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AN ADVOCATE'S RESPONSE TO PROFESSOR SAGE

TOBY S. EDELMAN*

As an attorney who has represented the rights and interests of nursing home residents in a legal services program and, now, in a public interest law firm that represents Medicare beneficiaries, I oppose the proposals to create health courts and to expand Medicare's administrative appeals process to include malpractice claims. Under both proposals, Medicare beneficiaries would have a difficult time getting compensated for torts committed against them, with even less possibility of recovering non-economic damages, and the potential that the tort system offers for significant institutional change would be lost. At its best, the tort system not only compensates individual patients who are injured; it also leads to changed care practices and removal of the worst providers from practice, complementing the official regulatory systems.¹

IMPROVING HEALTH CARE WOULD REDUCE THE POOR OUTCOMES THAT LEAD TO MALPRACTICE LITIGATION

A large portion of malpractice claims—at the individual practitioner level and at the institutional level, including nursing homes—is committed by a relatively small portion of the provider community. The distribution of cases is not random. A review of nursing home lawsuits filed between 1996 and 2000 in central and south Florida found that a very small number of facilities accounted for a large proportion of the total cases, while half the facilities had never been sued or had been sued only once or twice.² The Center's unpublished study of tort litigation against nursing homes in the District of Columbia had similar findings. Over an eight-year period, two of the District's nineteen facilities accounted for more than half of the cases, and ten of these nineteen nursing homes were not sued at all.³ There can be no question that getting the worst handful of providers out of

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1. See CTR. FOR MEDICARE ADVOCACY, TORT REFORM AND NURSING HOMES: A STUDY (2003); LAWRENCE CHIMERINE & ROSS EISENBREY, ECON. POLICY INST., THE FRIVOLOUS CASE FOR TORT LAW CHANGE: OPPONENTS OF THE LEGAL SYSTEM EXAGGERATE ITS COSTS, IGNORE ITS BENEFITS 15 (2005).

2. Diane C. Lade, *For Some, It's a Place to Call Home; Residents Voice Their Happiness*, SUN-SENTINEL (Ft. Lauderdale, FL), Mar. 6, 2001, at 17A; Diane C. Lade, *For Seniors, Insurance Crisis Hits Home: Retirement Communities Struggle with Soaring Rates in Wake of Nursing Home Suits*, SUN-SENTINEL (Fort Lauderdale, FL), Apr. 1, 2001, at 1B.

3. COMM. ON THE WORK ENV'T FOR NURSES & PATIENT SAFETY, INST. OF MED., KEEPING PATIENTS SAFE: TRANSFORMING THE WORK ENVIRONMENT OF NURSES 235 (Ann Page ed., 2004).

the practice of medicine—or out of the business of providing nursing home care—would eliminate a large number of the bad outcomes for patients and residents.

Requiring good practices, by law and regulation, and explicitly prohibiting the poor practices that lead to predictably bad results would also improve health care outcomes and reduce tort litigation. Work hours are a case in point. A 2004 Institute of Medicine (IOM) report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, found strong evidence that “prolonged work hours and fatigue affect worker performance.”⁴ The IOM recommended that “state regulatory bodies . . . prohibit nursing staff from providing patient care . . . in excess of 12 hours in any given 24-hour period. . . .”⁵

Despite this recommendation, the Office of Inspector General of the Department of Health and Human Services (HHS) last year commended a nursing facility for allowing nurses to work two sixteen-hour shifts over the weekend, while getting paid for full-time employment.⁶ It makes very little sense to allow, let alone praise, such poor care practices.⁷ Comprehensive research conducted by the federal government in the late 1990s found that about 91% of nursing homes did not have enough staff to prevent harm to residents or to meet the standard of care that was established in 1987 by federal law and subsequent regulations.⁸ While Congress increased Medicare reimbursement rates for nurse staffing in 2000,⁹ the change in federal reimbursement policy did not increase staffing levels. The Government Accountability Office found that nurse staffing remained stagnant, despite increased Medicare reimbursement focused on staffing, and that

4. *Id.*

5. *Id.* at 236.

6. Memorandum from George Grob, Assistant Inspector Gen. for Evaluations & Inspections, Dep’t of Health & Human Servs., to Dennis G. Smith, Dir., Ctr. for Medicaid & State Operations, Dep’t of Health & Human Servs. 4 (Mar. 2, 2005), available at <http://oig.hhs.gov/oei/reports/oei-01-04-00070.pdf>.

