Innovative Cost Control: An Analysis of Medical Malpractice Reform in Massachusetts

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I. Introduction

In passing the Patient Protection and Affordable Care Act ("PPACA")1 in March 2010, Congress and President Obama took a historic step toward reforming the United States' health care system on a national level. PPACA is largely based on the Massachusetts health care reform model set forth in 2006, sharing two main objectives: (1) to expand access to health care for all Americans; and (2) to provide affordable health insurance and health care.2 Unlike the Massachusetts model, which expanded access to health insurance in 2006 and cost containment in a separate, secondary phase in 2012, PPACA focuses on improving access to both health care and cost-containment simultaneously.3 On the state level, Massachusetts became the first state to implement

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2 John Z. Ayanian & Philip J. Van der Wees, Tackling Rising Health Care Costs in Massachusetts, 367 NEW ENG J. MED. 790, 791 (2012). Key components of the 2006 legislation enacted in Massachusetts, such as the individual insurance mandate and Medicaid eligibility expansion, were incorporated into PPACA. Id.; HENRY J. KAISER FAMILY FOUND., MASSACHUSETTS HEALTH CARE REFORM: SIX YEARS LATER 5-6 (2012) (describing the dual, two-phase goals of Massachusetts health care reform legislation and comparing to PPACA). PPACA and the Massachusetts health care reform bills share six main provisions: (1) insurance market reforms; (2) state-based exchanges; (3) subsidies for private coverage; (4) expansion of Medicaid coverage; (5) individual insurance mandate; and (6) employer shared responsibility requirements. HENRY J. KAISER FOUND., supra at 9. Because of Massachusetts' success in creating an individual mandate and expanding access to insurance, the rest of the nation is now looking to Massachusetts as a model for how to implement the federal health care reform requirements. Id. at 8.

3 Robert B. Doherty, The Certitudes and Uncertainties of Health Care Reform, 152 ANNALS INTERNAL MED. 679, 679 (2010) ("The goal of the PPACA is to help provide affordable health insurance coverage to most Americans, improve access to primary care, and lower costs."). The Congressional Budget Office ("CBO") has projected that PPACA will provide health insurance
cost control provisions through health care legislation by passing the Health Care Cost Containment Bill ("Cost Bill") on August 6, 2012. Interestingly, the federal and state plans for cost control differ in one key, oft-debated area of health care costs: medical malpractice reform. The impact of medical malpractice costs on provider behavior and expenses has been extensively analyzed by legal and medical scholars. Therefore, the absence of medical malpractice reform in PPACA is conspicuous, and has been largely scrutinized. Massachusetts, on the other hand, recognized the costs of medical malpractice on the health care system and addressed them by instituting tort reforms through the Cost Bill.


5 Leonard J. Nelson et al., Medical Liability and Health Care Reform, 21 HEALTH MATRIX 443, 444-45 (2011). National medical malpractice reform, particularly a damage cap, was a politically divisive issue during Congressional discussions about the federal health care reform bill. Id. at 445-47. Republicans supported a national damage cap and cited the effectiveness in states like Texas and California, while Democrats opposed this reform. Id.

6 Ronen Avraham, An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments, 36 J. LEGAL STUDIES S183, S183-84 (2007). The issue may not be important to the public, but it has held the attention of numerous professional associations, political organizations, and political interest groups. Id.; Allen Kachalia & Michelle M. Mello, New Directions in Medical Liability Reform, 364 N ENG. J. MED. 1564, 1564 (2011) ("Medical liability reform has maintained a tenacious hold on the national policy agenda").

7 Thomas L. Hafemeister & Joshua Hinckley Porter, The Health Care Reform Act of 2010 and Medical Malpractice: Worlds in Collision or Ships Passing in the Night? 64 SMU L. REV. 735, 736-37 (highlighting lack of medical malpractice reforms in PPACA despite significant political attention). PPACA does not include any medical malpractice liability reform provisions, but rather, allocates federal funding to set up state-based demonstration projects to experiment with various types of medical malpractice reforms. Kachalia & Mello, supra note 6, at 1564.

8 MASS. GEN. LAWS ch. 231, § 60L(a)-(k) (2010); see infra Part IV.
This note will analyze how the medical malpractice reform provisions of the Cost Bill will likely have an impact on controlling costs in the post-PPACA, Massachusetts health care system. Part II will review how and why medical malpractice costs directly and indirectly affect overall health care costs. Next, Part III will generally explain traditional and non-traditional types of medical malpractice tort reform before outlining the specific Cost Bill tort reforms in Part IV. Part V will propose the likely effects of this bill in Massachusetts, and conclude that Massachusetts is in a unique position to serve as a model for how alternative tort reforms can contribute to the overall cost containment goals of PPACA.

II. Why Malpractice Costs Matter in the Health Care System

The cost of the current medical malpractice system has been estimated by numerous sources, but is generally cited as approximately $55.6 billion, or roughly 2.4% of the current $2 trillion spent on health care in the United States each year. At such a low percentage of total spending, one issue has been whether malpractice reforms are, in fact, worth exploring. In response, the CBO estimated that the United States could potentially save $11 billion in 2009 dollars, or 0.5% of the total federal health care budget, with a proposed malpractice tort reform plan. Yet with 98,000 Americans dying each year from preventable medical errors, what dollar amount will be enough to make reform worthwhile? Historically, traditional malpractice reforms have evaluated the impact on the financial bottom line for physicians and insurers, but more recently, the conversation has shifted toward improving patient safety and overall transparency in the health care system. This movement has strengthened the position that an analysis

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10 Nelson et al., supra note 5 (noting President Obama’s statement that total medical malpractice costs were “relatively insignificant” compared to total health care spending).

11 Elmendorf Letter, supra note 9, at 3.


13 Kachalia & Mello, supra note 6, at 1564. This new perspective may be attributed to the passage of PPACA and the legislature’s commitment to implementing an effective law. Id.
of medical malpractice reform must include its impact on both direct and indirect costs in the health care system.\textsuperscript{14}

A. Direct costs

The direct costs of medical malpractice in the health care system can be measured in a straightforward manner.\textsuperscript{15} Typically these costs are comprised of the litigation costs, administrative costs, and the total malpractice judgment award.\textsuperscript{16} The CBO estimated in 2008 dollars that the direct costs of medical malpractice were estimated to be $9.85 billion, or approximately 0.5\% of national health care spending.\textsuperscript{17} Administrative costs, which include attorneys’ fees, plaintiffs’ fees, and insurers’ administrative overhead, totaled an estimated $4.13 billion in 2008 dollars.\textsuperscript{18} Award payments accounted for the remaining $5.72 billion of direct costs to the health care system.\textsuperscript{19}

Malpractice payments are representative of the financial burden placed on physicians, but are also a steady measurement tool used to evaluate trends in medical malpractice claims.\textsuperscript{20} In 2010, the national average malpractice payment was $200,000 for a settlement and $523,111 for a trial judgment.\textsuperscript{21} Across the nation, the number of

\textsuperscript{14} Id. at 1570. PPACA’s focus on patient safety coincides with the holistic goals of alternative medical malpractice reforms. Id. at 1568; see also discussion infra Part III-B (explaining how types of non-traditional tort reforms incorporate goals of systemic efficiency and patient safety along with financial savings).

\textsuperscript{15} See Mello et al., supra note 9, at 1570-71.

\textsuperscript{16} Id.

\textsuperscript{17} Id. at 1570. In this study, the author incorporated the CBO’s 2008 estimate, but concluded with its own final estimate. Id. The CBO has focused its malpractice cost reduction methods on traditional reforms, like damage caps, which will limit the award payments and, essentially, impact direct costs. See Nelson et al., supra note 5, at 484-85.

\textsuperscript{18} Mello et al., supra note 9, at 1570-72.

\textsuperscript{19} Id. at 1570-71. While the cost of medical malpractice insurance premium is often cited as part of the system’s costs, it is excluded from this study’s estimate because, theoretically, this premium should equal the payments paid out plus the insurer overhead. Id. Therefore, to include the premium would be double-counting it, and thus lead to a skewed measure of the direct costs of malpractice. Id.

\textsuperscript{20} Avraham, supra note 6, at S190 (relying on malpractice award payments as main data source for analyzing total cost on the health care system); Jordon Walker, Malpractice Lawsuits in the US: Trends over Time and How Recent Reductions in Damage Awards Could Change Medicine, YALE J. MED. & LAW: AN UNDERGRADUATE PUBLICATION (Dec. 5, 2011), http://www.yalemedlaw.com/2011/12/malpractice-lawsuits-in-the-us-trends-over-time-and-how-recent-reductions-in-damage-awards-could-change-medicine/#.

