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## CRITIQUE OF OCTOBER 9, 2009, CBO LETTER TO SENATOR HATCH ON MEDICAL MALPRACTICE ISSUES

The Congressional Budget Office has presented a new analysis (in the form of a 7-page letter) of “the effects of proposals to limit costs related to medical malpractice (‘tort reform’),” finding that “tort reform could affect costs for health care.” It seems to base its new analysis on a small handful of studies, several of which are noted to contradict each other. One of them suggests that 50,000 more people could die in the next ten years (beyond the 98,000 that already die annually from medical errors<sup>1</sup>) should Congress further limit legal rights of patients.

### FINDINGS

Even with all of its flaws, which are explained below, the CBO’s findings are noteworthy for a number of reasons:

- **Cost Savings.** CBO finds that even if the country enacted the entire menu of extreme tort restrictions listed,<sup>2</sup> it can go no farther than to find an extremely small percentage of health care savings, “about 0.5% or \$11 billion a year at the current level -- far lower than advocates have estimated”<sup>3</sup> To put this in perspective, it totals about what Americans spend annually on dog and cat food.<sup>4</sup>
- **Defensive Medicine.** Despite much heated rhetoric about the widespread use of so-called “defensive medicine,” CBO finds little evidence of this except in studies of Medicare, not studies of private managed care systems.<sup>5</sup> Obviously doctors operate under the same liability rules no matter the patient’s age, so the explanation for this disparity cannot lie

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<sup>1</sup> *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 1999.

<sup>2</sup> A \$250,000 cap on non-economic damages, \$500 cap or two times the amount of economic damages, repeal of the collateral source rule, one-year date of discovery statute of limitations (3 years for children), and repeal of joint and several liability.

<sup>3</sup> Alexander C. Hart, “Medical malpractice reform savings would be small, report says,” *Los Angeles Times*, October 10, 2009; <http://www.latimes.com/news/nationworld/nation/la-na-malpractice10-2009oct10.0.4877440.story>

<sup>4</sup> Pet Food Institute, <http://www.petfoodinstitute.org/Index.cfm?Page=USPetFoodSales>

<sup>5</sup> This is consistent with other studies. When the GAO tried to find evidence of “defensive medicine,” they found instead, “Some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate defensive practices. According to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit.” *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003. See also, Dr. Atul Gawande, “The Cost Conundrum; What a Texas town can teach us about health care,” *New Yorker*, June 1, 2009 (“‘Come on,’ the general surgeon finally said. ‘We all know these arguments [about defensive medicine] are bulls\*\*t. There is overutilization here, pure and simple.’ Doctors, he said, were racking up charges with extra tests, services, and procedures.”)

with the legal system. Rather, according to CBO, the problem is Medicare's emphasis on "fee-for-service" spending, whereas private managed care "limit[s] the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as 'defensive medicine')." In other words, CBO virtually admits that to the extent defensive medicine exists at all, it can be controlled through simply managing care correctly as opposed to taking away patients' rights and possibly killing and injuring more people.

- **"Tort Reforms" Can Increase Costs, Not Save Them.** CBO's evidence suggests that the single most widespread "tort reform" currently on the books – limiting joint and several liability,<sup>6</sup> a measure that now exists in over 40 states<sup>7</sup> – has the *opposite* impact on costs, i.e., it "may increase the volume and intensity" of physician services. The only logical conclusion is that Congress should not enact this measure, and states should repeal these laws, as well.

## CRITIQUE

**Selection of "Tort Reforms."** To accomplish its predicted savings, CBO must envision such extreme restrictions on the legal rights of patients that likely no single state in the nation has imposed all of them collectively on patients in their states. Therefore, the selection of these particular tort restrictions is odd at best.

