THE HIDDEN COSTS OF "HEALTH COURTS"

"Health Courts" shift costs of medical negligence to taxpayers

Those who urge that medical malpractice cases be removed from the civil justice system and replaced by an administrative process usually fail to mention the massive costs that would be shifting to taxpayers. Proponents like Common Good and their allies from Harvard claim that their administrative model could be substituted for the traditional medical malpractice remedy at a comparable cost while compensating more injured patients.[1] They recognize that the cost of any alternative cannot, and should not, exceed the current costs of medical malpractice liability.[2] To stay within this "budget," however, they must shift costs dramatically.

Taxpayers and private health insurers would pay for negligence

First, the "health courts" model is designed to shift most of the costs of the negligence away from negligent parties and onto taxpayers and private health care insurers. Currently, Medicare and Medicaid have a statutory right to be reimbursed (or "subrogated") for the amount paid for a patient's medical expenses in the event that a patient receives compensation from a medical malpractice liability claim.[3] In fiscal year 2005, Medicare alone saved $325 million by exercising its statutory right to reimbursement.[4] Similarly, most private health insurers have a contractual right to subrogation from a patient's legal recovery and collect monies paid out on behalf of the patient.[5] Thus, at present, Medicare, Medicaid, and private health insurers are the payors of last resort in the context of third party liability because they are all reimbursed by negligent medical providers, typically through those providers' liability insurers.

However, for the "health courts" model (or any similar administrative alternative) to stay within budget, the medical provider(s) responsible for a medical error must be allowed to shift the costs of their negligence to these public and private health insurers.[6] For example, under the Harvard proposal, the total costs (*i.e.*, the total amount available annually for patient compensation in any individual state) cannot exceed the total annual cost of medical malpractice liability in that state (*i.e.*, the equivalent of the total annual cost of medical malpractice premiums paid in that state). To stay within this budget, the Harvard proposal suggests *extinguishing* the subrogation rights of Medicare, Medicaid, and private health insurers.[7]

Stated simply, under this scheme, medical providers and their liability insurers want to become the payors of last resort. Yet, shifting these massive costs onto Medicare, Medicaid and private health insurers would dramatically increase the cost of health care for *everyone*, as these public and private health insurers would likely have to both raise rates and to limit coverage. Further, shifting these costs would create a strong

disincentive: Medical providers and their liability insurers would not continue to guard against negligent acts or improve patient safety. There is no cost incentive to correct errors if others are footing the bill.

The bottom line is that *taxpayers and private health insurers* would pay for the negligence of health care providers.

Taxpayers would pay twice

Second, the resources needed to run an administrative program would be a costly addition to a state court system. For example, Common Good and its Harvard allies envision their alternative "health courts" as state enterprises.[8] Their alternative is an elaborate bureaucracy involving a complex, multi-stage process. (See attached: Health Court Claims Process.[9]) To implement and maintain this system would require many professionals from various disciplines, as well as personnel such as clerks and administrators. In addition, resources would be needed to maintain facilities in various locations, and these facilities would require computers, office equipment, supplies, and security. At the same time, taxpayers must also fund the state's court system.

The bottom line is: *Taxpayers would pay twice* – once for state courts, and again for a parallel "alternative."

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[1] Barringer, Paul J. III, and Samis, Sarah. "Health Courts – Promoting Reliable Medical Justice." Health Insurance Underwriter. October 2006. Available at http://hiu.nahu.org/article.asp?article=1447 ; Mello, Michelle M., Studdert, David, Kachalia, Allen B., and Brennan, Troyen A. "Health Courts and Accountability for Patient Safety." The Milbank Quarterly. Vol. 84, November 3, 2006. ("Nov. 2006 Harvard Health Proposal").

[2] Studdert, David M., Brennan, Troyen A., Thomas, Eric J. "Beyond Dead Reckoning: Measures Of Medical Injury Burden, Malpractice Litigation, And Alternative Compensation Models From Utah And Colorado." 33 Ind. L. Rev. 1643;1673-1674 (2000).

[3] 42 U.S.C.A. § 1395y provides, in part: "(2) Medicare secondary payer (A) In general Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that-- (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." Payments made under liability insurance, including malpractice, are included; see also: 42 C.F.R. § 411.20; Center for Medicare and Medicaid Services at http://www.cms.hhs.gov/MSPRGenInfo/02_contactMSPRC.asp

[4] According to the Office of Financial Management, Centers for Medicare and Medicaid Services, Baltimore, MD, this figure reflects the total amount saved from all types of liability claims, including medical malpractice, under Medicare Part A (hospitals and other institutions) and Part B (physicians and other providers). For FY 2004, Medicare saved $281 million, in FY 2003 $240 million, in FY 2002 $225 million, in FY 2001 $220 million and in FY 2000 Medicare saved $229 million.

[5] Private insurers create this right through contract, and the Employment Retirement Income Security Act (ERISA) also protects private insurers in employment-based insurance plans from becoming the first payor.

[6] Nov. 2006 Harvard Health Proposal at 8; Studdert, Mello, et al. and Common Good draft Health Court Proposal Skeleton presented October 17, 2005, at 7 ("Harvard Skeleton Proposal").

[7] Proponents recognize that to avoid financial disaster, "*[s]tatutory amendments at the state level and possibly also at the federal level will be required* This is because Medicare and Medicaid both enforce second payer rules of their own, and the Employee Retirement Income Security Act may limit the ability of states to place first-payer mandates on employment-based insurance plans." Harvard Skeleton Proposal at 7. Emphasis added.

[8] Nov. 2006 Harvard Health Proposal at 15.

[9] Nov. 2006 Harvard Health Proposal at 4 (Figure 1: "Health Courts Claim Process").