\textsuperscript{21} AM. MED. ASS’N, MEDICAL LIABILITY REFORM – NOW! 4, 6 (2012), available at
malpractice awards and the dollar amounts paid per award has been almost cut in half over the past ten years. This trend, however, varies greatly by state. In Massachusetts, for example, the amount paid per claim filed was significantly higher in 2011 than in 2001. Further, with regard to the average dollar amount awarded in a medical malpractice lawsuit, Massachusetts had the fourth highest average award nationally. Because of the high medical malpractice awards and correspondingly high malpractice insurance premiums, Massachusetts has been deemed a state in malpractice crisis.

B. Indirect costs

A more pronounced discrepancy exists between how to measure the indirect costs.
costs of medical malpractice, which mainly refers to the cost of physicians practicing defensive medicine.26 Defensive medicine can be characterized by two types of behavior, both of which impact the health care system.27 First, physicians may develop assurance behavior, in which they order additional testing and screenings to affirmatively rule out any possible negative outcomes, even if they feel such steps are not medically necessary.28 By ordering these additional services, physicians induce patients to collectively purchase more tests and screenings, increasing overall spending on unnecessary medical treatment.29 Alternatively, physicians may choose avoidance behavior, in which they change their practice to alter or even eliminate services that are more risky and vulnerable to malpractice claims.30

The cost of defensive medicine to the national health care system has been estimated to range widely between $45.6 billion and $126 billion annually.31 These

26 Kachalia & Mello, supra note 6, at 1572. The U.S. Congress Office of Technology Assessment (“OTA”) defines defensive medicine as “the ordering of tests, procedures, or visits, or the avoidance certain high-risk patients or procedures, primarily, (but not necessarily solely) to reduce [a physician’s] risk of malpractice liability.” U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE 161 (1994), available at http://biotech.law.lsu.edu/policy/9405.pdf.

27 BIEBELHAUSEN & LISCHKO, supra note 9, at 3-5. See generally AM. MED. ASSN, supra note 21, at 7-9 (citing several studies concluding defensive medicine exists and is costly to health care system).

28 BIEBELHAUSEN & LISCHKO, supra note 9, at 5 (explaining assurance behavior).


31 Kachalia & Mello et al., supra note 6, at 1572. This estimate represents one of the most recent studies on the estimated cost of defensive medicine. MEDICAL LIABILITY REFORM, supra note 21, at 9. Limited research projects focused on estimating the cost of defensive medicine have been conducted over the past ten years. Id. In 2003, the Department of Health and Human Services (“HHS”) estimated the cost of defensive medicine to range between $70 billion and $126 billion annually. U.S. DEP’T OF HEALTH & HUMAN SERV., ADDRESSING THE NEW HEALTH CARE
figures represent spending that can be reduced to bend the health care cost curve downward, as well as indicate the deep potential impact that effective malpractice reform could have on improving health care quality.\textsuperscript{32} Physicians should be able to focus on providing top medical care based on their training, rather than focusing on avoiding the legal liability of malpractice suits in the event of an error.\textsuperscript{33} Traditionally, this defensive behavior was only associated with higher risk specialties such as obstetrics; however, with 91% of physicians reporting they practice defensive medicine, the practice now pervades the entire profession.\textsuperscript{34} It has also been suggested that high malpractice costs deter physicians from entering into certain state markets or high-risk specialties, which can lead to physician shortages and create additional obstacles for patients’ access to necessary health care.\textsuperscript{35}

In Massachusetts, 44% of physicians report altering their practice in 2011 based on fear of malpractice claims and cost.\textsuperscript{36} The Massachusetts Medical Society (“MMS”)

\textsuperscript{32} See Horton & Hollier, supra note 29, at 233-34. Malpractice costs put financial pressure on physicians, which drives an increase in patient volume to bring in more revenue, and in turn, reduces the amount of time and control physicians have over patient care. \textit{Id.} Fear of malpractice can also lead physicians to cut services to avoid liability, which may limit patient access to those services. KLAGHOLZ \textit{& STRUNK}, supra note 30, at *2-3.

\textsuperscript{33} MEDICAL LIABILITY REFORM, supra note 21, at 4. Physicians admit that fear of malpractice litigation can motivate them to change their practice, avoid high-risk services or patients, relocate to different states, and order more tests “simply to avoid” medical liability. \textit{Id.}

\textsuperscript{34} Tara Bishop et al., \textit{Physicians’ Views on Defensive Medicine: A National Survey}, 170 ARCHIVES INTERNAL MED. 1081, 1082 (2010). Of 1,231 physicians surveyed, the overall results did not vary by specialty: 91.2% of generalists, 88.6% of medical specialists, 92.5% of surgeons, and 93.8% of other specialists agreed that physicians order more tests and services than necessary to protect themselves from malpractice. \textit{Id.}


\textbf{CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 11} (2003), available at http://aspe.hhs.gov/daltcp/reports/medliab.pdf. This is the most recent HHS estimate and modern articles still cite to these figures. See Horton & Hollier, supra note 29, at 232; MEDICAL LIABILITY REFORM, supra note 21, at 9.

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\textit{Id.}

\textit{Id.}

\textit{Id.}


\textit{Id.}

\textit{Id.}


\textit{Id.}

estimates that the cost of defensive medicine in Massachusetts alone was approximately $1.4 million in 2011.7 A “critical shortage” of physicians exists in key specialties, such as urology, neurology, and internal medicine.8 Massachusetts also has some of the longest patient wait times in the country, largely attributable to the physician shortage in the Commonwealth.9 Because of these statistics, it is likely that the current cost and access challenges in Massachusetts were factors that led to the legislature incorporating malpractice reform into phase two of the Commonwealth’s health care reform plan.10

A final consideration is whether physicians have any other choice than to practice defensively. This behavior may not be a result of a broken system, but rather the only possible effect given the legal framework of malpractice litigation.11 In the United States, courts use a negligence analysis to evaluate physician malpractice.12 The court must first determine whether the physician breached the duty of reasonable care, as defined by the skill and care of the average physician practicing at the time of the alleged negligence.13 As the majority of physicians practice defensive medicine, the cost

MMS WORKFORCE SURVEY]. Survey results vary by specialty, with nearly 60% of obstetricians, urologists, and neurosurgeons reporting that they have changed their practice in at least one way because of fear of malpractice liability. Id.

37 MASS. MED. SOC’Y, INFORMATIONAL REPORT I-08-02, INVESTIGATION OF DEFENSIVE MEDICINE IN MASSACHUSETTS 7 (2008), available at http://www.massmed.org/AM/Template.cfm?Section=Research_Reports_and_Studies2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=27797 [hereinafter INFORMATIONAL REPORT I-08-02].

38 MMS WORKFORCE SURVEY, supra note 36, at 67. Survey results indicate that Massachusetts has a physician shortage in numerous specialists, including dermatology, general surgery, psychology, urology, neurology, internal medicine, and family medicine. Id.

39 MERRITT HAWKINS & ASSOCIATES, 2009 SURVEY OF PHYSICIAN WAIT TIMES 16 (2009), available at http://www.merritthawkins.com/pdf/mha2009waittimesurvey.pdf. Of the fifteen major cities evaluated in the survey, Boston had the longest average wait time to schedule an appointment, with an average of 49.6 days to see a specialist. Id. at 14. The next, longest, average wait times were 27 days in Philadelphia, 24.2 days in Los Angeles, and 23.4 days in Houston. Id. The shortest wait time was 11.2 days in Atlanta. Id.

40 See INFORMATIONAL REPORT I-08-02, supra note 37, at 67-68 (concluding physician work environment must change and medical malpractice reform should be enacted).

41 Horton & Hollier, supra note 29, at 232. The American legal system drives physicians to practice defensively because the current standard of reasonable care within the profession now routinely includes the practice of defensive medicine. Id.

42 John C.P. Goldberg & Benjamin C. Zipursky, The Restatement (Third) and the Place of Duty in Negligence Law, 54 VAND. L. REV. 657, 658-59 (2001) (confirming every state has adopted that negligence has four elements: duty, breach, causation, and injury).

43 Brune v. Belinkoff, 235 N.E.2d 793, 798-99 (Mass. 1968) (establishing the Massachusetts standard of care for medical negligence). The standard of care is whether the physician has “exercised the skill and care” of the qualified, reasonable physician practicing in a given specialty at the time the medical negligence occurred. Id.
and scope of the standard of "reasonable care" also increases. The result is that physicians who choose not to practice defensively may be more likely to be deemed negligent under this higher standard. The effect of this legal framework on physicians underscores that defensive medicine may impact health care costs even more than the billions of dollars currently estimated.

