Despite President Obama’s call to “scale back the excessive defensive medicine that reinforces our current system,” the Affordable Care Act does not explicitly address medical liability reform.11 Efforts to pass national tort reform legislation have long been stymied. Some states, including California as early as 1975, have implemented more progressive approaches, but success at the state level has been inconsistent. (The details of these federal and state liability provisions are discussed beginning on page 8.) In addition to the political contest surrounding medical liability reform, there is much debate about what policies would have the most beneficial effects. So far, the evaluations of traditional reforms have primarily focused more on measures of the liability system than on the downstream effects on patient care. Liability-related metrics include claims frequency; indemnity costs (amounts paid in verdicts or settlements); overhead costs; and the costs of malpractice insurance. Care-related metrics include the amount of defensive medicine, supply of physicians in an area, and patient outcomes.12 (See Table 1, this page, for a list of traditional legislative reforms and a summary of the evidence related to each approach.)

<table>
<thead>
<tr>
<th>Proposed reform</th>
<th>Description</th>
<th>Effects</th>
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| Caps on damages                  | Limit amount of awards for non-economic losses or punitive damages          | • Reduces some defensive practices  
• Modestly improves physician supply  
• Reduces indemnity payments  
• Constrains growth of insurance premiums  
• Limited or equivocal evidence on claims frequency or care quality |
| Statute of limitation and repose | Limit the amount of time a patient has to file a claim                      | • Associated with modestly lower premiums  
• No effect on indemnity payments  
• Limited or equivocal evidence on defensive medicine, physician supply, quality of care, claims frequency, and overhead costs |
| Pretrial screening panels        | Expert panels review cases to determine merit                               | • May reduce defensive practices  
• No effect on indemnity costs, claims, or premiums  
• Limited or equivocal evidence on physician supply and quality of care |
| Certificate-of-merit requirement | Requires an affidavit from a medical expert affirming merit                  | • Limited or equivocal effect on defensive medicine, physician supply, indemnity costs, overhead costs, claims frequency, and premiums |
| Limit on attorneys’ fees         | Limits amount plaintiff’s attorney may charge as a contingency fee          | • No effect on indemnity costs, claims frequency, premiums, or physician supply  
• Limited or equivocal evidence on defensive practices and quality of care |
| Joint and several liability      | When multiple defendants exist, liability is limited to the percentage of fault allocated to that defendant | • No effect on indemnity costs, premiums, overhead costs, or physician supply  
• Limited or equivocal evidence on defensive medicine, quality of care, and claims frequency |
| “fair share rule”                |                                                                             |                                                                                                                                                            |
| Collateral-source rule           | Allows deduction of an award if injured patient has received compensation from another source | • No effect on defensive medicine, physician supply, quality of care, indemnity costs, claims frequency, premiums, or overhead costs |
| Periodic payment                 | Allows awards to be paid over a period of time rather than lump sum         | • No effect on physician supply or indemnity costs  
• Limited or equivocal effect on defensive medicine, quality of care, claims frequency, premiums, and overhead costs |