7. Recent research indicates that nurses should work even fewer consecutive hours. One study found that nurses who work twelve-and-a-half-hour or longer shifts in the hospital make three times the number of errors as nurses who work eight-and-a-half hours. Liz Kowalczyk, *Hospitals Cutting Nurses’ Long Shifts*, BOSTON GLOBE, Sept. 17, 2005, at A1. Yet nurses are allowed to work these excessive shifts while hospitals decide whether to change their rules and prohibit such practices.

8. MARVIN FEUERBERG, CTRS. FOR MEDICARE & MEDICAID SERVS., APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES 1-7 (2001).

9. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554 app. F, § 312(a), 114 Stat. 2763, 2763A-498 (codified at 42 U.S.C.A. § 1395yy (2005)). In the Act, Congress “increased the nursing component of the [prospective payment system for skilled nursing facilities] by 16.66 percent, effective April 1, 2001.” GEN. ACCOUNTABILITY OFFICE, REPORT TO CONGRESSIONAL COMMITTEES: SKILLED NURSING FACILITIES: AVAILABLE DATA SHOW AVERAGE NURSING STAFF TIME CHANGED LITTLE AFTER MEDICARE PAYMENT INCREASE 1 (2002) [hereinafter SKILLED NURSING FACILITIES]. The nursing component includes “medical social services and nontherapy ancillary services,” such as drugs and laboratory tests, as well as nurse staff time. *Id.* at n.1. The GAO found that this increase “raised the overall [skilled nursing facilities] payment rates by 4 to 12 percent.” *Id.* at 1.

staffing increased primarily in the few states whose state laws explicitly required increased staffing.¹⁰ Despite these findings—that facilities do not employ sufficient staff and that increasing reimbursement does not by itself increase staffing levels—policy-makers generally refuse to enact staffing ratios and continue to allow nursing homes to staff at grossly inadequate levels. The inevitable consequence is that poor care results and harms both residents and staff.

MEDICAL MALPRACTICE REFORM PROPOSALS

Instead of focusing on the elimination or reduction of medical errors, the focus of public policy discussions is developing different approaches to limit the ability of those who are harmed to get full and appropriate compensation.

Medical malpractice reform proposals publicly focus on the most sympathetic health care professionals—physicians who are claimed to be leaving the practice of medicine because of rising malpractice premiums. Swept into medical malpractice reform proposals, however, are the pharmaceutical industry, the medical device industry, and the nursing home industry.¹¹ I bring particular skepticism to this debate because of the role of the nursing home industry in promoting tort reform.

Nursing homes are included in medical malpractice reform legislation, even though they have very little connection to medical malpractice. There are virtually no physicians in nursing homes and, in fact, few nurses. Most of the direct care is provided by paraprofessionals, nurse aides who, under federal law, need only seventy-five hours of training to do their jobs.¹² Moreover, the subjects of tort cases are not one-time events and errors by medical professionals, but, usually, long-standing neglect by multiple staff members. Nevertheless, the nursing home industry gets the protection of medical malpractice reform to shield nursing homes from liability for poor care practices. Reports on the recent legislative debate on tort reform in Texas indicate that a major financial supporter of tort reform was the Alliance for Quality Nursing Home Care, the trade organization of major multi-state nursing home chains.¹³ These hospital corporations often self-insure and do

10. SKILLED NURSING FACILITIES, *supra* note 9, at 3-4. “[N]urse staffing ratios changed little after the increase in the nursing component of the Medicare payment rate took effect.” *Id.* at 3. Skilled Nursing Facilities’ “average nursing time increased by 1.9 minutes per patient day....” *Id.* “There was a small shift in the mix of nursing time that [Skilled Nursing Facilities] provided, with slightly less registered nurse (RN) time coupled with slightly more licensed practical nurse (LPN) and nurse aide time.” *Id.* “[Skilled Nursing Facilities] in four states increased their staffing by 15 to 27 minutes per patient day; three of these states—Arkansas, North Dakota, and Oklahoma—had made Medicaid payment or policy changes aimed at raising or maintaining facilities’ nursing staff.” *Id.* at 4.

11. See, *eg.*, Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. (2005).

12. 42 U.S.C. § 1395i-3 (2000).

13. Dave Mann, *A Death in McAllen: What the Death of Noe Martinez Sr. Reveals About the Nursing Home Crisis to Come*, TEXAS OBSERVER, Sep. 23, 2005, available at http://www.texasobserver.org/showArticle.asp?ArticleFileName=050923_mcallen.htm.

not buy malpractice insurance on the open market.¹⁴ Consequently, claims that malpractice reform is necessary because of rising insurance premiums have little direct relevance to them, underscoring tort reform's purpose of stopping litigation by people who are harmed by poor care and malpractice.

