhat analogous to Medicare because they tend to increasingly follow the lead of Medicare in most cases in setting reimbursement rates over the long term. Further, not only does the government drive private insurance reimbursement to a significant extent, it also subsidizes it. Because private health insurance is largely employer-based and employers receive a tax deduction for their employee healthcare expenses, the government, in effect, is paying a significant portion of private-healthcare-insurance expense through reduced tax revenues.

Reimbursement plans in the employer-based insurance market can be divided into four types: (1) FFS, (2) HMOs, (3) preferred provider organizations (PPOs), and (4) point of service plans (POS). Under traditional FFS plans, providers pay a fee for each service provided. Insurance companies have no influence over choices of physician and treatment and do not bargain strongly on the basis of price – a system that naturally led to overuse and high prices. HMOs came about as a means of reducing costs through the integration of the provider and insurer functions and placed more power in the hands of insurers with respect to treatment authorization. The numbers of insured through HMO plans grew rapidly from the middle 1980s, peaking in 2000 at slightly over 80 million, but dropping subsequently by approximately 10 million indicating a decline in popularity. Under such plans, PCPs have received approximately 12% of premium dollars while specialists received approximately 32% and hospitals received

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308 Paduda, supra note 304.
309 Hogan, supra note 292.
310 Chernew, supra note 297.
311 Id.
approximately 36%. PPOs are essentially a discounted price for service arrangement among HCPs, patients and insurers governed by less restrictive rules than HMOs. With PPOs, the provider organization assembles a provider list, controls and monitors quality of service, and receives a profit. HCPs benefit by maintaining market share and receiving faster payments in return for discounted fees. Under POS plans, insurers choose PCPs who control referrals, but such plans otherwise work similarly to PPO plans in that those insured can obtain out-of-network coverage if they are willing to pay a higher out-of-pocket price. Over the past decade, PPO plans have come to dominate all other types as the most popular with over 50% of the employer-based insured population. Accounting for this popularity is perhaps the fact that PPO plans have experienced the smallest cost increase on any plan type.312

Plan type becomes highly important when considering the influence on physician incentives. FFS plans are characterized by supplier-induced demand in that the more care physicians provide the more they earn. Conversely, plans that focus on capitation - an annual fee paid to a physician for each insured in the plan313 - are characterized by demand dissuasion in that the less care provided for any one patients, the more patients that can be treated by a given physician and the more that physician can earn.314 The same physician can be reimbursed by both FFS and capitation for different patients depending upon contractual arrangements.315

312 Id.


314 Chernew, supra note 297.

315 Employer-based health insurance plans can also be categorized as high-deductible, self-insurance, and wrap-around plans. High-deductible plans cover most medical expenses after employees have paid a set amount for medical care and are priced lower than other plans predicated on the expectation that such deductibles will
Irrespective of differences in the types of private insurance and their associated mechanics of physician reimbursement, physicians’ relationships with insurance companies have proven increasingly problematic. Insurance companies are alleged to have systematically and consistently underpaid physicians over the past decade, a practice that has resulted in a substantial number of lawsuits many of which have been won by physicians. In addition to litigation involving reimbursement policies, insurance companies and physicians have litigated encourage insured to be more judicious in their use of healthcare. Self-insurance plans are custom plans set up to pool risk for employers, which assume some or all of the financial risk for employee healthcare. Wrap-around plans involve combining high-deductible and self-insurance plans such that employers pay for some or all of the deductible. Such plans have been heavily opposed by insurers which maintain that such plans destroy the incentive for employees to use healthcare judiciously and, in effect, undermine the intent behind high-deductible plans resulting than higher than anticipated cost to the insurer. See Kathy Robertson, Insurers Warn Brokers,


over insurers illegally coercing physicians to do business with them.318 Exacerbating these difficulties, physicians have also been denied the right to negotiate collectively with insurance companies over reimbursement rates by the Federal Trade Commission,319 a restriction that increasingly places physicians at a disadvantage as mergers of insurance companies increase their bargaining power relative to that of individual physicians.320 Physicians’ concerns over reimbursement difficulties have also spawned ratings surveys in which insurance companies are evaluated based upon claims payments.321 Moreover, insurance companies have been accused of inflating estimates of the amounts of claims paid in reports to state regulators.322 These difficulties imply a growing tension between physicians and private insurers regarding reimbursement for healthcare services – one that calls into question the effectiveness of regulation in limiting questionable insurance practices323 and suggests an increasing propensity of physicians resorting to the judicial system for remedies to such practices.


321 Fuhrmans, supra note 298.


323 Regulation of health insurance is subject to both state and federal regulation, but states remain the primary regulators of insurance companies and products despite an increasing presence of federal regulation through such
Medicare Reimbursement

Instead of universal healthcare the U.S. has what has been termed a “patchwork” of public and private health programs of which Medicare is the foremost public program closely followed by its slightly smaller, but fast growing, brother, Medicaid. Medicare, administered by the U.S. Department of Health and Human Services (HHS) through CMS, is totally federally funded and divided into components, two of which are hospital insurance (HI) and supplementary medical insurance (SMI). HI, also known as Medicare part A, which is funded by payroll laws as the Employee Retirement Income Security Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. Mila Kofman & Karen Pollitz, Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change. Health Polic Institute, Georgetown University (Apr. 2006), available at http://www.allhealth.org/BriefingMaterials/HealthInsuranceReportKofmanandPollitz-95.pdf. Insurance regulation appears to be primarily directed at protection of healthcare consumers and silent about insurance company practices regarding reimbursement of HCPs.


John B. Shoven, The Impact of Major Improvements in Life Expectancy on the Financing of Social Security, Medicare, and Medicaid, in COPING WITH METHUSELAH: THE IMPACT OF MOLECULAR BIOLOGY ON MEDICINE AND SOCIETY 166, 175-6 (Henry J. Aaron & William B. Schwartz, eds., 2004) (noting that HI is funded primarily by a 2.9% payroll tax with its only other sources of revenue being trust fund interest and a share of recycled tax payments on Social Security benefits and that SMI receives approximately 75% of its funding from general revenues and 25% from participants.)
taxes, helps pay for hospital, home health, skilled nursing, and hospice care, while SMI - also
known as Medicare part B, which is funded by a combination of general fund, insurance and co-
payments - pays for physician, hospital outpatient, and some other services.\textsuperscript{326}

Inasmuch as participation in Medicare is legally voluntary, courts have been liberal in
allowing almost unlimited discretion to limit reimbursement and require compliance with
preconditions for reimbursement.\textsuperscript{327} HHS can impose maximum ceilings on the reimbursement
for certain costs, audit the reported costs for services provided, and use the audited costs to
determine future reimbursement rates irrespective of fairness to physicians.\textsuperscript{328} Medicare
spending for physician services is basically a function of three variables: payment rates for
individual services, volume of services, and the mix of services.\textsuperscript{329} In 1983, Congress created a
system in which CMS manages physician reimbursements based upon 745 Medicare severity

\textsuperscript{326} Id. Medicare Part C relates to Medicare Advantage, an effort to blend private and public reimbursement that is
discussed subsequently. Part D relates to prescription drug coverage. Medicare Part B Matters, Center for Medicare

\textsuperscript{327} W\textsc{ing}, supra note 105, at 147, 164 citing Garelick v. Shalala, 987 F.2d.913 (2d Cir 1992), cert. denied, 510 U.S.
821 (1993); Whitney v. Heckler, 780 F.2d. 963 (11th Cir. 1986), cert. denied, 479 U.S. 813 (1986) (freeze on
Medicare Part B reimbursement rates upheld); Good Samaritan Med. Ctr. v. Heckler, 605 F. Supp. 19 (S.D. Ohio
1984), aff’d, 776 F.2d. 594 (6th Cir. 1985).

\textsuperscript{328} W\textsc{ing}, supra note 105, at 130, 194 (noting that since 1982 HHS has had the authority to contract with “peer
review organizations” “to review the quality, necessity, and appropriateness of services paid for by Medicare.”)

\textsuperscript{329} W\textsc{illiam J. Scanlon}, U.S. Gov. Accountability Office (GAO), Pub. No. GAO-02-441T, Medicare
diagnosis-related-groups (MS-DRGs) predicated on the severity of illness.\textsuperscript{330} The MS-DRG system is supposed to be prospective in that the amounts paid are fixed in advance.\textsuperscript{331} In reality, however, payments have never been completely prospective since events subsequent to the onset of treatment (e.g. changes in diagnosis) exert significant influence over payments.\textsuperscript{332}

In 1989 in an effort to control healthcare spending by reducing incentives to over treat patients, Congress also instituted a resource-based-relative-value scale (RBRVS) within the MS-DRG system with the goals of providing a rational basis for physician reimbursement, removing excess profits from some services, and assuring adequate payment for evaluation and management services.\textsuperscript{333} Under the RBRVS, CMS sets rates for each service provided by physicians using approximately 9,000 current procedural terminology (CPT) codes with a code associated with each medical procedure.\textsuperscript{334} Physician reimbursement under the RBRVS is determined by three fundamental factors: (1) work relative value units (wRVUs) which are a measure of work performed by the physician and which assign values to each individual CPT

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\textsuperscript{332} Id.


code, (2) geographic practice cost indices, and (3) a monetary conversion factor.\footnote{Barbara Peck, Future of Medicare Reimbursement Uncertain, position paper, available at http://www.neurosurgeon.org/advocacy/wc/archives/medicare/IssueOverview-FutureofMDreimbursement.pdf.} As a cost control measure, however, the RBRVS has had only partial success in controlling costs at best. Physicians tend to increase the quantity of services provided as Medicare rates move downward\footnote{RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 2 (noting that under the FFS RBRVS system, physicians actually make more money when they are slow to diagnose and treat a problem because they are paid for more services).} despite an amendment to the RBRVS legislation that is supposed to lower the Part B reimbursement rates for a service in response to increases in utilization of that service.\footnote{Wing, supra note 105, at 137.} The actual reimbursement calculation is computed as follows: 

\[
\text{Medicare payment to physician} = \left(\text{total relative units reimbursement} \times \text{Medicare dollar conversion factor for that year}\right) 
\]

\[
= \left(\text{work relative value units} \times \text{budget neutrality work adjustor} \times \text{work geographic practice cost index} + \text{practice expense relative value units} \times \text{practice expense geographic practice cost index} + \text{malpractice professional liability insurance relative value units} \times \text{professional liability insurance geographic practice cost index}\right) 
\]

\[
= \text{total relative units reimbursement} \times \text{Medicare dollar conversion factor for that year} 
\]

The three relative value units (RVUs) in the formula represent the values assigned by CMS to the resources needed to provide a given physician service reflecting the time, skill, effort, intensity and risk required by that service and depending upon specialty. The geographical practice cost indices (GPCI) are intended to adjust for differences in cost across different locales. The budget neutrality work adjustor is intended to adjustment physician payments to comply with the budget neutrality cap to total Medicare payments mandated by Congress. The Medicare conversion factor is a dollar amount necessary to translate total RVUs into a reimbursement amount. Edgardo Tenreiro, Medicare Rx for Physician Reimbursement, blog position paper (Sep. 20, 2007), available at http://mises.org/Community/blogs/edgardo_tenreiro/archive/2007/09/20/medicare-rx-for-physician-reimbursement.aspx.
The basic assumption underlying Medicare reimbursement is that the price of a given health service should reflect the cost of providing that service leading to a cost-based physician reimbursement system.\textsuperscript{338} Given that Medicare expenses already constitute a large part of federal spending, controlling Medicare costs has become a focus of a great deal of attention, especially in light of an aging population that threatens to exacerbate what is already a major problem for the U.S. economy.\textsuperscript{339} As a result Congress has capped Medicare reimbursement to physicians using a sustainable growth rate (SGR) in determining the annual updates to the monetary conversion factors in the RBRVS formula\textsuperscript{340} - in effect making changes Medicare reimbursement a zero-sum game in which there are winners and losers among physician specialties.\textsuperscript{341} The SGR mechanism is supposed to use information about physician spending in

Medicare pays for physician services based on a list of services and their payment rates, called the physician fee schedule. In determining payment rates for each service on the fee schedule, the Centers of Medicare & Medicaid Services (CMS) considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to those three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule’s conversion factor, to arrive at the payment amount. Medicare’s payment rates may be adjusted based on provider characteristics, additional geographic designations, and other factors. Medicare pays the provider the final amount, less any applicable beneficiary coinsurance. \textit{See, Physician Services Payment System, supra} note 324.

\textsuperscript{338}Tenreiro, \textit{supra} note 335. \textit{See also, Graham, supra} note 26, provides the following example of Medicare’s alchemy for setting physician reimbursement:

Medicare’s economists concluded that a hysterectomy takes twice as much time as a psychotherapy session, 3.8 times as much mental effort, 4.47 times as much technical skill and physical effort, and 4.24 times as much risk. Add it all up, and a hysterectomy is 4.99 times as much work as a psychotherapy session – at least according to the government. Just about every possible procedure, treatment and appointment was calculated similarly. That’s how the government determined the prices it would pay under Medicare.

\textsuperscript{339}Id., at 180. \textit{See, also, text accompanying notes} 68-72.

\textsuperscript{340}Medicare Reimbursement to Physicians, \textit{supra} note 7.

relation to cost increases, changes in the number of beneficiaries, and economic growth to impose fiscal discipline on Medicare spending.\textsuperscript{342} This SGR cap has proven untenable, however, for two reasons. First, even if reimbursement rates go unchanged and no new CPT codes are added, growth in the number of beneficiaries – together with fraud, waste and abuse - adds to spending necessitating continuous Congressional overrides of the cap by waiving the SGR formula for one year.\textsuperscript{343} Second, the cumulative nature of its calculation makes future spending a function of past spending caps that have been temporarily suspended by Congressional intervention, thereby resulting in projections of unrelenting decreases in reimbursement for many years.\textsuperscript{344} The series of one-year Congressional fixes achieved by waiving the SGR formula has been characterized as merely kicking the problem down the road.\textsuperscript{345} Indeed, Medicare spending seems barely under control, if that, with such problems as $198 million spent on unapproved pharmaceuticals during the period 2004-2007 alone.\textsuperscript{346}

In an effort to reform Medicare reimbursement through privatization, claims are now processed through a patchwork system of fiscal intermediary carriers such as insurance companies.\textsuperscript{347} Physicians who accept Medicare patients can accept or reject assignment of

\begin{footnotes}
\footnotetext{342}{Scanlon, \textit{supra} note 329, at 11.}
\footnotetext{343}{Medicare Reimbursement to Physicians, \textit{supra} note 7.}
\footnotetext{344}{\textit{Id.}}
\end{footnotes}
Medicare reimbursement. Physicians who accept assignment bill Medicare for its responsible portion through a carrier and bill the patient for the balance, the patient’s co-payment. Any physician accepting assignment agrees to accept Medicare’s “reasonable charge” which is often less than the physician’s normal charge. If a physician does not accept assignment, the claim must still be sent to the carrier, but the patient is responsible for any amount above Medicare’s reasonable charge. Under this arrangement, the patient typically pays the bill including any amount above what Medicare allows and then submits a claim to Medicare for its portion of payment.348 This carrier system of processing Medicare claims has created difficulties for physicians inasmuch as the carriers are chosen essentially through a low-bidder process. Because of the cost pressures resulting from low bids, carriers are often unable to provide good service resulting in slow claims processing and cash flow problems for some physicians.349

Another problematic issue for physicians arising from the complexity of Medicare reimbursement is that of possible regulatory and legal action for false claims resulting from overbilling for Medicare-covered services, the consequences of which can be quite significant from both financial and legal standpoints.350 The federal government has developed data-mining methodologies to assess healthcare claims and assist in its enforcement against infractions under


349 Glendinning, supra note 347.

the False Claims Act.\textsuperscript{351} Medicare billing violations can also surface from whistleblower lawsuits or \textit{qui tam} actions.\textsuperscript{352} Such violations can involve severe financial penalties and criminal prosecution.\textsuperscript{353} For example, in \textit{United States v. Rogan}, several physicians were required to make financial restitution for false claims and received prison sentences.\textsuperscript{354} Consequently, physicians are well advised to exercise caution and avoid a pattern of mistakes in billing Medicare for patient services.

Recent attempts by CMS to force HCPs to tighten quality controls, though laudable in many respects, also adversely impact physician compensation.\textsuperscript{355} In the past, HCPs were able to externalize a majority of the costs of medical errors which provided a disincentive for investment in quality improvement.\textsuperscript{356} CMS now disallows incremental payments associated with eight secondary conditions that it considers preventable complications resulting from the provision of medical care. These include such errors as objects left in the patient during surgery, air embolisms, blood incompatibility, pressure ulcers, and catheter-associated urinary tract

\begin{footnote}{Cheryl L. Wagonhurst & M. Leann Habte, \textit{Health Care Boards of Directors’ Legal Responsibilities for Quality}, 10 \textit{Compliance Today} (Dec. 2008), 9, 13.}
\end{footnote}

\begin{footnote}{\textit{Id.}}
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\begin{footnote}{\textit{Id.}}
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\begin{footnote}{U.S. v. Rogan, No. 02-C3310, 2006 WI. 2860972 (N.D. Ill. Sept. 29, 2006). Medicare’s tentacles reach even into purchases of one physician’s practice by another where a buying physician’s failure to exercise good due diligence with respect to the billing practices of the seller’s could subject the buyer to legal and financial risk. See \textit{generally}, Greg Brock et al., \textit{What Every Compliance Officer Should Know about M&A Due Diligence}, 10 \textit{Compliance Today} (Dec. 2008), 30, 30.}
\end{footnote}

\begin{footnote}{Rosenthal, \textit{supra} note 331, at 1574.}
\end{footnote}

\begin{footnote}{AHIP Medical Affairs Issues Report, Recent Study Shows Hospitals Externalize a Majority of Costs for Hospital Errors (May 7, 2008), http://www.ahiphiwire.org/News/Print.aspx?channel=Clinical&doc_id=167018.}
\end{footnote}
infections.\footnote{357} To make matters worse for physicians, some private insurers have been quick to jump on this bandwagon consistent with their increasing propensity to follow Medicare’s lead on physician reimbursement.\footnote{358}

\textit{Medicaid Reimbursement}

Title XIX of the Social Security Act established Medicaid as a joint federal/state program for the purpose of providing healthcare funding primarily for low-income and disabled persons.\footnote{359} Medicaid is an open-ended entitlement program under which the federal government pays a share (50-83\%) of the expenditures with the remainder covered by states.\footnote{360} Unlike Medicare, within broad federal requirements, each state administers its individualized Medicaid program according to its own plan and reimburses providers for patient care provided.\footnote{361} Medicaid provides a growing safety net for a broad cross section of the population, covers 60\% of the poor, and differs philosophically from Medicare in its orientation toward the underclass rather than the aged.\footnote{362} Medicaid reimbursements for health services are typically low compared to

\footnote{357} Rosenthal, supra note 331, at 1574.


\footnote{360} GAO, Pub. No. GAO-07-214, supra note 60, at 8.

\footnote{361} \textit{Id.} at 8-9.

\footnote{362} Richmond & Fein, supra note 33, at 236.
private insurance and even Medicare reimbursement such that Medicaid has been described as a “community service.”

Generally, federal Medicaid law does not set precise requirements for setting reimbursement rates for physician services, but instead requires only the following: “[A]ssure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and plan services are available under the plan at least to the extent that such care and services are available to the general population in the geographical area.” The import of this is that rates for a given service can vary widely from state to state. Even though Medicaid fees for primary care increased significantly during the period 1998-2003, Medicaid replaced higher-paying private insurance for many patients during that period resulting in a net loss in physician compensation and a reluctance to treat Medicaid patients.

A principle reason for Medicaid’s increasingly low reimbursement for patient services is found in its cost growth, which has exceeded even that of Medicare in recent years, in part

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363 Wirtz, supra note 286 (quoting a hospital official in Minnesota).


365 42 U.S.C §§ 1396a(30)(a).

366 Milligan, supra note 364, at 5 (noting, for example, rates for CPT code no. 99245 paying amounts of $113, $215, $49, $151, $164, and $178 across six sates and the District of Columbia compared to Medicare’s rate of $232.

367 Id. at 6-8.

because of the erosion of private health insurance and growth in the uninsured population, and in part because of rampant fraud and abuse in which even some states have been willing participants. Total Medicaid costs more than doubled during the period 1988-1993, and by 2006 combined federal and state Medicaid spending had reached a level of $317 billion annually compared to Medicare’s $384 billion. Cost pressures have also resulted in cutbacks in various Medicaid-funded services. During 2006, all 50 states and the District of Columbia implemented some sort of Medicaid cost control measures to include reduced benefits, restricted eligibility, and increased co-payments.


