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**Featured Discussion:**

**Do caps on medical malpractice damages hurt consumers?**

**New Featured Discussion: MI and Cato scholars debate med-mal**

[December 5, 2011, 10:10 AM](http://www.pointoflaw.com/feature/archives/2011/12/new-featured-discussion-mi-and.php)

**James R. Copland**

On October 20, our friends at the Cato Institute published [a study](http://www.cato.org/pub_display.php?pub_id=13780) by Cato adjunct scholar [Shirley Svorny](http://www.cato.org/people/shirley-svorny) claiming that existing empirical evidence suggests that "medical malpractice awards do track actual damages" and that noneconomic damage caps and other "policies that reduce liability or shield physicians from oversight by carriers may harm consumers." An economics professor at California State University, Northridge, Svorny has since publicized her findings [in outlets such as the *Huffington Post*](http://www.cato.org/pub_display.php?pub_id=13883), in which she not only argued against the medical-malpractice reform provision of the [Jobs Through Growth Act](http://isakson.senate.gov/documents/Jobs%20Through%20Growth%20Act%20Outline.pdf) but also suggested that "[r]educing liability, as caps do, is rarely a good idea in any situation."

Needless to say, Svorny's position is at odds with that we've generally taken here at [*Point of Law*](http://www.pointoflaw.com/medicinelaw/) (see back posts [here](http://www.pointoflaw.com/medicinelaw/category_archive.php)), including our former editor, Svorny's Cato colleague [Walter Olson](http://www.cato.org/people/walter-olson) (see, e.g., [here](http://www.cato-at-liberty.org/libertarians-medical-malpractice-and-contract/), [here](http://www.pointoflaw.com/archives/2009/06/from-linda-gorm.php), [here](http://www.pointoflaw.com/archives/2006/06/60-percent-equa.php), [here](http://www.pointoflaw.com/columns/archives/2005/02/the-times-on-me-1.php)). (See also [this seminal contribution](http://www.jstor.org/pss/827952) by MI visiting scholar [Richard Epstein](http://www.manhattan-institute.org/html/epstein.htm) and [this Manhattan Institute study](http://www.manhattan-institute.org/pdf/cjr_10-bw.pdf) by libertarian economist [Alex Tabarrok](http://mason.gmu.edu/~atabarro/).)

This week, Professor Svorny has graciously agreed to come to Point of Law to discuss her paper with MI adjunct fellow and PoL editor [Ted Frank](http://www.manhattan-institute.org/html/frank.htm). The featured discussion will be available below; please check back throughout the week as the discussion continues.

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**Svorny's shaky premise**

[December 5, 2011, 10:15 AM](http://www.pointoflaw.com/feature/archives/2011/12/a-response-to-svorny.php)

**Ted Frank**

Shirley Svorny's paper for Cato arguing that caps on medical malpractice damages hurt consumers got a lot of attention. I found the paper very disappointing, however: it cherry-picked studies and ignored real-world practices by largely assuming away the problem. As such, it was not just contrarian, but counterproductive.

Virtually everything in the paper is premised on the idea that there's no haphazard aspect to medical malpractice liability: "Researchers have found that awards are not haphazard. The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims." That adverb "generally" covers a lot of room, however, and is too thin a reed to sustain Svorny's first sentence, much less eventual conclusions. Svorny's paper engages in a non sequitur: Svorny correctly refutes the idea that the malpractice system is completely haphazard, but she then proceeds under the presumption that the system is therefore not at all haphazard. This fails to consider the ramifications of the intermediate case. A hypothetical judicial system that gets it right 60% of the time, for example, "generally awards damages to victims of negligence and fails to reward meritless claims," as Svorny correctly states the *status quo* does. But that 40% error rate would still be the sort of haphazard results that call for a policy response. We don't see an error rate of 40% today. But we do see one large enough that we need to consider alternatives to an unfettered liability regime.