Moreover, the call for malpractice reform is itself cyclical.¹⁵ Insurance companies invest the premiums they collect in the stock market and make most of their money from investments, not premiums. When they are doing well in the stock market, they keep their premiums relatively low. This pattern occurred during the decade of the 1990s.¹⁶ In 2001, when the stock market stopped booming, insurance companies reported a 30% decline from 1998 in realized capital gains.¹⁷ They became more selective in the companies and industries they would insure.¹⁸ The insurance industry's great success in the stock market in the 1990s was followed by a series of natural disasters and then by September 11th. Insurance companies had to pay out great sums, their incomes declined, and they raised their premiums. Once again, the demand for malpractice reform was raised.

Compared to previous shifts in the insurance cycle, the focus recently has been on federal legislative solutions. At Congressional hearings on malpractice reform several years ago,¹⁹ Democrats advocated states' rights and Republicans demanded a federal solution—a bizarre reversal in customary positions, as one

14. GEN. ACCOUNTABILITY OFFICE, REPORT TO CONGRESSIONAL REQUESTERS: MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 39 (2003).

15. *Harming Patient Access to Care: The Impact of Excessive Litigation: Hearing Before the H. Subcomm. on Health of the Comm. on Energy and Commerce*, 107th Cong. 110-11 (2002) (statement of Travis Plunkett, Legislative Director, Consumer Federation of America).

16. Joseph B. Treaster, *Malpractice Rates Are Rising Sharply; Health Costs Follow*, N.Y. TIMES, Sept. 10, 2001, at A1.

17. *Id.*; see also Scott Shepard, *Insurance Rates Soar as Fear of Litigation Mounts*, MEMPHIS BUSINESS JOURNAL, July 16, 2001, at 3 ("Carriers can still turn a profit even when their loss ratios exceed 90%, provided investments they make with premium dollars continue to perform. The high-tech bust and a chronically soft stick market have wiped out that revenue stream."); Phill Trewyn, *Nursing Home Liability Insurance on the Rise*, BUSINESS JOURNAL OF MILWAUKEE, July 16, 2001, at 17 (noting that the downturn in the stock market caused insurance companies to raise their premiums to make up for the lower returns on their investments).

18. Reed Branson, *Tort Reform Faces Tough Miss. Fight*, COMMERCIAL APPEAL (Memphis, TN), Jan. 22, 2002, at B1 ("[A]s the stock market began retreating last year, insurance companies—whose profits are closely tied to investments—have clearly become more selective in their coverage, both here and around the nation.").

19. *Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care? Hearing Before the H. Subcomm. on Commercial and Administrative Law of the Comm. on the Judiciary*, 107th Cong. (2002). A second Congressional hearing on malpractice reform took place that year, this time before the House Committee on Energy and Commerce. *Harming Patient Access to Care: The Impact of Excessive Litigation: Hearing Before the H. Subcomm. on Health of the Comm. on Energy and Commerce*, 107th Cong. (2002).

member of Congress acknowledged at the hearing.²⁰ A proponent of federal malpractice reform testified that federal legislation was necessary because tort reform enacted at the state level had been declared unconstitutional by some state supreme courts.²¹

TORT LITIGATION CAN SERVE AN IMPORTANT PUBLIC FUNCTION

While tort litigation serves an important private function of compensating people who are injured, it also serves a public function of assuring that health care providers actually provide good care. Tort litigation is important because other public mechanisms of assuring good care are insufficient by themselves. The peer review is largely ineffectual as a method of improving health care. Peer review systems rarely take action against individual practitioners, even those who commit serial malpractice.²² Relying on health care providers to police themselves sufficiently is unrealistic.

A second method is the public regulatory system. This system is not used effectively, and in health care, its tools are generally small. Most hospitals are accredited and deemed to be in compliance with public standards of care without undergoing a public survey.²³ Accredited hospitals are rarely subject to the public regulatory system; validation surveys by state health departments occur infrequently (and find significantly more deficiencies than the accrediting surveys).²⁴ Non-accredited hospitals that are more regularly subject to regulatory oversight—only 17% of the total²⁵—also largely escape public scrutiny. A recent report by the HHS Office of Inspector General found that non-accredited hospitals were not surveyed on the three-year schedule required by federal rules and that eighty hospitals had not been surveyed in five years.²⁶ In response to the report, the Centers for Medicare & Medicaid Services indicated that it would reduce

20. *Harming Patient Access to Care*, *supra* note 15, at 23 (statement of Rep. Albert R. Wynn, Maryland).