In summary, all three basic types of third-party payers are problematic for physicians and have been the subject of severe criticism from the standpoints of their cost to their clients or taxpayers and also the manner in which they reimburse physicians for healthcare services. Governments, particularly the federal government, play an increasing role in both funding healthcare and determining physicians’ payment for services. More than 60% of national healthcare expenditures are now funded through federal and state budgets when income tax expense deductions for employer-sponsored plans are included. With this section as a foundation, the following section discusses the connections among reimbursement systems, malpractice insurance costs, physician compensation and shortages, and quality of care.

V. Payment Systems, Malpractice Insurance Cost, Physician Compensation and Shortages, and Quality of Care

Despite the fact that physicians in the United States are said to receive particularly generous remuneration in contrast to their counterparts in other first-world countries, reimbursement practices can have a profound impact upon the quality and quantity of care. As two leading healthcare commentators have put it, “[t]he risks in any payment system are apparent. The way dollars flow changes incentives and therefore behavior.” A recent study conducted by the Medical Group Management Association (MGMA) cited the following as four of the five primary current concerns of medical groups: (1) maintaining physician compensation in an environment of declining reimbursement, (2) operating cost rising more rapidly than revenue, (3) managing finances in light of uncertainty over Medicare reimbursement rates, and (4) recruiting

375 RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 10.
376 AARON ET AL., supra note 33, at 7.
377 RICHMOND & FEIN, supra note 33, at 84.
sufficient numbers and types of physicians. In the following subsections we examine the nexuses among third-party reimbursement, professional liability insurance cost, physician compensation, shortages and quality and availability of care.

There are several difficulties in attempting to determine the effects of medical malpractice cost and reimbursement systems on physician compensation and shortages. First, there is no universal, agreed-upon measure of physician shortages. Second, most evidence is anecdotal, but what empirical evidence exists is not always in agreement, often lacks causal inference, and is subject to mixed interpretation. Third, much of the research that has been conducted has used surveys of physicians raising concerns about self-selection bias with respect to how representative the respondents are of the physician population as a whole and about physicians’ obvious financial incentives to exaggerate the consequences of malpractice liability cost with respect to their patient populations. Finally, some demographic areas, particularly rural and

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380 Id. (noting an Agency for Health Research and Quality study found a correlation between tort exposure and physician supply in that states with malpractice liability caps have 12% more physicians per capita, but Pennsylvania, which has no cap, ranked 12th among all states in physicians per capita).

381 See, e.g., surveys reported in Id.; Wisconsin Hospital Association & Wisconsin Medical Society, WHO WILL CARE FOR OUR PATIENTS? WISCONSIN TAKES ACTION TO FIGHT A GROWING PHYSICIAN SHORTAGE, (Mar. 2004), at 7, available at http://docstor.rms.med.wisc.edu/document_11_66781.pdf; and Baretta R. Casey, et al., Rural Kentucky’s Physician Shortages: Strategies for Producing, Recruiting and Retaining Primary Care Providers within
inner-city areas, have long experienced shortages of certain types of physicians, quite possibly more due to quality of life and practice issues than malpractice liability concerns.\textsuperscript{382}

Consequently, to aid in our examination of reimbursement systems and malpractice insurance cost on physician compensation and shortages, we develop a database (hereinafter, “pooled dataset”) using data drawn from the following four sources and taken from the period 1999-2007: (1) MGMA annual \textit{Physician Compensation and Production Survey} containing data on compensation and RVU production,\textsuperscript{383} (2) MGMA \textit{Cost Survey: Multispecialty Practices Report} containing data on physician practice costs to include professional liability insurance,\textsuperscript{384} (3) CMS \textit{Medicare Utilization for Part B} report containing data on submitted Medicare charges and numbers of Medicare patients served, and numbers of services provided per Medicare patient,\textsuperscript{385} and (4) the AMA’s \textit{Physician Characteristics and Distribution in the U.S.} containing numbers of practicing physicians by specialty.\textsuperscript{386} The pooling of data from these sources enables empirical insights to be drawn with respect to changes over time and by specialty in physicians’


\textsuperscript{382} See, e.g., \textit{id.}.


compensation, production, patients served, professional liability insurance cost, and general practice costs as well as changes in numbers of physicians. Although we do not possess data on changes in private insurance reimbursement broken down by specialty and Medicaid reimbursement which varies state by state, changes in Medicare reimbursement rates may serve as reasonable for proxy for changes in private insurance, privately administered Medicare, and Medicaid reimbursement rates, especially when viewed over a longer period and not simply year to year.

**Effects of Third-Party Reimbursement on Physician Compensation and Shortages**

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387 The vast majority of third-party payers use the RBRVS to determine physician reimbursement. The approximate percentages of RBRVS usage for various third-party payers are as follows: Blue Cross/Blue Shield companies = 78%, privately administered Medicare programs = 95%, Medicaid = 64%, and other private insurers = 75%. See, Joel F. Bradley, CPT Coding and Reimbursement Update 2006, presentation given to the National Vaccine Advisory Committee, June 6, 2006, available at www.dhhs.gov/nvpo/nvac/documents/BradleyJun06.ppt. Because private insurance companies differ among each other and even within a given company with respect their particular plans, there is no simple method for determining their reimbursement rates. Studies using claims data from various sources indicate a growing convergence with Medicare rates, however. See, e.g., Hayes & Hogan, supra note 304, at 9.

Over the past century the total supply of physicians has been reasonably adequate, and the issue of shortages is largely one of mal-distribution by specialty and location. An area of primary concern is that of PCPs - including the specialties of family practice, internists, obstetrics/gynecology, and pediatrics - for whom reimbursement policies are creating extraordinary difficulties. For example, over the past five years the percentage of medical students entering family practice has dropped from 14% to 8%, and only 2% of currently graduating medical students plan to become PCPs. One fifth of PCPs earned less than $120,000 in 2007, and PCPs struggle “…to get decent reimbursement from health plans.” The cost of private and public medical schools increased 50% and 133%, respectively, over the past two decades in real dollars. Physicians graduate medical owing $139,517 in debt on average.

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389 RICHMOND & FEIN, supra note 33, at 204.


391 Medicare Reimbursement to Physicians, supra note 305.

392 Poses, supra note 390.


394 Ken Terry, 2008 Exclusive Survey-Earnings: Good News for Primary Care Income, MEDICAL ECON. (Aug. 1, 2008), available at http://license.icopyright.net/user/viewFreeUse.act?fuid=MTQxNDgwOA%3D%3D (noting that, although “…family physicians’ total compensation advanced 5 percent [in 2007], the median incomes of GPs [general practitioners], internists, and ob/gyns [obstetrician/gynecologists] dipped slightly compared to prior year statistics.”)

with 75% having debt of at least $100,000 and 87.6% having outstanding loans.\textsuperscript{396} With slow growth in compensation, young physicians face increasing difficulty repaying this debt, a problem that has directly contributed to a shortage of PCPs.\textsuperscript{397} As one commentator has stated, “[t]he number of U.S. medical students choosing careers in primary care or family practice has drastically fallen in recent years, threatening the stability of the overall healthcare system . . . ,” a problem attributed to medical specialists earning almost twice as much as PCPs for serving the same number of patients.\textsuperscript{398} Some nurses are said to be better compensated that PCPs.\textsuperscript{399} PCPs are reportedly feeling overworked, and nearly half plan to either cut back on their practices or quit medicine entirely.\textsuperscript{400} The result is an apparent shortage of PCPs despite an adequate supply of most other types of physicians in most locales\textsuperscript{401} - a problem that contributes significantly to

\begin{flushleft}
\textsuperscript{396} Id.
\textsuperscript{401} Id.
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what has been termed the “relentless rise in health-care costs” by encouraging even more costly acute care versus less costly preventive medicine.\footnote{402}

A major reason for shortages of PCPs is the bias in the application of Medicare’s RBRVS which favors procedural medicine over cognitive medicine.\footnote{403} PCPs spend more time listening and interacting with patients than do specialists in surgery, gastroenterology, and anesthesia who are more procedurally focused.\footnote{404} CPT codes for new services were the major drivers of growth in the volume of physicians’ work per Medicare beneficiary during the period 1992-2002, with the greatest increases coming in procedure-heavy specialties such as cardiology and gastroenterology.\footnote{405} This bias favoring procedural medicine has been perpetuated by an AMA committee created in 1991 known as the RVS Update Committee (RUC) that advises CMS on setting physician reimbursement rates for services.\footnote{406} The RUC is overwhelmingly dominated by procedural sub-specialists with the result that medical students, given their aforementioned debt load upon graduation, are driven into higher-paying procedural specialties for financial reasons.\footnote{407} The RUC consists of 29 members, 23 of whom are nominated by major national medical specialty societies and appointed by the AMA board of directors.\footnote{408} Despite its advisory role as an advocacy group, the RUC appears to be the sole source of external input

\footnote{403} Id.  
\footnote{404} Poses, \textit{supra} note 390.  
\footnote{405} Maxwell et al., \textit{supra} note 341, at 1853.  
\footnote{406} \textit{Physician Reimbursement under Medicare, supra} note 334.  
\footnote{407} Id.; and Poses, \textit{supra} note 390.  
\footnote{408} Bradley, \textit{supra} note 387.
received regularly by CMS about physician reimbursement rates, \textsuperscript{409} and has been described as secretive, unrepresentative, and unaccountable with neither its membership nor its proceedings made public. \textsuperscript{410} The RUC’s recommendations take on even more importance when taken with the federally legislated requirement that CMS must maintain budget neutrality. \textsuperscript{411} Federal law requires that the budgetary impact of increases in existing CPT codes or the establishment of new codes be offset by decreases for other codes, thereby creating conflict among various specialties. \textsuperscript{412} In light of the previously acknowledged bias of the RUC toward procedural medicine, this zero-sum arrangement virtually guarantees winners and losers with PCPs having generally been the losers. \textsuperscript{413}

In addition to its direct effect on physician compensation as an antecedent of physician mal-distribution, insurance reimbursement also has indirect effects on physician compensation. For

\textsuperscript{409} Poses, \textit{supra} note 390.

\textsuperscript{410} \textit{Id.}

\textsuperscript{411} \textit{Physician Reimbursement under Medicare, supra} note 334.

\textsuperscript{412} \textit{Id.} The mechanics of this process can be summarized as follows. If the conversion factor used to reimburse physicians increases, reimbursement for all physicians services increases and vice versa. CMS estimates an annual expenditure target for physician services which is determined by medical cost inflation, the gross domestic product, increase in the number of beneficiaries, and changes in law and regulation. If actual spending for physician services exceeds the target, physicians receive what is known as a “negative update” amounting to a decrease in the conversion factor and payments. Actual expenditures have exceeded targets annually for the past several years (mainly due to radiation, cardiology, and physician-administered drug costs), and Congress has repeatedly intervened to prevent negative updates from decreasing physician payments. This has a material impact on future updates, however, because both the targets and the actual payments are calculated on a cumulative basis. Peck, \textit{supra} note 335.

\textsuperscript{413} See \textit{supra} text accompanying notes 406-13.
example, several studies have found that, as physicians increase the volume of care to offset the loss of revenue due to Medicare fee cuts, they increase the volume of care per patient, not the number of patients. Further, to the extent that more-care-per-patient means longer hours for physicians, this only exacerbates the PCP shortage because more and more physicians prefer medical specialties that offer more control over their professional work schedules. The adverse interaction between lower compensation and uncontrollable lifestyle for PCPs is said to represent “two strikes” according to one study.


Further, it should also be noted that Medicare law affects physician compensation indirectly through the anti-kickback and anti-self-referral statutes associated with Medicare/Medicaid-related law which place restrictions on income physicians can earn though ownership of ancillary medical entities and through their affiliations with hospitals. Although such restrictions are a

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417 The federal anti-self-referral statute known as the Stark Law, 42 U.S.C. § 1395nn (2006), provides that a physician generally cannot refer patients to a healthcare entity with which the referring physician has a financial relationship, if payment for the relevant healthcare services is to be made through the Medicare and Medicaid programs. Id. § 1395nn(a)(1)(A). Entities that have furnished healthcare services pursuant to an unlawful referral are prohibited from seeking and obtaining Medicare and Medicaid payment for those services. Id. § 1395nn(g). In the event of submission of a bill requesting Medicare or Medicaid payment for a service resulting from a prohibited referral, any party submitting such a bill or causing it to be submitted may be assessed a civil monetary penalty of up to $15,000 per service, assuming the party knew or should have known that the performance of the service resulted from a prohibited referral. Id. Civil penalties as high as $100,000 may be assessed on any participant in an ongoing scheme such as a cross-referral arrangement, if the participant knew or should have known that prohibited self-referrals led to the furnishing of the relevant healthcare services. Id. In addition, healthcare providers can be barred from the Medicare and Medicaid programs for knowing violations of the Stark Law. See 60 Fed. Reg. 16,580-16,584 (Mar. 31, 1995) (codified at 42 C.F.R. pt. 1003). There are several exceptions, however, to the Stark Law's ban on physicians' referrals to entities with which they have a financial relationship. Among the various exceptions are ones allowing self-referrals when the physician is employed by the entity to which he makes a referral, see 42 U.S.C. § 1395nn(e)(2), when certain other types of personal services arrangements exist between the referring physician and the referred-to entity, see id. § 1395nn(e)(3), when the referred-to entity is the same medical group with which the physician practices, see id. § 1395nn(b)(1), (2), and when certain arrangements involving rental of space or equipment exist between the referring physician and the referred-to entity, see id. § 1395nn(e)(1). Unless an exception applies, any referral otherwise prohibited constitutes a violation of the Stark Law. Id. § 1395nn(a)(1)(A). For useful overviews of the Stark Law, its considerable breadth and ambiguities, the exceptions to its application, and the controversy it has generated, see A.B.A. HEALTH LAW SECTION, E-HEALTH BUSINESS &
complex topic easily deserving of a separate study, they are not a focus of this study and might
best be summed up succinctly the following statement: “It is quite clear that OIG [Office of the

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TRANSACTIONAL LAW 120-123 (Barbara Bennett ed., 2002) (hereinafter "E-HEALTH BUSINESS"); STUART

The federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b) (2006), prohibits the knowing and willful
solicitation, receipt, offer, or payment of remuneration of any sort in an effort to induce a healthcare services referral
for which payment is made under a federally funded healthcare program. Id. § 1320a-7b(b)(1), (2). This statute and
the Stark Law, see supra note 406, rest on the apparent rationale that consumers of healthcare services are at a
significant disadvantage compared to providers because of a material and unfavorable information asymmetry, and
that there must be checks against providers whose financial motivations might induce them to make referrals for
self-interested reasons rather than on the basis of what is best for the patient. See E-HEALTH BUSINESS, supra note
417, at 114-15. Because it may be violated by any person or entity, the anti-kickback statute sweeps even more
broadly than the Stark Law, which addresses self-referral by physicians. Compare 42 U.S.C. § 1320a-7b(b)(1), (2)
(anti-kickback statute's applicability to "[w]hoever knowingly and willfully solicits or receives . . ." and ",whoever
knowingly and willfully offers or pays . . .") with 42 U.S.C. § 1395nn(a)(1)(A) (Stark Law's ban on self-referral by a
"physician"). A violation of the anti-kickback law can lead to a felony criminal prosecution in which fines of up to
$25,000 and imprisonment for a maximum of five years can be imposed. 42 U.S.C. § 1320a-7b(b)(1), (2). The
statute and regulations promulgated by the HHS allow for numerous exceptions and safe harbors that classify
particular arrangements and relationships as permissible and non-violative of the anti-kickback law. See id. § 1320a-
7b(b)(3); 42 C.F.R. pt. 1001 (2006). Among these exceptions and safe harbors are ones providing protection for
remuneration furnished pursuant to an employment relationship (see 42 U.S.C § 1320a-7(b)(3)(B)) an independent
contractor relationship that meets certain conditions (see 42 C.F.R. § 1001.952(d)) and certain qualifying space and
equipment rental contacts (see id and § 1001.952(c)). For an overview of the anti-kickback statute, its exceptions
and safe harbors, and other federal laws dealing with fraud and abuse in regard to federally funded healthcare
programs, see E-HEALTH BUSINESS, supra note 417, at 114-20, 126-27. For a history of the development of
Medicare and Medicaid-related anti-kickback law see WING, supra note 36, at 206-14.
Inspector General, HHS] and CMS expect assessments of need in health care arrangements to be made without regard to referrals or the generation of business between the parties.\textsuperscript{418}

In addition to the foregoing evidence, we examine the associations among physician reimbursement, compensation, and shortages in more detail using the aforementioned pooled dataset. This dataset permits comparison of percentage changes in Medicare reimbursement over the period 2000-2006 with those of physician compensation and numbers across fifteen different specialties for which complete data could be obtained for all years.\textsuperscript{419} Appendix A displays annual values for certain key variables such as median compensation, the number of work RVUs performed, number of Medicare services performed broken down into four categories: all specialties, primary care specialties, non-primary-care specialties, and high-risk specialties.\textsuperscript{420} Appendix B shows year-to-year and total percentage changes in selected variables across all years.

For all specialties, during the seven-year period Medicare reimbursement per service increased 15.14\% while median average physician compensation increased 27.52\%. Together with the aforementioned evidence that private insurance reimbursement rates are converging with Medicare rates,\textsuperscript{421} the remaining reason for physician compensating increasing more than

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\textsuperscript{419} These 15 specialties included anesthesiology, cardiology, family practice, gastroenterology, general surgery, hematology/oncology, internal medicine, neurology, OB/GYN, ophthalmology, orthopedic surgery, otorhinlary, pediatrics, radiology, and urology.

\textsuperscript{420} Primary-care specialties include family practice, internal medicine, OB/GYN, and pediatrics. High-risk specialties include cardiology, general surgery, orthopedic surgery, and OB/GYN.

\textsuperscript{421} See \textit{supra} text accompanying notes 307-10.
\end{footnotesize}
Medicare rates is that physicians increased the volume of Medicare services provided. In addition to having the lowest reimbursement rate per wRVU, PCPs also had the lowest percentage change in median compensation consistent with the notion that PCPs’ incomes are not keeping pace with those of other specialties. Median compensation as a percentage of total medical revenue rose 27.52% for all specialties in the database, but only 17.07% for PCPs. Medicare reimbursement per service provided rose 20.56% for primary care, 10.21% for the other specialties, and 7.28% for high-risk specialties; but the change in 2006 more than accounted for these increases and probably reflected an effort by the federal government to correct a previous bias that worked against PCPs. The amount of wRVUs per physician increased by 6.56% during this period consistent with the previously noted assertions that physicians are increasing the amount of treatment they provide. The number of total physicians increased 10.87%, PCPs by 12.53%, other specialties by 8.01%, and high-risk specialties by only 5.54%.  

In general, our data tend to provide some support for the argument that Medicare reimbursement has an adverse effect on physicians’ compensation and physicians have increased the amount of treatment provided to offset changes in Medicare reimbursement rates that have lagged private insurance at times and have been erratic. However, since the numbers of physicians in all categories increased, without knowing changes in national demand by specialty,  

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422 These figures are not adjusted for changes in the demand for physicians and specialties for which our literature uncovered no reliable source of national data. The figures also do not reflect very recent career decisions by medical students because of the two-year lag in the available data and the fact that physicians who were emerging from residencies in 2006 would have made their career specialty decisions some years prior while still in medical school.
it is difficult to know whether these data are indicative of shortages or not. It appears that the number of PCPs did grow during the data period despite primary care severely lagging other specialties in median compensation. Consequently, assuming the afore-referenced reports of PCP shortages are accurate, such shortages are either more recent than our data can detect, more pronounced in certain locales, and/or a result of a rapidly growing demand.

**Effects of Professional Liability Insurance Cost on Physician Compensation and Shortages**

Despite the evidence that only a small percentage of patients who are harmed by medical errors pursue litigation, even fewer actually receive any compensation for their injuries, and those who do wait an average of five years to receive it, assertions that medical malpractice liability is adversely affecting physician compensation to such an extent that it contributes significantly to physician shortages continue to be widespread and are of particular concern in primary care. For example, the Massachusetts Medical Society 2007 Workforce Study found shortages in primary care, and, based upon survey responses by physicians, attributed a large influence of professional liability on medical practice. In that study, physicians in four

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423 Joint Commission, supra note 255.


425 Massachusetts Medical Society, *Physician Workforce Study Confirms Continuing Physician Shortages in Primary Care, Psychiatry, and Six Other Specialties*, MASS. MED. SOC’Y, July 2007, at 38, 39, available at
specialties (emergency medicine, neurosurgery, OB/GYN, and orthopedics) reported that their practices have been significantly impacted by fear of lawsuit, and five specialties (OB/GYN, neurology, urology, general surgery and orthopedics) reported that high professional liability insurance rates were pressuring them to make career changes. For many physicians, then, the practical concern is not the cost of being sued per se, but the cost of purchasing professional liability insurance.

