
NOTES

FIXING MEDICAL MALPRACTICE THROUGH HEALTH INSURER ENTERPRISE LIABILITY

The United States medical malpractice regime is broken. Medical malpractice liability exists to serve two ends: it encourages efficient behavior by providers and compensates those harmed by the providers' negligent acts or omissions.¹ Unfortunately, empirical evidence shows that the system is exceedingly imperfect on both counts. The current malpractice regime distorts physician incentives in a manner that is harmful for both the patient and the provider. Moreover, compensation often has neither the correct magnitude nor the correct target: judgment and settlement sums vary widely for similar injuries, undeserving patients get compensated, and negligently injured patients slip through the cracks.²

Even more disturbing are the recent flare-ups with the malpractice insurance market that have risen to such a level that the word "crisis" is frequently invoked.³ Though it is clear that rising premiums and a drop in the number of insurance companies are impacting the medical profession, the cause of the recent crisis is unclear. Professor Kenneth Thorpe suggests that the recent downturn may be the result of a nadir in the cycle that is inherent in all insurance markets, decreased investment yields, increased damage awards, increased reinsurance costs, decreased insurance capacity, and increased frequency of malpractice

¹ Daniel P. Kessler, *Evaluating the U.S. Malpractice System and Paths to Its Reform* 2 (Dec. 2006) (unpublished manuscript, on file with the Harvard Law School Library).

² Paul C. Weiler, *Reforming Medical Malpractice in a Radically Moderate — and Ethical — Fashion*, 54 DEPAUL L. REV. 205, 215 (2005) ("[T]here is just one paid malpractice claim for every twenty-one negligent medical injuries, and just one for every eight serious or fatal injuries."). Professor Richard Epstein provides a different take on Professor Paul Weiler's numbers, pointing out that there is no reason to believe that all, or even most, of the relatively few paid claims come from the pool of negligently injured patients, making the system not only undercompensatory but also inaccurate. Richard A. Epstein, *Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice*, 54 DEPAUL L. REV. 503, 512 (2005).

³ See, e.g., Richard E. Anderson, *Effective Legal Reform and the Malpractice Insurance Crisis*, 5 YALE J. HEALTH POL'Y L. & ETHICS 343 (2005); Michelle M. Mello, David M. Studdert & Troyen A. Brennan, *The New Medical Malpractice Crisis*, 348 NEW ENG. J. MED. 2281, 2281 (2003) (describing eighteen states as "in crisis"); Lindsay J. Stamm, Comment, *The Current Medical Malpractice Crisis: The Need for Reform To Ensure a Tomorrow for Oregon's Obstetricians*, 84 OR. L. REV. 283 (2005); Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFF. WEB EXCLUSIVE, Jan. 21, 2004, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20>. A Westlaw search for "TI(malpractice & crisis)" yielded fifty-two results in the "Journals & Law Reviews" database as of November 9, 2007.

claims.⁴ Likely, all of these problems have come together at once to mire the United States in its current healthcare crisis.

Though some states have tried to fix the problems of the insurance market with modest solutions, many academics feel that there is something endemically wrong with the market. They have consistently discussed solutions such as a no-fault insurance regime that would be similar to worker's compensation⁵ or a contractual regime where patients, insurers, and doctors would be left to bargain over their rights and obligations.⁶ Other commentators have suggested that holding hospitals responsible for the malpractice of their physicians (a form of enterprise liability) is the ideal solution.⁷ Another proposed solution, which has garnered significant political attention, is to limit noneconomic damages in negligence cases; unlike the other three reforms, this one has actually been implemented in various jurisdictions — most famously California — to mixed reviews.

This Note suggests a reform that is at once more fundamental and more revolutionary than those mentioned above. Patients' health insurers should be liable for the medical malpractice of the physicians whom they reimburse. This reform would eliminate the tension between physicians' interest in avoiding malpractice risks and insurers' interest in limiting costs. It would place the financial burden on a party that is in a position to control the physicians whom it insures. It would mitigate defensive medicine incentives. It would also eliminate much of the cross-subsidization inherent in the current compensation system. Finally, it would allow experience rating, which has heretofore failed in traditional malpractice insurance markets.

Part I describes the flaws of the current medical malpractice system. Part II assesses the strengths and weaknesses of various reforms proposed in the literature. Part III details this Note's proposal for health insurer enterprise liability. Part IV examines the relative advantages and disadvantages of this program. Part V concludes.

⁴ Thorpe, *supra* note 3, at W4-22 to W4-24.

⁵ See, e.g., Weiler, *supra* note 2.

⁶ See, e.g., Epstein, *supra* note 2.

⁷ Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381 (1994).

I. MEDICAL MALPRACTICE IN THE UNITED STATES AND ITS FLAWS

A. *Defensive Medicine*

“Defensive medicine is a deviation from sound medical practice that is induced primarily by a threat of liability.”⁸ It manifests itself when doctors provide unnecessary care or refuse treatment to “high risk” patients.⁹ The former causes waste when the value of the ordered procedure to the patient is lower than the cost paid by the insurer. The latter allows an available surplus to go uncaptured.

Defensive medicine is extremely common in the United States, with 93% of physicians in high-risk specialties reporting that they practice it.¹⁰ Many physicians reported providing care that they thought was unnecessary, including tests (59%), invasive tests (32%), medication (33%), and specialist referrals (52%); in addition, doctors reported avoiding high-risk but indicated procedures (29%) and high-risk patients (39%).¹¹ The American Medical Association estimates that the cost of defensive medicine is between \$70 and \$126 billion per year.¹²

Nonetheless, defensive medicine is a perfectly rational behavior for physicians in the current malpractice environment. Excessive medical care often decreases physicians’ liability because it (inefficiently) decreases the probability of injury, the probability that a jury will find negligence, or the damages. Excessive care also spreads damages among more physicians. Finally, avoiding high-risk procedures and patients avoids those risks entirely, at the expense of the patients comprising that group. As long as physicians are allowed to mitigate their own risk at the expense of others, it is reasonable to assume that they will do so.

B. *Lack of Experience Rating*

Another significant problem with the current malpractice regime is that it is nearly impossible to provide experience-rated malpractice insurance. Experience-rated insurance regimes “base future premiums on past claims or loss experience of insureds.”¹³ Historically, experience rating of physicians has not been successful in the United States.

⁸ David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2609 (2005).

⁹ *Id.*

¹⁰ *Id.* at 2612.

¹¹ *Id.*

¹² AM. MED. ASS’N, MEDICAL LIABILITY REFORM — NOW! 8 (2006), available at <http://ama-assn.org/ama1/pub/upload/mm/-1/mlrnow.pdf>.