Svorny, for example, trumpets the success of insurers working with anesthesiologists to reduce medical error. But she takes the wrong lesson from that experience. Anesthesiologists improved their safety record considerably, reducing patient deaths an astounding 97% over twenty years, thanks to adoption of some basic scientific techniques in a practice that was previously more of an art form. That wiped out their medical liability problem, right? Wrong: anesthesiologist malpractice insurance costs have dipped only 37% in real dollars. [I seem to be the only one who's noticed this disconnect](http://www.pointoflaw.com/archives/2005/06/anesthesiologis-1.php), but it sure indicates a lot of haphazardness to me. Anesthesiologists are unique in the medical profession: they were unnecessarily killing scores of patients in the twentieth century. I'm not aware of any other branches of medicine that would benefit to the same extent that anesthesiology did, but the anesthesiologist experience doesn't suggest that a comprehensive insurance effort to reduce medical injuries ten percent would have much of an effect on malpractice costs, given that anesthesiologists reduced their problems thirty fold, but couldn't even halve their malpractice costs.

Svorny ignores other evidence of haphazardness. In nursing homes, for example, [objective measures of quality have only a slight inverse relationship to litigation expenses](http://www.pointoflaw.com/archives/2011/04/lawsuits-arent-.php): moving from the lowest-performing decile to the top decile reduces the chances of being sued from 47% to 40%. Another study found "no rational link between the tort system and the reduction of adverse events." Morris *et al*., "Surgical Adverse Events, Risk Management, and Malpractice Outcome: Morbidity and Mortality Review Is Not Enough," *Annals of Surgery* 237, no. 6 (June 2003): 844-852. The Harvard Study found that, holding severity of injury constant, the litigation system was just as likely to award damages in a case where no medical malpractice has taken place as one where medical malpractice has taken place; indeed, the sued non-negligent doctors paid more on average to injured patients than the sued negligent doctors, and the majority of patients receiving compensation weren't injured by negligence. Brennan *et al*., "Relation between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation," 335 NEJM 1963 (Dec. 26, 1996). The statistics were somewhat better in a larger study done a decade later, but far from evidence of lack of haphazardness: 40% of malpractice lawsuits are meritless, and 28% of meritless claims receive compensation.

No one is contending that medical malpractice awards are entirely random. But they don't need to be entirely haphazard to be creating more costs than they are resolving. Svorny assumes that because she has rebutted the strawman, she can base the rest of her argument on the premise that the underlying system works. And certainly, it would be true that if the system were working (or if legal errors were considerably more rare than medical errors), caps would be counterproductive. But Svorny can be correct that the system "generally" works (in the weak sense that it does outperform a coin-toss in assigning liability) while being incorrect about the conclusions she draws from that. I'll discuss that more later in the week.  
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**Liability Protects Patients**

[December 6, 2011, 10:14 AM](http://www.pointoflaw.com/feature/archives/2011/12/liability-protects-patients.php)

**Shirley Svorny**

The medical professional liability insurance industry takes actions that improve patient safety in this country. It is liability that motivates efforts of underwriters to assess the practice risk of individual physicians and to penalize those who present such high risk, and it is liability that motivates medical professional liability insurers to take what steps they can to reduce practice risk.

If the court system were as random as some people think, there would be no reward to efforts to identify high risk physicians, to identify practices that result in bad outcomes, or to create incentives to encourage physicians to reduce their practice risk. Yet the insurance companies all make these efforts, at significant expense. Each year, underwriters at medical professional liability insurance companies review applications for insurance. They have access to a physician's entire claims history and they use professionals to evaluate the validity of the claims. Why would they do this if court decisions were random?

Admitted carriers, those approved by the state, put surcharges on the premiums of some physicians and offer credits to those who are claims free. If the level of underwriting needed to assess a physician's risk is high, the physician will be denied insurance by an admitted carrier and forced into the surplus lines market. Premiums in the surplus lines market are up to five times those in the admitted market. When new, risky procedures are introduced, the surplus lines carriers are heavily involved in assessing physician training and practice risk. The level of oversight is so high as to, where warranted, include visits to offices of physicians to assess and reduce practice risk.

