Journal of Health Care Law and Policy

Volume 9 | Issue 2 Article 2

The Role of Medicare in Medical Malpractice Reform

William M. Sage
Texas A&M University School of Law, william.sage@tamu.edu

THE ROLE OF MEDICARE IN MEDICAL MALPRACTICE REFORM

WILLIAM M. SAGE*

The medical malpractice crisis we think we are in is not the medical malpractice crisis we actually are in. Today's malpractice crisis is not an epidemic of lawsuits, impressionable juries, or even excessive insurance premiums. The real medical malpractice crisis is that the law has formed little connection between the malpractice system and the health care system.

I. MALPRACTICE AND HEALTH POLICY

There are many ways in which medical liability affects cost, access, and quality in health care—which are universally accepted as the central considerations in health policy. It is well known among academics that there is a two-sided mismatch between negligence and litigation.[1] Some lawsuits are not grounded in provable negligence, but there are also high rates of uncompensated injury and avoidable medical error.[2] Procedures for resolving medical malpractice disputes, to use a technical term, are just plain lousy. Physicians and patients who should be intimates are recast as strangers and adversaries in an expensive, protracted, tactical dance. Moreover, both malpractice litigation and malpractice insurance focus on individual physicians rather than on organizational care processes that we know are responsible for the majority of preventable medical injuries.

---

* Vice Provost for Health Affairs and James R. Dougherty Chair for Faculty Excellence in Law, The University of Texas at Austin. A.B., Harvard University, 1982; M.D., J.D., Stanford University, 1988. This essay was adapted from the Stuart Rome Lecture delivered at the University of Maryland School of Law on October 28, 2005, in conjunction with a conference titled "Beyond the New Medical Malpractice Legislation: New Opportunities, Creative Solutions, and Best Practices for Patient Safety, Tort Reform and Patient Compensation." The article is supported by a grant from the Commonwealth Fund to the author and to Professor Eleanor D. Kinney at the University of Indiana-Indianapolis School of Law to study Medicare's role in malpractice reform. Data from Texas contained in this essay is from the project on medical malpractice at the University of Texas School of Law, and was provided by Professors Bernard Black, Charles Silver, and David Hyman. The author also thanks Myungho Paik and Benjamin Wallfisch of the University of Texas for research assistance.

1. *See* HARVARD MED. PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 6 (1990) (finding that while many claims of negligence were unsubstantiated, other patients who suffered injuries from negligence did not file lawsuits); Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1618-20 (2002) (summarizing studies which analyzed "the problem of poor fit" between claims of medical negligence and actual injuries from medical negligence).

2. In the Harvard Medical Practice Study, approximately one-eighth of events judged negligent by the researchers led to malpractice litigation, and only half of those were eventually compensated. For every valid claim filed, roughly six were filed with respect to non-negligent care. Mello & Brennan, *supra* note 1, at 1619; *see also* HARVARD MED. PRACTICE STUDY, *supra* note 1, at 6.

We need to turn a corner in medical malpractice policy. The old Clinton campaign mantra "It's the economy, stupid" can be restated for medical malpractice as "It's patient care, stupid." For the most part, the malpractice reform debate has been about things outside of the health care system, such as lawyers, courts, or the supposed litigiousness of the American public.[3] Many of the presentations at the University of Maryland conference, "Beyond the New Medical Legislation: New Opportunities, Creative Solutions, and Best Practices for Patient Safety, Tort Reform and Patient Compensation," were about patient care, and that is wonderful. But even in Dr. Deborah Roter's presentation, which applied "thin-slice" analysis to physician-patient communication, the connection between the malpractice side and the patient care side seemed tentative.[4] It is not merely that bad communication leads to malpractice litigation. Bad communication is bad medicine.[5]

Malpractice reform is fundamentally about resolving problems with medical care.[6] In its 2001 report, *Crossing the Quality Chasm*, the Institute of Medicine (IOM) argued that a high quality health care system should be safe, effective, patient-centered, timely, efficient, and equitable.[7] I believe that the current medical malpractice system furthers none of those goals. The solution is to integrate malpractice policy with health policy. A better malpractice system requires a better health care system, and a better health care system requires a better malpractice system.[8] That is what I am hoping to give voice and substance to in this essay discussing Medicare's role in malpractice reform.

---

3. *See* William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, *in* HEALTH LAW HANDBOOK 1, 1-2 (Alice G. Gosfield ed., 2003) (describing the medical community's view of malpractice lawsuits as "patient opportunism and lawyer entrepreneurship").

4. *See* Debra Roter, *The Patient-Physician Relationship and its Implications for Malpractice Litigation*, 9 J. HEALTH CARE L. & POL'Y 304, 310-11 (2006).

5. *See* William M. Sage, Editorial, *Putting the Patient in Patient Safety: Linking Patient Complaints and Malpractice Risk*, 287 JAMA 3003, 3004-05 (2002) (suggesting a system-wide incorporation of "patient perspectives" to minimize the risk of malpractice litigation).

6. There is an increasing recognition of the need for a systems-oriented approach. *See, e.g.*, JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., SETTING THE STANDARD: THE JOINT COMMISSION & HEALTH CARE SAFETY AND QUALITY 1 (2005), *available at* http://www.jointcommission.org/NR/rdonlyres/6C33FEDB-BB50-4CEE-950B-A6246DA4911E/0/setting_the_standard.pdf.

7. INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 3 (2001), *available at* http://www.iom.edu/CMS/8089/5432/27184.aspx.

8. By contrast, most tort reformers seek simply to discourage malpractice claims and reduce recoveries. *See, e.g.*, President George W. Bush, Remarks at the University of Scranton (Jan. 16, 2003), *available at* http://www.whitehouse.gov/news/releases/2003/01/20030116-1.html; OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM (2002), *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.pdf; Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFF. WEB EXCLUSIVE, Jan. 20, 2004, at W4-20-W4-21, http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1/DC1.