¹³ Frank A. Sloan, *Experience Rating: Does It Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. 128, 128 (1990).

One 1990 study by Professor Frank Sloan showed that of fourteen malpractice insurers, thirteen had attempted to introduce some sort of experience rating.¹⁴ However, the experience rating regimes were not viable for a number of reasons. First, insurers did not share their experiential information, so when a previously negligent physician was surcharged, he could immediately find a lower premium by migrating to another company.¹⁵ In addition, physicians and medical associations vigorously opposed experience rating.¹⁶ As a result, when the regimes were implemented, they were implemented only on a limited scale; less than one percent of physicians were surcharged, various exceptions excluded claims from the database,¹⁷ no physician was charged more than double the average premium, premiums were decided by physician boards rather than by actuaries, and physicians could appeal surcharges.¹⁸

Nevertheless, Professor Sloan believes that experience rating should be a goal of the market.¹⁹ Insurers have the appropriate statistical tools to experience rate, and “[e]mpirical evidence clearly indicates that past experience predicts future experience.”²⁰ In addition, the frequency of claims has risen significantly, allowing more powerful models.²¹

The potential benefits of experience rating are large. In regimes such as worker’s compensation, unemployment insurance, and automobile insurance, it has improved the deterrent incentive, reducing claim frequency and severity.²² In fact, it has been so successful that it is now universal in those markets in the United States.²³ Intuitively, the benefits should be of similar magnitude in the medical malpractice insurance market. Even if experience rating cannot eliminate risk by changing behavior, it can still force frequently negligent physicians out of the business.²⁴

¹⁴ *Id.* It is worth noting that all thirteen did so of their own volition and not because it was mandated by law. *Id.*

¹⁵ *Id.* at 129.

¹⁶ *Id.*

¹⁷ Low-dollar-value and old claims were excluded because their relevance to current risk was unclear. *Id.* at 128.

¹⁸ *Id.* at 128–29.

¹⁹ *Id.* at 132.

²⁰ *Id.*

²¹ *Id.* The comparatively astronomical increase in claims frequency since Professor Sloan wrote in 1990 can only fortify this point.

²² *Id.* at 129–30.

²³ *Id.*

²⁴ One could question whether physicians subject to frequent judgments ought to be forced out of business or into another practice demographic, and the answer would depend on the specificity of the court system. If malpractice judgments correctly target negligence on the part of the physician, then the answer is yes. If, however, judgments are highly correlated with other factors, such as the underlying risk of the patient, then the answer is more complicated; in that case, ex-

C. Incentives To Avoid High-Risk Patients

One of the worst problems with the current medical system is that doctors have extremely strong financial incentives to avoid sick patients. Perhaps the strongest reason for this problem is the general correlation between health and wealth. In general, the wealthy are able to afford comprehensive health insurance with high reimbursements. The poor are either uninsured or stuck with a low-reimbursement insurance, such as Medicaid. The rich are healthy because they (and their insurance carriers) spend money on health care, while the opposite is true for the poor. Therefore, doctors make the most money from seeing the healthier (wealthier) patients, and the best doctors, who presumably have their choice of which patients to see, will tend to choose rich patients even if their expertise would be better spent on the poor.

D. Small Insurance Pools

The insurance pools in the current market are relatively small compared with what they could be in an enterprise liability system.²⁵ This leads to two problems: first, the risk is inadequately spread, leading to large premium increases when the market hits hard times; second, insurers with small pools have a significantly lower incentive to research innovations with high fixed initial costs.²⁶ Larger pools would hopefully lead to both lower risk and superior deterrence of negligent actions.

E. Systematic Prevention Incentives

Another problem with the current malpractice regime is that there is no incentive to use “systems approaches” to deliver superior health care.²⁷ It is not optimally productive to examine physician behavior in a vacuum; observing and aggregating actions within a given health-care system can lead to fundamental reforms that would otherwise be unavailable. But the current malpractice regime raises significant obstacles to the data collection and research that would be required for a systems approach to error prevention. Individual physicians lack the incentives to do expensive research that would nevertheless be profitable from the perspective of the entire country. More importantly, nobody else is able to do the research. Litigation and reputational con-

perience rating would remove cross-subsidization effects, which, while economically inefficient, might have equality or fairness effects that one may want to take into consideration.

²⁵ See Abraham & Weiler, *supra* note 7, at 401–02.

²⁶ *Id.*

²⁷ David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 217–18 (2001).

cerns discourage honest reporting of errors,²⁸ inhibiting the entrance of academics, and malpractice insurers lack a sufficiently large or coherent physician pool to make this type of research worthwhile. Without significant reform, gains will be realized only through self-insured institutions and luck.

F. Cross-Subsidization

The current malpractice regime forces the healthy to pay much of the healthcare cost of the sick. As the likelihood and damages of malpractice are correlated with the degree of underlying illness (it is much easier to negligently harm a patient that is already sick), the current malpractice regime cross-subsidizes the ill. As a result, the relatively healthy are paying too much for health insurance and the relatively sick are not paying enough. There are excellent arguments for subsidizing health care, but subsidizing the sicker with revenues from the sick is not an efficient way to go about it. While having the sickest segment of the population “overconsume” healthcare may not strike some as a problem, the underconsumption on the other side of the spectrum should. The dynamics of health insurance²⁹ are already driving many young people out of the pools because the ratio of the cost of the plan to their expected consumption is obscene; removing the contribution of malpractice to this problem would be a step in the right direction.

II. TRADITIONAL PROPOSALS TO REPAIR MALPRACTICE

A. Hospital Enterprise Liability

Professors Kenneth Abraham and Paul Weiler advocate for an enterprise liability system in which hospitals would be responsible for the liability of their employees by default.³⁰ They describe the malpractice system as serving three distinct groups of patients. First, patients who have already suffered injury as a result of their treatment desire efficient compensation.³¹ Second, patients who are about to be treated desire the effective prevention of negligent medical injuries.³² Finally, patients who are part of the insurance market but not seeking treatment at the time want compensation and prevention to be accom-

²⁸ *Id.* at 218.

²⁹ This is a reference to the informational asymmetry problem in which healthy subscribers drop from a plan, which causes premiums to rise, which in turn causes more healthy subscribers to drop, which causes premiums to rise again, and so on.

³⁰ Abraham & Weiler, *supra* note 7. Under their proposal, hospitals may contract with insurers to allow insurers to finance malpractice costs. *Id.* at 419.

³¹ *Id.* at 400.

³² *Id.*

plished by the most efficient administration possible.³³ Professors Abraham and Weiler believe that hospital enterprise liability would provide a superior alternative for all three.

