



## Public plan for malpractice

*A vastly expanded Federal Tort Claims Act would protect both doctors and patients*

By Heather R. Mizeur

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Almost any doctor will readily offer up horror stories of trying to find and pay for medical malpractice insurance. Such policies are cost-prohibitive and increasingly scarce, and require many to practice “defensive medicine” – ordering extra precautionary tests and procedures that contribute mightily to the rise in health costs.

A growing number of policymakers are calling for a cap on medical malpractice awards as a partial solution to the national health care debate. Rooting out frivolous lawsuits is a laudable goal, but limiting damage awards for patients who have been wronged is akin to fixing a broken leg with a band-aid. High-dollar, juror-granted purses are not the only drivers of professional liability costs for doctors; much can be blamed on the greedy practices of medical malpractice insurance companies. The time has come to cut the middleman out of the equation.

Some health care providers have already done this, but at great personal and professional peril. Doctors who self-insure against potential malpractice claims are “naked” in their practices because of their exposure to high risk. We must replace the risk with rewards to incentivize more providers to forgo private medical malpractice insurance and to instead rely on a government-securitized option.

The basic model already exists – we just need to build upon it. Primary-care providers who practice at federally qualified health centers do not need to purchase medical malpractice insurance. Why? The government promises to cover any claims against them under the Federal Tort Claims Act. If a patient has a successful malpractice case against the health center provider, the government becomes the insurer and agrees to pay the claim.

The national health reform debate should include a proposal to expand Federal Tort Claims Act coverage to all primary care providers, regardless of where they practice, and to certain specialists (such as obstetricians) where access to care is threatened. Doing so would have multiple benefits: Doctors, nurse practitioners and other primary care providers would be freed from the burdens of finding and paying for costly malpractice insurance; future medical students would have an incentive to choose primary care, addressing a critical shortage; and we would finally begin to bend the “cost curve” in health care.

This program is popular with participating health care providers, and it is not hard to understand why. The federal Health Resources and Services Administration estimates that health center providers saved more than \$203 million on the cost of purchasing private insurance in 2008 alone. The program has also proven to weed out frivolous claims. More than half of all health center claims were settled administratively without going to court. From 1993 to 2009, only \$298 million in resolved claims were paid under health centers’ coverage – a pittance compared to 16 years of claims history in the private sector for any other provider type.

Adding new providers into an expanded program could allow for the plan to pay for itself by charging these providers a nominal participation fee to offset the costs of any payable claims. This fee would still be less than the cost of private sector malpractice coverage yet high enough to fully fund the program's obligation. In the best-case scenario, this proposal could even be a profit center to pay for other health care costs as the fund's reserves grow.

By setting the rules for who can and cannot come into the government-backed program, lawmakers have numerous options for dialing up or down the policy to drive physician behavior. We can assure more widespread use of electronic medical records; reward providers that practice in designated shortage areas; or assure that more private providers accept public health insurance options such as Medicare, Medicaid, and the Children's Health Insurance Program. We can do this and more by requiring such rules as a condition of participation in the new federal medical malpractice protection program.

The proposal could be further enhanced to incorporate specialty-care providers either in the same new program but with slightly different participation rules or by creating a separate option to buy into a plan in which the government functions as a reinsurer for their highest-cost cases.

For too long, this issue has been mired at the political margins on each end of the debate. Our nation is ready for fresh thinking and common sense solutions to the problems that have plagued us for too long.

And if a creative federal malpractice solution is not adopted in the near term, we should stand ready to get it done in Maryland.

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