

# HARMING PATIENT ACCESS TO CARE: THE IMPACT OF EXCESSIVE LITIGATION

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## HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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JULY 17, 2002  
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## **HARMING PATIENT ACCESS TO CARE: THE IMPACT OF EXCESSIVE LITIGATION**

**WEDNESDAY, JULY 17, 2002**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ENERGY AND COMMERCE,  
SUBCOMMITTEE ON HEALTH,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Barton, Greenwood, Deal, Whitfield, Ganske, Norwood, Wilson, Pickering, Bryant, Buyer, Brown, Waxman, Strickland, Barrett, Capps, Pallone, Deutsch, Eshoo, Stupak, and Wynn.

Also present: Representatives Cox and Fletcher.

Staff present: Patrick Morrissey, deputy staff director; Steven Tilton, health policy coordinator; Cheryl Jaeger, majority professional staff; Eugenia Edwards, legislative clerk; Jonathan Cordone, minority counsel; and Bridgett Taylor, minority counsel.

Mr. BILIRAKIS. Can we please take our seats? I call this hearing to order. I'm advised that there probably will be a vote at 10:30, so we'll try to get in as many opening statements as we can.

I'd like to thank our witnesses for appearing before the subcommittee today. This subcommittee certainly values your expertise and we're grateful for your cooperation and attendance.

Today, the Health Subcommittee is going to focus on how the current medical liability system is harming patient access to care. The United States is facing a crisis that in the end is going to harm patients. One has to look no farther than my home State of Florida where some obstetricians/gynecologists are paying in excess of \$200,000 per year for their liability insurance. Or Mississippi, where neurosurgeons have been leaving the State to practice in Louisiana which has significantly lower insurance premiums.

The most disturbing indication of the severity of this crisis, however, might in Las Vegas, where the county-operated trauma center was forced to close because the Center's trauma surgeons could no longer afford to risk their livelihoods in this climate of runaway litigation. I'm advised that the trauma center recently reopened, which will spare the city from the dubious distinction of being the largest metropolitan area of the United States without a trauma center.

Although it would be easy enough to gauge the severity of this crisis just by reading the newspapers, I decided to hold a field forum in my District to hear from providers about how this issue

is affecting how they practice medicine. The event highlighted the scope of the problem and the urgent need for congressional action. As one solo practitioner remarked, "it is imperative that we act now to stem this crisis. If no action is taken soon, and if the present trends are allowed to continue, there will be no medical system left to save."

I'm sure that everyone here today believes that we're facing a crisis and that patients are going to find it increasingly difficult to find an OB/GYN or a neurosurgeon or a trauma surgeon, unless the Federal Government intervenes. And I know that there are very different ideas about what format the solution should take and that's what this is all about.

While I have no doubt that many of my colleagues will use today's hearing to advocate for increased Federal regulation of insurance companies, I would point out that this industry is already regulated at the State level. In fact, State insurance commissioners already approve each premium rate before it goes on the market. I will say, however, that that is a very legitimate and merited concern and topic and it's something that we certainly should focus on. And this is the first of a series, certainly of two or three hearings, in any case, and we will be emphasizing that aspect of the situation more so in future hearings.

Instead of talking about increased regulation of an already regulated industry, however, I would prefer that we look to models that we already know work. For example, in 1975, California enacted the Medical Injury Compensation Reform Act or MICRA. That's in 1975. The defining feature of MICRA is the limits it places on non-economic damages. This reasonable law has done a commendable job of protecting patients' rights, while also keeping insurance premiums at a relatively low level.

The United States has seen steady increases over the past several years in both jury awards and malpractice suits and the average amount paid by insurance companies for claims merely alleging malpractice. However, California has remained relatively immune to the pressures brought about by these trends, largely thanks to MICRA. It is a time tested system that certainly seems to work and we should not be discarding any consideration of that type of a process.

I'm a co-sponsor of legislation H.R. 4600 that closely mirrors this ground breaking law. Without delving into the specifics of this particular bill, I do believe that it represents a common sense solution to this problem that respects the States' traditional role as regulators of the insurance industry. Although I'm aware that many members of this subcommittee have some strongly held views on this issue, I would hope to use this hearing to take advantage of our witnesses' expertise and explore this issue in depth. Hopefully, we will leave with a better understanding of why this problem exists and what our role is in identifying and implementing a solution.

While I often say that not every problem requires action by the Federal Government, this one apparently does. And I believe we can stabilize our out of control medical liability system without harming the ability of patients to recover adequate compensation when they have been harmed.

And I'll now yield to the ranking member, Mr. Brown, for his opening statement.

Mr. BROWN. I thank the chairman. I'd like to thank all of our witnesses for joining us this morning.

I share your interest, Mr. Chairman, in this issue. A physician friend of mine in Ohio was recently informed that his medical malpractice carriers are leaving our State. He tells me many carriers have either limited their coverage or left the State. The least expensive premium he has been quoted represents a 300 percent increase over his current year premium. There's something wrong with this picture and I'm pleased the subcommittee is looking into it.

I assume, Mr. Chairman, that the purpose of this hearing is to take an objective look at the diversity of factors that could be contributing to the spike in medical malpractice insurance premiums and the gaps and access to this type of coverage. I'm assuming the underlying goal is to make informed decisions about how best to remedy these problems and to do that, we must take into account the full range of factors contributing to the current situation. Not only do we have a responsibility to the doctors who are reeling at the size of medical malpractice premiums and in some cases trying to react to an unavailability of coverage, we also have a responsibility to patients who expect and deserve access to high quality health care.

Malpractice insurance shouldn't hinder access to high quality care. It should help ensure access to high quality care.

Harming patient access to care, the impact of excessive litigation, the title of this hearing, implies that this hearing is perfunctory, that we've already drawn a conclusion about what is causing the spike in medical malpractice insurance premiums. Doctors in my District, who justifiably wonder whether the recent premium increases are actually the insurance industry's attempt to recoup stock market losses or perhaps bad management decisions by the insurance company. Perhaps, instead of calling this hearing "harming patient access to care, the impact of excess of litigation", we should title the hearing, "harming patient access to care, the impact of corporate abuse on stock market volatility and insurance profit objectives" or maybe we should call the hearing, "harming patient access to care, the impact of huge insurance companies' CEO salaries" or perhaps we should call the hearing "harming patient access to care, the impact of the insurance underwriting cycle."

The point of this, Mr. Chairman, is that doctors have raised valid concerns about medical malpractice insurance premiums, about access to medical malpractice coverage, about the nature of medical malpractice litigation itself. But the current medical malpractice crisis and it is undoubtedly a crisis because of its effect on patients, first and foremost, and on physicians, importantly, the current crisis should not be used as an excuse to decimate a system that protects patients and doctors. We shouldn't use this hearing as an excuse to beat up on the insurance industry or to demonize lawyers or to trivialize the concerns of providers or dismiss the legitimate rights of patients. The doctors in my District and others around the

country whom I know and whom I respect, have no problem with being held accountable as long as the system is fair.

That brings me back to my doctor friend in Northeast Ohio. I wouldn't call a 300 percent premium increase fair. I would call it an outrage. I hope and expect that today's witnesses can help us build a factual basis for doing something about it, not simply to exploit preconceived notions.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. And I thank the gentleman. I would say to the gentleman that there is merit in everything that he has said and as I've indicated, this is a first of a series of hearings. I can't tell you how many we will have, but certainly we will look into some of the areas we are not looking into today.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. I thank you for holding the hearing on access to care for patients and the need for medical liability reform.

As you know, I'm deeply committed to solving this problem which is affecting both of our States and impacting health care across the Nation. A few weeks ago at the committee field event in your District, we heard about the dire circumstances that your constituents find themselves in throughout Florida.

And let me tell you about how this is impacting care in Bucks County in Southeastern Pennsylvania. Philadelphia, and the surrounding five county area with its world-class hospitals, medical schools, doctors and other institutions is one of the Nation's and I dare say the world's crown jewels in health care. However, the fabric that holds together these doctors, patients and institutions has become more than frayed. It has begun to tear and disintegrate before our eyes.

The long term damage caused by the exorbitant cost and concomitant lack of medical liability insurance in Pennsylvania has become incalculable. Let me give you an example. Recently, Methodist Hospital in South Philadelphia, was forced to close down its obstetrics practice which has been in the present in the hospital since 1892.

Mr. Chairman, let me read for you from several letters I received from constituents who describe this crisis most poignantly. This came from a woman in the Philadelphia area, my District. "I was born and raised in the Philadelphia area, an area that used to be known for excellent medical care. Eight months ago I again found a wonderful OB/GYN office. The doctors are wonderful, respectful, well educated and overall just great. They delivered my beautiful baby girl for me and I could not have been happier with their care. I referred my sister who is currently pregnant and due in a few short weeks to them. She too, is satisfied with them. But 2 weeks ago we were outraged to discover that they were closing their doors at the end of May 2002. My sister who has been going to their office for all of her prenatal care visits, cannot even have her after delivery exam by the doctor who delivers her first child. I will not be able to return to them for subsequent prenatal care or even normal GYN care. This is an outrage. It is also the second physician's office I've been to in the last couple of years that has been forced to close due to medical liability costs. Another office that I was

aware of closed as well for the same reason. I can't even switch to see them because they no longer exist within our State. I don't know who I can even go to now. No other OB/GYN physicians practice in my area any more. I plan to be in Doylestown area for quite a while and it would be a disaster to have families leaving the State so that they know they will be cared for properly in the event of an emergency medical situation."

Here's another letter. This is from the husband of a physician. "My family has a 200-year history in lower Bucks County and my wife and I decided to stay local. After my wife's residency at Penn and after four grueling years there and another at the MCP Honnoman Department of Neurology, she entered a group practice of neurology in the area. Her time there finished, she is trying to start her own practice, focusing on the underserved members of the lower Bucks senior population, those in nursing homes, long-term care facilities and home bound. Her desire to serve these patients was inspired not by a business decision, but for a true concern for those who find it difficult to get the quality of neurological care she has been trained to provide. Five months ago after sending her first application for insurance she is still not insured. The State administered JUA, Joint Underwriting Association, is not an option for a new physician starting out and the cost is prohibitive."

Mr. Chairman, this crisis affects more than just patients and doctors. Recently, the orthopedics practice that was to cover the Doylestown Hospital emergency room on a weekend found that its insurance coverage would lapse. After months of searching, the hospital then had to find other practices to cover the ER. Other orthopedics practices are also having trouble finding insurance in the area.

What happens when we can't find orthopedists to treat the broken bones and dislocated joints in the ER on weekends? Worse, St. Mary's Medical Center, the only trauma center in Bucks County, faced closing its doors last fall since it could not find insurance. Luckily, the State came through with emergency coverage. However, this is not sustainable in the long run. Las Vegas, for the past few weeks, as we've seen in the news has not been so lucky.

This is about patients, doctors and health care institutions where care is delivered. This is not merely a crisis. It is more than that. It is beyond a meltdown. It is a full-blown catastrophe that is having a damaging and detrimental impact on the health care of Pennsylvania and millions of Americans.

Worse, this catastrophe will result in people dying because trauma centers will continue to close their doors or emergency rooms will be unable to provide care since doctors won't be available. I am saddened and angered that this catastrophe is having permanent and long term effects, weakening hospitals, debilitating medical schools, reducing the number of doctors who practice and destabilizing health care institutions.

The cause, Mr. Chairman, is clear, unfettered litigation. The median malpractice by jury awards rose from \$500,000 in 1995 to \$800,000 in 1999. We need reforms now.

Mr. Chairman, the reforms that I have proposed, along with you, Chris Cox, John Murtha and a number of other bipartisan co-sponsors are common sense, time tested reforms. They follow the model

used in California and a number of other States. This bill is fair and straight forward. The bill, H.R. 4600, the bipartisan Health Care Act includes reforms to make medical malpractice insurance affordable again and encourage health care practitioners to maintain their practices and to continue to serve patients.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Pallone, for an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman. We can tell from the title of this hearing that the supporters of H.R. 4600 believe that excessive litigation is the precise direct reason for the current malpractice crisis and that by passing legislation that limits non-economic damages to \$250,000, the problem will be easily solved.

Mr. Chairman, I think this is far too simplistic. For example, you have the chart up there, but in 1975, California enacted the Medical Injury Compensation Reform Act into law that has severely limited the rights of patients injured by medical malpractice. From what I understand, California's medical malpractice liability premiums actually increased by 190 percent in the 12 years following enactment of that law.

I'd also like to add that medical malpractice insurance profits have been 10 times greater than the profits of other lines of insurance in California. Skyrocketing malpractice insurance premiums have been particularly acute in high risk specialties. This is clearly because inherent in high risk practices are bad outcomes that are beyond the control of providers. Further, this is compounded by the fact that medicine is changing in the direction of becoming more and more complex. For example, if a 50-year-old woman goes to her OB/GYN and wants to have a baby, it makes a high risk specialist liable for an even higher risk pregnancy where the chances of a bad outcome are dramatically increased. The OB/GYN is not going to turn the patient away or tell her that it's not possible to have the baby, but my point is that although the face of medicine is changing, we have yet to examine how insurance needs to be changed in order to reflect the rapid advancements taking place in various fields of medicine.

Aside from this example, if we take a surface level look into other changes in health care we see that HMOs for the last 15 to 20 years have entered the market. Doctors have been subject to certain limitations under HMOs that may prevent patients from receiving the best care possible from their doctors. Is there a direct correlation between care under HMOs and bad patient outcomes? Well, it's something we have to look at.

I'm also curious, given the atmosphere of corporate malfeasance which we've seen so often in the last few weeks whether bad accounting or bad business judgment on the part of insurance companies has anything to do with dramatic rises in medical malpractice premiums.

Mr. Chairman, I propose legislation the Federal Medical Malpractice Insurance Stabilization Act of 2002 that would create a national reinsurance fund. This proposal mandates the Secretary of Health and Human Services to establish a program where insurance companies pay into a Federal fund and in times of crisis these funds would be made available to those companies in an effort to

provide stability in the market for medical malpractice insurance coverage.

Some other ideas that my own State of New Jersey are examining are deductible option of about \$10,000 that would lower premiums, a risk management program for doctors that would correspond with the decrease in premiums and allowing doctors to make installment payments for high premiums over time without a penalty.

I'm not suggesting that these are answers, but I think the title of this hearing, once again, shows that some on the committee just the cap, if you will, on damages as something that's going to solve all the problems and I don't think that's the case. There's no question that we have a crisis here. Certainly in my home State of New Jersey it is acute. We've had forums at my local hospitals with physicians to talk about this. We've had the State Insurance Commissioner in. We had a rally on the steps of the State House by physicians and other health care providers, basically begging that something be done.

So I appreciate the fact, Mr. Chairman, that we're having the hearing and that we will have others. I don't think there's any question that we need to address this. But I just hope that we can work together in this subcommittee and come up with sensible legislation that will effectively address the current problems with medical malpractice insurance and not just assume that certain aspects of tort reform are going to solve all the problems.

Thank you.

Mr. BILIRAKIS. I thank the gentleman. Mr. Cox?

Mr. COX. Thank you, Mr. Chairman. The purpose of today's hearing is to learn how to put patients first. Our health care lawsuit system today is destroying hospitals. It's eliminating patient choice. It's driving specialists out of entire States and out of their practices. And it's enriching a handful of amoral trial lawyers beyond any level previously imagined.

In days gone by, medicine and law were the professions. Both were respected. Both were considered upstanding members of the community. Members of both professions earn handsome compensation for their valued services. But neither doctors nor lawyers were paid extravagantly compared to say investment bankers.

Today, in the early 21st century, that has changed. Doctors' compensation by any standard is being squeezed. Hospitals are having trouble staying in business. OB/GYNs face such financial risks that many now refuse to deliver babies. Meanwhile, America is home to the world's only billionaire lawyers. Many of those billions have been taken from the health care system and directly from patient settlements.

In a national poll taken this week, lawyers rank at the bottom of the list, below politicians, below accountants, below CEOs, on a list of whom Americans can trust.

In California, during the malpractice crisis of a generation ago, a Democratic legislature and a Democratic Governor, Jerry Brown, signed into law MICRA which regulates health care lawsuits for the benefit of all patients, not the lawyers.

In California, specialists are not leaving our State. The malpractice insurance crisis so acute in other States, has not struck

California. There's a simple way to test this fact. Ask the doctors. In America, it's high time we trusted our physicians, not our lawyers, with our Nation's health care.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Ms. Eshoo for an opening statement.

Ms. ESHOO. Thank you, Mr. Chairman. And good morning to all my colleagues and to our distinguished witnesses. Thank you for holding this hearing. I think it's important to hear from a variety of witnesses, people that are steeped in the background that certainly Members of Congress need to hear and be made aware of.

I agree with many of my colleagues that we have a problem and that it needs to be addressed. Physicians across the country are having trouble meeting the skyrocketing cost of malpractice insurance. We know that and that is cause for alarm. To have a stable health care system, we have to have a stable malpractice system. My father used to say at the end of the day you want the best doctors standing on one side of you and a great lawyer on the other side. So I don't think that we should fall into the trap of either defending one side and damning the other or vice versa. We have to have strength on both sides and we have to have really a balance between the two.

Just as patients need to have access to medical care and that we need top physicians that are going to provide the care that only they can, as well as their corollaries in the system, when something goes wrong, that has to be spoken to in our system as well. It hurts the medical practitioner in the country if there is a bad apple in the barrel, just as it hurts Members of Congress when we have bad apples in the political process as well.

So where I disagree with some of my colleagues is in the total presumption, in the total presumption that the rising cost of malpractice premiums are solely due to patient litigation. We have to restrain ourselves a little here and we need to get more information. Is there something wrong? Yes. But I don't think we can afford to just leap frog today. That's why the hearing and hearings, subsequent hearings are very important.

In reality, there are a whole host of factors in my view that have led to the increases and that the Congress has the duty to examine each and every one of the factors before we act. As a Californian, my State created MICRA and it's been referenced in 1975. I'm pleased with how that law has helped to moderate malpractice premiums in our State and I know that Representative Greenwood has introduced legislation that's based on the MICRA law. I'm concerned that there's an urgency to act before understanding. We have to understand things before we can accept or reject, so developing, Mr. Chairman, and you're doing that by having the hearing, is really important and I can't state that enough.

I also understand that there's a GAO report that's been requested on the role of market conditions and insurance company practices and I look forward to the results of that report and I think we all should. That needs to be taken into consideration as well.

So the testimony of today's excellent witnesses, amongst them, I think one of the real greats on behalf of women and the issues of breast cancer in our country, Fran Visco; with the GAO report and

the data we already have on the effect of litigation on the malpractice system should really allow us to more ably and responsibly address this serious problem. So thanks again, Mr. Chairman and certainly to Mr. Greenwood whom I admire as a legislator. He's serious. He always works to be fair and as a complete disclosure he's been—I'm about to have been and still am, a partner with him on many pieces of legislation.

If I have any time left, I yield back. Thank you.

Mr. BILIRAKIS. Thank you. We have 3 minutes to make this vote, so we're going to run over and make this vote. In 15 minutes to 20 minutes at the latest we should get started again. When I get back into this chair, we're going to get started.

[Brief recess.]

Mr. BILIRAKIS. Please take your seats. The gentleman from Kentucky, Mr. Whitfield, to give his opening statement.

Mr. WHITFIELD. Thank you very much, Mr. Chairman, and of course, I'm also delighted that we're having these hearings on this particularly important subject. There's been a lot of comments made about the possibility that insurance companies are doing some gouging and so forth, but I find it interesting that last year the Nation's second largest malpractice insurer had underwriting losses of \$940 million, the St. Paul Companies and they announced that they were getting out of the insurance business, the malpractice insurance business. So if they're making so much money, then why are they getting out of the business?

An article in the Wall Street Journal indicated that the consequences of actions like that, because other malpractice carriers were getting out of the business, and the consequences are being felt by patients all around the U.S. Last year, Bolivar County in western Mississippi had six doctors providing obstetrical care. Today it has three. Obstetrics insurance for a doctor in Bolivar County jumped from \$28,000 to \$105,000 with a \$25,000 deductible. In neighboring Sunflower County, all four doctors who delivered babies have quit private practice. In the northern half of the State last year, there were nine practicing neurosurgeons. Today, there are three on emergency call.

And I could go on and on. There's an article just a few days ago in my home State of Kentucky, "State losing doctors to insurance hikes." Coverage for malpractice jumps as much as 204 percent. And the doctors are blaming jury verdicts for this increase. And another part of this article indicates that, for example, in Corbin, Kentucky, the Corbin Family Health Center lost malpractice coverage and closed down. We have doctors leaving Kentucky, going to Indiana because the Indiana insurance rates are much lower for malpractice insurance than in Kentucky and one reason that they're lower is that Indiana adopted a meaningful tort reform legislation some time ago. And so there is a real difference in insurance rates between those areas where tort reform has been adopted and where it has not been adopted.

So I'm delighted with this hearing. I look forward to the testimony and I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I welcome this hearing today on the crisis of high medical liability insurance

and its impact on doctors and patients around the country. The title of the hearing which focuses on the impact of litigation is unfortunate. It's unfortunate because it assumes that increases in malpractice premiums are simply the result of the legal system out of control. With that conclusion which we heard during the insurance crisis of the mid-1980's and many times since, it's far from clear. We don't know, for instance, to what extent the business cycle and the business practices of insurance companies have contributed to these increases. There is substantial evidence to suggest that rates are more closely related to these factors than to lawsuits and large jury verdicts. These are fundamental questions that need to be answered before we attempt any legislative fix for the problem and before we enact what is essentially a bill that may be considered a bailout for the insurance industry.

In 1975, California adopted MICRA which stands for the Medical Injury Compensation Act. It imposed significant limitations on the rights of injured patients to sue and recover for malpractice-related injuries. For example, MICRA imposed a \$250,000 cap on non-economic damages and eliminated joint liability. Some of the witnesses appearing before us today are going to tell us that MICRA has worked well in California and that because of that we should adopt legislation even more restrictive on the national level.

H.R. 4600, for example, adopts many of MICRA's major provisions and goes further. It extends limitations to product liability cases for defective drugs and medical devices and it imposes caps and other significant limitations on punitive damages.

I have serious reservations about moving quickly to adopt limitations along these lines. Insurance regulations is an area that Congress has traditionally left to the States and for good reason. It's a complex business. It varies market by market and community by community. We do not license medical doctors and other health professions. That's done at the State level. One size does not fit all.

We will hear testimony that raises serious questions about the California experience from Jamie Court, the Executive Director of the Foundation for Taxpayer and Consumer Rights who will testify that MICRA has prevented the courts from awarding adequate compensation to many deserving victims. He's also expected to testify that MICRA has given a windfall to insurance companies in California and it has not delivered the reductions it promised for medical malpractice insurance. He will contend that the malpractice premiums in California have stayed close to premium trends around the country, and in fact, between 1991 and 2000, premiums grew at a rate of 3.5 percent which is higher than the national average of 1.9 percent.

According to Robert Hunter, who is an actuary from the State of Texas and a former Texas Insurance Commissioner, in the years since MICRA was enacted, medical malpractice insurers have profited more from their business in California than in any other State. Since 1989, California medical malpractice insurers paid out less than 50 cents in claims to every premium dollar they took in. In other parts of the country, he contends that malpractice insurers typically paid out more than two-thirds of every dollar taken in through premiums. In addition, California medical malpractice insurers earn higher operating profits, that is profits earned as a per-

centage of premiums than to medical malpractice insurers outside the State.

In short, there are a number of serious questions to sort through. We should be careful before we rush to use any one model for the entire country.

I look forward to the testimony that we're going to receive from witnesses today and to work with my colleagues on this very difficult issue.

Mr. BILIRAKIS. I thank the gentleman. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman, for holding this hearing. I think this is a very important issue. In my home State of Iowa, we are not in a crisis yet. We are probably about 12 to 18 months from that.

Let me give you a real life example. A woman, family practitioner in Iowa, gets called to the emergency room because a Hispanic woman who has received no prenatal care has shown up in labor. Out of the goodness of her heart and her professional ethics, this woman physician goes to the hospital, delivers a baby, no problems during the delivery. Baby is handed over to the neonatal unit. Subsequently becomes septic and dies. Needless to say, very shortly afterwards, this woman family physician is named in the lawsuit, for basically her pro bono work.

Mr. Chairman, I will tell you we have worked on this issue. How many times have we voted on this now in the House in the last 8 years? I think we've passed this at least twice, medical mal. tort reform, if not three times. And we'll do that again.

The real problem has been the hold up in the U.S. Senate in terms of getting something done on this. Now I don't know whether insurance companies, investments in the tech bubble have had some effect on their ability to cap their reserves. That's something we can find out easily, but I do know this, I know that the incidence of the types of lawsuits that this woman physician experienced recently in Iowa are driving insurance rates. And it is something we need to do something about or I'll tell you, if you're looking at going to Las Vegas, you may be gambling a little bit more than your money, if you have an accident. And this is happening all over the country.

So thank you, Mr. Chairman, for holding this hearing. I look forward to learning from it.

Mr. BILIRAKIS. Thank you, Dr. Ganske. Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman, and thank you for holding this hearing today on the impact of litigation on medical malpractice insurance premiums. No doubt about it, this is an issue that merits our attention. We need today to sort out fact from fiction and to help us understand the real underlying reasons for those steep premium hikes.

I'm concerned, however, that some of us here have already made up our minds as the reason for these hikes. Has blame already been placed? Let's look no further than the topic and title of today's hearing, "Harming Patient Access, the Impact of Excessive Litigation."

In this area, as in so many other areas, the right to sue is being attacked as the root of all evils and stopping Americans from suing is being proposed as the magic cure all. In fact, when you take

away the incentive to behave or to be sued, you eliminate deterrence. This is a proven fact. I recommend to this committee in light of what the last couple of speakers on the other side of aisle have said, look at two Wall Street Journal articles written less than a month ago. First one on June 24, it says Wall Street Journal, June 24, insurers' price wars contributed to doctors facing soaring costs. Lawsuits alone didn't inflate malpractice premiums. Reserves at St. Paul distorted pricing picture in the 1990's.

I also recommend another article, again on June 24. Wall Street examines medical malpractice liability crisis. Finds it is insurance industry generated. Insurance company executive admits the crisis is self-inflicted. It goes on to say the insurance industry's questionable accounting exposed. Sounds like Enron and WorldCom to me all over again, so we're going to blame the victims of malpractice.

We've seen this happen with disastrous results with securities litigation that we passed, the Private Securities Litigation Reform Act of 1995. Accountants and executives had no incentive to be good corporate citizens and look what's happened since then. The largest corporate bankruptcies in American history. And it's not the fat cats that are paying, Mr. Chairman. The people who are paying are our constituents and now we have a proposal to do the same for those harmed by medical mistakes.

H.R. 4600 introduced by the distinguished gentleman from Pennsylvania, Mr. Greenwood, I believe would do a similar injustice to medical consumers as the Private Securities Litigation Reform Act did to shareholders and investors. As we've done for shareholders, we're now proposing to do for patients. I commend Mr. Greenwood for attempting to find a solution, but this bill is not the answer. This bill is a one size fits all approach to a complex issue. Experts on this issue in front of us today will testify that stopping lawsuits and capping damages is not the magic bullet. In fact, the insurance companies themselves have stated unequivocally that tort reform will not reduce premiums and will not fix the medical malpractice liability system.

In my home State of Michigan, many of these reforms that have been listed in this bill before, have been done in Michigan, and yet Michigan is listed as one of these critical crisis States for malpractice reform.

I understand and I sympathize with the doctors facing huge premiums, but this bill is not the answer they're seeking. Careful, thoughtful consideration of all factors contributing to this dilemma is what we're here to do today. I'm particularly bothered by section 7(c) in this bill found on page 10 and it states on line 17, subsection (c) "no civil monetary penalties for products that comply with FDA standards."

We've seen this over and over again, much like the PLSRA. Again, go back to Los Angeles Times, December 20, 2000, headline, "How a New Policy Led to Seven Deadly Drugs." Medicine. Once a Wary Watchdog, the USFDA Administration set out to become a partner of the pharmaceutical industries." Since 1997, these drugs have been approved with expedited process, only to find they have to be certainly withdrawn. According to the adverse events reports filed with the FDA, the seven drugs were cited as suspects in 1002 deaths. It goes on to say that a total of 10 drugs have been pulled

from the market in just the past 3 years for safety reasons, including three pills that were approved before the shift that took hold in 1993. That was PADUFA. Never before has the FDA overseen the withdrawals of so many drugs in such a short period of time. More than 22 million Americans, about 10 percent of the Nation's population took these drugs and the drug company himself benefited to the tune of over \$5 billion before they were withdrawn. So the answer is is not to restrict to FDA or say because the FDA approved a drug it is suddenly immune from any kind of tort liability or certainly restrict the rights of patients to bring lawsuits.

Look, we need to look at our past mistakes on tort reform, PLSRA and some of these other bills that have passed through this committee and learn from them.

So Mr. Chairman, I look forward to hearing from our witnesses today, looking forward to working with you and the gentleman from Pennsylvania, Mr. Greenwood, and let's really look at the real cause of the problem and not just artificially go after medical malpractice as the answer.

Mr. BILIRAKIS. The gentleman's time has expired. Dr. Norwood.

Mr. NORWOOD. Thank you very, Mr. Chairman. As we all know, all of us, both sides, that we are in the midst of a full-blown health care crisis. I like to liken it to a perfect storm where many storms are coming together. One of those storms could very well be the insurance industry and I want to know more about that and this committee is going to find out. But one of the storms we do know a lot about and are for certain of is the liability crisis and it would be of help if everybody on this committee would recognize that that is part of the problem. It may not be the entire part of the problem, but it is one that we do have a lot of information on.

I don't know any physician or health care provider who has not witnessed drastic increases in their insurance premiums over the past year. Whether these rate increases are 30 percent or 300 percent, the bottom line is that these premium increases threaten the physicians' ability to continue to practice, especially specialty physicians such as OB/GYN. But while the financial burden forced on to physicians is the most obvious symptom of this crisis, the greatest harm that is occurring is patient access and patient care. On July 3, the trauma center of the University Medical Center in Las Vegas closed its doors as Dr. Ganske alluded to. Facing a 93 percent premium hike, what are the surgeons going to do? They had to walk out, obviously. Casino floor defibrulators has become the closest thing to emergency care as a 10,000 square mile was left without a trauma center.