From the patient perspective, individual physician liability is a significant problem because doctors often do not purchase enough insurance to cover multi-million-dollar judgments.³⁴ This causes patients to needlessly complicate litigation by joining as many physicians as possible in order to increase the pool from which the judgment can be drawn.³⁵ From the physician perspective, the major problem with the current system is that the risk pools are small, causing judgments or market fluctuations to have exaggerated effects.³⁶ Enterprise liability would fix both of these problems. Holding hospitals responsible would increase the size of the risk pool, mitigating the sharp premium spikes that currently plague the market, and deepen the pockets of the liable party, ensuring that adequate compensation can be found whether or not tangential parties are dragged into the case.³⁷

With regard to administration, hospital enterprise liability would drastically reduce litigation costs by eliminating multiple defendants in many cases.³⁸ Because different defendants have divergent interests, they require separate counsel and insurers, and they must achieve unanimous agreement for complete settlements. Professors Abraham

³³ *Id.*

³⁴ *Id.* at 402-03. Some physicians decline to purchase any liability insurance at all, instead deciding to make themselves judgment-proof by transferring assets to relatives. *Id.* at 403 n.81.

³⁵ *Id.* at 403.

³⁶ *Id.* at 402. The small size is the result of the fact that insurance pools are limited to a single state and subdivided by specialty. Thus, the maximum number of physicians in a pool would be the number of specialists in the state. Competition between insurers drastically reduces that number, so the end result is that insurance pools are small when compared with the size of an average hospital. *Id.* at 401-02.

³⁷ *Id.* Professors Abraham and Weiler believe that the damage awards for pain and suffering would have to be mitigated to compensate for the deeper pockets of the new defendants, though they prefer guidelines instead of caps. *Id.* at 405. They figure that average damages would increase because jurors would be more inclined to deliver larger sums from an enterprise than from an individual physician and that this factor would outweigh jurors' disinclination to hold liable an enterprise that is a degree of separation away from the physician. *Id.* What this reasoning does not take into account is that enterprise liability would involve a single defendant, whereas under the current system there are multiple defendants with divergent interests. This effect cuts in both directions; however, it is likely that the strength of a unified defense would outweigh the rare cases in which there is not enough evidence to find any particular defendant liable but it is clear that one of them did something wrong — a problem that the doctrine of *res ipsa loquitur* attempts to mitigate. In any event, this Note does not address the problem of differential damages because it assumes that juries can adequately assess the proper damages for pain and suffering. Capping these damages would lead to suboptimal deterrence, so it should be done only for a compelling reason. A desire to maintain the status quo in terms of damage awards is not a compelling reason.

³⁸ *Id.* at 406.

and Weiler estimate that the cost of multiple defendants is between twenty and thirty percent of malpractice insurance revenue.³⁹

Hospital enterprise liability also would deter injuries more efficiently than the current system does, for two reasons. First, hospital enterprise liability would introduce experience rating into the system and create deterrent incentives where previously there were none.⁴⁰ Second, hospitals are in a better position to improve the quality of care.⁴¹ After a significant number of anesthesiology-related accidents, a committee reviewed previous malpractice cases at Harvard hospitals and proposed a set of recommendations that were implemented over the objections of doctors who claimed it would lead to “cookbook medicine”; the reforms were so effective that the premium ratings of the physicians were cut in half.⁴² From this lesson, Professors Abraham and Weiler infer that many accidents are the result of simple mistakes — rather than a desire to profit at the expense of quality — and that team approaches and a significant amount of data are invaluable when devising solutions to healthcare problems.⁴³ Moreover, unlike most institutions, hospitals are well positioned to conduct the relevant reviews. Traditional academics cannot access the data because malpractice insurers are often reluctant to share it. Malpractice insurers can analyze the data but cannot do anything about what they find because they do not control the physicians. The Harvard medical system was self-insured,⁴⁴ so it had both the ability and the incentive to institute the reforms.

Professor Clark Havighurst argues in favor of enterprise liability for managed care organizations using similar arguments.⁴⁵ Managed care organizations, he argues, should be liable because they participate in “both financing and delivering care, and in both roles they exercise substantial influence over the personnel and institutions actually providing it.”⁴⁶ Professor Havighurst, however, limits the scope of his reform to managed care organizations; unlike the regime proposed by this Note, indemnity-type insurers would be specifically excluded.⁴⁷ This is a very significant difference, as implementing Professor

³⁹ *Id.* at 406 & n.92.

⁴⁰ *Id.* at 410.

⁴¹ *Id.* at 411.

⁴² *Id.* at 411–12. The recommendations included mechanized monitors for the patients’ respiration, circulation, and oxygen saturation; an alarm that sounded when vitals reached dangerous levels; and the presence of trained personnel at all times. *Id.* at 411 n.115.

⁴³ *Id.* at 412–13.

⁴⁴ *Id.* at 410.

⁴⁵ Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 587–88 (1997).

⁴⁶ *Id.* at 607.

⁴⁷ *Id.* at 587.

Havighurst's plan would likely cause most insurers to flee the managed care market into indemnity, whereas the regime proposed by this Note would have the opposite effect.

B. No-Fault Liability

No-fault liability, made popular by worker's compensation, has long been a reform option for malpractice. Professors Abraham and Weiler saw their hospital enterprise liability system as the first step toward a no-fault regime,⁴⁸ and Professor Weiler later expanded on his no-fault advocacy.⁴⁹ He finds three obvious gains. First, everybody who is injured would be compensated.⁵⁰ Second, there would be significant redistributive gains if, like worker's compensation, wage reimbursement were scaled from one-hundred percent for poor workers to fifty percent or less for more wealthy ones.⁵¹ Finally, administrative costs would be a much smaller percentage of the reimbursement in a no-fault regime; administrative costs are approximately sixty percent in the current medical malpractice system but only about twenty percent in worker's compensation.⁵²

Professors David Studdert and Troyen Brennan also argue in favor of no-fault liability, though from a different perspective.⁵³ They point out that a no-fault system is already in use in many countries, such as

⁴⁸ Abraham & Weiler, *supra* note 7, at 435. It should be noted that enterprise liability is practically a predicate for no-fault liability; without enterprise liability, no-fault liability fails to realize deterrence gains.

⁴⁹ Weiler, *supra* note 2, at 227.

⁵⁰ *Id.*

⁵¹ *Id.* at 227–28. Professor Weiler notes that the wealthy would be able to purchase disability insurance. *Id.* at 228. Without significant reforms, wage reimbursement in a no-fault regime would be regressive because the rich would not be charged more for care than the poor would be charged, even though their economic damages would be much larger. Even Professor Weiler's hospital enterprise liability system does not alleviate this problem, as hospitals have no way of charging the wealthy more for no-fault insurance. It should be noted that — though this Note does not advocate for a no-fault regime — holding the insurer exclusively liable in a no-fault matter could avoid regressive consequences, as the insurer can easily charge the wealthy more by tailoring premiums to salary or adjusting the reimbursement limit and, in this case, it would have a strong financial incentive to do so.

