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Dear Karen:

This is in follow up to your July 2019 email asking for "any research or data on the effects of medical malpractice legislation that you recommend we consider."

I would first like to thank you for reaching out to us. We would have gotten this to you sooner had a busy summer not gotten in the way. I also want to thank CBO for issuing a far more detailed explanation of your score than was done in 2009, as well as asking for feedback. Our experience in 2009 was far less "hospitable."[1]

We appreciate your acknowledging that no evidence exists that five of the six extreme tort restrictions examined by CBO, which are part of the last federal bill passed by the U.S. House in 2017, have any impact on health care spending. We also agree with your view that one of the six tort restrictions – a cap on attorneys' fees – would have the opposite budgetary impact than proponents suggest because it would cost the government money. Given the politicized nature of this tort restriction, which was not even included in CBO's original 2009 analysis, we respectfully ask that CBO make its budgetary impact more clear instead of burying the point. We also ask that CBO replace misleading industry language to describe tort laws with accurate legal descriptions used by the very studies on which you rely. Using industry language undermines CBO's credibility for no reason and should be changed.[2]

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[1] I wrote about our experience in "What I've Learned About the Congressional Budget Office and Health Care," *Huffington Post*, March 18, 2010, https://www.huffpost.com/entry/what-ive-learned-about-th_b_391034

[2] In particular, instead of "several liability," CBO uses the term "fair-share rule." This is an industry poll-tested term used by industry in political fights and is highly misleading. Indeed, CBO's entire definition of "joint and several liability" is misleading. Under joint and several liability, which has been part of the common law for centuries, only fully or substantially responsible defendants can be held "individually responsible for the entire amount of an award," not just any defendant. From the plaintiff's perspective, there is nothing "fair" about several liability since it means the injured victim must pick up the tab for the harm done to them by other fully-responsible defendants. *See, e.g.,* Richard Wright, "The Logic and Fairness of Joint and Several Liability," 23 *Memphis State L. Rev.* 45 (1992).

Aside from these issues, we have three main concerns with your recent analysis. First, we believe there are major problems with data on which CBO relies, specifically the miscataloging of states and the reliance on incorrect payout and premium numbers. Second (and related to the first), CBO's findings and conclusions about medical liability insurance costs reflect common misunderstandings about the medical liability market and are seriously flawed. Third, we are troubled by CBO's devaluation of findings from recent robust studies on the impact of caps, done with "comprehensive high-quality data" and estimated with "reasonable precision," demonstrating that caps on damages may actually cause higher Medicare Part B spending. We will address each in more detail.

DATA PROBLEMS

Miscataloging states. CBO's entire analysis and precise score depend on an accurate initial grouping of states into two categories: states that capped damages during its 1999-2014 sample period ("treated" states) and the rest ("control" states). Of course, many of the "control" states enacted caps before 1999. But CBO's grouping is fraught with other problems too. For example:

- North Carolina is coded as a "cap" state. But as the database on which CBO relies notes in its explanatory list of "concerns,"[3] in some states, "Caps [are] lifted when injury is severe, so it is not clear they bind at all." North Carolina should qualify for that category.[4] This raises the question: if the cap is not operating in most cases, what impact could it have?

- Illinois raises similar questions, where the cap never really took effect during the five years it existed. It was immediately regarded as unconstitutional with virtually no influence. That was made clear by the Illinois Division of Insurance, who said that the law's strong insurance regulatory reform is what kept rates under control during those five years, and not the cap.[5]

- Oregon and Pennsylvania were pulled completely from the sample because CBO said these two states removed a "traditional malpractice liability law over the sample period." This is unexplained. As caps are the only tort restriction being considered by CBO, and neither had a cap during the sample period, ignoring data from these states seems

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[3] https://law.utexas.edu/faculty/ravraham/concerns-about-dstlr-5.1-02022015.docx. The database also arbitrarily "codes states [that] lowered caps to date only to the date when the cap was lowered." This seems odd. That said, there are states that lowered or changed their caps during the sample period: Maryland lowered its cap in 2005; Missouri lowered its cap in 2005, declared it unconstitutional in 2012 (It was re-passed it in 2015.)