Abstracting trends from medical malpractice insurance costs is difficult for several reasons. Under Medicare accounting, professional liability insurance reimbursement is normally 1% to 3% of the total relative value units under RBRVS, and, although originally charge-based, it has been resource-based since 2000 varying because of specialty specific premium data, levels of risk, and utilization. Given the afore-referenced complexities and secrecy associated with setting Medicare rates, however, it is difficult to draw conclusions regarding trends in malpractice cost from Medicare data. Another difficulty in interpreting trends in medical malpractice insurance cost is that premiums are not individual-experience-based as is automobile liability insurance, so many physicians in a given subspecialty are affected by errors committed by a few of its members. Other difficulties are that the malpractice costs are dramatically affected by insurance companies’ investment returns, and premium actuarializing usually lags insurance companies’ actual loss experience which can result in sudden and dramatic premium


426 Id. at 80.

427 See, WING, supra note 105, at 316.

428 Bradley, supra note 387.

429 JOHN BANJA, MEDICAL ERRORS AND MEDICAL NARCISSISM 125-6 (2005).
hikes.\footnote{Id. at 131.} Consequently, in the following paragraphs we attempt to shed some empirical light on this issue through the use of our pooled dataset.

Appendices A and B suggest a substantial increase in professional liability insurance as a percentage of medical revenue over the 2000-2006 period of 64.13\% for all specialties, 20.33\% for PCPs, 49.89\% for physicians other than PCPs, and 57.89\% for the high-risk specialties. These are large percentage changes compared to percentage changes in median compensation as a percentage of medical revenue and are only partially explained by the aforementioned increases in wRVUs. This suggests there is validity to the physicians’ arguments about rising malpractice liability costs - at least during the 2000-2006 period. The lower increases in primary care liability insurance cost relative to other specialties do not suggest professional liability insurance cost is a factor in driving emerging physicians away from primary care and into other specialties, except in the case of OB/GYNs, the sole primary care specialty that falls into our high-risk category.

The costs of professional liability should obviously be higher in certain specialties, which carry higher risks such as obstetrics, and also specialties such as orthopedic surgery, and general surgery that deal with trauma cases.\footnote{Massachusetts Medical Society, supra note 425, at 83.} For example, surgical cases accounted for 26.1\% of payments and obstetrics for 9.5\% in 2004.\footnote{Medical Malpractice Payout Trends 1991-2004: Evidence Shows Lawsuits Haven’t Caused Doctors’ Insurance Woes, Public Citizen Congress Watch (Apr. 2005), at 7, available at http://www.citizen.org/documents/Malpracticeanalysis_final.pdf.} The early part of the current decade saw a decrease
in OB/GYN residency applications in some states, but it is unclear that liability costs are continuing to grow worse because professional liability expenses actually declined for some high-risk specialties such as OB/GYN and orthopedic surgery in 2007. Nonetheless, a growth rate in professional liability insurance cost as percentage of medical revenue, which is twice that of the comparable growth rate in median compensation, is cause for concern and may explain why the growth rate in the number of physicians in high-risk specialties is the lowest of any of any of the groups in our dataset. Again, absent demand data it is difficult to draw firm conclusions, however.

The appendices indicate that the cost of professional liability insurance as a percent of medical revenue is relatively small, generally falling in the 2-3.5% range even for the high-risk specialties. The erratic nature of increases in professional liability insurance, however, is noteworthy. For example, there were changes of approximately 12%, 13%, and 20% in three of the years across all specialties. Clearly, such dramatic increases in a single year would likely panic many physicians—especially when compared to small and stable changes in total practice operating costs as a percentage of medical revenue—and may partly explain why medical malpractice liability is such an emotional topic for physicians. High variance in cost makes financial planning and budgeting more difficult. This is consistent with the notion of sticker shock resulting from surprisingly large premium increases in some years, possibly having significant influence on physicians’ attitudes toward the costs of malpractice insurance than the

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433 See, e.g., Guadagnino, supra note 379 (noting this phenomenon occurred in Pennsylvania).


435 But see id. (noting that In 2007, operating costs for many physician practices rose faster than revenues).
absolute impact on their incomes. It is also consistent with the aforementioned issue of lagged and erratic actuarialization of loss experience.

**Effects of Physician Compensation and Shortages on Quality and Availability of Care**

The notion that patients will always be protected by physicians’ patient advocacy is said to have been eroded by increasing financial pressures. Current reimbursement systems reward physicians for ordering more tests, performing more procedures, and moving the maximum number of patients through practice, while spending as little time as possible with each patient. Various studies have examined the nexus between physician reimbursement and the quality of healthcare with the general finding that third-party reimbursement has an effect on health services. For example, artery bypass graft surgeries increased when Medicare reimbursement for such surgeries was reduced. Similarly, a study released in 2002 by Rand Health found that lower levels of insurance reimbursement explained why only a small percentage of the estimated 460,000 to 740,000 people with serious hearing impairment received cochlear implants which

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436 *Id.* at 85.

437 Medicare Reimbursement to Physicians, *supra* note 7.


439 Robert Kastner & Jose Guardado, *Medicare Reimbursement, Nurse Staffing, and Patient Outcomes*, 27 J. HEALTH ECON. 339, 339-40 (Mar. 2008), (“There is abundant evidence that providers respond to financial incentives by altering their treatment practices or case mix.”)

cost approximately $40,000 each.\textsuperscript{441} Medicare reimbursement cuts have been found to affect physicians’ decisions regarding treatment of prostate cancer patients.\textsuperscript{442} CMS’s efforts to reform reimbursement for certain drugs have apparently led to increased temptations for physicians to overuse injectable drugs.\textsuperscript{443} At a more macro level, a study of physicians treating FFS Medicare beneficiaries found that financial incentives to increase services influenced the intensity of services provided each patient but not the volume of patients.\textsuperscript{444}

\textsuperscript{441} Rand Corporation, \textit{Low Levels of Insurance Reimbursement Impede Access to Cochlear Implants} (2002), available at http://www.rand.org/pubs/research_briefs/RB4532-1/index1.html. At times, the outcomes of the U.S. healthcare system’s reimbursement rules can border on perversity. For example, Medicare patients requiring drug infusion therapy must either bear the cost themselves or undergo hospitalization to receive coverage instead of receiving the drugs at a lower cost to the government in their own homes. Angela Maas, \textit{Senators Have an Eye on 2009 as They Introduce Legislation that Could Close the Gap in Home Infusion Coverage for Medicare Patients}, AIS HEALTH.COM (Oct. 15, 2008), available at http://www.aishealth.com/Bnow/hbd101508.html.


Since the advent of Medicare in the 1960s, the federal government has been struggling with the myriad inefficiencies, misallocations, and other economic dysfunctions associated with the fee-for-service (FFS) private health insurance system on which Medicare was modeled….That FFS reimbursement would encourage providers to deliver more care than might be clinically appropriate was an idea that emerged, with supporting data, back in the 1970s, codified as Roemer’s Law….A flood tide of research in the decades since has elevated Roemer’s Law to health care’s equivalent of a Newtonian
Similar issues arise with Medicaid reimbursement where allegedly low reimbursement rates have resulted in some HCPs refusing to treat Medicaid patients, and insurance companies refusing to enroll sick people in Medicaid programs they administer and withdrawing from Medicaid-sponsored programs. Because of low reimbursement, a significant number of physicians have historically limited the portion of patient treatment funded by Medicaid. A study of the Illinois Medicaid system found that less than half the children on Medicaid received even a single medical screening in the first year after birth consistent with inadequate reimbursement limiting care. Emergency physicians have testified during litigation that their attempts to make discharge referrals to PCPs were met with great difficulty in finding physicians willing to accept Medicaid patients, and one federal judge ruled that children in Cook County, Illinois were unable to secure Medicaid covered care, in part because of low reimbursement rates.

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445 Rubenstein, supra note 368.


448 Rosenberg & Cohen, supra note 369, at 809.

449 Id.

450 Id.
A former CMS administrator has stated that a fundamental problem with Medicare is price fixing in that HCPs are paid the same whether they provide quality care or not, and former HHS Secretary Levitt admitted that the SGR formula used to determine physician compensation is seriously flawed. These perversions caused by incentives lead to a paradoxical situation where educators emphasize the importance of taking a complete patient history and understanding the patient and the social context of the patient’s health problems to medical students, all of which require time—physicians’ scarcest resource—while the reimbursement system emphasizes the number of procedures performed. Moreover, consistent with demand inducement theory, evidence also suggests that increases in the volume and intensity of patient care results in overtreatment. The reason that such overtreatment is possible is directly a function of the absence of price and quality transparency in healthcare and information asymmetry between patients and physicians.

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453 RICHMOND & FEIN, supra note 33, at 97.

454 Yip, supra note 440, at 695 (noting both that there is a spillover effect from Medicare service volume and intensity to the private insurance sector as well and that, taken generally, this evidence raises concerns about the reliability of price regulation in the form of the Medicare Fee Schedule in controlling healthcare costs). The combination of shortages of PCPs and the fact that most of the volume increases stems for the provision of additional services rather that simply accepting more patients as the supply and demand imbalance might indicate suggests that most PCPs are already reached volume capacity.

455 Id.
Turning to the results reported in Appendices A and B from our pooled dataset, we have already noted that physicians are working harder than previously in terms of wRVUs generated per annum. Median compensation appears to be rising faster than compensation per wRVU suggesting that volume of services provided played a significant role in increases in compensation. Although it can be hazardous to draw inferences from only a few data points in a time series, after some substantial increase in the early part of the study period, total wRVUs seem to have stabilized in the latter part possibly suggesting that physicians may have reached their practical volume capacity in terms of numbers of patients. If that supposition is accurate, then any increases in services provided to offset insurance payment-rate cuts in the future will by necessity result from changes in the volume and/or mix of services per patient rather than simply treating more patients. Although there is some fluctuation year to year in Medicare payment per service provided, these rates are reasonably stable. One seemingly plausible reason is that physicians may alter their service mix in an effort to stabilize incomes. Of particular interest is primary care given the alleged looming shortage of PCPs. Examination of the change in compensation as a percentage of medical revenue reveals that PCPs have essentially seen no increase in this ratio (0.16%) compared with other specialties which have enjoyed a 28.45% increase over the study period providing yet another perspective on the PCP compensation issue.

Not only can the quality of care be affected by reimbursement, but the availability of certain types of care can also be affected because some services (e.g., heart-bypass surgery) are reimbursed at much higher rates than others thereby creating a physician demand on hospitals to make capital expenditures that will enable the provision of such services, even if that means
redundant capabilities in some locales.\textsuperscript{456} Medicare and Medicaid cutbacks and managed care fee reductions by private insurers are creating uncertainty about the ability of physicians to invest in health information technology that has the potential to improve care.\textsuperscript{457} Given that medical information technology is said to hold great promise for reducing medical errors and concomitantly reducing healthcare costs,\textsuperscript{458} this outcome seems highly undesirable.

An inherent side effect of prospective payment systems such as Medicare and other third-party payers is that, in the absence of perfect risk adjustment and to the extent that certain observable patient characteristics are associated with higher costs to the physician and not accounted for in the reimbursement formula, HCPs have incentives to avoid patients with those risk factors.\textsuperscript{459} Perhaps one of the biggest impacts of physician reimbursement on the quality and availability of care has been a recent trend of more and more physicians refusing to treat Medicare patients due to allegedly low reimbursement rates.\textsuperscript{460} Despite participation in Medicare being voluntary, most physicians have accepted Medicare patients in the past,\textsuperscript{461} and, to a large extent, many physicians may have little choice to participate given the extent to which

\textsuperscript{456} Wirtz, supra note 286.


\textsuperscript{458} See generally, Hill, Langvardt & Massey, supra note 1, at 235-37.

\textsuperscript{459} Rosenthal, supra note 331, at 1575.

\textsuperscript{460} Milligan, supra note 364, at 9.

their practices rely upon Medicare and/or Medicaid patients.\footnote{See, e.g., Zagreus Ammon, Medicare Reimbursement, Physicians, Hospitals and Your 401K, PHYSICIAN EXEC. (Dec. 6, 2007), available at http://executivephysician.blogspot.com/2007/12/medicare-reimbursement-physicians.html.} However, there is some evidence and ample rhetoric suggesting that, where demand for physician services by non-Medicare/Medicaid patients is sufficient, more physicians are refusing to accept new Medicare and Medicaid patients.\footnote{Id.} Some rural physicians – who often rely heavily on Medicare patients - have allegedly been forced to change the structure of their practices as a result of inadequate Medicare and Medicaid reimbursement.\footnote{Id.} The magnitude of this problem is exacerbated by the existence of private insurance companies which fractionate the pool of potential insured and exclude those persons with preexisting health conditions who arguably need coverage the most and must therefore resort to Medicare and Medicaid.\footnote{RICHMOND & FEIN, supra note 33, at 239.}

Also worsening the Medicare/Medicaid reimbursement picture for physicians is the recent cost-saving decision by CMS to no longer pay for so-called “never events” occurring due to certain types of preventable medical errors which some say penalize HCPs for some unavoidable errors as well.\footnote{Change in Medicare Payment Rules Disturbs Hospital Reps, 25(3) MED. MALPRACTICE L. & STRAT., Dec. 2007, at 5.} Not only does this rule adversely impact physicians’ compensation directly through reduced reimbursement, it may also raise malpractice costs inasmuch as HCPs fear that this new rule provides an advantage for plaintiff’s attorneys because they will now be able to argue that Medicare refused to pay for procedures because CMS deemed a mistake had
occurred. Some fear that this possibility may, in turn, result in HCPs’ attempting to protect themselves from lawsuits by avoiding treating patients if they are more at risk of developing the types of problems for which CMS refuses to pay.

To summarize, it would appear that third-party reimbursement and physician shortages are having an adverse impact on healthcare services, with perhaps the greatest difficulties being in primary care. With medical associations already predicting that the demand for PCPs will outpace demand for other types of physicians, the potential effects of physician shortages on primary care become even more significant in light of the movement that management of chronic illness holds great potential to reduce healthcare cost—the movement toward Medical Homes and other new healthcare delivery models. There is also the possibility that healthcare reform might insure many previously uninsured thereby releasing a pent-up demand for primary care that would swamp existing capacity in locales where there are waiting lists of patients to be seen. Consequently, absent some radical change in two interrelated principal factors that drive physicians’ career choices—compensation and quality of life—physician shortages in some specialties appear to represent a growing threat to the U.S. healthcare system.

467 Id.
468 Id.
469 Cross, supra note 290.
470 See infra text accompanying notes 530-43.
472 See Massachusetts Medical Society, supra note 23, at 3. With the cost of U.S. healthcare so high, more and more patients are resorting to traveling abroad to obtain less expensive medical care, and some insurance companies are beginning to accommodate this practice in an effort to save themselves money. See, e.g., Indiana Insurers
VI. A Smorgasbord of Ongoing and Proposed Healthcare Reforms

The foregoing sections strongly suggest that the U.S. healthcare system is broken from the standpoints of cost, quality, and accessibility, and that its organization is so badly flawed that reasonable people might maintain that we have a non-system when it comes to delivery and

“Medical Tourism as Growing Trend, INSIDE IND. BUS., Nov. 11, 2008, available at http://www.insideindianabusiness.com/newsitem.asp?id=32524 (noting that “WellPoint, Inc. (NYSE:WLP), the nation’s largest health benefits company in terms of medical membership, today announced a new international medical tourism pilot product that will allow members to access benefits for certain common elective procedures at designated facilities in India.”) Some argue that medical tourism represents a growing competitive threat to U.S. healthcare because the number of patients going abroad for treatment exceeds that for patients coming tin to the U.S. JOINT COMMISSION, supra note 255, at 13. Although medical tourism may eventually reduce the demand for some subspecialties and encourage more emerging physicians to select primary care as a career, it holds little promise for reducing the PCP shortage in the immediate future inasmuch as Medical Homes obviously require continuous local access to medical attention, and logically travel costs and possibly greater risks associated with medical procedures performed abroad should impose natural limits on medical tourism. See, e.g., Sarah Freeland, The Risks of medical Tourism – Is It Safe? EZINE ARTICLES (undated), http://ezinearticles.com/?The-Risks-of-Medical-Tourism---Is-It-Safe?&id=372503 (noting that the main medical risks involve travel complications and aftercare with long flights increasing the likelihood of pulmonary embolisms and blood clots). Additionally, the absence of legal systems that permit adequate redress of medical errors in some foreign countries may also discourage medical tourism once the risks become better known. Natalia Casas, Medical Tourism Overview, NEWIMAGE.COM (July 5, 2007), http://www.newimage.com/resource-center/medical-tourism.html (noting that, despite competitive rates, state-of-the-art facilities, and internationally trained medical specialists, “…because U.S. law is rarely enforceable overseas, medical tourism clients often have little or no legal recourse in the event of negligence or malpractice by the physician or institution.”)

473 See supra text accompanying notes 34-145.

474 RICHMOND & FEIN, supra note 33, at 238.
Various initiatives are ongoing or are being proposed in an effort to improve the quality and affordability of healthcare. These include pay-for-performance incentives, a consumerist movement aimed at increasing price and quality transparency, Medicare Advantage, and a shift toward various new models of preventive care. This section discusses the nature of these reforms and assesses the potential efficacy of each.

**Pay-for-Performance**

Pay-for-performance (P4P) programs have been instituted by both Medicare and private insurers in an effort to tailor reimbursement to physician to performance. Medicare spending has heightened Congressional concerns over physician payments, and some experts believing that the current healthcare finance system is contributing to this rapid spending growth by not encouraging physicians to make efficient use of resources. Consequently, Congress authorized experimentation with monetary incentives for physicians to reduce healthcare costs through better care. Such experimentation was stimulated, in part, by the rapid growth in the use of P4P programs by private insurance companies. These companies-initiated P4P programs for

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475 Id. at 231.

476 Medicare Reimbursement to Physicians, supra note 7.


479 Medicare Reimbursement to Physicians, supra note 305.
the purpose of providing incentives for physicians to follow the care of chronically ill patients more closely and help promote patient compliance with treatment regimes.⁴⁸⁰

P4P is a hybrid methodology that combines Medicare FFS payments with a bonus payment that physicians can earn by demonstrating savings in rendering patient care and meeting certain quality-of-care performance targets.⁴⁸¹ The underlying purpose behind P4P is to reduce the tendency for physicians to eliminate or forget certain desirable processes as part of a service by providing positive (and more rarely negative) financial incentives for quality care.⁴⁸² Congress recently once again stepped into this arena with a draft bill that would more closely link Medicare reimbursement to quality of care rather than the current FFS system.⁴⁸³

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⁴⁸¹ GAO, PUB. NO. GAO-08-65, supra note 477, at 2, 9-11. For example, one P4P methodology uses a three-step process as follows. In step 1, CMS determines whether a participating physician group is eligible for a bonus based upon whether the group achieved an annual savings greater than 2% of the target expenditure amount. In step 2, a determination is made of the size of the bonus pool whereby 80% of the savings in step 1 is available as a bonus pool and 20% reverts to Medicare. In step 3, a determination of the actual bonus payment is made whereby 70% of the 80% from step 2 is awarded as a cost-savings bonus and up to 30% of that amount is awarded to those who meet certain quality of care outcome targets.


Despite the hope and hype that have accompanied P4P initiatives and some modest successes notwithstanding, P4P has many shortcomings and seems far from a panacea for the healthcare system’s ills having been dismissed by some as a band-aid on a broken system. At least one study has found that P4P does not improve the quality of healthcare. A possible reason is that the amounts of performance bonuses and penalties in most P4P systems are too small to offset volume incentives. In one P4P program designed to improve diabetes care, only 2 of the 10 participating physician groups were able to meet the criteria for earning a bonus payment through cost savings despite CMS’s efforts to level the playing field, such as the use of comparison groups to adjust for differences in health status of patients, and despite the fact that the physician groups were larger than normal providing them certain size-related advantages. Another criticism is that P4P tends to favor physicians who care for healthier and wealthier patients. Perhaps even more compelling arguments against P4P are that in the demonstration study CMS was unable to provide timely performance feedback to the physicians due to the complexities of the data, and that smaller physician groups, which are the norm, lack the costly

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487 Miller, supra note 482, at 7.


489 Miller, supra note 482, at 7.

490 GAO, PUB. NO. GAO-08-65, supra note 477, at 5-6.

491 Lee, supra note 480.
human and IT resources to handle the reporting/tracking requirements.\textsuperscript{492} In other words, it appears that even if P4P is able to achieve both quality and cost improvement in demonstrations designed under more or less optimal conditions, extrapolating P4P to smaller physician groups seems highly problematic at best and possibly counterproductive if its administrative burden distracts physicians from patient care.