⁵² *Id.* at 228. Part of the reduction in administrative costs would be due to the increased willingness of physicians to admit their errors. *Id.* But two factors cut against this benefit. First, causation is more difficult to determine in medicine than in worker's compensation. *Id.* Second, overall reimbursement might increase drastically. If the sixty-twenty ratio is to be believed, overall costs would rise unless the value of compensated injures rose by a factor lower than three. Given the breadth of no-fault insurance, and the significant number of negligence injuries that currently slip through the cracks, overall compensation amounts would almost assuredly rise. However, Professor Weiler points out that the additional compensation might not be a large fraction of the U.S. healthcare budget, which is over \$1.4 trillion. *Id.* at 227.

⁵³ See Studdert & Brennan, *supra* note 27.

Denmark, Sweden, Finland, and New Zealand.⁵⁴ Based on empirical research in Utah and Colorado, implementing a “generous” no-fault regime would cost only about fifty percent more than the current system, even though sixty-seven to ninety-five percent more injuries would be compensated.⁵⁵ Moreover, they argue, no-fault liability provides superior deterrence when compared to a negligence system because of no-fault’s ability to experience rate.⁵⁶

Professor Richard Epstein, meanwhile, provides a cogent argument against no-fault insurance.⁵⁷ He has three principal criticisms. First, it is difficult to draw the line as to what injuries should be covered.⁵⁸ Professor Epstein points out that various treatments — his examples are surgery and chemotherapy — almost always cause harm, and it is very difficult to come up with a consistent rule that requires or denies coverage.⁵⁹ This uncertainty could deter the development of novel treatments.⁶⁰ Second, Professor Epstein points out that Virginia’s no-fault experiment for infant neurological injuries was “nightmarish to administer and fund.”⁶¹ Finally, Professor Epstein argues that patients might not desire no-fault coverage.⁶² Worker’s compensation arose in a contractual setting in which both workers and employers realized that they would be better served by a no-fault regime in which compensation is reduced.⁶³ No-fault has not arisen in the malpractice context, perhaps because no insurer would underwrite the policy,⁶⁴ or perhaps because people already have no-fault insurance through their health insurance and reason that money would be of no use to them if they are killed or put into a vegetative state.

⁵⁴ *Id.* at 219. The funding source differs drastically among the countries. For example, New Zealand uses tax revenue, while Sweden uses premiums charged to “regional councils and physicians.” *Id.*

⁵⁵ *Id.* at 220.

⁵⁶ *Id.* at 221. It should be noted that Professors Studdert and Brennan acknowledge that experience rating attaches due to the enterprise liability portion of the no-fault regime, *id.*, though the increased number of claims would undoubtedly increase the statistical power.

⁵⁷ Epstein, *supra* note 2. Professor Epstein’s argument is a response to Professor Weiler’s advocacy of no-fault insurance. *Id.* at 519.

⁵⁸ *Id.* at 520.

⁵⁹ *Id.* Missed diagnoses also present a thorny issue, as some sort of “fault” must come into play unless the system is to compensate every illness. *Id.*

⁶⁰ *Id.*

⁶¹ *Id.* However, Professors Studdert et al. report a moderately successful outcome in an analysis of Florida’s obstetric neurological injury no-fault regime, although they also note a significant number of concerns, primarily with patients’ filing malpractice cases in addition to no-fault claims. See David M. Studdert, Lori A. Fritz & Troyen A. Brennan, *The Jury Is Still In: Florida’s Birth-Related Neurological Injury Compensation Plan After a Decade*, 25 J. HEALTH POL. POL’Y & L. 499, 516–20 (2000).

⁶² Epstein, *supra* note 2, at 519.

⁶³ *Id.*

⁶⁴ *Id.* at 520.

C. Insurance Through Contract

According to Professor Epstein, “the most forthright and sensible way to deal with the [malpractice] liability crisis is to remove the minimum constraints on liability set by law and allow the parties to cut their own deals, either directly or through professional intermediaries, such as employer healthcare groups and the like.”⁶⁵ Professor Epstein disputes the idea that a rational patient would never agree to restrict his right to sue *ex ante*,⁶⁶ positing that there are situations in which it is efficient for the patient to wholly assume the risk for negligent treatment.⁶⁷ He believes that high transaction costs and monetary disincentives to seeking or providing medical care can combine to outweigh the deterrent effect provided by a negligence regime, especially if the malpractice system is not very well correlated with negligence.⁶⁸

Professor Epstein believes that there are three issues over which patients and providers would negotiate: liability, damages, and procedure.⁶⁹ With regard to liability, a no-fault liability regime has proven nonviable not only because it is difficult to determine the causation of injuries, but also because many injuries that arise out of treatment are unavoidable or predictable but worth risking in order to pursue a cure.⁷⁰ Also, health insurers are not well positioned to provide what amounts to life insurance.⁷¹ In the end, Professor Epstein concludes that “customary practice appears still to be the most practical and efficient standard for use in prescribing a physician’s duty — both in tort doctrine and in private contracts.”⁷² As for damages, they would likely be significantly lower in a contractual regime. Even though worker’s compensation provides an inapt analogy in the liability context, it is relevant with regard to damages; lowering damages decreases patients’ moral hazard, reduces costs associated with liability determination mistakes, reduces litigation costs, and eliminates multiple insurance of the same risk.⁷³ Finally, with regard to procedure, private arbitration, extremely popular in many contractual settings, may be able

⁶⁵ *Id.* at 509.

⁶⁶ *Id.* at 508.

⁶⁷ *Id.* at 512–13.

⁶⁸ *Id.* at 513–14.

⁶⁹ Richard Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, LAW & CONTEMP. PROBS., spring 1986, at 201, 205.

⁷⁰ *Id.* at 207.