We have an opportunity here before us to defend patients' access to health care and shore up the solvency of the health care industry. I realize the complexity and the multitude of issues impacting this medical liability crisis, regardless of what anybody on this committee says and the surplus of editorial page banner that's going on, but the issue of tort reform is front and center. We know a lot about that, to have unlimited liability is part of the problem and it deserves all of our attention.

We have clear and convincing evidence of the overwhelmingly positive results of medical liability reform for 25 years' worth of data under California's MICRA. This reform measure is centered

on limiting non-economic damages and restricting abusive lawyer contingency fees. Let's be clear, non-economic damages are rewarded to compensate for pain and suffering or other nontangible, unquantifiable, nonmonetary losses. And punitive damages are left to a sliding scale.

I strongly believe in fair compensation to patients injured by health care provider negligence, but not in excess of these great jury verdicts. But of course, when we talk about limiting runaway jury awards, we're also talking about limiting runaway fees for lawyers which form the only true opposition to this legislation. The only opposition to this legislation. The medical liability industry is caught in a vicious cycle that hurts patients any way you cut it. Let's fight for patients' access to care and patient care.

Mr. Chairman, I look forward to the testimony of our witnesses today. I look forward to our other hearings as we look at different parts of this storm and hopefully we can come together to improve the health care in this country.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank you, Doctor. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. There is trouble in the medical malpractice insurance industry. That much is clear. I have heard from doctors in my District since early this year about spikes in costs and fears that more serious problems in the neighboring States of Pennsylvania and West Virginia will be replicated in Ohio.

As a Representative of a rural area, I am particularly concerned about this issue. My District already suffers from chronic access problems and I am very worried that a malpractice crisis in which doctors simply cannot buy insurance would exacerbate this problem to the point of emergency. I received a letter last week from a physician in my District who told me that his malpractice insurance has gone from \$12,000 last year to over \$45,000 this year. That obviously is not sustainable. But the question we must ask and answer is why?

As many of the witnesses before us today will confirm and discuss, a variety of factors have contributed to the current crisis. Certainly, we should consider what tort reforms may be needed, but as has been mentioned, the recent Wall Street Journal article illustrates other problems that may be serious factors in this escalating problem.

Many of my colleagues are championing this H.R. 4600 bill, a bill that seeks to address the problem in medical malpractice using just one approach, tort reform. A look at research from across the country though finds that the States have dramatically different situations with respect to medical malpractice systems demonstrating how complicated this industry is. It is wrong to think that we can assign only one size fits all solution. That will adequately address this crisis. In fact, I fear that H.R. 4600 will not fix the problems. I worry that the bill may though hurt patients. Specifically, I fear that this bill could (1) violate States' rights by stripping away State law and Federalizing a new body of law and procedure; (2) set a very short and unfair statute of limitations that could actually increase the number of lawsuits that are filed because people may rush to file before their window of opportunity expires; and (3) I

fear that H.R. 4600 would create laws that have already been found unconstitutional such as the limit on non-economic damages. Even more importantly though, H.R. 4600 does absolutely nothing, nothing to address the reforms that are needed in the insurance industry to repair the current crisis and ensure that it doesn't happen again.

I am particularly concerned about the cap on uneconomic damages. I find this cap egregious because it limits access to our legal system. It disproportionately caps damage awards for women and others who earn low incomes.

In addition, there is no evidence that these caps will actually reduce malpractice rates. The California situation has been alluded to, a \$250,000 cap on economic damages has been in place since 1975 and still the State of California has premiums that are 56 percent higher than in my State of Ohio which doesn't currently have caps. Limiting access to our legal system and place the burden of this limited access disproportionately on the most vulnerable in our society won't ensure that malpractice rates stop rising. All of these reasons are why I am working with some of my colleagues, including Representative Sandlin to craft a thoughtful legislative response to malpractice crisis that takes all dimensions of the crisis into account including tort reform and insurance industry reforms. We must look critically at all of these systems and the problems that are plaguing them instead of believing that a single issue as addressed in H.R. 4600 will do the job. The problem is far too serious for us to do that and the health of all Americans depends upon the actions that we are likely to take in this committee.

Thank you, Mr. Chairman, with this hearing and I yield back whatever time I—

Mr. GREENWOOD. Mr. Chairman, will the gentleman yield the balance of his time just for one quick correction?

Mr. STRICKLAND. Yes, I would.

Mr. GREENWOOD. The gentleman from Ohio I think misspoke when he said that California caps economic damages.

Mr. STRICKLAND. Non-economic damages. If I misspoke, thank you for correcting that.

Mr. BILIRAKIS. Dr. Fletcher for an opening statement.

Mr. FLETCHER. Thank you, Mr. Chairman, and I appreciate your allowing me to sit in on this hearing and I want to thank Mr. Greenwood for his work on H.R. 4600.

I don't think there's any question that runaway lawsuits have contributed to the increased cost of health care. There may be other problems that have additionally increased the cost of health care, but I don't think there's any question it's had an impact on both increased cost of health care as well as access to health care.

Let me say that I don't believe any of us want to take away the appropriate redress that patients who have been injured by negligence have in this Nation. I don't think there's any question that we all believe that we need to certainly rid our communities of those who would practice negligently and that if physicians or other health care providers do such, that they need to be held accountable and that patients need to be compensated for that injury.

But let me say what the runaway lawsuits have done. They have increased the cost of health care. They've ciphoned money from

health care and from patient care and they've gone into the pockets to make personal injury lawyers very, very wealthy. Now I don't have any problem with people being successful in life, but we've got to realize that the money comes out of health care and a large portion of it goes into personal injury lawyers' pockets.

Second, if you look at the IOM report, and you look at other studies, there's a physician-attorney at Harvard named Troy Brennan who's done studies to show that the runaway liability we have does not improve the quality of health care. And in fact, in promoting defensive medicine may actually have a deleterious effect on the quality of health care. It may worsen the quality of health care.

Third, California rates and people have talked about California, actually, there's been 125 percent increase in malpractice costs in California versus 425 percent across the United States in the same time period. There may be aberrations of that within certain States, as the gentleman mentioned, Ohio, but in fact, the procedures or the policies that have been in place in California have reduced the increase in escalation costs of premiums.

I don't question that there's probably not some concerns with insurance companies. The gentleman mentioned the New England Journal of Medicine article. I read that article and from my recollection of that article, when you look at St. Paul, the problem with health insurance rates—correction, malpractice premium insurance rates are much higher now because they were under charging in the 1990's. They were charging less than actuarially the responsibilities were laid upon them which meant the increased cost of the liability and all the lawsuits exceeded the premiums in the 1990's. So because of that they have to compensate, make up for that with increased cost.

It is about patient access and I reference an article out of our local newspaper, "doctors seek cure from skyrocketing insurance, malpractice rates take toll on medical care." Here's an OB/GYN that's leaving rural Kentucky where he delivers a large portion of Medicaid patients, delivers babies there. His insurance rates went from \$65,000 to \$185,000 a year. Now he's leaving Kentucky because he can't make a living there. We have a crisis, a malpractice crisis in this country. It affects some States more than others and I want to commend Mr. Greenwood for his effort on this bill. I think you put together, contrary to what's been said, a very thoughtful piece of legislation. It is not the full answer of rising health care costs, but it's a very thoughtful piece of legislation to address this problem. And, thank you, Mr. Chairman. I yield back the remainder of my time.

Mr. BILIRAKIS. Ms. Capps.

Ms. CAPPS. Mr. Chairman, I am pleased we are considering recent increases in professional liability insurance premiums. These increases may, in fact, be barriers to access for our constituents, but I have to say that I think we're putting the cart before the horse with this hearing. Even its title is prejudicial. It assumes that so-called excessive litigation is the cause of premium increases and that it does reduce access to care. But I'm not sure this has been established yet. There is serious debate about why premiums are rising and what should be done to stem that growth, but until we resolve that debate, it seems unwise to determine solutions. The

wrong solution could be harmful to many people and not prevent an increase in premiums.

Some have suggested that the malpractice insurance companies are trying to make up for money they have lost playing the stock market. If that is true, we need to look at regulating the insurance industry. Others think that frivolous lawsuits and exorbitant awards for damages are driving them up. These people argue we need legislation to cap non-economic damages to patients who have been harmed by doctors, mistake or negligence. The problem with this argument is that these lawsuits are not by definition frivolous. In cases where large damages are awarded, a jury has found that the patient has been severely harmed. And I have to say that I'm very skeptical of putting caps on the damage awards that a severely injured patient receives. This puts the burden on to someone who is rightfully seeking redress and it will unfairly penalize people who do not work or who are paid little such as senior citizens, stay at home moms, people with disabilities. They would have their damage payments limited while corporate CEOs will see massive payments. It is non-economic damages that make sure everyone gets the redress they deserve. I cannot support measures to cap damages in a way that will harm the neediest in society, particularly not when it has not been demonstrated that capping them will have a positive result on premiums. California has caps, as has been pointed out. And we in my area of California are still suffering great shortages of doctors. With our caps in place and even though they are in place, doctors are still leaving their practices in droves. So I hope that as this committee moves forward on this issue, Mr. Chairman, that we will carefully consider all the factors and not jump to conclusions about the remedies. And I yield back the balance of my time.

Mr. BILIRAKIS. California does have caps in more ways than one.

Ms. CAPPS. More than one kind, yes, thank you.

Mr. BILIRAKIS. More than one kind. Mr. Buyer?

Mr. BUYER. Thank you. I've sat on quality assurance risk management meetings at hospitals. I've litigated medical malpractice. I've done personal injury and I'm going to tell you, I'm stunned when I hear individuals willing to defend the lawyers here and blame insurance companies, blame hospitals, blame medical providers. I look at my own bar. My own bar has lawyers in there, some of whom are very responsible and have an individual who has been harmed by someone's negligence. And we also have individuals in that bar who will take any case imaginable and really disgust me in what they do to my profession. And we have become too litigious of a society and I'm not surprised at all that you can even break this down.

We went through this whole Medicare thing and others had a lot of fun saying Republicans are in the pockets of so and so. It's not even debated in this country that the Democrats are in the pockets of the trial lawyers. That's not even debated. So we're not even surprised at all that we would hear that today—

Ms. ESHOO. Would the gentleman yield? Would the gentleman yield?

Mr. BUYER. No, I'm having fun. And so I'm not surprised at all that we would hear that.

But let me share something. It's not—Ms. Capps is correct when she says it's not just the lawyers. You see, the fear of lawsuits, not medical necessity, drives the ordering of many tests even. Doctors go to extensive lengths and expensive lengths to protect themselves from lawsuits and that ends up becoming a driver of medical costs.

There is a better way. Now I have something that's really interesting here. You want to say well, in California we have caps, but we have all these expenses. Let me share a perspective with my colleagues. Indiana, 20 years ago, Dr. Otis Bowen, who was the former, not only Governor of Indiana, but he also went on to serve as the Secretary of Health and Human Services under President Reagan, the State of Indiana took steps to protect its citizens by balancing the ability of patients harmed by the health care system to seek redress and the need to ensure continued access to health care by all Hoosiers. Indiana was one of the first States to pass a comprehensive medical malpractice reform and the Indiana model has now been used by other States in reforming medical tort law. So it's workable for both injured patients and health care providers.

Briefly, Indiana law places limits on the liability of health care providers. Any recovery over this limit is provided by a patient compensation fund. It's managed by the State of Indiana and is funded through insurance surcharges. The total recovery is capped. Attorney fees are capped. And importantly, a medical review panel is convened for each case to review the validity of medical claims and must make its findings before a party can go to court. The findings of the medical review panel are admissible in court and there are time constraints on convening the panel and the panel making its findings so the case is not drawn out indefinitely. Injured patients receive compensation in a timely fashion.

As I listen to some of my colleagues, let me do a little quick comparison. I have a medical liability rate survey here and in Indiana, people mentioned OB/GYN. In Indiana, the insurance average for the State of Indiana is \$13,800. I heard testimony from my colleagues in Kentucky. In Kentucky, the average is \$57,000. Let me go to Ohio, since I heard some of my colleagues talk about Ohio's problems and flight of doctors to Indiana. Ohio, for OB/GYN, the average is around \$57,000 to \$58,000. New Jersey. New Jersey is around \$72,000. So you can defend the lawyers all you like. You can do rallies on whatever steps you choose, but don't stick your head in the sand here and defend the lawyers and ignore the problems. It's happening throughout the country and it's a driver of costs and if you want to say we're not too litigious a society, you're having a huge impact on individuals' responsibility and as a member of the bar, I just am disgusted by the conduct of some of my colleagues. I yield back.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Wynn.

Mr. WYNN. Thank you, Mr. Chairman. Thank you for calling this hearing. I just wanted to make a couple of observations that kind of struck me in the course of this discussion. First of all, we've heard about California and now we've heard about Indiana and I can reflect on the experience from my own State of Maryland which also has caps. And it says one thing. States are competent to make this decision and the Federal role or Federal intrusion in this area

is not necessary. There's no real pressing issue here. If he cites a good example in Indiana, perhaps other States will follow as they see fit.

The second observation that I want to make is this notion of so-called runaway lawsuits. Lawsuits in medical malpractice cases reflect the decisions of a jury of ones peers. They reflect what the citizens of that community believe is fair in light of the injuries that an individual has suffered, so the suggestion that somehow it's the malpractice lawyers that are the villains in this scenario is just not accurate. You would think hearing the rhetoric that the other side doesn't have lawyers, that there's no standard of medical care to which practitioners can be held or critiqued on. That's the reality of malpractice law, that there's two sides in the courtroom, very competent lawyers representing doctors and most lawsuits are not runaway lawsuits. Most awards are not astronomical and that most of the people who receive these awards are average citizens, most of them women, in fact, who get awards that their community feels are fair. So I think that has to be taken into consideration.

Third, you hear about runaway lawsuits driving health care costs, but I hope that this panel would share with us some concrete data and the analysis supporting it to show that that is, in fact, the case.

Finally, I think we have to look at the business practices of the insurance companies. They made decisions during the 1990's regarding setting premiums. In many cases they made some bad decisions, underpriced their premiums in relation to their true cost, used profits in the booming 1990's to patch over these bad decisions and now are reaping the consequences of those business decisions. So I don't see that we can portray them as the poor victims of the malpractice system because they made bad decisions.

I think this is a good hearing to have. I'm looking forward to hearing the witnesses, but I hope it will be a balanced hearing and not one that just attempts to characterize the malpractice attorneys as villains in a very balanced judicial system which the forefathers conceptualized as a means to which citizens could have their grievances addressed.

I hope we'll have good testimony on all these issues and I look forward to hearing the witnesses. I would like to yield the balance of my time to my colleague, Ms. Eshoo.

Ms. ESHOO. I thank the gentleman. I'd like to jump in and say something here and that is that if any of us went to a doctor and said we weren't feeling well and the doctor said I'm only going to examine one part of your body, you'd move on to someone else. I think that this committee with all due respect to my colleague from Indiana who said I'm just having fun, this is not meant for fun. There are problems each person here, whether I agree 100 percent with them or not has pointed out something that we need to pursue. To come here and to pretend that we have the entire answer simply because we showed up this morning and think we're having fun, I think, does a disservice to the people that we represent. So let's listen to our witnesses and let's see what we can develope out of this. I think that we should stay away from the bluster. It doesn't do anything for me and most frankly for anyone that's listening because this is being carried. I think it's going to turn them

off instead of being instructive and sensitive and see what we can come up with to resolve the problems that are being pointed out.

I thank the gentleman for yielding.

Mr. NORWOOD. Mr. Wynn, would you yield for just a second?

Mr. WYNN. If I have any time left.

Mr. BILIRAKIS. Yes, he has time.

Mr. NORWOOD. I don't think anybody here has said in any way that this is the only part of the problem. Nobody is saying that.

Mr. WYNN. If I could just reclaim my time.

Mr. BILIRAKIS. Mr. Wynn, we're not going to get into a debate here. These are opening statements only.

Mr. WYNN. Mr. Chairman, I yielded to my colleague. I just wanted to respond to his statement merely to say that I would like to know the facts on that question because it's being characterized that this is the driving force behind the increase in health insurance rates and access to care and if there are facts to support that, I think we'd certainly like to hear them. But just to keep saying this and making this allegation without evidence, I don't think is very helpful.

I yield back the balance of my time.

Mr. BILIRAKIS. The intent of the Chair is that we will get into those facts regarding the impact of litigation regarding what might be the impact of insurance regulation or lack of it or whatever the case may be.

Mr. BROWN. Mr. Chairman, Mr. Chairman, our side is not real happy with the title of the hearing, just that it appears that all of the problem from the title of the hearing, all of the problem is one thing and I think all of us when we're more introspective of it understand the problem is much more complicated than that, whether it's physicians I know in Ohio or Mr. Wynn knows in Maryland or whether it's our own judgment. We all know that it's more complicated and we just wanted to express some unhappiness with the title and the direction.

Mr. BILIRAKIS. If the gentleman will yield, the title "Harming Patient Access to Care, the Impact of Excessive Litigation" whatever that impact might be. And it's only one of the impacts. There are other impacts, all right? So there's nothing wrong with the title. It's the way I think that you interpret it.

Mr. WYNN. Mr. Chairman, Mr. Chairman, if the chairman will yield for just—

Mr. BILIRAKIS. I'll be glad to yield. You have the time.

Mr. WYNN. I wanted to say that perhaps it's the use of the term "excessive" that creates this impression that there may be somewhat of a predetermined—I yield back.

Mr. BILIRAKIS. Let's get to the problem here for crying out loud and quit quibbling about the title of the hearing. That's why we quite often don't get things done the way we should around here.

Let's see, Mr. Deal for an opening statement.

Mr. DEAL. I thank the chairman. Mr. Chairman, quite frankly, I've enjoyed these opening statements better than any series of opening statements I've heard in a long time. I do think that this hearing is appropriate and I think the comments of all of our colleagues have likewise been appropriate. I think the reason this issue has been surrounded with so much intensity is that it lit-

erally involves life and death issues. It likewise involves two of the great professions that are the hallmark of our Nation, the medical profession and the legal profession.

It is not a solution that is easy to come by as we have seen from experiments in our various States. Now I know that we're going to hear from various points of view, but I'm here to say there's plenty of blame to go around in every way and direction you wish to point your finger. Let me give you just a few examples.

With regard to the insurance industry. For years, as a member of the State Legislature in Georgia, I continually asked the question why are you charging the same premiums for the same specialties in the metropolitan city of Atlanta as you are charging in rural North Georgia? I never got a satisfactory answer. The reason was simply they're in the same specialty. When you compare that to what most insurance premiums are dictated upon and that is a loss ratio. There was no correlation in most instances to loss ratios, nor any adjustment for geographical areas in which the practice is being maintained. I think they have done better in recent years to make those adjustments, but still I think they have a long way to go in that direction.

With regard to my own profession and I was, as Mr. Buyer previously a trial lawyer, I am totally disgusted by the fact of the advertisements on television by members of our profession who say come down to see me, I can get you thousands or millions of dollars for your claim with no understanding of whether there was a meritorious claim or not. That to me is taking and I regret that the Supreme Court had gone so far as to the extend the first amendment to that kind of advertising, but unfortunately, we live in that era.

With regard to the medical profession, certainly there are innocent medical providers who have been harmed and who are fearful of the effects of potential malpractice judgments where they think they may be blameless, but I know that there are some things in the medical community that need to be looked at. For example, they have constantly shielded their own members from their own malpractice as far as the public is concerned. It is a known fact that it is almost impossible in many instances to find out where the bad doctors are and many times the way to discipline a bad doctor is simply to ship him to another community where they're unsuspecting and have no knowledge of his negligence and his background. That is something the medical community in my opinion has not come face to face with and until they do, they're going to continue to have, as Mr. Wynn says, the peers in their own community who are suspect of what they're doing and they are the ones delivering the verdicts. So maybe the bedside manner does translate into jury verdicts or perhaps in some cases the lack thereof.

My point is this, there's a lot of blame to go around. I think the purpose of this hearing is to look at all of the facets that surround this very emotionally charged issue, but the fact and reality is it is having an effect on the availability of health care in many parts of the country. My District, like many of your Districts, are seeing premium increases of 1000 percent or more in a 1-year period of premium jumps and that cannot be justified in most instances based on lost claims that have been paid. They have no relation-

ship in most instances. So I think the question is why are these premiums so high, what are the justifications for them and what can we do in a reasonable considered fashion not to do unjust damage to our judicial system which is the foundation for resolving all civil disputes in our country.

I yield back, Mr. Chairman.

Mr. BILIRAKIS. The voice of reason yields back. Mr. Pickering.

Mr. PICKERING. Mr. Chairman, I would yield to my senior member.

Mr. BILIRAKIS. He was hiding back here behind Mr. Cox and I didn't see he was there. All right, he will not accept the yield. Mr. Pickering.

Mr. PICKERING. I always try to follow my good Subcommittee on Energy Chairman, Mr. Barton. But Mr. Chairman, I want to thank you for having this hearing. I want to thank Mr. Deal for his comments, his attitude and I wanted to talk about the issues before us today.

You know I come from a family, my father was a trial lawyer. Today, he is a Judge. I can remember going to the courtroom as a boy, as he tried his cases and I was always proud that I thought that he was trying to bring justice to somebody who may have been harmed or injured, but I looked today at my home State and the situation that we face and I try to make decisions, how do we maintain the principles, making sure that we have a jury system? How do we deter when there are wrongful acts or negligence, but how do we also protect health care in my home State where we're seeing some terrible losses. We're seeing 400 doctors leave our State. For the first time in the history of the University of Mississippi Medical Center, and the OB/GYN specialties, not one, not one OB/GYN medical student is staying in the State of Mississippi. We're seeing clinics close. We're seeing hospitals talk about moving away from Mississippi, across the river into Louisiana. We are seeing from Jackson, Mississippi to Memphis, Tennessee, which if you know anything about geography, is a lot of territory, a lot of communities, a lot of folks, that we will only have about two neurosurgeons.

We're seeing in OB/GYN an acute crisis and shortage. We're seeing in rural hospitals that cannot afford health medical malpractice insurance premiums, whether they're hospitals, for example, in Franklin County, Mississippi, a community or county of about 8,000 people, their insurance premium has increased over the past year from \$54,000 to \$265,000. Now that health care clinic or hospital if you went to it, you would see that it is in terrible need of capital investment to improve their facilities. And they're struggling to pay that bill so that they can give quality health care and then having a five fold increase in insurance premiums.

There has to be a balance here that I hope that we can strike. I do believe that some cap, some limit, so that we do not have the excessive, so that we do not drive hospitals, we do not drive doctors, we do not drive specialties, we do not close clinics as a result of excessive verdicts.

In my home State of Mississippi, the average malpractice case across the Nation is \$3.5 million, but in Mississippi it's \$8.2 million. The rate, the number of claims for medical negligence, those

cases brought is 55 percent greater than the combined averages of all States. So you see a terrible crisis in a State that is rural, that is low income. Many of the citizens on fixed income and you're creating a crisis because of the excessive.

We've got to maintain the principles of our judicial system. But we have to find a way to have a balance that we do not harm health care. I believe in the right to a jury, but I also believe in the right to good health care, that our mothers have a right to see an OB/GYN when they need to deliver a child, that if we have a tragedy, a trauma, a car wreck, and you have minutes that window of opportunity, that window of life to get care, that we'll have a neurosurgeon that will treat our sons and daughters, our husbands and wives if that tragedy occurs.

And so we've got to find a way, as Mr. Deal was talking about, to find a way to address all the issues and find a way to bring justice, but also protect affordable, accessible health care.

Mr. WYNN. Would the gentleman yield?

Mr. PICKERING. Yes.

Mr. WYNN. I really appreciate the statement you made. I know it's made out of a great deal of sincerity, but I have to ask the question, why can't the State of Mississippi address this problem in a way that it sees fit just as other States have done including my own and others that have been referred to here?

I feel kind of awkward on the Democratic side arguing States' rights, but—

Mr. BILIRAKIS. These are opening statements for crying out loud. Now, let's not get into debating. If you choose to respond to that, Chip, please do so very briefly.

Mr. PICKERING. Like I was saying, I do believe in States' rights, but we have a situation in my home State, the States that are around us that have implemented reforms have seen 30 percent reductions in medical malpractice insurance premiums and the question is what we're saying is any State that adopts reform, this legislation will not apply. So we are giving incentives for the States to take care of this problem themselves, but if they don't, my fundamental responsibility and I think fundamental responsibility of all members is to make sure that our mothers have health care, our families have health care, our families have health care and we've got to protect that right. Thank you.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman, and the public, happy birthday, plus one. Yesterday was Chairman Bilirakis' birthday. He's now old enough to buy alcohol legally in his State. And I want to compliment you and Chairman Greenwood for—there you go, see—holding this hearing. I wish that my subcommittee members paid as much attention to the titles of the hearings that I do as they do to yours.

I have waited to give my opening statement, Mr. Chairman, because my staff put together a really good statement. In fact, it's so good that Congressman Norwood told me that his staff helped my staff put it together, so I felt like I needed to be here to do it. This is a good bill that we're going to hold a hearing on, H.R. 4600 that you and Chairman Greenwood have introduced. We do have a crisis, in my opinion, in our medical liability system. I've heard from

many of the doctors in my District down in Texas. They're facing astronomical increases in their medical malpractice premiums. They've had their premiums doubled and in some cases tripled. Because of that, they've stopped performing certain procedures. Some have even retired from medicine all together.

I believe that it is a crisis in medical liability and that this crisis is creating a barrier to obtaining quality health care. For example, women in South Texas are now finding it difficult to find an OB/GYN to help deliver their expectant child. I'm told that out in Nevada, in Clark County, one of their emergency rooms, trauma centers just shut down, just closed the doors because of the rise in medical liability premiums, so I think the crisis is real.

We all agree that if a patient is injured through malpractice or negligence that patient should be compensated for their injuries and that compensation should not be abridged. The Health Act contains no cap on economic and medical damages. If a patient is injured, he or she will rightly have the ability to be made whole through the judicial system.

The Health Act allows unlimited recovery of economic damages. That person will be able to recover all past, present and future economic losses. There is a cap on non-economic damages of \$250,000. Punitive damages are still allowed and can be levied against those who demonstrate malice or gross negligence.

Our courts have become a system or a form of legal lotto. The purpose of lawsuits is not to compensate injured victims so much as it is to enrich the plaintiff lawyers that bring the lawsuits. They work on contingency fees and they're looking and hoping that their winning ticket will turn them into instant millionaires. This system has clogged up the courts with frivolous lawsuits and has delayed the judiciary from processing more meritorious claims.

One of the most important reforms in the Act before us is the elimination of joint and several liability. Joint and several liability encourages trial lawyers to search for deep pockets regardless of the culpability. This country was founded on the ideal of personal responsibility, the idea that a person should be responsible for his or her actions. Joint and several liability is the antithesis of this idea.

Mr. Chairman, I want to thank Mr. Cox for helping me to pronounce antithesis and for my staff for putting in a big word so that I can learn a new word today.

Mr. NORWOOD. That was my staff.

Mr. BARTON. That was your staff that did that? Under the concept of joint and several liability, a party could be found to be 1 percent at fault for a particular injury, yet could be responsible for paying 100 percent of the damage award. This encourages trial lawyers to file a claim, throw everything up against the wall and hope that something sticks.

Our current medical liability system, in my opinion, creates one group of winners and that's the plaintiff lawyers. However, there are numerous losers, the injured patients whose lawsuits linger in the judicial system because they're overwhelmed by other frivolous lawsuits; the patients who can't get care period because their providers no longer provide that care.

I come to this hearing with an open mind. I want to thank you and Chairman Greenwood for putting in the bill and I hope that after the hearing we can work in a bipartisan basis to move the bill.

Mr. BILIRAKIS. All right, I thank the gentleman. I believe that finally completes the opening statements to the relief of all of us.

The first panel, oh yes, by all means. Unanimous consent request.

Mr. BROWN. Mr. Chairman, I ask that all members have the opportunity to submit testimony in writing.

Mr. BILIRAKIS. Without objection. That will be the case. I thank the gentleman.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Mr. Chairman, for holding this hearing today, and thank you for the leadership that you have demonstrated in advancing this important issue.

For over eight years, Members of this Committee have taken the lead in drafting legislation to help restore some degree of common sense to our tort system. They have realized that our current system is too slow, too expensive, too inefficient and most importantly, fails to improve the health of patients.

Today, this Committee will hear from several witnesses about the current medical liability crisis, which is indeed a grave problem in need of serious attention. Health care providers in eleven states are in dire straits, having to make quick decisions about whether or not to move out of specialty practices, move to another state to practice, or retire early. Patients are the hidden victims here: when there is no doctor, there is no health care. It makes no difference that your HMO or Medicare covers a particular procedure. When there is an inadequate number of physicians available to perform procedures, there is limited health care access for patients. It's that simple.

This hearing is not about potential consequences. We are talking about real events, real trauma that is hurting patients before they even get in the door to see a doctor. Approximately two weeks ago, the University Medical Center in Las Vegas closed. The UMC trauma center serves a 10,000-square-mile area; when the center closed, Las Vegas became the largest metropolitan area in the nation without a trauma center. It is truly a miracle that no major catastrophes occurred during the ten-day period that the facility was closed. What can we do to prevent an occurrence like this from becoming a trend? What has happened to the business climate in Nevada that health care professionals who have dedicated their lives to saving patients are no longer willing to serve?

The problem is not an isolated one. As policymakers, we need to find a solution fast, before more patients are harmed. Why are doctors fleeing the state of Nevada for the California coast? Why did a hospital that has operated for over a hundred years in Philadelphia, PA board its windows and lock the doors? Why have one-third of neurosurgeons left the state of Mississippi? While I am sure, no doubt, that my colleagues from Louisiana welcome the influx of doctors from the state of Mississippi, this is not how Louisiana wants to attract new residents to the State.

