

The Top 15 Things We Learned From Our Deep Dive Into CBO's New Medical Malpractice Working Paper

In April 2019, the Congressional Budget Office (CBO) issued a new “preliminary” analysis of the potential impact of federal medical malpractice legislation on federal health care spending.¹ Without knowing anything else about this densely written 49-page study, there are three important takeaways:

- CBO has slashed nearly in half its estimate of health care savings from this legislation;
- Probably 90 percent of the medical malpractice “tort reform” provisions in bills that Congress has considered over the last two decades would have no impact on health care costs; and
- Caps on attorneys’ fees cut revenue, not spending. In other words, those laws don’t save money, they cost money.

Instead of CBO’s highly-secretive 2009 approach to this topic, consisting of a seven-page public letter² containing very suspect conclusions with no empirical data,³ this time CBO has issued a “Working Paper” to enhance transparency and encourage external review. It’s an admirable goal, even though the paper’s difficult writing style and charts are clearly not written for laypeople tasked with developing actual policy, or at least those without PhDs in math and economics. That said, transparency has at least revealed more about CBO’s methods, including some new insights into its extremely flawed and appropriately-criticized 2009 approach.⁴

¹ See Karen Stockley, “How Do Changes in Medical Malpractice Liability Laws Affect Health Care Spending and the Federal Budget?” Congressional Budget Office Working Paper 2019-03 (April 2019), <https://www.cbo.gov/publication/55104>

² Congressional Budget Office, “CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (‘Tort Reform’),” October 9, 2009, <http://www.cbo.gov/publication/41334>

³ See, e.g., Joanne Doroshow, “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 (“When Senator Jay Rockefeller (D-WV) asked CBO for a ‘complete empirical analysis of the cost savings associated with medical malpractice reforms,’ CBO’s response was another seven-page letter without any empirical analysis or data.”)

⁴ Says CBO, “The most recent evidence indicates that changes in traditional malpractice liability laws have a smaller effect on health care spending than the available evidence indicated when CBO last comprehensively updated its

It appears that CBO has completely revamped its methodology based on new studies. The lower overall “savings” number is the result of CBO greatly reducing the programs it believes would be affected by federal medical malpractice legislation, particularly Medicare. Notably, while finding no evidence of any impact on Medicare spending, it also devalued findings from recent robust studies, done with “comprehensive high-quality data” and estimated with “reasonable precision,” demonstrating that caps on damages may actually cause *higher* Medicare Part B spending.⁵ And there are other problems with this new score. In our view, while lower than before, this estimate is still far too high.

We know that CBO has asked insurance industry lobbyists for assistance and feedback, which is not surprising given how little CBO (or economists and scholars on which it heavily relies) seems to understand about what actually drives liability insurance rates.⁶ The insurance industry is never honest about this, and we expect nothing different from whatever interactions it may have with CBO.⁷

Unlike the insurance industry, we have not been asked for feedback. Nonetheless, we have prepared an initial analysis. Here are the top 15 things we’ve learned from the new report:

ITEMS 1-7: GENERAL TAKEAWAYS

1. CBO now estimates that if Congress imposed an extreme menu of tort restrictions on every state, even those that are unconstitutional, federal health care savings would total a mere \$28 billion over 10 years. This is nearly half its prior estimate of \$54 billion in total health care savings.⁸ Both estimates amount to a tiny 0.5 percent in savings.

approach. As a result, CBO estimates substantially lower estimated reductions in federal spending under the updated modeling approach than under the modeling approach used from 2009 to 2018.”

⁵ 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

⁶ See Comments of Brian Atchinson, President & CEO, Medical Professional Liability Association, “A.M. Best State of the Medical Professional Liability Market 2019 Webinar,” May 7, 2019.

⁷ Unfortunately, lawmakers and regulators often turn to medical and insurance lobbyists for explanations as to why doctors’ insurance rates go up and down. The lobbyists always have one explanation: claims and lawsuits. Yet this is never true. See Americans for Insurance Reform, *Stable Losses/Unstable Rates 2016* (November 2016), <http://centerjd.org/system/files/MasterStablelosses2016F9.pdf>. For example, 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 – a period also examined by CBO – the amount that major medical malpractice insurers collected in premiums more than doubled while their claims payments remained essentially flat. 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 to pay estimated future claims – during the prior three years. Jay Angoff, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry* (July 2005), <http://centerjd.org/system/files/ANGOFFReport.pdf>

⁸ Congressional Budget Office, “CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (‘Tort Reform’),” October 9, 2009, <http://www.cbo.gov/publication/41334>