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.* at 209.

to help rein in an unfortunate “malpractice system [that] incurs more costs in evaluating claims than in paying them.”⁷⁴

D. Damages Restrictions

Restrictions on damages are the most frequently implemented reforms in the United States; they are a favorite of doctors and hospitals because they transfer risk from providers to patients. The paradigm of damage caps is the California Medical Injury Compensation Reform Act of 1975,⁷⁵ which limits compensation for noneconomic damages to \$250,000.⁷⁶ As of 2001, five states capped both noneconomic and economic damages, and nineteen capped noneconomic damages alone.⁷⁷ In states with caps, premiums were 17.1% lower and the loss ratio (the ratio of awards and litigation costs to premiums) was 11.7% lower than in states without caps.⁷⁸ The natural, and tautological, conclusion is that caps work. The real question, however, is whether caps are efficient. Unfortunately, research in this area is sparse, and the results are unclear.⁷⁹ Theoretically, damage caps undercompensate injured patients and insufficiently deter negligent conduct (assuming the current system deters it at all).⁸⁰ However, to the extent that patients ex ante do not want insurance for medical injuries, which seems likely given the lack of private contracting for medical injuries in general, perhaps damage caps are somewhat efficient. Regardless, it is clear that the problems that plague malpractice law cannot be fixed by damage caps alone.

E. Universal Insurance Subrogation

Kenneth Reinker and Professor David Rosenberg have advocated a system of subrogation⁸¹ that is in one sense the opposite of this Note’s proposal. Their proposal would “allow insurers to take over the proc-

⁷⁴ *Id.* (citing PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 187 (1985)).

⁷⁵ CAL. CIV. CODE § 3333.2 (West 2007).

⁷⁶ *Id.* § 3333.2(b). The cap was a result of swift (perhaps hasty) action in response to a very sudden state malpractice crisis in which premiums more than tripled and doctors either stopped working or worked without any insurance at all. See Amanda Edwards, *Recent Development, Medical Malpractice Non-Economic Damages Caps*, 43 HARV. J. ON LEGIS. 213, 216–18 (2006).

⁷⁷ Thorpe, *supra* note 3, at W4-25.

⁷⁸ *Id.* at W4-26.

⁷⁹ See Mello et al., *supra* note 3, at 2283–84 (questioning whether the conclusion that damage caps reduce premiums is justified given that the relevant studies “are based on data from earlier eras and present mixed findings”).

⁸⁰ See *id.*

⁸¹ Kenneth S. Reinker & David Rosenberg, *Improving Medical Malpractice Liability by Allowing Insurers To Take Charge* (John M. Olin Ctr. for Law, Econ., & Bus., Harvard Law Sch., Discussion Paper No. 556, 2006), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=923424.

ess of litigating and resolving claims,” permitting the entire claim to be subrogated to the health insurer.⁸² This would make the health insurer the de facto plaintiff, whereas this Note advocates making the health insurer the actual defendant.

Reinker and Professor Rosenberg purport to remedy two problems with the current malpractice regime. The first problem is that optimal damages for deterrence are usually not equivalent to optimal damages for compensation.⁸³ The second problem is that contingency fees distort optimal litigation incentives: attorneys attempt to maximize their profit and not the overall return for their client when litigating cases under contingency.⁸⁴ Unlimited insurance subrogation would solve both of these problems by allowing the patient to purchase only the coverage desired (subsidized by the expected ex ante damages), while leaving the healthcare provider liable for the damages; additionally, by consolidating the recovery, it would remove the contingency distortion effect.⁸⁵

III. A PROPOSAL FOR HEALTH INSURER ENTERPRISE LIABILITY

This Note attempts to craft a cure for malpractice woes by advocating for a system of enterprise liability that would place malpractice risk on the health insurer. Implementing health insurer enterprise liability would change the applicable law to require health insurers to defend claims and pay malpractice damages for the physicians whom they reimburse. Several points require clarification: First, rules must be defined. Second, the conflict with “any willing provider” laws must be settled. Third, limits for contracting out of the regime must be set. And fourth, rules must be set for uninsured patients and those insured by a government program, such as Medicaid or Medicare.

The main parameters of the regime are which liability standards should be covered and whether there should be damage caps on the coverage. With regard to the first question, there are a number of options. The first is to require the health insurer to cover any damage that a physician causes to a patient in the course of work for which the insurer reimburses. A second option is to draw the line at reckless or intentional conduct, absolving the health insurer of any liability for the egregious conduct of the physician. A third option is to cover compensatory damages but not punitive damages.⁸⁶ A fourth option is to

⁸² *Id.* at 5.

⁸³ *Id.* at 20.

⁸⁴ *Id.* at 17.

⁸⁵ *Id.* at 16–17.

⁸⁶ It should be noted that the difference between the second and third options is that, in the case of reckless or intentional conduct on the part of the physician, the second would not cover any liability, whereas the third would cover the compensatory but not the punitive damages.

cover economic damages, but not noneconomic (including punitive) damages.

A number of factors are important in deciding among these regimes. First, is there something about reckless or intentional conduct or different types of damages that is harder for insurers to predict or experience rate? Second, how would the regime affect the physician incentives, and as a corollary, how would it affect the insurance companies' ability to control reckless and negligent conduct? Third, what are the efficiency impacts of restricting coverage?

Finding empirical answers to these questions is extremely difficult, as there are no analogous situations to use as comparisons.⁸⁷ The likely outcome, however, is that allowing health insurers to abdicate responsibility for certain damages would result in a decreased incentive to prevent them. If some liability were not shifted to the health insurer, then the physician would likely purchase independent malpractice coverage for the uninsured risk. Hence, the choice of a liability standard represents the dilemma of how to divide the liability for mistakes between health insurers and traditional malpractice insurers.

The best regime is for health insurers to cover all liability that physicians would pay to insure if it were not otherwise covered. The current system allocates healthcare costs to the health insurer and all other liability costs to the malpractice insurer. Any regime in which health insurers did not cover all risks would maintain this divide to some extent. This Note argues against the divide in general, and the same arguments cut against maintaining a divide of a smaller magnitude. Not only would such a divide decrease deterrence, but it would also likely be more inefficient, as more companies would have to evaluate the risk.

"Any willing provider" laws, which require health insurers to cover the services of any healthcare professional willing to adhere to their contracts,⁸⁸ pose a much thornier problem. In order for the health insurer enterprise liability regime to be viable, it must be able to operate without the constraint of these rules. The crux of the regime is the ability to treat providers differently, to direct patients to the top providers, and to influence the actions of providers who choose to accept the business of the insurer.

⁸⁷ Limits on noneconomic damages, for example, do not provide a reliable proxy because they remove liability altogether instead of shifting it from one regime to another.

⁸⁸ James W. Childs, Jr., Comment, *You May Be Willing, but Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 CUMB. L. REV. 199, 199-200 (1997). Some any-willing-provider laws apply only to pharmacies. *Id.* at 200 n.3. Laws so limited make more sense than laws that apply to all health providers, as pharmaceuticals are much more of a commodity than healthcare services are.