What my home state has in place and what California have benefited from for over 27 years are common sense guidelines for health care lawsuits. These guidelines ensure that injured patients receive greater compensation while at the same time deterring frivolous lawsuits that extort health care professionals and drive doctors from the practice of medicine.

It is difficult for me to believe that the reason so many of our health care providers are being sued is that they are bad doctors. The Texas Medical Examiner Board reported that half of the doctors in the state had lawsuits filed against them. Are half of the doctors in the state of Texas bad doctors? Members on both sides of the aisle know this is absurd. Just as there are good doctors, and bad doctors, there are good lawyers, and bad lawyers. Our judicial system must protect the good doctors, and provide speedy recourse for patients when they are harmed. Our judicial system should not be manipulated to benefit special interests at the expense of patients.

Our task today is clear. Members on this Committee must evaluate if our current judicial system is serving patients well. When injured patients have to wait years

before a medical injury case is complete, our judicial system has failed. When injured patients lose 58 percent of their compensation to attorneys and the courts, our judicial system has failed. When 60 percent of malpractice claims against doctors are dropped or dismissed, but the fear of litigation still forces doctors with twenty-five years of experience to retire early, our judicial system has failed.

It's time for this Congress to enact common-sense reforms that protect injured patients while restoring sanity in our judicial process. Patient care should not be harmed by special interest politics. This is an issue that deserves action this year.

I look forward to the witness testimony.

Mr. BILIRAKIS. Dr. Lisa Hollier is with the LBJ General Hospital, Department of OB/GYN in Houston and she is here on behalf of the American College of Obstetricians and Gynecologists; Ms. Fran Visco, National Breast Cancer Coalition. Ms. Visco's been with us before. Sam Roberts is from Elkins, West Virginia. Ms. Lauren Townsend, Coalition for Consumer Justice, from Philadelphia; and Mr. Stuart Fine, Chief Executive Officer of Grand View Hospital in Sellersville, Pennsylvania, here on behalf of the American Hospital Association.

I don't know whether Mr. Greenwood wanted to introduce Mr. Fine and supplement my introduction without Mr. Fine.

Mr. GREENWOOD. I'd be delighted to, Mr. Chairman. Stuart Fine is the Director of Grand View Hospital, one of the finer hospitals in our region. He's a good long time friend and really has been a leader in trying to change the medical system, the health care system and a fighter against abuses in a variety of ways. We're just delighted to have him here. And now I understand why we call this a hearing because you come and hear us for 2 hours.

Mr. BILIRAKIS. True. Anyhow, your written statements, those would be matter of the record. I would hope that what you would do is complement if you will, or supplement your statements. I will set the clock at 5 minutes. Hopefully you will try to abide that as well as you can.

Dr. Hollier, please proceed.

**STATEMENTS OF LISA M. HOLLIER, LBJ GENERAL HOSPITAL, DEPARTMENT OF OB/GYN; FRAN VISCO, NATIONAL BREAST CANCER COALITION; SAM ROBERTS ON BEHALF OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS; LAUREN TOWNSEND, COALITION FOR CONSUMER JUSTICE; AND STUART H. FINE, CEO, GRAND VIEW HOSPITAL**

Ms. HOLLIER. Thank you, Mr. Chairman. As an obstetrician/gynecologist, I welcome the opportunity to speak with you this morning on behalf of the American College of Obstetricians and Gynecologists, 44,000 partners in women's health care.

I am here today because excess litigation has left American women asking who will deliver my baby. An ailing civil justice system in severely jeopardizing patient care for women and their newborns, forcing one out of ten obstetricians to stop delivering babies and countless more physicians to contemplate the same.

After a brief overview, today I will delineate the inevitable health consequences for women if we allow excessive litigation to persist. In my home State of Texas and across the country, liability insurance for obstetrician/ gynecologists has become prohibitively expensive. Premiums have tripled and quadrupled practically overnight. In some areas, OB/GYNS can no longer obtain liability insurance

at all as insurance companies fold or abruptly stop insuring doctors. When OB/GYNs cannot find or afford liability insurance, they are forced to stop delivering babies, curtail surgical services, or close their doors.

This shortage of care affects hospitals, public health clinics, and medical facilities in rural areas and inner cities. Now women's health care is in jeopardy and this crisis will only end soon with legislative intervention. This crisis involves more than just the decisions of individual insurance companies. The manner in which our antiquated tort system resolves medical liability claims is at the root of the problem. A liability system should equitably spread the insurance risk of providing affordable health care for our society. It should fairly compensate patients harmed by negligent medical care. It should provide compensation to patients with devastating outcomes, unrelated to negligence, like newborns born with cerebral palsy. Our current system fails on all counts. It's punitive, expensive, and inequitable for all, jeopardizing the availability of care.

Although the number claims filed against all physicians climbed in recent decades, the phenomenon does not reflect an increase rate of medical negligence. In fact, OB/GYNs win the vast majority of the claims filed against them. One half of claims against OB/GYNs are simply dropped by plaintiffs' attorneys, dismissed or settled without a payment. Of cases that did precede to court, OB/GYNs won seven out of ten cases closed by a jury or court verdict. What should not be overlooked here are the ripple effects that excessive litigation is directly having on the delivery of women's health care.

Today, the liability crisis is causing women and their newborns to suffer in the following six ways. No. 1, less prenatal care. With fewer obstetricians, it's harder for women to get prenatal care, a significant factor in the delivery of a healthy baby. The greater availability of this care over the last several decades has resulted in the country's lowest infant mortality rate. Now, our ability to maintain that standard is threatened.

No. 2, shorter visits and longer waits. Doctor shortages mean women have to travel longer distances for prenatal appointments and to deliver their babies, especially in rural areas. Wait times for appointments increased while quality time with doctors inevitably decreases.

No. 3, losing gynecologic surgery. As doctors stop performing gynecologic surgery, women can lose access to care that helps protect fertility and pelvic pain, or treat precancerous conditions early.

No. 4, less preventative health care. Fewer doctors offering fewer services means less regular screenings for reproductive cancers, infections, and other health risks for women.

No. 5, less for the underserved. Clinics that provide prenatal and delivery care to underserved and high risk populations included rural, inner city, and teaching hospitals, will have trouble recruiting and affording positions.

And finally, No. 6, less training in women's health. Hospitals may drop their residency training programs in obstetrics and gynecology when they can no longer afford to insure OB/GYNs residents and teachers. The result? Fewer new doctors trained to treat women, particularly pregnant women.

As a physician, I strive to provide every woman in my practice with affordable health care of the highest quality. And without question, I believe that patients who have been harmed by professional negligence should have the opportunity to be adequately compensated for their injuries. But today the scales of justice are out of balance, and until this Nation enacts common sense medical liability reforms, America's women and mothers will continue to suffer.

Thank you, Mr. Chairman, for your leadership on this important issue and for the subcommittee's attention to this crisis. I appreciate the opportunity to present our concerns for the panel's consideration and look forward to working with you to protect women's access to health care.

[The prepared statement of Lisa M. Hollier follows:]

PREPARED STATEMENT OF LISA M. HOLLIER, ON BEHALF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 44,000 physicians dedicated to improving the health care of women, we urge you to bring an end to the excessive litigation restricting women's access to health care.

In addition to providing an overview of the issue, this statement will explain how the medical liability crisis compromises obstetric care for women and detail the consequences for women's health care if excessive litigation persists. This statement will also highlight how the medical liability crisis is acutely affecting nine states, including Florida, explaining how access to basic and important women's health care in those states is severely jeopardized because of a liability system gone awry.

I. EFFECTS OF EXCESSIVE LITIGATION ON WOMEN'S HEALTH CARE: AN OVERVIEW

The number of lawsuits against all physicians has been rising over the past 30 years in an increasingly litigious climate, and obstetrics-gynecology—considered a “high risk” specialty by insurers—remains at the top of the list of specialties affected by this trend.

An ailing civil justice system is severely jeopardizing patient care for women and their newborns. Across the country, liability insurance for obstetrician-gynecologists has become prohibitively expensive. Premiums have tripled and quadrupled practically overnight. In some areas, ob-gyns can no longer obtain liability insurance at all, as insurance companies fold or abruptly stop insuring doctors.

When ob-gyns cannot find or afford liability insurance, they are forced to stop delivering babies, curtail surgical services, or close their doors. The shortage of care soon affects hospitals, public health clinics, and medical facilities in rural areas and inner cities.

Now, women's health care is in jeopardy for the third time in three decades. This crisis will only end soon with legislative intervention. The recurring liability crisis involves more than the decisions of individual insurance companies. The manner in which our antiquated tort system resolves medical liability claims is at the root of the problem.

A liability system—encompassing both the insurance industry and our courts—should equitably spread the insurance risk of providing affordable health care for our society. It should fairly compensate patients harmed by negligent medical care. It should provide humane, no-fault compensation to patients with devastating medical outcomes unrelated to negligence—as in the case of newborns born with conditions such as cerebral palsy. Our current system fails on all counts. It's punitive, expensive, and inequitable for all, jeopardizing the availability of care.

Jury awards, which now soar to astronomical levels, are at the heart of the problem. The average liability award increased 97% between 1996 and 2000, fueled by states with no upper limits on jury awards. This “liability lottery” is enormously expensive, and patients who need, but can't get, health care, pay the price.

The current liability system encourages attorneys to focus on relatively few claims with exorbitant award potential, ignoring other claims with merit. Even then, much of a jury award goes straight into the lawyers' pockets; often, less than half of every medical liability dollar ever reaches the patient.

Patients and physicians need a real solution to this crisis. In the 1980s, the Institute of Medicine warned that the liability crisis compromised the delivery of obstetric care for women across the nation. It urged Congress to provide both immediate relief and long-term solutions. ACOG has asked the Institute to reexamine this issue and update its report.

The liability crisis continues to compromise the delivery of health care today. A recent Harris survey showed that three-fourths of physicians feel their ability to provide quality care has been hurt by concerns over liability cases. And, patients understand the problem, too. An April 2002, survey by the Health Care Liability Alliance found that 78% of Americans are concerned about the impact of rising liability costs on access to care.

## II. HOW EXCESSIVE LITIGATION COMPROMISES THE DELIVERY OF OBSTETRIC CARE

Obstetrics-gynecology is frequently among the top three specialties in the cost of professional liability insurance premiums. Nationally, insurance premiums for ob-gyns increased over time: the median premium increased 167% between 1982 and 1998. The median rate rose 7% in 2000, and 12.5% in 2001, with increases ranging from 0.3% to 69%, according to a survey by *Medical Liability Monitor*, a newsletter covering the liability insurance industry.

A number of insurers are abandoning coverage of doctors altogether. The St. Paul Companies, Inc., which handled 10% of the physician liability market, announced in recent months that it was withdrawing from that market. One insurance ratings firm reported that five medical liability insurers failed in 2001. One-fourth of the remaining insurers were rated D+ or lower, an indicator of serious financial problems.

According to Physicians Insurance Association of America, ob-gyns were first among 28 specialty groups in the number of claims reported against them in 2000. Ob-gyns were the highest of all specialty groups in the average cost of defending against a claim in 2000, at a cost of \$34,308. In the 1990s, they were first—along with family physicians-general practitioners—in the percentage of claims against them closed with a payout (36%). They were second, after neurologists, in the average claim payment made during that period (\$235,059).

Although the number of claims filed against all physicians climbed in recent decades, the phenomenon does not reflect an increased rate of medical negligence. In fact, ob-gyns win most of the claims filed against them. A 1999 ACOG survey of our membership found that over one-half (53.9%) of claims against ob-gyns were dropped by plaintiff's attorneys, dismissed or settled without a payment. Of cases that did proceed to court, ob-gyns won 7 out of 10 cases closed by a jury or court verdict.

When a jury does grant an award, it can be exorbitant, particularly in states with no upper limit on awards. Jury awards in all civil cases averaged \$3.49 million in 1999, up 79% from 1993 awards, according to the latest reports from Jury Verdict Research of Horsham, Pennsylvania. The median medical liability award jumped 43% in one year, from \$700,000 in 1999, to \$1 million in 2000: it has doubled since 1995.

Ob-gyns are particularly vulnerable to this trend, because of jury awards in birth-related cases involving poor medical outcomes. The average jury award in cases of neurologically impaired infants, which account for 30% of the claims against obstetricians, is nearly \$1 million, but can soar much higher. One recent award in a Philadelphia case reached \$100 million.

We survey our members regularly on the issue of medical professional liability. According to our most recent survey, the typical ob-gyn is 47 years old, has been in practice for over 15 years—and can expect to be sued 2.53 times over his or her career. Over one-fourth (27.8%) of ACOG Fellows have even been sued for care provided during their residency. In 1999, 76.5% of ACOG Fellows reported they had been sued at least once so far in their career. The average claim takes over four years to resolve.

## III. WOMEN'S HEALTH CONSEQUENCES OF EXCESSIVE LITIGATION

The medical liability crisis is complex, affecting every aspect of our nation's ability to deliver health care services. As partners in women's health care, we urge Congress to end the medical liability insurance crisis. Without legislative intervention, women's access to health care will continue to suffer. We urge you to bring an end to the meteoric rise in liability premiums that is already impeding women's access to health care.

This crisis is obstructing mothers' access to obstetric care. When confronted with substantially higher costs for liability coverage, ob-gyns and other women's health

care professionals stop delivering babies, reduce the number they do deliver, and further cut back—or eliminate—care for high-risk mothers. With fewer women's health care professionals, access to early prenatal care will also be reduced, depriving them of the proven benefits of early intervention.

Excessive litigation also threatens women's access to gynecologic care. Ob-gyns have, until recently, routinely met women's general health care needs—including regular screenings for gynecologic cancers, hypertension, high cholesterol, diabetes, osteoporosis, sexually transmitted diseases, and other serious health problems. Staggering premiums continue to burden women's health care professionals and will further diminish the availability of women's care.

Legislative intervention is needed to avert another rural health crisis. Women in underserved rural areas have historically been particularly hard hit by the loss of physicians and other women's health care professionals. With the economic viability of delivering babies already marginal due to sparse population and low insurance reimbursement for pregnancy services, increases in liability insurance costs are forcing rural providers to stop delivering babies. Help sustain those providers dedicated to caring for America's rural women and mothers.

Allowing the crisis to continue will mean community clinic cutbacks. Also hurt by the medical liability crisis are the nation's 39 million uninsured patients—the majority of them women and children—who rely on community clinics for health care. Unable to shift higher insurance costs to their patients, these clinics have no alternative but to care for fewer people.

Acting now can save more women from the ranks of the uninsured. Health care costs continue to increase overall, including the cost of private health care coverage. As costs continue to escalate, employers will be discouraged from offering benefits. Many women who would lose their coverage, including a large number of single working mothers, would not be eligible for Medicaid or SCHIP because their incomes are above the eligibility levels. Last year, 11.7 million women of childbearing age were uninsured. Without reform, even more women ages 19 to 44 will move into the ranks of the uninsured.

As partners in women's health care, ACOG urges Congress to act swiftly to avert further access issues for women.

#### IV. WOMEN'S HEALTH SUFFERS NATIONWIDE

As ob-gyns, our primary concern is access to affordable, quality health care. Help us maintain the highest standard of care for American's women and mothers by ending the crisis in the following nine "Hot States": Florida, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Texas, Washington, and West Virginia. In three other states—Ohio, Oregon, and Virginia—a crisis is brewing, while four other states—Connecticut, Illinois, Kentucky and Missouri—should be watched for mounting problems.

In identifying these states, the College considered a number of factors in the escalating medical liability insurance crisis for ob-gyns. The relative weight of each factor could vary by state. Factors included: the lack of available professional liability coverage for ob-gyns in the state; the number of carriers currently writing policies in the state, as well as the number leaving the medical liability insurance market; the cost, and rate of increase, of annual premiums based on reports from industry monitors; a combination of geographical, economic, and other conditions exacerbating an already existing shortage of ob-gyns and other physicians; the state's tort reform history, and whether tort reforms have been passed by the state legislature—or are likely to be in the future—and subsequently upheld by the state high court.

##### A. Florida

- With the highest average premium for ob-gyns in the nation in 2000, at \$158,000 per year, Florida has a high number of medical liability lawsuits and a history of large jury awards. According to First Professionals Insurance Company, Inc., Florida's largest medical liability insurer, one out of every six doctors is sued in the state as compared to one out of every 12 doctors nationwide.
- In South Florida, where insurers say litigation is the heaviest, annual premiums for ob-gyns went as high as \$208,949 in 2001—the highest rates in the country, according to *Medical Liability Monitor*.
- The liability situation has been so chronic in Florida that during the crisis of the 1980s, the state began to allow doctors to "go bare" (not have liability coverage), as long as they could post bond or prove ability to pay a judgment of up to \$250,000.
- Double- and triple-digit premium increases have forced some doctors to cut back on staff, while others have left the state or have stopped performing high-risk

procedures to avoid the lofty rates. Ob-gyns in this state are more likely than their colleagues in other states to no longer practice obstetrics.

- Florida already has some tort-reform laws aimed at protecting doctors. But more recent Florida Supreme Court rulings have weakened such laws, causing the number of lawsuits to climb again. Now Florida is one of at least a dozen states contemplating another round of legislation.

#### B. Mississippi

- According to the Mississippi State Medical Association, medical liability insurance rates for doctors who deliver babies have risen 20% to 400% in the past year, depending on the carrier. Annual premiums range from \$40,000 to \$110,000.
- The *Delta Democrat Times* reported that from 1999 to 2000, the number of liability lawsuits faced by Mississippi physicians increased 24%, with an additional 23% increase in the first five months of 2001.
- According to the DELTA DEMOCRAT TIMES, 324 Mississippi physicians have stopped delivering babies in the last decade. Only 10% of family physicians deliver babies.
- In Cleveland, Mississippi, three of the six doctors who deliver babies dropped that part of their practice in October 2001 because of the increase in premiums.
- In Greenwood, Mississippi, where approximately 1,000 babies are born every year, the number of obstetricians has dropped from four to two. The two remaining obstetricians are each limited to delivering 250 babies per year, leaving approximately 500 pregnant women searching for maternity care, reports the *Mississippi Business Journal*.
- In Yazoo City, Mississippi, which has 14,550 residents, there is no one practicing obstetrics.
- Natchez, Mississippi, which serves a 6-county population of over 100,000, has only three physicians practicing obstetrics.
- The State Legislature defeated 12 tort and insurance reform bills this year. No reforms were approved during the 2002 session, which adjourned in mid-April.
- The St. Paul Companies, Inc., was the 14th insurer to leave Mississippi in five years, according to the Mississippi State Medical Association.
- State Insurance Commissioner George Dale has stated that unless tort reform is passed, it is unlikely that insurance companies will be interested in doing business in Mississippi.

#### C. Nevada

- In December 2001, The St. Paul Companies, Inc., the nation's second largest medical liability insurer, announced it would no longer renew policies for 42,000 doctors nationwide—including the 60% of Las Vegas doctors who were insured by St. Paul. Replacement policies are costing some Nevada doctors four or five times as much as before: \$200,000 or higher annually, more than most doctors' take-home pay, the *Los Angeles Times* reports. Prior to the St. Paul announcement, insurance premiums for Las Vegas ob-gyns had been in the \$40,000 range.
- A February 2002 survey of Clark County ob-gyns, commissioned by their ob-gyn society, revealed:
  - 60% indicated that they are going to drop obstetric care from their practices because they cannot afford the increases in their professional liability insurance.
  - 50% reported they have been quoted premium increases ranging from 50% to 200%.
  - 42.3% are making plans right now to leave the state if there is no resolution in the medical liability situation in the next couple of months.
  - 78% percent indicated that they ultimately will have to leave the state if there is no long-term solution.
- According to a March article in the *Las Vegas Review-Journal*, many Las Vegas Valley doctors say they will be forced to quit their practices, relocate, retire early or limit their services if they cannot find more affordable rates of professional liability insurance by early summer.
- According to the Nevada State Medical Association, it is estimated that between 200 and 250 physicians will be facing bankruptcy, closing their offices, or leaving Nevada this year.
- In February 2002, the *Las Vegas Sun* reported that medical liability cases in Clark County had more than doubled in the past six years. In that period, plaintiffs' awards in the county totaled more than \$21 million.
- *USA Today* reports that in the past two years, Nevada juries have awarded more than \$1.5 million each in six different medical liability trials.

- Recruiting doctors to Las Vegas is extremely difficult because of the escalating medical liability premiums and the perception that it is highly litigious. Nevada currently ranks 47th in the nation for its ratio of 196 doctors per 100,000 population. The state's medical school produces just 50 physicians a year.
- Unlike neighboring California, which has a cap on noneconomic damages, there is no limit in Nevada as to what juries can award patients in medical liability cases.

#### D. New Jersey

- In February 2002, the NEWARK STAR-LEDGER reported that three medical liability insurance companies went bankrupt or announced they would stop insuring New Jersey physicians in 2002 for financial reasons. The state's two largest medical liability insurers have stated that they cannot pick up all the extra business and are rejecting doctors they deem high risk.
- MBS Insurance Services of Denville, one of New Jersey's largest medical liability insurance brokers, estimates that approximately 300 to 400 of the state's doctors cannot get insurance at any price.
- According to the Medical Society of New Jersey, premiums have risen 50% to 200% over last year.
- According to the *Star-Ledger*, "An obstetrician with a good history—maybe just one dismissed lawsuit—can expect to pay about \$45,000 for \$1 million in coverage. Rates rise if the physician faces several lawsuits, regardless of whether the physician has been found liable in those cases."
- The president of the New Jersey Hospital Association says that rising medical liability premiums are a "wake-up call" that the state may lose doctors. Hospital premiums have risen 250% over the last three years, and 65% of facilities report that they are losing physicians due to liability insurance costs.

#### E. New York

- New York State currently faces a shortage of obstetric care in certain rural regions. Increasing liability insurance costs will only exacerbate these access problems.
- In 2000, New York was second only to Florida in the average cost of annual liability insurance premiums for ob-gyns (\$144,973 per year).
- Also in 2000, there was a total of \$633 million in medical liability payouts in New York State, far and away the highest total in the country. According to the insurance consumer web site [www.insure.com](http://www.insure.com), this is 80% more than the state with the second highest total.
- Increased insurance rates have forced some physicians in New York to "quit practicing or to practice medicine defensively, by ordering extra tests or procedures that limit their risk," according to a recent New York Times report.
- Physician medical liability insurance costs have historically been a problem in New York State. The legislature and governor had to take significant action in the mid-1970s and again in the mid-1980s to avert a liability insurance crisis that would have jeopardized access to care for patients.

#### F. Pennsylvania

- Pennsylvania is the second-highest state in the country for total payouts for medical liability. During the fiscal year 2000, combined judgments and settlements in Pennsylvania amounted to \$352 million—or nearly 10% of the national total.
- From the beginning of 1997 through September 2001, major liability insurance carriers writing in Pennsylvania increased their overall rates 80.7% to 147.8%, according to a January 2002 *York Daily Record* article.
- Philadelphia and the counties surrounding it are hardest hit by the liability crisis. From January 1994 through August 2001, the median jury award in Philadelphia for a medical liability case was \$972,900. For the rest of the state, including Pittsburgh, the median was \$410,000.
- One-quarter of respondents to an informal ACOG poll of Pennsylvania ob-gyns say they have stopped or are planning to stop the practice of obstetrics. 80% of medical students who come to the state for a world-class education ultimately choose to practice elsewhere, according to the Pennsylvania State Medical Society.
- On April 24, 2002, Methodist Hospital in South Philadelphia announced that it will stop delivering babies due to the rising costs of medical liability insurance. The labor and delivery ward closed on June 30, leaving that area of the city without a maternity ward. Methodist Hospital has been delivering babies since its founding in 1892.
- Despite some tort reform measures passed by the state legislature (House Bill 1802) this past winter, ob-gyns were disappointed the measures did not provide

more relief. The law did not include: caps on jury awards; sanctions on frivolous suits; changes in joint and several liability; limits on lawyers' fees; or, a guarantee that a larger share of jury awards will go to injured plaintiffs.

- The rules for venue of court cases in Pennsylvania are very liberal. Recently approved measures only appoint a committee to study venue shopping, but do not limit the practice.
- Since HB 1802 passed, experts predict a 15% to 20% overall reduction in doctors' liability premiums. But with the 50% to 100% premium increases of the last two years, medical officials believe the bill is not enough to stop physicians from leaving practice or to attract new physicians. Nor do they believe new insurers will begin writing policies in Pennsylvania.

#### G. Texas

- Preliminary results of a recent Texas Medical Association physician survey indicate that:
  - More than half of all Texas physicians responding, including those in the prime of their careers, are considering early retirement because of the state's medical liability insurance crisis.
  - Nearly a third of the responding physicians said they are considering reducing the types of services they provide because of recent premium increases for medical liability. The percentage of physicians answering "yes" to that question was higher in Fort Worth, Houston, San Antonio, and Dallas than in Brownsville or El Paso.
- Medical liability insurance premiums for 2002 are expected to increase from 30% to 200%, according to the Texas Medical Association. In 2001, ob-gyns in Dallas, Houston, and Galveston paid medical liability insurance premiums in the range of \$70,00 to \$160,000.
- According to Governor Rick Perry's office, between 1996 and 2000 an average of one in four Texas physicians had a medical liability claim filed against them. In the Lower Rio Grande Valley, the situation is even worse.
- According to a February 2001 Texas Medical Association survey, one in three Valley doctors say their insurance providers have stopped writing liability insurance.
- In 2000, 51.7% of all Texas physicians had claims filed against them, according to the Texas Medical Examiners Board. Patients filed 4,501 claims, up 51% from 1990.
- By some estimates, as many as 86% of medical liability claims filed in Texas are dismissed or simply dropped without payment to the patient. Yet providers and insurance companies must still spend millions of dollars in defense, even against baseless claims.
- According to a Texas Medical Association study, the amount paid per claim in 2000 was \$189,849 (average for all physicians), a 6% increase in one year.
- Texas has no limits on noneconomic damages in medical liability cases, although the legislature enacted such limits in the 1970s as part of a comprehensive set of reforms. The Texas Supreme Court later rejected them in the 1980s.
- Texas has procedures in place to screen lawsuits for merit and to sanction lawyers who file frivolous suits, but these are not enforced uniformly across the state, according to an April 2002 news release issued by Governor Rick Perry.
- Only about 30% of the medical liability insurance market is served by insurance companies that are regulated by the Texas State Department of Insurance and subject to rate review laws, according to Governor Perry's office.

#### H. Washington

- According to *Medical Liability Monitor*, in late 2001 the second largest carrier in Washington State announced that it was withdrawing from providing medical liability insurance for Washington physicians. This decision by Washington Casualty Company impacted approximately 1,500 physicians.
- In 2001, state ob-gyns paid medical liability insurance premiums in the range of \$34,000 to \$59,000. For many physicians, this meant an increase of 55% or higher from the year 2000.
- According to the Pierce County Medical Society, some Tacoma specialists reported 300% increases.
- Unlike California, Washington has no cap on noneconomic damages in medical liability cases. The State Supreme Court found a previous cap unconstitutional in 1989.
- In April, *The Olympian* reported that Washington State Insurance Commissioner Mike Kreidler's office has heard repeatedly from physicians throughout the

state that they may be forced out of Washington because of high medical liability rates or the lack of available insurance.

#### *I. West Virginia*

- There are only three carriers in the state—including the state-run West Virginia Board of Risk and Insurance Management—currently writing medical liability policies for doctors. Annual premiums range from \$90,700 to \$99,800.
- In 2000, many physicians had problems affording or finding insurance. This urgency prompted Governor Bob Wise to issue a request for proposals to commercial insurance carriers asking them to provide terms under which they would be willing to come to the state. The governor's office received no response at all. To date, some carriers previously active in West Virginia are under an indefinite, self-imposed moratorium for new business in the state, according to the West Virginia State Medical Society.
- Legislation eked out during a grueling special session in the fall of 2001 reestablished a state-run insurer of last resort. However, with rates 10% higher than the highest commercial rate, and an additional 50% higher for those physicians who are considered high risk, the state-run insurer does not solve the affordability problem, according to ob-gyns in the state.
- According to an informal survey of ACOG's West Virginia section, more than half of all ob-gyn residents plan to leave the state once they have completed training because of the state's medical liability insurance climate. A majority of private practitioners who provide obstetric care plan to leave the state if there is not improvement in the insurance crisis.
- West Virginia cannot afford to lose more doctors. The West Virginia State Medical Society reports that a majority of the state is officially designated by the federal government as a health professional shortage area and medically underserved.

#### *V. Conclusion*

Thank you, Mr. Chairman, for your leadership on this important issue and for the Subcommittee's attention to this crisis. ACOG appreciates the opportunity to present our concerns for the panel's consideration. The College looks forward to working with you as we push for a solution.

Mr. BILIRAKIS. Thank you very much, Doctor.  
Ms. Visco.

#### **STATEMENT OF FRAN VISCO**

Ms. VISCO. Thank you very much, Mr. Chairman. As you know, I'm the president of the National Breast Cancer Coalition and a 15-year breast cancer survivor. The National Breast Cancer Coalition is a group of more than 600 organizations from across the country. We are dedicated to eradicating breast cancer through action and advocacy and we focus on increasing Federal funding for breast cancer research and collaborating with the scientific community to make certain that research is well done, to increasing access to health care for all women and certainly to quality clinical trials and to increasing the influence of women with breast cancer and other breast cancer advocates and all decisionmaking around breast cancer.

We've been fighting as an organization for access to high quality health care since our inception in 1991. And much of the debate over the past decade has focused on how to finance and deliver health care. But we believe, and equally, if not a more important question is, how do we define quality care? What is it? How does it compare to the kind of care the patients usually and currently receive?

You know, we're talking today about whether excessive litigation is harming patient's access to care, and I have to say in listening to a number of the opening statements, I was questioning whether I'm in the right room. Because really what I'm focusing on is and what the National Breast Cancer Coalition is focused on, what our

goals are, to make certain that patients have access to quality health care.

And there are many barriers standing in the way of access to quality health care. You're dealing today with whether excessive litigation is one of those barriers. There's an assumption that excessive litigation is increasing medical malpractice rates and increasing medical malpractice rates have resulted in a barrier to access to health care. Those are all assumptions that you're going to have to test and put into the context of all the other barriers and prioritize what is the most important and how can we achieve as quickly as possible access to quality care for all Americans.