2. There is no evidence that five of the six extreme tort restrictions examined by CBO,⁹ which are also part of the latest federal legislation passed by the U.S. House in 2017,¹⁰ have any impact on health care spending.¹¹ If members of Congress think most of this legislation saves health care costs, they have been misled.
3. One of the six tort restrictions – a cap on attorneys’ fees – would have the opposite budgetary impact than proponents suggest. Not only would this provision have no impact on federal health care spending, it would cost the government money.¹² (By this reasoning, any state that currently has an attorneys’ fee cap is costing the state money.)
4. Although CBO finds that attorneys’ fee caps cut *revenue* (not spending), this point is nearly impossible to deduce from the report.¹³ Given the politicized nature of this tort restriction, which was not even included in CBO’s original 2009 analysis, it is disturbing that CBO would not make its budgetary impact clearer to lawmakers. While CBO’s writing may be due to sloppiness or political naiveté, it also suggests bias.
5. Reeking of bias (but again, perhaps just sloppiness or political naiveté) is CBO’s use of misleading industry language to describe tort laws, instead of accurate legal descriptions used by the very studies on which it relies. This undermines CBO’s credibility for no reason and should be changed.¹⁴
6. Buried in the Working Paper and almost as an aside, CBO accepts the finding of other recent studies showing that imaging and testing actually *increase* after a state enacts a

⁹ The six tort restrictions examined by CBO are: 1) a \$250,000 cap on non-economic damages; 2) a \$500,000 cap or two times the amount of economic damages; 3) repeal of the collateral source rule; 4) one-year date of discovery statute of limitations (3 years for children); 5) repeal of joint and several liability; and 6) newly added to the analysis – a percentage cap on attorneys’ fees, which grows higher the larger the award.

¹⁰ H.R. 1215, 115th Congress.

¹¹ CBO says, “Few studies estimate the effect of other liability laws on spending, and studies that do so find zero or inconsistent evidence of an effect on spending.” The impact of these measures is also described as having “no measurable effect on liability pressure,” no “consistent evidence” and “would not affect the deficit.”

¹² CBO says, “[B]ecause caps on attorneys’ fees would reduce attorneys’ taxable income, revenues would be reduced under proposals that include that policy. Capping attorneys’ fees would not affect federal spending.”

¹³ For example, the following two paragraphs follow each other on page 24 of the Working Paper, exactly as worded (emphasis added): 1. “In CBO’s view, no consistent evidence exists to indicate that changes to other traditional liability laws (punitive damage caps, modifications to collateral source rules, modifications to joint and several liability, *attorney fee caps*, and shortening statutes of limitations) reduce health care spending. That assessment is based on CBO’s review of the research literature and analyses conducted by the agency.” 2. “CBO now estimates that enacting federal malpractice legislation CBO’s that caps noneconomic damages at \$250,000 and *caps attorneys’ fees* would reduce the federal budget deficit by \$27.9 billion over 10 years.”

¹⁴ 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).

cap.¹⁵ This undermines a major political talking point used by “tort reform” proponents, *i.e.*, the reduction of so-called “defensive medicine.”

7. Caps on non-economic damages are the only tort restriction that CBO is willing to even consider scoring.¹⁶ However, the effort to try to reach a precise number is convoluted. In CBO’s own words, many of its assumptions are variously described as “fundamentally untestable,” “theoretically ambiguous” and “imprecisely estimated.” Serious questions must be asked as to why CBO is even engaged in this exercise when its conclusions are largely based on guesswork. The responsible course of action would have been to simply walk away.¹⁷

ITEMS 8-10: DATA PROBLEMS

We commend CBO for changing its modeling approach to one that actually tries to examine state experiences. More specifically, much of the new analysis is an attempt to compare the experiences of states that have capped damages to those that have not. While this is an appropriate goal, there are fundamental problems with CBO’s methodology, namely miscataloging states, relying on incorrect payout data and relying on incorrect premium data.