21. *Health Care Litigation Reform*, *supra* note 19, at 76-78 (statement of Stuart Fine, Chief Executive Officer, Grand View Hospital, Bucks County, Pennsylvania) (testifying at the behest of members of the Pennsylvania State Legislature that the Pennsylvania Supreme Court recently held non-economic damage caps unconstitutional).

22. See Gail Garfinkel Weiss, *Is Peer Review Worth Saving?*, *MED. ECON.*, Feb. 18, 2005, at 47, 48, 51 (suggesting widespread misuse and underuse of the peer review system).

23. 42 U.S.C. § 1395bb(a) (2000).

24. See GEN. ACCOUNTABILITY OFFICE, REPORT TO CONGRESSIONAL REQUESTERS: MEDICARE: CMS NEEDS ADDITIONAL AUTHORITY TO ADEQUATELY OVERSEE PATIENT SAFETY IN HOSPITALS 4, 8, 27 (2004) (reporting that the Joint Commission on Accreditation of Hospitals “did not identify the majority—about 69 percent—of serious deficiencies found by state agencies.”).

25. OFFICE OF INSPECTOR GEN., DEP’T OF HEALTH & HUMAN SERVS., CMS OVERSIGHT OF SHORT-TERM ACUTE CARE NONACCREDITED HOSPITALS 1 (2005), available at <http://oig.hh.gov/oei/reports/oei-01-04-00020.pdf>.

26. *Id.* at 5.

public oversight.²⁷ In the future, it intends to survey non-accredited hospitals, on average, every four-and-a-half years, and some hospitals on a six-year cycle.²⁸ Public oversight is limited and becoming more so. Most public oversight occurs in nursing homes, because there is no deemed status for accredited facilities.²⁹ Nevertheless, nursing home oversight has been notoriously weak and repeatedly criticized since Medicare and Medicaid began paying for long-term care services in the mid 1960s.³⁰ The new enforcement system, enacted as part of the 1987 Federal Nursing Home Reform Act, was intended to “minimize the time between the identification of violations and final imposition of the remedies” and to “provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.”³¹ The statutory requirements have been emasculated by federal guidance that almost always allows facilities a chance to correct their problems before remedies are imposed.³² Senator Charles E. Grassley, first, as chairman of the Senate Special Committee on Aging and, later, as chairman of the Senate Finance Committee, held a series of hearings on nursing home care between 1998 and 2000, featuring GAO reports on the “overly tolerant” nursing home regulatory system.³³

27. *Id.* at 9.

28. *Id.* at 9, 14.

29. The Reagan Administration’s 1982 proposal to grant deemed status to nursing homes led to an Institute of Medicine study of nursing homes and enactment of the 1987 Federal Nursing Home Reform Act. COMM. ON NURSING HOME REGULATION, INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES (1986).

30. *See id.* at 148-49 (criticizing regulation as being too soft on nursing homes with repeated violations).

31. Federal Nursing Home Reform Act, Pub. L. No. 100-203, 101 Stat. 1330-180 - 1330-181 (1987) (codified as amended at 42 U.S.C. § 1395i-3(H)(2)(B)(iii) (2000)).

32. *See* OFFICE OF INSPECTOR GEN., DEP’T OF HEALTH & HUMAN SERVS., NURSING HOME ENFORCEMENT: THE USE OF CIVIL MONEY PENALTIES 6 (2005), available at <http://oig.hhs.gov/oei/reports/oei-06-02-00720.pdf> (reporting significant numbers of outstanding payments due on assessed civil money penalties due to established notice periods and delayed effective dates).

33. *See, e.g., Betrayal: Quality of Care in California Nursing Homes: Hearing Before the S. Special Comm. on Aging*, 105th Cong. 30 (1998) (statement of Sen. Charles Grassley); *Residents at Risk? Weaknesses Persist in Nursing Home Complaint Investigation and Enforcement: Hearing Before the Senate Special Committee on Aging*, 106th Cong. 3 (1999) (statement of Sen. Charles Grassley); GEN. ACCOUNTING OFFICE, NURSING HOME QUALITY: PREVALENCE OF SERIOUS PROBLEMS, WHILE DECLINING, REINFORCES IMPORTANCE OF ENHANCED OVERSIGHT (2003), available at <http://www.gao.gov/new.items/d03561.pdf>; GEN. ACCOUNTING OFFICE, REP. TO THE SPECIAL COMMITTEE ON AGING, U.S. SENATE: NURSING HOME CARE: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY (1999), available at <http://www.gao.gov/new.items/he00006.pdf>; GEN. ACCOUNTABILITY OFFICE, REPORT TO THE CHAIRMAN AND RANKING MINORITY MEMBER, SPECIAL COMMITTEE ON AGING, U.S. SENATE: NURSING HOMES: COMPLAINT INVESTIGATION PROCESSES OFTEN INADEQUATE TO PROTECT RESIDENTS (1999), available at <http://www.gao.gov/new.items/he99080.pdf>; GEN. ACCOUNTING OFFICE, REPORT TO THE SPECIAL COMMITTEE ON AGING, U.S. SENATE: CALIFORNIA NURSING HOMES:

A third method remains: the tort system, with the potential for recovery for non-economic damages and for punitive damages for egregious conduct. The tort system brings accountability to health care when bad things that should not have happened do happen and when patients are harmed. It compensates injured patients, and, at its best, serves an important public function.

The tort system can step in when the public response is inadequate. In October 2005, the Arkansas Attorney General's office settled twenty-six incidents involving twelve nursing homes for \$1.5 million; the state Medicaid program received one million dollars and the corporation committed itself to spend another half-million dollars to improve care at the twelve facilities.³⁴ This settlement, the Attorney General's second settlement with the corporation in three years, is less than a tenth of 1% of its \$2.15 billion dollar annual revenues³⁵—hardly something the corporation will even notice. The same month, two consolidated class action tort cases involving two Beverly facilities in Arkansas settled for \$18.9 million³⁶—something more than just the cost of doing business.

The tort system also can supplement the regulatory system. An attorney in New Mexico settled a wrongful death case with a facility involving a resident who was strangled to death on her bedrail.³⁷ In negotiations, he offered to settle the case for \$100,000 less than an agreed-upon amount if the facility used the money to hire a nurse to work specifically on reducing restraints.³⁸ The facility and its insurance company accepted his offer, hired a nurse, and reduced use of restraints, protecting future residents from a similar death.³⁹ In a related claim, the same attorney persuaded the restraint manufacturer to send letters to all purchasers of its bedrails, advising them how to use the product safely.⁴⁰ Institutional changes can be made as a result of tort litigation.

CARE PROBLEMS PERSIST DESPITE FEDERAL AND STATE OVERSIGHT (1998), *available at* <http://www.gao.gov/archive/1998/he98202.pdf>.

34. Press Release, Mike Beebe, Arkansas Attorney General, Attorney General Mike Beebe Announces \$1.5 Million Nursing Home Settlement with Beverly Enterprises (Oct. 3, 2005), *available at* http://www.ag.state.ar.us/index_high.htm.

35. The *Arkansas Times Record* reports that “[t]he \$1.5 million settlement represents less than 0.07 percent of BEI’s about \$2.15 billion annual revenues.” Mary L. Crider, *BEI, State Reach Deal*, *TIMES RECORD* (Ark.), Oct. 4, 2005, *available at* <http://www.swtimes.com/articles/2005/10/04/business/business01.txt>.

36. Cristal Cody, *Beverly pays \$18.9 million to settle cases*, *ARK. DEMOCRAT-GAZETTE*, Oct. 6, 2005. The cases “allege wrongful care” in two Beverly facilities between December 1998 and June 2004. *Id.*

37. *Litigation for Residents*, *NURSING HOME LAW LETTER* (National Senior Citizens Law Ctr.), Mar. 21, 1997, at 16 (discussing *Trew v. Smith & Davis Mfg. Co., Inc.*, No. SF 95-354(C) (N.M. Dist. Ct., July 1996)).

38. *Id.* at 16.

39. *Id.*

40. *Id.* at 16, 18, *citing* Everest & Jennings, Safety Alert Concerning Entrapment Hazards with Bed Side Rails (Sept. 5, 1996).

LIMITATIONS IN THE MEDICAL MALPRACTICE SYSTEM ARE NOT CORRECTED BY THE
PROPOSALS FOR HEALTH COURTS OR ADMINISTRATIVE RESOLUTION OF
MALPRACTICE CASES IN THE MEDICARE SYSTEM

Problems certainly exist with the tort system. The measure of damages is limited for older people who have neither a long life expectancy nor any earning capacity, two primary measures of damages in the civil justice system. Although the tort system also provides compensation for medical expenses, older people who are harmed either do not have medical expenses or the medical expenses they incur are reclaimed by the Medicare and Medicaid programs that paid them. Beneficiaries' primary damages may be non-economic, for pain and suffering.