The insurance industry publishes research findings based on studies of claims that highlight where risk is highest in various areas of medical practice. These findings are used by hospitals and other providers to reduce the likelihood of bad outcomes for patients. Physicians are rewarded (with premium credits) for participating in risk management courses based on these findings.

If the system is haphazard, why is all of this going on? And, why would the vast majority of cases settle before they reach trial? In a haphazard system, the potential return to a court trial would be random, not be a function of the actual negligence.

As things are, it appears that most cases that go to court are based on the mistaken belief of the plaintiff that negligence was involved when it was not, given that plaintiffs lose in the majority of cases.

We know that liability creates the kind of incentives that motivate appropriate behaviors to reduce bad outcomes. For years, it has been said that the medical malpractice industry did not create the appropriate incentives. It has been the conventional wisdom that malpractice insurance premiums were not experience rated. I found that this is not true; the industry charges risky physicians higher premiums than their same-specialty, same-location peers.

And I found much more. It turns out that not only are premiums set to encourage clinicians to reduce their practice risk (the only path to a lower premium) but the industry does a lot of other things that are likely to reduce practice risk and protect consumers.

The point is that liability works to protect consumers and that caps will reduce liability. This is especially important in this industry because consumers believe any state-licensed physician is competent. Consumers are not protected by state licensing boards (see my [2008 Cato Policy Analysis](http://www.cato.org/pub_display.php?pub_id=9640)) but, instead, by an interconnected private system of oversight based primarily on liability.

Let me address two specific points that Frank makes in his post. Frank quotes an empirical study by Morris, et al., which concludes there is "no rational link between the tort system and the reduction of adverse events." If you read the article you will see that this is conclusion is not supported by the evidence. Morris and his colleagues find more system failures in cases where plaintiffs received awards. That sounds like a rational link to me. The [best article](http://weber.ucsd.edu/~miwhite/farber-white.pdf) I've read about the litigation process is by Henry Farber and Michelle White (RAND Journal of Economics, 1991). They describe a system that works to penalize negligence.

Frank says anesthesiologists were "unnecessarily killing scores of patients" and that he is "not aware of other branches of medicine that would benefit to the same extent." Well, no one was aware - other than, perhaps, the insurers. Many people argue it was high medical malpractice claims and premiums that gave anesthesiologists an incentive to figure out what was going on, making anesthesiology that much safer.

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**When do liability costs exceed liability benefits?**

[December 7, 2011, 8:15 AM](http://www.pointoflaw.com/feature/archives/2011/12/when-do-liability-costs-exceed.php)

**Ted Frank**

Professor Svorny's response commits the same error I identified in [my opening post](http://www.pointoflaw.com/feature/archives/2011/12/a-response-to-svorny.php). There's an intermediate position between "the system is entirely rational" and the strawman "the system is entirely haphazard," but Svorny isn't willing to recognize it. As such, she only considers the benefits of liability, and not the costs. Certainly, when the judicial system correctly imposes costs for malpractice, it sends economic signals to reduce malpractice. But at the same time, when the judicial system imposes costs upon doctors who have done nothing wrong—and there is no doubt that it does—it sends economic signals that reduce medical *practice*, as well as weakens the incentive to avoid engaging in malpractice, because the marginal cost of doing so becomes lower. There becomes some point where the costs of the inaccuracies of the malpractice system outweigh the benefits, where it deters more beneficial medical practice than harmful medical malpractice. We can dispute where that inflection point is, but nothing in Svorny's paper attempts to make the evaluation in the first place, or even acknowledges that the evaluation is necessary.

The fallacy of this can be seen by a hypothetical alternative medical malpractice regime. The benevolent dictator of Fredonia, Rufus T. Firefly, reads Svorny's paper. "Ah ha!" he says, "Liability encourages insurance companies and doctors to avoid malpractice, and caps on liability harm consumers. If some liability is good, then more liability is better." Therefore, Fredonia decrees, any doctor found having committed malpractice shall surrender her entire wealth to their victim, and be executed by firing squad.