\textbf{Consumerism and Pricing Transparency}

As foreshadowed in Section II, there is substantial evidence that, at least among some segments of the U.S. population, a shift is occurring in the way in which health care consumers view their own and their physicians’ roles in their healthcare.\textsuperscript{493} This shift involves consumers moving from a passive, inactive role in which they are dependent upon physicians to make decisions about their health, to an activist role in which they collaborate about healthcare decisions with physicians acting as coaches rather than decision-makers.\textsuperscript{494} Those who favor free, efficient markets as a solution to the ills of healthcare in general and reimbursement in particular are quick to embrace this movement and argue for market transparency in quality and

\textsuperscript{492} \textit{Id.} at 17, 34. P4P program complexities are evinced by the fact that four different statutory authorities were used to authorize five demonstration P4P programs with somewhat different criteria obviously creating difficulties for already busy physicians to know what is being rewarded and how as well as exacerbating the measurement and monitoring difficulties for CMS.

\textsuperscript{493} \textit{See generally,} Deloitte Center for Health Solutions, \textit{supra} note 107.

\textsuperscript{494} \textit{Id.} at 20.
A number of states such as California, Colorado, Minnesota, New York, and North Carolina have seen initiatives involving healthcare quality ratings. With respect to pricing, is it impossible for markets to function efficiently without information about costs and quality, but such information has been absent in the healthcare market. Unlike other marketplaces, consumers of healthcare have virtually no control over the prices they pay and are not even allowed to avoid what has been termed the “Medicare morass” by funding their own health savings accounts. The healthcare market is more asymmetric than most because buyers possess much less knowledge than sellers, and consequently the market is


Graham, supra note 26.
not fully competitive. Finally, the buyer is often not the patient receiving care but rather the patient’s employer, which obviously reduces the patient’s incentives to make informed cost/benefit decisions about care.

There have been some limited successes resulting from increased consumer transparency in healthcare. For example, providing risk-adjusted data on cardiac-bypass surgery had the salutary effect of spotlighting the worst-performing physicians with the result that some ceased to practice in New York. It would be premature and “unduly optimistic” however to believe that most healthcare consumers will suddenly become skilled purchasers of healthcare and that consumerism and price transparency alone will reform healthcare delivery for several reasons. First, accurate determinations of physician quality represent a challenge because there is intense debate over the accuracy of physician ratings and strong resistance by physicians and some regulators to having physicians’ records made public to include medical malpractice payments. Second, physician rankings have been more concerned over cost savings for

499 Richmond & Fein, supra note 33, at 229.

500 Id.


502 Id.

insurers and employers than over physician quality, and obtaining accurate quality data from patients is difficult because of reluctance to speak about their experiences with physicians. Third, there is some doubt that merely posting prices will be of substantial benefit to many consumers because of disparities in the accuracy of reported prices and the fact that such prices are rarely representative of the total cost of the bundle of services necessary for treatment. Fourth, despite “moderately strong” interest among consumers in using price information to make healthcare decisions, given the complexities of healthcare choice and billing, there is a question of how many consumers will be savvy enough to appropriately use information about healthcare quality and cost inasmuch as they usually seek this information from providers who

http://www.fiercehealthcare.com/story/legal-company-helps-mds-fight-online-defamation/2007-08-30; Senators to Revise Health IT Bill to Ease Doctors' Concerns, iHealthBeat (Nov. 27, 2007),

504 Kalogredis, supra note 503, at 1.

505 Major Problems Remain with Quality Data Collection, FIERCEHEALTHIT (May 13, 2007),

506 Critics Doubt Benefit of Posting Hospital Prices Online, FIERCEHEALTHCARE (Oct. 24, 2007),
themselves often lack this information. Only 17% of consumers view their health insurers as trustworthy sources of information about the best treatments. Less than two thirds of patients trust their physicians in this regard, raising the question of just how consumers will gain an understanding of the excessively complex existing delivery and reimbursement system. Sixth, “[i]ncreased patient activism is not an unalloyed good” in that patients who shop for healthcare may demand inappropriate prescription drugs and treatments. Consequently, although there seems to be a strong role for consumerism and pricing transparency in new models of care delivery and reimbursement, as a silver bullet for healthcare reform their efficacy seems highly doubtful. In the long run, reform needs to go beyond the disclosure of quality and price information and include other reforms and incentives.

**Grafting Medicare to Private Insurance**

Private enterprise aficionados who favor market solutions to the healthcare crisis have been the principal proponents of Medicare Advantage (MA), the latest in a continuing series of programs that graft private plans to Medicare. MA replaced the Medicare+Choice program

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508 See, Deloitte Center for Health Solutions, supra note 107, at 20.

509 DIGITAL CONNECTIONS COUNCIL OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 497, at 39.

510 See, e.g., *From Volume to Value*, supra note 507, at 22.

511 See id., at 41.

512 Gold, supra note 61.
authorized under the Balanced Budget Act of 1997, and over the past few years Congress has increased payments to MA plans to induce more insurers to enter this market. MA plans now serve one fourth of all Medicare beneficiaries and are widely available nationwide. Approximately 22% of the 44 million people enrolled in Medicare receive their health benefits via private insurers.

There is strong indication, however, that MA plans have added cost for little gain in the improvement of care. The higher payments to MA plans mean that such plans have greater flexibility to expand basic Medicare benefits at a cost subsidized by Medicare. Instead of cost savings, such plans are said to offer an average of over $1,100 in additional annual benefits to enrollees above that of traditional Medicare. This has spawned demands that MA reimbursement be brought into line with that of traditional Medicare, and President Obama has declared that “excessive subsidies” to MA insurance companies need to be eliminated. For every dollar private insurance companies receive under MA plans, they pay only 87 cents out in medical care.

513 Id.
515 Id.
517 Id. See also, Steve Davis, Former CMS Head: 2009 will be an “Ugly Year” for Medicare, AIS HEALTH BUS. DAILY, Oct. 14, 2008, available at http://www.aishealth.com/Bnow/hbd101408.html (“. . . MA insurers haven’t yet demonstrated that they can improve the health of enrollees . . . .” (quoting former Health Care Financing Administration administrator, Gail Wilensky)).
518 Gold, supra note 61.
519 Id.
as opposed to 97 cents for traditional Medicare; and much of the recent debate over the most recent Medicare bill enacted on July 15, 2008 concerned payments to private insurance companies offering MA plans.\textsuperscript{520} Moreover, pharmacy benefit managers are also said to be overcharging consumers for drugs under Part D of Medicare,\textsuperscript{521} and, as a result, in what has been described as an unprecedented, move CMS is pressing for more information about MA plans.\textsuperscript{522}

Despite these seemingly high subsidies, insurance companies - which unlike the federal government, have marketing costs and have to return cost of capital to their shareholders - are placing a dicey, long-term bet that the federal government will be a good business partner over time by offering rates that are sufficiently high and stable.\textsuperscript{523} In the past, the Bush Administration opposed cuts to MA, but, fueled in part by some senior citizen lobbies, pressure is building in Congress to reduce MA subsidies.\textsuperscript{524} Some argue that the glory days of MA are over and insurers can expect lower payment increases, new operational requirements and more accountability.\textsuperscript{525} To make matters worse, MA policy sales are said to likely be slow in 2009

\begin{footnotesize}
\begin{enumerate}
\item Medicare Reimbursement Rates 2008 Update 1, \textit{supra} note 345.
\item Id.
\item Marsha Gold, \textit{supra} note 61.
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\end{footnotesize}
due to recent CMS attempts to reduce allegedly excessive commissions, \(^{526}\) and a former CMS administrator has predicted that 2009 will be a “big ugly year” for MA plans. \(^{527}\) The unlikelihood that MA will save money in the short run, the fact that the United States already experiencing the highest healthcare administrative cost percentage in the world, while over one third of the population goes without some form of care because of cost, \(^{528}\) and the uncertainty about long-term payoffs, all call into question the future of MA plans as a serious healthcare-cost-reducing mechanism. \(^{529}\)

**New Delivery Models Focused on Preventive Care and Chronic Care Management**

Some medical policy experts hold that healthcare costs might be greatly reduced by placing more emphasis on preventive care and proactive treatment of chronic disease, as opposed to reactive treatment of acute illnesses. \(^{530}\) One of the more promising recent developments in healthcare reform has been the proposed Medical Home, Chronic Care, and Ideal Medical

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\(^{527}\) Davis, *supra* note 517 (quoting former CMAS Administrator, Tom Scully).

\(^{528}\) Medicare Reimbursement Rates 2008 Update 1, *supra* note 345.

\(^{529}\) Gold, *supra* note 61.

\(^{530}\) Miller, *supra* note 482, at 24-28; *From Volume to Value*, *supra* note 507, at 6.
Practice Models that emphasize preventive care and chronic disease containment. The basic concept behind the Medical Home Model is that each patient would enjoy an ongoing relationship with a team of healthcare professionals that would collectively assume responsibility for providing, arranging, and coordinating all healthcare needs across all elements of the healthcare system to enhance quality, safety, and access. The fundamental benefits motivating Medical Homes are that (a) it is both more efficient and cost effective to prevent debilitating diseases that to treat them once they manifest, and (b) the best way to do this is proactive health management provided by PCPs aided by “mid-level” physician’s assistants and nurse practitioners who become the focal point of care for a given patient. Inasmuch as evidence suggests that a great deal of the cost associated with chronic illness might be prevented through proactive versus reactive care, Medical Homes have great appeal conceptually from both cost and quality perspectives. Further, there is evidence that patients give the highest grades to healthcare systems in which there is one physician in charge of their care.

The Chronic Care Model is somewhat similar to the Medical Home Model but focuses on patients who have chronic diseases and has six key components: (1) mobilization of community

531 Miller, supra note 482, at 25-27.
532 Id., at 25
533 See, e.g., From Volume to Value, supra note 507, at 13; WIS. HOSP. ASS’N & WIS. MED. SOC’Y, supra note 381, at 16 (noting that certain barriers need to be overcome with respect to mid-levels to include the need to change state licensure in some cases).
534 RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 12, 21.
535 Steven Reinberg, Many Americans Dissatisfied with Their Medical Care, HEALTHDAY (Nov. 2, 2007), http://www.healthcentral.com/caregiver/news-193096-31.html
resources to meet patient needs, (2) the creation of a culture, organizational structure and processes that deliver high-quality care, (3) educating and empowering patients to assist in their healthcare management, (4) efficient and effective delivery system design, (5) use of evidence-based medicine, and (6) use of information systems and technology to promote efficiency and effectiveness of care. The primary differences from the Medical Home Model are a stronger emphasis on self-management of chronic diseases and linkages to community resources outside a physician’s practice. There is substantial evidence gathered from more than 39 studies that the Chronic Care Model produces both quality and cost-effectiveness.

The Ideal Medical Practice Model has goals somewhat similar to the Medical Home and Chronic Care Models but places even more emphasis on collaborative interaction between patient and physician. It has the following key elements: (1) focus on patient interactions, (2) design of office operations for patient convenience, efficiency and physician continuity, (3) minimization of factors that inhibit patient interaction, (4) measurement of patient outcome, and (5) real-time patient self-reporting.

Although many healthcare professionals argue that the only way to reduce the demand for acute care is to emphasize preventative medicine, chronic care management, and healthy lifestyles, not all agree that this emphasis alone will fix the healthcare cost problem because it will likely lead to more screening and tests resulting in more false positives and more patient

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536 Miller, supra note 482, at 26-7.
537 Id. (noting that a HCP could be viewed as meeting the criteria for a Medical Home but not meeting that of the Chronic Care model).
538 Medicare Reimbursement to Physicians, supra, note 7.
539 Id. at 27.
encounters. There are also questions about the current quality of primary care in non-institutional settings as evinced by a recent study that found some parents resorting to emergency departments for child treatment out of concerns about the care and attention received at PCPs’ offices. Further, the problem of the concept’s dependency on PCPs when PCPs are already in short supply in some locales is obvious and discussed in more detail the next section. Despite

540 See, e.g., Rubenstein, supra note 336, physician blog comments.


542 Casual examination of the medical home concept reveals some similarities to the recent movement toward in-house clinics offered by some employers for their employees. We see little necessary differences assuming the in-house clinics function with the aforementioned characteristics of medical homes. See, RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 26. There has also been a recent trend toward retail health clinics offered by pharmacy and retail chains. See, e.g., Regina E. Herzlinger, Who Killed U.S. Medicine? WASH. POST, July 25, 2007, available at http://www.washingtonpost.com/wp-dyn/content/article/2007/07/24/AR2007072401850.html. Although it would appear that these clinics may offer greater convenience and lower-cost care and therefore be particularly attractive to lower-income, uninsured or under-insured patients with who frequent hospital emergency departments – therefore taking some pressure off overcrowded emergency departments as well as some PCPs, the clinics are set up to treat only minor illnesses and will likely to fall short in most cases of being a medical home as envisioned in this subsection. Health Plans Continue to Eye Retail Clinics to Build Market Share and Reduce Costs of Care, AIS’S HEALTH BUS. DAILY (Sept. 15, 2008), http://www.aishealth.com/Bnow/hbd091508.html. Most retail clinic patients do not have a PCP. See, e.g., Jacob Goldstein, Which Patients Are Going to Retail Clinics? WALL ST. J., Sept. 11, 2008, available at http://blogs.wsj.com/health/2008/09/11/which-patients-are-going-to-retail-clinics/. Consequently, despite the potential for retail clinics to deliver some appreciable reduction in healthcare costs and improve some aspects of care for an under-served segment of the population, we do not regard the movement to have the potential for wholesale reform of healthcare delivery. See, e.g., Bruce Jaspen, Retail Clinic Users Lack Personal Doctors, CHI. TRIB., Sept. 25, 2008, available at http://www.chicagotribune.com/business/chi-thu-notebook-0925-sep25,0,2566351.story.
these concerns, it seems apparent that quality problems and extreme budget pressures will
necessitate bold changes in healthcare delivery and reimbursement to counter perverse incentives
that encourage accelerating patient throughput at the expense of quality in order for physicians to
maintain their compensation levels.\textsuperscript{543}

\textbf{VII. Likely Future Directions for Healthcare Delivery and Reimbursement Reform}

This section presents a holistic approach to redesigning both the healthcare delivery and
reimbursement systems to reduce costs and improve care and accessibility.\textsuperscript{544} Because the extant
system is not oriented toward early detection and prevention of disease and management of
chronic disease to prevent its becoming acute,\textsuperscript{545} we argue that the best hope for redesigning the

\textsuperscript{543} See, e.g., \textit{JOINT COMMISSION, supra} note 255, at 10-12. One proposed major change to healthcare that is
sometimes labeled a reform is the movement toward the use of various information systems technologies such as
electronic medical records and computerized decision support systems up to and including a national health
information network (NHIN) to connect all providers. Although we have written that a NHIN has the potential to
greatly improve healthcare quality and reduce its costs (\textit{see generally}, Hill, Langvardt & Massey, supra note 1), we
concur with the Research and Policy Committee of the CED that better health information systems “…would not
solve the fundamental, systemic weakness in health-care delivery” and “…merely superimposing a veneer of IT on
top of the current mal-constructed health-care system will not solve the underlying problems.” See \textit{RESEARCH AND
POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra} note 302, at 3, 29. Therefore, we
believe that a NHIN is not a distinct healthcare delivery reform but rather an important complement to reform
despite the need for medicine to treat information technology as a core competence that links HCPs rather than a
intra-office tool. \textit{See RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra}
note 302, at 38.

\textsuperscript{544} See, e.g., \textit{RICHMOND & FEIN, supra} note 33, at 230 (noting the tendency to deal with healthcare reform issues in a
piecemeal manner instead of holistically).

\textsuperscript{545} \textit{RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra} note 302, at 2.
healthcare delivery system to simultaneously reduce costs and improve quality is to focus more on preventative medicine and chronic disease management in a patient-centric manner. We then argue that the reimbursement system must itself be redesigned to align itself with this change in delivery.\(^{546}\) This section deals with the movement toward a new model of healthcare and the need for a bundled, case-rate reimbursement system to complement this movement. The following section, in turn, discusses how these changes will necessitate a shift in the focus of medical malpractice litigation thereby presenting new challenges for the courts and proposes changes in the current system for processing medical malpractice claims.

**SCM Approach to Preventive Healthcare Delivery that Reduces Costs and Improves Outcomes**

Any new delivery model should enhance the value of healthcare by producing improved care outcomes, providing greater patient and physician satisfaction, and reducing total healthcare costs.\(^{547}\) We believe that U.S. healthcare could benefit greatly from embracing the concepts underlying strategic cost management (SCM) paradigm borrowed from business practice.\(^{548}\) SCM theory holds that costs and cost management become most meaningful in the context of the particular strategy being followed and different strategies call for different priorities in measurement systems\(^{549}\) - a matter of particular importance in healthcare inasmuch as “30-40%...”\(^{549}\) Spann, *infra* note 556, at S19.

\(^{546}\) Spann, *infra* note 556, at S19.

\(^{547}\) See, *id.*

\(^{548}\) See *id.*, at 4 (noting “Our goals should be adaptive delivery systems that move toward the attributes of the modern firm in virtually every other industry...”).

\(^{549}\) See generally, John K. Shank & Vijay Govindarajan, *Strategic Cost Management: The New Tool for Competitive Advantage* 91-3 (1993); and John K. Shank, *Cases in Cost Management: A Strategic Emphasis* 133-36 (2006). Value-chain analysis refers to the entire set of linked activities from beginning to end of a particular process. In the context of disease management this would mean the risk identification, prevention,
of treatment cost is the cost of not having gotten it right the first time.” 550 By using basic SCM tools such as value chain analysis, activity-based management, strategic positioning analysis, economic value to the customer, and life-cycle costing to redesign healthcare delivery and reimbursement, it is possible to unlock strategic costs that are now locked in by the current systems’ design. 551

We propose that the set of value-creating, linked activities in healthcare should run along the lines of risk identification, chronic illness prevention, management of chronic illness when necessary, treatment of acute illness when necessary, outcome measurement, and system

treatment, and outcome measurement process. Each value activity in the chain has a set of unique cost drivers. For example, a risk-identification cost driver would be a cost of updating patient data. Cost containment is a function of regulating the cost drivers for each link in the chain through activity-based management - by identifying and controlling these cost drivers or by reconfiguring the value chain to reduce driver activity. For example, patient data might be updated electronically using patient inputs thereby reducing costs to HCPs. Strategic-positioning analysis identifies the most appropriate strategy for economic success. For example, more frequent heart monitoring might be provided at lower cost through remote electronic systems from home rather than in the physician’s office. Life-cycle costing would mean focuses on the cost of services over the life of a disease rather than the cost of any single service with the goal of obtaining the lower cost for the entire stream of services. Economic-value-to-the-customer uses life cycle costing to measure the value of services to healthcare consumers. In a healthcare framework, the economic-value-to-the-customer is equal to the sum of the initial costs of the services plus future costs beyond the initial service plus any incremental benefit above and beyond the life cycle cost of the services compared to that of a “reference” provider. In other words, a HCP could add more value than a reference provider by offering the same life-cycle services at a lower cost than a reference provider, more benefits at the same cost, or more benefits at a lower cost.


551 Id. at 13-22.
performance feedback with self-correcting adjustments. In the healthcare value chain, the primary focus is currently on treating illness, and, given the failure of the system from a value perspective, this must change in two ways. This first is moving toward a systems-based process, and the second is strategically rebalancing the focus appropriately across all value-creating activities with more emphasis upon preventive care, chronic care management, outcome measurement, and feedback adjustment. Because it is estimated that patients with chronic conditions account for 83% of all healthcare costs and 62% of healthcare spending was on behalf of patients with two or more chronic conditions, identification and prevention of such conditions - together with improved treatment of patients with chronic conditions to prevent them from becoming acute holds the best hope of material reductions in healthcare costs.