Why is malpractice policy not part of health policy? I won't belabor the question, but will make some educated guesses. Part of the disconnect derives from 150 years of antagonism between doctors and lawyers.[9] Another part has to do with politics. The politics of the malpractice crisis that began in 2002 are strikingly different from the politics of the crises of the 1970s and 1980s.[10] Malpractice politics today are subsumed by the overall politics of general tort reform. This country is embroiled in a deep partisan and ideological debate over the effect of personal injury lawyers on the American economy and social fabric.[11] This is not fundamentally a debate about health care, although constituencies on both sides use health care whenever it is convenient to support their general arguments.[12]

Periodicity is another barrier between malpractice and health policy.[13] I sometimes describe medical malpractice as the "Rip Van Winkle" issue of American health care because it wakes up every decade or two rather than evolving as general health policy evolves. Each reprise merely echoes the previous debate.

A final barrier that I think bears emphasis, and that leads towards the Medicare-related proposals that I discuss, is government structure. Malpractice has been a judicial branch issue, while health care has been a legislative and executive branch issue. Malpractice has been a state law issue, while health care is governed increasingly by federal law. The ascendance of federal law is attributable to the enactment of Medicare and Medicaid in 1965, but those major programs have been invisible where medical malpractice is concerned.

II. PATHS TO COMPREHENSIVE MALPRACTICE REFORM

To appreciate the need for testing dramatic alternatives to the existing malpractice system, one must consider how malpractice looks as a public policy problem now compared to twenty years ago. The medical malpractice system has three parts: legal process, health care delivery, and liability insurance. Before the Harvard Medical Practice Study, before the patient safety movement, and before the IOM's reports, medical malpractice reform seemed only to be about frivolous

9. JAMES C. MOHR, DOCTORS AND THE LAW: MEDICAL JURISPRUDENCE IN NINETEENTH-CENTURY AMERICA 105 (1993) (describing early antipathy between doctors and lawyers); William M. Sage, *The Lawyerization of Medicine*, *in* UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE 302-17 (Peter J. Hammer et al. eds., 2003).

10. Sage, *supra* note 3, at 2.

11. *See* Postings of William M. Sage to PointofLaw, http://www.pointoflaw.com/feature/condition_critical1205.php (Nov. 14, 2005, 10:18 EST - Dec. 6, 2005, 11:18 EST); Postings of James R. Copland to PointofLaw, http://www.pointoflaw.com/feature/condition_critical1205.php (Nov. 14, 2005, 01:50 EST - Nov. 24, 2005, 02:38 EST). *See generally* Theodore B. Olson, *The Parasitic Destruction of America's Civil Justice System*, 47 SMU L. REV. 359 (1994) (describing the negative effect of litigiousness and the costs of the tort system on the American economy, society, and culture).

12. Sage, *supra* note 3, at 4-6.

13. *Id.* at 1-2.

lawsuits and excessive damage awards—in other words about the tort system.[14] Malpractice reform today also is about inadequate compensation for injury, excessive rates of medical error, a poor litigation process, and unnecessarily volatile liability insurance premiums.

Patient safety has become incorporated into the rhetoric of malpractice reform, but liability insurance is still ignored, particularly in reforms with high public visibility.[15] If we are to avoid recurring problems with insurance availability and affordability that send lobbyists scurrying to state legislatures seeking general tort reform, it is crucial to find public policy vehicles for looking at the insurance side of the medical liability crisis. Specifically, liability insurance should be structured and priced to reduce the burden on physicians in a few "high-risk" specialties to finance the coverage needs of an increasingly industrialized, coordinated health care system.

Something else that has revealed itself in this crisis is that premium volatility for hospitals and institutional providers, unlike for physicians, is seldom related to their primary coverage.[16] Hospitals are large enough to self-insure or negotiate acceptable experience-rated primary coverage; what they cannot afford these days is excess layer coverage (the risk corridor from, say, five to 50 million dollars). Excess layer coverage is the major source of hospitals' financial anxiety about malpractice. It is also an opportunity for government to offer financial assistance with excess coverage in exchange for improvements in error prevention and compensation at the institutional level.

Put it all together, and we need comprehensive malpractice reform, not just measures to discourage lawsuits and limit financial recoveries. A few steps toward reform can be taken voluntarily by individuals or institutions. For example, I strongly favor immediate disclosure of medical errors to patients, apology where appropriate, and early mediated discussions about safety improvements and fair compensation.[17] Doug Wojcieszak of Sorry Works! is right when he tells physicians to apologize for errors because "you don't need the politicians to help you."[18] However, we also need sources of systematic reform that can address the broader problems that I have identified.

---

14. *Id.*

15. William M. Sage, *Medical Malpractice Insurance and the Emperor's Clothes*, 54 DEPAUL L. REV. 463, 463-64 (2005).

16. *Id.* at 479.

17. *See* Gerald B. Hickson et al., *Patient Complaints and Malpractice Risk*, 287 JAMA 2951, 2951 (2002) (concluding that patient complaints are correlated with physicians' malpractice risk).

18. *See* Doug Wojcieszak, *The Sorry Works! Coalition: Executive Summary*, SORRYWORKS.NET, http://www.sorryworks.net/WhatIs.phtml (last visited Sept. 21, 2006) (encouraging physicians and insurers to "be honest when mistakes happen, offer apologies, and provide compensation up-front to patients and their attorneys").

There are three possible avenues for comprehensive reform, meaning reform that includes improvements to patient safety and liability insurance as well as dispute resolution. First, state-based demonstration projects of the sort the IOM recommended in 2002 would be able to test administrative compensation systems and other less adversarial mechanisms for identifying, compensating, and ultimately preventing medical errors.[19] Second, employer initiatives might be an avenue for malpractice reform experiments. The so-called "ERISA shield," as currently interpreted by the Supreme Court, gives private employers considerable leeway to develop innovative programs that take malpractice disputes involving beneficiaries of employment-based health coverage out of the courts.[20] However, private employers have conflicting interests where tort reform is concerned. They want better, safer medical care for their workers, but they also want to reduce lawsuits against business generally. It is very hard for private employers, I suspect, to support major initiatives that attempt systematic restructuring of the malpractice system, because those initiatives might sap energy from general tort reform efforts that employers have supported for decades. Some innovative employer coalitions might try it, such as the Pittsburgh Regional Healthcare Initiative, or perhaps the Pacific Business Group on Health.