Existing insurers have already complained that any-willing-provider laws defeat their ability to select high quality health providers. Typical any-willing-provider statutes allow insurers to consider certain objective quality standards, though these are of extremely limited value.⁸⁹ Such standards include board certification, Medicare sanctions, suspended privileges, licensing board complaints, private sanctions, and civil judgments.⁹⁰ Though this list constitutes a decent starting point for judging the quality of physicians, it is insufficient to develop an effective experience rating system. The entire point of health insurer enterprise liability is to encourage health insurers to come up with innovative ways to send patients to quality providers and encourage those providers to behave efficiently. Restricting insurers' sight to obvious criteria eviscerates the ability to innovate, so either these laws would need to be repealed or an exception would need to be created.

Fortunately, health insurer enterprise liability is designed to alleviate some of the concerns that any-willing-provider laws are designed to address. Proponents of any-willing-provider laws fear that HMOs desire only to limit their costs and maximize their profits.⁹¹ HMOs allegedly select the cheapest — and possibly lowest quality — providers and limit patients' ability to select the good physicians that they find on their own. The providers that HMOs select are also presumably the ones that are most likely to refuse to order tests and referrals in order to keep costs down. Health insurer enterprise liability, however, forces insurers to internalize the entire cost of low quality health care, which should make such actions unprofitable.

The third question with regard to this Note's proposal is whether health insurers should be allowed to alter the insurance regime by contract. In order to succeed, the regime should not be materially alterable by contract. Health insurer liability would require significant interoperability between insurers and healthcare providers. Currently, each physician has exactly one malpractice insurer, but health insurer liability would give each physician significantly more. It would be inefficient for a new negotiation to take place for each individual relationship; mandating the coverage by law would have tangible benefits.

Moreover, there is very little benefit to allowing negotiation of the terms of these contracts. Under this Note's proposal, the line between what is covered and what is not would be extremely clear. In all likelihood, negotiation would take place only as a result of the health insurer's trying to limit its exposure to certain risks, for example, by ab-

⁸⁹ *Id.* at 212–13.

⁹⁰ *Id.* at 213.

⁹¹ *Id.* at 200.

solving itself of certain conduct or imposing damage caps. But allowing insurers to escape liability would be inefficient. In order for the program to succeed, doctors would need identical coverage from all of the insurers with which they contract. The best way to standardize this coverage is by regulation.

What is the argument against limiting the insurer's liability if both the insurer and the physician (presumably for more money) agree? Such an agreement means that the physician will either purchase alternative coverage or self-insure. In either case, the motivations and effects are suspect. If a physician purchases alternative coverage, that could indicate an information asymmetry problem where both the physician and the health insurer know the risk is high, so the physician may want to cheaply pass on the risk to a third party malpractice insurer.⁹² If the physician self-insures, then he is either very confident in his abilities or judgment-proof. Given the lack of specificity of malpractice judgments and the extremely high risk, even for good physicians, the latter scenario is much more likely.

As explained above, Professors Abraham and Weiler propose a system of enterprise liability that would fall on hospitals by default but could be shifted onto healthcare insurers.⁹³ They claim that, when the financial institution can bear the burden more efficiently, the parties will contract to shift it over.⁹⁴ What they do not take into account is that the transaction costs of such a shift would be enormous and that dividing the burden would dilute many of the system's benefits. With respect to transaction costs, once the burden is shifted, there would be two institutions responsible for liability instead of just one. Providing liability insurance would be significantly more expensive because the pools would be smaller: the risks would not be adequately spread, and costs would vary widely with the ebbs and flows of the market. With respect to dilution of benefits, if a hospital were responsible for only a portion of the liability related to its patients, its incentives to research would be proportionally cut. If liability were divided between the hospital and insurer, the likely outcome would be that both would reach for the same low-hanging fruit. In the end, which system of en-

⁹² It is unclear whether a third party insurance market would even be viable in the face of a "lemon" stigma that would be associated with the search for supplemental coverage. Presumably, the health insurer is in possession of better information, so physicians with low coverage would be "lemons" and extremely expensive to insure. This would likely trigger the vicious cycle that unfortunately plagues many insurance markets where the premiums go up, causing the lower risk physicians to drop, which causes the premiums to go up, and so on. Alternatively, it might be more efficient for another company to insure the doctor. If this efficiency outweighs the benefits of placing the risk on the health insurer, then the entire regime advocated by this Note is inefficient; thus, this Note assumes that this is not the case.

⁹³ Abraham & Weiler, *supra* note 7, at 419-20.

⁹⁴ *Id.*

terprise liability is superior depends on whether the liability is more efficiently placed entirely on hospitals or entirely on insurers. There is no reasonable way to divide it.

In sum, this Note proposes a regime where health insurers must cover all malpractice liability for the physicians whom they reimburse. This obligation should not be alterable by contract. Finally, the insurers should not be required to comply with any-willing-provider statutes, so they can have a free hand when rating physicians.

IV. ADVANTAGES AND DISADVANTAGES OF HEALTH INSURER ENTERPRISE LIABILITY

A. Advantages

1. *Convergence of the Defensive Medicine Incentives.* — Health insurer enterprise liability would drastically reduce the incentives to practice defensive medicine. As described above, doctors act inefficiently because they bear almost none of the costs of ordering extra tests yet face reputational damage from malpractice suits. Defensive medicine is, at heart, a tradeoff between negligence damages and healthcare costs, with doctors acting as the arbiter between health and malpractice insurers. Given the prevalence of defensive medicine,⁹⁵ it would seem that the costs in terms of reputation and time place physicians squarely on the side of the malpractice insurers. Health insurers have tried to fight back by introducing economic incentives, such as capitation, to dampen physician enthusiasm for excess health care.⁹⁶ The problem is that society does not trust health insurers to make appropriate decisions and constantly worries that HMOs are going too far and sacrificing patient health so that they can increase their profit margins.⁹⁷

Health insurer enterprise liability would change this dynamic. By having the same institution responsible for both health coverage decisions and malpractice liability, there would not be any inefficient tension. Instead of two organizations sacrificing value in their efforts to secure a transfer, there would be one organization deciding whether to put the money in its right pocket or its left. Society would be able to trust insurers to make optimal coverage decisions, knowing that if they skimp they will have to foot the bills for the damages. Defensive medicine, of course, cannot be completely eliminated, but insurer enterprise liability would likely have the effect of a drastic reduction,

⁹⁵ See *supra* p. 1194.

⁹⁶ Abraham & Weiler, *supra* note 7, at 396.

⁹⁷ See Havighurst, *supra* note 45, at 591.

which is better than any other malpractice reform — aside from the complete elimination of liability — can claim.