III. History of Malpractice Reforms

There are many criticisms of the United States' medical malpractice system, including that the system encourages frivolous litigation and prevents open communication between physicians and patients when errors occur. Because malpractice insurance companies pay for the defense of physicians, tort reform has garnered political and media attention when insurance premiums spike due to increases in claims. During these periods, high premiums cause physicians to struggle with the accessibility and affordability of the insurance coverage for their individual practice. To combat higher overhead costs, physicians may feel pressure to increase patient volume, spend less time with each patient, or raise office visit and procedure prices. State legislatures and researchers have typically focused tort reform efforts on mechanisms that limit award payments because of the impact on the insurance market; however, non-traditional reforms that focus on both cost and quality outcomes are now emerging.

44 Horton & Hollier, supra note 29, at 232.
45 Id. Physicians who strive to be cost-conscious rather than defensive may be more likely to be deemed negligent because "in a real courtroom, it is not practical for a defendant physician to tell a jury that he or she was trying to save the health care system a few dollars by avoiding low-suspicion test or consult." Id.
47 MEDICAL LIABILITY REFORM, supra note 22, at 3.
48 Id. There have been three separate periods in recent history that were considered malpractice crises: (1) the mid-1970s; (2) the mid-1980s; and (3) the early 2000s. Nelson et al., supra note 5, at 453-54; Hyman et al., supra note 35 (stating tort reform is a response to the medical malpractice insurance premium spikes). The malpractice crisis has remained a focal point of national policy agenda during the 21st century. Kachalia & Mello, supra note 6, at 1564.
49 Nelson et al., supra note 3, at 453-54.
50 Horton & Hollier, supra note 33, at 232.
51 Kachalia & Mello, supra note 6, at 1564. The passage of PPACA has made it timely to re-evaluate malpractice liability from both a cost and quality perspective. Id. "Today, reform is taking place outside of state legislatures through federal sponsorship of voluntary policy experiments led by hospital systems, liability insurers, and state agencies. The experiments target both liability cost control and patient safety improvement." Id.
A. Traditional Tort Reforms

Historically, states have responded to malpractice crises by implementing caps on the damages that courts can award to plaintiffs in malpractice suits. By limiting non-economic damages for harms like pain and suffering, tort reform efforts have been successful in reducing the dollar amount of award payments to plaintiffs. Currently, thirty-eight states have implemented caps on non-economic damages in medical malpractice suits. Some state supreme courts, however, such as Georgia and Illinois, have struck down non-economic damages cap laws as unconstitutional, posing an additional challenge to state tort reform efforts. Other traditional types of tort reform include limiting recoveries for attorney’s fees, restricting joint and several liability statutes, and shortening the statute of limitations. Traditional reform efforts have varying levels of effectiveness in mitigating the number of award payments, but ignore related goals, such as improving patient safety by reducing the frequency of medical errors and encouraging open dialogue about negative outcomes.

Federal malpractice reforms have been hotly debated in relation to health care reform, with support and criticism breaking down along party lines. In 2009, the CBO

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52 Nelson et al., supra note 5, at 453 (stating caps on damages are the only reform empirically proven to lower malpractice insurance costs).
53 Kachalia & Mello, supra note 6, at 1566. “Studies have nearly uniformly found that caps are an effective means of reducing the size of indemnity payments.” Id. Avraham, supra note 6 at S221-22 (concluding caps on non-economic damages and limitations on joint and several liability reduced settlement payments).
56 Teresa M. Waters et al., Impact of State Tort Reforms On Physician Malpractice Payments, 26 HEALTH AFFAIRS 500, 501-02 (2007), (explaining four categories of traditional, state-based tort reform). A study concluded that while some reforms were more effective than others, the overall impact of controlling tort payments is limited. Id. at 507.
57 Id. at 508. The current tort system puts patients at risk by stifling conversations with physicians about medical errors, giving them the option to sue rather than to talk frankly with physicians about the errors. Hillary Rodham Clinton & Barack Obama, Making Patient Safety the Centerpiece of Medical Liability Reform, 354 N. ENG. J. MED. 2205, 2207 (2006). Physicians do not feel they can discuss medical errors with patients because of fear that the admission will be used against them in legal proceedings. Id.
58 See supra notes 5-7 and accompanying text.
estimated that a federal cap on non-economic damages could reduce the budget deficit by $54 billion over a ten year period,\textsuperscript{59} while President Obama co-authored a 2005 bill to implement a national medical error disclosure program to improve patient safety.\textsuperscript{60} Yet, despite this awareness in Washington, DC, PPACA omits any federal malpractice reform in its effort to control cost and improve quality.\textsuperscript{61} Of PPACA's three sections addressing medical malpractice, only § 6801(3) arguably addresses any substantive reform by stating that Congress should develop state demonstration programs to explore alternatives to the current medical malpractice system.\textsuperscript{62}

States have embraced several types of traditional tort reform. First, joint and several liability statutes control which defendants a plaintiff may sue after a suspected medical error, regardless of any individual defendant's proportional fault.\textsuperscript{63} For example, in states where joint and several liability theories are accepted, a plaintiff may try to recover damages from a hospital, even if the physician is more at fault than the

\textsuperscript{59} Elmendorf Letter, \textit{supra} note 9, at 3.

\textsuperscript{60} S. 1784, 109th Cong. (2005), \textit{available at} http://thomas.loc.gov/cgi-bin/query/z?c109:S.1784. The National Medical Error Disclosure and Compensation ("MEDiC") program was sponsored by Senator Hillary Clinton and co-authored by Senator Barack Obama. Clinton \& Obama, \textit{supra} note 57, at 2208. The MEDiC program had four goals: (1) promote open communication between physicians and patients; (2) reduce the rate of medical errors; (3) ensure fair compensation for injured patients; (4) lower malpractice insurance premiums. \textit{Id.} at 2206. President Obama also suggested in pre-PPACA speeches that his health care reform plan would include national medical malpractice reform. Hafemeister \& Porter, \textit{supra} note 7, at 737.

\textsuperscript{61} \textit{Id.}

\textsuperscript{62} Patient Protection and Affordable Care Act of 2010 § 6801, Pub. L. No. 111-148, 124 Stat. 119, 804. Section 6801 states:

\begin{quote}
It is the sense of the Senate that—(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; (2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court; and (3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.
\end{quote}

\textit{Id.}

\textsuperscript{63} See Avraham, \textit{supra} note 6 at S194. In 2011, twenty-seven states statutorily permit joint and several liability, eighteen states have several liability laws, and seven states recognize modified several liability. \textit{Medical Liability/Medical Malpractice Laws, supra} note 54.
facility itself. Additionally, collateral source laws are designed to prevent the introduction of evidence that a plaintiff's losses may have been covered by another source, like an insurance company, so that a court cannot offset the damages awarded by these amounts. Researchers have studied whether these reforms lower payments and overall costs; however, there have been no definitive conclusions that either reform has a statistically recognizable impact on lowering payment costs.

B. Non-Traditional Reform Development

While Congress has yet to pass a federal malpractice reform bill, the House of Representatives has passed a bill that included several traditional malpractice tort reform provisions. Further, the Department of Health & Human Services ("HHS") is in the process of evaluating non-traditional theories after awarding $25 million in planning and demonstration grants to state organizations for medical liability reform projects. In Massachusetts, the Beth Israel Deaconess Medical Center ("BIDMC") received a one-year demonstration grant in the spring of 2010 and partnered with the MMS to explore the roadblocks to medical apology, disclosure, and compensation programs. This

