

...news, views and reviews from the Center for Justice & Democracy

CENTER FOR JUSTICE &
DEMOCRACY
NEWS

Dear Friend,

Law students in our public policy clinic at New York Law School did some exciting things this semester as we integrated them directly into our public policy non-profit work.

For example, the students researched and prepared detailed letters to Congress on two House bills: H.R. 2655, which would make terrible changes to Rule 11 of the FRCP; and H.R. 982, which would delay and deny compensation to people suffering from asbestos-related diseases. Students also submitted written statements for two congressional hearings: one on forced arbitration; and the second on a bill that would preempt all state regulatory and tort law in the area of chemical regulation. Their final projects for the semester include preparing written comments to the FDA supporting its new proposed generic drug labeling rule.

We are thrilled to be providing law students with exciting opportunities to learn beyond the classroom about the value of the civil justice system. We can't wait until next semester!

Sincerely,
Joanne Doroshov
Executive Director

IN THIS ISSUE: OBAMACARE

WHAT THE ACA MAY MEAN FOR INJURY CASES

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA, also known as "Obamacare") into law. The ACA mandated comprehensive reform of the U.S. healthcare system in order to expand individual insurance coverage, control health care costs and improve the quality of our nation's health care delivery system. Since its passage, much attention has been paid to the law's constitutionality, what the states are doing and, more recently, the technical problems Americans have faced trying to enroll in federal- or state-run online insurance exchanges. What's missing from the broader public conversation is how the ACA will impact patients when it comes to the quality of patient care and injury cases.



In the statute, there are only two provisions that explicitly address medical malpractice: Sections 10607 and 10608. Section 10607 earmarked \$50 million in grants for states exploring alternatives to medical malpractice litigation. However, injured patients can opt out of these state-created demonstration projects at any time. Section 10608 extended Federal Tort Claims Act immunity to free clinic board members, officers,

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ACCOUNTABLE CARE ORGANIZATIONS

One of the latest developments in health care is the rise of accountable care organizations (ACOs). ACOs are groups of primary care doctors, specialists, hospitals and other health care providers who form networks to better coordinate patient care. These provider-led entities contract with payers and make money if they're able to cut costs without sacrificing or by improving the quality of patient care. ACOs can partner with insurers; insurance companies can form their own ACOs as well.

According to the LP Center for Accountable Care Intelligence, by the end of September 2013, an estimated 20.1

million lives were covered by approximately 500 ACOs. "Consumers probably don't know whether their doctors and other health providers belong to an accountable care organization or not," explained Rand Corporation policy analyst David Auerbach in October 2013.

At this point, consumers also don't know whether ACOs will be beneficial to patients. As Duke University Law Professor Barak Richman told a U.S. House Judiciary subcommittee in September 2013, "ACOs, in theory, could offer an attractive solution to prob-

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employees and contractors, leaving injured patients with limited damages and virtually no access to the courts if they've been harmed by negligent medical care.

Cutting Medicare reimbursements for excess hospital readmissions is another significant ACA patient safety initiative. The Centers for Medicare and Medicaid Services estimate that one in five Medicare patients discharged from the hospital are readmitted within 30 days. And according to a Medicare Payment Advisory Commission analysis of 2005 Medicare claims data, 84 percent of 7-day readmissions, 78 percent of 15-day readmissions and 76 percent of 30-day readmissions were potentially preventable. By penalizing hospitals for too many readmissions, the ACA creates a direct financial incentive for hospitals to improve their quality of care.

Other parts of the ACA seem also aimed at improving patient care, but they raise questions about whether the landscape of medical malpractice litigation may change, as well. For example, the statute requires two government-appointed panels to develop new clinical care guidelines for health care providers. While non-compliance with these standards does not appear to give rise to new medical malpractice claims, such guidelines, if widely-adopted, "could impact the standard of care against which provider conduct is assessed in medical

malpractice litigation." This was the finding of a March 2012 GAO report, commissioned to examine the ACA's potential effect on civil litigation against health care providers.