I'd hope Svorny would concede that the hypothetical (and, yes, ridiculous) Fredonia legal regime would produce health results inferior to the status quo. But to do so is a concession that excessive liability for judicial findings of malpractice can have adverse effects—adverse effects that are entirely ignored by Svorny's paper. Nowhere does Svorny's paper acknowledge [the problem of incommensurate noneconomic damages](http://www.pointoflaw.com/feature/archives/2004/09/in-defense-of-caps.php) (or the evidence that such damages are, indeed, relatively haphazard, or the evidence that consumers rationally prefer not to insure for noneconomic damages when given the choice in states like New Jersey), and the *in terrorem* effect of eight-digit noneconomic damages awards, much less how to avoid these problems without some sort of cap on noneconomic damages.

In the Huffington Post, Svorny goes farther, and says that "reducing liability, as caps do, is rarely a good idea in any situation." It seems hard to believe that Svorny actually believes that. We, as a society, reduce liability all the time because we recognize that the costs of liability exceed the benefits.

For example, most states refuse to allow a wife to sue her husband and the other woman for infidelity; a cap of zero, though the noneconomic damages from being cheated upon are just as real as the noneconomic damages in medical malpractice cases. Corporate executives have [the defense of the business judgment rule](http://www.pointoflaw.com/feature/medical_judgment0806.php): they can not be held liable by shareholders for business malpractice, even when good-faith incompetent business decisions create very real economic damages to those shareholders. In both sets of cases, the judicial system recognizes that the costs of liability and after-the-fact second-guessing exceed the benefits of judicial intrusion; indeed, we don't even blink twice in the twenty-first century that these suits are not permitted.

Closer to home, Professor Svorny's students are not allowed to sue her for any alleged educational malpractice, another cap of zero. I trust that Svorny's lack of incentives created by liability do not reduce her efforts in teaching, even though she does not have an educational malpractice insurer charging her a quarter of her salary to work with her to minimize the risk of a student not being taught properly. How much more would Svorny demand in pay to keep teaching if she *were* exposed to potential liability, even if she believed the system was 100% rational and had no risk of haphazard false positives? (Even if the system never fails, Svorny would face real insurance costs, assuming she's not a perfect teacher. And note that even meritless claims properly dismissed by the courts would be costly to insure, because under the American system the winner of a lawsuit does not recover costs from the loser.) How many fewer students would take Svorny's classes because they couldn't afford to pay that marginal increase in cost? Would that be a social cost militating against liability for educational malpractice or not? Why is it inappropriate to apply the same analysis to doctors?

Returning to the anesthesiologists, we know that their case is unique because their case *is* unique. It's not like anesthesiologists have been exposed to malpractice liability that other doctors aren't. Svorny can't have it both ways: if the risk of liability is what caused anesthesiologists to engage in sounder practices, then the reason that neurologists and obstetricians have not been able to make similar safety improvements is because they're already working at close to the optimal safety level. Svorny's argument makes testable predictions that have already been falsified: medicine in Texas (despite a [fairly pathetic licensing board](http://www.pointoflaw.com/archives/2011/11/arafiles-update.php)) hasn't gotten unsafer in the wake of caps. If anything, the state of healthcare there has improved, as more doctors have entered the state in response to the incentive of lower insurance costs. [Doctors in New Zealand haven't turned into the second coming of Sweeney Todd despite the absence of any individual malpractice liability in that jurisdiction](http://www.pointoflaw.com/archives/2006/11/new-zealand-nof.php). There's no evidence for the legal system working as well as Svorny necessarily presumes it to work for her conclusions.