8. CBO’s entire analysis and precise score depends 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:
 - a. North Carolina is coded as a “cap” state. But as the database on which CBO relies notes in its explanatory list of “concerns,”¹⁸ in some states, “Caps [are] lifted

¹⁵ CBO puts it this way: “[A]lthough both theory (Frakes 2015) and anecdotal evidence indicate that laws that lower malpractice liability, such as noneconomic damage caps, would be expected to (weakly) reduce utilization of imaging and testing services, CBO estimates modest increases in the utilization rates of those services after the enactment of noneconomic damage caps (estimates not shown).” Indeed, as other researchers have said, “An often proposed remedy [to so-called ‘defensive medicine’] is caps on non-economic damages.... We report evidence, from a careful study with a large, patient level dataset, of a more complex and nuanced response to caps. Rates for cardiac stress tests and other imaging tests appear to rise, instead of falling, and overall as does Medicare Part B lab and radiology spending. Yet cardiac interventions do not rise, and likely fall. There is no evidence of a fall in overall Medicare spending and, consistent with a recent prior paper (Paik et al., 2017), some evidence of higher Part B spending.” Bernard Black, Steven Farmer and Ali Moghtaderi, “Damage Caps and Defensive Medicine: Reexamination with Patient Level Data,” Northwestern Law & Econ. Research Paper No. 16-xx, June 13, 2018, <http://ssrn.com/abstract=2816969>

¹⁶ CBO says, “[T]his paper presents only estimates of the effect of noneconomic damage caps.”

¹⁷ As one example, “CBO must therefore rely on empirical estimates to determine both the direction and magnitude of the effect of those laws on spending, with the expectation that the effects may differ depending on the type of care and patient population. Empirical studies cannot easily fully characterize the interpretation of the effect – that is, how much of a change in treatment is appropriate or inappropriate – because spending data do not include enough information on patient health and quality of treatment delivered.”

¹⁸ <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,

when injury is severe, so it is not clear they bind at all.” North Carolina should qualify for that category.¹⁹ This raises the question: if the cap is not operating in most cases, what impact could it have?

- b. 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*.²⁰
 - c. 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 clearly improper. Pennsylvania’s Constitution actually prohibits caps. (Also note that Ohio’s Constitution prohibits caps in wrongful death cases.)
 - d. Because Arkansas, Maine, Kansas, Idaho, West Virginia and Missouri have “missing or unreliable” Medicaid data, they were entirely excluded from that 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.
9. 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*.” Of course, payouts *not covered by insurance* is critical here, since the question CBO is examining is 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.²¹ But *CBO obviously 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, it says it is using data from the National Practitioner Data Bank (NPDB), a data source plagued by longstanding underreporting

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.)

¹⁹ 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

²⁰ 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>

²¹ 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.”)

problems.²² These problems are growing due to the migration of doctors into hospital systems and hospitals' use of the "corporate shield" to avoid NPDB reporting.²³ 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.²⁴ (It is what we use.²⁵) 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.

10. 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.²⁶ (It is what we use in finding that caps have no impact on rates.²⁷) 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.²⁸ Any conclusions reached by examining this data is simply wrong.

ITEMS 11-12: IGNORING NEW COSTS

11. 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.²⁹ Laws that block them shift costs of an injury from the

²² 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>

²³ 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

²⁴ 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).

²⁵ 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>

²⁶ 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 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.

²⁷ See Americans for Insurance Reform, *Premium Deceit 2016* (November 2016), <http://centerjd.org/system/files/MasterPremiumDeceit2016F3.pdf>

²⁸ Apparently, CBO relied on data collected by the National Association of Insurance Commissioners and perhaps Medical Liability Monitor (MLM), although it is unclear.

²⁹ See, e.g., Congressional Budget Office, *The Economics of U.S. Tort Liability: A Primer*. Washington, D.C.: 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].)

culpable provider onto either the victim or the government, as Medicare or Medicaid can end up covering the costs of an injury.³⁰ 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.

12. CBO also again fails to consider how caps weaken the deterrent potential of the tort liability system, leading to new costs associated with increased patient harm. It shelved any consideration of this problem because one study dismissed it.³¹ Yet there exists an extremely credible study, ignored by CBO, which shows the exact opposite – that patient harm *increases* when states cap damages.³² Notably, in its 2009 analysis, CBO at least acknowledged this possible impact,³³ but it failed to address it in any cost calculations. Any legitimate analysis of tort system costs must consider the countervailing cost benefits of a fully-functioning legal system without so-called “tort reform.” Those costs might include future injuries and deaths prevented, health care costs (*i.e.*, cost and physician utilization inherent in caring for newly maimed patients) not expended and wages not lost.