Based on the aforementioned evidence, a preventive model of healthcare utilizing concepts from the Medical Home, Chronic Care, and Ideal Practice Models offers the best hope for

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553 Most errors are multi-factorial and frequently involve both cognitive/knowledge and system/process failures. Consequently, a value-chain approach would facilitate stage mapping to identify and localize where errors occur. Tightening linkages might involve such changes as simplifying and standardizing procedures, reducing the number of patient handoffs from one provider to another, building in appropriate redundancies to minimize errors, and improving access to information across links in the value chain. See Gordon Schiff, Understanding Diagnostic Errors, presentation at Harvard Seminar Nov. 2008 (notes on file with authors).


reforming the care delivery process to effect real cost savings. Our analysis of the characteristics of each of these models for improving primary care suggests that, although each may have a different emphasis, there is little, if any, appreciable incompatibility among them. All three could therefore be adopted in combination by the same healthcare entity. Indeed, the American Association of Family Practitioners has proposed a "New Model" of care based on the following characteristics: personal Medical Home, patient-centered care, team approach to care, elimination of barriers to access, advanced information systems including electronic health records (EHRs), redesigned offices for greater functionality, whole-person orientation, care provided in a community context, a focus on quality and safety, enhanced practice finance, and a defined basket of services. Examination of these characteristics reveals a number of commonalities across the Medical Home, Chronic Care, and Ideal Medical Practice Models embodying elements of each. Rebalancing the linked set of value creating activities with more focus on risk identification based upon evidence-based medicine and preventive care means


557 Although the preventive care entity proposed herein may seem similar to HMOs which, as previously discussed, appear to be on the decline, there are important differences. HMOs mostly evolved into “…insurance companies marketing the services of independent, solo-practice fee-for-service doctors under a comprehensive-care contract characteristic of HMOs, without reorganizing the fragmented, uncoordinated delivery systems.” Also, many employers, in effect, coerced employers into HMO plans that gave them little or no choice of physicians thereby creating a backlash. RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 23.

558 See, e.g., id. at 30 (noting “Evidence-based Medicine (EBM) is an attempt to synthesize the scientific literature and detailed health records to determine which treatments work under which circumstances and to steer the practice of medicine toward those treatments.”); COMMITTEE ON QUALITY HEALTH CARE IN AMERICA, CROSSING THE
less emphasis on illness treatment - and, as we shall see, substantially less cost because, as noted above, the greatest gains are to be made from preventing chronic illness rather than treating it after it becomes acute. 559 Supporting this concept is evidence that more reliance on PCPs results in lower costs and healthier outcomes. 560

The first link in the healthcare value chain involves better identification of the risks of a particular patient contracting a chronic illness through evidence-based medicine. 561 Under the New Model, patients' family medical histories, genomic structures, and past and current health conditions would be continuously monitored and compared with national, large-sample data for early identification of risks and corresponding preventive treatment. 562 The second and third

559 See, Leape presentation, supra note 555.

560 Id. at S18 (noting that outcomes were measured based upon 24 quality measures developed by the Medicare Quality Improvement Organization). See also, Leape presentation, supra note 555 (noting that overuse of healthcare contributes approximately 20% to its cost).

561 Decision-support tools using evidence from research and practice can serve as systems-level interventions, increasing the total expertise available and allowing medical generalists to function as experts. See Eta S. Berner & Mark L. Graber, Overconfidence as a Cause of Diagnostic Error in Medicine, 121 AM. J. MED. S2, S12 (2008).

562 Genomics holds the possibility for diagnosing people at risk to develop certain types of diseases and to develop specific treatments targeted directly at those diseases, but enabling legislation may be needed to facilitate the creation of generic substitutes by entry companies once patents have expired. “Effective use of these resources will require systematic approaches, including evaluation of those who should be tested, and what prevention strategies and therapies they should be offered.” RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 39.
links involve acting upon identified risks by illness prevention followed by management of chronic illness if prevention fails. The fifth link involves measuring patient outcome to facilitate creation of a large-sample evidentiary database which can be used by medical researchers and clinicians to study the efficacy of care regimes. The sixth and final link involves a cybernetic feedback loop in which the entire healthcare delivery process is continuously improved by identifying and incorporating best practices with the goal of lowering the patient's total life-cycle healthcare costs by incurring more cost up front but less cost over a patient’s lifespan.

Within the SCM framework, identification and control of cost-driver activities inside each segment of the value chain also has the potential to generate a substantial benefit in terms of reduced costs and improved quality because there are currently “remarkably wide variations in physician practice patterns, indicating that most doctors do not have a very well-informed idea of the best practice.” Through the use of root-cause and failure mode/effects analysis tools such as cause and effect diagrams and flow charts, the activities that comprise healthcare processes at the clinical level would be identified and streamlined. For example, in operating rooms emphasis would be placed on measuring and controlling such metrics as start-time efficiency, intra-operative pathways, staff turnover, cost of new hires, and supplies usage.

563 See generally, SHANK & GOVINDARAJAN, supra note 549, at 151-67 (discussing the potential for cost-driver analysis and activity-based management to reduce costs.

564 RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 27.


The new care delivery system should also focus on economic value for the consumer which contemplates patient centricity as opposed to the current system of provider centricity.\textsuperscript{567} Instead of healthcare revolving around meetings between physicians and ill patients wherein the patients listen to instructions, under the New Model consumers would be encouraged “to take greater responsibility for their own health and to make choices that reduce the likelihood of illness.”\textsuperscript{568} Moreover, under a patient-centric model, patients can assist in preventing medical errors if they are able to identify potential problems, communicate the problems to physicians, and behave

\textsuperscript{567} See Conway, supra note 550 (noting the need to build the healthcare system around patients).

\textsuperscript{568} DIGITAL CONNECTIONS COUNCIL OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 497, at 37.

Not only can patient-centric care reduce medical errors, evidence suggests that it may also play important role in reducing malpractice lawsuits inasmuch as some maintain that two thirds of medical malpractice lawsuits may be avoided through better patient/physician communication. Moorman, supra note 566. There is an aspect of the patient communication problem that involves whether and how medical errors should be communicated to patients, a rather controversial topic that is receiving a fair amount of attention in medical circles with an acknowledged gap between patients and physicians perspectives and, correspondingly, between clinical practice and what some patient-centric-care visionaries believe should happen. Physicians see the issue as one of informed consent - that is whether the patient will actually use the information. Patients see disclosure as a matter of respect. Questions abound in the debate such as whether to characterize errors as errors or “unanticipated outcomes,” how much to disclose about errors, whether nurses should be involved in the disclosure, and whether disclosure helps head off lawsuits or encourages them. Thirty five states have adopted some type of protection for medical error apologies and two states (Oregon and Pennsylvania) require disclosure of medical errors. Only four states, however, protect the entire disclosure with most not protecting “what happened” disclosure. Twenty five states protect expression of remorse only, and six protect the expression of remorse plus an explanation only - reflecting that, in general, most state laws do not view apology and disclosure as an integrated process. Thomas Gallagher, Apology and Disclosure Workshop, presentation at Harvard Seminar Nov. 2008 (notes on file with authors).
themselves in a safe manner.\textsuperscript{569} Logic suggests that better care, fewer medical errors, and shared decisions between physicians and patients is likely to lead to less malpractice litigation inasmuch as there will be less cause for litigation and patients will feel more a sense of responsibility when unfavorable outcomes occur.

Current shortages of PCPs create a chicken/egg conundrum in that more PCPs are needed under the New Model, but, until the model is in place, too few medical students may be attracted to primary care. This difficulty might be resolved in two ways. First, the use of more mid-levels\textsuperscript{570} to treat minor illnesses and screen patients would have the effect of reducing the demand for PCPs and also reduce costs. Second, personal financial incentives might be used appropriately to make adjustments to effect a rational distribution of physicians in the nearer term, particularly in the short run until shortages in certain specialties have been rectified. Given that federal regulation and reimbursement have likely contributed to local shortages of PCPs, it seems appropriate, we believe, that federal intervention should help rectify the problem in the near term. For example, expanded loan forgiveness programs along the lines of the provision inserted into legislation reauthorizing federal student loan programs in March 2008 to help

\textsuperscript{569} Weingart, \textit{supra} note 552. One survey reports that 52\% of primary care patients bring information obtained via the internet to meetings with PCPs. \textsc{Digital Connections Council of the Committee for Economic Development}, \textit{supra} note 497, at 39.

\textsuperscript{570} See, \textit{e.g.}, \textit{From Volume to Value}, \textit{supra} note 507, at 13; \textsc{Wis. Hosp. Ass’n & Wis. Med. Soc’y}, \textit{supra} note 381, at 16; \textit{and} Leape presentation, \textit{supra} note 555.
medical students pay for their educations, might be used to encourage more students to select primary care as a field.\textsuperscript{571}

Current third-party payer systems create incentives for patients to over consume healthcare services because someone else is paying the immediate bill for an episode of care.\textsuperscript{572} The New Model should contain financial incentives for patients to adhere to treatment plans and engage in healthier lifestyles, and disincentives to free ride by simply passing the cost of poor lifestyle decisions on to other consumers and taxpayers.\textsuperscript{573} This might take the form of higher co-payment for patients who engage in such habits as smoking, diets that lead to obesity, and refusal to exercise. Further, consumers should have choices about which HCPs to use, but should be required to incur some financial cost such as paying the excess of cost over the cost of high-value providers if they choose lower-value providers.\textsuperscript{574} Although “drawing the line between ‘necessary care’ and ‘consumer-preference care’ can be difficult,”\textsuperscript{575} making the consumer explicitly responsible to the last dollar of healthcare cost instead of just the first dollar as is the case with current co-payment methodology would provide incentives for consumers to make high-value choices in their selection of physicians.\textsuperscript{576}

\textsuperscript{571} See, e.g., Dave Hansen, \textit{House Passes Partial Forgiveness for Medical Student Loans}, AMEDNEWS.COM (Mar. 10, 2008), http://www.ama-assn.org/amednews/2008/03/10/gvsc0310.htm; and Weingart presentation, \textit{supra} note 552 (floor comment).

\textsuperscript{572} See Shank, \textit{supra} note 549, at 133-36, for a discussion of economic value to the customer. \textit{See also} Conway, \textit{supra} note 550.

\textsuperscript{573} See \textit{From Volume to Value}, \textit{supra} note 507, at 19.

\textsuperscript{574} Id., at 19.

\textsuperscript{575} \textit{Research and Policy Committee of the Committee for Economic Development}, \textit{supra} note 302, at 53.

\textsuperscript{576} Id., at 20-21. \textit{See also}, \textit{Research and Policy Committee of the Committee for Economic Development}, \textit{supra} note 302, at 2 (noting that under current reimbursement systems “In any given year, well over 80% of health
Broadening our discussion of value, SCM theory and strategic-positioning-analysis suggest HCPs can potentially improve outcomes in one of the following ways: (1) providing superior care at a cost equal to or less than that of other HCPs, (2) providing equal care at a lower cost than other HCPs, or (3) by providing equal care at equal cost compared to other HCPs but with a lower investment in delivery assets. Strategic positioning of this type requires measures of quality delivered for cost, however, which is impossible under the current reimbursement system that involves separate payments for each service provider after the fact – making it impossible to budget to plan or allocate resources in the most rational manner. Consequently, with the implementation of a radically new healthcare delivery system comes the need for improved quality metrics to measure the value associated with improved care and patient outcomes - in a very real sense, metrics that indicate which HCPs are providing the greatest value. Value in this context not only means providing the best care for patients but doing so in a reasonably economical manner, a cost/benefit analysis analogous embraced by SCM.

expenditure dollars will be spent on people who have exceeded their deductibles or can safely expect to do so, for any level of deductible that is reasonable.’’

577 See SHANK & GOVINDARAJAN, supra note 549, at 17-18.

578 See, RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 36.

579 See DIGITAL CONNECTIONS COUNCIL OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, HARNESSING OPENNESS TO TRANSFORM AMERICAN HEALTH CARE, at 40 (noting that it is impossible for markets to function efficiently without value information, information that neither patients nor most physicians currently possess).

580 See Miller, supra note 482, at 44.
Currently, causal relationships among quality and cost in healthcare are not widely understood by consumers, and consumers often believe that lower cost means lower quality. If consumers are to be expected to choose physicians based upon them being high-value HCPs, then it is important for value to be defined in terms of what consumers believe is valuable – a critical tenet of the SCM tool of economic value to the consumer. Accurate measurement of healthcare quality is essential for the success of a reformed delivery and reimbursement system because “[a] system cannot be designed and operated effectively unless the quality of the product or service can be understood or correctly measured.” Currently healthcare consumers have difficulty in assessing the quality of services received. Despite the fact that excellent healthcare quality measures have proved elusive, there is therefore a definite need for a national methodology for reporting quality. New initiatives to develop sound quality measures that appropriately value healthcare services are being developed and hold promise of

581 Id., at 3.
582 From Volume to Value, supra note 507, at 37.
584 Id., at 234.
585 Id., (noting that “Service quality is an exclusive and abstract concept because of its ‘intangibility’ as well as its ‘inseparability of production and consumption’” quoting Parasuraman, et al., A Conceptual Model of Service Quality and Its Implications for Future Research, 49 J. MARKETING (FALL 1985), 41-50.
586 FROM VOLUME TO VALUE, supra note 507, at 4. The need to improve quality reporting is exemplified by one study 13 adverse events occurred in every 100 patient cases and none of these events were reported in HCPs’ incident-reporting systems, and only 75% even appeared in patients’ medical records. Weingart presentation, supra note 552.
vast improvement over past attempts.\textsuperscript{587} Although we have previously maintained that
transparency in and of itself is not the panacea for runaway healthcare cost, there is a strong role
for transparency in the New Model for helping consumers select HCPs who deliver the highest
value for the cost.\textsuperscript{588}

Assuming the emergence of some delivery system focused on the New Model, what would
be the financial impact? Shifting to such a model has been estimated to offer and annual cost
savings of 5.6\% savings over current health expenditures.\textsuperscript{589} Given the approximately $2 trillion

\textsuperscript{587} There are many facets of healthcare quality, and there is a need to measure performance on many measures, and
the right number is probably in the hundreds. The benefits, however, are exemplified by the remarkable success of
simple checklists in the rates of medical errors (e.g., major reduction in reducing central-line infections rates).
Weingart presentation, \textit{supra} note 552. Developing a system of such measures will not be easy for several reasons.
First, consumers may have difficulty in understanding many of the measures. Hanjoon Lee et al., \textit{supra} note 583, at
234. Second, data that underlies the measures may be contentious and subject to gaming, and, third, such
information will require an enormous amount of collaboration over a long period using an electronic data collection
infrastructure. Dale V. Shaller, \textit{A National Action Plan to Meet Health Care Quality Information Needs in the Age
of Managed Care}, 279(16) J. AM. MED. ASS’N., Apr. 22, 1998, \textit{available at} http://jama.ama-
assn.org/cgi/content/full/279/16/1254. Measure standardization falls under the auspices of the National Quality
Forum which uses a formal development process and consensus-based protocols for collecting data to reduce
variation in results. \textit{JOINT COMMISSION}, \textit{supra} note 255, at 15.

\textsuperscript{588} \textit{From Volume to Value}, \textit{supra} note 507, at 18. There is preliminary evidence that transparency reduces
physicians legal problems, but this has not been well established. \textit{See}, Kim, \textit{supra} note 565.

\textsuperscript{589} \textit{Id.} It should be noted that a SCM approach would add value by reducing medical errors in addition to reducing
costs. Three main strategies for reducing medical errors using a systems approach that embodies process
reengineering such as that embraced by SCM are prevention of errors, making error visible, and mitigating the
effects of error. \textit{See} Berner & Graber, \textit{supra} note 561, S8.
spent on healthcare in the United States annually, this holds promise of annual savings of over $100 billion each year. In addition to this macro cost savings, there are other financial and non-financial benefits promised by the New Model. Two of these are greater PCP income and career satisfaction, important benefits given that almost half of the PCPs in one survey indicate that they are dissatisfied with their careers. Coincident with providing more value for patients, PCP incomes are projected to increase by 26% under the New Model which, along with increased satisfaction with their practices, should, over time, help rectify any PCP shortage. Admittedly, this shift toward cognitive medicine means that increases in PCP incomes will likely come at the expense of decreasing those of some types of specialists who are heavily focused on procedural medicine, but a successful reimbursement system would be one that “... reduce[s] costs by deploying physicians in the numbers and types needed.” Also, given the previously noted substantial disparities in relative incomes of PCPs compared to many other specialties,


591 Massachusetts Medical Society, supra note 23, at 22.

592 Spann, supra note 556, at S1.

593 Perversions caused by reimbursement can lead to wholesale misallocation of health resources in some cases. “For example, Medicare has created a boom in cardiology procedures by overpaying and making them more profitable than other kinds of care, which in turn is leading to a boom in heart hospitals that Congress is now seeking to curb.” Research and Policy Committee of the Committee for Economic Development, supra note 302, at 28.

594 Research and Policy Committee of the Committee for Economic Development, supra note 302, at 36.

595 See Spann, supra note 556, at S3 for a discussion of the benefits of the New Model to include PCP income effects.
some adjustment seems both appropriate and necessary as a precondition for New Model implementation. Moreover, there appears to be widespread agreement that PCPs should receive better compensation under a new healthcare model.596

In summary, the New Model - focused on risk identification, disease prevention, better management of chronic care, outcome measures, and a cybernetic loop for continuous systems improvement holds - the best hope for large-scale healthcare improvement and cost reduction. Quality and cost transparency is integral to the effectiveness of such incentives because consumers must be aware of the consequences of their decisions, and consumer education about value-driven care will be required.597 Such transparency can be partially achieved through the recommendations for a new reimbursement system discussed in the following subsection.

The Need for a New Reimbursement System that Emphasizes Value, Not Volume

The New Model necessitates a complementary new reimbursement system,598 a necessity supported by SCM theory which holds that measurement systems should be designed to support the purposes underlying the goals of the processes they measure.599 As noted by the American Association of Family Practitioners, “[t]he urgency to transform the design, delivery, and financing of healthcare converges well with interest in more broadly implementing a model of chronic care that demonstrated improved quality and cost-effectiveness.”600 A major cause of quality and cost problems in U.S. healthcare is that of reimbursement systems which encourage

596 See, e.g., From Volume to Value, supra note 507, at 32.
597 Id., at 22.
598 Spann, supra note 556, at S19.
599 SHANK & GOVINDARAJAN, supra note 549, at 8.
600 Medicare Reimbursement to Physicians, supra note 7.
volume of service over value-driven healthcare. Irrespective of differing ideological positions regarding private versus public health, the evidence strongly suggests that the federal government is de facto increasingly driving physician reimbursement in dysfunctional ways as previously noted. The healthcare reimbursement system, influenced increasingly by Medicare, has placed physicians in a difficult position whereby reductions in physician reimbursement due to the current zero-sum approach can only be restored by increasing the volume of services provided to the physician’s extant patient base. Unsurprisingly, many physicians have learned to game the reimbursement system to the extent possible. As far back as 1996, critics of the current reimbursement system argued that Medicare was not just sick, its condition was fatal and radical surgery was required. In 2008, Medicare began paying out more than it takes in and, to a significant extent, is in deep financial trouble because of its payment model. Just as concerning as cost is the problem that existing reimbursement systems frequently penalize

601 From Volume to Value, supra note 507, at 1.
603 Graham, supra note 26.
604 Brief Analysis No. 208, The Medicare Program: The Need for Radical Surgery, National Center for Policy Analysis (July 3, 1996), http://www.ncpa.org/ba/ba208.html. “Conflicts of interest – the quintessential misalignment of the interests of patients and providers – are widespread in treatment and procurement decisions in medicine” RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 35 (noting that U.S medicine is a “fragmented non-system” with care settings resembling “separate silos” in which physicians are mostly “free agents” with interests that conflict with each other and hospitals, and an important part of any incentives alignment must be minimization of such conflicts).
605 Graham, supra note 26.
physicians for providing higher quality services because they lose revenues when the keep patients healthy and avoid unnecessary care. 606

Medicare reimbursement to physicians – and also that of private insurers which largely follow Medicare’s lead – is based upon cost-plus pricing. 607 As one commentator has stated, “[f]or policy makers seeking to realign the price signals sent to physicians to ensure that the nation’s medical needs are met, the primary policy lever is Medicare and Medicaid payments rates.” 608 Research indicates that providing more services per patient in an attempt to restore income following cuts in Medicare payment rates does not improve outcomes and, in fact, often results in poorer outcomes. 609 This observation points to a need for changing Medicare regulations for developing reimbursement rates to better reflect current costs of providing care

606  Miller, supra note 482, at 1.
607  Tenreiro, supra note 335.
608  Tu & Ginsburg, supra note 287.
609  From Volume to Value, supra note 507, at 1. To better understand the causes of healthcare inflation it is instructive to examine the following equation that expresses the variables contributing to the cost of care per patient:

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\text{Cost/patient} = (\#\text{conditions per patient}) \times (\#\text{episodes of care per condition}) \times (\# \text{of a given type of service per episodes of care}) \times (\#\text{processes per service}) \times (\text{cost per process})
\]

The situation described by this equation has been analogized to a balloon whereby, for example, squeezing the balloon to control costs of individual processes or services alone causes the costs to “pop out” elsewhere such as in the number of services provided. If an attempt is made to control the number of services within a particular episode of care, the result may be more episodes of care. Under the FFS system physicians are paid a fixed fee for each service provided with few, if any, limits on the numbers of services. Under such a system the physician is at reimbursement risk for the number and cost of processes covered by a separate fee but little else. Such a system rewards volume, does not penalize poor quality, and focuses on short-term as opposed to long-term outcomes. See Miller, supra note 482, at 6.
and to adjust the numbers of physicians in specific specialties to better meet the nation’s needs.\textsuperscript{610} In particular, PCPs cannot make the changes in primary care delivery contemplated in the shift to the New Model discussed in the previous subsection without improved payment systems to support this model.\textsuperscript{611}

In an explicit acknowledgment of the need for reimbursement change the RUC recently voted to increase the value of cognitive services relative to that of procedures, and in March 2006, the Medicare Payment Advisory Commission recommended that HHS establish a panel of experts to study the relative values of medical services.\textsuperscript{612} However, given the magnitude of the problems with the healthcare system and highly political process by which reimbursement rates are set,\textsuperscript{613} it seems doubtful that these initiatives represent an effective, permanent solution to the PCP shortage. Merely tweaking the existing, volume-driven physician reimbursement system through pay-for-performance programs and/or making Medicare semi-private through programs such as Medicare Advantage seems unlikely to rectify these dysfunctions. Rather, an entirely new approach is needed.\textsuperscript{614}

Perhaps the most promising blueprint for reimbursement reform emanated from the Network for Regional Healthcare Improvement’s 2008 Healthcare Payment Summit\textsuperscript{615} which recommended a complete revolution of healthcare reimbursement from the current FFS to a

\begin{footnotesize}
\begin{enumerate}
\item Id.
\item Id, at 2.
\item Id. at 1.
\item See supra text accompanying notes 405-13.
\item Graham, supra note 26.
\item See generally, From Volume to Value, supra note 507.
\end{enumerate}
\end{footnotesize}
“case rate” system. Under this system, a health problem prevention entity such as Medical Homes would be paid a diagnosis-based, prospectively defined, condition-specific capitation (single) price for all services needed by a patient for both acute illnesses and outpatient care. Such a system would involve “bundling” all treatment services into one package and paying one entity for this bundle of services with the entity distributing payment in some rational fashion among the participants. The proposed reforms also contemplate the following facets: (1) warranties by HCPs in the form of commitments to address preventable errors of complication without additional charges, (2) severity-risk adjustment mechanisms to compensate for difficulties in a specific patient’s condition, and (3) “outlier payments” to cover cases that result in extreme and unpredictable costs.