Certainly, Svorny is correct that caps on damages create the possibility of false negatives where legitimately aggrieved patients are undercompensated. But she fails to acknowledge that the status quo creates numerous burdensome false positives that impose real costs on doctors and consumers. The public policy goal should be to minimize the total social cost of these false positives and false negatives, but that necessary balancing is not acknowledged, much less attempted by Svorny before she issues her sweeping conclusions. Fortunately, contrary to Svorny's public-policy prescriptions, there is no liability for public-policy malpractice.

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**No system is entirely rational**

[December 8, 2011, 8:00 AM](http://www.pointoflaw.com/feature/archives/2011/12/no-system-is-entirely-rational.php)

**Shirley Svorny**

I do not believe, as Mr. Frank summarizes my view, that the system is entirely rational. No system is entirely rational. As Mr. Frank points out, researchers have looked at the tort system. Using the numbers in Mr. Frank's original post, if there is no negligence in 40 percent of claims and, of those, 28 percent result in awards, then 11 percent of claims are both bogus and result in damages.

It is hard to say whether that incidence is too high--we wouldn't expect any system to be error free-- but perhaps the focus should be on getting that number down. Proposals to change how the courts work, such as substituting medical experts for lay jurors have been touted as a way to improve outcomes, but Neil Vidmar cites several reputable studies that find jury verdicts on negligence are similar to assessments made by medical experts. [[Vidmar](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628507/pdf/11999_2008_Article_608.pdf), p. 369]

There are real benefits to liability that cannot be swept under the rug by laws that limit liability. Just because my students cannot sue me for educational malpractice, it does not mean it does not exist and that students are not harmed. If students could sue their professors, the outcome would probably be a lot like that for medical malpractice, but even fewer cases would move forward as educational malpractice would likely be harder to prove than medical malpractice. But, in a liability regime, education would be more expensive, many professors would take greater care in preparing their courses, and the most egregious teachers would be out of a job.

Mr. Frank mentions New Zealand as an example of a country that has no-fault insurance and people there don't seem to be dying left and right. Perhaps they have other protections in place, but it is hard to imagine what protections could be as efficient as private liability. It may be, as it was with anesthesia and hospital infections, that a level of injury is thought reasonable when, in fact, at fairly low cost, there could be significant improvements. In a [2006 paper](http://www.wpri.org/Reports/Volume19/Vol19no10.pdf), Linda Gorman ([see](http://www.wpri.org/Reports/Volume19/Vol19no10.pdf) p. 17) cited a study published in the Canadian Medical Association Journal that found adverse events more common in New Zealand than in the U.S. ([see](http://www.wpri.org/Reports/Volume19/Vol19no10.pdf) p. 17). Of course other factors, such as income, might explain the difference in outcomes across countries; it may not be malpractice liability.

As Mr. Frank notes, the costs of a system may outweigh the benefits. Right now we don't have much to go on to make this determination. My research on the medical professional liability insurance industry identified a benefit previously missed by analysts. Would going to a no-fault insurance system (the extreme case of caps) save enough money to offset the benefits forgone from the loss of oversight by the medical professional liability insurance industry?

The right question to ask is whether we can improve the current system in a way that reduces costs more than benefits.

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**Agreements and disagreements**

[December 9, 2011, 8:10 AM](http://www.pointoflaw.com/feature/archives/2011/12/agreements-and-disagreements.php)

**Ted Frank**

I'm surprised that Svorny is so unwilling to concede that educational malpractice liability is unquestionably a bad idea. There seems to be a fundamental disagreement between us about the transactions costs of the legal system. It's easy to think, as a theoretical matter, that legal adjudication is frictionless, but that leads to dramatic policy mistakes by courts, legislators, and regulators. (I've seen first-hand someone drag out a frivolous libel suit for two years without resolution of a straightforward legal issue.) I'm happy to agree to disagree about the merits of uncapping liability for educational malpractice, and let readers decide for themselves who has the grasp of the facts that better reflects the realities of legal-system transactions costs.

