Liability for Quality: A Modest Proposal

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Debate over managed-care liability for bad patient outcomes has reached a frenzied pitch. The politicization of the issue is obvious. As a consequence, much heat, little light, and strategically placed diaphanous veils have characterized the policymaking as well as the advocacy devoted to the cause. Throughout, the most essential concern is missing: How should health-care entities be held accountable for the quality of their care?

There is no question that the American public is unhappy with a managed-care system that appears to operate in secret, and proprietary protocols that thwart physician and patient desires, turning Marcus Welby into Dr. No—"no, you can't have that procedure"—when the physicians adhere to the aligned incentives and utilization mandates of the new world order. Although there is also no question about the bipolar nature of the public demands—patients want the best and the most care at the lowest cost—heartrending anecdotes have led to legislative reform that in many ways begs the real question. Much of the legislative and regulatory approach to reform has centered on disclosure by plans of their incentives, rules, and performance, with highly focused limitations on the types of utilization controls that make for the worst anecdotes, including 1-day mastectomies and short postpartum stays.

Stymied by the impact of ERISA to shield plans from certain challenges, plaintiffs' lawyers, whose backgrounds are in securities fraud and tobacco litigation, have launched new lawsuits against plans in their quest for deep pockets. Whether any of this will do anything to improve patient care is questionable. Now that the two houses of Congress have adopted separate federal liability proposals, the reconciliation of which Rep. Bill Thomas (R-Calif) has described as the mating of a Chihuahua with a Great Dane, perhaps a different lens on the issue may stimulate a different dialogue.

I am not a malpractice attorney. I do not even litigate. For the past 25 years, in both my private law practice and my public interest activities, my energies have been devoted to techniques that use legal mechanisms—contracts, regulation, legislation, and joint ventures, for example—to improve care. How to motivate health-care systems to assure quality has proven an elusive public policy challenge for the entire time that I have worked on these matters. From the old PSRO program, to the advent of AHCPR, to the Office of the Inspector General's new attention to managed-care quality as fraud and abuse, public policy has struggled mightily to incentivize the health-care system to provide a better foundation for better care. Throughout this time, defensive medicine, overprescription, and mistakes have endured.

Despite these problems and the undeniably painful managed-care horror stories that garner high-profile media attention, the managed-care revolution in this country has performed one utterly unassailably positive consequence: we are now talking about quality of care more and in a different way than we ever have. Even the widespread consolidation of providers and plans around the country provides a locus around which still better evaluation of quality can occur. Taken together, these developments offer a tantalizing new opportunity to position the quality question. Against this background my proposal ensues.

For the managed-care industry which claimed to offer a better mousetrap, it is time to step up to the plate and accept accountability for the fundamental premise of *managed* care—to change clinical behavior and foster more appropriate delivery. At the same time, the new provider configurations in "integrated" systems and other acronymic constellations (POs, PHOs, EPOs) seeking to take on actuarial risk have stepped into the shoes of the managed-care organizations in many ways. Worse yet for them, when patients are harmed by their changes in delivery, the principles of legal liability can cast them as the traditional providers they are when they are functioning in some ways more as insurers.

When the system changes clinical behavior, out of necessity some patients will be denied some services they might have gotten before, and some benefits will be considered noncovered. This was the point, after all. It is inevitable that among the vast numbers of patients who receive services in this context, some will suffer some harm as a result of or arising out of these new approaches. What to do?

If we really care about quality and choice, then plans, provider systems, and large physician groups should be eager to be held accountable by being evaluated as to whether their infrastructure in fact supports quality and drives toward quality improvement—accreditation, if you will. Still further, these health-care organizations should be required to report significant data that can be shared

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publicly regarding their quality performance to permit exercise of informed choice of plan, system, or clinician. At the same time, when problems do arise, these organizations should be required to analyze the factors leading to the patient's harm and should be required to report this understanding to a protected clearinghouse from which all other similarly motivated providers and clinicians can learn. Health-care delivery will never be perfect and "mistakes are treasures" in a quality improvement culture; but if these vital data are to be meaningful, then they must be protected from being used to punish those who are willing to be accountable. However, protection of these data should be available only to quality accredited entities who also provide publicly reported data on quality performance.

If a health plan, integrated system, or large physician group is generally working to improve quality and is willing to be held accountable in this rigorous way, then when patients are harmed, these entities ought be able to opt out into an alternative liability system that would compensate patients for their injuries, but not in the context of the punitive and emotional damages that characterize traditional tort remedies. Patients choosing a plan, system, or clinician ought be put on prior notice that the high performance of the entity generally will create this different approach.

There are obviously many operational and conceptual challenges lurking in this proposal. What are the critical standards of evaluation that would form the accreditation platform? Should standards differ for different types of organizations (eg, plan, system, clinician, group)? How will common data reporting be assured? Who should have access to the learning clearinghouse and how? In addition, others are more qualified to propose which liability compensation systems offer the most workable models, eg, no fault, workers' compensation. But the potential results of this proposal are alluring: improved health-care quality that can lower costs overall; truly aligned incentives among payors, providers, and clinicians to aggressively improve care over time; lowered liability insurance costs; and, at long last, a real self-interested motivation for certain elements of the system to do the right thing.

This proposal is not just a managed-care solution, because health-care quality is not just a managed-care issue. Cost pressures will continue to be a significant force in the health-care system. Unfettered health-care reimbursement is now but an ancient dream. Managing care will characterize health-care delivery for the foreseeable future, whatever specific forms it takes. It should be recognized, however, that managing care provides the foundation upon which evaluation, accreditation, public reporting of quality performance, a protected learning clearinghouse, and therefore an alternative liability system can proceed.

This proposal is not predicated on universal application. Part of the point is to differentiate and reward the plans, providers, and groups who are really working to make things better from those who will not undertake the undeniably difficult task of real accountability for quality. For the remaining laggards, let the traditional tort system take their best shots when things go wrong, but under my proposal there is finally a real business case for quality improvement. If the battle lines on liability are truly about the costs of litigation vs patient protection, then let's craft a solution for both sides of that argument while making things better for us all, and not just those who find their way to a personal injury lawyer.

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Tough Pill to Swallow

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President Clinton has proposed expanding Medicare to provide prescription-drug coverage for senior citizens. The president's plan, however, would substantially harm seniors. There are better ways to proceed.

Under the president's plan, starting in the year 2002 seniors would pay an additional premium of $24 per month for the proposed drug coverage, which would pay 50% of the first $2,000 per year in expenses. When the plan is fully phased in by 2008, seniors would pay $44 per month for the drug coverage, and the plan would pay 50% of the first $5,000 in drug costs. There would be no coverage for costs over $5,000 per year, though some of the latest, most advanced drug therapies would exceed this limit.

Incredibly, most seniors would actually pay more for prescription drugs under the Clinton plan than they do now. According to the National Academy for Social Insurance, 72% of all seniors spend less than $500 per year on drugs. More than half spend less than $200 per year. Only 14% spend more than $1,000 per year, and only 4% spend more than $2,000 per year.

If you do the math you will find