The National Breast Cancer Coalition is one of a number of organizations that have supported very strong enforcement mechanisms in all litigation. We have opposed caps and liability damages. We are one of a number of organizations that take and continue to take that position.

You're asking today, again, whether the prevalence and amount of jury awards has been the cause of sky rocketing insurance premiums. And if that is the case, we're asking well, would limiting lawsuits be the solution? Perhaps a better solution, one of a number of better solutions would be to limit the need for lawsuits.

You know, there's an atmosphere in this country now among the public and the patient community of distrust, distrust certainly for corporations, for institutions, and the medical community. We're looking at what are the barriers in the way. What is it that we need to work on and focus on.

The Institute of Medicine has issued a number of reports that have identified so many problems in the health care system in this country, the Quality Chasm Report, Medical Errors Report, the Data Report. There is much dialog and much research going in to looking at the barriers to health care. There are the issues of corporate individual and institutional actions. You're looking at issues like Imclone. It's not just the insider trading issues, but the issue of conflict of interest of institutions and clinicians who are involved in research. How does that impact access to quality care? What effect does that have on individuals? Those conflicts are serious and they're real and they're undermining the trust in the country for the medical community.

We're looking at recent, there are a number of examples given but there was also a recent article in the paper about a large pharmaceutical company hiding toxicity data when it presented data to the FDA for drug approval. That drug was then approved out in the public and a number of deaths occurred. We're looking at a lack of evidence base medicine in this country. You've seen the recent report on arthroscopic surgery. You're looking at the hormone replacement clinical trial recently. Breast self exam. Mammography screening. You're looking at a system that needs serious attention and fixing in order to get access to quality care. You're looking at tens of millions of Americans who lack health insurance. You're looking at millions and millions of Americans whose health insurance premiums are increasing.

There are barriers to doctors and institutions to providing care. There may be an overuse of technology. They're saturated markets in competition. There's lack of a focus on evidence based medicine,

and we're dealing with a necessary shift to evidence based medicine from a fee for service system.

Now practice premiums are too high, but what caused that? Was it corporate mismanagement? Was it excessive litigation? The resources of the grass roots and the patients across this country that are part of the National Breast Cancer Coalition are precious. And we're very careful how we utilize them. We're very careful when we ask them to get behind a particular issue. And the resources of the U.S. Congress are equally precious. We look to you for leadership. We look to you for focusing on the right priorities on what we really need to accomplish to get all Americans access to quality health care.

If excessive litigation turns out to be the case, then that is something I hope you will look at extremely carefully and we can work on together. But we need to work together to fixing the health care system. And as an organization, along with a number of other organizations to date, we do not believe that putting caps on what a patient is going to receive as a result of malpractice is the answer to this problem. Thank you very much.

[The prepared statement of Fran Visco follows:]

PREPARED STATEMENT OF FRAN VISCO, PRESIDENT, NATIONAL BREAST CANCER COALITION

INTRODUCTION

Thank you Mr. Chairman, and Members of the Committee, for inviting me to testify today. I am Fran Visco, President of the National Breast Cancer Coalition (NBCC), and a breast cancer survivor. I am one of the 3 million women living with breast cancer in the United States today.

The National Breast Cancer Coalition is a grassroots advocacy organization dedicated to ending breast cancer through the power of action and advocacy. The Coalition's main goals are to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates in the decision-making process.

NBCC has been fighting for access to high quality breast cancer care since its inception in 1991. While much of the debate over the past decade has focused on how to deliver and finance health care, we believe that these are secondary issues. Before we can determine what system best delivers quality breast cancer care, we first have to answer a more basic question: what is quality care? How does it compare to the kind of care that patients currently receive?

The issue before the Committee today deals with whether excessive litigation is harming patient access to care. However, rather than focusing on whether litigation has increased, and whether jury awards are too high, we think the more important questions are: What type of care do patients deserve? Why are they turning to the court system to get it? Will limited accountability and capping damages solve the problem?

The Institute of Medicine has published a number of reports—*Crossing the Quality Chasm, To Err is Human, and Enhancing Data Systems to Improve the Quality of Care*, which address important concerns about the quality of the health care that patients currently receive. These reports revealed that in many ways the healthcare system is broken, and that patients do not have access to the care they deserve. The focus must be on improving the system—and ensuring a patient-centered, accountable system of care.

The National Breast Cancer Coalition is focused through its Quality Care Initiative to accomplish this goal. In fact, NBCC believes that the most effective way to reduce lawsuits is to create a fair and transparent system of accountability for health care. Once defined, a high quality health care system would be one where everyone knows the rules. Doctors would follow it. Insurance companies would embrace it. And patients would benefit from it.

Moreover, in a quality health care system, no one would assume that the doctor is always right, that the health plan is always wrong. Rather, we would have guidance from a comprehensive set of high quality health care standards. Patients would have access to evidence-based medicine. Health plans would deny certain procedures only if they were ineffective, not because of the bottom line. Patients would not assume that more care is better care, because with a more transparent system, they would be better educated and more empowered. In NBCC's vision of a quality care system, providers would be trained in a patient-centered perspective—from the beginning.

I would like to focus my testimony on two main points:

**First, the reason that the National Breast Cancer Coalition cares about this issue is that we are committed to quality cancer care, and we believe that accountability is a key component to getting this care.**

NBCC is working with its 600 member organizations, and tens and thousands of breast cancer advocates across the country in a partnership with committed health insurers, providers and public policy officials to define a quality health care system, to put it in place, and to ensure that all breast cancer patients have access to it. Ultimately, we know that without accountability in the system, we will never have quality care.

In the Coalition's vision of quality, patients would get access to high quality evidence-based medicine. Patients would be ensured access to approved clinical trials, which provide the best evidence about what works, and what does not. Patients would have a seat at the tables where decisions about breast cancer are made, and the system would be more transparent. Transparency would lead to trust. Transparency would also result in a built-in infrastructure of accountability—one that would limit the number of patients harmed in the system, and compensate those who were injured. Providers and institutions would place the highest premium on delivering high quality care to their patients, and health plans would support providers in this endeavor.

NBCC appreciates the difficult challenge in working to fix a system that may be broken as opposed to just saying what is wrong with it. It is for that reason that we hope you will embrace the opportunity to work to improve the quality of our healthcare system, and to reduce patients' need to turn to the courts to get the care they deserve.

When patients are diagnosed with breast cancer, the last thing they want while they fight for their lives is to have to go to court and fight for their care. If lawsuits are increasing, it is fair to assume that patients may not be getting access to the type of care they need, when they need it. We have a responsibility to work together to improve patients' outcomes in the healthcare system.

Recently, we have seen first hand the harm that results when there is a lack of accountability for corporate and individuals' actions. We can pull relevant examples from the accounting world where corporate executives acted in bad faith, at the expense of their employees and the public, without concern that they'd be held liable for their actions. It is only now that the bad actors are splashed across the front pages of newspapers, and forced to testify before Congress to explain their actions, that the corporate culture is seeking to improve the system. And it is only because the corporate world is being held accountable for its illegal activity that it is committed to change. There is no doubt that accountability can be a powerful deterrent, and that it is an essential component of change.

Why, then, would Congress seek to limit accountability in the health care system rather than improve the quality of care that patients receive? The way to improve quality care, minimize medical errors, reduce medical costs, and deter bad actors cannot be achieved by simply reducing damage awards or limiting enforcement. While the solution may be complex, the National Breast Cancer Coalition is committed to working with Members to ensure that all individuals have access to a quality healthcare system where they receive their care without having to go to court.

NBCC believes that the right to sue also serves as an assurance that patients who have been injured have access to redress for injuries caused by medical errors and malpractice.

Congress has made it clear that employees of Enron and WorldCom should have recourse for life savings they have lost due to actions of others. Likewise, shouldn't a patient, who after being denied access to high quality care, or being the victim of medical malpractice, have the chance to be compensated for her loss?

We have all heard the horror stories about patients who are denied access to quality care, and suffer tragic consequences as a result. While these individual stories are compelling and important to address, we believe that the focus of today's hearing should be on what we can do to move forward toward a more patient-centered,

evidence-based system of quality health care within which patients are survivors rather than victims.

**Second, the ultimate goal is to make certain that patients have access to quality healthcare. Extensive litigation may not be standing in the way.**

While medical malpractice insurance rates are increasing, there is no conclusive evidence as to why. There also seems to be a lack of clarity about what this really means for patients. NBCC feels strongly that medical decisions must be evidence-based; likewise, we believe that legislation must stem from an evidence-based analysis. We must ensure that we are addressing the real issue, the right way, rather than rushing to enact a solution before we truly understand the problem.

According to a recent “Wall Street Journal” article, business decisions made by the insurance industry may also have contributed to the current crisis in affordable coverage. During the last decade, malpractice insurers competed for a national market share, keeping prices artificially low and inadequate to cover claims. Losses from inadequate pricing and poor investment decisions have forced many insurers either to withdraw from the malpractice market or restrict their coverage.

It may be that too little oversight and regulation of the insurance industry has led to dramatic price increases and fluctuations in the availability of coverage, leaving many providers without access to affordable coverage.

Of course at issue today is also whether the prevalence and amount of jury awards has been the cause of skyrocketing insurance premiums, and if that is the case, one must ask: would limiting lawsuits be the solution? NBCC believes that the better solution would be to limit the need for lawsuits.

It is also important not to become alarmist about reports that patients are having difficulty in accessing healthcare due to medical malpractice rates. While there may be incidents in some states where patients had difficulty in accessing a provider, we have a responsibility not to suggest that the problem is widespread relative to all patients in all states, until we have conclusive information.

The National Breast Cancer Coalition looks forward to working with Members of Congress to address the issue of access to high quality health care for all Americans. Attached for the record is NBCC’s position paper on our vision for quality health care, and a copy of our recently published “Guide To Quality Breast Cancer Care”. Thank you for the opportunity to testify, and I’d be happy to answer any questions.

#### POSITION STATEMENT

##### POSITION

NBCC has been fighting for access to quality breast cancer care since its inception in 1991. Much of the debate over the past decade has focused on how to deliver and finance health care, but we believe this is a secondary question. Before we can determine what system best delivers quality breast cancer care, we have to first answer a more basic question: what is quality care? NBCC believes that quality breast cancer care is a patient-centered, evidence-based system of care that fulfills the following overlapping core values: Access, Information, Choice, Respect, Accountability, and Improvement.

##### THE PROBLEM

The term “quality health care” is often used but rarely defined. There is no national consensus on what makes breast cancer care “quality” care. But even without a precise definition, we know that breast cancer care in this country is inconsistent and sometimes dangerously inadequate. Recent studies are revealing the depth and breadth of the problem.<sup>1</sup>

As breast cancer activists, we know too well that the present health care system—or rather, lack of a system—does not work for everyone. We believe everyone affected by breast cancer should have full access to the best care available, care that

<sup>1</sup>The National Cancer Policy Board, in its report *Ensuring Quality Cancer Care* (NIM/NRC, 1999), found that we do not have good evidence about what constitutes good quality care. But it concludes that our current cancer care “system” leaves a substantial number of patients with far less than ideal care. The RAND Corporation, in *How Good is the Quality of Health Care in the United States* (RAND/RP-751, 1999), also notes the surprisingly small amount of systematic knowledge available on the quality of health delivered in the United States. But based on existing data, it also concludes that there are large gaps between the care people should receive and the care they do receive. In *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM/NAP 2001), the Committee on the Quality of Health Care in America concludes that quality problems are everywhere and that the U.S. health care delivery system is in need of fundamental change.

is based on sound scientific evidence and delivered in a respectful and timely manner. This is a far cry from reality.

We also strongly support evidence-based medicine and know that more care is not always better care. We do not want to waste our limited resources—or risk our health or lives—on treatments that are based on little more than a hope. We deserve health care that works, and access to a wide range of well-designed and efficiently run clinical trials that help us find better treatments for breast cancer.

But evidence-based care is just one part of quality breast cancer care. Because we do not have a sure cure, breast cancer patients and clinicians are often forced to make crucial choices with inadequate information. Sometimes there are no best answers. In such an uncertain and frightening environment, psycho-social concerns become paramount.

For these reasons, NBCC does not view quality care as simply a checklist of procedures or a measurement of over-treatment and under-treatment. Instead, our vision is of overlapping core values. We believe the following six core values are the essential components of quality breast cancer care: Access, Information, Choice, Respect, Accountability, and Improvement.

#### ACCESS

Comprehensive affordable health care must be available to everyone. All patients must have access to coordinated care that is user-friendly, culturally respectful, timely, and integrated both among and within provider offices and systems.

#### INFORMATION

All information must be accurate, timely, readily available, and disseminated in an appropriate format. Health care providers must offer clear information on the risks and benefits of all treatment options, and the evidence and lack of evidence relating to each option. They must encourage multiple opinions to assure the patient that the provider's recommendation is appropriate.

There must be transparent standards of evidence that explain what level of evidence is acceptable and what happens in the absence of sufficient evidence.

Providers and patients must be given time and resources to review evidence, and efforts to review and synthesize evidence must be expanded so the system reflects current scientific/medical knowledge.

A national advocacy advisory panel should be established to work with advocates, health literacy specialists, economists, and the public health community to review evidence and help design effective methods for communicating health care information to consumers, providers, and insurers.

#### CHOICE

Recommended treatments must offer the best possible outcome consistent with patients' personal preferences. Patient preferences for information and involvement in determining the course of treatment must be respected.

Patients must have choices among a reasonable range of providers and treatment options, including specialists and complimentary care with proven efficacy.

#### RESPECT

Care must be patient-responsive and culturally respectful. Patients should feel comfortable asking questions, voicing opinions, and being participants (at whatever level is appropriate for them) in all health care decisions. They must have justified confidence in the experience and training of health care providers and know that providers listen to them and advocate on their behalf.

Patient confidentiality is paramount, and patients must have assurances that it is respected.

There must be a system-wide emphasis on comprehensive care that respects patients' fears, beliefs, culture, time, bodies, pain, decisions, and family members. The system must enable patients for whom breast cancer is a chronic illness to take care of themselves, avoid complications, and maintain their quality of life. The system must provide a wide range of services related to end of life issues for those dying of breast cancer.

#### ACCOUNTABILITY

There must be national standards of quality care that are continually updated; every aspect of care must meet these standards at all sites of care. Services provided should be "needed and effective" as determined by a decision-making body that in-

cludes consumers; the end result should be based on democratically developed unambiguous criteria.

There must be a well-designed and trusted grievance procedure that is clearly articulated to patients and includes meaningful consequences for both system and health care/insurer provider errors.

Patients must bring health issues forward to their providers and accept the choices they make for themselves. All providers and patients must be accountable to our society for the responsible use of health care dollars.

#### IMPROVEMENT

There must be an ongoing commitment to increasing the quality and quantity of available evidence, especially regarding the causes and prevention of breast cancer, and with an emphasis on learning from mistakes. All patients must be fully informed of clinical trials for which they are eligible, and there must be no financial barriers to participation in these trials.

There needs to be more creative and meaningful measures of quality, and more effective ways of collecting and disseminating this information. Designing scientific tools for measuring health care quality has, until recently, been the domain of health services researchers. Breast cancer survivors and activists bring a unique and crucial perspective to this issue, and must be involved at every level of the quality breast cancer care research process.

A patient-centered evidence-based vision of quality must deeply permeate our medical educational system, including continuing medical education, so both current and future providers understand and appreciate their role in creating quality breast cancer care.

#### CONCLUSION: A GUIDE TO QUALITY

The specific methods and strategies for fulfilling these core values will vary, but the core values themselves will not. Together, they serve as a guide to design and evaluate quality health care public policy. We believe that successfully incorporating all of these core values into our health care system is the key to achieving quality breast cancer care.

#### ABOUT NBCCF

The National Breast Cancer Coalition Fund is a grassroots organization dedicated to ending breast cancer through the power of action and advocacy. The Coalition's main goals are to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates in all aspects of the breast cancer decision making process.

Mr. BILIRAKIS. Thank you, Ms. Visco. Before I introduce Dr. Roberts, I would like to announce that Ms. Capito, Congresswoman from West Virginia, who is not a member of the committee that of course greatly interested in this issue because of the problems in West Virginia, particularly, has joined us to listen in. Thank you for being here.

Dr. Roberts.

#### STATEMENT OF SAM ROBERTS

Mr. ROBERTS. I'm Dr. Samuel Roberts from Elkins, West Virginia. I live in a town of about 10,000 people. The county is approximately 30,000 people. We take care of seven counties, approximately a 100,000 patient population. We have one hospital there. When I first went into practice in Elkins, 1978, there were six hospitals, providing full service, obstetrics, surgery, and emergency room intensive care work. There's now one hospital in that area. We serve 100,000 people. We are losing physicians by the day. We have four OB/GYNs and myself delivering babies in that community. One of our OB/GYNs went to Canada last week to interview

for a job because he could not find malpractice insurance in West Virginia.

The three other OB/GYNs went to work for the hospital. I'm presently in private practice. My partner, who is also a family physician, stopped doing obstetrics 2 years ago because he could not afford the malpractice costs. I'm a second generation family physician. My father and I have delivered over 9,000 babies in Elkins, the town of 10,000. In the last 63 years, there's been a Dr. Roberts practicing medicine, other than the 5 years that my father was gone during World War II as a medical officer in the European theater. Four years, excuse me. And I'm very proud of that.

But he and I practiced together for approximately 6 years. And I have tried to continue that heritage. I have a daughter named Leah Roberts, who is a second year medical student at West Virginia University. Leah had hoped to come back to practice with me as I did with my father carrying on the tradition of caring for people in our community. Leah and many of her classmates do not feel that they can come back to West Virginia because they cannot afford to pay the malpractice premiums. I have four children in college and graduate school. I'm having difficulty paying their tuitions and continuing to keep my practice open. My practice is approximately 90 percent welfare, Medicaid and Medicare. And my obstetrical is 90 percent Medicaid.

We provide services. I have two physician's assistants, and a nurse practitioner. I have ten employees total that try to take care of as many people as we can. We're not in it for the money. We're there to try to help people. And honestly, it's not an issue of money. It's an issue of access to care. And the people really have a chance to see their family doctor, have a chance to do something to help themselves provide their family with the best care possible.

The number of OB providers in West Virginia in 1978 was approximately 200 and included 140 family physicians and approximately 60 OB/GYNs. Now there are approximately 100 providers. In the last 24 years, the number of providers has dropped, from approximately 200 to less than a 100. So access to prenatal care and delivery services has diminished. For every dollar spent on prenatal care you save \$4 on the care of pre-term infant. As the gentleman mentioned earlier, a woman comes into the emergency department at 26 or 28 weeks. If that woman had had good care, anticipatory prenatal care, she could have been prevented possibly from being brought in an emergency situation to deliver in an emergency department.

That child, that family, and the society will pay the bill the rest of their life. When that child is born at 26 weeks, it's going to have respiratory problems, many times cerebral problems, blindness, many complications that can occur from excessive prematurity. We need to be aware that this has long term impact on the people of America. The access to care is not there.

In West Virginia it is critical. We are losing people by the day. We have four surgeons in Elkins. Two of them are going to retire this year because they had to change companies and they cannot afford to pay their tail. If they switch to a new company, they have to buy tail at that company.

I had to switch BRIM, which is the Bureau Risk and Insurance Management, which is run by the State of West Virginia. It was initially brought about in order to provide services for professors at the universities, such as Marshall University and West Virginia University. And what's happened is that BRIM has, in this emergency situation, taken up the individual physician, such as myself, that could not find other malpractice insurance.

I have never had a malpractice claim in 24 years. My rates doubled last year from \$17,000 to \$35,800. I can't afford that next year, because they tell me it's going to double again. I can not afford to continue to provide obstetrical services in Elkins, West Virginia. I have families I have delivered eight, nine children for. It makes me very sad to know that I'm not going to be able to be there for those families. I am delivering babies of women that I delivered. And that's a very wonderful feeling. To live in a small community in West Virginia and realize we're going to lose that special touch. It makes me very sad that my daughter doesn't feel that she can come back and practice with me.

I think it's a loss to West Virginia, it's a loss to the United States. We don't have a sense of what's right here. The lawyers are pointing at the insurance companies. The insurance companies are pointing at the lawyers. The doctors are pointing at the insurance companies and the lawyers. We need to sit down and work out something we can all live with that allows our people to have the right to health care. We need to use common sense. We need not to make this a political issue. I'm a Democrat. My grandfather was Governor of West Virginia in the 1930's. He brought West Virginia through some hard times. And I hope that we can come through this hard time. I hope that medically we can make a difference. We can stabilize the situation. But it takes people sitting down and working together and that's the reason I'm here today. I appreciate you listening. Thank you.

[The prepared statement of Sam Roberts follows:]

PREPARED STATEMENT OF SAM ROBERTS, ON BEHALF OF THE AMERICAN ACADEMY OF  
FAMILY PHYSICIANS

Thank you, Mr. Chairman, Ranking Member Brown and members of the Health Subcommittee. My name is Dr. Sam Roberts. I am a family physician from Elkins, WV, here today on behalf of the American Academy of Family Physicians and the National Medical Liability Reform Coalition.

I am here because I am concerned that the medical liability crisis threatens my patients' ability to get the health care they need. I am the second generation to serve as the local physician in Elkins. My father was the local physician in Elkins before me. Between the two of us, we have delivered 9,000 babies in a town of 10,000. I have never been sued in twenty-five years of practice, but I cannot afford the insurance to continue delivering babies. This year I will have to stop, leaving the seven counties around me with no family physician delivering prenatal or maternity care. This will mean my pregnant patients will have to drive four to six hours for their prenatal care and delivery. This is a hard decision both for both my patients and me. But the litigation environment in West Virginia has driven up premiums so that I cannot afford the insurance.

I am also concerned that West Virginia is facing a larger health care crisis. My daughter, Leah Roberts, is sitting behind me today. She is in her first year of medical school at West Virginia University Medical School. Her incoming class was surveyed at the beginning of the year and over ninety percent expected to stay in West Virginia to practice medicine. At the end of this year, they were surveyed again. Over two thirds of the class now expects to leave the state for states that are not experiencing a litigation crisis.

We need passage of liability reforms on the national level. The AAFP and the National Medical Liability Reform Coalition support H.R. 4600, the Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

Mr. BILIRAKIS. Thank you very much, Dr. Roberts, for your excellent testimony.

Ms. Townsend.

#### STATEMENT OF LAUREN TOWNSEND

Mr. TOWNSEND. Thank you very much, chairman, members of the committee and for the civics lesson for my son who has been listening to all the back and forth throughout the day.

I'm the Director of Citizens for Consumer Justice. We're Pennsylvania's largest consumer coalition and organization. I'm also representing U.S. Action. I'm on the board of U.S. Action nationally. We applaud you for addressing this very, very important issue. However, with all due respect to our own Representative Greenwood, we vehemently oppose the contents of H.R. 4600, because we know that it will hurt victims of medical malpractice. It will immunize wrongdoers and be a boon for the insurance industry.

We, as patients, I know you've heard this over and over again, are regularly subjected to the hassle factor when we seek health care. Because of HMOs, because of these corner the market hospital system giants, our relationship with many doctors, unlike Dr. Roberts, is tenuous at best. Our hands, patients and doctors, are tied because of bureaucrats calling the shots and deciding how health care should be delivered. And the result is health care cost containment, and that means frequently blowing through patients, avoiding costly referrals to specialists, making nurses work overtime, and not modernizing or streamlining systems and processes and procedures to avoid mistakes.

Doctors are finding themselves in a terrible, terrible predicament. They're told how to practice medicine by administrators all the while finding the environment for practicing more difficult because of the sky rocketing insurance rates we've been talking about all day.

Another issue that's really important, the AMA itself has said that medical errors, medical mistakes account for the fifth leading cause of death in this country. At a rally last fall, Pennsylvania victims spoke of malpractice and their own personal horror stories. Donald Davis used to work at a Home Depot. In September of 2000, he went to a doctor to have a bone spur removed from his right baby toe. Shouldn't have been a big surgery and he was expected back to work within a few weeks.

Because of a mistake on the part of the doctor, the surgery incision didn't heal properly and become gangrenous. Ultimately, the infection ensued and he had to have the toe amputated and needed bi-pass surgery in his leg. By January of that year, he developed a massive blood infection and in his own words, he said, "if I hadn't ended up finding a new doctor, I would have died because of the blood infection. But unfortunately, the only way to save my life was to have both legs amputated. What happened to me was the result two doctors' errors and it was preventable. Because of my amputation I had to leave my job and my life will never be the same. I

came in with a problem with one toe and came out without my legs.”

H.R. 4600 is not the answer. It will only further hurt injured victims and do nothing to foster patient safety or lower insurance premiums. It tells a woman whose doctor's negligence costs the life of her child that the child's life is only worth \$250,000. And it tells Donald Davis that having no legs for the rest of his life because of malpractice is worth the same.

Through caps on non-economic damages, we place an arbitrary price tag on the most horrendous of injuries. Should legislation decide the value of your baby's life or your eyesight when taken from you by a negligent doctor? Wouldn't we prefer to have that decision in the hands of your constituents on a jury that has heard all the facts?

Last summer, at Philadelphia's St. Agnes Hospital, a number of people died because of mistaken lab tests that went on for weeks without detection and affected hundreds of patients. This bill does nothing to upgrade technology and processes and procedures at our Nations' hospitals. Instead it eliminates joint and several liability which just further immunizes hospitals and HMOs. It also does nothing to deal with the issue of fatigue on the job. Health care workers have to work brutal schedules without adequate rest. The government doesn't allow truck drivers or airline pilots to work for such long hours. Why should we let our health care providers?

Throughout our Nation, most doctors do wonderful things for people and it's just a small percentage that repeatedly make errors. This bill does nothing to weed out the regular offenders, the ones that regularly malpractice. In fact, it's a double whammy for victims because it caps damages against the repeat offenders and then compensates victims through periodic payments that many victims, particularly women and the disabled, need sooner rather than later.

Americans need insurance reform. We need it desperately. In Pennsylvania, we've gone from eight malpractice insurance providers, the big ones, to four in a very short period of time. Industry experts, like Charles Kolodkin of Gallagher Health Care Insurance Services, tell us that a quick examination of the medical malpractice insurance market place might lead a dispassionate observer to conclude that that segment of the insurance industry is confused, in disarray, and generally in a state of disorder. Premiums are doubling. Hospital deductibles are tripling. Claims for the physicians are being nonrenewed and insurers are leaving territory en masse.

We've seen St. Paul drop its malpractice branch. We've seen two notorious medical malpractice insurers, PIE & PIC that are no longer in business. In fact, the president of PIE Insurance company admitted that he stole \$6.8 million from the company to buy a pig farm in Tennessee to pay off gambling debts. He pleaded guilty in Federal Court to charges of conspiracy, insurance fraud, and tax evasion.

Mr. BILIRAKIS. Please summarize, Ms. Townsend.

Mr. TOWNSEND. The bottom line is we should not allow the insurance and health industries to play divide and conquer politics.

We applaud members of this committee for calling on the GAO to investigate the insurance industry's role in creating this havoc. And we need to be asking questions and demanding answers.

Aren't the regulators of the insurance industry supposed to head off problems before they become disasters? Whose rates are too high? Whose rates are too low? What is responsible pricing.

When we're confronted with a PIC or a PHICO or a St. Paul, how do we get to the root cause of why the insurer got itself into trouble? And then why aren't reviewing other insurance providers to find out whether they're engaged in the same bad practices?

The culprit is the insurance industry for this insurance crisis. And the system is rigged. This kind of legislation just further sabotages an already damaged system. And we know that passage of tort reforms do nothing to really eliminate the mistakes from happening.

Mr. BILIRAKIS. You're testimony is very excellent, but your time is long expired. You're 2 minutes over.

Mr. TOWNSEND. Forgive me.

Mr. BILIRAKIS. I will forgive you. But we do have to move on.

Mr. TOWNSEND. I will just say one final thing. Study after study has shown that tort reform measures across the country have not lowered insurance rates. There's no evidence to prove that and members of the American Insurance Association have said so as well. Thank you.

[The prepared statement of Lauren Townsend follows:]

PREPARED STATEMENT OF LAUREN TOWNSEND, EXECUTIVE DIRECTOR, CITIZENS FOR CONSUMER JUSTICE

Hello. My name is Lauren Townsend. I am a Pennsylvania Board Member of USAction and Executive Director of Citizens for Consumer Justice, Pennsylvania's largest consumer organization. Both organizations are dedicated to an agenda of economic, racial, social, and environmental justice.

I'd like to thank the members of the Health Subcommittee of the House Energy and Commerce Committee for inviting me to speak today about HR 4600, the HEALTH Act of 2002.

Citizens for Consumer Justice has become the state's leading organization working on quality, affordable, safe health care for all, strengthening Social Security and Medicare, lowering prescription drug prices for consumers, and passing a strong Patients' Bill of Rights with a right to sue HMOs.

As you are no doubt aware, we in Pennsylvania have been mired for the last few years in a medical malpractice insurance crisis that has been spreading across our country and is the impetus for the introduction of HR 4600. While we applaud members of Congress like our own Pennsylvania Representative Jim Greenwood for wanting to solve the problem through legislative means, we vehemently oppose HR 4600 which we know will hurt victims of medical malpractice, immunize wrongdoers and be a boon for the monolithic giant that should be the target of everyone's ire: the insurance industry.

OUR HEALTH CARE SYSTEM IS RIGGED FOR FAILURE

We patients are regularly subjected to the "hassle-factor" when we seek health care. We are either uninsured and find ourselves using trauma centers as primary care facilities OR we have insurance and are put through the wringer to get the care we need. Because of the advent and dominance of HMOs, and the merger of hospitals that have become corner-the-market-giants, our relationship with doctors is tenuous at best. Our hands—patients' and doctors'—are tied because of administrative bureaucrats who are calling the shots and making health decisions. The result: "health care cost containment," a fancy way of saying cut corners wherever and whenever possible. And that means: blow through patients; avoid costly referrals to specialists; make nurses work overtime; and don't modernize and streamline systems and procedures to avoid mistakes.