As the GAO explained, "in a medical malpractice action, a provider's conduct is evaluated in terms of the standard of care, which is generally established through the testimony of an expert witness, whose testimony is likely to be based either on his or her own experience or on his or her observations of the relevant medical standard of care. As a result, to the extent that these guidelines and standards become generally accepted as the standard of care by the relevant medical community, they may shape an expert's own experience or his or her observations of the relevant medical standard of care." Plus, "an expert's views may be explicitly informed by these standards or guidelines, with an expert drawing directly from them when testifying in a particular medical malpractice action as to whether a particular provider's actions did or did not comport with the standard of care." Moreover, at a minimum, "a court is likely to consider whether the standards or guidelines or provider's performance on them are relevant to determining whether a provider is negligent.... Once admitted into evidence, courts may assign varying degrees of weight to the standards or guidelines."

It remains to be seen what these new guidelines or standards will look like, much less how they will be used in

medical malpractice cases. A one-size-fits-all-approach for what constitutes acceptable medical practice ignores the huge variation in how patients present. Moreover, such guidelines may not be unbiased but rather tailored to meet non-safety-related goals, like cost-cutting or shielding medical practitioners from liability. Those kinds of clinical care standards can negatively impact patient safety and lead to unfair results in the courtroom.

Interestingly, there is a movement in Congress to prevent federal guide-

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WHAT THE ACA MAY MEAN FOR INJURY CASES continued...

lines from becoming legal standards in malpractice cases. In April 2013, Rep. Gingrey (R-GA), who is a physician and major “tort reform” advocate, introduced H.R. 1473, legislation that would prevent “any guideline or other standard under any Federal health care provision” from becoming “the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice case.” This is a bipartisan bill and the Senate may consider it soon.

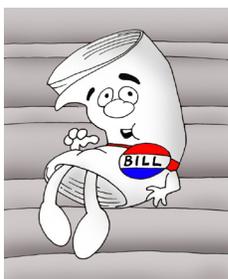
In addition, a troubling trend is surfacing in state personal injury cases – liability insurers are beginning to claim they do not need to pay injured patients’ future health care costs in medical malpractice and other personal injury cases because Obamacare (including the taxpayer-assisted provisions) will pay for the injuries their clients cause. This argument has no merit, however. First, not everyone has or will have insurance under the health care law, even after full implementation of the ACA. According to Congressional Budget Office estimates, in 2013, 55 million non-elderly people will remain uninsured under Obamacare. In 2014, the number will be 44 million; in 2015, 37 million; in 2016, 31 million; from 2017 through 2020, 30 million; and from 2021 through 2023, 31 million. Second, even those with coverage are at the mercy of insurance companies who are highly unlikely to make victims whole by providing funding for such expenses.

Ironically, this litigation position is the opposite of what liability insurers are saying outside the courtroom. Insurance industry representatives, like the Physicians Insurance Asso-

ciation of America, have been telling Congress and the public that the new law is going to stop doctors from doing all the “defensive medicine” tests that their doctors want to do. So claims will go up, meaning errors will go up. In other words, what they call “defensive medicine” is actually good medicine that prevents errors. Apparently insurers want it both ways –complaining about the law for supposedly increasing claims while trying to profit from the law by not paying claims.

Finally, some lawmakers who have, so far, been unsuccessful in their bid to include sweeping medical malpractice “tort reforms” in the ACA, continue to push for legislation that would undermine victims’ abilities to hold negligent healthcare providers accountable in court. The “American Health Care Reform Act of 2013” (H.R. 3121), championed by the U.S. Chamber of Commerce, among others, would cap non-economic damages at \$250,000, create a narrow statute of limitations, eliminate joint and several liability, undermine contingency fee arrangements and impose strict evidentiary and monetary limits on punitive damages.

As of publication, this bill has gone nowhere. Hopefully other attempts to weaken injured patients’ legal rights will meet the same fate.



NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS

On June 28, 2012, the U.S. Supreme Court upheld the central provision of the ACA – the individual mandate requiring most Americans to obtain health insurance by 2014 or pay a penalty – as a constitutional exercise of Congress’ taxing power. Yet the decision also placed an unprecedented limit on Congress’ regulatory powers to enact social welfare legislation under the Commerce Clause. This new limit could open existing laws to legal challenges as well.

As Justice Ruth Bader Ginsburg wrote, “Since 1937, our precedent has recognized Congress’ large authority to set the Nation’s course in the economic and social welfare realm.” Our past decisions “acknowledge Congress’ authority, under the Commerce Clause, to direct the conduct of an individual today...because of a prophesied future transaction is certain to occur, the sole uncertainty being the time the activity will take place.... The Chief Justice’s limitation of the commerce power to the regulation of those actively engaged in commerce finds no home in the text of the Constitution or our decisions.” (citations omitted)

President Obama agreed, telling *Rolling Stone* in a November 8, 2012 interview, “The truth is that if you look at the precedents dating back to the 1930s, this was clearly constitutional under the Commerce Clause. I think Justice Roberts made a decision that allowed him to preserve the law but allowed him to keep in reserve the desire, maybe, to scale back Congress’ power under the Commerce Clause in future cases.”

lems stemming from the complexity and fragmentation of the health care delivery system. Together with good information systems and compensation arrangements, vertical integration of complementary health care entities can achieve important efficiencies by reducing medical errors, obviating duplicative services and facilities, and coordinating elements needed to deliver high quality, patient-centered care.”

Yet, in practice, ACOs don't have to tie their clinical policies to recognized standards of care. ACOs can link physician income to cost containment, meaning that doctors have a personal financial interest in devoting fewer resources to patients which could compromise care. In addition, ACOs may give providers more market power and

fuel monopolies, driving up health care prices for consumers nationwide.

Moreover, it's unclear to what extent ACOs will be held accountable for medical malpractice. Some argue that the very foundation of ACOs – incentivizing members in order to contain costs – exposes them to new liability risks. As explained in a July 10, 2013 JAMA op-ed, “When cost-saving efforts play a role in medical decision-making, there is an inevitable tension between cost containment and medical liability.” The result: ACOs may face institutional liability for medical malpractice in state courts when “the ACO's actions or policies prioritized cost savings over patient safety, contributing to the patient's harm.” Derek A. Jones, actuary for insurance industry consulting firm Milli-



man, reached a similar conclusion in a May 29, 2012 article, stating, “As ACOs attempt to control costs, procedures determined to be ‘non-critical’ will be reduced or eliminated. To the extent that this leads to fewer diagnostic tests, there could be increased exposure to liability claims that would be due to new failures to diagnose.”

Only time will tell whether ACOs pose a threat to patient welfare.

REIGNING IN THE HEALTH INSURANCE INDUSTRY

Ending abusive health insurance industry practices that harm consumers is a major focus of the ACA. Among the key changes enacted:

- No more lifetime or annual dollar limits on coverage.
- No dropping coverage when insureds get sick.
- No denying coverage because of a pre-existing condition.
- Implementation of an effective appeals process for coverage determinations and claims.
- Providing consumers with easily understandable information about their health plan benefits and coverage so they can make informed choices.
- Public justification of any rate increase of 10 percent or more in every state. States are also given resources to review and block premium hikes.
- Spending at least 80 cents of a premium dollar on health care or improvements to care. If insurers don't, customers receive a rebate.



Not surprisingly, the insurance industry has found a new way to victimize consumers. According to the December 3, 2013 *New York Times*, “Millions of people have received notices saying their policies were being canceled because they did not comply with minimum coverage requirements of the new health care law.” The Obama administration is now trying to clean up the mess, even floating a proposal “offering more money to insurance companies as an incentive for them to let people keep insurance policies that were to have been canceled next year,” reports the *NYT*. Government subsidy of an already extremely lucrative industry should not sit well with the American public. As Consumer Watchdog's Jamie Court told the paper, “Insurers are already being paid by taxpayers for the vast majority of new enrollees....”