The third possibility—and the focus of this article—is to jumpstart reform through the Medicare program by sponsoring federal demonstration projects that would change the way that Medicare beneficiaries are treated when medical care causes unexpected injury. There are four major reasons why Medicare should take a leadership role in malpractice reform. I will state them briefly and then describe each in some detail. First, conventional malpractice litigation serves Medicare beneficiaries very poorly. Elderly patients file fewer claims and receive lower payments when they do pursue legal action. Second, Medicare brings both patient care and insurance directly into the malpractice debate. Medicare is a progressive presence in quality improvement, patient safety, and pay for performance. The federal government also is uniquely positioned to offer reinsurance to health care institutions in exchange for improving the performance of the malpractice system. Third, Medicare has significant procedural advantages over conventional litigation in terms of dispute resolution. Notably, Medicare's existing administrative system

19. INST. OF MED., FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS 81-89 (Janet M. Corrigan et al. eds., 2002) [hereinafter FOSTERING RAPID ADVANCES] (proposing state-based demonstrations in categories including chronic care, information and communications technology infrastructure, state health insurance, and liability as part of a "major redesign of health care processes").

20. *See, e.g.*, Aetna Health Inc. v. Davila, 542 U.S. 200, 204 (2004) (invalidating as preempted by ERISA a state law allowing claims for medical complications arising from a benefits determination); *see also* Russell Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POLICY, L. & ETHICS 89 (2005); Karen A. Jordan, *Recent Modifications to the Preemption Doctrine & Their Impact on State HMO Liability Laws*, 1 IND. HEALTH L. REV. 53, 57-58 (2004).

of adjudication for benefits disputes constitutes a promising foundation for a "health court." Fourth, Medicare politics are more oriented to health care than are the general politics of tort reform.

A. Malpractice Litigation and the Elderly

How do the elderly fare in conventional malpractice litigation? Let us examine data from Texas on the outcome of malpractice claims.[21] A handful of states collect data on malpractice insurance, but only Texas and Florida make that information widely available, even to researchers.[22] The Texas Department of Insurance (TDI) closed claim database is unique. Since 1988, property and casualty insurers have been required to file reports on all payments made on medical malpractice claims.[23] The Texas data has some limitations. We do not know detailed information, such as claimant age, about payments of less than $25,000 (not adjusted for inflation), and we do not know anything about claims that do not generate payments.[24] We cannot match payments to physician specialties. We do not know clinical details such as cause or severity of injury. But the Texas database is mandated by law, and its reports are complete and reliable, at least from 1990 on, once insurers became accustomed to the reporting system.[25]

How often do elderly patients receive payment on malpractice claims? There were nearly 12,000 malpractice payments of $25,000 or more (in 1988 dollars) made in malpractice cases in Texas between 1990 and 2003, which totaled $3.8 billion.[26] Senior citizens generated 16% of these paid claims.[27] Adults aged 19-64 generated 64%, children aged 1-18 generated 9%, and infants under one generated 11% (mainly representing neonatal injuries).[28] These are raw numbers. They are not adjusted for the size of the population of each of those age groups in Texas or, more importantly, for the "opportunity" to be injured by health care as measured by hospitalizations, physician visits, or other units of medical service.

---

21. The data contained in this section is explained in greater detail in William M. Sage et al., Medicare Beneficiaries and Malpractice Litigation: Data from Texas (2006) (working paper on file with author) [hereinafter Data from Texas].

22. Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 J. EMPIRICAL LEGAL STUD. 207, 211 (2005).

23. *Id.* at 213-15.

24. *See id.* at 215 (describing the aggregate reports filed by insurers of claims with total payments of $10,000 or less).

25. Data from 1988 and 1989 are limited by underreporting. *Id.* Beginning with 1990, TDI's reconciliation and review process makes this data more reliable. *Id.*

26. Data from Texas, *supra* note 21, at 4.

27. *Id.*

28. *Id.* at 4, 7.

We can say more about two groups, people ageed 65 and over, and people aged 1-64. Because we know what percentage of medical services is financed by Medicare compared to other payers, we can control for how many days elderly and non-elderly Texans spent in the hospital during the study period. We will omit neonatal admissions and claims, and adult admissions and claims related to labor and delivery.

Between 1990 and 2003, there was only one large malpractice payment on behalf of an elderly patient for every 50,000 days that elderly patients spent in the hospital.[29] An elderly patient was only 20% as likely as a non-elderly patient to be paid on a large malpractice claim.[30] On the other hand, paid claims for elderly patients are increasing at over 14% annually, and wrongful death claims for elderly patients are increasing at 20% annually.[31] Paid claims for other age groups are not increasing.[32]

What about payment amounts? From 1990 through 2003, the median payment for claimants ages 65 and over was $113,000, compared to $129,000 for ages 19-64, $155,000 for ages 1-18, and $218,000 for neonatal claimants (who often have suffered lifelong disability).[33] Mean payment amounts look even more disadvantageous to the elderly than do medians: $287,000 for ages 19-64 versus $198,000 for ages 65 and over.[34] It is striking that, of the 100 largest payouts during the study period, only one case involved an elderly patient. Overall, elderly claimants receive on average 31% less on paid claims than non-elderly adult plaintiffs.[35] In regression analysis, for every one-year increase in a patient's age, payments decrease by 0.5% (again, excluding the neonatal group). Over time, however, payment amounts (in constant dollars) to elderly claimants are increasing, while those to other age groups are not.