Svorny pushes her research on experience rating as demonstrating benefits to the system, but she draws the wrong conclusions from her data. There are high-risk doctors, to be sure, and low-risk doctors: why can't the surgeons be more like the pediatricians who never get sued? That sort of classification does not do much to protect good surgeons, however, since [nearly all surgeons end up getting sued](http://www.pointoflaw.com/archives/2010/08/majority-of-doc.php). And, sure enough, even Svorny's own numbers show that intra-practice experience rating doesn't make much difference: the Massachusetts insurer she looked at most closely charged 98.6% of physicians within the same 25% range, with only a tiny percentage of those getting any surcharges at all. (And even then, all she found was that the small percentage who are charged outside of that 25% range are being charged "surcharges" that sometimes reflect factors other than experience rating.) Little wonder: [there does not seem to be any empirical evidence that previous claims experience predicts future claims experience](http://www.pointoflaw.com/archives/000837.php) once one controls for the riskiness of the practice. That's first-hand evidence of haphazardness: if medical malpractice were predictable, we'd see more effective experience rating. (Life insurance and car insurance certainly don't operate within a 25% band.) But Svorny again works with a binary metric: if it's not the case that insurers *never* experience rate (another strawman), then there isn't a problem with uncapped damages because insurers can always experience rate. She never asks why, if efficient experience rating is possible, it has so little effect on insurance rates.

I'm pleased to see that Svorny agrees with me that the medical malpractice legal system is not producing perfect results. I can agree with Svorny that we should look to reforms that reduce the error rate of the legal system.

What she has failed to recognize in her paper, however, is that non-economic damages caps can work to reduce the error rate of the legal system. Svorny considers only the false negatives, the cases where a cap might result in undercompensation; she never looks at the costs of the false positives, the cases where the lack of a cap results in overcompensation.

The error rate is not just the "11%" Svorny calculates in her most recent post. It's the uncompensated costs put on doctors when meritless malpractice suits are brought in the hopes of jackpot justice—another 29% of the cases. But that the other 60% of cases supposedly have merit (and, as we've seen, merit is often judged with hindsight bias, whether by lay or expert evaluators) does not mean that they're not also imposing erroneous costs. Even where an individual doctor commits malpractice, a shotgun complaint might bring in another dozen entities in the hopes of extorting a settlement. And the biggest cost of all comes from the outlier verdicts that caps are intended to address.

The problem is that the legal system is poorly situated to make judgment calls about complex medical decisions. Returning to the anesthesiologists again, [even expert witnesses suffer from extraordinary hindsight bias](http://www.pointoflaw.com/archives/2004/10/outcomes-affect-expert-testimo.php) when evaluating the quality of medical care: we can hardly be surprised [when lay juries, encouraged by attorneys with an incentive to slant the evidence](http://overlawyered.com/?s=merenstein) do not do any better. Uncapped economic damages present gigantic opportunities for injustice: John Edwards by himself won tens of millions of dollars in verdicts based on junk science. When non-economic damages are uncapped, a single outlier judgment can impose tremendous disproportionate costs that get spread across all doctors. Obstetricians or neurologists facing uncapped noneconomic damages (and the hospitals that employ them) are always at risk of an eight-digit award.

When damages are uncapped, obstetricians are playing a game of Russian roulette. If ten meritless cerebral palsy cases are brought, and jackpot-justice litigators can get a $20 million or more judgment when they win, a legal system that gets it right "only" 90% of the time will have disastrous consequences: the one error more than overwhelms the effect of the nine cases where the system got it right. A noneconomic damages cap limits the false-positive error rate of any single outlier jury. Such caps also reduce the incentive to bring low-merit/high-potential-damages cases that impose other costs on the system. Caps have benefits as well as costs. It's one thing to say that one's research shows that caps have a marginal cost that has previously been unconsidered (though the "unconsidered" part of that is questionable, as I [argued about it with reform opponents six years ago](http://pointoflaw.com/columns/2005/02/malpractice-myt.php)); it's another to leap to the conclusion that therefore caps are always a bad idea when one admittedly hasn't evaluated the relative costs and benefits.