The proposals for health courts and for Medicare administrative resolutions of personal injury cases do not change these measures of damages. Both would fully compensate economic damages, particularly medical bills. However, non-economic damages—if available at all in either new system—would be based on a schedule. This result is not different from typical tort reform proposals, which also cap non-economic damages, often at \$250,000.⁴¹

Another limitation in the tort system is that attorneys generally file cases only where the chances for recovery are large.⁴² People with relatively small claims do not get representation and their claims are not heard. The proposals for health courts and administrative resolution of cases would not solve that limitation either. Both proposals call for undefined, but minimum, thresholds before claims would be compensable.

CREATING HEALTH COURTS OR USING THE MEDICARE ADMINISTRATIVE SYSTEM
TO RESOLVE TORT CASES OFFERS FEW BENEFITS TO MEDICARE BENEFICIARIES

Health Courts

As others have described, the advantage of health care courts are questionable and the significant dangers of health courts include politicization of decision-making, a narrowed perspective by judges, and higher costs to litigants.⁴³ The Center for Justice and Democracy, a nonpartisan public interest organization that focuses exclusively on educating the public about the civil justice system and tort reform, is more pointed in its criticism. Its April 2005 report, *The Fantasy of*

41. See AM. BAR ASSOC. STANDING COMMITTEE ON MEDICAL LIABILITY, CAPS ON MEDICAL MALPRACTICE AWARDS (Jan. 2005), available at <http://www.abanet.org/media/docs/mmcapaward05.pdf>.

42. Stephen E. Kalish, *The English Costs War, 2000-2003, and a Moment of Repose*, 83 NEB. L. REV. 114, 117 (2004); Diana Vance-Bryan, Note, *Medicare's Prospective Payment System: Can Quality Care Survive?*, 69 IOWA L. REV. 1417, 1442-43 (1984).

43. CATHERINE T. STRUVE, PEW PROJECT ON MED. LIAB., EXPERTISE IN MEDICAL MALPRACTICE LITIGATION: SPECIAL COURTS, SCREENING PANELS, AND OTHER OPTIONS 72-77 (2003).

Health Industry Tribunals – HITting Patients While They're Down,⁴⁴ responds directly to the Progressive Policy Institute's paper on health courts. Among its arguments, the Center for Justice and Democracy contends that:

1. Health courts are based on the workers' compensation model, which has failed to provide adequate compensation to injured workers. The Center for Justice and Democracy cites numerous reports about the inadequacy of workers' compensation, including a report from the Chairman of the National Commission on State Workers' Compensation Laws, who found that in the 1990s, "insurer profits increased dramatically and employers' workers' comp costs dropped, while benefit payments to workers decreased substantially."⁴⁵ In addition, the National Academy of Social Insurance found that for eight consecutive years, workers' compensation benefits dropped as a percentage of wages.⁴⁶

2. Medical errors would increase under a health court system. For this point as well, the Center for Justice and Democracy cites studies of workers' compensation—including the 1972 National Commission on State Workmen's Compensation Laws⁴⁷ and a 1982 study by the Rand Institute for Civil Justice⁴⁸—reporting that because the financial incentives in workers' compensation do not reflect the full costs of accidents, they do not serve the deterrent role that a tort system serves.⁴⁹

3. Jury verdicts serve as strong signals to health care practitioners that certain practices are not acceptable, citing a report in the *New England Journal of Medicine*.⁵⁰

Medicare Adjudication of Torts in the Administrative Process

Equally troubling is Professor William Sage's proposal to have Medicare's administrative system expand to accommodate malpractice claims.⁵¹ Such an expansion would be neither easy nor appropriate. Many questions remain unanswered.

44. CTR. FOR JUSTICE & DEMOCRACY, *THE FANTASY OF HEALTH INDUSTRY TRIBUNALS: HITTING PATIENTS WHILE THEY'RE DOWN* (2005).

45. *Id.* at 7, citing John F. Burton, Jr., *Workers' Compensation Benefits, Costs, and Profits: An Overview of Developments in the 1990s*, 9 JOHN BURTON'S WORKERS' COMPENSATION MONITOR 4 (1996).

46. *Id.*

47. *Id.* at 11.

48. *Id.*

49. *Id.*

50. *Id.* at 12.

51. William M. Sage, *The Role of Medicare in Medical Malpractice Reform*, 9 J. HEALTH CARE L. & POL'Y 217 (2006).

Eligibility and coverage decisions, which the administrative process currently addresses, are very different from issues of negligence and personal injury. Adjudicators would need to learn a different body of law.