- Two items – a \$250,000 cap on non-economic damages with no exceptions<sup>8</sup> and one-year statute of limitations - have been rejected by the vast majority of states.<sup>9</sup>
- The \$250,000 cap was considered and rejected by the U.S. Senate out of hand - on Motions to Proceed - five times between 2003 and 2006, despite being pushed hard by President Bush and a then Republican Senate.<sup>10</sup>
- Many states have also declared unconstitutional caps, limits on joint and several liability, and repeal of the collateral source rule.<sup>11</sup>

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<sup>6</sup> For some reason, CBO has decided to adopt the spin of conservatives and Big Business by calling repeal of joint and several liability a "fair share" rule. This is outrageous - there is nothing "fair" about this for injured patients. The doctrine of joint and several liability has been part of the common law for centuries. It is a rule that applies to allocating damages when more than one defendant is found *fully responsible* for causing an entire injury. If one of them is insolvent or cannot pay compensation, the other defendants must pick up the tab so the innocent victim is fully compensated. Courts have *always* held that it applies only to injuries for which the defendant is fully responsible. That means that their negligent or reckless behavior must be an "actual and proximate" cause of the entire injury, a high standard. See, e.g., Richard Wright, "The Logic and Fairness of Joint and Several Liability," 23 *Memphis State Law Review* 45 (1992).

<sup>7</sup> See, e.g., Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, Appendix C, July 2009. <http://insurance-reform.org/pr/090722.html>.

<sup>8</sup> This kind of cap is one of the cruelest "tort reforms." A Rand study "found that the most significant impact of California's 29 year old medical malpractice caps law falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes."

<http://www.consumerwatchdog.org/patients/articles/?storyId=16557>

<sup>9</sup> For example, it is estimated that 90 percent of states have statutes of limitations for medical malpractice actions of two years or more. At least 90 percent have *not* enacted caps of \$250,000.

<sup>10</sup> The Senate failed to invoke cloture on 7/09/03 (S.11); 2/24/04 (S.2061); 4/07/04 (S.2207); 5/08/06 (S.22 and S.23). Most bills of these would have imposed non-economic damages caps of \$250,000 without any exceptions; some applied only to certain types of malpractice; some allowed a limited stacking of damages depending on the number of defendants. See, Dana Milbank, "Take Two of These and Call Us Next Year," *Washington Post*, May 9, 2006. <http://www.washingtonpost.com/wp-dyn/content/article/2006/05/08/AR2006050801317.html>.

<sup>11</sup> See, e.g., Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, Appendix C, July 2009. <http://insurance-reform.org/pr/090722.html>.

**Health Impact and Other Costs Ignored.** Given the extreme parameters CBO has established, the following observations cannot be ignored:

- **More could die and be injured, yet the costs of newly injured are ignored.** Inasmuch as these kinds of extreme “tort reform” would weaken the deterrent potential of the tort system, (which even CBO acknowledges<sup>12</sup> but does not consider in its cost calculations), with accompanying increases in cost and physician utilization inherent in caring for newly maimed patients and for care which ultimately leads to more deaths, it seems irresponsible for CBO to make legitimate claims of potential savings until it knows those added costs.
  - **Deaths.** Shockingly, the report 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 do address the issue of mortality, CBO notes that one study finds such tort restrictions would lead to a .2 percent increase in the nation’s overall death rate.<sup>13</sup> If true, that would be an additional 4,853 Americans killed every year by medical malpractice, or 48,250 Americans over the ten-year period CBO examines,<sup>14</sup>
  - **Injuries.** Based on these same numbers, another 400,000 or more patients could be injured during the 10 years examined by CBO (given that one in 10 injured patients die.<sup>15</sup>) The costs of errors, which the Institute of Medicine already puts between “\$17 billion and \$29 billion, of which health care costs represent over one-half,” would clearly increase.<sup>16</sup> Consider, for example, that the average length of stay per hospitalization is around 4.4 days<sup>17</sup> and the average cost per day in the hospital is around \$2,000 per day per injury.<sup>18</sup> Consider those costs on top of physician utilization inherent in caring for these new patients. And those costs do not consider lost contributions to the workforce and tax revenues for the most seriously injured who cannot work, or for those who have died.<sup>19</sup>