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64 Id.
65 Nelson et al., supra note 5, at 450. Thirty-eight states have adopted collateral source rule reforms. Collateral Source Rule Reform, AM. TORT REFORM ASS'N, http://www.atra.org/issues/collateral-source-rule-reform (last visited Apr. 30, 2013). One empirical study found that the strictness of a state's collateral source rule was inversely proportionate to the impact on claim reduction. Waters et al., supra note 56, at 508.
66 Avraham, supra note 6, at S221-22. "The joint effect of all six reforms was statistically significant in reducing the number of cases but not [state-level] average awards or total payments." Id. at S183. Caps have been associated with limiting defensive medicine, while joint and several liability and collateral source rule reforms have had little to no impact on reducing defensive medicine. Kachalia & Mello, supra note 6, at 1566. Studies have typically analyzed the empirical data on lowering claims and payments, not a reform's effect on improving patient safety or health care quality. Id.
68 Press Release, Dep't of Health & Human Serv., HHS Announces Patient Safety and Medical Liability Demonstration Projects (June 11, 2010), available at http://www.hhs.gov/news/press/2010pres/06/20100611a.html. HHS's Agency for Healthcare Research and Quality ("AHRQ") awarded seven planning and ten demonstration grants for organizations to research alternative methods of malpractice claim adjudication, for example, judge-directed negotiations, physician "safe harbor" guidelines, and physician disclosure of medical errors. Id. These seventeen grants are each one year long, and will focus exclusively on medical liability reform within the context of the health care delivery system. Id.
69 Press Release, Beth Israel Deaconess Medical Center, Mass. Medical Society Unveils
project identified four key concerns for stakeholders in the malpractice system: (1) physicians’ discomfort with disclosure of medical errors and apology; (2) the difficulty coordinating with insurers; (3) the legal community’s interest in maintaining the current system; and (4) Massachusetts’ physician liability laws.\textsuperscript{70}

Massachusetts’ demonstration grant project was rooted in the theory of apology programs, which emerged as a non-traditional type of reform in the late 1980s.\textsuperscript{71} A medical apology is a physician’s statement of remorse to a patient or family after a failed medical action or error causes the patient physical or psychological harm.\textsuperscript{72} An effective apology has four parts: (1) acknowledgement of the error; (2) explanation of any reason for the error (if one exists); (3) expression of sympathy or regret for the mistake; and (4) reparation.\textsuperscript{73} Apologies cannot erase the harm caused in many situations, but a sincere apology to a patient may generate a number of healing effects, including the patient feeling respected, comforted, empowered, assured, and encouraged by the open dialogue.\textsuperscript{74} By providing answers, accountability, and commitment to possible resolution, physician apologies can address the underlying desires of malpractice plaintiffs, who often are looking for more than compensation.\textsuperscript{75}

Research projects studying the impact of apologies for medical errors began as an effort to explore ways to improve patient safety and medical ethics.\textsuperscript{76} The realization
that apologies reduced both the cost and number of malpractice claims filed was an unintended outcome of this research. The most compelling evidence comes from the University of Michigan Health System’s (“UMHS”) implementation of this alternative approach. UMHS adopted a three-prong philosophy to medical liability risk management: (1) acknowledge unreasonable medical errors and compensate for them quickly; (2) zealously defend reasonable medical care; and (3) investigate medical errors so that frequency declines and patient safety improves. Key innovations in its approach were the expansion of the claims review committee to include nurses, physicians, and administrators, as well as the introduction of an early disclosure meeting for patients, physicians, and their attorneys to openly discuss negative outcomes before litigation commenced.

By improving overall transparency, UMHS was able to reduce the number of new malpractice claims and shorten the processing times of the claims. The early disclosure meeting permits patients and physicians to meet their pre-litigation goals of explanation and reparation without litigation. Every patient with a potential claim is invited, with a lawyer, to meet with the claims committee to discuss grievances, errors, apologies, and compensation. Expert opinions that would be introduced at trial are also included in this discussion. At the end of the early disclosure meeting, the patient may decide to drop the claim, pursue a settlement, or still litigate; however, the

Organizations, now known as the Joint Commission, published safety regulations as a response to the same Institute of Medicine report, which further galvanized medical error disclosure programs. Improving quality of care and patient safety continues to be a goal of non-traditional medical malpractice reforms like apology programs, particularly post-PPACA. Kachalia & Mello, supra note 6, at 1568.

Richard C. Boothman et al., A Better Approach to Medical Malpractice Claims? The University of Michigan Experience, 2 J. HEALTH & LIFE SCI. L. 125 (2009). UMHS implemented its disclosure and apology program in 2002 and published results for the period of 2002-2006. Id. at 143-44. The program was implemented and controlled by the health system’s Risk Management department, which was expanded and reorganized for the purpose of the project. Id. Experienced nurses were added to the department to help provide a layer of medical oversight to the claims notification and review process. Id.

Boothman et al., supra note 78, at 143-44. The authors of the UMHS report recognize that there was a downward trend in malpractice claims nationally between 2001-2007; therefore, the new disclosure model cannot solely account for the decrease in claims. Id. However, they do cite the new model as an important factor in the reduction of claims and processing time at UMHS, as well as a contributor to many other quality improvements in the system. Id. at 144-45.
difference is that both parties have discussed the facts, risks, and costs of each possibility in an open non-litigious environment. \textsuperscript{85} Physicians and attorneys in Michigan agree that the disclosure system is an improvement over traditional reform efforts and that both parties' goals are met more efficiently and cost-effectively. \textsuperscript{86} Departing from the traditional "deny and defend" approach defense attorneys historically have relied upon, UMHS physicians can focus on moving forward with their patients without fear that an admission of error or apology for a mistake will be used as evidence of guilt in a lawsuit. \textsuperscript{87}

UMHS's apology and disclosure program has received criticism as well. First, UMHS's claims review committee lacks any conflict of interest protections. \textsuperscript{88} The committee members are all employees of the hospital, so whether their evaluation of the claims can be truly independent from the hospital's incentive to control costs and liability is questionable. \textsuperscript{89} Second, UMHS has not released any information on its negotiation strategy with patients during the disclosure meetings. \textsuperscript{90} The majority of attorneys who participated in UMHS's program reported the settlement awards were below the initially anticipated valuation amount. \textsuperscript{91} While UMHS does not report data on actual settlement amounts, a hospital-controlled negotiation could possibly intimidate patients to accept less compensation than deserved, even when their attorney is present. \textsuperscript{92} Finally, while patients are invited to bring their attorney, it is not required by

\textsuperscript{85} Boothman et al., supra note 78, at 142.

\textsuperscript{86} See id. at 146. A UMHS physician survey demonstrated that 98% approved of the new approach and 55% agreed that the program was a significant reason to keep practicing at UMHS. \textit{Id}. at 145-46. The plaintiffs' bar survey showed that 81% reported their costs were reduced as a result of the program, 86% agreed they made better decisions on pursuing claims under the new model, and 57% admitted they would pursue fewer claims in the future than if the disclosure model were not in place. \textit{Id}. Additionally, 71% stated their settlement awards with UMHS were lower than expected. \textit{Id}.

\textsuperscript{87} \textit{Id}. at 127. The "deny and defend" approach refers to the current, common practice where doctors are advised by their insurance companies and defense attorneys to not speak to the patient or patient's family after an adverse medical outcome. Boothman et al., supra note 78, at 127; Shari Welch, Quality Matters: Deny and Defend: Apologizing Hampered by Physician Culture, Risk Management, \textit{EMERGENCY MED. NEWS} (Wolters Kluwer Health), Mar. 2011, at 23, available at http://journals.lww.com/em-news/Fulltext/2011/03000/Quality_Matters__Deny_and_Defend__Apolo..12.aspx; Lazare, supra note 71, at 1403.

\textsuperscript{88} Teninbaum, supra note 76, at 319.

\textsuperscript{89} \textit{Id}. at 319.

\textsuperscript{90} \textit{Id}. at 320.

\textsuperscript{91} Boothman et al., supra note 78, at 146 (stating 71% of surveyed plaintiff attorneys reported lower settlement amounts than anticipated).

\textsuperscript{92} Teninbaum, supra note 76, at 326-27. Apologies may reduce tension, anger, and frustration, while increasing feelings of compassion and sympathy. \textit{Id}. It has been suggested that these
UMHS; therefore, there is a concern that unrepresented patients may unknowingly relinquish some legal rights.93

Despite criticism, this non-traditional approach to handling malpractice has been embraced and incorporated into various state malpractice laws.94 Currently, thirty-six states and the District of Columbia have statutes permitting physicians to make an apology or sympathetic gesture to patients,95 while eight states and Puerto Rico introduced similar legislation in 2012.96 Although these statutes vary in scope, they generally protect physicians by making the evidence of an apology or an acknowledgment of error inadmissible in court.97 One study suggests that states with medical apology laws settle moderate medical injury claims 16-18% more quickly than states without these laws, and that these states paid out approximately $50,000-$80,000 less for more severe medical injury claims.98 Additionally, the HHS demonstration projects are currently testing variations of UMHS' medical error and apology programs simultaneous psychological effects may cause a patient to accept a lower offer than they may have accepted without the apology. Id.

