MPL | MEDICAL PROFESSIONAL LIABILITY ASSOCIATION

July 17, 2019

Ms. Karen Stockley
Congressional Budget Office
Ford House Office Building, Fourth Floor
Second and D Streets, SW
Washington, DC 20515-6925

Dear Ms. Stockley:

I am writing in regard to the recently released U.S. Congressional Budget Office Working Paper (2019-03) concerning the budgetary impact of medical professional liability reforms.

The Medical Professional Liability (MPL) Association is the leading trade association representing insurance companies, risk retention groups, captives, trusts, and other entities owned and/or operated by their policy holders, as well as other insurance carriers with a substantial commitment to the MPL line. MPL Association members insure more than 2 million healthcare professionals around the world— doctors, dentists, nurses and nurse practitioners, and other healthcare providers—including more than two thirds of America's private practicing physicians. MPL Association members also insure more than 3,000 hospitals and 5,000 medical facilities.

With information on more than 300,000 closed claims, the MPL Association Data Sharing Project is the largest, collaborative ongoing MPL data base of closed claims in the United States. As stewards of these data, we are keenly aware of the need for the most accurate data available when addressing healthcare issues involving risk management, patient safety, and public policy. The Congressional Budget Office Working Paper appears to provide a basis for beginning a thorough, informed, and balanced consideration of all of the relevant factors concerning the economic impact of reforms to medical malpractice or, as it is now referred to in the industry, medical professional liability. We look forward to providing you with additional information and studies to supplement those cited in the Working Paper.

In the interim, we would like to address several concerns raised in the Working Paper.

To begin, we would request information on how the studies cited in the Working Paper were chosen. As you may be aware, the MPL industry has experienced an unprecedented level of stability over the last decade, which some have attributed to the enactment of tort

reform laws in numerous states in the 1990s and early 2000s. Consequently, fewer studies may have been done than during periods of crisis, limiting the Congressional Budget Office's ability to get a truly timely and comprehensive set of reports upon which to base its analysis.

The Working Paper also stated that "the large increase in home health, hospice, and skilled nursing facility spending may be interpreted as an increase in overtreatment if changes in those settings consist of increases in services for risky patients that are profitable on the margin." On what basis does the Congressional Budget Office make this claim? As noted later in the Working Paper, "no other known research findings show that home health, hospice, and skilled nursing facility providers…are particularly responsive to decreases in malpractice liability." These two statements would appear to be contradictory, raising additional questions about conclusions reached in the paper. Without a clear causal link between medical liability reforms and the increased use of such types of care, it would appear that the connection between reforms and increased Medicare spending (which offsets budgetary savings more directly attributable to medical liability reform) is tenuous, at best.

Finally, the working paper uses the term "inappropriate" 14 different times to describe treatment that ranges from negligent to precautionary. This phrasing is misleading because it implies, incorrectly, that all of medicine can be easily classified as either "appropriate" or "inappropriate." Furthermore, this word choice injects an accusatory tone into the entire document, which raises questions about the objectively of the paper.

For example, rather than refer to positive defensive medicine as "inappropriate," it would be more accurate to refer it is as "relevant, but not always necessary to a specific diagnosis or treatment." This clarifies that such activities are not negligent, and may, under some circumstances, be completely appropriate. This also helps clarify one of the great dichotomies in the delivery of medical care and treatment–care that could be considered unnecessary for one individual (ordering an MRI on a patient suffering a severe headache) but that may be viewed as completely necessary and appropriate under a slightly altered circumstance (an MRI for a patient with a headache and a family history of brain tumors). Using "appropriate" and "inappropriate" suggests healthcare professionals frequently choose from right/wrong options (and choose "wrong" when the threat of liability is reduced), when the reality is that they are using their comprehensive knowledge to choose from numerous options that may be neither right nor wrong at that moment.

We appreciate your willingness to offer the Congressional Budget Office's Working Paper (2019-03) for public comment and for your consideration of the comments and questions above.

If your office has a time frame for submission of comments and constructive input regarding the Working Paper and next steps, please provide that information as soon as possible so that the MPL Association may submit formal comments. We also look forward to meeting with you, as indicated in an earlier e-mail exchange, to discuss these matters further.

Should you have any questions or need further information, please do not hesitate to contact me at batchinson@MPLassociation.org or 240.813.6128 or my colleague Mike Stinson, Vice-President of Government Relations & Public Policy at 240.813.6139 or via email at mstinson@MPLassociation.org.

Thank you.

Sincerely,

Brian K. Atchinson
President & CEO