Paying for episodes of acute care may help control cost associated with each episode, but it does little to control the number of episodes a patient may have. Consequently, the reform proposal also contains provision for periodic payments to some healthcare entity such as a proposed in the New Model to cover care management, preventive care, and minor acute services associated with chronic illnesses because such illnesses do not always end in some fixed period

616 Id. at 2.
617 Id. at 12, 41-43. (Condition-specific capitation means that while there is a single payment for a patient, the amount of that payment varies depending upon the specific condition that the patient has, unlike traditional capitation systems that pay the same amount for each patient regardless of how many for what types of conditions they have.)
618 Id. at 1-2, 15, 25.
619 Id. at 2, 25.
620 Id. at 43.
of time. Preventing chronic disease from becoming acute disease would be the goal. Ultimately, the current FFS system would be entirely replaced and PCPs would receive a single periodic payment for providing preventive care for a patient. Healthcare consumers would receive incentives in the form of reduced co-payments for utilizing a Medical Home under the New Model.

Under the present reimbursement system, physicians make more money when they are slow to diagnose and treat a problem, and there is little or no incentive to use cost-saving technological advantages such as information technologies. Under the proposed reimbursement system, physicians would no longer be restricted by a complicated set of codes that govern treatment and would no longer have incentives to over treat patients. Instead, physicians would have incentives to maintain or improve patients’ health, prevent hospital admissions, and work collaboratively to coordinate patient care. Physicians would also have incentives to improve their practices such that they are considered high-value providers. There would be funding flexibility to utilize the best combination of providers to maximize value, and patients would have incentives to select physicians who provide the best value.

A principal tenet of the Payment Reform Summit plan is that preventive care would reduce the incidence of advanced chronic illnesses and achieve reductions in healthcare spending per

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621 Id. at 42-3.
622 Leape presentation, supra note 555.
623 Id. at 12.
624 RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 2.
625 From Volume to Value, supra note 507, at 43-4.
capita through preventive medicine and focusing on value, not volume. Consumers often reap the benefits of both reductions in cost and improvement in quality in industries other than healthcare, so there seems no reason that healthcare costs cannot decrease while quality increases. This possibility is again consistent with SCM theory, wherein HCPs would deliberately attempt to strategically position their practices to provide economic value to consumers.

In effect, the proposed reimbursement system can be thought of as another link in the healthcare value chain - one that provides value to physicians for the care they provide and value to healthcare consumers by creating incentives for HCPs to provide quality and timely care. As previously discussed, however, bundled, case-rate reimbursement systems of the type proposed still have the drawback of creating incentives to under treat. As explored in the following section, this creates a role for the legal system in helping to counterbalance this incentive and providing redress if HCPs engage in under treatment that leads to patient harm.

VIII. Legal Implications of the Likely Direction of Delivery and Reimbursement Reforms

Collectively, the previous sections have important implications for law in the healthcare crisis. We first turn our attention to three inferences drawn from our preceding presentation of evidence. We next discuss new challenges that will be presented for the judiciary resulting from new healthcare delivery and reimbursement systems, which gives rise to the moral hazard of

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626 Miller, supra note 482, at 3.
627 Id.
628 From Volume to Value, supra note 507, at 24.
629 See From Volume to Value, supra note 507, at 12.
under-treatment and how under treatment can be effectively discouraged in a preventive care environment. We also address the challenge of the legal system helping to foster a new culture in medicine focused on patient-centricity and continuous healthcare improvement through a cybernetic feedback loop. We then turn to our proposal for a redesigned legal regime that addresses these challenges and complements new healthcare delivery and reimbursement systems to obtain better outcomes for plaintiffs injured by medical errors while concurrently improving the quality of healthcare and reducing its costs.

**Important Legal Inferences Emanating from Examination of the Healthcare Crisis**

One important inference is that physicians’ difficulties with professional liability insurance are not simply the magnitude of its cost but also with the variance in its year-to-year increases. Our examination of the evidence does not suggest a massive, pervasive, national-level professional insurance cost problem, but rather, a somewhat more complicated problem than the rhetoric that attends it might suggest. Although physicians, particularly in high-risk specialties, appear to have legitimate complaints about the growth in professional liability insurance costs in recent years which have grown considerably more than their compensation, the absolute dollar cost of professional liability insurance still remains a fairly small portion of medical revenues, at least at the national level. Further, some recent evidence we have referenced suggests it may have temporarily plateaued. As previously discussed, what seems particularly problematic is that high variability in premium increases on a year-to-year basis, especially in high-risk specialties, creates a potential sticker shock that complicates budgeting and evokes a visceral

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reaction from physicians. This phenomenon has received little, if any, attention in the tort reform debate.

A second and related inference is that the cost of medical malpractice is not independent of the healthcare reimbursement system. Therefore, physicians’ attempts to hold medical revenues constant, as reimbursement rates decline by increasing the volume of services provided per patient logically suggests that professional liability risk should increase as more services are provided, particularly in light of the previously referenced evidence that providing more services per patient does not improve healthcare and may actually degrade it. This relation should eventually cause an increase in liability insurance premiums as loss experiences increase due to service volume. Although we cannot determine how much of the increase in insurance cost is due to increases in volume of service per patient, volume of patients in general declines in insurance companies’ rates of return on their investment portfolios, court outcomes, and/or increase in the frequency of medical errors; this nexus between service volume and insurance cost is an important point that has largely gone largely unrecognized in the tort reform arguments.

A third inference – one that, like the first two, has gone largely unrecognized - is that, given the lack of independence between reimbursement and medical errors, tort reform absent reimbursement reform is ill advised. There is widespread acceptance that the current reimbursement system is badly flawed\textsuperscript{631} and creates incentives for physicians to emphasize volume of patients over quality in the provision of care with inferior outcomes.\textsuperscript{632} Given the evidence that the extant system of physician reimbursement is contributing to the problem of

\textsuperscript{631}See, e.g., RICHMOND \& FEIN, supra note 33, at 238; and Medicare Reimbursement to Physicians, supra note 7

\textsuperscript{632}From Volume to Value, supra note 507, at 1.
medical errors, which in turn, increase malpractice costs, an important implication is that tort reform is best not addressed in a vacuum that ignores this interrelationship. Indeed, two notable healthcare commentators state the following:

Few things in medicine and its infrastructure are quite as simple as might first appear. That is certainly the case with the “malpractice crisis”….In bringing reform to a malpractice arena that is overlaid with emotion, it is especially necessary that changes be made on the basis of information and careful analysis rather than on the basis of anecdotes and horror stories. The existing adversarial approach to change assumes that every gain for patients and their attorneys represents a loss to physicians and insurers, and that every change that would benefit physicians would necessarily harm patients. That need not be the case.

Consequently, despite potential cost reductions in some healthcare niches, higher-than-necessary professional liability insurance costs are, in part, a result of quality problems stemming from perversities in the reimbursement system, not simply flaws in the tort system. Moreover,

633 Id.

634 RICHMOND & FEIN, supra note 33, at 209-74.

635 See, e.g., RESEARCH AND POLICY COMMITTEE OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 302, at 31 (noting that research suggests that in the case of fresh heart attacks tort reform could save 5-10% of the costs, but that this might prove to be a one-time reduction in costs with no reduction in their growth rate over the long term).

636 There is some evidence that frivolous lawsuits may be becoming less of an issue to hospital administrators in relation to the myriad other challenges healthcare faces. In annual surveys malpractice insurance was listed as a top issue confronting hospitals by 24% by hospital administrators in 2003. That figure had dropped to only 3% by 2006. Conway, supra note 550. Evidence from claims data involving 1496 claims found that 97% involved an injury, 61% of the 97% involved a medical error, and only 73% of the 61% resulted in a payout. This suggests that 27% of the patients (236 cases) who arguably deserved compensation did not receive it. On the other hand, there were payments in 28% (145 cases) injury cases that did not involve medical errors. See Allen B. Kachalia, Current Controversies in Liability and Medical Error, presentation at Harvard Seminar Nov. 2008 (notes on file with authors). The data reported by Kachalia can be interpreted in different ways, but it would appear that injustices
even if tort reforms such as a federal cap on non-economic damages slow increases in liability insurance premiums, they “. . .will not alter the fundamental unfairness to patients and physicians and the deleterious impact on patient safety that are inherent in the existing tort system.”

Thus, we maintain that ad hoc tort reform initiatives absent healthcare delivery and payment reform seem contraindicated until the major problems with delivery and reimbursement are substantially resolved. To the contrary, some commentators argue that, given the evidence from empirical research on the relatively poor performance of the malpractice claims system in helping to identify negligent providers and compensate injured patients, the system for enforcing patient rights needs to be strengthened, not weakened.

**New Challenges for the Courts Post Delivery and Reimbursement Reform**

If the answer to improving healthcare quality and reducing costs rests with a new, preventative focus in medical service delivery and a concomitant shift toward case-rate reimbursement, then the legal system needs to broaden its focus from primarily that of medical errors resulting reactive care to include ensuring adequate preventative care. Similar to the changes in health service delivery and payment, however, this will likely not be without challenges.

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imposed by the legal system upon physicians by non-meritorious lawsuits are fewer than injustices imposed on patients with meritorious suits. One study found that physicians’ perceptions of the risk of being sued for malpractice is three times greater than the actual risk. *See Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* 3, 9 (1990).


First, we argue that under the reimbursement reforms proposed by the Payment Reform Summit the need for legal enforcement of patient rights will increase in some respects despite the prospects for improved quality of healthcare and a possible attendant drop in some types of medical errors. The reason rests with the inherent moral hazard problem associated with case-rate or capitation-type payments, which carry incentives to under treat patients or refuse care to patients who appear likely to develop poor outcomes. Even P4P incentives layered on top of the case-rate reimbursement system for physicians $A = \pi r^2$ are unlikely to rectify this problem inasmuch as prior research has evinced such incentives fail to fully address this moral hazard issue. Thus, in the world of the reformed reimbursement system envisioned by the Payment Reform Summit, a strong tort system is needed as much, if not more, than ever to counterbalance incentives to under treat.

Second, we foresee that the nature of medical malpractice defendants becoming less one of individual physicians and more that of teams of healthcare professionals. Since under the New Model the medical entity will likely be a principal focus of the new reimbursement system which must somehow allocate payment to its various members, then those members should collectively bear the risk of harm resulting from under-treatment. In jurisdictions embracing comparative fault regimes, apportioning damages may be more problematic. Given that more states have begun to shift to comparative fault regimes this potential difficulty takes on even

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639 From Volume to Value, supra note 507, at 24.

640 Id.

641 See supra text accompanying notes 556, 618.

642 From Volume to Value, supra note 507, at 2.
greater significance.\footnote{See Ellen M. Bublick, \textit{Comparative Fault to the Limits}, 56 Vand. L. Rev. 977, 978 (2003).} Further, to an appreciable extent, state law drives the choice of defendant (i.e., a medical entity or an individual physician).\footnote{Interview with Jeffrey L. Peek, Esq., Partner, Cardaro & Peek, LLC, Baltimore, MD and Washington, DC (December 11, 2008) (notes on file with authors) (hereinafter, “Peek Interview ”). Mr. Peek has 17 years experience as a medical malpractice attorney. He is a member of the Board of Governors of the Maryland Trial lawyers Association and listed among \textit{Who’s Who in American Law}. Prior to becoming a plaintiff’s attorney, Mr. Peek worked for a large, prominent law firm defending hospitals and physicians. As a plaintiff’s attorney, Mr. Peek has successfully represented clients in malpractice claims involving almost every major hospital and health system in Maryland and the District of Columbia, winning a number of 7-figure verdicts or settlements. In 2007, a client he represented was awarded the highest verdict in a medical malpractice case in the history of Baltimore.} Complicating this landscape will be situations in which patients who are harmed have been involved with more than one medical entity and/or previously changed Medical Homes due to relocation, thus giving rise to jurisdictional and venue issues that may be problematic if multiple preventive care entities in multiple jurisdictions are involved.\footnote{See Miller, \textit{supra} note 482, at 57, 61.} Therefore, a second challenge for the legal system will be making an enterprise liability concept workable.

Third, it seems likely that a preventative care focus will involve a much longer time frame and possibly more healthcare professional participants than the current system which places more emphasis shorter-term, episodic events. Developing the scientific evidence necessary to establish causality is one of the most problematic requirements for successful malpractice cases, and such evidence is usually more lacking with respect to preventive care.\footnote{Peek Interview, \textit{supra} note 644.} Some medical malpractice plaintiffs’ attorneys tend to avoid preventative care cases because of difficulties in
proving causality.\textsuperscript{647} One of the difficulties in cases involving preventive medicine is that of contributive fault where two factors are perhaps most concerning: (1) the longevity of the treatment process during which many intervening patient-specific variables such as obesity as a condition of choice may affect care, and (2) patient compliance with a treatment regime. Further, development of such evidence will take a considerable amount of time given the necessity of dealing only with closed claims as opposed to claims in progress, a cumbersome system given that it may take years for claims to close.\textsuperscript{648} Therefore, a third challenge for the judicial system is to find improved ways of developing evidence related to extended preventive care.

Fourth, if medical systems are left uncorrected, the systemic nature of medical errors stemming from the highly complex nature of medicine creates an environment where catastrophic results are almost inevitable at some point.\textsuperscript{649} Many extant clinical systems are open-loop (non-feedback-controlled) systems that do not formally observe the outcomes of the processes they are controlling, but rather, make decisions on preprogrammed criteria,\textsuperscript{650} and success in using such evidence to reduce medical errors requires a willingness to make process improvements. Such cybernetic loops would permit communication feed back from downstream outcomes that reliably “pulls” physicians back to patients and facilitates continuous redesign of

\textsuperscript{647} Id.

\textsuperscript{648} Joint Commission, supra note 255, at 19.

\textsuperscript{649} See Banja, supra note 98, at 8-9.

\textsuperscript{650} Gordon D. Schiff, Minimizing Diagnostic Error: The Importance of Follow-up and Feedback, 121 Am. J. Med. S38 (2008). See, also, Kachalia, supra note 636 (noting the collision between reluctance of physicians to disclose mistakes due, in part, to fear of legal liability and mandated reporting of adverse events now, the legal protection for which varies state by state thereby raising issues of discoverability, accessibility, and discoverability).
continuous redesign of healthcare delivery that results in fewer and fewer medical errors will ultimately reduce physicians’ malpractice liability risks and costs, and the medical profession need only look to its own ranks for first-hand evidence of the veracity of this claim. One of the greatest success stories in medical process improvement rests with anesthesiology, a specialty that has cut its mortality rate from one in 10,000 to one in 200,000 through examination of scientific evidence and changes in processes. Despite its potential for improving patient safety, development of scientific evidence regarding medical malpractice and efforts to correct deficiencies is impeded by “gag clauses” that require permanent, confidential sequestering of all information relating to settled cases. Consequently, another challenge for

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651 Schiff, supra note 650, at S40-41.

652 See, JOINT COMMISSION, supra note 255, at 19.

653 Id. at 19, 37. In addition to their implications for Medicare reimbursement rules and malpractice, the healthcare delivery and reimbursement reforms outlined in the previous subsections may require changes in other laws. For example, under the federal Civil Money Penalty Law provisions governing physician incentive plans there are currently very tight restrictions on “gain-sharing,” the practice of hospitals and physicians accepting separate payments but having arrangements for sharing portions of payments for each other. From a practical perspective, there is little difference between hospitals and physicians accepting a bundled payment and having arrangements for dividing it. Under these laws, hospitals are prohibited from knowingly making payments to physicians as an inducement to reduce or limit services to Medicare and Medicaid patients. In addition, Stark Law prohibits a physician from making referrals for health services the cost of which is reimbursed by Medicare or Medicaid to an entity in which the physician has a financial relationship. Although the Office of Inspector General, HHS, has in the past approved waivers under the Civil Money Penalty Law on a case-by-case basis, such waivers are cumbersome and would obviously represent a serious impediment that does not support what already promises to be a difficult reform transition. See From Volume to Value, supra note 507, at 18. Although a detailed examination of the legal implications of healthcare delivery and payment reform other than those related to medical malpractice is beyond the scope of this study, these concerns strongly suggest that modifications in federal law may be needed to
the judicial system will be finding ways to get information from settled cases into the feedback loops that reduce medical errors.

Fifth, the legal system should play a role in helping to create a “just culture” in medicine that fosters learning to reduce medical errors while improving systemic accountability for errors. In considering this challenge, the question arises as to why other medical specialties have not been able to achieve results similar to those obtained in anesthesia. As two commentators note, “[m]any providers have failed to adopt patient safety measures of proven effectiveness, and they have similarly failed to use information already in their possession to protect patients from harm.” Physician participation is essential for such a cybernetic loop to be effective since physicians hold the trump card in most medical treatment decisions. One commentator states, however, that there is virtually no evidence that physicians who are sued subsequently change their practices ex post noting that physicians have difficulty admitting mistakes and normalize errors by rationalizing that “these things happen.” The answer, then, to the question of why

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654 See, Joint Commission, supra note 255, at 40.

655 Hyman & Silver, supra note 200, at 991.

656 Banja, supra note 98, at 29, 31-32, 125-6 (noting that physicians are “. . . trained in a culture where disclosure to peers is a sign of weakness. Instead, skill in ‘roundsmanship’ is valued, that is, creative and contemporaneous responses to cover deficiencies or errors when reporting to more senior physicians” and citing a survey of physicians, nurses, pharmacists and medical quality assurance personnel in which 88% agreed that rationalization
medical practice has not followed the example of anesthesia may well rest in physician narcissism and its contamination of medical culture. Obtaining physician participation in

excusing medical errors are common in hospitals, 76% agreed that rationalizations are one of the chief reasons why errors are not disclosed, and 89% agreed that healthcare providers are strongly tempted to rationalize their errors. Volumes have been written about physician narcissism, its causes, and its contribution to medical errors. For an especially thorough treatise of the topic by a clinical ethicist, see, generally, id. It might also be noted that physicians’ objections to the legal system have not prevented some in the profession who are sanctioned by professional bodies from resorting to the courts in an attempt to avoid loss of privileges and licensure. See, JOINT COMMISSION, supra note 255, at 18. Physician narcissism manifests itself in various ways to the detriment of healthcare quality. For example, reports indicate that 84% of physicians and 62% percent of nurses and other healthcare workers have seen co-workers taking shortcuts that could be dangerous to patients but fewer than 10% of directly confront their colleagues about their concerns with one-in-five physicians indicating they have seen harm come to patients as a result. Rennig Roszak, HOSPITALS MUST IMPROVE WORKPLACE COMMUNICATIONS TO HELP REDUCE MEDICAL ERRORS, 79(3) HOSPITAL & HEALTH NETWORKS, Mar. 2005, at 66. This suggests the presence of an element of fear perhaps resulting from disruptive behaviors (e.g., throwing scalpels, yelling, and making accusations) that is the leading cause of physicians being reported for behavioral problems. Booker T. Bush, The Impaired Provider, presentation at Harvard Seminar Nov. 2008 (notes on file with authors) (noting that disruptive behavior is defined as a pattern of [a physician] being unable, or unwilling, to function well with others to the extent that his or her behavior, by words or action, has the potential to interfere with quality healthcare. Physician behavioral disorders are of three types: (1) boundary violations which involve taking advantage of patients for monetary or other personal gain such as sexual relations, (2) dishonesty to include such problems as physicians diverting drugs from patients for their personal use, and (3) disruptive behavior which is described as a “huge problem” and results in healthcare workers being afraid to approach a physician about inappropriate responses to patient needs. Another problem related to narcissism is overconfidence which can lead to such errors as refusal to change incorrect diagnoses even in light of contrary evidence from decision-support systems about the correct diagnoses. See, Berner & Graber, supra note 561, at S8. Nurses are said to fear that physicians will blame them for medical errors in conversations with patients. Thomas H. Gallager, DISCLOSING MEDICAL ERRORS TO PATIENTS: RECENT DIRECTIONS AND FUTURE
creating a just culture in medicine means developing an ethos in which patient welfare trumps ego and emotion.