93 Id. at 319, n.66 (quoting UMHS attorney’s email to author about patient legal representation). While negotiation and settlement may appease the patient, there is no evidence of what percentage of patients are aware of the potential compensation forgone by accepting apologies and settlements. Id. at 329. Apology programs could be improved by ensuring that patients are educated on their full legal rights prior to settlement discussions. Id. at 332-33.

94 See Medical Liability/Medical Malpractice Laws, supra note 54 (listing table of all state malpractice laws).

95 Id.; see e.g. CONN. GEN. STAT. ANN. § 52-184d (West 2012) (prohibiting “any and all” physician statement of apology from admission as evidence of liability); MD CODE ANN., CTS. & JUD. PROC. § 10-920 (LexisNexis 2012) (deeming oral and written apology statements by health care providers inadmissible); 12 VT. STAT. ANN. tit. 12, § 1912 (LexisNexis 2012) (protecting physician’s oral apology and explanation for medical error as inadmissible evidence of liability); VA. CODE ANN. §8.01-581.20:1 (LexisNexis 2012) (stating physician written or oral statements of apology shall not be evidence of liability).


in different health care arenas, with the goal of evaluating alternative ways to improve areas of criticism.¹⁹

Recently, New Hampshire became the first state to implement a statutory early offer and disclosure program.¹⁰⁰ Surviving New Hampshire Governor John Lynch’s veto in July 2012, the bill passed with an aim to fix a slow, costly malpractice litigation system.¹⁰¹ The bill provides hospitals with the option to extend settlement offers to injured patients, who can agree to waive certain legal rights, such as the right to seek compensation for non-economic damages.¹⁰² After an adverse event, a patient may choose to pursue a lawsuit or enter the early offer process, the latter which entails sending a written notice of injury and a waiver of some legal right to the provider.¹⁰³ The provider then has ninety days to respond with a financial offer and the patient has sixty days to either accept the offer by signing the waiver or request a hearing.¹⁰⁴ If a patient chooses to sign the waiver without seeking legal representation, the state will appoint a licensed attorney, who will serve as a “neutral advisor” to the patient.¹⁰⁵ There is a five day period to withdraw the waiver; however, this short time period and the other statutorily imposed restrictions on patients’ legal rights are the main reasons the bill has received mixed reviews.¹⁰⁶

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¹⁹ Kachalia & Mello, supra note 6, at 1569. Texas is implementing programs like the UMHS program at six university hospitals. Id. Illinois and New York are instituting similar programs at hospitals that are fully-insured, not self-insured like UMHS. Id. Washington is testing disclosure approaches with insurers in multiple defendant cases. Id. Missouri and Minnesota are experimenting with evidence-based best practices for perinatal care. Id. Massachusetts is evaluating physician disclosure after adverse medical events. Id.


¹⁰³ N.H. REV. STAT. ANN. § 519-C:2 (2012). Part (III) states: “If the claimant elects to pursue a remedy under this chapter, the claimant shall serve a notice of injury to the medical care provider alleged to be responsible for the injury and an executed notification and waiver of rights in the form set forth in RSA 519-C:13, by certified mail, return receipt requested.” Id. The waiver language can be found in the New Hampshire Revised Statutes § 519-C:13.

¹⁰⁴ N.H. REV. STAT. ANN. § 519-C:2 (VI-IX).

¹⁰⁵ Id. § 519-C:3 (I-II).

¹⁰⁶ J. Brandon Guida, What New Hampshire’s ‘Early Offer’ Law Really Does, UNIONLEADER.COM, (July 11, 2012, 11:03PM), http://www.unionleader.com/article/20120712/OPINION02/707129912 (supporting the program as a viable alternative to lengthy litigation). The bill also
Another type of non-traditional malpractice reform is a formal notice period. Sometimes referred to as "cooling-off periods," notice requirements mandate that plaintiffs send certain written information to defendant physicians a set number of days before filing a lawsuit.\footnote{Waters et al., supra note 56, at 503.} The UMHS project cites Michigan's statutory notice period as a favorable feature of its disclosure program, but not a prerequisite.\footnote{Boothman et al., supra note 78, at 137-38.} Because Michigan already requires a 182-day notice period, UMHS took advantage of this built-in six-month period to have their committee thoroughly review claims and hold the disclosure meetings, without the added pressure on both parties of an already-pending lawsuit.\footnote{Id. at 138.}

Even without disclosure programs, notice periods grant plaintiffs time to investigate the strength of their claims and re-evaluate whether to pursue them, while allowing defendants time to investigate the claims and approach the plaintiff with alternative remedies.\footnote{Id. at 1346.} Disclosing information upfront that will eventually be shared during discovery promotes efficiency, as well as the opportunity to shorten or eliminate litigation.\footnote{Id. at 1345.} The primary reason plaintiffs give for dropping malpractice claims is the acquisition of additional information that reduces the strength or monetary value of their claim.\footnote{Id. at 1345.} In a Massachusetts study, 46.4% of the sampled claims were dropped, a percentage consistent with national studies on the same topic.\footnote{Id. at 1345.} If the parties can use the notice period to review and exchange information pre-litigation, then it saves time, futile work, and the costs of actually litigating the claim.\footnote{Id. at 1345.} Notice periods can be used requires a patient to post bond if one chooses to reject the offer and pursue litigation. \textit{Id.} Additionally, if that patient loses in court, the patient pays the provider's attorney's fees. \textit{Id.; but see Allison Torres Butka, Mid-mal Early Offer Program becomes Law in New Hampshire, AMERICAN ASSOCIATION FOR JUSTICE TRIAL NEWS (July 19, 2012), available at http://www.justice.org/cps/rde/justice/hs.xsl/18838.htm (stating program may limit patient's recovery without fully understanding rights).}
to achieve this transparency without the plaintiff sacrificing any right to bring suit later.\textsuperscript{115}

Safe harbor laws are a third type of non-traditional malpractice reform that seek the dual purpose of improving patient safety and controlling medical liability. Safe harbor laws create a set of evidence-based clinical care guidelines, which protect physicians from liability if medical decisions fall within them.\textsuperscript{116} Setting these guidelines is challenging because of the fine line between standardizing care for the patient's benefit and limiting a physician's ability to practice medicine with independent, sound judgment.\textsuperscript{117} However, as defensive medicine already impedes most physicians' ability to practice medicine autonomously, safe harbor laws may provide clearer standards by which to practice medicine and evaluate medical malpractice.\textsuperscript{118} These guidelines would also be an opportunity to incorporate a cost-benefit evaluation into the standard of care, which currently does not exist in the negligence analysis.\textsuperscript{119} The HHS planning project in Oregon is currently evaluating a form of safe harbor guidelines in an effort to assess their impact on cost control and medical outcomes more fully.\textsuperscript{120}

IV. Massachusetts Health Care Cost Containment Bill of 2012

Massachusetts passed the second phase of state health care reform with the Cost Bill on August 6, 2012.\textsuperscript{121} The Cost Bill seeks to control state health care costs in several ways, and is estimated to cut the state's health care spending by up to $200

\textsuperscript{115} Golann, \textit{supra} note 111 at 1348.
\textsuperscript{116} BIEBELHAUSEN & LISCHKO, \textit{supra} note 9, at 13.
\textsuperscript{118} BIEBELHAUSEN & LISCHKO, \textit{supra} note 9, at 13.
\textsuperscript{119} Horton & Hollier, \textit{supra} note 29, at 232; Blumstein, \textit{supra} note 117, at 1035. Traditional tort paradigms do not take cost-benefit analysis into account, yet safe harbor guidelines would need to incorporate this evaluation. Id.
\textsuperscript{120} OREGON HEALTH POL’Y & RESEARCH, AHRQ MEDICAL LIABILITY & PATIENT SAFETY PLANNING GRANT: FINAL PROGRESS REPORT 4 (2012), available at http://www.oregon.gov/oha/OHPR/PSDM/AHRQ_MLPS_Report.pdf. The AHRQ grant funded a one-year planning project to explore two uses of safe harbor guidelines: (1) as a clinical defense only; and (2) as a clinical defense and standard of care. Id. at 9. The project concluded that Oregon could save approximately $4 million in medical malpractice costs by implementing safe harbor guidelines. Id. at 11. Savings were attributed to quicker claim resolution, injury prevention, and indemnity payment reduction. Id.
\textsuperscript{121} See Governor Press Release, \textit{supra} note 4 (summarizing the passage of Cost Bill and its importance).
billion over 15 years.\textsuperscript{122} Major changes include tying medical inflation to a percentage of
state gross domestic product, creating a Health Policy Commission to set standards for
Accountable Care Organizations and patient-centered medical homes, and requiring the
use of electronic health records in private practice and other health care provider
organizations.\textsuperscript{123} The Cost Bill implements multiple medical malpractice reforms, using
both traditional modifications and non-traditional theories to improve overall health
care cost control, system transparency, and quality improvement.\textsuperscript{124}

