

Tort Reform: The Impact of the ACA on Medical Malpractice

The impact of the *Patient Protection and Affordable Care Act* (ACA) on the U.S. medical malpractice system is relatively unknown, due to: (1) the lack of direct impacts; (2) the ACA's insurance provisions not becoming effective until 2014; and, (3) medical malpractice insurance being based on a historical "tail" method, i.e., the allowance of claims to be reported to an insurer of an expired policy. This uncertainty continues to reflect the concerns of medical liability insurers, in part, because there have been few, if any, answers to alleviate their uncertainty and measure the ACA's impact on the incidence and cost of medical malpractice. This is the third *Health Capital Topics* article in a three-part series on tort reform, and will summarize the impact of the ACA on the medical malpractice environment.

Only two sections of the ACA directly address the medical malpractice system. Section 6801 of the ACA simply provides a policy statement regarding the importance of medical malpractice reform and encourages Congress to develop program alternatives to the current civil litigation system for medical malpractice.¹ Additionally, Section 10607 of the ACA authorizes the *Department of Health and Human Services* (HHS) to award grants to states "for the development, implementation, and evaluation of alternatives to current tort litigation" for medical malpractice claims.² This section allows HHS to make available \$50 million in grants for these demonstration projects, subject to congressional approval.³ Congress planned demonstration projects to give states improved statistical evidence on certain types of malpractice reform, such as impacts due to apology programs, where physicians apologize for faults in care, or early disclosure, where physicians immediately disclose faults in care to patient representatives.⁴ Evidence resulting from these projects could consequently be used to develop state or federal malpractice reform laws. As of May 2016, HHS awarded seven demonstration grants totaling \$19.7 million.⁵ The projects conducted by the grantees included: (1) studies of communication methods, such as when and how physicians talk to families about instances of malpractice, including apologies;⁶ (2) improving medical procedures in risk-prone specialties, and then measuring for decreases in malpractice rates;⁷ and, (3) examining the efficacy of alternative claim settlements involving health courts, medical malpractice deferments, or judge-led

negotiations.⁸ For example, a demonstration grant in New York's funded an alternative malpractice-specific dispute system, which was found to be quicker and more financially efficient than traditional litigation, and popular with both plaintiffs and defendants.⁹ After the demonstration period, New York self-funded the project to expand it beyond Manhattan.¹⁰ However, as of April 2017, HHS has not utilized the full \$50 million in grants, and many of the grant programs failed to show a decrease in malpractice rates, greatly lessening the direct effects of the ACA on current malpractice rates.¹¹

Even without these potential direct impacts, the medical malpractice system may still face changes as a result of the ACA. The *Medical Liability Monitor's* 2016 *Annual Rate Survey Issue* found that the ACA did not *directly* impact malpractice risk, but *indirectly* impacted it through incentivizing provider consolidation and self-insurance within the industry.¹² As providers consolidate with larger health systems, insurers fear that the medical liability insurance market "will shrink as their former customers become their competitors."¹³ From 2011 to 2016, medical liability insurers consistently noted to the *Medical Liability Monitor* that hospital or *accountable care organization* (ACO) acquisitions of physician practices serve as "the biggest threat to their market share" because of the larger entity's ability to better absorb the risk related to malpractice liability.¹⁴ In theory, this ability to absorb this risk will allow for higher rates of self-insurance, which can negatively affect the rates of straight indemnity insurers.

Upon the 2010 passage of the ACA, the number of malpractice claims was expected to increase as more individuals gained health insurance coverage. Building on the premise that insured people receive more care than the uninsured,¹⁵ a RAND report on the ACA and liability insurance relationships estimated that with the expected influx of newly-insured individuals, particularly in states expanding Medicaid, more physician-patient encounters would increase the volume of overall medical errors, leading to an increase in medical malpractice lawsuits.¹⁶ Consequently, the RAND report estimated that the number of liability payments in medical malpractice actions would increase by 3.4 percent.¹⁷ However, according to the 2016 *Annual Rate Survey Issue*, claim frequency levels are at "historic lows [with] little-to-no evidence of a significant upward trend in the near future."¹⁸ It also remains unclear whether this depressed

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claim frequency actually reflects decreased numbers of medical malpractice lawsuits, although it may be attributable to the efforts by states over the past 40 years to limit noneconomic damages for this type of litigation, which may, in part, disincentive plaintiff attorneys, who work on a *contingency fee basis*, from assuming the risk of representing a client in a case that will only result in a certain (i.e., capped) amount of damages.¹⁹

One direct effect of the ACA is the remedy it has provided for a for medical malpractice cases. Due to the ACA's requirement that most individuals have health insurance (i.e., the *Individual Mandate*),²⁰ as well as the statutory out-of-pocket spending limits placed on insurers,²¹ both defense attorneys and scholars have asserted that medical malpractice future damages should be limited to the total sum of insurance premiums and out-of-pocket expenditures of plaintiffs (in contrast to the *retail rate* of each future medical service).²² Prior to ACA implementation, future medical costs comprised the bulk of damages in malpractice cases, due in part to the inability of plaintiffs to find insurance as their resulting disability qualified as a *preexisting condition*, barring them from obtaining insurance coverage and significantly increasing their out-of-pocket expenses.²³ If courts allow this proposed remedy, damages would ostensibly be limited to an individual's annual insurance premiums and ACA out-of-pocket cap of \$7,150, a total damages amount that would be significantly less than all future healthcare costs for an uninsured individual.²⁴ Due in part to this significant difference in potential damage awards, some courts are hearing defense arguments to limit damages to this future insurance limit, or are allowing defendants to pay only the future *insurance out-of-pocket amounts* for a harmed plaintiff rather than the *future health costs*.²⁵ Other states, including Minnesota, Illinois, Alabama, Michigan, New York, and Washington, have expressly disallowed this new remedy based on the *collateral source rule*, which allows