Another motivation for the legal system helping to address the need for a just culture in medicine is that the New Model embodies patient-centricity as one of its tenets.\textsuperscript{658} In the past, physicians were regarded with great deference because of the knowledge asymmetry that existed between them and their patients.\textsuperscript{659} Today, however, many healthcare consumers want to play a decision-making role in their care decisions.\textsuperscript{660} As patients are empowered by more and more health information via the internet, and, as the numbers of diseases, tests and treatments increases with the inexorable march of medical research and technology, physicians – particularly generalists such as PCPs – are less likely to possess all of the information related to patients’ care.\textsuperscript{661} Inasmuch as misdiagnoses represent the cause of almost 60% of malpractice claims and evidence suggests patients can help detect potential problems such as medication errors, errors would be reduced if physicians spent more time listening to patients and encouraging patient involvement in health decisions.\textsuperscript{662}

\begin{footnotes}
\item[658] Spann, \textit{supra} note 556, at S2.
\item[659] DIGITAL CONNECTIONS COUNCIL OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, \textit{supra} note 497, at 42.
\item[660] Deloitte Center for Health Solutions, \textit{supra} note 107, at 20.
\item[661] See DIGITAL CONNECTIONS COUNCIL OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, \textit{supra} note 497, at 42.
\item[662] See BANJA, \textit{supra} note 98, at 156; DIGITAL CONNECTIONS COUNCIL OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, \textit{supra} note 497, at 42-3; and Weingart presentation, \textit{supra} note 552.
\end{footnotes}
A fifth challenge, then, for the legal system is how to best help bring about positive changes in the culture of medicine such that closed-loop, cybernetic systems that evoke appropriate improvements to healthcare delivery can function well and patient feedback is incorporated into these loops. Why should this be considered as part of the function of a revised regime for adjudicating medical malpractice cases? Perhaps the best answer is summed by the following three points: (1) inherently hazardous systems such as medical treatment should be heavily defended against failure; (2) despite the failure of medical self-regulation in preventing medical errors, no other profession dealing with life and death matters enjoys as much freedom from regulatory controls over their behaviors, and (3) “. . . no one imagines healthcare providers will achieve appropriate safety levels on their own.”

Absent physician willingness and strong self-regulatory pressure absent in the past to change medical culture, some form of external encouragement is needed; and, given governments’ past unwillingness to impose this discipline, the judicial system represents the last defender of moral justice to ensure that this change occurs. In the following subsection we argue for a revised legal regime for medical malpractice can become just such a change agent.

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663 Banja, supra note 98, at 11.

664 Harris, supra note 638, at 253.

665 For a discussion of the practice of allowing HCPs to exempt themselves from government inspections based on self-regulation—a practice that would be inconceivable in other industries in which human lives are at stake. See Id. at 76.

666 Hyman & Silver, supra note 200, at 970

667 In addition to their implications for Medicare reimbursement rules and malpractice, the healthcare delivery and reimbursement reforms outlined in the previous subsections may require changes in other laws. For example, under the federal Civil Money Penalty Law provisions governing physician incentive plans there are currently very tight
A New Framework for Resolving Medical Malpractice Claims Post Healthcare Reform

Given that only a small percentage of patients injured by medical malpractice ever pursue litigation, even fewer receive compensation for those injuries, and it takes five years on average for a medical liability case to come to closure, the current tort system appears to fall woefully short in compensating patients harmed by medical errors. Whatever the reasons for and the validity of physicians’ concerns about the tort system, the greatest concern for the public should be the fact that the current tort system is apparently neither deterring medical errors to an

restrictions on “gain-sharing,” the practice of hospitals and physicians accepting separate payments but having arrangements for sharing portions of payments for each other. From a practical perspective, there is little difference between hospitals and physicians accepting a bundled payment and having arrangements for dividing it. Under these laws hospitals are prohibited from knowingly making payments to physicians as an inducement to reduce or limit services to Medicare and Medicaid patients. In addition, Stark Law prohibits a physician from making referrals for health services the cost of which is reimbursed by Medicare or Medicaid to an entity in which the physician has a financial relationship. Although the Office of Inspector General, HHS, has in the past approved waivers under the Civil Money Penalty Law on a case-by-case basis, such waivers are cumbersome and would obviously represent a serious impediment that does not support what already promises to be a difficult reform transition. See From Volume to Value, supra note 507, at 18. Although a detailed examination of the legal implications of healthcare delivery and payment reform other than those related to medical malpractice is beyond the scope of this study, these concerns strongly suggest that modifications in federal law may be needed to accommodate the new healthcare environment as reforms get underway. These regulations may need revisited anyway as a result of a recent rise in the numbers of conflict-of-interest situations arising from physicians’ financial interests in treatment alternatives which have been demonstrated to affect their objectivity. See DIGITAL CONNECTIONS COUNCIL OF THE COMMITTEE FOR ECONOMIC DEVELOPMENT, supra note 497, at 43. Because changes in these laws are not central to our discussion of a modified process for adjudicating medical malpractice claims, we leave further exploration to another study.

668 JOINT COMMISSION, supra note 255, at 31.
acceptable extent nor adequately compensating patients for harm incurred through such errors. 669

Most victims of substandard care never file claims or recover any compensation. Even when patients do receive compensation, malpractice litigation can often drag on for years with multiple appeals before payment. 670 Current medical malpractice tort reform efforts suffer from the problem of treating medical errors as separate from the healthcare system. 671 Focused on reducing HCP costs, most tort reform proposals have centered on ways to make it more difficult for patients to recover damages and hold HCPs liable for negligence. Instead of reforming medical malpractice solely as a means of reducing costs, the system should be reformed to better accomplish the goals of deterrence and compensation in a more equitable and efficient manner. 672

If the New Model and complementary payment reforms eventually occur as seems probable, the task of medical malpractice appears even more formidable. The aforementioned difficulties in (1) countering incentives to under treat, (2) apportionment of damages, (3) establishing causality given the paucity of scientific evidence related to preventive care, (4) getting feedback on settled cases into the healthcare cybernetic loop, and (5) helping to create a just culture in medicine further complicate the malpractice landscape – collectively suggesting that, absent substantive change in the way medical errors are dealt with by legal systems, victims of medical malpractice may be even less well served going forward. The central question then is – how can

669 Id. at 4 (“Several studies have, with remarkable consistency, revealed the inconsistency of the medical liability system in determining negligence and compensating patients.”)

670 Todres, supra note 84, at 681.

671 Id. at 669, 680.

672 HARRIS, supra note 638, at 254.
medical liability be restructured to encourage patient safety through process improvement and to reduce the incidence of negligent medical errors while at the same time providing swifter and more patient-friendly compensation for the injured?

Over the years there has been much contentious lobbying by the medical profession for tort reform and vigorous academic debates regarding how to reform medical malpractice litigation. As noted in Section III, many of these debates have centered on legal theoretical issues such as whether contract law is preferable to tort, or whether a new basis for a standard of care based on a fiduciary concept is preferable to the existing tort system.\textsuperscript{673} Despite the lobbying and debates, what little change has taken place has been, for the most part, relegated to the development of stopgap measures such as caps on non-economic damages.\textsuperscript{674} Consequently, we emphasize that the framework for malpractice dispute resolution discussed \textit{infra} is proffered as a pragmatic solution to a grave national problem. Although other, more theoretical approaches proposed in the past may have some merit, the barriers to implementation of these approaches have apparently been so formidable that their implementation in the foreseeable future seems

\textsuperscript{673} See, \textit{e.g.}, Peter D. Jacobson and Michael T. Cahill, \textit{Applying Fiduciary Responsibilities in the Managed Care Context}, 26 Am. J. L. \& Med. 155 (2000). Jacobson and Cahill, however, suggest that reformation of medical malpractice through implementation of fiduciary concepts “. . . is indifferent to how health care is organized.” \textit{Id.} at 171. As has been shown, however, institutional change is a necessary element of addressing the overall healthcare crisis, malpractice liability being no exception.

\textsuperscript{674} Todres, \textit{supra} note 84, at 670.
We posit that the stakes are too high for a perpetual tort reform debate. Instead, it is time to reform the medical malpractice legal process in a way that serves the needs of all parties.

With the advent of new delivery and reimbursement systems, the time has come to develop an alternative, practical framework for adjudicating medical malpractice claims that, like the New Model of care delivery, provides greater value to patients in both preventing under treatment and redressing preventable medical errors. Professor Todres has argued that a care-based, healing–centered approach to medical malpractice tort reform should achieve the following goals: (1) providing compensation to injured patients, (2) promoting safety, (3) minimizing suffering, (4) fostering exchange of information, and (5) offering restorative dialogue. In our opinion, the most promising approach to creating a practical framework for medical malpractice liability that accomplishes these goals rests upon the following five pragmatic pillars: (1) mandated pricing and quality disclosure of healthcare services to foster a more efficient marketplace for healthcare services, (2) a shift to enterprise liability that complements the nature of the new bundled, case-rate payment concept, (3) mandated disclosure of all material and harmful medical errors to patients and a regulatory authority to ensure that patients are advised when they have been potentially harmed, (4) a first-best attempt at compensating plaintiffs based upon mandated, but non-binding, mediation that preserves the right to jury trial under tort law, and (5) mandated disclosure of the nature of medical errors.

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675 For a more detailed analysis of some, though by no means all, of the problems facing current tort reform efforts, see Mathew Shon Manweller, *Understanding Tort Reform: Strategic Actors, Public Policy, and Feedback Loops*, 5 BUS. & POLITICS 95 (2003).

676 Id. at 13, 40.

677 Todres, *supra* note 84, at 667.
associated with settled cases to release the useful information errors currently sealed.\textsuperscript{678} Although none of these proposed pillars are new conceptually, it is their combination, practicality, and their complementary nature to the evolving healthcare delivery and reimbursement systems that makes their case compelling.

The first pillar, mandated pricing and quality disclosure, is aimed at reducing both the cost of healthcare in general and the medical error rate (and therefore the frequency of medical malpractice litigation) in particular. As previously discussed,\textsuperscript{679} despite recent trends toward greater disclosure, healthcare cost and quality remain masked in a confusion of complexities in which patients rarely know either prior to treatment. Such masking frustrates the ability of patients to make informed cost/benefit decisions regarding their care and self-select away from poor quality.\textsuperscript{680} As Professor Morreim has noted,

\begin{quote}
Patients bring considerable vulnerability to the health care setting . . . . Patients and physicians rarely include costs in their discussion of proposed interventions….Many patients often have no idea what an intervention costs until after they receive the bill, and even then the bill may be so confusing that they still have no idea what cost how much . . . . The current system, in which physicians or third party payers make cost-value tradeoffs and simply issue them to patients, is simply unacceptable.\textsuperscript{681}
\end{quote}

Mandated disclosure of the cost and quality of healthcare is consistent with the current trends toward quality measures, patient-centric medicine and improving the quality of care through

\textsuperscript{678} \textit{JOINT COMMISSION, supra} note 255, at 31-32.

\textsuperscript{679} \textit{See supra} text accompanying notes 497-500.

\textsuperscript{680} \textit{See, e.g.,} E. Haavi Morreim, \textit{Redefining Quality by Reassigning Responsibility}, 20 AM. J. L. \& MED. (1994), 79, 94-5. Similar logic has been used to invalidate many healthcare provider policies of refusing to deliver certain information to patients. Section I of the Sherman Act (antitrust) is violated when HCPs agree \textit{inter alia} to limit the information delivered to their patients. \textit{See, e.g., F.T.C. v. Ind. Fed’n of Dentists}, 476 U.S. 446 (1986).

\textsuperscript{681} Morreim, \textit{supra} note 680. at 79, 95-6.
patient participation. \(^{682}\) Allowing patients to make cost and quality decisions based upon clear, understandable disclosures, facilitates a more efficient and higher quality healthcare marketplace. \(^{683}\) Given that a large percentage of medical errors are made by a small minority of HCPs, \(^{684}\) allowing free markets to identify and avoid those providers should go a long way toward reducing the incidence of medical errors. Poorer quality providers would be encouraged to improve quality or face declines in business, and quality providers will be encouraged to identify themselves and maintain or improve their own quality standards. \(^{685}\) O’Connell and Neale have suggested that, “[i]deally, civil liability should fully compensate injured patients and adequately deter negligent providers without affecting the behavior of non-negligent providers.” \(^{686}\) We elect to take this concept one step further to suggest that the truly ideal system is one that does not content itself with the status quo, even for those who perform well, but rather provides an incentive for constant improvement.

An additional benefit is likely to be a reduced incidence of malpractice suits against physicians as patients are allowed to take a greater role in their medical decision making and assume a greater degree of responsibility for the outcomes. \(^{687}\) Studies suggest that patients

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\(^{682}\) See Todres, supra note 84, at 670-1, 674.

\(^{683}\) See Morreim, supra note 680, at 100.

\(^{684}\) See Leo Boyle, The Truth About Medical Malpractice, TRIAL, April, 2002, at 9.


\(^{686}\) Id.

\(^{687}\) The concept that patient autonomy can have benefits of its own is not a new one, though an exhaustive analysis is beyond the scope of this study. For a better understanding of the potential costs and benefits associated with patient autonomy, see, for example, Edmund D. Pellegrino, Physician and Patient Autonomy: Conflicting Rights and
involved with their care are more satisfied and demand fewer marginal interventions resulting in fewer lawsuits. If patients cannot be held accountable for things that they cannot control, the corollary is that increased patient control means shared responsibility and increased accountability for outcomes because the freedom to make decisions is an important prerequisite for responsibility.

The second pillar of our proposal is that of enterprise liability to complement the medical entity and bundled payment concepts that are likely to form the thrust of healthcare reform. Enterprise liability appropriately shifts the liability from individual physicians to the healthcare

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688 See Morreim, supra note 680, at 102.

689 Id. at 97.

690 See, BANJA, supra note 98, at 123 (describing enterprise liability as “…an amalgam of various forms of liability – notably vicarious liability, agency, and corporate liability-that essentially make an organization responsible for the wrongdoings of its workers.”) See also Morreim, supra note 680, at 80, stating “…we have placed these responsibilities [for healthcare quality] almost exclusively on physicians, but that powerful economic changes now require a reallocation of the responsibilities of providers, patients, and payers in defining and delivering quality in health care.”
entity providing treatment\textsuperscript{691} because most medical errors happen because of failed systems, not failed people,\textsuperscript{692} and there are almost always multiple contributing factors to medical errors.\textsuperscript{693} Consequently, enterprise liability would offer a more representative defendant than individual physicians.\textsuperscript{694} Holding healthcare entities responsible for medical safety would shift the emphasis from one of individuals adhering to safe procedures to one of helping to ensure that treatment is integrated and coordinated across all members of the healthcare-entity team and processes are appropriately controlled. This would have the effect of promoting institutional safety while helping to stabilize liability insurance rates.\textsuperscript{695} A complementary effect we envision would be to limit the psychological impact of litigation, an impact that one commentator has suggested “. . . pervades all aspects of medical practice . . . [resulting in a] lasting emotional

\textsuperscript{691} Id. Arlen and MacLeod demonstrate analytically that it is optimal to not only hold managed care organizations (MCOs) liable for both their own negligence but also for the negligence of their affiliated physicians even in situations where the MCOs do not exercise direct control over physicians. Jennifer Arlen & W. Bentley MacLeod, \textit{Malpractice Liability for Physicians and Managed Care Organizations}, 78 N.Y.U.L. REV. 1929, 2005 (2003). On the other hand, Danzon and Sloan argue against vicarious liability preferring a contractual approach (Patricia Danzon & Frank Sloan, \textit{The Regulation of Managed care Organizations and the Doctor-Patient Relationship}, 30 J. LEGAL STUD. 661, 661 (2001) offering little empirical or analytical evidence for their position; however, Arlen and MacLeod show analytically that contracts and market forces are insufficient to ensure optimal care absent legal sanctions even in situations where patients correctly anticipate the risks impose upon them.

\textsuperscript{692} Leape presentation, \textit{supra} note 555 (noting the necessity of changing the culture to reorient how physicians think about themselves).


\textsuperscript{694} BANJA, \textit{supra} note 98, at 125.

\textsuperscript{695} JOINT COMMISSION, \textit{supra} note 255, at 31-32.
This fear, in turn, perversely incentivizes overtreatment, leading inexorably to more chances for medical error.

Because healthcare safety is about working in teams, and evidence that the majority of medical errors are system failures as opposed to individual failures, an enterprise liability approach that places the burden of responsibility on a medical entity as opposed to individual physicians would be a logically symmetric companion to the movement toward the New Model for delivery reimbursed through bundled, case-rate payments. Enterprise liability also seeks to ensure greater coverage for patients harmed by medical errors and has the benefit under our proposed framework of reliance upon the same liability requirements as the extant negligence-based tort system.

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697 Keriakes and Willerson note that fear of medical malpractice forces many physicians to engage in so-called ‘defensive medicine’, ordering treatments and medication that they would not otherwise order. This overtreatment, then, necessarily interjects new opportunities for medical error in procedure or prescription. Id.

698 Leape presentation, supra note 555 (noting the necessity of changing the culture to reorient how physicians think about themselves). A floor comment by one physician during a medical seminar regarding the absence of teamwork is telling: “As someone working in the hospital, I don’t know what is going on. So much of the time no one knows what is going on.” Weingart presentation, supra note 552 (floor comment).

699 BANJA, supra note 98, at 125.

700 Todres, supra note 84, at 701 (noting that a major criticism of enterprise liability is that it does nothing to address patients’ emotional healing and may or may not result in more efficient resolution of claims. The criticisms are addressed, however, by other facets of our proposed framework that are compatible with enterprise liability).
An enterprise approach to liability, however, begs for movement from the current top-down, “captain of the ship” culture in which physicians dictate stop or go on medical decisions to an “aircraft carrier” approach in which anyone on deck can stop a launch due to a safety problem. All team members such as nurses should feel free to report hazards and expect to be treated with respect for doing so. Although this change in extant healthcare culture is a desirable - and arguably necessary - complement to the evolving delivery and reimbursement systems, such an attitudinal transformation, may prove to be as difficult as any aspect of the overall healthcare transformation envisioned in this study. The reason is that it requires an admission by physicians

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701 BANJA, supra note 98, at 127. The top-down nature of medical practice is evidenced by the tension that often exists between physicians and nurses, a relationship that has been described as problematic. See, e.g., Mark Todd, Doctors Don’t Have Germs, Nurse Told, SYDNEY MORNING HERALD, June 21, 2005, available at http://www.smh.com.au/news/national/doctors-dont-have-germs-nurse-told/2005/06/20/1119250928025.html (relating a story about an Australian physician now in the U.S.); S. Robert Hernandez, The Perfect Storm: Nursing in Twenty-First Century America, 25(4) HEALTH AFFAIRS 1372 (2005), available at http://content.healthaffairs.org/cgi/reprint/24/5/1372.pdf (reviewing SUZANNE GORDON, NURSING AGAINST THE ODDS: HOW HEALTH CARE COST CUTTING, MEDIA STEREOTYPES, AND MEDICAL HUBRIS UNDERMINE NURSES AND PATIENT CARE (2005)). This tension among healthcare workers who should be part of a team but are not manifests itself errors as disparate as the wrong chemotherapy and absence of good hand hygiene. See, Weingart presentation, supra note 552.