[4] Specifically, the statute expressly exempts cases where "The plaintiff suffered disfigurement, loss of use of part of the body, permanent injury or death. (2) The defendant's acts or failures, which are the proximate cause of the plaintiff's injuries, were committed in reckless disregard of the rights of others, grossly negligent, fraudulent, intentional or with malice." N.C. Gen. Stat. § 90-21.19, https://www.ncleg.net/EnactedLegislation/Statutes/PDF/BySection/Chapter_90/GS_90-21.19.pdf

[5] *See more here*: Center for Justice & Democracy, "Fact Sheet: 'Caps' Do Not Lower Insurance Premiums for Doctors (and Insurance Insiders Admit It)," https://centerjd.org/content/fact-sheet-caps-do-not-lower-insurance-premiums-doctors-and-insurance-insiders-admit-it

improper. Pennsylvania's Constitution actually prohibits caps. (Also note that Ohio's Constitution prohibits caps in wrongful death cases.)

- Because Arkansas, Maine, Kansas, Idaho, West Virginia and Missouri have "missing or unreliable" Medicaid data, they were entirely excluded from the analysis. Some have caps and some don't. Yet as CBO admits, so much Medicaid data is generally unreliable that it's unclear if excluding these states even matters.

Payouts. CBO defines "direct costs" to providers as "malpractice insurance premiums, costs related to self-insuring for malpractice expenses, and any other *settlements, awards, and administrative costs not covered by insurance*."[6] In other words, when it comes to payouts, those *not covered by insurance* are what's relevant since CBO is examining the influence of costs on the behavior of doctors. Studies clearly show that payments are almost never larger than a doctor's insurance policy limits no matter what a jury rules.[7] But it seems that CBO does not have that data. Table 3 appears to be a full-blown, year-by-year analysis of all payouts and claims. Making things even worse, CBO says it is using data from the National Practitioner Data Bank (NPDB), a data source plagued by longstanding underreporting problems.[8] These problems are growing due to the migration of doctors into hospital systems and hospitals' use of the "corporate shield" to avoid NPDB reporting.[9] CBO's choice of data here is baffling since it could have easily used more reliable insurance industry "Direct Losses Paid" data from A. M. Best.[10] (It is what we use.[11]) No database is perfect, but NPDB seems uniquely bad. The bigger issue, however, is that CBO reaches conclusions on "payouts" that violate its own definition of direct costs.

Premiums. The only way to properly analyze the impact of "caps" on rates is to examine "pure premium" data (also known as "loss costs"). Loss costs isolate the part of the premium that companies use to pay, adjust and settle claims, including legal expenses, and it is what insurance companies and state insurance departments actually rely upon to determine rates.[12] (It is what we

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[6] Emphasis added.

[7] *See*, *e.g.*, Tom Baker and Charles Silver, "How Liability Insurers Protect Patients and Improve Safety," 68 *DePaul L. Rev* 209 (2019), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3220642 ("[P]ayments rarely exceed primary carriers' policy limits, even when jury verdicts establish that the legal value of plaintiffs' claims is far higher"; "when the providers are independently-employed physicians, insurers provide all but a minute fraction of the dollars that are paid.")

[8] U.S. Government Accountability Office, *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability*, GAO-01-130, November 17, 2000, https://www.gao.gov/products/GAO-01-130

[9] According to researchers, "The shield is employed when 'the medical corporation for which the doctor works is named in the suit, and the doctor is either not originally named or is released specifically for the purpose of avoiding a report to the NPDB.' Although the extent to which this tactic reduces the number of payments that are reportable to the NPDB is not known, some authors believe that one-half of otherwise reportable adverse events are deflected by this means." Tom Baker and Charles Silver, "How Liability Insurers Protect Patients and Improve Safety," 68 *DePaul L. Rev* 209 (2019), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3220642

[10] This data should then be controlled by the number of doctors and by medical care inflation or the Urban Consumers Inflation Index (Bureau of Labor Statistics).

[11] Best will calculate and license state by state breakdowns. *See* Americans for Insurance Reform, *Stable Losses/Unstable Rates 2016* (November 2016), http://centerjd.org/system/files/MasterStablelosses2016F9.pdf

[12] Pure premium data are compiled by a private company called the Insurance Services Office (ISO), which has the largest database of audited, unit transaction insurance data of any entity in the United States. ISO uses its data in its filings with state insurance departments on behalf of the insurance companies using their services. The results are

use in finding that caps have no impact on rates.[13]) CBO did not do that, relying instead on data that are loaded with uncontrolled variables that have nothing to do with the tort system or settlement costs, including profit, commissions, other acquisition expenses, general expenses and taxes, which can vary state to state.[14] Any conclusions reached by examining this data is simply wrong.