plaintiffs to recover damages regardless of insurance recovery.²⁶ California, a state without the *collateral source rule*, did not allow this remedy in a case, but the defendant only argued the full ACA-based remedy on appeal, leaving a window for future litigators to try again.²⁷ This remedy can greatly decrease the financial burden of malpractice cases on defendants, and could lower malpractice insurance premium costs, however it is unclear if courts will allow its use.

Because the ACA's insurance provisions did not take effect until 2014, there is little data to quantify the effect (if any) of the law on the amount and frequency of medical malpractice claims.²⁸ This uncertainty is also due to the structure of medical malpractice insurance. Most malpractice insurance operates on a "*tail coverage*" basis, which covers any lawsuits that may arise within a contractually-specified extended time period after an initial policy coverage period ends.²⁹ Analyzing *tail coverage* schemes requires years, and even decades, worth of datasets, which are not yet available for ACA-related claims.

Although the (direct and indirect) impacts of the ACA on medical malpractice are still unknown, the larger debate concerning the ultimate path of tort reform will continue as Congress focuses on healthcare reform. With the approval by the House Judiciary Committee of the "*Protecting Access to Care Act of 2017*,"³⁰ which seeks to implement a non-economic damages cap of \$250,000 for medical malpractice actions, the Republican-controlled Congress has signaled an intent to push for tort reform on the federal level.³¹ Healthcare and legal professionals may find it prudent to closely monitor federal tort reform bills in addition to state-level proposals, and explore the potential impact, if any, of such bills on issues affecting medical malpractice, including risk levels and the cost of professional liability insurance.

- 1 "Patient Protection and Affordable Care Act," Pub. L. No. 111-148, § 124, Stat. 804 (March 23, 2010).
- 2 *Ibid.* Stat. 1009
- 3 *Ibid.* Stat. 1014
- 4 "Medical Liability Demonstration Projects: A Small but Important Step Towards Malpractice Reform and Cutting the Costs of Health Care" By Megan Donohue, *Annals of Health Law Advanced Directive*, Vol. 20, (Fall 2010), pp. 39-48.
- 5 "Longitudinal Evaluation of the Patient Safety and Medical Liability Reform Demonstration Program" By Michelle Pillen et al., Report For Agency for Healthcare Research and Quality, May 2016, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/candor/psml-demo-grants-final-report.pdf> (Accessed 4/13/2017) p. 1.
- 6 *Ibid.* p. 12.
- 7 *Ibid.* p. 22.
- 8 *Ibid.* p. 30.
- 9 *Ibid.* p. 44.
- 10 *Ibid.*
- 11 *Ibid.* p. 39.
- 12 "Do Still Waters Still Run Deep? Medical Professional Liability in 2016" By Paul Greve, JD, RPLU and Alison Milford, ACAS, MAAA, *Medical Liability Monitor*, Vol. 41, No. 10 (October 2016) p. 6.

- 13 "From Crunchy Candy to Simmering Frogs: Waiting and Hoping for a Hardening Market as the Market Trends Slowly, Steadily Softer" By Chad C. Karls, FCAS, MAAA, *Medical Liability Monitor*, Vol. 36, No. 10 (October 2011), p. 5.
- 14 "The Slinky Effect: With Medical Professional Liability Insurance Rates Continuing to – Slowly and Steadily – Decline During the Most Recent Soft Market, It Appears It will Take Several More Years Before the Market Hardens and Rates Accelerate Upward" By Chad C. Karls, FCAS, MAAA, *Medical Liability Monitor*, Vol. 39, No. 10 (October 2014), p. 6; "Casualty Actuarial Society Session Debates Potential Medical Professional Liability Implications of PPACA" *Medical Liability Monitor*, Vol. 39, No. 7 (July 2014), p. 4; "Do Still Waters Still Run Deep? Medical Professional Liability in 2016" By Paul Greve, JD, RPLU and Alison Milford, ACAS, MAAA, *Medical Liability Monitor*, Vol. 41, No. 10 (October 2016) p. 2.
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- 16 "How Will the Patient Protection and Affordable Care Act Affect Liability Insurance Costs?" By David I. Auerbach et al., RAND Corporation, 2014, p. 30.
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- 18 Paul Greve, JD, RPLU and Alison Milford, ACAS, MAAA, *Medical Liability Monitor*, Vol. 41, No. 10 (October 2016), p. 1.

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- 21 "Out-of-pocket maximum / limit" Healthcare.gov, 2017, <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/> (Accessed 4/20/2017).
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- 24 "Out-of-pocket maximum / limit" Healthcare.gov, 2017, <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/> (Accessed 4/20/2017).
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- 27 "Leung v. Verdugo Hills Hosp., B204908, 2013 WL 221654, at *10 (Cal. Ct. App. Jan. 22, 2013).
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