There are several possible explanations for why the elderly fare poorly in malpractice litigation.[36] Elderly patients tend not to realize that they have suffered

---

29. *Id.* at 6.

30. *Id.*

31. *Id.* at 10 ("Paid claims for patients aged 65+ increased on average 14% annually. . . . [But there was] an even sharper increase over time (20% annually) in paid wrongful death claims for elderly patients. . . .").

32. *Id.*; *see also* Black et al., *supra* note 22, at 209.

33. Data from Texas, *supra* note 21, at 7.

34. *Id.*

35. *Id.* at 1.

36. Studies from the 1980s also showed that elderly patients are less likely to obtain compensation for injury through malpractice litigation. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: MEDICARE/MEDICAID BENEFICIARIES ACCOUNT FOR A RELATIVELY SMALL PERCENTAGE OF MALPRACTICE LOSSES 3, 19 (1993) (noting that "Medicare patients' percentage of hospital malpractice awards is significantly lower than their portion of hospital discharges and inpatient days.") [hereinafter GAO, MALPRACTICE LOSSES]; *see also* OFFICE OF TECH. ASSESSMENT, U.S. CONG., DO MEDICAID AND MEDICARE PATIENTS SUE PHYSICIANS MORE OFTEN THAN OTHER PATIENTS? 13-14 (1992) (finding that Medicare patients sue "less frequently than expected given their

negligent injuries. Even if they recognize a problem, seniors depend on their doctors and hospitals and often do not want to alienate them by filing a lawsuit. If elderly patients do seek redress, their lower remaining life expectancies and reduced employment rates are less likely to generate damages substantial enough to induce lawyers, who are often paid on contingency, to accept them as clients. Lawyers also know that it is difficult to settle cases involving elderly clients because causation of injury is seldom clear-cut in patients with pre-existing illnesses. Nor can elderly clients easily endure the long delays involved in litigation; in our data, the median claim took over three years to resolve.

There are also potential explanations for the trend toward convergence with non-elderly claimants, including changing public expectations regarding life expectancy and quality of life for seniors. It would be interesting to consider how Texas compares to Florida, a state with a much higher elderly population and the only other state that allows researchers access to its database of paid malpractice claims.[37] Might there be greater parity in Florida because its jury pools sympathize with the elderly more than in Texas? Nursing home litigation also may have a regularizing effect. As lawyers take cases involving elder abuse or neglect in nursing homes, they become accustomed to making arguments on behalf of seniors and to finding experts who can help them prove significant damages in court.

The takeaway message from our Texas data is that elderly patients are poorly compensated by the current system of malpractice litigation. Over time, however, claims involving elderly patients are becoming a greater burden on the malpractice system. It is rare, in my experience, for someone with a policy proposal to appeal simultaneously to tort law defenders and tort law reformers. But this may be one such case. On one hand, it is necessary to improve access to compensation for seniors who suffer medical injury. On the other hand, doing nothing may well lead to problems of cost and unpredictability as tort litigation involving elderly patients expands. A reason to begin reform now through Medicare is to remedy the former injustice without an epidemic of litigation that might dissuade physicians from treating Medicare patients. If Medicare does not begin to take ownership of the issue, moreover, medical liability will be governed, if at all, by conventional state-

---

heavy use of health services"); Helen R. Burstin et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697, 1699 (1993) (discovering that patients over 65 were "less likely to file malpractice claims than younger patients"). When they are compensated, Medicare patients tend to receive awards that are half the size of those won by privately insured patients. *See* GAO, MALPRACTICE LOSSES, *supra*, at 13. More recent studies confirm this disparity, showing that the elderly are less likely to file malpractice claims and suggesting that they are doubly harmed because they also suffer "higher rates of medical injury." David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 257 (2000).

37. *See* Neil Vidmar et al., *Seeking the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. 315 (2005). The Vidmar study does not report findings based on claimant age.

based tort reform. In 2003, for example, Texas capped malpractice damages and made other changes that may reverse current trends toward more frequent claims and higher payments for elderly plaintiffs.[38] Flat caps on damages are a blunt instrument that I consider undesirable when other, more targeted reforms exist.[39]

B. Substantive Benefits of Medicare-Led Malpractice Reform

The need for Medicare to be involved in medical liability should be self-evident. Only the long, contentious history of malpractice reform, which has divided federal payment policy from state-based tort law, makes the notion of Medicare-led reform sufficiently original to merit academic exposition.

Let me share with you some of Medicare's obvious advantages. Medicare is the largest health insurance program in the nation. Consequently, Medicare often sets the standard for the entire health care system. Health insurance is first-party rather than third-party coverage, which positions it to address problems with the current malpractice system better than malpractice insurance. Third-party liability insurance exists to protect a policyholder against lawsuits from "outside." It ignores the fact that, in malpractice cases, the person who is filing the claim is an intimate, a patient, who deserves something better than to be regarded as stranger and adversary. By contrast, the interest of a first-party insurer such as Medicare is to serve the patient-beneficiary directly.

Medicare also is the de facto regulator of American hospitals—either directly or through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[40] Hospitals remain the locus of most serious medical errors, and have greater financial capacity than individual physicians to bear or insure the costs of compensating avoidable injuries. Furthermore, if one believes, as most experts do, that patient safety advances require organized systems of care, Medicare's indispensability to American hospitals offers a unique opportunity for linking malpractice reform and quality improvement. Accordingly, in early 2005, JCAHO

---

38. TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.301-.303 (Vernon 2005).

39. Because malpractice caps reduce the number of large paid claims and the average payout per claim, they can result in lower insurance premiums. *See* W. Kip Viscusi & Patricia H. Born, *Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance* 18-20 (Harvard Law School John M. Olin Center for Law, Economics, and Business Discussion Paper Series, Discussion Paper No. 467, 2004), *available at* http://ssrn.com/abstract=607203. However, there can be undesirable consequences as well. *See* David M. Studdert et al., *Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFF. 54, 60 & ex. 4, 63 (2004) (finding that flat caps disproportionately affect severely injured patients, especially those with chronic pain or disfigurement).

40. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 182 (5th ed. 2004) (describing "deemed status" for JCAHO-approved hospitals). Through prescribed "conditions of participation," the Medicare program has broad authority to impose, via regulation, operating conditions on health care institutions. *See, e.g.*, 42 U.S.C. § 1395z (2000); 42 U.S.C. § 1395x(e) (2000); 42 C.F.R. § 482.1(a)(1)(ii) (2005).

endorsed demonstrations of comprehensive malpractice reform, including through Medicare.[41]

Medicare is governed by a federal statute, allowing administrators to impose uniform requirements nationally notwithstanding variation in state constitutions, statutes, and common law. Medicare has a well-developed administrative structure, including mechanisms for adjudicating disputes, and enjoys broad authority to sponsor demonstration projects.[42] Lawmakers and administrators have been trying, since Medicare's inception, both to defend quality in the program and to make sure that financial waste is reduced.[43] Consequently, Medicare deals daily with difficult questions of medical science and medical economics, and regularly issues rules, creates or modifies monitoring procedures or bodies, and tests new ideas.

Consider the conceptual infrastructure necessary for testing radical malpractice reform (I will return to the procedural infrastructure later). The recommendations for state-based demonstration projects issued in 2002 by the IOM recognized that an administrative, non-judicial compensation system for medical injuries requires a research base, an expert process for turning research into operational standards for administrative adjudication, and a public process to ensure that the resulting system meets social criteria regarding rationality and fairness.[44]

Several questions must be answered for a reformed malpractice system housed in Medicare to become operational. Which injuries should receive compensation, and based on what evidence? How should "avoidable" injury be defined? Should certain events be designated as automatically compensable? Should there be injury thresholds to qualify claimants for compensation? What scope of error disclosure to patients and families should be required? What amount of compensatory damages is appropriate, both economic and non-economic (i.e., pain and suffering)? How should compensation awarded following preventable injury relate to compensation available from first-party systems of

---

41. JOINT COMM'N ON ACCREDITATION OF HEALTH CARE ORGS., HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR IMPROVING THE MEDICAL LIABILITY SYSTEM AND PREVENTING PATIENT INJURY 33, 39 (2005), *available at* http://www.jointcommission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F/0/Medical_Liability.pdf.

42. 42 U.S.C. § 1395ll (2000). For example, the Medicare Modernization Act gives the Centers for Medicare and Medicaid Services (CMS) authority to offer "incentives to improve the safety of care provided to beneficiaries" on a demonstration basis. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 646(b)(1), 117 Stat. 2324 (2003) (codified as amended at 42 U.S.C. § 1395cc-3 (2005)).

43. *E.g.*, Peer Review Improvement Act of 1982, Pub. L. No. 97-248, § 1511, 96 Stat. 383 (codified as amended at 42 U.S.C. § 1320c (2000)) (creating Peer Review Organizations to perform utilization review and enforce professionally recognized standards of quality); Social Security Amendments of 1972, Pub. L. No. 92-603, § 201(a)(2), 86 Stat. 1371 (codified as amended at 42 U.S.C. § 1395x(k)) (requiring utilization review for hospital services).

44. FOSTERING RAPID ADVANCES, *supra* note 19, at 85-86.

health or disability insurance (including the legal question of subrogation rights)? How should information gathered in the course of awarding compensation be used for safety improvement? Public policy experts and reform advocates have been studying these issues for years, but it will take a sustained commitment from government to resolve them.

Medicare has various ongoing efforts that are intended to improve quality in health care. Some involve consumer information;[45] others are based on changing providers' financial incentives; still others involve direct oversight or feedback. A few, such as the Premier Hospital Quality Incentive Demonstration,[46] apply new rules selectively to hospitals that elect to participate and fulfill defined participation criteria. These demonstration programs can include, and can leverage, malpractice reform.

One approach that has gathered steam in recent months, both within Medicare and outside it, is "pay for performance."[47] I confess to being shameless about jumping on bandwagons where I think it serves public policy goals. "Performance" could easily include an improved malpractice system. If avoidable injury is bad medicine, communicating poorly with patients and their families after injury is bad medicine, and not compensating patients fairly and promptly is bad medicine, then Medicare might pay physicians and hospitals for doing these things better.

How could Medicare pay for this sort of performance? One possibility is through federally subsidized liability coverage, particularly excess or stop-loss coverage that is extremely costly to hospitals in downturns of the insurance cycle. When global insurance capacity is strained, as it has been in recent years primarily because of natural disasters and terrorism, government can provide affordable, reliable reinsurance for medium-sized lines of coverage, such as medical liability, that are too uncertain and too costly to administer to be attractive to commercial insurers during dips of the insurance cycle. It is likely that hospitals in the current liability environment would welcome federal assistance, even if it were contingent

45. For example, a new quality tool developed by CMS, Hospital Compare, allows consumers to access information on the comparative performance of hospitals on health care quality. U.S. Dept. of Health & Human Services, Hospital Compare, http://www.hospitalcompare.hhs.gov (last visited Aug. 30, 2006).

46. CTRS. FOR MEDICARE & MEDICAID SERVICES, U.S. DEPT. OF HEALTH & HUMAN SERVICES, REWARDING SUPERIOR QUALITY CARE: THE PREMIER HOSPITAL QUALITY INCENTIVE DEMONSTRATION FACT SHEET (Jan. 2006), http://www.cms.hhs.gov/HospitalQualityinits/downloads/HospitalPremierFS200602.pdf.

47. AM. MED. ASS'N, PHYSICIAN PAY FOR PERFORMANCE (PFP) INITIATIVES 4 (2004), *available at* http://www.wsma.org/memresources/p4p_revised_wc2.pdf; William M. Sage, *McDonald-Merrill-Ketcham Lecture: Pay for Performance: Will It Work In Theory?*, 3 IND. HEALTH L. REV. 305 (2006); William M. Sage & Dev N. Kalyan, *Horses or Unicorns: Can Paying For Performance Make Quality Competition Routine?*, 31 J. HEALTH POL. POL'Y & L. 531 (2006); David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427, 1429 (2001).

on greater accountability for medical error and assurances that they would pay reasonable compensation for avoidable injury.