Moreover, as Professors Sage and Tim Jost⁵² recognize, Medicare is in the process of creating an entirely new appeals process. Most hearings will be conducted by telephone.⁵³ In-person hearings will be held in just three locations: Cleveland, Ohio, Miami, Florida, and Irvine, California (and possibly a fourth location, Arlington, Virginia).⁵⁴ Beneficiaries and their attorneys will be required to go to those cities to have their administrative appeals heard.⁵⁵

In addition to the points made by Professor Jost about Professor Sage's paper, the proposal raises a number of questions about how such a system would work in actual practice. For example, Professor Sage suggests that bringing malpractice into Medicare would allow for "more careful incorporation of liability costs into reimbursement formulas."⁵⁶ How would the inclusion of liability costs reflect good public policy? Why should malpractice be part of the reimbursable cost of doing business? Isn't the opposite appropriate policy—that malpractice is not compensable care? A series of cases have been filed under the federal False Claims Act against nursing homes, based on the theory that when the care a facility provides is egregiously bad, its request for reimbursement for the care constitutes a false claim.⁵⁷ A major premise of Professor Sage's proposal is that health care providers would identify adverse events and either settle the claim directly with the patient or refer the claim to the Medicare contractor or health plan to assess the possible need for compensation.⁵⁸ Since secrecy, not disclosure, has been the prevalent response when medical errors occur, it is hard to imagine how a process based on self-identification of compensable medical errors could work in practice. Requirements for mandatory disclosure would be difficult to implement and impossible to enforce, especially when the process, in many instances, takes place

52. Timothy Stoltzfus Jost, *Health Courts and Malpractice Claims Adjudication Through Medicare: Some Questions*, 9 J. HEALTH CARE L. & POL'Y 280 (2006).

53. Robert Pear, *Medicare Change Will Limit Access to Claim Hearing*, N.Y. TIMES, Apr. 24, 2005, § 1 (Late Edition).

54. *Id.*

55. *See id.*

56. William Sage, Stuart Rome Lecture: The Role of Medicare in Medical Malpractice Reform, Remarks at the University of Maryland School of Law conference "Beyond the New Medical Malpractice Legislation: New Opportunities, Creative Solutions, and Best Practices for Patient Safety, Tort Reform and Patient Compensation" (Oct. 28, 2005).

57. The United States Attorney in Philadelphia has brought more than a dozen cases under this theory—all settled—with the facilities paying back money and instituting changes in their practices. *See, eg.*, Angela S. Quinn, *Imposing Federal Criminal Liability on Nursing Homes: A Way of Deterring Inadequate Health Care and Improving the Quality of Care Delivered?*, 43 ST. LOUIS U.L.J. 653, 671-72 (1999); *Interview with Mark H. Gallant, Esq., Cozen & O'Connor*, NURSING HOMES, May 2001, available at http://findarticles.com/p/articles/mi_m3830/is_5_50/ai_75454608.

58. *See Sage, supra* note 51, at 227-28.

entirely in private. Too big a leap of faith is required to expect that full and honest disclosures would occur on a regular basis. There is nothing in the proposal that describes the consequences for health care providers who do not disclose, or who withhold relevant information, or who do not act in good faith in their conversations (i.e., negotiations) with their patients. And if physicians and health care providers do approach Medicare beneficiaries who are injured, what process will assure that beneficiaries' interests are protected? Who will oversee these private conversations? The parties are not in an equal bargaining position in these circumstances. They are likely to have totally different levels of understanding about what happened and what it means. What happens if the physician apologizes and promises to make changes and the beneficiary accepts the apology and walks away? This result is contemplated by Professor Sage's proposal, which advocates "immediate disclosure of medical errors to patients, apology where appropriate, and early mediated discussions about safety improvements and fair compensation."⁵⁹ What happens to beneficiaries' medical costs, not to mention their non-economic damages, in these cases? They would most likely be waived.

Beneficiaries are unlikely to be represented by attorneys when potential damages would just compensate medical expenses, with, at most, a small amount for non-economic damages. As it is, trial attorneys reject many cases because potential damages are too small. They are unlikely to represent beneficiaries under this system when potential damages are even smaller.