2. *Experience Rating.* — The second large benefit of health insurer enterprise liability is its ability to introduce experience rating into the mix. If the health insurers were to self-insure, then they would experience rate by default. If they attempted to reinsure their aggregate risk, then it is extremely likely that an experience rating system would attach. Professors Abraham and Weiler⁹⁸ and Professors Studdert and Brennan⁹⁹ claim that experience rating would attach in a hospital enterprise liability regime. Given the size of modern health insurers such as Aetna and Blue Cross, which are orders of magnitude larger than any individual hospital, it is extremely likely that experience rating (or self-insurance) would be the norm if insurers bore enterprise liability.

Once experience rating attached, all of the corresponding benefits would follow, including a full incentive to control negligent actions on behalf of the physician. Insurers' effectiveness would depend on their differential abilities to control the actions of physicians. Hospitals admittedly are likely in a superior position to control the actions of their employees at this time. However, much of this superiority stems from the current liability regime. As Professor Havighurst points out, managed care organizations specifically avoid exerting any control or apparent control over physician operations in order to avoid vicarious liability determinations.¹⁰⁰ If insurers were to become liable, they would no longer be subject to this disincentive and likely would immediately begin to exercise control.

Finally, health insurer enterprise liability has an additional advantage over hospital enterprise liability in that it would cover all physicians instead of only transactions that involve a hospital setting. Hospital enterprise liability could attempt to pick up the stragglers by including all claims against physicians who have privileges; however, this would run into two thorny issues. First, it is unclear who would be liable when a physician has privileges at multiple hospitals.¹⁰¹ Second, it is likely that the pool of outpatient malpractice risk may be so

⁹⁸ See Abraham & Weiler, *supra* note 7, at 410.

⁹⁹ See Studdert & Brennan, *supra* note 27, at 221–22.

¹⁰⁰ Havighurst, *supra* note 45, at 610 (“[I]n most cases MCOs will be held liable for physician negligence only if the plaintiff makes an additional factual showing — which an MCO can make more difficult by distancing itself from its physicians and prominently disavowing any agency relationship with, or any warranty concerning, providers of any kind.” (footnote omitted)).

¹⁰¹ Professors Abraham & Weiler say the solution to this problem is to determine with which hospital the physician is principally affiliated, a system which is currently used in New York for supplementary physician coverage. Abraham & Weiler, *supra* note 7, at 421–22. The danger of this idea is difficult to overstate. It makes physicians with principal privileges at other hospitals extremely desirable, and it could cause large hospitals to cross-subsidize small ones or eliminate multiple privilege rights altogether.

small that the incentives to innovate would not be optimal. Hospitals have the advantage of being able to target recidivist physicians who are disproportionately liable for malpractice costs and revoke their privileges. However, given scholars' beliefs that the major innovations are to be found in systems approach innovation,¹⁰² and given the inability of the current regime to experience rate individual physicians, the magnitude of this benefit is likely quite small.

3. *Larger Insurance Pools, Risk Spreading, and Systems Innovations.* — One of the greatest advantages of health insurer enterprise liability is the size of the insurance pool. The size of the pool impacts the insurer's ability to spread risk. Average health insurers likely have claims frequencies that are orders of magnitude higher than those of all but the largest hospitals. Moreover, the health insurer enterprise liability regime would cover all specialists from the same pool, reducing the variance that is due to stratifying the physician population into smaller samples.¹⁰³ Given their size, health insurers seem better situated to spread risk than any other actor except the government.¹⁰⁴

A second advantage of a larger risk pool finds its origin in the theory of economies of scale and public goods. An actor is required to spread the fixed costs of an innovation over the entire pool. Hence, the difference between the marginal cost of an innovation and its benefit must be greater than the fixed cost of the innovation divided by the number of participants in the pool. For an example, assume the marginal cost of the anesthesiology innovations discussed above¹⁰⁵ is ten dollars, the marginal benefit is twenty, and the fixed cost is one million dollars. In order to make innovating profitable, the innovator must be able to spread the fixed costs over more than 100,000 patients.

¹⁰² See *supra* pp. 1196–97.

¹⁰³ One interesting inquiry is whether this would have a cross-subsidization effect, with low-risk specialties, such as dermatology, subsidizing the high-risk ones like obstetrics. The answer is probably not. In a competitive market, if one insurer is underpaying dermatologists, dermatologists will likely drop that insurer and seek one with a higher reimbursement. It does, however, seem paradoxical that the health insurer can better spread risk without spreading it between different specialties. Part of the solution may lie in the fact that there could be fewer health insurers than malpractice insurers, especially when the pools are separated by state lines. For example, in 1985 the number of neurologists and neurosurgeons in Florida, a relatively large state, was only about 500, see Abraham & Weiler, *supra* note 7, at 401 n.77 (citing David J. Nye et al., *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L.J. 1495, 1532 (1988)), so pools must have been very small when divided among the individual malpractice insurers. It should be noted that Professors Abraham and Weiler believe that enterprise liability would cause some cross-subsidization between specialties and that that may be a good thing, as the cost is spread among the patient population anyway. *Id.* at 402. This argument is not convincing, however, given that subsidizing risky activities with safe ones seems inefficient per se.

¹⁰⁴ Hence, the risk is optimally placed on health insurers, given the government's questionable ability to respond to financial incentives.

¹⁰⁵ See *supra* p. 1199.

Innovation would be possible at an extremely large self-insured organization like a Harvard teaching hospital, but it would not be worth it for smaller pools. Describing the benefits of large pools in these terms, however, vastly understates their value. Healthcare innovations are public goods with enormous externalities; in the Harvard anesthesiology example, the innovations spread quickly throughout the country and reduced complications nationwide.¹⁰⁶ Given that health insurers could not keep their innovations as internal trade secrets because they would have to share them with providers, one could expect a health insurer enterprise liability regime to have tremendous public benefits.

4. *Removing the Sick's Cross-Subsidization of the Sicker and Mitigating Physicians' Incentive To See Healthy Patients.* — Health insurer enterprise liability would eliminate cross-subsidization between patients of the same physician or physician class. If health insurers bore the malpractice liability, they would have a very strong incentive to pass the financial costs of sick patients onto the sick patients' insurance premiums instead of dividing it among the population. Hopefully, this effect would lessen the problem of the healthy avoiding insurance because the cost is so much higher than the expected utilization. If the cross-subsidization of the sick is efficient, it can be funded by general tax revenues, putting the burden where it belongs.

Enterprise liability unfortunately would not affect the incentive of a physician to see a sick patient. The poor would still likely have inferior insurance, and the sick would still cause lost time and increased malpractice risk, though doctors would bear only reputational damage from an adverse judgment. What enterprise liability would do is incentivize insurers to send their patients to quality doctors. In the current system, the incentive is to send the patient to the cheapest doctor possible and let the malpractice insurer clean up the mess in the case of mistake. Placing malpractice liability on the health insurer would increase the incentive to send the patient to a quality physician — even one that is more expensive — in cases where low quality physicians would be unable to provide adequate care.