The process of qualifying for, as well as agreeing to participate in, a demonstration of an improved malpractice system is what I call "earn-in." If a hospital wants to substitute a damage-capped, administrative system of dispute resolution for conventional tort liability, it has to show that it deserves the privilege. It has to do things that health care providers should be doing to keep patients safe and resolve disputes expeditiously. It has to demonstrate its patient safety infrastructure: the ability to identify, collect, and analyze adverse events. It has to commit to disclosing unexpected outcomes of care to patients and families. It has to compensate clearly avoidable injuries promptly and compassionately.

Notice that if providers with these positive attributes are participating in Medicare malpractice demonstration projects, it gives a very different flavor to malpractice reform. Instead of conferring tort immunity on providers that are average, or possibly below average, we would be conferring tort immunity on providers that can prove themselves above average. That changes the nature of the debate. Those institutions have earned the right to participate in a better system; we are not just sheltering them from the legal consequences of their mistakes.

C. Procedural Advantages of a Medicare-Based Malpractice System

Let us turn to Medicare's capacity for dispute resolution, which offers significant advantages over most alternatives, including generic "health courts" proposals. Medicare offers a federal administrative law—as opposed to a state tort law—model for resolving malpractice cases. Administrative law proposals have an established place in the history of malpractice reform. In the late 1980s, the American Medical Association (AMA) and many physician specialty societies proposed an intricate, scholarly model for a fault-based administrative system of malpractice dispute resolution.[48] Many of its features are strikingly similar to what many public policy experts are talking about today, in particular its commitment to preserving accountability for error.

---

48. AM. MED. ASS'N, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED, ADMINISTRATIVE SYSTEM (1988); *see also* COMM. TO STUDY ALTERNATIVES TO THE PRESENT SYS., PHYSICIAN INSURERS ASS'N OF AM., A COMPREHENSIVE REVIEW OF ALTERNATIVES TO THE PRESENT SYSTEM OF RESOLVING MEDICAL LIABILITY CLAIMS 125-62 (1989) (outlining four proposals for changes to the judicial compensation system from concerned organizations); Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1367 (1989) (describing the AMA proposal). *See generally* Eleanor D. Kinney, *Malpractice Reform in the 1990s: Past Disappointments, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99 (1995) (providing a general background on malpractice reforms, especially this "second generation" of reforms).

Proposals like the IOM's[49] or JCAHO's[50] that apply an "avoidability" standard instead of a classic "negligence" standard to determine eligibility for compensation are often mislabeled "no-fault" reforms.[51] The term "no-fault" should be reserved for situations of true accident, where the transaction costs of assessing fault are so high, and the usefulness of those determinations for future injury prevention so limited, that it is simpler just to pay compensation and spread the cost as broadly as possible. Nobody, not the medical profession, not the patient safety community, and not the general public, thinks that medical errors should be written off as accidental.

The current generation of "no-trial" ideas, like the AMA's fault-based system fifteen years ago, is more accurately analogized to systems of strict liability for defective products.[52] In strict liability, someone is always held accountable. The difference between the 1980s and today is which "someone." In the AMA proposal, it was the individual physician.[53] In more recent proposals such as the IOM's, it tends to be the "enterprise"—a hospital, organized system of care, or physician group—that is considered responsible, with less blame attaching to individual professionals.[54]

In both the AMA proposal from the 1980s and the IOM proposal from 2002, the determination that things should have been done better is rendered by an expert administrative system, not by a trial court of general jurisdiction. I think there are persuasive reasons for moving as much medical injury compensation as possible into administrative resolution systems and out of civil litigation. This is not because I dislike lawyers; obviously, I respect lawyers. But if one asks an experienced plaintiff's malpractice lawyer how much in damages a case has to offer for her to consider taking it, the answer usually is around $200,000, reflecting the high costs of expert witnesses and the long delays that typically precede settlement or trial. That means anybody who suffers an injury worth less than $200,000 cannot find a lawyer, or at least a lawyer actually capable of handling a complex malpractice case. Administrative systems can do better on access-to-

49. FOSTERING RAPID ADVANCES , *supra* note 19, at 82.

50. JOINT COMM'N ON ACCREDITATION OF HEALTH CARE ORGS., *supra* note 41, at 13-14.

51. *See, e.g.*, David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225, 226-28 (2001); David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 217 (2001) (using the IOM's mandates to advocate no-fault reforms).

52. *See* FOSTERING RAPID ADVANCES, *supra* note 19, at 81.

53. *See* AM. MED. ASS'N, *supra* note 48, at ii-iv.

54. FOSTERING RAPID ADVANCES, *supra* note 19, at 83, 86; *see also* William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1, 19 (1994) (discussing the variability in who may be liable for medical malpractice and the resulting increased transaction costs).

justice grounds alone, not to mention faster resolution, lower cost, greater satisfaction for both plaintiff and defendant, and better prevention of future injury.

A striking aspect of the AMA's proposal, which distinguished it from the routine tort reform of the 1980s, was that it conceded the need to compensate more injured patients than does litigation.[55] The AMA did not seek to create a system "on the cheap" that merely would take people who currently go to court and pay them lesser damages while incurring reduced administrative expense. The AMA recognized that a major goal of an administrative law-based malpractice system was to compensate a larger percentage of avoidable injuries.[56] I think most current "health courts" proposals share this basic commitment.[57] I disagree with people who argue that saving money is the principal reason to pursue malpractice reform. It is not just about saving money. It is about better medical care. It is about dealing constructively with bad situations, for the benefit of both patients and physicians.