The proposal suggests that oversight could be provided by the Medicare beneficiary ombudsman or by the Qualified Independent Contractor program.⁶⁰ Neither suggestion seems appropriate. The Medicare beneficiary ombudsman is a new position⁶¹ with a small staff located only in Washington, D.C. The office cannot reasonably be expected to oversee individual cases throughout the country. Qualified Independent Contractors (QICs) are also an entirely new entity.⁶² At this point, it is not even known which organizations have been awarded the QIC contracts, although some recent information indicates that some of them are the same insurance companies that administer the Medicare program. Until more is known about QICs, there is no reason to believe that they would have the qualifications or expertise to review claims and settlements. Professor Sage

59. *Id.* at 220.

60. *See id.* at 232.

61. 42 U.S.C.A. §§ 1395b-9(c)(1)-(2) (West 2003).

62. Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, 114 Stat. 2763A-537 (codified as amended at 42 U.S.C. §§ 1395ff(c)(1)-(5) (2000)). QICs provide reconsiderations of initial determinations in the Medicare appeals process. 42 U.S.C.A. § 1395ff(c)(1) (2000). While QICs were established by the Benefits Improvement and Protection Act of 2000, the legislation was amended before implementation by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Pub. L. No. 106-554, 114 Stat. 2763A-537 (codified as amended at 42 U.S.C. §§ 1395ff(c)(1)-(5) (2000)); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 206 (codified as amended in scattered sections of 26 and 42 U.S.C.).

suggests that beneficiaries who do not reach a settlement with their provider could file a claim with the program contractor, who would then determine whether the claim was just a grievance or a real medical injury worthy of compensation.⁶³ A similar process occurs now when Quality Improvement Organizations⁶⁴ receive beneficiaries' complaints about care. Although there is absolutely no information available about how this process is working, QIOs' documents explaining the program express the belief that many beneficiaries just do not understand or just do not like how they were treated.⁶⁵ Medicare contractors are likely to evaluate claims with a similar orientation.

HOW WOULD THE FOLLOWING CASES FARE UNDER THE PROPOSALS FOR HEALTH COURTS AND ADMINISTRATIVE ADJUDICATION OF MALPRACTICE CLAIMS?

The proposals for health courts and use of the Medicare administrative process to resolve malpractice claims are best analyzed by considering their effectiveness in representative cases. A description of two nursing home cases follows. How would the family members of these residents fare under either a health court or a Medicare administrative proceeding?

The first case is from Florida:

A resident was admitted to a Florida nursing home in March 1995. Within months, he had contractures and was in a fetal position. He fell, experienced medical traumas, and had multiple bedsores by January 1996. In March 1996, he experienced gross mismanagement of his feeding tube and he lost 43 pounds over the next 67 days. He died in October 1996. Fraudulent and inconsistent charting entries included entries showing care during hospitalizations and the day after he died.⁶⁶

Did this resident have compensable injuries? What about his pain and suffering over a period of eighteen months?

The second case is from Texas:

Alta David, a 79-year old woman, was admitted to a Texas nursing home in September 1996 after suffering a stroke. The resident received physical and speech therapy and showed signs of improving until a pressure sore on her coccyx made her unable to continue with therapy.

63. See Sage, *supra* note 51, at 234.

64. The Tax Equity and Fiscal Responsibility Act of 1982 included the Peer Review Improvement Act of 1982 to establish a utilization and quality control peer review program. Pub. L. No. 97-248, 96 Stat. 381 (codified as amended at 42 U.S.C. § 1320c-2 (2000)).

65. Press Release, The American Health Quality Association, QIOs Expand Services to Address Quality of Care Complaints (Oct. 10, 2003), available at http://www.ahqa.org/pub/media/159_678_4572.cfm; THE AMERICAN HEALTH QUALITY ASSOCIATION, FACT SHEET: MEDIATION, http://www.ahqa.org/pub/media/159_766_4573.cfm (last visited Sept. 21, 2006).

66. *Boston v. 2510 Eagle, Inc.*, No. 97-333 (Leon Cty. Jud. Cir. Ct. Fla. May 20, 1999). The case settled for \$1.5 million. *Id.*

Restorative care that was ordered was not provided. In February, she was transferred to the hospital; she was completely bedridden and suffered from multiple infections in her Stage IV pressure sore. The hospital recommended hospice care. In March, Ms. David was returned to the hospital, again dehydrated and infected. She died in April. The family alleged that her pressure sore was ignored for 34 days and that the facility failed to give her 40% of her pain medication.⁶⁷

These are real cases.

67. *Ronning v. Heartway Corp.*, No. 98-CV1162 (Tex. Dec. 1999). The case was settled in December of 1999 for \$5 million and is also referred to as the *Alta David* case because that was the elderly woman's name. *Id.* Ronning is the representative of all wrongful death beneficiaries and for the estate of Alta David. *Id.*