First, the Cost Bill mandates a 182-day cooling off period, requiring plaintiffs to
send written notice of intent to file a malpractice claim to the potential defendant
physician before filing a lawsuit.\textsuperscript{125} The notice must contain the factual basis for the
claim, applicable standard of care, alleged breach of that standard, alleged action that
should have been taken, explanation of causation, and the names of all providers that to
be included as defendants.\textsuperscript{126} This period may be shortened to 90 days if the claimant
previously filed the same claim against another physician and provided the requisite
notice.\textsuperscript{127} The plaintiff must then permit the named provider to access all available
medical records related to the claim within 56 days of sending notice.\textsuperscript{128} Within 150
days of receipt of the notice, the defendant must provide a written response, including a
factual basis for any available defense, comments on the standard of care, and whether
the defendant met the standard of care and was a proximate cause of the alleged
injury.\textsuperscript{129} If no response is received, then the plaintiff may move forward with filing the
claim after 150 days.\textsuperscript{130}

Second, the Cost Bill increases the damage awards cap for charitable
institutions, such as nonprofit hospitals.\textsuperscript{131} Specifically, with regard to medical

\begin{footnotes}
\footnote{122}{Ayanian & Van der Wees, \textit{supra} note 2, at 793; Governor Press Release, \textit{supra} note 4.}
\footnote{123}{An Act Improving the Quality of Health Care and Reducing Costs Through Increased
Transparency, Efficiency and Innovation, \textit{supra} note 4, at §15 (cost benchmarks), §15 (Health
Policy Commission formation), and §15 (electronic health records). For a summary of all key
provisions of the Cost Bill, see Ayanian & Van der Wees, \textit{supra} note 2, at 792.}
\footnote{124}{Ayanian & Van der Wees, \textit{supra} note 2, at 791.}
\footnote{125}{\textit{Id.} \textsection{} 60L(c).}
\footnote{126}{\textit{Id.} \textsection{} 60L(d). Additionally, the notice period does not apply if the statute of limitations is expiring six months, or if the statute of repose is expiring within one year. \textit{Id.} \textsection{} 60L(j).}
\footnote{127}{\textit{Id.} \textsection{} 60L(e).}
\footnote{128}{\textit{Id.} \textsection{} 60L(f).}
\footnote{129}{\textit{Id.} \textsection{} 60L(g).}
\footnote{130}{\textit{Id.} \textsection{} 60L(h).}
\footnote{131}{\textit{Id.} \textsection{} 85K.}
\end{footnotes}
malpractice claims, the cap on damages was increased from $20,000 to $100,000.132 While this is not a large monetary increase, it may encourage more patients to include hospitals as co-defendants in suits.133 By increasing this cap, patients hope to recover more money to help pay for future care, medical bills, and other losses caused by a hospital's negligence.134 The increased hospital liability also may incentivize facilities to re-focus on patient safety, appropriate staffing, and quality equipment.135

The third, and arguably most significant, change is the implementation of a disclosure and apology statute in Massachusetts.136 Modeled after the UMHS

132 Id. § 85K.
133 Bill Archambeault, MBA Secretary Catalano Testifies on Medical Malpractice, Charitable Cap Bills, MASS. LAWYERS J., 4 (Feb. 2010), available at http://www.massbar.org/media/711334/lj_feb10_web.pdf. The Massachusetts Bar Association Secretary, Jeffrey N. Catalano, testified before the Joint Committee in favor of increasing the charitable cap, calling the legislative change "long overdue." Id. Patients will now be able to collect higher judgments in cases where the hospital may be at fault. Id.
134 Testimony of Mary K. Hellenga, Public Testimony on H1849, May 16, 2011 [hereinafter Hellenga Testimony].
136 MASS. GEN. LAWS, ch. 233 § 79L(b) (as amended by S. 2400, 2012 Leg., 187th Sess. (Mass. 2012)). Section 79L(b) states:

In any claim, complaint or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, all statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error or a general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative proceeding, unless the maker of the statement, or a defense expert witness, when questioned under oath during the litigation about facts and opinions regarding any mistakes or errors that occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in which case the statements and opinions made about the mistake or error shall be admissible for all purposes. In situations where a patient suffers an unanticipated outcome with significant medical complication resulting from the provider's mistake, the health care provider, facility or an employee or agent of a health care provider or facility shall fully inform the
program,\textsuperscript{137} the Massachusetts bill encourages physicians to apologize to injured patients by making the apology inadmissible "as evidence in any judicial or administrative proceeding." \textsuperscript{138} The disclosure provision requires the provider to "fully inform" the patient or family about any adverse medical outcome or error. \textsuperscript{139} The provider organization or hospital can then work with its insurer to determine fair monetary compensation where appropriate; however, it is important to note that the program should not be considered no-fault insurance because physician fault is required in order to offer compensation. \textsuperscript{140} Full details on official programs have yet to be released, but this legislative step puts Massachusetts at the forefront of quality and cost-focused malpractice reform. \textsuperscript{141}

The statutory change also represents an important compromise and partnership between the medical, legal, and legislative communities. \textsuperscript{142} The MMS fully supports this patient and, when appropriate, the patient's family, about said unanticipated outcome.

\textit{Id.}


\textsuperscript{138} \textit{Mass. Gen. Laws}, ch. 223 § 79(b). This section also cautions that an apology may be admissible if the defendant, or their expert, makes a statement of fact or opinion contradictory to the apology under oath. \textit{Id.} § 79(b).

\textsuperscript{139} \textit{Id.} § 79(b). An "unanticipated outcome" is defined as a result of "a medical treatment or procedure, whether or not resulting from an intentional act, that differs from an intended result of such medical treatment or procedure." \textit{Id.} § 79(b).

\textsuperscript{140} Beaulieu, \textit{supra} note 137. The MMS states that unlike no-fault insurance, where a claimant is awarded damages regardless of the cause of the harm, the Massachusetts program's compensation "generally [should] only be offered when a root-cause analysis clearly demonstrates that the health provider or system is at fault for a preventable event, such as a wrong-site surgery or other unforeseen consequence." \textit{Id.}

\textsuperscript{141} Beaulieu, \textit{supra} note 137; Governor Press Release, \textit{supra} note 4. Because Massachusetts has been the national model for federal health care reform, the Cost Bill is anticipated to be "closely watched by other states and the federal government." Ayanian & Van der Wees, \textit{supra} note 2 at 793.

\textsuperscript{142} Massachusetts Medical Society, Press Release, \textit{Landmark Agreement Between Physicians and Attorneys Provides for Medical Liability Reforms in Massachusetts}, http://www.massmed.org/AM/Template.cfm?Section=Search8&Template=/CM/HTMLDisplay.cfm&ContentID=74661 (Aug. 7, 2012) (describing the partnership between physicians and attorney to implement reform as "historic and unprecedented") [hereinafter MMS-Landmark Agreement]. The Vice President of the Massachusetts Bar Association stated the "[Association] is pleased and honored to have worked with MMS, the governor, and the legislature to create a law that is in the best interests of patients . . . while also protecting a patient's right to seek legal
apology program because it changes the role of the physician from adversary to advocate when medical errors occur. In order to help change the culture of the medical liability system in the Commonwealth, the MMS has committed to building physician training, peer mentor groups, and other support programs at its hospitals and facilities. From a legal perspective, the Massachusetts Bar Association and the Massachusetts Trial Attorneys Association support the goals of the Cost Bill, but were initially concerned that the notice period and apology program might act as roadblocks for plaintiffs. Both organizations testified before the Massachusetts Health Care Finance Committee that the language declaring physician statements of "mistake and error" inadmissible was overbroad and would prevent patients from entering valuable evidence during a trial. Additionally, they expressed skepticism as to whether the notice period will improve settlement rates or decrease claims, as well as concern that it may pose unnecessary delay in filing meritorious suits.