Doctors find themselves in an awful predicament. They are told how to practice medicine by administrators—a veritable petri dish for increasing the number of medical mistakes—all the while finding the environment for practicing medicine more difficult because of skyrocketing malpractice insurance rates.

#### MALPRACTICE IS REAL AND IT DEVASTATES LIVES

According to the AMA, medical errors are the 5th leading cause of death in this country. It is the potential for (and reality of) these errors that compels doctors and hospitals to have malpractice insurance in order to practice medicine.

At a rally last fall, Pennsylvania victims of medical malpractice told their horror stories and spoke out about the need for patient safety legislation and continued access to the courts. The individual stories that were told by the rally participants were sobering and dramatized how far behind Pennsylvania and our nation are in taking steps to reduce the medical errors that result in so much unnecessary suffering:

**Jenny Stephens** is a victim of serious dental malpractice. Prior to May 19, 2000, she was a vibrant 40 year old woman, fully articulate and pursuing a career as a speaker within her industry. Today she suffers from facial paralysis, a large hole in her mouth that continues to baffle specialists with regard to restoration and chronic pain for which she must take very expensive medication on a daily basis. *“Would it surprise you to know,”* she told CCJ and members of Pennsylvania’s state legislature, *“that the dentist who inflicted this life long impairment upon me had been under state investigation for years prior to my seeing him? Or that I was unable to reach this dentist during the emergency he created because he was incarcerated and on a work release program for multiple DUI arrests and convictions? Worse yet, the insurance company who referred me to him had supposedly investigated his credentials, education, practice and ability prior to accepting him into their plan.”*

After talking about the need for real patient safety legislation, Stephens said, *“Although my personal experience was a nightmare, I have learned one very important thing: you never know. On May 19, 2000, my life changed forever and now encompasses challenges I never dreamt possible. It could happen to you or one of your loved ones. It shouldn’t happen to anyone.”*

**Donald Davis**, a medical malpractice victim, used to work as the manager at a local Home Depot. In September of 2000, Davis went to a doctor to have a bone spur removed from his right baby toe—it should not have been a big surgery and he was expected back to work within a few weeks. Because of a mistake on the part of the doctor, the surgery incision did not heal properly, and became gangrenous. Because of the infection he had to have the toe amputated and needed bypass surgery in his right leg. By January of that year he had developed a massive blood infection from the bypass surgery. The blood infection prevented him from standing or walking and was making him increasingly ill. So not only had his doctor failed to treat a minor infection that caused him to lose his toe, he failed to take care of the blood infection which almost cost Davis his life. Davis said *“If I had not ended up finding a new doctor, I would have died because of the blood infection. But, unfortunately, the only way to save my life was to have both my legs amputated... What happened to me was the result of two doctors’ errors, and it was preventable. Because of my amputation, I’ve had to leave my job and my life will never be the same... I went in for a problem with one toe and came out without my legs.”*

**Bernadette Hudack** is the mother of a three-year-old boy who suffers from cerebral palsy and mental retardation. In May of 1998, she came down with asthmatic bronchitis. She had a terrible cough, congestion and shortness of breath. She was also 32 weeks pregnant. On her first full day in the hospital her obstetrician ordered a test to evaluate the well-being of her baby and the test indicated that the baby was fine. During her stay in the County hospital (four full days), doctors continued to treat her bronchitis. Unfortunately, they neglected to monitor her oxygen saturation levels and neglected to monitor the baby, until it was too late.

Hudack explained, *“As my own oxygen saturation level dropped, so did my baby’s. Finally, on my fourth day in the hospital, a nurse repeated the test to evaluate the well-being of my baby and realized that he was in distress and needed to be delivered immediately. But the damage had already been done.”*

Hudack hopes that after hearing stories like hers, that patient safety legislation will be passed. When she spoke of the mandatory overtime issue, she said *“I know first hand what it means for patients to be with tired nurses who’ve worked more than the shift they originally came to work. Because I AM a nurse.”*

## HR 4600 IS NOT THE ANSWER

On the contrary, HR 4600 will further hurt already injured victims and will do nothing to foster patient safety or lower insurance premiums for doctors:

- Insurers have convinced too many doctors that the answer to higher medical malpractice premiums is to limit the liability of insurance companies for malpractice. H.R. 4600 tells a woman whose doctor's negligence cost the life of her child, that that child's life was worth only \$250,000. It tells Donald Davis that having no legs for the rest of his life, because of malpractice, is worth only \$250,000. **Through caps on non-economic damages, H.R. 4600 places an arbitrary price tag on the most horrendous of injuries. Should legislation decide the value of your baby's life, or your legs, or your eyesight, when taken from you by a negligent doctor? Wouldn't you prefer to leave that decision in the hands of 12 of your constituents on a jury that has heard all the facts?**
- Hospitals have resisted technology used in other states to guard against errors in medications and lab tests. Last summer patients at Philadelphia's St. Agnes Hospital died because of mistaken lab tests that went for weeks without detection and affected hundreds of patients. One in every 250 prescriptions is wrong. Prescription errors are the worst offenders in the world of medical mistakes. **HR 4600 does nothing to upgrade technology and processes and procedures in our nation's hospitals. Instead, it eliminates joint and several liability, which will further immunize hospitals and HMOs from their responsibility to make victims and/or their families whole again.**
- Interns, residents and nurses still have to work brutal schedules without adequate rest. The government won't allow truck drivers or airline pilots to work after so many hours. Why then do we routinely schedule our health care providers on double shifts when they, too, hold our lives in their hands? We don't need studies to know that careless human errors increase when people are tired or sleep deprived. **HR 4600 does nothing to prevent health care worker fatigue. On the contrary, without a Patients' Bill of Rights that would enable us to hold HMOs and these huge hospital systems accountable for bottom-line motivated cost containment that limits the number of staff needed to deliver high quality health care, preventable medical errors will continue to be rampant.**
- It's ironic that hospital systems like those in Pennsylvania have vied for tobacco settlement money that was secured through the doctrine of joint and several liability when these very entities **want to use HR 4600 to destroy this doctrine of fairness for consumers who are victims of medical malpractice.** Hospitals regularly tout their renowned doctors and the good things that happen in their facilities to attract patients. BUT, when medical malpractice occurs, suddenly they want to distance themselves from the mistake and shirk their responsibility.
- In Pennsylvania and many other states throughout our nation most doctors do wonderful things for people and it's just a small percentage that repeatedly make errors. **HR 4600 does nothing to weed out those who regularly malpractice. In fact, it's a double whammy for victims because it caps non-economic damages against these repeat offenders and then compensates victims through periodic payments that many victims—particularly women and the disabled—need sooner rather than later.**
- What's more, while doctors and hospitals are crying out for an expedited reimbursement policy from insurers and Medicare, **they want those to penalize victims of malpractice who are smart enough or lucky enough to have health insurance by imposing a one-sided collateral source rule.**

## AMERICANS NEED INSURANCE REFORM.

In Pennsylvania, we've gone from eight principle malpractice insurance providers to four in a very short time. Industry experts, like Charles Kolodkin of Gallagher Healthcare Insurance Services, tell us that "a quick examination of the medical malpractice insurance marketplace might lead a dispassionate observer to conclude this segment of the insurance industry is confused, in disarray, and generally in a state of disorder. Premiums are doubling, hospital deductibles are tripling, claims-free physicians are being non-renewed, and insurers are leaving territories en masse. Simply put, the market is in chaos."

Kolodkin tells us that throughout the 1990s insurers were charging premiums at such low rates that when the time came to pay losses (losses are when mistakes are made, doctors are held accountable and patients are compensated for their loss and injury by the responsible party's insurance company), the money wasn't there.

In large part this emphasis on increasing market share was driven by a desire to accumulate large amounts of capital that the insurers could place in higher risk, but potentially more lucrative, investments.

Here are some good examples. St. Paul, one of the nation's largest malpractice carriers, will no longer write malpractice policies because of more than \$1 billion in losses nationwide. St. Paul also lost \$108 million with the collapse of Enron.

Two notorious medical malpractice insurers, PIE and PIC, are no longer in business. Larry E. Rogers, according to the *Cleveland Plain Dealer*, former President of the failed PIE Insurance Company, admitted that he stole more than \$6.8 million from the company to buy a pig farm in Tennessee and to pay off gambling debts. He pleaded guilty in federal court to charges of conspiracy, insurance fraud and tax evasion. Charges filed by the prosecutor claim that the theft and Rogers' corporate spending helped sink the insurer in 1998, leaving many doctors without insurance or with higher rates when other companies had to rush in to fill the void. The collapse left doctors in nine states without insurance. According to the *Plain Dealer*, "patients who might have collected millions of dollars have been forced to settle for far less."

In the last year, the list of "impaired" medical malpractice insurers got longer as the Pennsylvania Department of Insurance placed PHICO under official state scrutiny. PHICO—run by the Hospital Association of Pennsylvania and one of the largest writers of medical malpractice insurance—aggressively sold insurance during the late 1990s. "Rehabilitation" was necessary as it became obvious PHICO's premiums had been inadequate to cover losses.

**Citizens and Members of Congress should not allow the insurance and health industries to play divide-and-conquer politics by putting the blame of this crisis onto the backs of patients** through legislation like HR 4600 by limiting our access to the courts for malpractice that devastates, shatters lives and all too often kills. Patients harmed by medical malpractice should not be further penalized when they seek justice. **Instead, we should be asking questions.** If we're attempting to get to the bottom of Enron and Global Crossing, why aren't we getting to the bottom of the gross negligence and improprieties—and, yes, accounting shenanigans—that exist in the insurance industry?

**Citizens for Consumer Justice applauds members of the U.S. House of Representatives and its Energy and Commerce Committee for calling for a General Accounting Office (GAO) investigation of the insurance industry's role in creating such havoc for doctors and ultimately patients. That's what we should be doing: asking questions and demanding answers.**

Aren't the regulators of the insurance industry supposed to head off problems before they become disasters? Whose rates are too low? Whose rates are too high? What is responsible pricing? And how will our nation's and individual state insurance departments ensure that responsible pricing is enforced?

In Pennsylvania, PHICO, run by the Hospital Association of Pennsylvania, was put into rehabilitation after its surplus dropped to dangerously low levels. Our Insurance Commissioner was virtually absent while that was happening. This was right on the heels of Reliance going under, a demise that will likely cost Pennsylvania consumers billions of dollars.

Insurance Departments throughout our nation are supposed to regulate the insurance industry and protect the insurance consumer. In addition, they are supposed to monitor financial solvency, license agents/brokers, and review and approve rates and forms, and coordinate the takeover and liquidation of insolvent companies and rehabilitate financially troubled insurers.

When they are confronted with a PIC or a PHICO, do they investigate and get to the root cause of why the insurer was in trouble? And, if so, do they then review the other insurance providers to find out whether they are engaged in the same bad practices? How often are independent actuarial reviews conducted? Why aren't medical malpractice insurance rates, like auto and other lines, experience-based? These are just some of the questions that need to be asked and, more importantly, answered.

Also, the Joint Underwriting Associations (JUAs) across the country and in some states, Catastrophic Loss Funds or CAT Funds, are state run malpractice insurers. The JUAs around the country have historically been seen as the insurers of last resort because of high rates. However, the JUAs don't have to charge such high rates. If we were to have a single-payer malpractice insurance system state by state or nationwide (in the case of Pennsylvania, a JUA with the CAT fund to handle the catastrophic cases) that is regulated by the state and the federal government, the administrative cost of underwriting would go down. With one payer, doctors' premiums would go down, and having a centralized system would allow for comprehen-

sive monitoring of medical mistakes so that we can learn why and where they happen and how we can eliminate them.

WHAT CONGRESS CAN AND SHOULD DO TO PROMOTE PATIENT SAFETY

**Real Peer Review—Malpractice that injures patients cries out for strong sanctions from medical review boards. Patients deserve to be protected from chronic offenders who continue to make avoidable, costly mistakes.**

**Safe Rx—New technology and procedures need to be adopted, particularly in hospitals, that automatically check prescriptions against patients' records.**

**Doctor/Nurse Fatigue—Reasonable schedules and staffing level ratios for doctors and nurses will cut medical errors. Nurses, for example, should not be forced to work overtime.**

**Access to the Courts—For those unfortunate victims of continuing medical errors, access to the courts for redress must continue. Without a legal system to hold those who harm innocent patients accountable, the heavy financial costs of their care will be imposed on taxpayers. And that is all of us.**

CONCLUSION—LOWER INSURANCE RATES BY REGULATING THE INSURANCE INDUSTRY

The culprit of the malpractice insurance crisis is the insurance industry and our health care delivery system. The system is rigged. Legislation like H.R. 4600 further sabotages an already damaged system. We know that passage of the so-called tort-reforms like caps and the elimination of joint and several liability in this bill would do nothing to eliminate preventable medical errors from happening. Nor, as even the American Insurance Association and the American Tort Reform Association have admitted, would they reduce medical malpractice premiums.

Instead, H.R. 4600 would further hurt individual victims whose lives are already shattered from lost babies, wives, husbands, eyesight, the amputation of limbs, the wrong medication . . . the list goes on. What we do know about limiting the non-economic compensation to \$250,000 to a victim who has lost a baby, had the wrong breast amputated, or had a pap smear misdiagnosed, is that it is an arbitrary and paternalistic price tag hung on another person's life. And this is wrong.

It doesn't make sense that this legislation is being contemplated as a solution to skyrocketing insurance rates when the Congress has not yet investigated the industry's justifications or its accounting practices . . . and when the insurance industry itself has admitted that we shouldn't expect "tort reform" to reduce insurance rates.

The American Insurance Association (AIA), a major insurance industry trade group, said in a March 13, 2002 press release that lawmakers who enact "tort reform" should not expect insurance rates to drop. Evidently issued to critique the Center for Justice & Democracy's 1999 study, "Premium Deceit—the Failure of "Tort Reform" to Cut Insurance Prices," the AIA release leads with an astounding face-saving pronouncement: "[T]he insurance industry never promised that tort reform would achieve specific premium savings."

What's more, in 1999, ATRA President Sherman Joyce told Liability Week (July 19, 1999), "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." Victor Schwartz, ATRA's General Counsel, told Business Insurance (July 19, 1999) that "[M] any tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years."

"Premium Deceit" is an exhaustive look at the impact of tort reform on nationwide insurance costs between 1985 and 1999. It finds that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years. States with little or no tort law restrictions have experienced approximately the same changes in insurance rates as those states that have enacted severe restrictions on victims' rights. The losers are those patients—like Donald Davis who sought medical care for a problem with one toe and came out without his legs—injured through no fault of their own.

Citizens for Consumer Justice applauds Representative Greenwood and the Committee for delving into a grim problem facing our health care delivery system. However, we urge you to hold the real culprit accountable, and not punish innocent victims of medical malpractice by advancing H.R. 4600.

Thank you.

Mr. BILIRAKIS. Thank you.

Mr. Fine? Please use the mike.

**STATEMENT OF STUART H. FINE**

Mr. FINE. Thank you very much. Hi, I'm Stuart Fine, Chief Executive Officer of Grand View Hospital in Bucks County, Pennsylvania. I also chair the Cassatt Insurance group of 12 health care organizations from southeastern Pennsylvania that work together to improve patient safety and patient care quality and to share and ensure risk on a group basis.

I'm here today on behalf of the American Hospital Association.

We're pleased to testify before you about the harmful effects that excessive litigation is having on patient access to care. From my testimony this morning I hope to make three points. First, the cost of medical liability insurance is spiraling out of control. Next, the lack of affordable medical liability insurance is having a severe impact on patients' access to care. And finally, there's an expanding national problem that requires a timely Federal solution.

Grand View is our region's largest employer. We provide jobs to more than 1,500 people and have an annual payroll that exceeds \$55 million. These figures do not include the more than 250 physicians who comprise our medical staff, or the hundreds of employees who are employed by those physicians. It's often been said that as goes our hospital, so does the economy of our community. It's important to note that in Grand View's 89 years of operation, our hospital has never had a court judgment against it for a professional liability claim. I'll repeat that. We've never had a court judgment against us for a professional liability claim.

The experience of Grand View Hospital on our Cassatt group, however, is quite telling. We've self-insured certain professional and general liability exposures for more than 10 years. Until 2 years ago, we could secure reinsurance for our group at affordable rates due to competition among commercial carriers. However, because of the frequency of lawsuits and the size of jury awards that have recently resulted in our region, Grand View's cost for insurance increased last year by about one third, and we were forced as a group to accept the \$5 million deductible on each and every reinsured claim basis.

This year, our cost increased by almost 50 percent more. And the deductible both increased to \$7.5 million and involves a 50 percent per claim co-payment. This year, Grand View will allot an excess of \$750,000 every day, 365 days a year, for professional liability insurance coverage. That's nearly as much as we'll spend on medications for our patients. The Cassatt Group as a whole will spend an excess of \$60 million to insure itself in fiscal year 2003.

Securing this reduced level of coverage, even at its increase cost, was not easily accomplished. Earlier this year, I traveled with colleagues to London for 2 days of meetings with seven different reinsurers from Switzerland, Germany, and Lloyd's of London. We were told on three different occasions that along with Australia and Czechoslovakia, our region is viewed as being among the least attractive in the world within which to write insurance business.

Because reasonably priced insurance coverage is not available for practitioners in many specialties, many of our region's physicians have retired or are relocating. It's become much more difficult to recruit new doctors and to secure insurance for practicing physician. If this situation continues, we'll be forced to reduce important

patient services, leaving our community with little or no access to needed health care.

For example, if Grand View hadn't been able to secure insurance coverage for our largest OB/GYN group at a cost of approximately \$1,000 per delivery, Grand View would have lost five of our nine practicing obstetricians from practice 3 months ago. This would probably have resulted in the closure of our OB service, something that's already occurred at three other Philadelphia area hospitals. That's why Congress must help hospitals and physicians to find a solution to sky rocketing medical liability premiums, so we can continue to provide the right care at the right time and the right place 24 hours a day, 7 days a week. We must reform this system at the Federal level.

It's well documented that the United States has the world's most expensive tort system. Tort costs over the past 50 years have out-paced growth in the United States economy by a factor of four. According to the GAO, 43 percent of insurance defense costs are spent on claims that have no merit while other studies show that many claims with merit are never even filed. A Federal solution is warranted here. That's why AHA strongly supports H.R. 4600, Health Act of 2002 sponsored by my Congressman, Jim Greenwood. The AHA believes that the California style reforms reflected in H.R. 4600 should be adopted at the Federal level.

For more than 25 years, the reforms known as MICRA have demonstrated that patients' rights can be protected by reducing medical liability costs. The MICRA law has proven to be equitable, while the number of health care liability claims in California has remained steady on a per capita basis. The compensation actually paid to those medically injured in California has been higher after MICRA than before. This is not an issue of importance to just Pennsylvania and California. The medical liability insurance crisis affects hospitals and physicians nationally. Mr. Chairman, you already mentioned the reprieve recently realized by the University Medical Center trauma center in Los Vegas. Other members of the committee have discussed the situations that exist within their home States.

In conclusion, hospitals and physicians need Congress to enact H.R. 4600 to prevent even more hospitals from shutting down needed services or closing their doors. We have a mission of providing health care services that save lives and improve the quality of lives our patients. But hospitals can't fulfill that mission without your timely help. We look forward to working with you to enact H.R. 4600 and I'll be pleased to respond to your questions.

[The prepared statement of Stuart H. Fine follows:]

PREPARED STATEMENT OF STUART H. FINE, CHIEF EXECUTIVE OFFICER, GRAND VIEW HOSPITAL ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Stuart H. Fine, Chief Executive Officer (CEO) of Grand View Hospital in Sellersville, Pennsylvania. I am here today on behalf of the American Hospital Association's (AHA) nearly 5,000 hospital, health system, network, and other health care provider members. We are pleased to have this opportunity to testify before you concerning the harmful impact that excessive litigation is having on patient access to care. This issue is of critical importance for hospitals, physicians, and the patients and communities they serve across our nation.

Formed in 1913 as Bucks County's first hospital, Grand View Hospital is in most ways a typical community, not-for-profit hospital. Grand View provides a broad

array of patient services, from obstetrics to orthopedics, and from hospice/home care to oncology. Our mission, in brief, calls for us to “provide and coordinate the appropriate utilization of quality, cost-effective health care and related services” for the people of our community. We are our region’s largest employer, providing jobs to more than 1,550 people and having an annual payroll in excess of \$55 million. And these figures do not include the more than 250 physicians who comprise our medical staff, or the hundreds of individuals who are employed by those private practitioners. Solucient recently designated Grand View as operating one of the nation’s “Top 100” Intensive Care Units as measured by patient care outcomes and cost-effectiveness. Also of note is that Grand View has never had a court judgment against it for a professional liability claim in our 89 years of operation.

On a related note, I also serve as the chairman of Cassatt Insurance Co., Ltd., a Bermuda-based “captive,” through which 12 suburban Philadelphia hospitals and health care organizations endeavor to improve patient safety and the quality of patient care services being provided; manage and share risk; and insure, on a group basis, their professional and general liability exposures. It is with this combination of experience and perspectives that I come before you today to discuss the problems associated with medical liability insurance, its impact on hospital and physician services, and, ultimately, how these factors affect access to important health care services.

A recent AHA TrendWatch report, researched by the Lewin Group on behalf of the AHA, documented that health care providers across the nation are becoming increasingly concerned about their ability to find affordable medical liability insurance and how patients’ access to care has been undermined. The report confirmed that since 2001, many physicians have, and are continuing to experience, premium increases in the high double digits. Premiums for hospitals have more than doubled! The report suggests that the current crisis is likely to be more complicated than medical liability insurance problems that occurred in the 1970s and 1980s. It stated that the factors influencing the wide geographic differences in premiums include the following:

- State regulations,
- Characteristics of physician organizations,
- Local culture and legal practices,
- Differences in the costs of defending claims, and
- Population size and degree of competition among insurers in the market.

The TrendWatch report also stated, “The exit of a large insurer, like St. Paul [one of the nation’s largest insurers that covered an estimated 750 hospitals and 42,000 physicians throughout the United States], from a market can push premium rates up and make coverage harder to find. In response, physicians may leave for another market and hospitals may need to alter the services they provide.”

The experience of Grand View Hospital and the Cassatt group of insured health care organizations is telling. As a group, we’ve self-insured certain professional liability exposures for more than 10 years. Until two years ago, however, we were readily able to group-purchase insurance at affordable rates for “excess” or “catastrophic” layers of coverage above our primary limits, and do so on a “first dollar” basis above the primary layer of coverage. We were able to obtain this coverage due to competition among a large number of commercial carriers who were very interested in securing our business.

Last year, Grand View’s cost for insurance coverage increased by approximately one-third. But that doesn’t tell the whole story. In addition to experiencing that huge increase in cost, we were forced to accept, on a group basis, a \$5 million dollar deductible or retention on an “each and every” claim basis.

This year, our insurance cost increased yet again—this time by almost 50 percent. Our deductible level is going from \$5 million to \$7.5 million. On top of that, we are being forced to accept a 50 percent “co-pay” for each \$5 million above the \$7.5 million for which we secured coverage. Consequently, Grand View Hospital will spend in excess of \$7,500 each and every day for our insurance coverage in the current fiscal year—about the same amount that we spend for medications/pharmaceuticals. Accordingly, the Cassatt group of hospitals will spend in excess of \$60 million to insure itself in fiscal year 2003!

Securing the coverage that I’ve described was not easily accomplished. In January, I joined four colleagues from other Cassatt hospitals and traveled to London for two days of meetings with seven different carriers and re-insurers from Switzerland, Germany, and the Lloyd’s of London insurance syndicates. While essentially marketing our group to these carriers and re-insurers, we were surprised to be told on three different occasions during our visit that, along with Australia and Czechoslovakia, the Philadelphia region is viewed by the international insurance markets as being among the least attractive within which to do insurance business. The ra-

tionale supporting that view was that, up until that time, there had been a lack of meaningful tort reform activity on the part of our state legislators.

#### THE EFFECT ON CARE

In addition to experiencing serious increases in the cost of health care liability insurance, hospitals are facing a growing workforce shortage; reductions in private, Medicare, and Medicaid payments; and redoubled disaster preparedness efforts. These additional burdens are threatening hospitals' ability to appropriately staff emergency departments, recruit new physicians to high-risk specialties, and deliver babies in the manner that most Americans have become accustomed.

While I am pleased to report that Grand View Hospital continues to deliver babies, three other hospitals in our immediate area have discontinued OB services. Warminster Hospital in Bucks County has discontinued the service altogether, as have both Methodist and Misericordia Hospitals in Philadelphia. More recently, Methodist and Doylestown Hospitals announced that they would no longer be providing prenatal care for low-income women. The primary reason given for these unfortunate reductions in service was the rising cost of medical liability insurance.

Our county has seen numerous OB/GYN physicians either retire from practice or eliminate the OB component of their practices. This has occurred at Doylestown Hospital, St. Mary Medical Center, and Lower Bucks Hospital. Already mentioned was Warminster Hospital's closure of its OB service. In the community of Quakertown, two of the three existing OB/GYN offices were closed as the physicians in those practices withdrew from our region based on the high cost of professional liability insurance. One of Doylestown Hospital's two orthopedic surgery groups has been unable to secure malpractice coverage and has discontinued its surgical practice and Emergency Room back-up coverage. At Grand View Hospital, we've lost physicians specializing in family practice, general surgery, plastic surgery, and interventional radiology. And, we have no neurosurgery coverage. Our efforts at recruiting replacement/successor physicians to those who have left our area, or are planning to retire, have proved fruitless. We currently need physicians in the areas of cardiology, family medicine, diagnostic and interventional radiology, neurosurgery, plastic surgery, and obstetrics. If our hospital had not been able to secure insurance coverage for our largest OB group at a cost of approximately \$1,000 per delivery, an increase of approximately 50 percent over the prior year, Grand View would have lost five of our nine practicing obstetricians from practice. That would probably have resulted in the closure of our OB service.

In the book "Ghost Soldiers," by Hampton Sides, a veteran of the Battle of Bataan describes how "the defense of Bataan devolved into a brutal war of attrition—a war...of consumption without replenishment." It is just such a circumstance that confronts our nation's hospitals and physicians. Without intervention by Congress, we will soon be unable to address the basic health care needs of our communities. Congress must help hospitals and physicians find a solution to skyrocketing medical liability premiums so that we can continue to provide the right care, at the right time, in the right place; 24 hours a day, seven days a week.

#### THE CURRENT SYSTEM NEEDS REPAIR

The current medical liability system is a costly and ineffective way of resolving health care liability claims and compensating injured patients. This has led to the growing crisis I've described. In many states, especially Delaware, Florida, Mississippi, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, South Carolina, Texas, Washington, West Virginia, and my own, inherent problems in the health care liability system are causing skyrocketing premiums.

For example, there are many reasons why Pennsylvania is currently struggling with medical liability problems. Insurers faced heavy losses when declining returns on investment exposed insurers to expenses that were significantly above premiums collected. In addition, large jury awards, which often set the standard for settlement awards, began to put upward pressure on premiums. Finally, the three largest insurers, PHICO, PIC, and PIE became insolvent and no longer offered medical liability insurance. In short, insurance capacity evaporated.

In an effort to address these issues, the Governor of Pennsylvania signed into law a medical liability reform bill in March of 2002. Pennsylvania's effort represents the latest in a series of legislative actions taken by the state to alleviate pressure on health care providers. While the law signed in March does not include a cap on damages, it does allow hospitals and physicians to appeal if paying those damages would force a doctor out of business or force a hospital to cut services, thereby affecting access to care in the community. In addition, it allows judgments for future medical costs to be spread out over time. More recently, a law reforming the rules

regarding “joint and several” liability was passed in June. This is especially important to hospitals because we are often singled out as the “deep pockets” in many litigation situations.

Because the effects of tort reform take time to be fully realized, in part due to the long trail of claims, the effects of the Pennsylvania legislation remain to be seen. At our hospital, due to our inability to obtain adequate medical liability coverage at a reasonable rate, many physicians have retired or relocated to areas with lower premiums. And it has become increasingly difficult to recruit new doctors and secure physician coverage. If this continues, we will be forced to reduce important patient services, leaving our community with little or no access to appropriate health care. Further, it is well documented that the United States has the world’s most expensive tort system, with tort costs over the past 50 years outpacing growth in the United States’ economy by a factor of four. Such growth has not translated into efficiency. According to the General Accounting Office (GAO), 43 percent of insurance defense costs are spent on claims that have no merit. Other studies show that many claims with merit are never filed.

#### LEGISLATIVE SOLUTION NEEDED

The AHA believes that a federal legislative solution to America’s medical liability crisis is warranted under the current circumstances. That is why the AHA strongly supports H.R. 4600, the bipartisan Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002, sponsored by my congressman, Representative Jim Greenwood (R-PA).

The AHA believes that the California-style reforms enacted under the Medical Injury Compensation Reform Act (MICRA) of 1975 and reflected in H.R. 4600 should be adopted at the federal level. For more than 25 years, MICRA has demonstrated that patients’ rights can be protected at the same time that medical liability costs are reduced. H.R. 4600 includes the following MICRA-type reforms:

*A limit on non-economic damages*—By placing a ceiling of \$250,000 on non-economic damages (pain and suffering), stability is restored to the insurance market. All economic losses and/or costs are paid in full. Such a cap provides affordable coverage, and ensures that health care providers can buy coverage. It does not affect a plaintiff’s ability to be fully compensated for economic damages such as medical expenses or lost wages.

*Establish a fair share rule*—The “joint and several” rule allows any defendant to be liable for the entire amount of an award, regardless of how small that defendant’s share of the fault may be. As a result, the rule generally punishes a co-defendant (or a sole defendant) who is fully insured or has substantial assets—the so-called “deep pocket” defendant. For some providers, this removes any incentive to carry full liability insurance coverage. By establishing a fair share rule in health care lawsuits, each party is liable solely for its share of damages and not for the share of any others.

*Periodic payments*—Periodic payments would allow compensation to be made in intervals rather than a lump sum, permitting settlements to be geared to a plaintiff’s needs over the course of his or her life. In addition, because periodic payments can be funded through an annuity, future needs can be fully met at a considerably lower cost to the health care system.