It's always tempting to oversell incremental improvements in data collection as having far-reaching policy implications. I've [been](http://www.pointoflaw.com/archives/2010/12/the-pro-busines.php) [critical](http://pointoflaw.com/columns/2005/04/is-there-a-cris.php) [of](http://www.pointoflaw.com/archives/001444.php) [this](http://www.pointoflaw.com/archives/2006/11/hyman-and-silve.php) [problem](http://www.pointoflaw.com/archives/2008/04/leroy-do-courts-create-moral-h.php) [before](http://www.pointoflaw.com/archives/2008/05/marc-a-rodwin-et-al-malpractic.php), including with papers Svorny relies upon. In this case it results in a non sequitur. The bottom-line conclusions of Svorny's paper are not supported by the data or the analysis.   
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**Assessing All Benefits and Costs of a Liability System**

[December 12, 2011, 9:14 AM](http://www.pointoflaw.com/feature/archives/2011/12/-assessing-all-benefits-and-co.php)

**Shirley Svorny**

Health economists and others have said medical professional liability insurance premiums are not experience rated. This led observers to conclude the system did not penalize malfeasant physicians. In that case, there would be little to lose if awards were capped. My contribution has been to point out that not only are premiums experience rated, but liability insurers take other steps to reduce practice risk. This is an important observation in a discussion over the value of caps. It is also an important observation with respect to state licensing of medical professionals.

For years, I have argued that state licensing is used by medical professionals to limit entry and does little to protect consumers. I have argued that consumers are protected by private efforts to reduce liability and that is what led me to look more closely at how the medical professional liability insurance industry works. The information presented in my paper was drawn from conversations with insurance industry professionals and a comprehensive review of state insurance filings. Physicians denied coverage by admitted carriers must seek insurance from surplus lines carriers who specialize in underwriting "hard-to-place" physicians. Few companies have those skills. And few physicians end up in that market. But those who do pay significantly more for medical professional liability insurance than their same-specialty, same-location peers.

If, as Mr. Frank suggests, once one controls for a physician's specialty, previous claims experience does not predict future claims experience, then medical professional liability underwriters are wasting a great deal of time and money evaluating individual physician's claims histories and practice risk. In pointing out that the few bogus claims are rewarded, I did not mean to suggest it is the only cost associated with the current system, my point was that the level of error in the system will never be zero or even close to zero. What we know is that the level of error in awards based on claims is relatively low. Most meritless claims do not move forward.

Whether the costs of the system are greater than the benefits is not something we have a handle on. From an economic perspective, it only makes sense to reduce costs-as caps would-if benefits do not fall more than costs. Any list of the costs and benefits of the medical malpractice system should include the benefits to consumers associated with the oversight and risk management provided by medical professional liability insurance companies. Mr. Frank asserts "the legal system is poorly situated to make judgment calls about complex medical decisions." As I mentioned before, [Farber and White's evaluation](http://weber.ucsd.edu/~miwhite/farber-white.pdf) of the tort system suggests it is well-situated to make judgment calls.

Mr. Frank mentions that my point is not new; he has participated in previous discussions that have addressed the negative consequences caps might have on medical practice risk. However economists and health policy analysts must not have been invited because they consistently, mistakenly, express the view that physicians are sheltered from liability by malpractice premiums that are not experience rated. It is important to clear up this mistaken impression if we are to have a fruitful discussion over whether the legal system works to deter malfeasance.

Mr. Frank is convinced that the costs of the current system outweigh the benefits and has credited me with the view that they don't. Then he writes that the conclusions of my paper are not supported by the data and the analysis. He is giving me credit for conclusions I did not draw. I do not conclude that the benefits of the tort system outweigh the costs. My paper points to a benefit of medical malpractice liability that had been overlooked in the economics and health policy literature due to the mistaken view that medical professional liability insurance premiums have not been experience rated.