Finally, Massachusetts has recognized, and chosen to address, the incredible cost impact of defensive medicine by creating a task force to study this issue within the already established Center for Patient Safety and Medical Error Reduction. After one

assistance.” Id. The program is the product of a joint effort by various players in the health care system, and grew out of the 2010 HHS demonstration grant given to BIDMC and MMS. Id. Both the high costs of malpractice and length litigation were likely factors that medical and legal professional sought to improve. See Beaulieu, supra note 137. The average Massachusetts malpractice lawsuit takes five and half years to litigate. Id. Beaulieu, supra note 137; Bill Testimony on Behalf of the Massachusetts Medical Society Before the Health Care Finance Committee Regard H.1849, 2, May 16, 2011 [hereinafter MMS Testimony] (“We believe the inclusion of language relative to ‘disclosure, apology, and offer’ will reduce defensive medicine, the costs associated with it and improve patient safety”). Beaulieu, supra note 137. Massachusetts Bar Association, Support with Limited Opposition for House Bill 1849, 1-3 [hereinafter MBA Testimony]; Massachusetts Academy of Trial Attorneys, Limited Opposition Sheet for House Bill 1849, 1 [hereinafter Trial Attorneys Testimony]; Lisa van der Pool, Jury is out on Malpractice Reforms, BOSTON BUSINESS, Aug. 17, 2012, available at http://www.bizjournals.com/boston/print-edition/2012/08/17/jury-is-out-on-malpractice-reforms.html?page=all (asserting legal community supports apology program goal of transparency while questioning reforms’ strength). MBA Testimony, supra note 145, at 1-2. Id. at 2-3. S. 2400, 2012 Leg., 187th Sess. (Mass. 2012). Section 272 of S. 2400, An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation, states:

Notwithstanding any general or special law to the contrary, the department of public health . . . shall create an independent task force consisting of no more than 11 members from a broad distribution of diverse perspectives to study
year of research on both the financial and non-financial impact of defensive medicine on health care costs, the task force will submit a formal report to the state Senate and House of Representatives. This section of the Cost Bill is separate from the sections on medical malpractice reform, but noteworthy because it represents partnership between the legislature and the medical community to tackle the challenges of health care cost control to reduce waste in the system and reduce medical errors. The MMS seeks to decrease defensive medicine overall because it believes reducing the fear of malpractice liability, particularly for high-risk procedures, will improve access to certain specialist and medical services throughout the Commonwealth.

V. The Cost Bill’s Viability to Reduce Malpractice Costs

The Cost Bill seeks to change many aspects of Massachusetts’ current health care delivery system in an effort to cut $200 billion in health care spending. Innovative in both substance and origin, the reform that will likely have the greatest impact on reducing health care costs is the disclosure and apology law. However, for this program to improve the current legal system’s efficiency, rather than stifle patients’ legal rights, both the health care providers and attorneys must adapt to the changing culture of transparency. Critics have been writing about the need for malpractice and reduce the practice of defensive medicine and medical overutilization in the commonwealth, including but not limited to the overuse of imaging and screening technologies. The task force shall issue a report on the financial and non-financial impacts of defensive medicine and the impact of overutilization on patient safety. The task force shall file a report of its study, including its recommendations and drafts of any legislation, if necessary, by filing the same with the clerks of the senate and house of representatives who shall forward a copy of the report to the joint committee on public health and the joint committee on health care financing within 1 year of the effective date of this act.

149 Id.
150 See Richard Gulla, MMS Urges Special Study of Defensive Medicine, MASSACHUSETTS MEDICAL SOCIETY (June 23, 2009), http://www.massmed.org/AM/Template.cfm?Section=Search8&template=/CM/HTMLDisplay.cfm&ContentID=30633 [hereinafter MMS-Defensive Medicine].
151 Id. (estimating cost savings of bill at $200 billion).
152 Ayanian & Van der Wees, supra note 2, at 793.
153 See MASS. GEN. LAWS, ch. 233 § 79L(b) (as amended by S. 2400, 2012 Leg., 187th Sess. (Mass. 2012)), supra note 136; see also Gulla, supra note 143 (noting importance of program).
154 Horton & Hollier, supra note 29, at 233-34. “Providers must concentrate on cost-effective care, and the law must recognize a standard of care that respects cost, or enact tort reform that
reform for decades, but only recently has there been an actual shift towards studying the impact of non-traditional tort reform.\textsuperscript{155} While the experience at UMHS, and in other states with apology laws, has been generally successful in reducing costs and decreasing claim settlement times, there are definitely valid concerns raised by the medical and legal communities that need to be addressed as Massachusetts implements these reforms.\textsuperscript{156}

The most important concern is that patients will waive their legal rights unknowingly.\textsuperscript{157} Patients and families who are already emotionally fragile from a negative medical outcome may feel put in a position of lesser power than the hospital, which has more medical knowledge and resources.\textsuperscript{158} Unlike the New Hampshire early offer program, however, the Cost Bill does not require patients to waive any legal rights in order to pursue alternative remedies.\textsuperscript{159} Regardless, Massachusetts hospitals need be cognizant of the possible unintended consequence of patients not seeking counsel and should require that programs expressly inform patients of the right to seek advice from an attorney.\textsuperscript{160} Written correspondence should further encourage patients to bring attorneys to mediation meetings.\textsuperscript{161} The UMHS program does not have this requirement, yet this type of notice to patients should be a best practice to facilitate awareness of legal rights at every stage of the process.\textsuperscript{162} This type of requirement has not been instituted by Cost Bill, but could potentially be an administrative regulation promulgated in the future.\textsuperscript{163}

Other concerns from the legal community are notable, but less worrisome. It is unlikely the notice period will increase the length of litigation because the discovery period for malpractice litigation in Massachusetts is already two and half years.\textsuperscript{164} With

\textsuperscript{155} See Nelson et al., supra note 48 (discussing tort reform periods in history).
\textsuperscript{156} Mastroianni et al., supra note 97, at 1615-16 (discussing general legal community concerns with apology programs).
\textsuperscript{157} Teninbaum, supra note 76, at 333-35; MBA Testimony, supra note 145, at 2-3.
\textsuperscript{158} Supra note 157 and accompanying text.
\textsuperscript{159} Compare MASS. GEN. LAWS ch. 223 § 79L(b) with N.H. REV. STAT. ANN. § 519-C:2. Alan Woodward, M.D., past president of the MMS and chair of its Committee on Professional Liability, stated that patients will be informed to obtain independent counsel before making any decision on an offer, and called the notion that patients will lose legal rights “unfounded.” Beaulieu, supra note 137.
\textsuperscript{160} See Teninbaum, supra note 76, at 332-333.
\textsuperscript{161} Id.
\textsuperscript{162} Id. at 335.
\textsuperscript{163} See Mastroianni et al., supra note 97, at 1616 (noting development of apology programs should be left to state agencies rather than legislation).
\textsuperscript{164} Beaulieu, supra note 137 and accompanying text (noting length of Massachusetts malpractice
the average trial length often double that amount of time, Massachusetts plaintiffs do not seem deterred by length of litigation.\textsuperscript{165} More generally, length of litigation has not been cited as a main reason for dropped claims.\textsuperscript{166} The required six-month notice period hopefully will permit Massachusetts attorneys and potential defendant physicians and hospitals to share information prior to the discovery period, which should lead to a weeding out of weaker claims or claims without merit.\textsuperscript{167} Moreover, attorney concerns that the notice period will stifle the legal rights of patients seem unfounded because the sharing of information during the notice period does not prohibit any ability to sue, either at that point in time or in the future, if new information arises.\textsuperscript{168}