Why do I emphasize the Medicare approach over more general "health courts" proposals, such as those offered by Philip Howard's organization Common Good?[58] At a conceptual level, I support Common Good's approach, but I think generic health courts have three significant limitations in practice. The first problem is that they are reactive. Patients still have to walk into lawyers' offices and say that something bad happened to them. And lawyers have to investigate, and then decide to file claims. A second problem with generic health courts is that they are stand-alone. They are not connected to anything else that exists to improve health care quality or assure good patient care. To Common Good's credit, they and other health court advocates seem genuinely interested in turning the corner from health courts as a litigation reform to health courts as a health care reform. But the legal institutions that they propose do not bear any logical relation to health care delivery or health care regulation. The third problem with health courts is that they are hypothetical. We do not have them yet, and it will take a lot of time and political capital to build them.

By contrast, we definitely have Medicare and it is not going away. Medicare is already immersed in medical quality and can relate malpractice dispute resolution to its overall health policy mission. As a result, Medicare can take a

---

55. AM. MED. ASS'N, *supra* note 48, at i.

56. *Id.* at i-ii.

57. *See, e.g.*, JOINT COMM'N ON ACCREDITATION OF HEALTH CARE ORGS., *supra* note 41, at 13.

58. The Common Good Institute advocates establishing health courts with "full-time judges, dedicated solely to addressing healthcare cases," neutral experts to assist those judges, faster procedures and lower costs, "liberalized recovery for injured patients," and a fixed-schedule for damages. COMMON GOOD, AN URGENT CALL FOR SPECIAL HEALTH COURTS: AMERICA NEEDS A RELIABLE SYSTEM OF MEDICAL JUSTICE (2005), http://cgood.org/assets/attachments/130.pdf (last visited Aug. 30, 2006).

proactive stance on error detection, compensation, and prevention. Medicare can find out if something bad happened to a patient, in large part because Medicare providers can be charged with monitoring and reporting unanticipated outcomes of care. This is especially true for providers who have voluntarily agreed to test a new system of dispute resolution as part of a demonstration project. Other health care regulators, self-regulators, or payers could play a similar anchoring role for medical courts, including JCAHO, state departments of health, state medical boards, patient safety authorities in the few states that have created them, and even large employers and business coalitions. But Medicare is one of our best opportunities for progress.

A demonstration of Medicare-led malpractice reform would build on Medicare's established systems for processing and deciding claims over benefits. Medicare benefit determinations frequently involve medical review by clinical experts and require decision-makers to estimate disability and future medical needs, as well as to award compensation based on pre-established schedules. This experience would also be useful in administering malpractice disputes.[59] Pursuant to the Medicare Modernization Act, the administrative law judges (ALJs) who have traditionally heard Medicare benefit cases and were lodged in the Social Security Administration have now been brought over to the Department of Health and Human Services (HHS).[60] This transition, which is being carefully monitored to ensure that the ALJs will be independent from HHS in their new role, offers a unique opportunity to assign a subset of those judges the task of deciding malpractice cases on a demonstration basis.[61]

Medicare's less formal dispute resolution processes, which precede and often avoid administrative and judicial review, would also be relevant to malpractice reform.[62] Medicare contractors—Part A intermediaries, Part B carriers, and

---

59. *See* William M. Sage & Eleanor D. Kinney, *A Malpractice System for Medicare, in* MEDICAL MALPRACTICE REFORM IN THE UNITED STATES (William M. Sage & Rogan Kersh, eds., forthcoming 2006).

60. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 931(a)(1), 117 Stat. 2396, 2396-99 (codified as amended at 42 U.S.C. § 1395ff (2005)); Medicare Program: Changes to the Medicare Claims Appeal Procedures, 70 Fed. Reg. 11,420, 11,422 (Mar. 8, 2005) (to be codified at 42 C.F.R. pts. 401 & 405).

61. The new Medicare law requires Medicare ALJs to be located in an office "organizationally and functionally separate" from CMS, which reports to the Secretary "but shall not report to, or be subject to supervision by" any other officer within HHS. Medicare Prescription Drug, Improvement, and Modernization Act § 931(b)(2).

62. Congress established the current process for Part A and Part B beneficiary appeals in 2000. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, § 521, 114 Stat. 2763, 2763A-534 to 543 (codified as amended at 42 U.S.C. § 1395ff (2005)); Medicare Program: Changes to the Medicare Claims Appeal Procedures, 70 Fed. Reg. at 11,420, 11,422; *see also* Eleanor D. Kinney, *Medicare Coverage Decision-Making and Appeal Procedures: Can Process Meet the Challenge of New Medical Technology?*, 60 WASH. & LEE L. REV. 1461, 1479-80 (2003) (describing the changes to the Medicare national and local coverage decision-making processes under the 2000 Act).

Medicare Advantage managed care plans—have internal procedures prescribed by law for handling grievances and disputes over benefits, including independent medical review.[63] Medicare also uses ombudsman programs to help beneficiaries gather information and air grievances over benefits,[64] and is experimenting with mediation.[65] Furthermore, HHS is involved in developing national coverage standards, medical practice guidelines, and other procedural and institutional mechanisms that can be brought to bear on avoidability determinations and damage calculations for medical injuries.[66] These administrative processes typically include provisions for soliciting expert and public input, conveying results of decisions, conducting further appeals, and assembling past practices into coherent guidance for the future.

D. Medicare Politics and Malpractice

The politics of Medicare often provoke concern and frustration among academics. As former Health Care Financing Administration (HCFA) Administrator Bruce Vladeck explains, Medicare's politics generally divide into three aspects: redistribution of wealth among citizens, distribution of federal resources among states, and financial and professional interests of health care providers and suppliers.[67] Medicare is such a large entitlement program that, for major policy decisions, Medicare politics blend into national fiscal politics, and political debate becomes less about health care and more about taxation and budgeting.