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<sup>12</sup> In its letter, CBO notes, “The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses ...” For example, the Harvard Medical Practice Study, on which the Institute of Medicine based in part its seminal 1999 book *To Err Is Human, Building a Safer Health System*, found, “[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.” Similarly, an article in the May 11, 2006, the *New England Journal of Medicine* argued that litigation against hospitals improves the quality of care for patients. The author noted, “Anesthesiologists were motivated by litigation to improve patient safety. As a result, this profession implemented 25-years-ago, a program to make anesthesia safer for patients and as a result, the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000.” George J. Annas, J.D., M.P.H., “The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” *New England Journal of Medicine*, May 11, 2006.

<sup>13</sup> CBO says, “[t]here is less evidence about the effects of tort reform on people’s health, however, than about the effects on health care spending – because many studies of malpractice costs do not examine health outcomes.”

<sup>14</sup> Based on 2,426,264 deaths according to the Center for Disease Control and Prevention.  
<http://www.cdc.gov/nchs/FASTATS/deaths.htm>

<sup>15</sup> Study of California hospitals cited in Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press, 2005.

<sup>16</sup> *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 1999.

<sup>17</sup> [http://www.cdc.gov/nchs/data/injury/InjuryChartbook79-01\\_UtilPayment.pdf](http://www.cdc.gov/nchs/data/injury/InjuryChartbook79-01_UtilPayment.pdf)

<sup>18</sup> <http://www.rtihs.org>

<sup>19</sup> The U.S. work force is 154.3 million including unemployed workers generating a gross domestic product of \$14.26 trillion. As such, each worker, including the unemployed is responsible for \$92,417 of the GNP.

<https://www.cia.gov/library/publications/the-world-factbook/geos/us.html>

- **Other studies not considered by CBO show the beneficial impact of lawsuits on health outcomes.** For example, in one August 2009 study, researchers found that in 86 percent of obstetrical cases they examined, “improved health outcomes associated with medical malpractice pressure” led to cost-savings in the health sector and these cost-saving *exceeded* any marginal costs of defensive medicine, leading also to “an improvement in net social benefits rather than a decline, as should be the case for defensive medicine.”<sup>20</sup>
- **CBO claims federal government spending will decrease by \$41 billion while revenue will increase \$13 billion,<sup>21</sup> yet direct financial burdens on the government should these laws pass are not recognized by CBO.**
  - **New Burdens on Medicaid.** If someone is brain damaged, mutilated or rendered paraplegic as a result of the medical negligence but cannot obtain compensation from the culpable party through the tort system, he or she may be forced to turn elsewhere for compensation, particularly Medicaid. None of these increased Medicaid costs are considered.
  - **Liens and Subrogation.** Whenever there is a successful medical malpractice lawsuit, Medicare and Medicaid can both claim either liens or subrogation interests in whatever the patient recovers, reimbursing the government for some of the patients’ health care expenditures. Without the lawsuit, Medicare and Medicaid will lose funds that the government would otherwise be able to recoup. Again, none of these lost funds are factored in by the CBO.
  - **Other Countervailing Tort System Benefits Are Overlooked.** Any legitimate analysis of tort system costs must consider the countervailing cost benefits of the legal system due to its deterrence function - future injuries and deaths prevented, health care costs not expended, wages not lost.
    - Even Tillinghast Towers Perrin, which annually issues bloated “tort cost” (based on insurance cost) figures each year, qualifies its numbers by noting it fails to factor in the benefits or cost-savings from the tort system. For example, in a 2006 report, Tillinghast noted, “this study does not attempt to quantify the benefits of the tort system. Such benefits include a systematic resolution of disputes, thereby reducing conflict, possibly including violence. Another indirect benefit is that the tort system may act as a deterrent to unsafe practices and products. From this perspective, compensation for pain and suffering is seen as beneficial to society as a whole.”<sup>22</sup>