5. *Decreased Administrative Costs.* — To the extent that multiple defendants increase the cost of litigation by involving separate insurers, redundant analysis, additional lawyers, and infighting due to conflicts of interest, enterprise liability would reduce the administrative costs of medical malpractice.¹⁰⁷ This cost is estimated to be between twenty and thirty percent of malpractice costs, so the benefits have the

¹⁰⁶ Abraham & Weiler, *supra* note 7, at 412.

¹⁰⁷ *Id.* at 406.

potential to be very substantial.¹⁰⁸ In fact, the benefits have the potential to be of an even greater magnitude, as the estimate was created assuming a hospital enterprise liability standard; multiple defendants are still possible in this regime, as care may be rendered at different hospitals. However, the patient's bills will almost always be paid by a single insurer, and so multiple defendants are even less likely in a health insurer liability regime.

6. *Specialization Between Large and Small Insurers.* — The final benefit of the program would come from the specialization of large national insurers and small local insurers. Given that large insurers draw from a much larger pool, they would have a much larger incentive to innovate to reduce malpractice liability. The insurers with a much smaller pool would have an incentive to free-ride. But when it comes to monitoring incentives, the opposite would be true. Large insurers would be much more likely to have a diverse patient base that contracts with many different physicians. Small local insurers would be likely to select the top physicians and hospitals and ensure that they deliver quality care. Thus, the smaller insurers would do the monitoring work for the bigger ones. This respective specialization ensures that each group would be able to direct its resources to what it must do in order to profit. Although the full benefits would not be shared, the synergy should be significant.

B. Disadvantages

1. *Uninsured and Medicaid/Medicare.* — The most obvious question about health insurer enterprise liability is what to do about the uninsured. There are two options. The first is to deny them malpractice reimbursement. The second is to force doctors to purchase supplemental coverage for the uninsured.¹⁰⁹

The first option may, at first blush, seem unfair to those that do not have health insurance. In reality, it is unfair to everyone else. Allowing the uninsured to self-insure lets them free-ride off of the systematic innovations that everybody else's insurers devise.¹¹⁰ This option, how-

¹⁰⁸ *Id.* It is both unclear and unlikely that defensive medicine deterrents were taken into account when formulating this estimate. To the extent that deterring defensive medicine would reduce the number of defense witnesses, the effect of litigation savings may be even greater.

¹⁰⁹ A third option is to mandate health insurance, eliminating the uninsured and this problem.

¹¹⁰ This would not be the case if physicians rendered inferior care to the uninsured; however, empirical research into differential treatment of patients based on HMO market penetration suggests that "the ability of physicians to modify their behavior when the patient population is heterogeneous may be severely limited." Sherry Glied & Joshua Graff Zivin, *How Do Doctors Behave When Some (but Not All) of Their Patients Are in Managed Care?*, 21 J. HEALTH ECON. 337, 352 (2002). The result is only strengthened when one assumes that the majority of innovations are going to be systematic.

ever, is politically unpalatable. Standard legal doctrine would reject it, and a legislature would probably not be able to pass it.

The obvious recourse is to force physicians to purchase supplemental insurance. Assuming the insurance is transactional — meaning that the insurer gets paid based on the number of patients and the different procedures — the concentration and deterrence incentives would be preserved. The disadvantages are twofold. First, coverage for the uninsured would likely be significantly more expensive than for an average patient, thus raising the costs of treatment. Second, because many uninsured never actually pay their bills,¹¹¹ paying patients would have to subsidize their compensation (as in the status quo). Nonetheless, given the politics of the situation, forcing doctors to purchase supplemental insurance is the best solution. Even if the politics were different, this solution would still be optimal if the cross-subsidization loss is less than the free-riding loss associated with the first option.

2. *Favoring Systematic Innovations at the Expense of Personal Accountability.* — The second disadvantage of health insurer enterprise liability is that it favors systems approaches at the expense of personal accountability. Because each individual doctor would be insured by many different companies, the incentives to monitor the morality and diligence of individual doctors would be decreased. Health insurer enterprise liability, therefore, would have less of a deterrent effect than hospital enterprise liability. This, however, is the price that must be paid in order to achieve a larger risk pool that includes every physician (even the ones who do not regularly practice at hospitals).

The deterrent effects of health insurer liability are likely better than those of the current malpractice regime, which gives physicians significantly less of an incentive to monitor their own behavior given that malpractice insurers do not experience rate.¹¹² In addition, it is possible, and perhaps even likely, that insurers bearing liability would cooperate in order to share data on physicians and develop a database akin to a credit report. There is no incentive to develop such a database now because an insurer benefits from dumping a money sink on a competing insurer. However, when multiple parties are insuring against a similar risk with regard to the same individual, cooperation becomes much more fruitful. This effect would likely mitigate the dis-

¹¹¹ See Jack Hadley & John Holahan, *How Much Medical Care Do the Uninsured Use, and Who Pays for It?*, HEALTH AFF. WEB EXCLUSIVE, Feb. 12, 2003, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.66v1> (estimating that the uninsured pay for only sixty-five percent of the care they receive).

¹¹² A physician's only incentive is the desire to avoid reputational damage and wasted time in litigation. Though significant, this is substantially less than the penalty for negligently killing or disabling someone.

advantage that health insurers face with regard to hospitals when it comes to bearing risk.

3. *Decreased Patient Choice.* — If health insurers became liable for malpractice, they would likely restrict the treatment options of those under their care. While this Note argues that such a restriction would be beneficial, it must concede that, to the extent patients value choice, they are harmed when that choice is sacrificed upon the altar of efficiency. Health plans that allow patients to visit any willing provider would still likely exist, but they would be significantly more expensive, given that they do not allow insurers to control the actions of physicians.

V. CONCLUSION

This Note advocates for a health insurer enterprise liability system. Malpractice would still be based on the current negligence standard, though a transition to no-fault insurance would be viable. Health insurers would be exclusively liable for all negligent damage done to a patient whose coverage they reimburse. The main advantages of the regime are the reduction of defensive medicine, the improvement of deterrence through experience rating, incentivizing innovation with high fixed costs, decreased administrative costs, and less cross-subsidization by sick patients of sicker patients. The most significant disadvantages are the difficulty posed by uninsured, Medicaid, and Medicare patients, and the decrease in patient choice that is likely to result from this regime. While implementing this proposal would require significant changes at both the federal and state level, the magnitude of the potential benefits indicates that it is worth the effort.