For malpractice policy, however, Medicare politics are quite favorable compared to traditional tort politics. Medicare's potential role in malpractice

---

63. The contractor makes an initial determination on the coverage or payment claim. 42 U.S.C. § 1395ff(a)(1)(C) (2005); 42 C.F.R. § 405.920 (2005). If dissatisfied with the outcome, a beneficiary can then seek a redetermination by the contractor. 42 U.S.C. § 1395ff (a)(3) (2005); 42 C.F.R. § 405.940 (2005). Independent review of the contractor's determination is available through a qualified independent contractor (QIC). 42 U.S.C. §§ 1395ff(b)(1)(A), (c)(3)(B)(i) (2005); 42 C.F.R. § 405.960 (2005). The process is slightly different for Medicare Advantage beneficiaries. 42 U.S.C. §§ 1395w-22(f)-(g); 42 C.F.R. 422.560, 422.564(a), 422.578-90, 422.594 (2005).

64. The 2003 legislation established within HHS a Medicare Beneficiary Ombudsman to assist Medicare beneficiaries with complaints, grievances, and requests for information with respect to any aspect of the Medicare program, including appeals from adverse determinations by Medicare contractors. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 923(a), 117 Stat. 2066, 2393-95 (2003) (codified as amended at 42 U.S.C. § 1395b-9 (2005)).

65. *See* Kathleen Scully-Hayes, *Mediation and Medicare Part A Provider Appeals: A Useful Alternative*, 5 J. HEALTH CARE L. & POL'Y 356, 359 (2002).

66. *See generally* Lucian L. Leape, *Practice Guidelines and Standards: An Overview*, 16 QUALITY REV. BULL. 42 (1990); Carter L. Williams, *Evidence-Based Medicine in the Law Beyond Clinical Practice Guidelines: What Effect Will EBM Have on the Standard of Care?*, 61 WASH. & LEE L. REV. 479 (2004).

67. Bruce C. Vladeck, *The Political Economy of Medicare*, 18 HEALTH AFF. 22, 23-24 (1999).

reform would have a trivial budgetary impact, so the most intransigent aspects of Medicare politics don't apply. What are the political advantages? A huge one is bringing medical injury into federal debate as a health care issue rather than as a tort litigation issue. Because of Medicare (and Medicaid), the federal government has a natural, understandable interest in health care. By contrast, asserting a federal preemptive role in tort litigation generally challenges longstanding traditions of state-level legal and political control.

This is reflected in the jurisdiction of congressional committees. Malpractice reform bills have languished each year in Congress because judiciary committees that have primary jurisdiction over the average malpractice bill are not particularly interested in health care. They are interested in the legal system, the politics of the legal system, and the social and economic effects of the legal system. But rarely, if ever, would they endorse legislation solely on the grounds that it might improve health care.

If Congress is going to accomplish something with respect to medical liability, the impetus must come from members of committees that have health care jurisdiction. Legislation involving Medicare is handled by health and finance committees. I support a bill, Senate Bill 1337 (the "Fair and Reliable Medical Justice Act"), which would fund state-based malpractice demonstration projects of the kinds suggested by the IOM.[68] Not surprisingly, the bill's bipartisan sponsors play important roles on the Health, Education, Labor, and Pensions (HELP) and Finance Committees of the U.S. Senate.[69]

Engaging the politics of Medicare is also an invitation to important health care constituencies to add their voices to the malpractice debate. For example, the American Association of Retired Persons (AARP) is incredibly important to Medicare and to overall health care, but it has never had any direct involvement with malpractice policy. The same is true for business coalitions with specific interests in health insurance and health care purchasing. These groups have been marginalized not because they are unimportant, but because their input has not seemed critical to the conventional politics of medical liability. Without a Medicare component, liability reform will always seem to be about courts and lawyers and states, not about the health care of the nation.

Any substantial proposal will be regarded skeptically by new political entrants because of the contentious history of malpractice reform. But these groups, especially if engaged through Medicare, also offer the best hope of dislodging the malpractice debate from its current stagnation, and of forging new coalitions rather than just perpetuating established ones. This can only be constructive where malpractice policy is concerned.

---

68. S. 1337, 109th Cong. § 3990 (2005).

69. Sen. Michael Enzi (R-Wyo.), Chairman of the Senate HELP Committee, and Sen. Max Baucus (D-Mont.), Ranking Member on S. Fin. Comm., co-sponsored S. 1337. *Id.*

III. CONCLUSION

Medicare can play an important role in improving the medical malpractice system. A Medicare-based malpractice system can help beneficiaries receive safer medical care, and experience a quick, comprehensive, and compassionate response if avoidable injuries nonetheless occur. Medicare's existing administrative appeals process could serve as the foundation for a truly effective "medical court," and liability reform could be integrated with Medicare's patient safety, pay for performance, and consumer information initiatives.

There are, of course, obstacles to be overcome in order for Medicare to take the lead on malpractice. For example, there are questions regarding the federal government's constitutional authority and the Medicare program's statutory authority, absent specific legislation, to replace state-based tort claims with a mandatory federal administrative remedy that permits limited judicial review but precludes trial by jury.[70] I do not consider these objections to be insuperable as a legal matter, but I think it a prudent first step for Congress to explicitly authorize a series of voluntary, Medicare-based demonstration projects.

Reform should begin as a pilot program, not a sweeping reform, with health care provider "earn-in" incentives to receive federally subsidized medical malpractice coverage, and Medicare beneficiary "opt-in" incentives designed to attract widespread, voluntary participation. These would supplement state-based malpractice demonstration projects funded by S. 1337, if enacted. If this innovation proves nearly as successful as I hope and believe it will, it can be replicated and expanded to other provider and beneficiary settings, including perhaps the Medicaid program. Done right, this approach—more than any other—could change medical liability from an issue buffeted by tort politics to an issue governed by health care policy, with long-term benefits for the public and the health care system.

70. *See generally* Eleanor D. Kinney & William M. Sage, *Resolving Malpractice Claims in the Medicare Program: Can It Be Done?*, 12 CONN. INS. L.J. 77 (2005).