**Direct Savings Due to Reduced Liability Premiums?** CBO finds that its package of “tort reforms” would lower medical liability insurance premiums by about 10 percent. After concluding that that medical malpractice liability (premiums, claims and expenses) “totals approximately \$35

<sup>20</sup> Praveen Dhankhar, Mahmud Khan, “Threat of Malpractice Lawsuit, Physician Behavior and Health Outcomes: A re-evaluation of practice of ‘Defensive Medicine’ in Obstetric Care,” Tulane University - Health System Management Area, August, 03 2009. [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1443555](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1443555)

<sup>21</sup> This number seems somewhat farfetched. It is based on the theory that savings, which are assumed, will find their way into the pockets of wage earners and, as such, become taxable. Moreover, it assumes these “savings” rise steadily each year, suggesting that the practice of medicine will so change based upon these tort restrictions that there will be a never ending increase in the savings, or that the cost to the government for health care will increase each year and, as such, the dollar figure of the “savings” will proportionately increase. In any event, if there is raw data to support this number, it is certainly not provided here.

<sup>22</sup> U.S. Tort Costs and Cross Border Perspectives: 2005 Update, at 11.

billion or 2 percent of health care expenditures.” CBO concludes that a 10 percent premium drop would reduce national health care expenditures by about 0.2 percent - or \$4.4 billion.

CBO provides no raw data to back up such a number, nor explanations nor sources, and while also noting that many states have already enacted these laws,<sup>23</sup> there is no indication how CBO incorporated the cost impact of already existing state laws into its figures. Moreover, given that CBO’s assertions about the direct connection between tort laws to premiums contradicts 30 years of liability premium insurance history and experience,<sup>24</sup> this calculation is troublesome.

- **Insurance Cycle Ignored.** It is remarkable that CBO draw such a far-reaching conclusion about liability insurance premiums without even mentioning the well-known insurance cycle, which results in cost increases or decreases having nothing to do with the tort system.<sup>25</sup>
- **Actual experience in states is ignored.** Some states with little or no restrictions on patients’ legal rights have experienced the same level of liability insurance rate changes as those states that enacted severe restrictions on patients’ rights.<sup>26</sup> For example:
  - Compare Missouri and Iowa, two neighboring states. Missouri has had a cap since the mid-1980s, as well as other “tort reform” in medical malpractice cases. Iowa has never had a cap. In the last five years, Missouri’s pure premium increased 1 percent. Iowa’s dropped 6 percent.<sup>27</sup>
  - Among states that had the highest pure premium increases - more than 5 percent in the last five years - were states with significant medical malpractice limits like Florida, Nevada, and Utah.<sup>28</sup>
  - The country has been in a “soft” insurance market for several years now, so premiums have stabilized irrespective of whether “tort reforms” were enacted.<sup>29</sup>
- **CBO’s “medical malpractice liability” number - \$35 billion - makes no sense.**
  - In 2008, doctors paid about \$11 billion in medical malpractice premiums. Direct paid losses (i.e., for all claims) were about \$5 billion, according to A.M. Best

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<sup>23</sup> A significant adjustment of costs would be required. While only a handful of states have a \$250,000 cap and one-year statute of limitations, over 40 states have limited joint and several liability for medical malpractice cases (which CBO says *increases* costs), 26 have limited punitive damages and 37 have repealed the collateral source rule.