702 Leape presentation, supra note 555 (noting such reports should go to department heads, not just to physicians directly involved with an episode of care). There is substantial evidence of tension between physicians and nurses that contributes to medical errors. For example, in one survey of surgeons and surgical nurses there was little congruence between their perceptions of barriers to communication with nurses reporting intimidation by surgeons, unknown expectations and assumptions, a fear of confronting surgeons, a lack of a sense of teamwork, a lack of leadership, power struggles, cultural differences, and a failure to stop and think before speaking – none of which were noted by the surgeons. Moorman, supra note 680.
that attitudinal change is needed and a concerted effort by the medical profession as a whole to press for change.\textsuperscript{703} Enterprise liability may play an important role in helping to bring about this cultural change inasmuch as physicians who routinely refuse to engage in appropriate team behaviors for error minimization may find themselves more ostracized.

The third pillar of our proposal involves mandated disclosure of any adverse medical event immediately to the patient or the patient’s legal representative.\textsuperscript{704} We perceive three key benefits flowing from this pillar: (1) the error and (ideally) its cause would immediately be imputed into the feedback loop of the New Model thereby limiting the likelihood of repetition;\textsuperscript{705} (2) increased transparency in quality of care would allow for increased consumer choice; and (3) compensation of harmed patients would be expedited. An additional, ancillary benefit of disclosure is that it affords a first opportunity for apologies which both facilitates patient healing and reduces the likelihood of lawsuits.\textsuperscript{706} Mandatory disclosure is already part of a physician’s ethical obligations according to the AMA.\textsuperscript{707} However, this ethical obligation, absent the force

\textsuperscript{703} See, Leape presentation, supra note 555 (noting the necessity of changing the culture to reorient how physicians think about themselves).

\textsuperscript{704} One commentator states, “. . . the most persuasive explanation for endorsing a patient-centered model of disclosure to think of the health professional-patient relationship as a contract.” \textit{BANJA}, supra note 98, at 23.

\textsuperscript{705} See Michael Waite, \textit{To Tell the Truth: The Ethical and Legal Implications of Disclosure of Medical Error}, 13 \textit{HEALTH L. J.} 1, 22 (2005). Waite argues, as do we, that non-disclosure is self-perpetuating. That is, non-disclosure leads to more medical errors (because errors cannot be studied and prevented without knowledge that they exist), which leads to more non-disclosure.

\textsuperscript{706} Todres, \textit{supra} note 84, at 686.

\textsuperscript{707} AMA Code of Medical Ethics, Opinion 8.12, June 1994:

\begin{quote}
It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be
\end{quote}
of law, appears not to create the desirable, arguably necessary, level of disclosure. Indeed, one study found that as many as 76% of physicians had not disclosed serious medical error to a patient.\textsuperscript{708} Twenty-six states currently have some form of legal disclosure obligation for hospitals, although this disclosure typically only requires disclosure of adverse events to state agencies and not to patients.\textsuperscript{709} Further, a federal study found that disparate state disclosure requirements made the data thus collected unsuitable for general use.\textsuperscript{710} Federal imposition of a mandatory, consistent disclosure error requirement for all states would address this problem.

The fourth pillar of our proposal is mandatory, nonbinding mediation once a claim has been filed. Mediation involves negotiation between concerned parties facilitated by a neutral third party under three basic principles: party autonomy, informed decision making, and confidentiality with no requirement to reach agreement in mediation,\textsuperscript{711} only to participate in the free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care….Ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results or any other information. This obligation holds even though the patient’s medical treatment or therapeutic options may not be altered by the new information….Concern regarding legal liability which might result following truthful disclosure should not affect the physician’s honesty with a patient.

\textsuperscript{708} Waite, supra note 704, at 7 (citing Albert W. Wu \textit{et al}, \textit{Do House Officers Learn from Their Mistakes}, 265:16 J. AM. MED. ASS’N. 2089 (1991)).


\textsuperscript{710} Id. at iii. Currently, of those states having any such requirement, New Jersey has the most comprehensive disclosure requirement, while Indiana and Ohio tie for the least comprehensive. \textit{Id.} at 26.

\textsuperscript{711} Todres, supra note 84, at 697.
process. Proponents of mediation maintain that it represents the best solution to the manner in which malpractice claims are currently handled because it reduces the resources expended in jury trials and results in fewer outlier verdicts.\textsuperscript{712} Mediation also offers a “forum in which patients can receive information and apologies to help foster emotional healing.”\textsuperscript{713} Under our proposal, apologies volunteered by HCPs in mediation cannot be used as evidence in a subsequent trial,\textsuperscript{714} mediation would not preclude pre-screening of cases bound for trial by special boards where permitted by state law, and both the plaintiff patient and defendant medical entity’s rights to a jury trial under tort and contract law would be preserved. Although the plaintiff’s right to sue individual defendants comprising the medical entity jointly and severally under tort would also be preserved, under the enterprise concept, the medical entity would be the only defendant in mediation providing a strong incentive for individual members to accept the outcome of the mediation.

Other proponents of mandatory mediation of medical malpractice claims note that the nature of mediation (an impartial forum of dispute resolution that does not declare a winner or loser) is

\textsuperscript{712} See Todres, supra note 84, at 698 (distinguishing the benefits of mediation from those of arbitration, the latter of which relies on the same tort law standards as jury trials and provides no opportunity for a plaintiff to appeal an arbitrator’s ruling. As a result, arbitration does not reduce HCPs’ incentives to engage in risk management by admitting no wrongdoing as opposed to focus on emotional healing for the patient and reduction of future potential errors.)

\textsuperscript{713} See Id. at 697-8.

\textsuperscript{714} Rule 408 of the Federal Rules of Evidence already precludes evidence acquired or apparent admissions made during the process of a settlement negotiation. A specific carve-out may be desirable in that Rule and analogous state evidence laws to ensure that all such mandated mediations fall under the ambit of the Rule. See Fed. R. Evid. 408 (2009).
particularly well suited for medical malpractice claims. Mediation provides for potentially expedited resolution of differences in a less costly and emotionally fraught environment. Limiting the emotional impact of the dispute resolution is essential to maintaining the physician-patient relationship, which, given the manner of current and proposed healthcare delivery, is a goal in itself. Forcible mediation could also facilitate provision of compensation of patients whose legitimate claims are too small to secure legal representation because attorneys fear they will not be able to recover their costs due to requirements for expensive expert testimony.

The fifth pillar of our proposal involves mandated disclosure of the nature of medical errors associated with settled cases. Many medical malpractice cases are settled, and currently many settled cases are subsequently sealed thereby depriving the medical community of the information contained in these cases about the nature of medical errors. The policy justifications for this pillar largely echo those for the mandatory disclosure to the affected patient. The likely benefit is two-fold: (1) input adverse events into feedback loops, and (2) increase transparency to the consumer.

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716 *Id.* at 25.

717 *Id.* at 26. Johnson notes “[t]hat would not normally be an important consideration in determining whether [to] mediate because the…relationship…is usually severed at the time of the negligence. But maintaining the physician-patient relationship is becoming important to hospitals as they are increasingly incorporating individual physicians into the institution as employees. The same is true for HMOs that administer ERISA health plans.”

718 See Todres, *supra* note 84, at 696; and Peek Interview, *supra* note 644.

719 JOINT COMMISSION, *supra* note 255, at 37.

720 See notes 36-42, *supra*. 
To summarize, we envision many benefits from our proposed framework. There is a likelihood of more reliable, credible, and equitable adjudication of claims.\textsuperscript{721} For example, an oft heard complaint is that juries make large awards for pain and suffering because they sympathize with injured plaintiffs.\textsuperscript{722} Regardless of the validity of this argument, reducing the number of jury trials would blunt this concern. The ability of HCPs to externalize the cost of their negligence by passing it on in their bills to the patient would also be reduced.\textsuperscript{723} The potential exists to compensate a larger number of injured plaintiffs but with less likelihood of large, aberrant jury verdicts.\textsuperscript{724} Smaller, injured patients with legitimate claims that are currently impractical to pursue because of the time and expense of litigation would be compensated in more instances.\textsuperscript{725}

Many in the medical profession argue that tort law forces physicians to practice defensive medicine, ordering unnecessary tests and treatments which incur unnecessary costs.\textsuperscript{726} It has been estimated that defensive medicine costs the federal government between $25.3 billion and 44.3 billion per year.\textsuperscript{727} Use of mediation in the manner we suggest, would send clearer messages regarding what is needed to deter adverse medical events.\textsuperscript{728} For cases that are settled

\textsuperscript{721} JOINT COMMISSION, supra note 255, at 35-6.

\textsuperscript{722} HARRIS, supra note 638, at 252-53.

\textsuperscript{723} See, id. at 253. The general idea being that pricing transparency will increase pricing competition amongst competing HCPs, thereby limiting the ability of HCPs to externalize cost.

\textsuperscript{724} JOINT COMMISSION, supra note 255, at 35.

\textsuperscript{725} See, WING, supra note 105, at 316.

\textsuperscript{726} Id.

\textsuperscript{727} Id.

\textsuperscript{728} JOINT COMMISSION, supra note 255, at 35.
through mediation, legal costs would also be reduced due to shorter court processing with less adjudication and a reduced need for expert testimony, which is both costly and sometimes difficult to obtain.\footnote{729 See, \textit{WING}, \textit{supra} note 105, at 315.} Non-meritorious cases would be easier to identify with greater disclosure of the nature of medical errors, thereby reducing one of the leading complaints voiced by physicians.\footnote{730 \textit{JOINT COMMISSION}, \textit{supra} note 255, at 35.} Because fault under tort negligence would attach only in the event of a jury trial stage - and fewer cases would likely be tried at that stage - there would likely be less emotion than with the current system, greater acceptance of error feedback, and a greater likelihood that the feedback would be acted upon.\footnote{731 \textit{Id.} at 35-6. The absence of individual fault in a legal sense under the enterprise liability concept provides a partial shield against being stigmatized in the eyes of parties external to the medical entity, it does not prevent \textit{Id.} at 35-6. The absence of individual fault in a legal sense under the enterprise liability concept provides a partial shield against being stigmatized by litigation.} Findings and settlement information from cases decided by mediation or settlement would be immediately available for public access\footnote{732 See, \textit{JOINT COMMISSION}, \textit{supra} note 255, at 36.} thereby facilitating the development of evidence regarding the effectiveness of preventive care. Under the enterprise concept there would tend to be greater consensus on what constitutes avoidable events and group incentives to encourage their prevention.

The establishment of group incentives under the enterprise liability concept with predetermined damages apportionment would also help to promote a “just culture” because a medical entity’s members would all have some stake in outcomes and be less likely to tolerate behaviors that threaten the group’s welfare. Although the diffusion of responsibility and absence of individual fault in a legal sense under the enterprise liability concept provides a shield of sorts against being stigmatized in the eyes of parties external to the medical entity, it does not prevent
blame from being assigned by members of that entity. This can be a healthy phenomenon when harms are caused by incompetence, reckless disregard for due care, and negligent incapacitation. Greatly reduced external stigmatization and group incentives for correcting systemic flaws and individual behavioral problems would help foster greater dissemination of information about medical errors and their causes, and help standardize procedures across jurisdictions thereby making it easier to identify best-practice. Also, a “just culture” means forthright disclosure of adverse medical events to the patient, a concept endorsed at least in theory by the AMA. Serendipitously, such disclosures have been shown to reduce the likelihood of malpractice lawsuits and improve patient satisfaction. At one hospital, over a five-year period every patient to whom a medical error was disclosed remained a patient of the hospital, and total payouts resulting from such disclosures were nominal.

In short, evolving healthcare delivery and reimbursement systems require a complementary medical malpractice liability regime. Our solution rests upon five pragmatic pillars, all of which seem more politically attainable than more radical reform measures and in combination meet the aforementioned goals of a care-based, healing-centered, medical malpractice liability regime. The following section summarizes this study and its principal arguments.

IX. Summary

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733 See, BANJA, supra note 98, at 6.34.

734 Id. at 35.

735 Id. at 24-5. See also AMA Code of Medical Ethics, Opinion 8.12, supra note 707.

736 Conway presentation, supra note 550 (floor comment).
U.S. healthcare is in a crisis, troubled by problems with cost, availability, and quality, with a long history of political wrangling such that it has been termed a $1.3 trillion [year 2000 figure] fiasco.\textsuperscript{737} Clearly, the nation is getting a poor return on healthcare spending measured by cost versus benefit of healthcare spending, and the United States falls short of all dimensions of a high performance health system.\textsuperscript{738} One commentator has suggested that healthcare spending might be cut in half by improving quality, stating that 47\% of healthcare spending in the United States is waste.\textsuperscript{739} The majority of Americans are dissatisfied with U.S. healthcare, and 82\% desirous of an overhaul of the system.\textsuperscript{740} For years, the legal system has been blamed for physicians’ woes with their compensation with virtually continuous demands for tort reform to reduce the cost of professional liability insurance. Our analysis suggests, however, that a main, but largely overlooked, culprit with respect to physician compensation is third-party reimbursement where the federal government plays an increasingly large role with respect to both the magnitude and uncertainty of physician compensation. Major changes in healthcare delivery and payment systems are needed to achieve the improvements in healthcare quality,

\textsuperscript{737} Todres, supra note 84, at 669 (citing J.D. Kleinke, Oxymorons: The Myth of the U.S. Health Care System 2 (2001)).

\textsuperscript{738} Conway, supra note 550.

\textsuperscript{739} Leape presentation, supra note 555 (noting the necessity of changing the culture to reorient how physicians think about themselves).

affordability, and accessibility necessary to resolve the healthcare crisis. The New Model of healthcare delivery has been proposed which – if based upon sound strategic cost management principles and complemented by a new reimbursement system that rewards value not volume - promises to substantially reduce healthcare cost and improve its quality in terms of outcomes.

Largely ignored in all the rhetoric associated with the healthcare crisis and the debate over medical malpractice tort reform, are the interdependencies among the current delivery and reimbursement systems that encourage lower quality care and physicians’ professional liability costs. Congress and the new administration have signaled that they are open to medical malpractice reform and determined to address the issue. We argue that past and ongoing efforts at tort reform state by state make little sense in light of these interdependencies, and their moral essence has been described as simply making it more difficult for patients who have suffered medical errors to obtain compensation. If the main culprits adversely affecting healthcare quality – and concomitantly physician compensation - are its delivery and reimbursement systems, the illogic of attempting to fix what is an admittedly flawed outcome of inferior health quality before first fixing the delivery and reimbursement systems that drive the current problems seems obvious. This should not be construed, however, to mean that the tort system should not be changed. To the contrary, it should be changed for several reasons. First, the system is currently not delivering good value to healthcare consumers because too few patients who are harmed are compensated. Second, some patients are compensated who should

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741 *From Volume to Value, supra* note 507, at 5, 40.


not be although the incidence of the previous problem appears to be the greater problem. Third, extreme variability in changes in premiums create sticker shock for physicians and complicate their financial planning. Fourth, and perhaps most important, the New Model’s delivery and reimbursement systems would refocus care toward greater emphasis on prevention and would depend upon case-rate payments that provide incentives to under treat patients. No case-rate-reimbursement system, no matter how carefully designed, is likely to totally prevent under treatment because there will be times when the economic benefits of under treatment exceed any incentives not to under treat. This means that, more than ever, the legal system is needed as a backstop to help ensure that patients receive appropriate care.

We propose a redesigned legal regime for adjudicating claims arising from medical errors that rests upon four pillars: (1) mandated price and quality disclosure of healthcare services, (2) a focus on enterprise liability in which the medical entity responsible for care is the defendant as opposed to individual physicians, (3) mandated disclosure of medical errors to patients, (4) mandated, non-binding mediation the function of which is to avoid costly, protracted trials and long delays in patient compensation whenever possible, and (5) mandated disclosure of medical errors in settled cases. This regime is designed to do the following: (1) provide a check on HCPs’ incentives to under treat patients in conjunction with the New Model, (2) increase the speed of compensation to injured plaintiffs, (3) de-stigmatize medical errors and thereby encourage communication through a tighter feedback loop that reduces medical errors and improves treatment quality, (4) help reduce both the costs of healthcare generally and more specifically the costs associated with medical malpractice litigation, and (5) facilitate the creation of a just culture in healthcare.
Such a system has many salutary benefits, some of which include incentives to improve the processes that led to errors as opposed to emotional denials of fault, less likelihood of non-meritorious lawsuits resulting in payment, faster patient compensation, and lower healthcare and legal costs. Infusing a greater degree of rationality into medical malpractice litigation through the proposed, or similar legal processes, should be a priority for state legislatures as new healthcare delivery and reimbursement systems evolve. The nation requires such changes because the status quo is simply unaffordable from the standpoint of ensuring access to high quality healthcare at an affordable cost. Until a greater degree of transparency in healthcare costs and quality is infused into the patient-physician relationship and the process for adjudicating medical malpractice cases reflects this transparency, little progress can be made against the practical problems that affect physicians’ difficulties with tort liability.
## APPENDIX A. KEY VARIABLES RELATED TO PHYSICIANS’ WORK ENVIRONMENT ACROSS 16 SPECIALTIES

### Type Specialty

#### Key variables

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### Compensation

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## APPENDIX B. YEAR-TO-YEAR CHANGES IN KEY VARIABLES RELATED TO PHYSICIANS’ WORK ENVIRONMENT ACROSS SPECIALTY CATEGORY

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<td>%Δ in wRVUs</td>
<td>-2.60%</td>
<td>7.88%</td>
<td>0.63%</td>
<td>0.26%</td>
<td>3.34%</td>
<td>-2.74%</td>
<td>6.56%</td>
</tr>
<tr>
<td>%Δ in liability insurance</td>
<td>8.59%</td>
<td>11.97%</td>
<td>13.12%</td>
<td>7.00%</td>
<td>-6.66%</td>
<td>19.48%</td>
<td>64.13%</td>
</tr>
<tr>
<td>%Δ in total operating cost</td>
<td>-1.56%</td>
<td>3.46%</td>
<td>1.60%</td>
<td>-1.09%</td>
<td>1.21%</td>
<td>1.32%</td>
<td>4.96%</td>
</tr>
</tbody>
</table>

| | | | | | | | |
| Primary Care | | | | | | | |
| %Δ in MC reimbursement per service | 6.09% | -0.62% | -3.46% | 0.16% | -11.81% | 34.09% | 20.56% |
| %Δ in median compensation | 2.15% | 1.92% | 2.65% | 2.86% | 3.82% | 2.59% | 17.07% |
| %Δ in #s physicians | 3.72% | 1.37% | 2.92% | 1.29% | 1.83% | 0.82% | 12.53% |
| %Δ in wRVUs | -2.30% | 6.81% | 1.81% | -2.74% | 3.38% | -3.01% | 3.60% |
| %Δ in liability insurance | 19.06% | 10.92% | -1.17% | -1.09% | -14.37% | 8.87% | 20.33% |
| %Δ in total operating cost | 0.96% | 0.72% | 1.96% | -0.22% | -0.25% | 0.28% | 3.49% |

| | | | | | | | |
| Specialties other than primary care | | | | | | | |
| %Δ in MC reimbursement per service | 5.55% | -2.59% | -19.77% | 0.07% | -12.97% | 53.40% | 10.21% |
| %Δ in median compensation | 5.19% | 3.45% | 8.45% | 1.32% | 7.06% | 1.56% | 30.02% |
| %Δ in #s physicians | 2.76% | 0.95% | 1.70% | 0.16% | 2.06% | 0.15% | 8.01% |
| %Δ in wRVUs | -4.25% | 12.65% | -1.93% | -1.76% | 2.12% | -8.35% | -2.74% |
| %Δ in liability insurance | 4.14% | 10.51% | 20.24% | 9.31% | -1.54% | 0.65% | 49.89% |
| %Δ in total operating cost | -2.65% | 4.69% | 1.45% | -1.47% | 1.86% | 1.77% | 5.60% |

| | | | | | | | |
| High-Risk | | | | | | | |
| %Δ in MC reimbursement per service | 4.10% | -5.70% | 0.18% | 1.64% | -3.92% | 11.72% | 7.28% |
| %Δ in median compensation | 4.92% | 1.20% | 4.91% | 3.93% | 5.56% | 1.70% | 24.30% |
| %Δ in #s physicians | 2.56% | 0.21% | 1.68% | 0.00% | 1.23% | -0.23% | 5.44% |
| %Δ in wRVUs | -14.64% | 22.21% | -4.17% | 2.44% | 3.77% | -0.19% | 6.07% |
| %Δ in liability insurance | 10.59% | 15.64% | 14.00% | 7.86% | -4.15% | -3.59% | 57.89% |
| %Δ in total operating cost | -0.22% | 4.03% | 1.63% | -0.53% | -0.17% | 1.51% | 6.35% |