*Regulation of attorneys’ fees*—Under the current health care liability system, patients awarded compensation are often shortchanged. Money that should go toward their long-term care goes instead to their attorneys. This is because, traditionally, attorneys in liability cases are paid through contingency fees, which provide the attorney a percentage of the plaintiff’s award. Percentage limitations should be applied to attorneys’ fees.

The California experience under the MICRA law has proven to be more equitable to the medically injured. While the number of health care liability claims brought by medically injured plaintiffs in California, on a per capita basis, is the same as before MICRA, the compensation actually paid to those medically injured in California was higher after MICRA than before.

The AHA also supports a uniform statute of limitations in health care liability cases and the continued development of successful conflict resolution programs. Bringing liability claims to court is often inefficient and costly and renders unpredictable results. Nontraditional approaches such as alternative dispute resolution systems can play an important role in reforming the health care liability system.

## A NATIONAL PROBLEM REQUIRES A FEDERAL SOLUTION

While I appreciate the opportunity to discuss some of the challenges we face in Pennsylvania due to the medical liability crisis, this issue affects hospitals and physicians throughout the United States.

I've already mentioned that Methodist Hospital in Philadelphia announced that it would no longer be able to provide prenatal care for low-income women, and just two weeks ago, the University Medical Center's (UMC) Level-I Trauma Center in Las Vegas, Nevada closed its doors due to the liability risk at the facility. As a result of the increased insurance premiums, 11 of UMC's 13 general trauma surgeons and 57 or 58 orthopedic surgeons resigned from trauma-care responsibilities. Within the past few days, the UMC Trauma Center has retained the temporary services of trauma and orthopedic surgeons who have agreed to be covered by the county's liability insurance for 45 days. This temporary reprieve allows the governor to call a special legislative session to address this issue. While the trauma center has been able to keep its doors open for a few more days, a large question mark remains regarding access to care in the community. Without the UMC Trauma Center, patients will instead be routed to the closest emergency room, where most doctors aren't trained to do surgeries and where specialists might not be readily available. The UMC Trauma Center serves a 10,000-square mile area in four states—Nevada, California, Arizona, and Utah.

Hospitals and physicians need Congress to enact H.R. 4600 to prevent even more hospitals from being forced to close their doors. We want to provide the type of health care that saves patients' lives and improves their quality of life, but we can't continue to do that without your help.

I appreciate the opportunity to testify before your committee today. The hospital and physician communities look forward to working with members of this committee, as well as the entire Congress, to ensure that this critical legislation is enacted into law.

Mr. BILIRAKIS. Thank you very much, Mr. Fine.

Dr. Roberts, you've testified that just a few years ago you had six hospitals in your immediate area—number of counties?

Mr. ROBERTS. Yes, there are seven counties.

Mr. BILIRAKIS. Seven counties. And now it's down to one.

Mr. ROBERTS. There's one. The other hospitals have either completely closed or they became emergency rooms or they have a 2-day holding bed possibility, but they don't do obstetrical care, surgery, or intensive care work.

Mr. BILIRAKIS. And what do you attribute these other five hospitals not being available?

Mr. ROBERTS. Largely it was by Federal mandate that they wanted to regionalize health care. And that has happened for question cost efficiency. The problem is that bad things happen to good people. Sometimes, malpractice situations occur because people are blaming someone, they're upset, they have to understand what happened. So the most proximate person is the health care provider. So many times we get caught in that phase of resolution that people are going through.

In our community, we have a very good feeling between our patients, I believe. But what is happening is that physicians are becoming afraid of their patients. Who's going to turn around and sue me next? So it creates a barrier as was mentioned earlier. There's a barrier between the physician and the patient. And I think it's critical that we address this and we look at access and the ability of people to find their health care provider and chose the person that will provide their family with family oriented care.

Mr. BILIRAKIS. Doctor, you indicated that your rates already have doubled. You received word that they plan to double next year?

Mr. ROBERTS. They have not given me a firm quote. My insurance is up in November, and they told it will probably double next

year. I was with PHICO, and PHICO went under, and then I picked up by BRIM and they doubled the rate.

Mr. BILIRAKIS. Have you inquired as to why this is taking place to the insurance commissioner of your State?

Mr. ROBERTS. Yes, I have.

Mr. BILIRAKIS. What is his or her response?

Mr. ROBERTS. Because BRIM is the insurance of last resort, they created premium on all BRIM rates to make us try to find other insurance companies. The problem is the insurance companies are leaving the State. We just had physicians last week be notified that they would not be renewed by medical insurance. St. Paul has already pulled out. So we are in a critical situation. We have positions on our staff that will not have insurance as of October 1 or November 1 at the end of this year. And they're going to have to leave the area. We're losing people to early retirement. We're losing people because we can't recruit new physicians into the community. Private practice physicians such as myself will have to, I may have to go back to West Virginia University. I'm a professor there, but I may have to go there and teach, and stop my private practice.

Mr. BILIRAKIS. You've already told us that you haven't had any claims against you. You've never had any claims against you?

Mr. ROBERTS. No, sir.

Mr. BILIRAKIS. How does the claims filed against the members of medical profession in West Virginia compare to other States?

Mr. ROBERTS. West Virginia has a very active litigation system, and we have a lot of claims. There were a lot filed last fall. The State legislator spent 60 days in session at \$35,000 a day trying to deal with this problem. And there were some cursory changes that were made, but I don't feel that they really made any significant change in the threat of major lawsuits.

Mr. BILIRAKIS. So you attribute then the doubling of the rates to the total number of claims that are taking place in the State of West Virginia?

Mr. ROBERTS. Absolutely. And then with my colleagues their rates have tripled. It really was quite fortunate that it wasn't higher. But next year, it will be and I'm going to have to stop delivering babies.

Mr. BILIRAKIS. All right. I have 1 minute left. I'm going to yield to Ms. Capito, if she would like to inquire to either Dr. Roberts or anybody else.

Ms. CAPITO. Welcome, Dr. Roberts from West Virginia in my District. I'm pleased to be here. I know that what you're saying is absolutely true and one of the hospitals in where I live in Charleston is actually paying the neurosurgeons to cover them a \$1,000 a day for each of the two neurosurgeons in the Charleston area medical center to cover their insurance. Doctors are leaving West Virginia early retirement, but you know they're going to other States. They go to Ohio. I hear stories of them going to Ohio, Virginia. What do you attribute that to? Is it the number of lawsuits filed in West Virginia?

Mr. ROBERTS. The rates presently in those States are approximately half or less than what they are in West Virginia. So positions in Bluefield, West Virginia move across the street to Bluefield, Virginia and their rates drop. I understand though that some

of the insurance companies have gotten wise to that and are now looking for the zip codes of the patients on the other side of the border. People from Wheeling move over into Ohio. I can't do that. I'm in the center of the State. I either stay there or I leave.

Ms. CAPITO. Well, I want to thank you for your years of service and your generational years of service. This is a crisis in West Virginia. No question about it. Not only does it affect our health care but it goes into affecting the economic fabric of our State because whose going to bring a company in if you can't get good health care? So I applaud your efforts in this and look forward to working for you—

Mr. BILIRAKIS. The Chair—

Mr. ROBERTS. I'm a physician that feels fortunate to have a chance to help people make a living doing that.

Mr. BILIRAKIS. It sounds that that's an appropriate time—

Mr. ROBERTS. I really feel we need to look at that aspect of this and how we serve our patients.

Mr. BILIRAKIS. If there's less rhetoric and our real interest on the part of all of us is to solve this problem in an objective, open minded manner and we're going to get it done. And hopefully we will.

The Chair recognizes Mr. Brown to inquire.

Mr. BROWN. I thank the chairman.

Dr. Roberts, my father practiced medicine as his father did in a town a little bit bigger than Elkins but in Mansfield, Ohio. He practiced some 50 years general practice, never had a claim against him. And he unfortunately was not able to practice with his father, but he had his father's practice after World War II. And I emphasize with you and thank you for doing the same kind of work I believe my father did. I'm not a lawyer, so I don't have a dog in this hunt, but I hear my friend, Mr. Norwood say it's only the lawyers who have concerns or are opposed to whatever exact term he used about the Greenwood Bill.

And I just want to enter into the record and ask consent request to enter into the record the National Partnership for Women and Families letter expressing their concern. And if I understand this as a nonlawyer, I'm a little confused about the non-economic caps. I understand that the Norwood Bill does not limit punitive damages, does not limit economic damages. But what that tells me, if you limit non-economic caps it's a little bit like the Republican tax cut. It helps those people that are already wealthiest and penalizes those that aren't.

[The prepared statement of the National Partnership for Women and Families follows:]

NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES  
July 17, 2002

The Honorable W.J. TAUZIN  
*Chairman, Energy and Commerce Committee*  
*U.S. House of Representatives*  
*Washington, DC 20515*

The Honorable JOHN D. DINGELL  
*Ranking Member, Energy and Commerce Committee*  
*U.S. House of Representatives*  
*Washington, DC 20515*

DEAR CHAIRMAN TAUZIN AND RANKING MEMBER DINGELL: We write on behalf of the National Partnership for Women & Families to submit comments for the Energy

and Commerce hearing being held today, “Harming Patient Access to Care: The Impact of Excessive Litigation.” Although the Partnership shares the Committee’s concerns about the harmful impact that the lack of affordable medical malpractice insurance is having on patients’ access to needed care, we urge you and other Committee members to fully investigate the multiple factors causing this crisis before taking any action that could further curtail patients’ access to quality health care.

As a nonprofit, nonpartisan advocacy organization dedicated to improving the lives of women and families, the Partnership advocates policies that ensure greater access to affordable, high quality health coverage. The Partnership is concerned about the barriers that patients are facing in accessing care as a result of doctors’ inability to afford medical malpractice coverage. Women may be disproportionately hurt as a result because Ob-Gyn doctors are more likely to have higher premiums and experience difficulty finding coverage than doctors in any other specialty. Some have suggested that the root cause of the current crisis is “excessive litigation” and are proposing federal litigation reforms to limit patients’ ability to bring suits and seek appropriate damage awards as the simple answer to this problem. Substantial evidence suggests that this problem is far more complex, having its roots in the insurance industry itself, and that federal tort limits are not the right approach to address this crisis.<sup>1</sup>

A key component in ensuring women and families’ access to quality medical care is providing meaningful accountability for harms resulting from poor or inadequate care. Without such accountability, patients and their families have no redress for serious, debilitating, and life-threatening injuries caused by medical errors and malpractice. Such accountability also provides an important deterrent against mistakes and malfeasance and ensures that providers and institutions make improved patient safety a top priority. And limits on non-economic damages of the kind often proposed in “tort reform” legislation disproportionately hurt women and children—because courts are less likely to value children’s lives or stay-at-home moms’ contribution to the family into economic terms, women and children are more likely to be seeking non-economic damages that exceed the damage limits imposed by so-called “tort reforms.” Congress has recognized the importance of preserving accountability as a means of ensuring better quality care from managed care plans by including accountability provisions in both versions of the Patients’ Bill of Rights legislation that passed last year. We strongly believe that curtailing accountability for medical wrongs will have the perverse effect of diminishing quality health care for women and families, not improving it.

Providers’ difficulty in finding affordable medical malpractice coverage may have little to do with litigation. According to a recent Wall Street Journal article, business decisions made by the insurance industry have contributed greatly to the current crisis in affordable coverage.<sup>2</sup> In the 1990s, malpractice insurers competed for national market share, keeping prices artificially low and inadequate to cover claims. Insurers’ recent losses from inadequate pricing and poor investment decisions in the stock market caused many to either withdraw from the malpractice market or restrict their coverage. Minimal regulation and oversight has led to dramatic price increases and fluctuations in the availability of coverage, leaving many providers without access to affordable coverage. More information is needed to clearly determine the factors that are driving this crisis before any action should be taken to redress it. In this regard, we applaud the recent request made by Representatives Conyers, Dingell and other members of Congress to have GAO study the role the insurance industry may be playing in this crisis.

It is also unclear whether limiting accountability would have any impact on the affordability of malpractice coverage. According to a recent study by the Center for Justice and Democracy, actual experience with insurance rates and tort reforms suggests that there is no correlation between strong restrictions on accountability and lower premium rates.<sup>3</sup> In fact, after looking at insurance rates and tort law limitations across the country from 1985 through 1998, the study found that states with little or no tort law restrictions experienced the same insurance rates as states that enacted very strong tort restrictions. These findings suggest that limiting accountability might have very little, if any, impact on the current crisis.

An alternative approach that could both address malpractice insurers’ concerns about rising claims and respond to consumers’ interest in improved quality would

<sup>1</sup>See, e.g., Zimmerman, Rachel & Christopher Oster, “Assigning Liability: Insurers’ Missteps Helped Provoke Malpractice ‘Crisis’” Wall Street Journal, Monday, June 24, 2002; Hunter, J. Robert & Joanne Doroshow, “Premium Deceit: The Failure of ‘Tort Reform’ to Cut Insurance Prices,” Center for Justice & Democracy, 1999.

<sup>2</sup>*Id.*, Zimmerman & Oster.

<sup>3</sup>Hunter & Doroshow, 2.

be to encourage malpractice insurers to partner with practitioners in promoting best practices and patient safety measures. For example, insurers could offer discounts in insurance rates not just based on actual claims experiences, but also based on a practitioners' implementation of proven safety measures that will improve health outcomes and reduce errors that could result in malpractice. This approach would have multiple benefits, including lowering premium rates, making insurance more affordable, and improving health care quality. As the Committee moves forward in this area, we encourage you to consider these types of alternatives.

For these reasons, we encourage the Committee to study this issue carefully before moving forward with any legislative proposals, especially those that might restrict access to meaningful accountability. We also encourage the Committee to further study the extent to which the insurers themselves may be playing an important role in creating this crisis and to determine whether further regulation of this industry is needed, at the state or federal level. Thank you for your concern and attention to this issue of tremendous importance to women and families.

Sincerely,

JUDITH L. LICHTMAN, *President*  
 DEBORAH L. NESS, *Executive Vice-President*  
 ALICE M. WEISS, *Director of Health Policy*

Mr. BROWN. I wish that Ms. Visco were still here because she talks very passionately and convincingly about how this hurts women, especially a 58-year-old woman who is working as a hotel maid or as a clerk at Walmart and has very little earning power in her future and so the non-economic damages are, the economic damages are pretty minimal to her compared to a 32-year-old investment banker who has got millions of dollars potential earnings while the 58-year-old woman who works as a clerk is close to retirement, if she could ever retire on the little bit of money she would make there, and has very little potential economic potential earning potential. To sort of limit the economic, the non-economic damages, again I'm not a lawyer and I don't totally get this, but to limit the non-economic damages is sort of like tax cuts for rich people. And we give tax breaks, you know, we're cutting taxes for everybody. Yeah, well if you're making a million dollars a year you get tens of thousands.

If you're making \$30,000 you get \$12. And there's a little bit of that in and this and it just sort of continued class warfare that my friends on that side of the aisle commit against working people in this country and poor people. And I'm frankly sick of it and I'm sorry that this hearing was used to continue that sort of assault.

I would like to move on and ask Ms. Townsend a couple of questions and I appreciate the testimony of all four of you. I think it was helpful and enlightening and Ms. Visco's was too.

I agree with, first of all Ms. Townsend, I agree with Mr. Fine's assessment that Congress must help hospitals and physicians find a solution to this very real crisis. And I hear Dr. Roberts. I remember my dad talking about it in a lesser way because the problems weren't perhaps as great 20 years ago when we retired 15 years ago.

But Mr. Fine mentioned three factors that contributed to increases in Pennsylvania. One, declining returns on investment for insurance companies. Second, that the three largest insurers were vacating the market. Third, large jury awards.

Based on your experiences in eastern Pennsylvania, what contributed most to these increases in premiums? Can you help us understand that better?

Ms. TOWNSEND. I think that the biggest culprit was the insurance industries' boon during the 1990's and the way it was investing and then spending the money that it brought in and not having enough money in reserves. And there were a lot of improprieties that are now coming out in the newspapers because there's litigation going on. The insurance commissioner is actually looking into PHICO and there's litigation going on about PIC and PIE right now too. I would say that that is the biggest culprit and I think it's critical.

It's been mentioned a number of times the comment from an insurance industry executive in the Wall Street Journal saying we have to look inwards. We made the mess and I think we really need to investigate the insurance industry as we are in Enron, Global Crossing and look for ways of making the system work better.

Mr. BROWN. You call it PIE. We in Ohio who are not as literate call it PIE, which I believe it's headquartered in Cleveland. What caused PIE to leave the Pennsylvania medical malpractice insurance market? Maybe you can talk more informationally about PIC or PHICO if that's how you say those, PHICO and PIC and PIE. What can you tell us about that?

Ms. TOWNSEND. To the best of my knowledge, I think it was because they ran out of money and they just could not continue the business.

Mr. BROWN. They ran out of money because?

Ms. TOWNSEND. Because they spent it all on poor investments and they invested unwisely and didn't have enough in reserves to be able to pay out when losses happened.

Mr. BROWN. And with PIE it was also obviously, you cited the case—

Ms. TOWNSEND. There was impropriety on the part of the president there.

Mr. BROWN. In these cases, is it mostly mismanagement, or is it fraud, or is it some sort—you know, one of the interesting things, and I'll wrap up, Mr. Chairman, the interesting thing about all this corporate abuse that president points out it's just not the illegal abuses that we should be concerned about. It's also the corporate CEOs sitting on each other boards and paying huge amounts of money in salaries, not illegal in bonuses, but ultimately cause layoffs in the companies. Is it some of that too in your—

Ms. TOWNSEND. Something that remains a mystery to me, if I can answer you question in a different kind of way, is we've had a catastrophic loss fund in Pennsylvania, and over time it has now going to be phased out as a result of recent legislation. The CAT fund, as opposed to the private insurers about which we're speaking with huge CEO salaries, runs in a very lean kind of way. The amount of money per claim, claims management they call it, per claim is about \$500 per claim to manage it from start to finish as opposed to what they're going to do. What they're going to do now which is phase it out and then shop it out to the for profit entities that will cost between \$4,000 and \$5,000 per claim with less experienced people managing them. I guess that's my way of saying because of the obscene amount of money that's made by the insurance industry which is one of the richest industries in America

today, consumers and patients are losing. And a suggestion that we had made that a number of people——

Mr. NORWOOD [presiding]. Please wrap it up, Ms. Townsend. Time has expired for Mr. Brown.

Mr. BROWN. That's fine, Mr. Chairman. I would like her to finish her thought. Yes, Mr. Chairman.

Ms. TOWNSEND. We have been talking about making a single payor malpractice insurance system in Pennsylvania. JUAs don't have to charge such excruciatingly high rates. If we had one payor per State or one payor nationwide, the administrative costs would go down and premiums would go down and we'd have a centralized place to monitor mistakes where and when they happen and why they happen and get to the root cause.

Mr. NORWOOD. Thank you, Ms. Townsend.

Mr. Brown, as the prerogative of the Chair, I wanted to point out that this is not the Norwood bill, but it is the Greenwood Bill for which I support the basic premise of which if you don't have some limits on liability, we are never going to solve the problem of excess. But Mr. Greenwood is certainly on the right track. I recognize Mr. Cox now.

Mr. COX. Thank you, Mr. Chairman. I think it's important to point out because some of the dialog that's taken place that the experience in California is that there are no real limits in MICRA, that is to say there is no limit on the amount that a party to a lawsuit can recover. It's unlimited. There is no limit, for example, on punitive damages. And Ms. Townsend gave an example of someone cutting off the wrong foot or doing something wrong. Punitive damages are routinely awarded, and the amount is unlimited. Likewise, after all medical expenses are paid, not just to remedy whatever went wrong, but also to take into account all future medical expenses for one's lifetime if that's caused by the injury. That, of course, is unlimited. But also, all manner of conceivable second order effects from the injury such as I can't work in exactly the same line of work I used to be in and so on. All that's unlimited. There are no limits overall in California to what can be recovered. The limit is effectively infinitive. The only thing that MICRA limits in California is non-economic damages by which we mean so-called injured feeling damages. The inherently nonquantifiable damages that juries assess based on a gut feeling, as it were. That was thought a quarter century ago was the main contributor to the jackpot nature of some verdicts or more specifically the lack of horizontal equity and the lack of predictability and the subtraction of significant amounts of money from the health care system.

We now have some experience with California versus the rest of the United States and because some people in their opening statements suggested that premiums might have gone up unduly in California notwithstanding MICRA, I think that it should be pointed out that since 1976 up until the turn of the 21st century, U.S. malpractice premiums over that period went up 420 percent. And in California the premiums went up 168 percent. That's a rather significant difference for the biggest most populous State and the most diverse State in the Union. And yet, we hear that we have these horrible problems in West Virginia. We hear that we have these horrible problems in Nevada. Horrible problems in Mis-

issippi. One can look around the country and sadly, tragically, some of it relates to OB/GYNs and I want to ask Dr. Hollier because you're here in that capacity and you are an OB/GYN yourself. Is that right?

Ms. HOLLIER. Yes, sir.

Mr. COX. Why it is that doctors who deliver babies are specially the targets of these kinds of lawsuits?

Ms. HOLLIER. Doctors who deliver babies are considered high risk practitioners because babies can be born with problems and very often babies who are born with problems are associated with lawsuits against physicians. And I think it's important to remember that the claims that are brought against these physicians are not necessarily truly medical negligence.

Mr. COX. Another specialty that is deemed high risk is neurosurgery.

Ms. HOLLIER. Yes, sir.

Mr. COX. On the one hand, I can understand the connection between delivering babies and the kinds of defects that might occur at birth and the insurance risk attended to neurosurgery because patients can become paralyzed or worse. But on the other hand, it strikes me, as a lawyer, not a doctor, that delivering babies in a certain sense is the most basic function of a health care system. It's sort of work a day. And so when people are run out of town, when they can't deliver babies anymore and Dr. Roberts has given us rather striking testimony in that regard, are we mischaracterizing that profession, that specialty, in calling it especially hazardous, especially high risk, because the human race is going to continue to propagate itself for a long time. We probably got by without neurosurgery, but I don't think we ever got by without delivering babies.

How does this characterization of your specialty, how is it justified?

Ms. HOLLIER. I think that obstetrician/gynecologists clearly provide an incredibly important service for women and the 4 million women who are going to deliver their children this year are relying on us to provide them with the highest quality of medical care. Perhaps my colleagues in the insurance industry can better explain why obstetricians and gynecologists pay such dramatically higher premiums than other types of physicians. We certainly work very hard to provide the best quality care that we can everyday.

Mr. COX. I'm wondering whether or not there might be more jury appeal when the injury occurs to an infant. Or whether it's the fact that there's a whole lifetime ahead for the infant that runs up the damages. But when I look at the Nevada situation and we have West Virginia on the panel here and Mr. Pickering spoke to Mississippi, but Nevada is also an extreme case. The University of Nevada Medical School tells us that this is as of last month 42 percent of obstetricians are making plans to move their practices out of southern Nevada. If that happens, only 78 obstetricians are going to be left in Las Vegas, which is a city of 1.5 million people and 23,000 births every year.

Seventy-six percent of the obstetricians in Las Vegas have been sued. Now is it conceivable in America that there is a city of such

substantial size where three quarters of the doctors are crooks or frauds or charlatans or quacks?

Dr. Roberts, maybe you'd like to respond to that.

Mr. ROBERTS. I think the problem is that everyone expects a perfect baby every time. When my father began practicing in the 1930's, they didn't have the antibiotics that we have today. They didn't have the procedures that we have today. So they expected to lose some children, to not always have a perfect outcome. Unfortunately today, people in America expect a perfect baby every time. It's not always someone's fault. Many times it's an act of God. It's something that was going to happen no matter what the individual physician did or the nurse or whoever is held accountable for the problem. So I think we need to have a more realistic expectation. We all pay for the lawsuit abuse. We pay the bill one way or another. It plays into the inflationary spiral that costs us all more money every day. You can't put a price on non-economic damages. You can't put a price on human life. You cannot give somebody a million dollars and tell them they feel better because they lost their loved one.

Unfortunately, our society has gotten to that point. We believe money is more important than feelings. Many times physicians need to communicate better. And this is a problem I see with many physicians as I teach students. I tell them to talk to people. Treat people the way you would like to be treated if you were that person, or if that were your wife, your child, or your parents. If we all did that, we'd have a much better communication system. We wouldn't be afraid of each other. We'd be treating each other with respect.

Mr. NORWOOD. Thank you, Dr. Roberts, Mr. Cox.

Ms. Eshoo, you're no recognized for 5 minutes.

Ms. ESHOO. I want to thank all of the witnesses that are part of this first panel. While you have some differing views, I think that you presented yours very, very well and with a great deal of sincerity and professionalism.

Doctor, I think that you have with your testimony, with your words, really etched into every single member's mind that we really do have a problem. I mean, here you are, someone that has continued a tradition in your community. You have never had a suit against you and yet, what is the cost of your premium this year?

Mr. ROBERTS. \$35,800.

Ms. ESHOO. And who is the carrier that you pay your premiums to?

Mr. ROBERTS. Bureau of Risk and Insurance Management in the State of West Virginia.

Ms. ESHOO. And it was how much last year?

Mr. ROBERTS. \$17,000. That was with PICO. And then PICO went, of course, into receivership. So they did double the premium. They have said it may be as much as twice that next year. And I obviously will not be able to afford that.

Ms. ESHOO. And approximately, what's the gross of your practice?

Mr. ROBERTS. I can't tell you that. There are two physicians, two nurse practitioners and two—

Ms. ESHOO. What does this present in terms of overhead for you?

Mr. ROBERTS. Excuse me. It represents, I'm going to say, 10 percent of my income. And there are expenses that come out of that.

Ms. ESHOO. It's a lot of money. I'm sure you've shopped for insurance.

Mr. ROBERTS. I can't get any other insurance in the State of West Virginia. All the other providers have pulled out. They will not ensure family physicians that do obstetrics. If I did not do obstetrics, my rate would be approximately half what it is. What happens is people drop procedures. They stop delivering babies. So women don't get prenatal care. Babies end up being born at 28 or 30 weeks in an emergency situation. They have to get in a helicopter and go to Morgantown. Those babies cost approximately \$1,500 a day besides the human cost for that family and that child. The State pays the bill. Eventually, we all pay. Providing pre-natal care is one of the most important things we can do as a society.

Ms. ESHOO. You're a good man. You really have touched me with how you've conducted yourself. You're a decent person, you're doing something that, and I'll tell you one thing, for a woman to, the relationship of women with their physicians, their OB/GYNs is something that no one can never drive a wedge through. We have very, very complicated bodies and we're reliant upon you.

I'd like to ask the person sitting next you. How do you respond to the doctor? I mean, here he is—just a little cross rough. I'm not looking to make mischief. Each one comes in with their 100 percent clear cut view. And yet this is a pretty, this is not, I don't think, a stand alone case. It speaks to the problem that we have in our system. He has never been sued. What do you have to say about the problem? And also, I appreciate your testimony. You point out some very important things. But how would you respond to what he's saying?

Ms. TOWNSEND. I've been equally moved by Dr. Roberts.

Ms. ESHOO. He's not a single, he's not just a single smokestack.

Ms. TOWNSEND. Oh no, he's not.

Ms. ESHOO. He underscores the problem that we have. Now, I understand the room that there is in the system for medical malpractice, but if the insurance rates are what they are and he has never done anything that's wrong, what does that say to you? Maybe that's the fairest way to ask the question.

Ms. TOWNSEND. That tells me that Dr. Roberts, I believe, is being price gouged by the insurance industry. And that tells me, and maybe this is a crazy idea, I don't know whether this happens elsewhere, but is there such a thing as experience-based insurance for medical professionals? It makes me think about that.

Ms. ESHOO. We have, I know, on our next panel, and I hope I'm going to be able to be here for it, because we've already been in for about 3 hours here. Well, there's a lot of discussion and debate. As long as it takes, we should do it.

Do the other two panelists, would you like to lean in on this and just say a few words? I give you the opportunity to.

Mr. FINE. If I may add—

Ms. ESHOO. Not very long so everyone else has a chance, but go ahead.

Mr. FINE. I understand. Physicians, and rightly so, take care of patients one at a time. Hospitals have to bridge taking care of pa-

tients one at a time while at the same time trying to play a public health role in preparing and addressing the health care needs of their communities. So we're caught in a "Catch-22;" we try to address the individual situations such as those that are discussed by Dr. Roberts and Ms. Townsend, and the need for us to be prepared to take care of the people in our community. Without resolving this problem, we will lose the capabilities in our community.

Ms. ESHOO. It becomes gum stuck to your shoe as well.

Mr. FINE. Exactly.

Ms. ESHOO. Doctor, would you like to say something before my time expires?

Ms. HOLLIER. Thank you very much for giving me the opportunity. We certainly appreciate your attention to this issue today and we appreciate the recognition of this committee that this truly is a crisis. The residents that I've trained who have debt from medical school, who have debt from brand new practices—

Ms. ESHOO. Another huge problem we should be addressing.

Ms. HOLLIER. They are going to be unable to continue to practice obstetrics next year, if premiums increase again. We desperately need of a solution.

Ms. ESHOO. Has the Academy looked at the whole issue of experience pricing? What is it?

Mr. NORWOOD. Your time is up, Ms. Eshoo.

Ms. ESHOO. If she could answer that, Mr. Chairman.

Mr. NORWOOD. This will be the end of it.

Ms. ESHOO. Has the Academy looked at that, Doctor?

Ms. HOLLIER. I am not aware of that.

Ms. ESHOO. Thank you. Thank you, Mr. Chairman.

Mr. NORWOOD. Yes ma'am. I now recognize myself for a couple of brief questions.

Dr. Roberts, your malpractice insurance company is whom?

Mr. ROBERTS. BRIM. The Bureau of Risk and Insurance Management of the State of West Virginia.

Mr. NORWOOD. So Ms. Townsend is applying that the State of West Virginia is gouging you with that high premium.

Mr. ROBERTS. I'll leave that question alone.

Mr. NORWOOD. Is that what you were implying, Ms. Townsend?