MEDICAL LIABILITY INSURANCE

In our experience, it is rare to find an academic or scholar versed generally in medical malpractice who has any understanding whatsoever of the unique and specialized medical malpractice insurance market. Unfortunately, those seeking to understand this market usually turn to medical and insurance lobbyists or trade associations for explanations as to why doctors' insurance rates go up and down. The lobbyists always offer one explanation: claims and lawsuits. There is no question that this explanation is in furtherance of a lobbying agenda to reduce claims by capping damages, at which they have been quite successful around the country.[15] Historically, policymakers have difficulty challenging the industry's explanation for rate variations for several reasons: the market is too complex for most policymakers to understand; state laws rarely force even licensed insurance companies to disclose meaningful information to authorities that could substantiate or refute their allegations about the financial health of the industry or the impact of the U.S. civil justice system; and the federal McCarran-Ferguson Act exempts the insurance industry from anti-trust laws, allowing companies to collude on important components of insurance prices, an anti-competitive practice that is illegal for other industries.

As a result, explanations that lobby groups consistently offer about rates are usually blatantly misleading.[16] Consider the last hard insurance market, a period also considered by CBO. In a 2005 study of the 15 leading medical malpractice insurance companies, former Missouri Insurance Commissioner Jay Angoff found that between 2000 and 2004 (in the midst of the last hard market), the amount that major medical malpractice insurers collected in premiums more than doubled while their claims payments remained essentially flat. (Notably, Angoff was one of the experts I brought to meet with CBO in 2009; our input was ignored.[17]) The report also found that many insurers substantially increased their premiums while their claims payouts were decreasing, and that some insurers also reduced projections of their ultimate payouts while increasing their premiums. In addition, the leading malpractice insurers accumulated record amounts of surplus – the extra cushion insurers hold in addition to the amount they have set aside

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pure premium changes approved by state insurance departments, which then are used by many insurance companies in their pricing models. If ISO data were unavailable to CBO, then the only credible place to find pure premium data is with a state insurance department. But any other data source will result in a flawed analysis.

[13] *See* Americans for Insurance Reform, *Premium Deceit 2016* (November 2016), http://centerjd.org/system/files/MasterPremiumDeceit2016F3.pdf

[14] Apparently, CBO relied on data collected by the National Association of Insurance Commissioners and perhaps Medical Liability Monitor (MLM), although it is unclear.

[15] *See, e.g.* Americans for Insurance Reform, *Premium Deceit 2016* (November 2016), http://centerjd.org/system/files/MasterPremiumDeceit2016F3.pdf

[16] *See* Americans for Insurance Reform, *Stable Losses/Unstable Rates 2016* (November 2016), http://centerjd.org/system/files/MasterStablelosses2016F9.pdf.

[17] *See,* "What I've Learned About the Congressional Budget Office and Health Care," *Huffington Post*, March 18, 2010, https://www.huffpost.com/entry/what-ive-learned-about-th_b_391034

to pay estimated future claims – during the prior three years.[18] In other words, insurance industry explanations for the need to raise rates were contradicted by actual data and experience.

As noted earlier, there are substantial problems with the data used by CBO regarding both its payout and premium figures. But indeed, every part of CBO's estimate on the insurance liability side is troubling, most particularly premium estimates. For example, when a state enacts a cap, insurers do not pass on savings to policyholders unless they are forced to do so, which is exceedingly rare. That is why industry insiders have repeatedly said that capping damages will not lower insurance rates.[19] In fact, accurate studies of state rate activity (pure premiums or loss costs) going back to 1999 and through 2015 have found no correlation between the enactment of caps and insurance rates.[20] In the period examined by CBO, data show that states that enacted or lowered caps saw an average 21.8 percent decrease in pure premiums from 2002 to 2016 – but the states that did nothing saw an even greater average drop of 28.9 percent.[21]

The reasons for this are clear. Rate activity is linked to the economic cycle of the insurance market. It is further influenced by whether a state has the authority to force the industry to disclose information, as well as to control the cycle through regulation.