ITEM 13: DIRECT COSTS – MEDICAL MALPRACTICE PREMIUMS

Although CBO “estimates that noneconomic damage caps significantly decrease medical malpractice liability and costs, as measured by malpractice claim payouts and premiums,” it also admits that these costs are a “relatively small component of health care spending,” so if caps lower direct health care costs at all, it’s “by only a small amount.” Nonetheless, CBO tries to score it. As noted earlier, there are substantial problems with the data used by CBO regarding

³⁰ See Joanne Doroshov, “Medical Malpractice – The Tragic Human Price Tag of ‘Tort Reform,’” *Huffington Post*, April 26, 2010, https://www.huffpost.com/entry/medical-malpractice-the_b_475374

³¹ CBO says, “Another possibility is that if lower liability causes physicians to reduce the quality of care for each service (for example, by spending less time or devoting less attention to a patient when providing a service), that could adversely affect patient health and consequently increase spending. However, Frakes and Jena (2016) examined the effect of noneconomic damage caps on quality of care and found no relationship.”

³² In their study, “The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform,” Professor Bernard S. Black and Dr. Zenon Zabinski found that: 1) “patient safety gradually worsens” after caps are passed; 2) the “decline is widespread, and applies both to aspects of care that are relatively likely to lead to a malpractice suit (e.g., PSI-5; foreign body left in during surgery), and aspects that are unlikely to do so (e.g., PSI-7; central-line associated bloodstream infection); 3) the “broad relaxation of care suggests that med mal liability provides ‘general deterrence’ – an incentive to be careful in general – in addition to any ‘specific deterrence’ it may provide for particular actions”; and 4) “state adoption of caps on non-econ damages in medical malpractice lawsuits predicts higher rates of preventable adverse patient safety events in hospitals.” Bernard S. Black and Zenon Zabinski, “The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform,” *Northwestern Law & Econ. Research Paper No. 13-09* (January 2019), <http://ssrn.com/abstract=2161362>

³³ In its 2009 letter, CBO noted, “The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses . . .” It admits that “imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes,” yet brushes aside the significance of this not because it is untrue, but because it says there are too few studies on the topic. Yet of the three studies that did address the issue of mortality, CBO noted that one study found such tort restrictions would lead to a .2 percent increase in the nation’s overall death rate.

both its payout and premium figures. However, there are other problems as well. Every part of its estimate is troubling, most particularly on the premium side.

13. When it comes to medical malpractice insurance premiums, it is not terribly surprising that CBO's understanding of the issue falls short. 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. That said, there is really no excuse for CBO to have attempted to score this cost without understanding how insurance works, leading to conclusions that are contradicted by 40 years of actual experience.³⁴ That experience shows three things:
 - a. 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.³⁵
 - b. 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.³⁶ 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.³⁷
 - c. As those numbers show, what *is* responsible for rate increases and decreases is the cyclical insurance market, and whether or not states have the authority to control

³⁴ This is not the first time we encountered this problem with CBO. See Joanne Doroshov, "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 ("When, for example, I raised the transparency issue and specifically asked how CBO could find a 0.2 percent savings due to lower medical malpractice insurance rates for doctors, when years of historical experience show this to be untrue, my comments were met with glares, not data.")

³⁵ 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>

³⁶ 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>

³⁷ Americans for Insurance Reform, *Premium Deceit 2016* (November 2016), <http://centerjd.org/system/files/MasterPremiumDeceit2016F3.pdf>

it through regulation.³⁸ History clearly shows that caps will not stop or even temper the impact of the industry's economic cycle.³⁹

ITEMS 14-15: INDIRECT COSTS – 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.

14. 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 even to get to that tiny number is a tortured analysis.
 - a. CBO decides 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.
 - b. 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.
 - c. Of these studies, it discounts the only truly robust analyses, which examine Medicare spending. They happen to contradict CBO's ultimate conclusion since they find that caps may cause *higher* Medicare spending.⁴⁰

³⁸ 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, the result is a “liability insurance crisis.”

³⁹ Missouri's experience is illustrative. During the last insurance crisis (2002-2006), the state was identified by the American Medical Association 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.” The insurance department's database found that paid claims against physicians fell 42.3 percent.” 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 Rein in Physicians' Insurance Premiums, Three Firms File for Big Rate Increases,” *Palm Beach Daily Business Review*, November 20, 2003; Missouri Department of Insurance, *Medical Malpractice Insurance in Missouri; The Current Difficulties in Perspective* (February 2003), <https://archive.org/details/2003MedMalInMO>

⁴⁰ See, e.g., Bernard S. Black, David A. Hyman and Myungho Paik, “Damage Caps and Defensive Medicine,

- d. CBO tries 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.
 - e. 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 in spending.”
15. CBO has decided to ignore the results of recent Medicare studies, none of which find that caps lead to lower health care spending and some of which find that caps may increase health care spending. Its reasons for doing this 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. 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.⁴¹ 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.

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.”

⁴¹ 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>