Ms. TOWNSEND. I think he's being charged too much money.

Mr. NORWOOD. So the State of West Virginia is charging you too much money, but nobody else will insure you.

Mr. ROBERTS. That's correct.

Mr. NORWOOD. That sort of leads me to the question, Dr. Hollier, about what happens if we have choices here. Would pregnant patients around the Nation rather have access to windfall jury awards because we refuse to admit there needs to be some limit on liability? And I'm not wishing to debate what that limit is, the fact that there needs to be some number out there in malpractice lawsuits. Or would the women of the country rather be ensured that they will have access to health ensure a safe pregnancy and a healthy child by having people stay in business? What would be your feeling about that?

Ms. HOLLIER. Thank you very much for asking that question. My feeling is that the women of this country, just as I did, would recognize that prenatal care is extremely important in a delivery of a

health child and would advocate for access to care. I think this legislation is important because we need to balance a few women who recover unquantifiable damages against the ability of all women in this country to receive the preventative and the diagnostic care that they need.

Mr. NORWOOD. So the American College supports H.R. 4600.

Ms. HOLLIER. The American College of Obstetricians and Gynecologists strongly supports H.R. 4600.

Mr. NORWOOD. Do you agree with what many members have said, and panelists, that actually physicians at a rapid rate for leaving medicine and in particular OB/GYN.

Ms. HOLLIER. Yes, sir. I absolutely agree with that. One of my colleagues in Cady, Texas just recently found out that his liability insurance was going to cost him \$70,000 for the practice of both obstetrics and gynecology. If he drops obstetrics it's only \$20,000. So he stopped obstetrics.

Mr. NORWOOD. And Dr. Roberts, you agree that positions in the country, particularly those around mine and your age that may have had experience are rapidly getting out of the practice of medicine and particular OB/GYN.

Mr. ROBERTS. Yes, sir.

Mr. NORWOOD. Then it's logical to conclude that women in this country do not have access. Now what we're discussing today is why are those premiums as high as they are.

Mr. ROBERTS. What is happening in the State of West Virginia, the Bureau of Risk and Insurance Management is dependent upon the State Treasury of West Virginia. They do not want physicians to be on BRIM program. BRIM program was initially begun so that the professors at West Virginia University and Marshall University would have coverage. What's happened is by default, they had to provide the availability of insurance to us, the other insurance companies have left. BRIM does not want us to continue. They are trying to get the State Medical Society to create a Physicians Mutual, which has in the past not done well—look at PIE and PHICO, and there are other examples across the country.

So the State Medical Society has been very reticent to produce an insurance alternative because it's just a stop gap measure. Until we address the real issue, which is the excessive awards and the fact that people have developed this lottery system, then we are never going to have anything that's going to have a significant meaning. The State Treasury does not want to be at risk. That's why they have made BRIM the highest price. There's a 10 percent premium. Whatever rate you can get in the State of West Virginia, they add 10 percent to it and that's your BRIM rate.

Mr. NORWOOD. So we can all then agree that part of the problem for the premium increase has got to be, part of it, the increased awards that are going on, and in many cases not even an award.

Dr. Hollier, you said in your statement that out of 10 cases taken to court of OB/GYNs, 7 were found for the defendant, meaning three 3 found to have done something wrong and there was then an award. But the other seven, having spent time, dollars, etcetera, were found not guilty.

Ms. HOLLIER. Yes, sir. That is absolutely correct. In addition, in Texas, in fact, one study has shown that 86 percent of claims

against physicians are ultimately dropped by plaintiffs' attorneys, thus these claims are nonmeritorious.

Mr. NORWOOD. Then why would these attorneys spend so much money taking a claim like that to court and lose so many of them?

Ms. HOLLIER. I think that's a very difficult question. But that certainly brings us to address one of the important legislative components of H.R. 4600 which is a limit on the contingency fees lawyers can charge in litigation involving professional liability.

Mr. NORWOOD. Well, does that mean that maybe 60 percent of an award that's supposed to go to a patient actually goes to the plaintiff attorney in court costs, therefore, windfalls are potential here, therefore it's okay to lose 7 out of 10, because all you have to do is win one and you don't even have to be right? To win one in the system you just have to be able to hire the most expert witness. So surely we can come to some agreement in this committee that there is a problem with the system that is contributing to the fact that women in this country are losing access to care no matter what side of this you're on, Mr. Brown. We ought to be able to sit down as grownups and discuss this and recognize. There's got to be some limit somewhere.

My time is up, I'm sorry to say.

Mr. Stupak, you're now recognized for 5 minutes.

Mr. STUPAK. Thank you, Mr. Chairman. In your comments to Mr. Brown, I think we probably could sit down and talk about this if we were to separate fact from fiction. I don't know of any State that allows a 60 percent recovery for attorney fees in malpractice cases as you claim for this big windfall for attorneys.

Mr. NORWOOD. Would you yield just a second?

Mr. STUPAK. Just as long as I get my time back, I will.

Mr. NORWOOD. I included court costs in that, too. Attorney's fees and court costs.

Mr. STUPAK. All right. I'll let it go. I don't tell you how to practice dentistry. You shouldn't tell us how to do malpractice. All right.

Dr. Roberts, you said that the West Virginia legislature had tried to address this malpractice situation?

Mr. ROBERTS. Yes, sir.

Mr. STUPAK. What did they determine?

Mr. ROBERTS. Well, they spent 60 days in session and I can give you this off the top of my head, but please don't quote me exactly. But they raised the fee to file a malpractice claim from \$85 to \$250. They increased the jury from 6 people to 12 people. Nine out of the 12 have to agree that there is malpractice. They created a tax credit. We have a provider tax in West Virginia. We pay 2 percent of our gross. Before we pay any bills, we pay 2 percent of our gross for the right to practice medicine in West Virginia. They gave us a partial tax credit. You deduct \$10,000 from your malpractice fee premium and you take 10 percent of that amount off of your provider tax. So those are the things that were primarily done in the State of West Virginia, which again I feel are relatively minimal in having an impact on the situation.

Mr. STUPAK. Let's back up here. You said your total income, your malpractice is about 10 percent of your total income and it's probably going to be \$35,800, so if that's 10 percent your income is about \$300,000. And if West Virginia taxes you, what, 2 percent?

Mr. ROBERTS. Two percent.

Mr. STUPAK. So how much is 2 percent of your gross income that's paid to West Virginia?

Mr. ROBERTS. \$6,000. Something like that.

Mr. STUPAK. So they gave you a rebate on that.

Mr. ROBERTS. Ten percent credited toward that amount.

Mr. STUPAK. They didn't go into caps and all this other stuff, right? West Virginia?

Mr. ROBERTS. No. There is a cap, a million dollars on non-economic damages now in West Virginia already in place.

Mr. STUPAK. If your legislature, you say you're State is in crisis. If your legislature won't take the steps you want them to do, as found in this bill, why then should the Federal Congress pass a law that affects all of the States?

Mr. ROBERTS. This is a very political issue. In the State of West Virginia, I don't believe any tort reform will be passed unless the State Bureau of Risk and Insurance Management is the only provider in the State, and the State Treasury becomes that risk. Then the legislature will have to do something to limit the awards.

The other thing that could happen is that a Federal bill, such as H.R. 4600, would come down to the State of West Virginia. They would have to comply with that.

Mr. STUPAK. We always hear up here that State legislatures are so much more closer to the people and they know better than we do, so why would we be Federalizing the system that the State won't do?

Mr. ROBERTS. State legislatures are just as prone to politics as they are on a national level.

Mr. STUPAK. Sure. Can you then tell me then, Dr. Roberts, you indicated you never had any claims or anything like that against you, right? You didn't get any credit for that from the insurance carriers?

Mr. ROBERTS. No.

Mr. STUPAK. Never, right? No claims, your policies keep going up? The premium keeps going up.

Mr. ROBERTS. Yes, sir.

Mr. STUPAK. And your license has never been suspended for anything then?

Mr. ROBERTS. I had a situation about 15 years ago, yes sir. It's a personal matter that's really not germane to this issue. And it did not affect my malpractice claims if that's your question.

Mr. STUPAK. No, no. I'm just trying to figure out why it always goes up, you never get a rebate if you never had a claim. But if your license is suspended, that's by the State of West of Virginia then, right?

Mr. ROBERTS. Yes, sir.

Mr. STUPAK. So something else there other than a malpractice claim.

Mr. ROBERTS. Yes, sir. It had nothing to do with malpractice, did not affect my rights in any way.

Mr. STUPAK. Your carrier told you that?

Mr. ROBERTS. Yes, sir.

Mr. STUPAK. I would just think that if the State would take a drastic action like taking away a license of a physician, that's a

right that you have a property right and your income right, that there has to be—

Mr. ROBERTS. Sir, I addressed this with the Board of Medicine in West Virginia in 1987, 15 years ago. It was addressed correctly, it was resolved at full licensure with the Federal Government and with the State government of West Virginia. This is not an issue. Obviously, you're trying to turn this into political process. I'm a Democrat, too. Why are you attacking me?

Mr. STUPAK. Wait a minute. I asked an innocent question. You said that you had never had a license suspended or anything like that. No malpractice claims. So I asked a question. There's a part of licensing, or malpractice, called licensing. Did you ever have your license suspended? Innocent question. I'm not trying to get into your personal life. What I'm trying to say does it have influence on these malpractice premiums. There's a lot of factors that go into it. It's not just lawsuits.

So answer this if you can, Doctor. What is it that States with caps on damages, why those with damages, caps, why isn't the premium higher than those without the caps?

Mr. ROBERTS. I don't know.

Mr. STUPAK. Was West Virginia then voted caps? Was that an option they had in the legislature to go to caps? Was that an option that they presented at West Virginia to go to caps on malpractice award for non-economic losses, for punitive damages? Did they propose caps in West Virginia?

Mr. ROBERTS. They proposed a cap of a million dollars on non-economic damages, yes. And there is no price on human suffering. I don't care if you call it a million dollars or \$250,000. You cannot replace human suffering with money.

Mr. STUPAK. Then why would we have put a cap on it then? Shouldn't you let the jury determine then what that suffering was?

Mr. ROBERTS. Because we all pay that price. Can you reward pain and suffering? Can you replace that individual? I don't think so.

Mr. STUPAK. But you said you can't put a price on it, but yet you want to put a cap on it. Correct?

Mr. ROBERTS. I think it's a matter of economics. The United States cannot afford to continue to pay the prices that we're paying.

Mr. STUPAK. So life is just a matter of economics then?

Mr. ROBERTS. It's economics if people can't find a doctor. It's economics if a baby is born weighing 1.5 pounds at 26 weeks and has to go on a ventilator. That's how it becomes blind because of oxygen toxicity, or has a ventricular leak because they could not find a doctor. They had no prenatal care.

Mr. STUPAK. It's also economics if you have to take care of that injured person for the rest of your life. That family then has some economic factors that have to be considered.

Mr. ROBERTS. It wasn't my fault if I wasn't able to be there to take care of the mother and baby.

Mr. STUPAK. It was your fault.

Mr. ROBERTS. They couldn't get care because there was no access.

Mr. NORWOOD. Thank you, gentleman.

Mr. STUPAK. If it was your fault. If you're talking about economics, it applies both ways. It can't just be one side.

Mr. NORWOOD. Thank you very much, Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. NORWOOD. And I want to apologize to you. I misspoke and I want to correct that. It's not 60 percent that goes into the administration and defense costs and attorney fees. It's actually 58 percent, and I'd like to submit for the record the Report on the Council of Economic Advisors and put that in the record the imply the problem is the patient doesn't receive as much as we think they do.

And now I'd like to recognize Mr. Buyer for 5 minutes.

Mr. BUYER. Thank you. I have some questions about this culture of fear. I sort of touched on it in my opening remarks about, I guess it can also be called practicing defensive medicine.

And so I would like Dr. Roberts, actually I'm not picking on the two docs here. Help me out here. You're practicing medicine. You're doing the best that you can. But you also know that the lawyers are out there and if a lot of these claims are being filed also are being classified then as frivolous suits or nonactionable or however you want to title them. Tell me about the inside, the sit down with your colleagues? Tell us about the inside, the practice of defensive medicine. Is it happening, is it not? I'm just curious.

Ms. HOLLIER. Thank you. It seems like my problems today are technical. We have quantifiable data that talks about the practice of defensive medicine, and it appears that more than three fourths of physicians feel concerned about malpractice litigation, in fact, 76 percent. This concern hurts their ability to provide quality of care in recent years.

Physicians also report that the fear of malpractice claims causes themselves and/or other physicians to order more tests than they would need based on professional judgment of what's truly medically needed. Ninety-one percent have noticed other physicians do this, and 79 percent report that they do this themselves due to concerns about professional liability.

Physicians may prescribe more medications such as antibiotics and only a scant 5 percent of physicians think that their colleagues are comfortable discussing medical errors with them.

I think the medical community is working very hard to limit medical errors. We are actively involved in research to limit medical errors. Hospitals, as I believe you addressed earlier in your opening remarks, have quality assurance committees, risk assessment committees, and physicians are working very hard to improve patient safety.

Mr. BUYER. Dr. Roberts?

Mr. ROBERTS. I think one thing that's happened in some States is that there are certain practice guidelines that have been established, and what they've done there is try to determine the standard of care in the community. And if you have met that standard of care, then you can be held nonresponsible. But sometimes this leads to unnecessary x-rays, scans, and lab procedures that are done purely because we are afraid. If you're afraid that you're going to be sued, you order the extra CAT scan whether you feel it's really necessary. If a child falls and the child is fine, you've done a complete neurological exam. You've looked in their eyes.

You've done all the screening tests. You go ahead and order the CAT scan in the emergency room because you're afraid if it's ever is that one in a million case that that is going to be the thing that's brought into court.

Mr. BUYER. Answer this as you like. You can even do it in the hypothetical. But if you have a doctor doing his diagnostic analysis and he thinks it's a, could be b, but I really think it's a. But you know what, I know that this individual's insurance covers an MRI. I just want to be 100 percent. Is it happening that they go ahead and go yeah, let's just go ahead and get that MRI done. Let's go ahead and get that other procedure. Is that happening out there?

Mr. ROBERTS. Absolutely. Every day. In every emergency room across the country and every doctor's office.

Mr. BUYER. So it wouldn't be just for an MRI. It could be for laboratory tests from blood. Give us some examples. And then Mr. Fine I'd like for you to jump in.

Mr. ROBERTS. What happens is the individual physician is put in the position of realizing that this case could be brought into court. They could be accountable whether it's their fault or not. Did you do the proper procedure? Did you order the proper test? And subsequently, the individual physician orders the test just because they know that, not because they feel it's necessary for the patient. And the problem is many of these people don't have insurance.

Mr. BUYER. So it exceeds the boundary of the community standard of quality of medicine and then it becomes defined as defensive medicine.

Mr. ROBERTS. Absolutely. I agree.

Mr. BUYER. Thank you. Mr. Fine?

Mr. FINE. Yes. To piggy back on that, it certainly occurs in every emergency room across the Nation regardless of whether has insurance or not for their health coverage. If someone comes in as the doctor described who has fallen and struck their head, CAT scan or MRI becomes the standard of care whether or not it's necessary in that incidence. And that occurs in the Philadelphia area whether or not the hospital paid for the case. Most of us are paid a flat rate for emergency room case, substantially less than a \$100 per case. But that person that comes in who has lost consciousness or has had a minor head injury can end up with a \$1,000 CAT scan or MRI because the emergency room can't afford, or the emergency room physician can't afford the exposure that's associated with not doing that test.

Mr. BUYER. Thank you, Mr. Chairman. I yield back.

Mr. NORWOOD. Thank you. Mr. Strickland, you are now recognized for 5 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman. And I'd like to say to my friend, Representative Deal, that I wish I had been wise enough to make your opening statement. I listened to all the opening statements, and I very much appreciated the balance and the passion with which you spoke. Thank you.

Dr. Hollier, I'm not sure I'm pronouncing you correctly?

Ms. HOLLIER. Hollier.

Mr. STRICKLAND. Do you believe that caps, if they are or were in place, would reduce malpractice premiums?

Ms. HOLLIER. Yes, sir. I believe that they would. I think that the MICRA reforms that we've been talking about today really have stood the test of time in California. We've talked a lot about how the absolute number of the premium paid by physicians in California is relatively similar to the number physicians pay in other States. And I think it's important for us to remember that we very well may be comparing apples and oranges.

Mr. STRICKLAND. Can I ask you to respond to this then? I have data here from Medical Liability Monitor. It presents the average liability premium for OB/GYN physicians for 2001. And then in States without caps, the average premium is \$44,485. And in the States with caps, the average premium is \$43,010.

How do you explain that data from what I believe is a credible source because it seems as if there is very insignificant difference, if any at all.

Ms. HOLLIER. Well, I have not had the opportunity to specifically review that data. I would like to say that it's important to remember that we need to compare rates for the same amount of coverage. For example, my physicians in the State of Texas can't obtain \$1 million, \$3 million coverage. In fact, what we're obtaining for our \$37,000 a year may in fact be \$5,000, not \$1 million. Or what is most common now in the State of Texas is actually \$200,000, \$600,000.

Mr. STRICKLAND. But you see, the problem that we face up here is that we hear all of these claims and accusations. At some point, there needs to be some coming together, some reasoning together to find out that we're looking at the same data, providing the same coverage. And I don't think we're there yet. I have a second question, if you'd be so kind.

Many of us are interested in exploring not only the solutions that have been suggested by many of you, but also exploring reforms in the insurance industry as a part of the solution to the current problem.

Now I have here information regarding several States that have already enacted caps. Florida caps both punitive and non-economic damages. Nevada caps punitive damages. New Jersey caps punitive damages and in wrongful death cases non-economic are not available. Michigan caps punitive damages and non-economic. Texas caps non-economic and punitive damages. Washington has abolished punitive damage.

Why is it that States with caps on damages are still facing this same crisis that we are describing if caps are going to provide the kind of premium relief that many of you seem to believe they will provide?

Ms. HOLLIER. I think that's a very good question. Clearly the problem is multi-faceted and we are interested in investigating multiple measures to reduce those prices and ensure access of our patients to care.

Mr. STRICKLAND. It seems to me that your answer, and I think it's an accurate one, it's a multi-faceted problem, calls for a multi-faceted solution. And my problem with what we're attempting to do here is that we seem to have a single shot solution to a problem that is multi-faceted in nature.

I'm very close to the hospitals in my District, Mr. Fine. I value what you and your association does and I'm wondering if you would just speak to that same series or a couple of questions that I've addressed to the good doctor here in regard to why our States which have these caps in place are still experiencing the kind of crisis that we're all recognizing as a reality?

Mr. FINE. A few points there. First of all, within States there are significant differences by region. In Pennsylvania, the southeastern Pennsylvania region's rates for professional liability coverage are substantially higher than the more rural central part of the State. So part of this has to do with the venuing of cases and the way in which cases are reviewed by local juries.

The listing that you had offered relative to States in which limits have been already implemented, as I understood the list, most of those limitations applied not to non-economic damages, but mostly to punitive damages and in H.R. 4600 those two things are addressed very, very differently.

Mr. STRICKLAND. If I could just make one concluding statement, Mr. Chairman. I'm conflicted because we trust the jury system to make life and death decisions regarding whether or not a person should be put to death, for example. It troubles me that we would trust the jury system to make decisions about life and not trust the jury system to make decisions about money. That is so fundamental to the conflict that I'm feeling, while recognizing that the problems that you've described here are very real ones and we need to address them.

Mr. Chairman, I would yield—I think my time is up, as a matter of fact. Thank you.

Mr. NORWOOD. Thank you very much, Mr. Strickland.

Mr. Deal, you are recognized for 5 minutes.

Mr. DEAL. Thank you, Mr. Chairman. As I observed in my opening statement, this is a multi-faceted issue that has, quite frankly, very few good and absolute solutions, but I am after being in Congress and State legislature and practicing law for over 20 years, I've concluded that the perfect is never really going to be achieved, but what we try to do is to come as close as we can to resolving these issues.

And Dr. Roberts, I would say that your testimony certainly is a graphic demonstration of the very practical problems that we're facing and I appreciate the fact that you would be willing to come and share your experiences with us because you come from an area that's very similar to my District and I'm sure the District that many people represent here and that is smaller communities where there has always been and hopefully will always continue to be a personal relationship between the doctor and the patient. The reputation of the doctor in that community spreads itself to the point that jurors who are assembled are confronted with a protectionist attitude, because this is our doctor and we have a relationship with him. Unfortunately, I think as we get into larger communities, much of that is lost.

One of the problems that I alluded to earlier is that even though in the breakdown I now see that Mr. Buyer has here about insurance malpractice rates, that in some companies they are beginning to make geographical distinctions between larger communities

many times where many of the larger verdicts come from and smaller communities where if there is ever a verdict it is always of a smaller magnitude.

One of the aspects of this whole issue, however, that concerns me and that I'm hearing from my medical community is a decline in the number of young people who are actually applying for medical schools. Is that a concern that you've heard expressed, and if so, would you comment on it, any of you?

Mr. ROBERTS. It's very much a concern. I teach at Western University. I'm a clinical professor and I also have worked on the medical school admissions board doing interviews with students. We have less applications every year. Students are discouraged from going into medicine because of fear. People actually in medical school such as my daughter are being questioned about where they're going to go and they're looking for States. She's considering going to Colorado. She worked out there for a year with an OB/GYN group and she found that their laws were much more stable than West Virginia. I'm not sure exactly the structure of that law, whether it's similar to the MICRA law or not, but I've noticed that Colorado is one of those States that's not as likely to get into a lawsuit.

So yes, it is a concern. It's a concern that it's discouraging, some of our good students, not to go into medicine, and it concerns me.

Mr. DEAL. Doctor?

Ms. HOLLIER. Thank you very much. I'd like to echo those concerns. I'm a teacher at the University of Texas Medical School at Houston and we are definitely seeing a decrease in the number of students who are interested in obstetrics and gynecology. In fact, one of the most frequently asked questions for me is what is the liability situation going to be like for me, am I going to actually be able to practice obstetrics. If I go through a 4-year residency training, a 3-year fellowship, am I going to be able to practice what I have learned? Our students are clearly demonstrating their concern about the current crisis and I'm afraid if this crisis continues, the quality of physicians that choose obstetrics and gynecology may decline.

Mr. DEAL. So the effect is, first of all, there is a declining interest in medical school, in general, in the population, plus there is obviously a selection process of specialties going on and it is in some part dictated by liability concerns in the particular specialties and certainly the OB/GYN being one of those high risk specialties from a liability standpoint. Is that what I hear both of you saying?

Mr. ROBERTS. Yes sir. Many family practice residents are electing not to obstetrics and not to do other high risk procedures because of that when they go into practice which again limits access to prenatal care and delivery care services.

Mr. DEAL. Mr. Fine, as a hospital administrator and CEO of a large hospital, I presume that one of your requirements for granting hospital privileges for physicians is that they must have liability insurance in their own right. Is that correct?

Mr. FINE. That's not only a requirement of our hospital, in order to be licensed as a physician in the Commonwealth of Pennsylvania, you must have a minimum of \$1.2 million of professional liability coverage.

Mr. DEAL. So there's no, in that case, there's no option about having to have liability insurance.

Mr. FINE. No option.

Mr. DEAL. You can't just elect to be self-insured, in other words?

Mr. FINE. Correct.

Mr. DEAL. And especially in situations where there is no separate liability allowed, but to joint and several liabilities in place, obviously the hospital is almost invariably a co-defendant in cases of alleged malpractice that occurred within the confines of the hospital. Is that correct?

Mr. FINE. Yes sir, that's absolutely correct.

Mr. DEAL. All right. With regard to the insurance coverage of the hospital itself, would you repeat what your percentage of increases have been?

Mr. FINE. Sure. Grand View Hospital specifically, 2 years ago was paying approximately \$1.5 million for its professional liability coverage. That went up to approximately \$2.3 million last year and will be over \$3 million this year, in addition to the increases in coverage. We've been now forced to take \$7.5 million deductible in the first layer of excess insurance, right above \$1 million. And a 50 percent co-payment for any claim that actually pierces into that layer. We have a tremendous exposure.

Mr. DEAL. I understand that that's a similar pattern that hospitals in my State and other States are experiencing is the larger up front deductibles and the larger percentage of co-pays. I don't think your situation is unique in that regard. Is that your general understanding?

Mr. FINE. That is my understanding.

Mr. DEAL. I think all of us—is my time up, Mr. Chairman? I'm sorry. I would not dare infringe on that. Thank you.

Mr. NORWOOD. Thank you, Mr. Deal. I sure didn't want to call you down on it either.

Mr. Deutsch, you're now recognized for 5 minutes.

Mr. DEUTSCH. Thank you, Mr. Chairman. I would throw this out. I know all of you in good faith answered my colleague from Georgia's question, but I'd be curious to see any empirical data to support the contentions that were just made about less quality of students and people choosing not to go into medicine based on liability issues, people choosing not to go into specialties because of liability issues. I just—I have a medical school in my District where I have not heard of any of that. So if it exists, maybe it exists in other States besides Florida, but I'd be curious about it.

Did you want to respond to that?

Ms. TOWNSEND. I actually have examples in three States to answer that question.

Mr. DEUTSCH. Okay.

Ms. TOWNSEND. One is New York State. According to the New York Public Interest Research Group, New York State is ranked third in the Nation in its number of obstetricians and gynecologists per capita which is ahead of California which is ranked 27th. And when compared to the region, Connecticut ranked second as ahead of New York State in the number of OB/GYNs per capita.

What's more, the number of physicians practicing in New York has gone up significantly and is increasing at a rate faster than the

national average. The Nation's ratio of physicians per capita rose by 43.6 percent compared with the 47.9 percent increase in New York during the period of I guess between 1980 and 1998. I'm trying to speed this up.

Mr. DEUTSCH. You know what, I'll tell you. I got the gist of what you're saying.

Ms. TOWNSEND. And also, this is from the Center for Justice and Democracy. There was also a study done called the Price of Practice from the Charleston Gazette in West Virginia, done by two reporters that found that despite claims from the medical association there, that the lack of tort reform had caused a mass exodus, that in fact, they were seeing an increase in physicians and the same goes for Pennsylvania. John Reed of the CAT Fund has—

Mr. DEUTSCH. Mr. Chairman, Mr. Chairman, if you want to take my time, can you ask me to yield?

Mr. NORWOOD. Would you yield to find out what study that was?

Mr. DEUTSCH. I'd be happy to yield to the chairman.

Ms. TOWNSEND. It's called, it's a series that appeared in the Charleston Gazette. It's called the Price of Practice and the reporters in question were Lawrence Messina and Martha Leonard.

Mr. NORWOOD. Thank you very much.

Mr. DEUTSCH. Thank you. Recalling my time, we've had a lot of testimony this morning and I guess a question that I would raise and give you the opportunity because as far as I'm aware it really hasn't been discussed, why are we here? Why are we talking about this as one of the unique things that the Federal Government needs to be involved in? Many of us on this panel have served as State legislators and actually dealt with malpractice issues in the legislature. This has traditionally been a legislative issue, a State legislative issue. Why all of a sudden is this an issue that has to be Federalized?

I'd like to thank my colleagues on the other side of the aisle, continuously, always say local government does better, State does better. Why are we choosing to have this hearing? Why are we choosing to discuss Federalizing what has historically and traditionally been a State issue?

Does anyone want to offer any reason for it? I mean sort of—

Mr. FINE. I'll offer the comment that in some States the crisis has already developed and in most of our neighborhood States, we see that the crisis is rapidly developing to the point that it would appear that a common solution to the problem would make more sense.

Mr. DEUTSCH. But again, I guess I would ask you, why can't you go to your legislatures? I mean there's a reason why we have not Federalized insurance. Again, my question would be if the crisis is so dramatic as you're describing, the numbers you presented I think would absolutely point to that, why isn't your legislator responding? And let me just follow up on that, that if they're not responding and the crisis is as bad as you're describing, you have the ability in a political process to elect new legislators. This is again historically not a Federal issue for some very good reasons. And it seems very selective that we're even here today, all of a sudden Federalizing this particular issue.

Mr. FINE. In Pennsylvania, I was asked to come here by members of the State legislature. In Pennsylvania, we have certain constitutional provisions that according to the Pennsylvania Supreme Court have precluded the establishment of such things as caps on non-economic damages. Members of the Pennsylvania House with whom we've worked closely on this, have worked to pass legislation that has then been overturned by the State Supreme Court. This occurred when—

Mr. DEUTSCH. Let me just—

Mr. FINE. Congressman Greenwood was sitting in the Pennsylvania Senate.

Mr. DEUTSCH. Let me just mention because I see I'm wrapping up on time. I mean in Florida, again, I have a fair amount of experience in Florida. Both sides of this issue or three sides of this issue, four sides of this issue on more than one occasion, again, I don't know, Pennsylvania, ability to do initiatives in terms of constitutional amendments, but in Florida, we've had some very aggressive constitutional amendments because of similar issues related to, as you said, in Pennsylvania.

The last thing I would mention, and really give people an opportunity and maybe Mr. Fine, you in particular, which always sort of—I have questions of this in terms of the whole malpractice issue. You mentioned a specific thing in terms of someone coming into an emergency room setting and getting a CAT scan. And I guess the perspective I have is in terms of either practice parameters or in terms of what is appropriate medical care. If it's not appropriate, even if it's one in one thousand times that the case that looks like the concussion is not a severe concussion, that only a CAT scan could pick up, then in any type of factual setting, why would someone, what's—it doesn't make sense that they would not do a CAT scan. It might not be for the—in other words, what I'm saying is you have to evidence. It's a factual issue. There has to be a factual basis at some point in a setting that that was an appropriate procedure to do, appropriate test to do. You're not doing CAT scans on fingers or broken arms because you're not and again, it might not be likely. It might not be that often. If you were paying out of pocket, maybe you wouldn't want to do it or maybe the patient might not want to do it, but I guess what I'm saying is if the test is actually showing something, even if it's unlikely, I mean in a sense it has to be showing something that very well might save the person's life. So I guess my question—

Mr. NORWOOD. Mr. Deutsch, I know you're a stickler for protocol and your time has expired.