To further explain, industry profit levels are cyclical, with insurance premium growth fluctuating during hard and soft market conditions. The periodic premium spikes that doctors experience, as they did most recently from around 2002 until 2006, are not related to claims but to the economic cycle of insurers. When investment income decreases because the stock market plummets (or as in past cycles, interest rates drop) and/or cumulative price cuts make profits unbearably low (competitive underpricing of policies characterizes soft markets, as exists today), the industry responds by sharply increasing premiums and reducing coverage, creating a "hard market." For policyholders, a "liability insurance crisis" is the result. Caps will not stop or even temper the impact of this.[22]

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[18] Jay Angoff, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry* (July 2005), http://centerjd.org/system/files/ANGOFFReport.pdf

[19] *See* Center for Justice & Democracy "Fact Sheet: 'Caps' Do Not Lower Insurance Premiums for Doctors (and Insurance Insiders Admit It)," April 12, 2011, https://centerjd.org/content/fact-sheet-caps-do-not-lower-insurance-premiums-doctors-and-insurance-insiders-admit-it

[20] *See, e.g.* Americans for Insurance Reform, *Premium Deceit 2016* (November 2016), http://centerjd.org/system/files/MasterPremiumDeceit2016F3.pdf; Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), https://www.insurance-reform.org/studies/TrueRiskF.pdf; Americans for Insurance Reform, *Premium Deceit 2002* (February 2002), https://centerjd.org/content/study-premium-deceit-failure-tort-reform-cut-insurance-prices

[21] Americans for Insurance Reform, *Premium Deceit 2016* (November 2016), http://centerjd.org/system/files/MasterPremiumDeceit2016F3.pdf

[22] Missouri's experience is illustrative. During the last insurance crisis (2002-2006), the state was identified by the AMA as a so-called "crisis state." Yet it had had a cap on non-economic damages since 1986. The cap started at $350,000 and was adjusted annually for inflation, reaching $557,000 in 2003. "New medical malpractice claims dropped 14 percent in 2003 to what the [Missouri Department of Insurance] said was a record low, and total payouts to medical malpractice plaintiffs fell to $93.5 million in 2003, a drop of about 21 percent from the previous year." And "the National Practitioner Data Bank, a federally mandated database of malpractice claims against physicians, found that the number of paid claims in Missouri fell by about 30 percent since 1991. The insurance department's database found that paid claims against physicians fell 42.3 percent during the same time period." Yet doctors' malpractice insurance premiums ***rose by 121 percent between 2000 and 2003.*** "State report says malpractice claims fell," *Associated Press*, November 5, 2004; Julie Kay, "Medical Malpractice; Despite Legislation that Promised to

Another economic pattern related to the hard and soft markets, which CBO does not address, is the manipulation of money insurers set aside as "reserves" for payment of future claims. During hard markets, insurers can vastly (and unnecessarily) increase reserves despite no increase in payouts or any trend suggesting large future payouts. This phenomenon seems often to be politically-inspired, used by insurers as a way to justify imposition of large premiums increases for doctors, and has been particularly problematic for high-risk specialties. It occurs whether or not a state caps damages. During subsequent soft markets, these reserves can be released through income statements as profits, as they are actually not needed to pay future claims. None of these factors, including how each individual state insurance department handles these trends or reacts to the hard and soft markets, are controlled for in CBO's work.

CBO's methodological failures here also beg the question: what happens when a hard market kicks in again? If 40 years of historical experience is any guide, there will soon come a time when rates around the nation will suddenly increase, whether or when a state has capped damages. [23] For CBO and policymakers, this should at least be acknowledged. The only proven solution to prevent this is stronger insurance department regulation and oversight.

MEDICARE AND MEDICAID

CBO devotes most attention to so-called "indirect costs" of malpractice liability as they affect "treatment behavior," like the ordering of tests. It says these costs "could have much greater potential to affect health care spending" and focuses on the two largest federal health programs: Medicare and Medicaid. CBO finds that caps "reduce spending by about 1 percent" for Medicaid and private insurance and have no impact on Medicare spending. Yet the journey to reach even that tiny number is tortured.

If I understand this correctly, CBO decided that the impact of tort restrictions on a physician's diagnostic testing behavior (it identifies four contradictory types, including tests done for financial profit) is so "theoretically ambiguous" when it comes to spending as to be empirically useless. Instead, it tries to find a spending impact based on empirical studies, but they're all inconsistent. CBO also admits that spending data in these studies "do not include enough information on patient health and quality of treatment delivered," so we have no real idea if testing or treatment examined in these studies is appropriate or not.