<sup>24</sup> See, Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. <http://insurance-reform.org/pr/090722.html>

<sup>25</sup> Insurance is a cyclical business. Its costs are cyclical as well. Three times in the last 35 years, insurance policyholders have experienced particularly large and sudden rate hikes. This is typical of what policyholders experience during the so-called “hard market” part of the insurance industry’s cycle. The cause of the hard market is always the same: a drop in investment income for insurers compounded by underpricing in prior years. When investment income drops, insurers always respond the same way: by reducing coverage, canceling policies and/or raising premiums, often dramatically. During hard market periods, insurers typically will fix their balance sheet to show an increase in “reserves” to pay claims. The increases in reserves are not the result of actual increases in claims or payouts (e.g., lawsuits, jury verdicts or other tort system costs.) Rather, they are an accounting device used by insurers to make up for previous inadequacies in reserves, hide excessive profits and justify price increases. For more detailed explanation of how the insurance cycle works, see Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. <http://insurance-reform.org/pr/090722.html> and Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press, 2005, at 45 et at.

<sup>26</sup> Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. <http://insurance-reform.org/pr/090722.html>

<sup>27</sup> *Ibid.*

<sup>28</sup> *Ibid.*

<sup>29</sup> *Ibid.*

figures.<sup>30</sup> In order to reach \$35 billion, expenses to settle claims would have to approach \$19 billion a year, more than total premiums and claims combined. This is absurd.

- It is possible that CBO based its numbers on discredited,<sup>31</sup> overinflated “tort cost” figures issued by the insurance-consulting firm, Tillinghast Towers Perrin, which pegged 2007 medical malpractice “tort costs” at \$30.4 billion. In addition to finding these numbers highly-exaggerated, one of the critiques of Tillinghast is that it “makes unfounded assumptions, adjusts figures without any basis, and fails to provide explanations or sources.”<sup>32</sup> The same can be said for this CBO analysis.

**The Re-emergence of the Long-Disputed Kessler McClellan Study.** The Kessler McClellan study is a study that CBO previously rejected, as have many other experts, but now seems to accept as evidence. CBO even cites it to contradict other new evidence showing an expected increased mortality due to enactment of malpractice tort limits.

- Kessler McClellan, the leading study relied upon by the Bush administration to attack the civil justice system and referenced in its controversial Department of Health and Human Service report on medical malpractice,<sup>33</sup> was written by Daniel P. Kessler and Mark McClellan. McClellan was then President Bush’s “top health care policy advisor and later headed the federal agency that runs Medicare.”<sup>34</sup>
- The Bush administration’s HHS report cited Kessler McClellan for the ridiculous proposition that “limiting unreasonable awards for non-economic damages could reduce health care costs by 5-9% without adversely affecting quality of care. This would save \$60-108 billion in health care costs each year.”<sup>35</sup>
- University of Pennsylvania Professor Tom Baker, in his book on medical malpractice, called Kessler and McClellan’s figures “fanciful and misleading” and said they “crossed the line between social science and advocacy.”
- The General Accountability Office said any findings in this study were so narrow that “it cannot be extrapolated to the larger practice of medicine.”<sup>36</sup>
- And in 2004, the Congressional Budget Office itself rejected it for estimating costs of defensive medicine.<sup>37</sup>

That CBO now finds this study worth citing is curious, at best.

October 13, 2009

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<sup>30</sup> Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. <http://insurance-reform.org/pr/090722.html>

<sup>31</sup> See, e.g., [http://centerjd.org/archives/issues-facts/stories/MB\\_2007costs.php](http://centerjd.org/archives/issues-facts/stories/MB_2007costs.php)

<sup>32</sup> See., e.g., [http://www.centerjd.org/air/pr/Tillinghast\\_Overstates.pdf](http://www.centerjd.org/air/pr/Tillinghast_Overstates.pdf)

<sup>33</sup> “Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System,” Department of Health and Human Services, July 2002.

<sup>34</sup> Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press, 2005, Chapter 6, p. 118 et al.

<sup>35</sup> “Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System,” Department of Health and Human Services, July 2002 at 7.

<sup>36</sup> Medical Malpractice, Effects of Varying Laws in the District of Columbia, Maryland and Virginia, General Accountability Office, October 1999.

<sup>37</sup> “Limiting Tort Liability for Medical Malpractice,” Congressional Budget Office, January 8, 2004.