Although disclosure and apology should be ethically required of physicians, Massachusetts has chosen to go a step further and statutorily require disclosure.\textsuperscript{169} The last sentence of Massachusetts General Laws Section 79L(b) requires physicians to “fully inform” the patient and their family about the “unanticipated outcome.”\textsuperscript{170} This is a very broad requirement, applying to all providers of care, namely physicians, facilities, and agents or employees.\textsuperscript{171} Surprisingly, there has not been any pushback from the medical community on either the disclosure mandate or the broad language of the statute.\textsuperscript{172} Compelling disclosure is the best way to meet the two goals of the reform bill: implementing transparency uniformly across the system, and putting downward pressure on costs.\textsuperscript{173} If the Commonwealth had chosen to encourage disclosure, rather than require it, then physicians would be able to opt out and the reform would lack the clout to effectively impact costs.\textsuperscript{174}

\begin{itemize}
\item \textsuperscript{165} Id.
\item \textsuperscript{166} See Golann, supra note 111, at 1345 (discussing main reasons for dropped claims).
\item \textsuperscript{167} Boothman et al., supra note 78, at 137-38 (suggesting notice period gives plaintiffs time to reassess lawsuit).
\item \textsuperscript{168} Golann, supra note 111, at 1348. The state’s trial attorneys are also concerned about the notice period pushing cases past their statute of repose. Trial Attorneys Testimony, supra note 145, at 6. The statute of repose in Massachusetts is seven years for adults. Mass. Gen. Laws ch. 260, § 4 (2012).
\item \textsuperscript{169} Mass. Gen. Laws ch. 233, § 79L(b). Massachusetts became the tenth state to require disclosure. Mastroianni et al., supra note 97, at 1614-15.
\item \textsuperscript{170} Mass. Gen. Laws ch. 233, § 79L(b).
\item \textsuperscript{171} Id. The National Quality Forum recommends a broad scope for medical apology laws to encourage comprehensive disclosures. Mastroianni et al., supra note 97, at 1616.
\item \textsuperscript{172} Beaulieu, supra note 137 (summarizing medical community’s response to provision).
\item \textsuperscript{173} Ayanian & Van der Wees, supra note 2.
\item \textsuperscript{174} Mastroianni et al., supra note 97, at 1614 (comparing effectiveness of mandating disclosure with discretionary disclosure).
\end{itemize}
The broad scope of Section 79L(b) fails to define the type of information that must be disclosed to the patient.\textsuperscript{175} Because the reform must be implemented uniformly across the system to be effective, physicians should be given a set list of information required during disclosure.\textsuperscript{176} It likely will be necessary for the Commonwealth to issue guidelines outlining this information; ideally, this information would include the cause of the error, the expected medical results or implications, and any potential remedies.\textsuperscript{177} This guidance would improve the quality of the apology program by creating equal transparency across all medical error situations and possibly would lead to wider acceptance by physicians.\textsuperscript{178}

The investment by the MMS to train physicians and hospitals should help reduce malpractice costs in the long-run in two ways. First, reducing the number of claims, either through earlier settlement or fewer lawsuits, will lower the direct cost malpractice places on the health care system.\textsuperscript{179} Beyond reducing direct costs to the system, plaintiff costs will be lower if they can find resolution outside of court.\textsuperscript{180} More significantly, these reforms can reduce the practice of defensive medicine by relieving physicians of the constant fear of lawsuits that is present in the current, rigid, opaque system.\textsuperscript{181} A system that encourages productive physician-patient conversation will ease the pressure on both parties when these situations arise.\textsuperscript{182} If direct costs and the number of suits can be reduced because of disclosure and apology, then physicians will not feel obligated to practice defensively, as they now do in Massachusetts.\textsuperscript{183}

\textsuperscript{175} See Mastroianni et al., \textit{supra} note 97, at 1614-15. The study notes that many state apology laws have “structural weaknesses that may discourage comprehensive disclosures and apologies and weaken the law’s impact.” \textit{Id.} at 1614.

\textsuperscript{176} \textit{Id.} at 1614-15. “Based on current research about patients’ needs, disclosures should include what is known about the event’s cause, plans for prevention, and available patient support services.” \textit{Id.} at 1616. The National Quality Forum has issued best practice recommendations in the following areas: protected content, covered parties, triggering events, timing of communication, form of communication, recipient of communication, voluntariness, and required content. \textit{Id.} at 1616-17.

\textsuperscript{177} Mastroianni et al., \textit{supra} note 97, at 1616-18.

\textsuperscript{178} \textit{Id.} at 1618. Transparency in the health care system should promote quality improvements and patient safety, while also controlling costs. Clinton & Obama, \textit{supra} note 57, at 2207.

\textsuperscript{179} See Mello et al., \textit{supra} note 9, at 1575 (concluding malpractice reforms can reduce health care costs).

\textsuperscript{180} Golann, \textit{supra} note 111, at 1345-46 (discussing cost of malpractice litigation).

\textsuperscript{181} BIEBELHAUSEN & LISCHKO, \textit{supra} note 9, at 5-6 (describing cost of practicing defensive medicine).

\textsuperscript{182} See Boothman et al., \textit{supra} note 78, at 141-42 (recommending open and honest disclosure helps both parties reach goals).

\textsuperscript{183} MMS WORKFORCE SURVEY, \textit{supra} note 36, at 28-29 (noting fear of malpractice liability impacts physician practice).
Malpractice reforms will have the largest impact on health care costs if they can inspire physicians to stop ordering unnecessary tests and services purely to avoid malpractice suits.\textsuperscript{184} The burden to embrace a culture of transparency also falls on the legal community. Attorneys must support the reforms and encourage meaningful dialogue when medical errors occur, rather than criticize the additional prerequisites to litigation.\textsuperscript{185} It is necessary to exclude disclosures and apologies from evidence in order to promote the implementation across the system.\textsuperscript{186} If these statements were admissible, then the reform would never work.\textsuperscript{187} By covering all statements of apology, sympathy, error, or mistake,\textsuperscript{188} the broad Section 79L(b) language may pose evidentiary challenges at first. But the legal standard for negligence requires that the plaintiff show the physician breached a duty of reasonable care, not prove that the error or harm factually occurred.\textsuperscript{189} The apology and disclosure reform may shorten the settlement process, but it in no way waives the right to sue later.\textsuperscript{190} The choice to litigate should belong to the patient – not the attorney – and under the current system, the patient has no other choice but to speak to an attorney in order to learn about potential remedies.\textsuperscript{191}

If the Cost Bill can reduce the frequency of malpractice claims through transparent, open discussion, as well as shrink the costs of the litigation through earlier settlement, then there is a very strong possibility the Commonwealth’s overall health care costs will be reduced.\textsuperscript{192} A heightened awareness of open dialogue will hopefully lead to improved transparency throughout the medical liability system and a shorter, more effective resolution process outside of the courtroom.\textsuperscript{193} Yet, as these direct costs are estimated to be only 0.5\% of health care costs nationally, the Commonwealth’s bottom line can only be nominally impacted.\textsuperscript{194} These reforms will have a more significant, derivative effect of reducing physician fears of malpractice lawsuits, which

\textsuperscript{184} See Mello et al., \textit{supra} note 9, at 1575; see also MMS Testimony, \textit{supra} note 143, at 2.
\textsuperscript{185} See MBA Testimony, \textit{supra} note 145, at 1 (supporting the bill’s goal of transparency yet criticizing its drafting).
\textsuperscript{186} Mastroianni et al., \textit{supra} note 97, at 1616-18.
\textsuperscript{187} \textit{Id}.\textsuperscript{188} MASS. GEN. LAWS, ch. 231 § 79(b), \textit{supra} note 136.
\textsuperscript{190} See \textit{supra} note 159 and accompanying text.
\textsuperscript{191} See \textit{supra} note 87 and accompanying text.
\textsuperscript{192} Beaulieu, \textit{supra} note 137; MMS Testimony, \textit{supra} note 143, at 2.
\textsuperscript{193} Boothman et al., \textit{supra} note 78, at 141-42; BIEBELHAUSEN & LISCHKO, \textit{supra} note 9, at 2.
\textsuperscript{194} Elmendorf Letter, \textit{supra} note 9.
should decrease defensive medicine practices.195 Cutting this waste from the system will not only reduce costs – it simultaneously will improve patient safety and quality, the ultimate goals of both Massachusetts and federal health care reform.196 PPACA chose to omit malpractice reform in favor of funding state-based models; therefore, the Massachusetts model is on the forefront of pursuing how alternative tort reforms are an important factor in achieving PPACA’s dual goals of expanded access to quality health care and reducing costs.197

VI. Conclusion

The Massachusetts Health Care Cost Containment Bill represents the cornerstone of PPACA: health care quality and costs can no longer be separately addressed by the legislature because they are intertwined goals which must be dually pursued. Because Massachusetts has already successfully implemented health insurance reform over the last six years, the impact of non-traditional malpractice reforms will be an insightful experiment on whether it is worthwhile for other states to replicate a similar bill that integrates malpractice reform into health care reform legislation. Of the malpractice reforms in the Cost Bill, disclosure and apology programs are poised to have the largest impact on reducing health care costs in Massachusetts by reducing the direct costs of litigation and indirect costs of defensive medicine. Along with PPACA’s encouragement of state experiments with malpractice liability, the Cost Bill will galvanize other states to explore and implement non-traditional malpractice reforms as an integral part of controlling health care costs.

195 MMS WORKFORCE SURVEY, supra note 36 (recommending malpractice reform to reduce fear of liability).
196 Ayanian & Van der Wees, supra note 2, at 792.
197 Id.; Doherty, supra note 3, at 679 (stating goals of PPACA); Press Release, supra note 4 (describing Massachusetts as national model for cost control).