Of these studies, CBO seems to discount the only truly robust analyses, which examine Medicare spending. They happen to contradict CBO's ultimate conclusion since they find that caps may

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Rein in Physicians' Insurance Premiums, Three Firms File for Big Rate Increases," *Palm Beach Daily Business Review*, November 20, 2003; Missouri Dep't of Ins., *Medical Malpractice Insurance in Missouri; The Current Difficulties in Perspective* (February 2003).

[23] *See, e.g.* Americans for Insurance Reform, *Premium Deceit 2016* (November 2016), http://centerjd.org/system/files/MasterPremiumDeceit2016F3.pdf; Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), https://www.insurance-reform.org/studies/TrueRiskF.pdf; Americans for Insurance Reform, *Premium Deceit 2002* (February 2002), https://centerjd.org/content/study-premium-deceit-failure-tort-reform-cut-insurance-prices

cause *higher* Medicare spending.[24] CBO then seems to try to find Medicaid data to examine instead, but reliable data do not exist. That means it either must extrapolate from other studies or give up. It decides to extrapolate.

But rather than extrapolating from the "comprehensive high-quality" Medicare studies (mentioned above), it extrapolates from a comparatively low-quality, sometimes "implausible" private insurance study to conclude that caps lead to lower spending. Yet it also admits that such a finding is "fundamentally untestable," and "it is always possible that unobserved factors … are driving the observed difference is spending."

The reasons for ignoring robust studies using Medicare data seem at least partly based on conjecture: "elderly" people are less likely to sue, reducing liability pressure on doctors who treat them. A creepier way to put this would be that physicians are sloppier when it comes to Medicare patients since the deterrent potential of the liability system is not functioning. There is no evidence that this is true. But devaluing the Medicare data seems wrong for other reasons. Medicare covers anyone 65 and over (and some younger people as well), many of whom still work. They are not all elderly. Moreover, it would seem equally compelling, or at least worth mentioning, that young people have disproportionately less interaction with the health care system than those who are older, so their chance of encountering negligence is also far less likely. And while it is true that noneconomic damages caps have a disproportionate impact on seniors, the same is true for women, children and low income people.[25] When it comes to the liability pressure on doctors, there would seem to be good reason to attach more weight to studies based on Medicare data than CBO currently does.

Finally, we are concerned that once again, CBO ignores any consideration of new financial burdens on the government caused by tort restrictions. As CBO itself has long recognized, paid claims are transfer payments, not new costs.[26] Laws that block them shift costs of an injury from the culpable provider onto either the victim or the government, as Medicare or Medicaid can end up covering costs of an injury. It should also be noted that whenever there is a successful medical malpractice lawsuit, Medicare and Medicaid can both claim liens or subrogation interests in whatever the patient recovers, reimbursing the government for some of the patients' health care expenditures. If lawsuits are blocked, the government loses money. None of these added costs are considered by CBO.

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[24] *See, e.g.,* Bernard S. Black, David A. Hyman and Myungho Paik, "Damage Caps and Defensive Medicine, Revisited," 51 *J. Health Econ.*84 (January 2017), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2110656. CBO says, "Taken together, in CBO's assessment, those two [Medicare] studies are the best recent evidence available on the effects of noneconomic damage caps on overall health care spending because they used comprehensive spending data and showed support for the necessary parallel trends assumption."

[25] Center for Justice & Democracy, "Fact Sheet: Compensation Caps – The War on Women, Children, Seniors and the Poor," https://centerjd.org/content/fact-sheet-compensation-caps-%E2%80%93-war-women-children-seniors-and-poor

[26] *See*, *e.g.*, Congressional Budget Office, *The Economics of U.S. Tort Liability: A Primer* (October 2003). ("[S]ome direct 'costs' merely shift money from injurers to victims and thus are not true costs to society as a whole. In economic terms, payments that do not involve any use of resources to produce goods or services are called 'transfer payments.' … Specifically*, the portion of a settlement or judgment that goes to the plaintiffs is a transfer payment*." [emphasis added].)

Finally, while we recognize that CBO has been asked to do a job, serious questions must be asked as to why it is proceeding when so many assumptions are variously described as "fundamentally untestable," "theoretically ambiguous" and "imprecisely estimated."

We would be happy to answer any questions about any of this information. Thank you again for your time and consideration.

Very sincerely,

Joanne Doroshow
Executive Director