Mr. DEUTSCH. But Mr. Chairman, I would ask to give the gentleman an opportunity to follow up and see if he can answer.

Mr. NORWOOD. Well, it wasn't a question, was it?

Mr. DEUTSCH. It really was.

Mr. NORWOOD. You want to answer, Mr. Fine?

Mr. FINE. If I understood the gist of the statement, the issue becomes that in retrospect any test that is found to be positive is determined to have been a necessary test and any test that was negative is generally viewed as having been unnecessary and that can only be determined after the fact, in retrospect. Until such time as we have, either reform such as those that are being discussed today

or we have practice parameters that are established and protect practitioners so that they will not be found retrospectively responsible for having made what seemed to be a very well informed decision at the time. We will continue to have the problem that I believe I understood you to be outlining.

Mr. NORWOOD. Thank you very much, Mr. Fine. Mr. Fletcher, Dr. Fletcher, you're now recognized for 5.

Mr. FLETCHER. Thank you, Mr. Chairman. Let me say I agree with some of the comments about Mr. Deal's opening statement. I think it was very thoughtful and I concur with him that in the profession of medicine we need to do a lot more on policing our own members and I'll ask a question about that just briefly regarding transparency which I think the runaway lawsuits decreases which makes it more difficult for peer review.

Additionally, let me make a statement regarding also the chairman's or Dr. Norwood's questioning regarding lawsuits, only 70 percent, of all liability claims result in no payment to plaintiffs. And this is one of the problems of having this possibility of getting this large settlement. It is this fact that attracts trial lawyers and we see a lot of their ads on television as I believe Mr. Deal had mentioned, to go after cases which don't have the facts with them, simply because it's kind of the roll of the dice. And not only that, but the median cost of defending such a case, one where the jury rules the defendant not guilty is \$66,767 and that was in 2001. So you see, there's a lot of money that changes hand, a lot of money to be made, even in these lawsuits that have no credibility and that are lost and that's part of the problem. That's what makes it broken.

Let me make a comment additionally on the quote about the poor and I want to quote from Cruz Reynoso, a Democratic Vice Chairman of the U.S. Commission of Civil Rights, professor of law at UCLA and a former Justice to the California Supreme Court. He stated that publicly funded medical centers are supportive of MICRA because in their own insurance rates they found they would go up much more without MICRA which would decrease their ability to serve the poor. And I think that's true for institutions all across this country. So I don't think as some have tried to purport here, that having unlimited liability somehow protects the poor disproportionately. I think it's just the opposite. We've heard where rural physicians have had to stop practicing and move to other States or out of the rural areas.

Dr. Roberts, you've talked about that. You and your father, delivering 9,000 out of 10,000 people, I don't know how that happened, but in your community, but obviously your departure of doing obstetrics there is going to have a tremendous impact on that community and young women are going to have travel.

Let me ask you, what percentage of the two physicians here, Dr. Hollier and Dr. Roberts, do you all deal with Medicaid patients or patients that you don't end up getting paid from? What do you all do with those patients?

Ms. HOLLIER. I practice at LBJ General Hospital in Northeast Houston, and the vast, vast majority—more than 90 percent of my patients—are uninsured or Medicaid patients.

Mr. FLETCHER. And so if you left practice because you can't afford the escalating premium cost of malpractice insurance, you'd leave those people trying to find some place to go, is that right?

Dr. Roberts?

Mr. ROBERTS. That's the same situation in West Virginia. We have a very high percentage of Medicaid and uninsured patients. They have expanded the Federal guidelines, so more people can be guaranteed by Medicaid, but the majority of my patients, probably 90 percent of my obstetrical patients are Medicaid patients.

Mr. FLETCHER. I think the point is well taken. Here's an individual who took care of a number, a majority of poor individuals, women, particularly, and his service is no longer available because of this crisis, so this bill certainly is not a perfect solution, but it is part of the solution and I think a very important part of the solution.

If I can ask the assistant to put up a chart here, there was a study done at Stanford on defensive medicine that shows a 5 to 9 percent increase in medical costs due to the unlimited liability and effective tort reform would lower the cost 5 to 9 percent. Savings nationally would be \$50 billion. Do you know how many prescription drugs we could provide for our seniors, low income seniors, if we could spend that \$50 billion on prescription drugs? Or what about on caring for the poor, those that have no insurance, almost 40 million people in this country.

I want to and the physicians, I think, spoke to this. Does defensive medicine affect your practice? Do you feel that sometimes there's a sense of fear of liability in the practice, that sometimes affects your judgment?

Dr. Hollier? It's a difficult question, but I've been there and let me say I've felt it personally.

Ms. HOLLIER. I think there's definitely a climate of fear in which we practice.

Mr. FLETCHER. Dr. Roberts?

Mr. ROBERTS. I think it absolutely affects the decision that every physician makes every day. I don't think you can decide if someone has insurance or doesn't have insurance whether they need a test. You need to order the test anyway and I think we need to be very careful that we don't become afraid to deal with people honestly and straightforwardly, that we continue to communicate with them in the way we would as if they were our own families.

Mr. FLETCHER. Well, thank you. Let me ask you a question, Ms. Townsend and I certainly appreciate your testimony. I'm sorry—

Mr. NORWOOD. Your time is up, without objection, you can have an additional minute.

Mr. FLETCHER. Thank you, Mr. Chairman. The IOM report, *To Err is Human*, notes over and over again that health care professionals are threatened from sharing information on medical errors because of fear of retaliation. The IOM report states "fears about the legal discoverability of information may undercut motivations to detect and analyze errors. Unless such data assures protection of information about errors will continue to be hidden and errors will be repeated. A more conducive environment is needed to encourage health care professionals and organizations to identify,

analyze, and report errors without the threat of litigation, without compromising patients' rights."

Let me ask you, does your organization support legislation to grant peer review protections for data related to patient safety and quality improvements?

Ms. TOWNSEND. Would you define the peer review system about which you speak?

Mr. FLETCHER. Does your organization support legislation to grant peer review protections or if you have a peer review program in a hospital that tries to identify any concerns or problems going on with a colleague/physician of protecting that peer review so that you can identify a problem and correct them to protect that data for patient safety and quality? Because the Institute of Medicine, I think they're a pretty good organization, has stated that this impairs the ability to improve the quality of medicine and to do as Mr. Deal was talking about, to identify bad practitioners.

Ms. TOWNSEND. That's a very interesting idea. My organization has not looked at that particular recommendation.

Mr. FLETCHER. So you have no stand on that?

Ms. TOWNSEND. I think we need to do something about making it more common place for doctors and health care workers to come forward and talk about what goes wrong in the hospitals.

It was interesting when I spoke with John Reed of the CAT Fund in Pennsylvania, he was a wealth of information. He could tell me which corner of the hospitals mistakes happen more often. He could tell me which day of the week was the least desirable date to go to a hospital, to get a procedure.

Mr. BILIRAKIS. Will you share all that with us?

Ms. TOWNSEND. Well, if we had a centralized location, if we had a single payer system, perhaps, we would have that information and you could fix the problems.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Greenwood to inquire.

Mr. GREENWOOD. Thank you, Mr. Chairman, and I apologize that I had to leave for an hour or so.

First off, if I could, Mr. Chairman, I'd like to enter into the record a series of letters that I've received from physicians and constituents in my District.

Mr. BILIRAKIS. Without objection, that will be included.

Mr. GREENWOOD. And let me turn my questions to you, Ms. Townsend.

Ms. TOWNSEND. Certainly.

Mr. GREENWOOD. And I apologize and I know I'm going to ask some questions that may have been asked already, but that's the way it works.

In your testimony, you say that H.R. 4600, that we vehemently oppose H.R. 4600 which we know will hurt victims of medical malpractice, immunize wrong doers and be a boon for the monolithic giant that should be the target of everyone's ire, the insurance industry.

Could you tell me how you know that victims of medical malpractice will be hurt by this legislation?

Ms. TOWNSEND. Well, in the case of somebody who is a low income person, the case of a woman, women traditionally today make

less money than men do. A senior citizen, a person with a disability—

Mr. GREENWOOD. Okay, let's take a woman who is low income and she's injured as a result of malpractice. How does this—

Ms. TOWNSEND. If she is injured as a result of malpractice and it's a severe malpractice and the jury decides that in addition to economic damages, she should receive non-economic damages to cap non-economic damages at \$250,000 is hurtful to that person who might need additional money—

Mr. GREENWOOD. For what?

Ms. TOWNSEND. To take care of her life for the rest of her life because she wasn't making a lot of money and economic damages are—

Mr. GREENWOOD. But she is entitled to say I lost my right arm as a result of an error by a physician and I'm not—this will be the limitations on my economic abilities. She will be able, you would agree that she can recover all of her medical costs, all of her medication costs, all of her therapy costs, all of her psychotherapy costs, whatever inability she has to achieve income, she'll be able to recover that, right?

Ms. TOWNSEND. My question to you would be, what would be the difference between that woman's economic damages versus a CEO of a company who had the same thing happen to him?

Mr. GREENWOOD. She would recover everything that she might have otherwise had and so would the CEO.

Ms. TOWNSEND. But the CEO would receive a significant sum more.

Mr. GREENWOOD. He was going to—he or she was going to get that anyway. In other words, she's going to recover, she's going to be—she's not—she's going to be held whole.

Ms. TOWNSEND. So he's going to be given money to give him the style to which he has grown accustomed and the woman who was struggling who perhaps will not be able to work for the rest of her life or has been severely altered what she can do, will never be able to factor in the fact that maybe that woman would be the American dream and was going to be a manager in a store 1 day and own the company the next day and ultimately be that CEO.

Mr. GREENWOOD. Well, she's, of course, able to get punitive damages as well.

Correct?

Ms. TOWNSEND. In this legislation is there not caps on punitive damages?

Mr. GREENWOOD. No, there are no caps.

Ms. TOWNSEND. There's no—is there a formula?

Mr. GREENWOOD. Excuse me, the cap is do you not know how we treat punitive damages in this legislation?

Ms. TOWNSEND. If you could tell me again. I know that there's a formula to it. And I don't have it committed to memory.

Mr. GREENWOOD. I don't mean to be insulting, but when you come and testify about a bill, it helps if you've read it.

Ms. TOWNSEND. And I'm honestly saying—

Mr. GREENWOOD. Mr. Chairman, now wait a second—

Mr. BROWN. Mr. Chairman, she's not testifying on the bill. She's testifying on the issue.

Mr. BILIRAKIS. Did you yield?

Mr. GREENWOOD. I did not yield the floor.

Mr. BILIRAKIS. Let's go on. Let's go on.

Mr. GREENWOOD. Ms. Townsend, the individual in this case can receive all of her economic damages. She can receive \$250,000 in non-economic damages and she can receive punitive damages equal to twice her economic damages.

Ms. TOWNSEND. I understand that now, thank you. What I do know about punitive damages, if this woman is—has had something so egregious happen to her that the jury decides that she should receive punitive damages, I believe (1) that it should be up to the jury to decide what that amount is, an amount that is oftentimes ratcheted down ultimately, because it's aimed at sending a message to the wrongdoer that they should never do that ever again.

Mr. GREENWOOD. That's what punitive damages are for.

Ms. TOWNSEND. They happen also very, very rarely. So we can't, unless we know the circumstances of that woman, count on punitive damages because they happen seldom.

Mr. GREENWOOD. Let me ask you this question, where does your organization receive its funding? From where does it receive its funding?

Ms. TOWNSEND. We receive funding from a variety of individuals and organizations from around the country and the States.

Mr. GREENWOOD. To what degree would you say that the trial bar constitutes your organization and funds your organization?

Ms. TOWNSEND. I would say that attorneys and the association just a very little bit, probably contribute some 25 to 30 percent of the organization's work. And like you, I'm sure you know that you need to raise money to run for office like we need to raise money in order to exist as an organization, and we work to bring in funding from individuals who agree with our organization on the issues, rather than adapting to the—

Mr. GREENWOOD. I just want the record that. Thank you, Mr. Chairman.

Mr. BILIRAKIS. All right, I think that finally that completes the work of this panel.

Mr. BROWN. Mr. Chairman, can I ask for a clarification? I was very confused by that, Ms. Townsend and Mr. Greenwood, back and forth discussion. Could I just ask a question to understand it better?

Mr. BILIRAKIS. Would you like a minute, 2 minutes?

Mr. BROWN. Two minutes would be fine.

Mr. BILIRAKIS. Two minutes, without objection.

Mr. BROWN. First, I heard Mr. Greenwood say that punitive damages aren't limited and then I think you said, Mr. Greenwood, and I will yield to you that they are, in fact, limited?

Mr. GREENWOOD. I said they're not capped. They are permitted to—punitive damages are limited to the result, to twice the economic damages.

Mr. BROWN. Okay, I reclaim my time. So the interesting thing here and I go back to this Congress, the majority in this Congress continuing to go after working families and rewarding the wealthy in society. Think about this. The cap on punitive damages is based,

is two times the amount of economic damages. That means if a doctor injures a CEO, the CEO can get more punitive damages than if the doctor injures or the hospital or the nurse whatever, injures a woman who works in a hotel. So that's just sort of inexplicable. I'll just leave it at that. I don't get that, why that should be the case. In addition to earning power in the future and all that we're doing on economic damages, that sort of to me, makes me wonder about the whole intent of this legislation.

Mr. NORWOOD. Mr. Chairman, could I have 2 minutes, too, please?

Mr. BILIRAKIS. No objection, but I don't want any more of that. This panel has been here for 4 hours.

Mr. NORWOOD. Just a quick thought.

Mr. BILIRAKIS. Without objection, go ahead.

Mr. NORWOOD. The purpose of economic damages is if a person is harmed economically they are to be made whole. And the person who is harmed economically as a CEO is made whole—

Mr. BROWN. These are punitive damages.

Mr. NORWOOD. Don't interrupt now. You all are sticklers for that. The other thing I wanted to quickly ask Dr. Roberts is I heard you say that defensive medicine is practiced. Mr. Fine said it also in the emergency room—is practiced all the time because you are afraid. And what I think you are afraid of is that juries today, and with so many plaintiff lawyers trying to take you to court, that you can lose everything. All your life's work. All at one lick. Because there is absolutely no limit as to what they can do and the trial attorney has great interest in driving that number up as high as possible.

Would you be less afraid if there were some reasonable limitation so that you could then protect yourself through reinsurance and be able once again to practice medicine rather than having to practice law to defend yourself.

Mr. ROBERTS. Absolutely. I think that would be an ideal solution.

Mr. NORWOOD. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair asks for unanimous consent that it document what appeared in the May 1996 issue of the Quarterly Journal of Economics entitled "Do Doctors Practice Defensive Medicine?" be made part of the record. That being the case without objection. Thanks so very much. I apologize for keeping you here this long. But I think you can see an awful lot was gained by all of us in terms of knowledge. We customarily have written questions which we send to witnesses, to panelists, if you will, and ask for responses in a timely fashion. You're all willing to do that, aren't you? I think Ms. Visco, she's appeared before us, so I expect that she would be willing to submit also. That having been the case with our thanks you are discharged. Thank you very much.

The next panel which has been so very, very patient consists of Dr. Richard Anderson, CEO of the Doctor's Company on behalf of the Physician Insurers Association of America; Mr. Jamie Court of the Foundation for Taxpayer and Consumer Rights here from Santa Monica, California; Mr. Jim Hurly on behalf of the American Academy of Actuaries from Atlanta, Georgia; Mr. Travis Plunkett with the Consumer Federation of America; and Mr. Victor E. Schwartz with the firm of Shook, Hardy & Bacon here in Wash-

ington, DC. Welcome, gentlemen, and thank you for being here and again we appreciate your understanding and your patience. Your written statement is, of course, a part of the record and we would hope that you would complement it verbally. We'll set the clock at 5 minutes and hope that you can stay within that period of time or shortly thereafter, if you would.

Dr. Anderson, if you would pull that mike closer so we can hear you. Please proceed, sir. The mike is not on.

**STATEMENTS OF RICHARD E. ANDERSON, CEO, DOCTOR'S COMPANY; JAMIE COURT, FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS; JAMES HURLY, AMERICAN ACADEMY OF ACTUARIES; TRAVIS PLUNKETT, CONSUMER FEDERATION OF AMERICA; AND VICTOR E. SCHWARTZ, SHOOK, HARDY & BACON**

Mr. ANDERSON. Chairman Bilirakis, Representative Brown, and members of the subcommittee, thank you for this opportunity to present our views on the implications of excessive malpractice litigation on our health care system and the need for Federal reform. I am Chairman of the Board of the Doctor's Company, one of the 45 doctor owned and/or operated medical liability insurers that comprise the Physicians Insurance Association of America, PIAA. PIAA members insure more than 277,000 physicians and 1,100 hospitals against the accusations of malpractice. Personally, as an oncologist, I must bear the knowledge that each and every cancer patient whose life I tried to save can be turned into a potential adversary in our current medical legal system by the effects of the terrible disease and an exploitative plaintiff's attorney.

In my testimony, I would like to discuss with you proven solutions to some of the most serious problems affecting our health care system. Today's crisis and medical care access is well known to you. What must be understood is that States like California have previously experienced very similar crises and have successfully adopted medical liability reform and have no such crises today.

Despite stunning advances in scientific knowledge, medicine remains more art than science because human beings are not machines. Medicines' achievements today and promise tomorrow, as remarkable as they are, cannot be guaranteed. It's a sad commentary on our society that approximately one of every six practicing physicians faces a malpractice claim every year.

In high risk specialties such as obstetrics, orthopedics, trauma surgery, and neural surgery, there is one claim for every doctor every 2.5 years. It is critical to understand that 7 or more out of 10 of these claims are found to be without merit. Nonetheless, each of these meritless cases requires costly legal defense averaging approximately \$23,000 per case. The Doctor's Company alone has spent more than \$400 million defending claims that were ultimately shown to be without merit.

The insurance system was able to accommodate even this inexcusable volume of litigation as long as the size of the few valid claims was predictable. Unfortunately, in the past few years, there has been an explosion in the cost of individual claims. Texas has seen a \$268 million verdict. A number of States have witnessed verdicts in excess of \$100 million. The city of Philadelphia alone

has recorded multiple verdicts in excess of \$50 million in just the past 2 years.

Mr. Chairman, insurance is not magic. If society expects insurers to pay unlimited awards, it should expect that those who are insured should pay corresponding premiums. As premiums rise, so must the cost of health care. Since health care today is a zero sum game, these cost increases mean corresponding decreases in access to necessary medical services.

Those are the largest claims. What about the size of the average claim? PIAA data shows that the average indemnity claim payment in 2001 was more than \$310,000, a 60 percent increase in just the past 5 years. The figure continues to be affected by the tens of thousands of malpractice claims closed every year. Whatever the number, beyond dispute, is that the cost of these claims is rising precipitously. The sum of the malpractice indemnities paid in New York and Pennsylvania alone was nearly \$1 billion in year 2000.

Those who would attempt to obfuscate the truth will argue that the numbers are much smaller. The Center for Justice and Democracy and J. Robert Hunter actually state the average claim payment in 2002 was \$8,066. He got this number by adding all the claims that closed without any payment whatsoever. In other words, zero dollar claims to the number of paid claims.

Put differently, Mr. Hunter would argue that the solution to today's malpractice crisis is more frivolous litigation because that brings down the average cost per claim. Such arguments are as without merit as the frivolous claims themselves.

Mr. Hunter also claimed that the cost of malpractice premiums had risen no more in California which has tort reforms than in the rest of the country. In fact, since the MICRA statutes of 1975 were enacted, rates in California have increased at a rate only one third that of the rest of the country. You don't need to take my word for this. This is data affirmed by the National Association of Insurance Commissioners.

Moreover, those who would obfuscate the truth would argue that stock market losses by insurance companies are the real driver of price increases. The truth is once again quite different.

I know of no insurance companies that have experienced net losses greater than their investment income. Not only do State insurance commissioners who closely regulate such investments, but rating agencies also monitor them closely. What has happened is that less investment income is available to subsidize premium levels. Therefore, today premium levels must more closely approximate claims losses.

California has 27 years' experience with MICRA. This is not an experiment. We know, we do not speculate, that genuine liability reform works. Since 1975, Doctor's Company Malpractice Premiums in California have decreased by 40 percent in constant dollars. This is true despite the fact that there has not been and is not today any limit whatsoever on actual damages awarded.

We know, we do not speculate, that claims settle about 33 percent faster in California than the rest of the Nation because the lottery aspect of non-economic damages has been controlled.

We know, we do not speculate, that even very large judgments can be accommodated by the insurance system because they can be

paid on an annual basis over the intended period of compensation, not as a single jackpot.

We know, we do not speculate, that injured patients take home a significantly higher percentage of awards in California because there is an upper limit on attorney contingency fees.

Mr. BILIRAKIS. If you could summarize, Dr. Anderson, I would appreciate it.

Mr. ANDERSON. Yes sir. We know, we do not speculate, the MICRA has not limited access to attorneys. California is a litigious State and the frequency of suits in California is 50 percent higher than the national average. But still 8 out of 10 claims in California are found to be without merit.

Finally, we know that not only does MICRA not limit total awards, but also that malpractice awards still arise faster than inflation in California. These same reforms are found in H.R. 4600, the PIAA and the Doctor's Company totally support the provisions of this Act, which when signed into law would provide the same protections to patients across the United States as found in California for over a quarter century.

We thank the members of the committee and their staff for this important hearing and inviting us to testify. We look forward to working with you to make the health care liability system fairer for everyone.

I'll be happy to answer any questions.

[The prepared statement of Richard E. Anderson follows:]

PREPARED STATEMENT OF RICHARD E. ANDERSON, CHAIRMAN, THE DOCTORS'  
COMPANY ON BEHALF OF PHYSICIAN INSURERS ASSOCIATION OF AMERICA

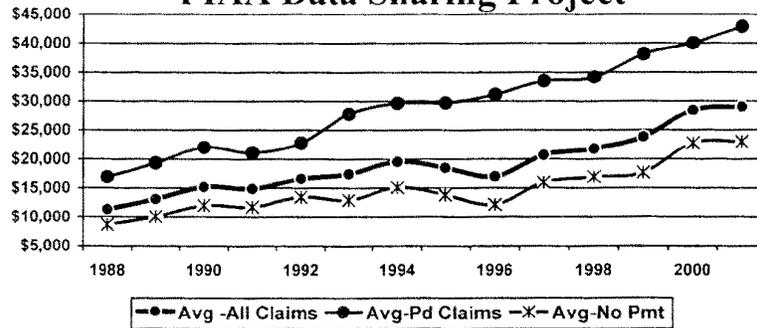
Chairman Bilirakis, Representative Brown and members of the subcommittee, thank you for this opportunity to present to you today our views on the implications of excessive litigation and the need for Federal health care litigation reform. My name is Richard Anderson and I am an oncologist with more than 25 years experience practicing cancer medicine in California. I am also Chairman of The Doctors' Company one of the 45 doctor-owned and/or operated medical liability insurers that comprise the Physician Insurers Association of America (PIAA). Collectively, the PIAA companies insure over 60% of the Nation's practicing physicians. At last count, PIAA companies insured more than 277,000 doctors and 1,100 hospitals. On behalf of our member companies and their insureds, the PIAA has always supported health care liability reform that will more equitably and rapidly compensate patients who have received substandard care, but which at the same time will also limit frivolous lawsuits and increase access to health care.

BACKGROUND

Despite stunning advances in scientific knowledge, medicine remains more of an art than science because human beings are not machines. Sadly, the tide of litigation against America's doctors has risen even faster. Approximately one of every six practicing physicians faces a malpractice claim every year. In high-risk specialties such as obstetrics, orthopedics, trauma surgery and neurosurgery, there is one claim for each doctor every 2½ years. However, fully 70% of these tens of thousands of cases are found to be without merit. Nonetheless, every single case requires a costly legal defense. Nationally, as the chart below shows, these loss adjustment expenses average \$22,967 per defendant. Those cases that go all the way through trial before a vindicating defense verdict average \$85,718 per defendant.<sup>1</sup> [See chart below] The Doctors' Company itself, for example, has spent more than \$400 million defending claims that ultimately were shown to be without merit.

<sup>1</sup> PIAA Data Sharing Project, May 2002.

### Average Expense Payment Values PIAA Data Sharing Project



#### ROOTS OF THE CURRENT ENVIRONMENT

Medical liability claims were fairly uncommon until the 1970s. In the 40 year period between 1935 and 1975, 80% of all medical malpractice lawsuits were filed in the last five years of that period.<sup>2</sup> Massive losses between 1970 and 1975 forced many commercial insurers to conclude that the practice of medicine was an uninsurable risk, and they simply refused to provide malpractice insurance at any price. This resulted in a “crisis of availability” to which providers responded emergently. Doctors contributed their own funds as capital to support the efforts of their state medical and hospital associations, among others, to start as many as 100 provider owned specialty carriers across the country. Dubbed “bed pan mutuals” by their commercial competitors (many of whom had fled the market), these upstarts were not expected to succeed where the giant commercials could not find success. Because their primary mission is to provide a service, and because they were entirely committed to remaining present even in the most difficult markets, these companies have succeeded and are the basis of the PIAA. As one example, The Doctors’ Company was formed by doctors, for doctors in 1976, and today insures more than 25,000 doctors throughout the nation.

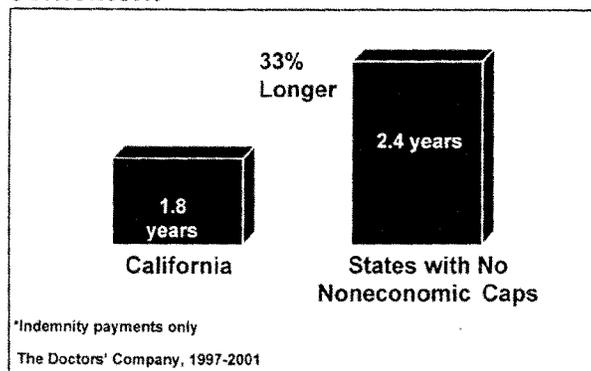
#### A LITIGIOUS SOCIETY GROWS

A second crisis emerged in the early 1980’s, known as a “crisis of affordability.” Insurers faced ever-mounting losses, with rampant increases in paid claim frequency (number of paid claims) and severity (amount of indemnity payment). PIAA data shows that on average it takes 5½ years for an insurer to close a malpractice claim after the date of the incident.<sup>3</sup> There is often a long lag before the claim is reported. The majority of the delay, however, comes because of the inefficiencies of the tort system. California enacted the Medical Injury Compensation Reform Act of 1975 (MICRA) which largely eliminates the lottery aspect of malpractice litigation in that state. The Doctors’ Company data reveals that claims are settled in one-third less time than the national average. [See chart below] This result not only decreases the cost of litigation, but it means injured patients are indemnified much faster in California.

<sup>2</sup> Professional Liability in the ‘80s, Report 1, American Medical Association, 10, 84, p4.

<sup>3</sup> PIAA Data Sharing Project, December, 2001.

### *MICRA Reduces Average Time to Settlement*



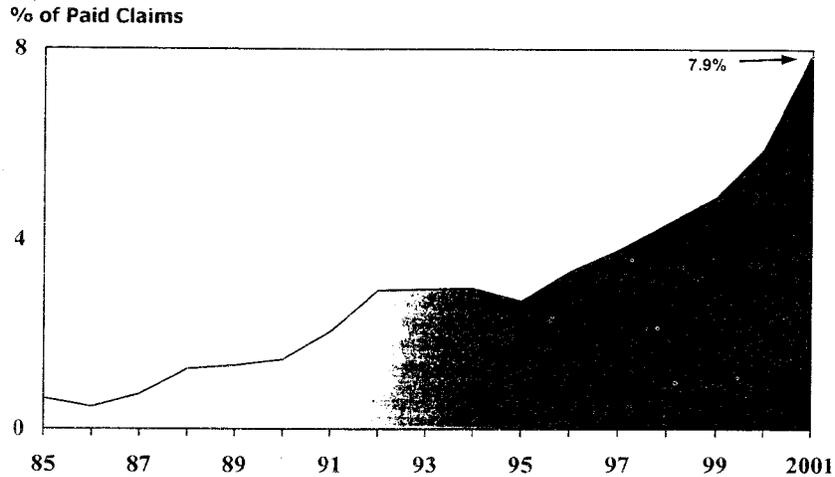
During much of the 1990s, PIAA companies exercised their fiduciary responsibility to wisely invest the premium deposits of their policyholders, who benefited from the rising bond markets. These returns were used not to line the pockets of the companies, but to subsidize the premium rates being charged to policyholders so that they could remain affordable. It was the policy holders (health care providers) who reaped the financial benefits.

It must be noted that insurance is a highly regulated industry. Every state department of insurance, as well as the national rating agencies, closely monitors both the kinds and qualities of investments. Virtually no medical liability insurance company has experienced net investment losses. In fact, 80% of investments by PIAA companies are in high-grade bonds. What has happened is that investment yields have declined due to falling interest rates and are no longer available to subsidize premium rates to the extent they once did. In other words, premium rates must now more closely match the actual cost of losses. The combination of these factors created "the perfect storm" for medical liability insurers.

#### THE PERFECT STORM

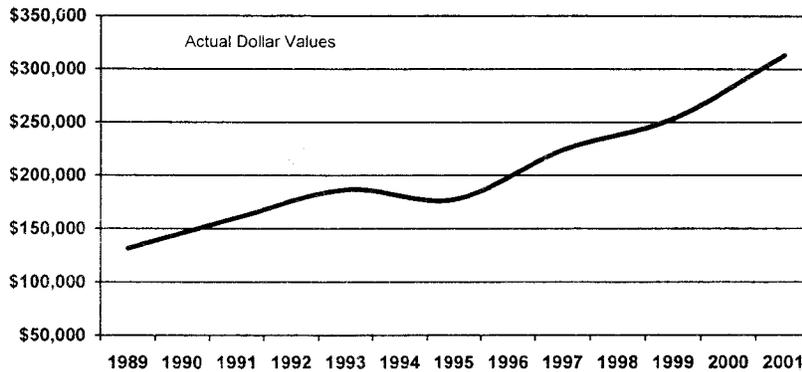
During this same time period, claim frequency and severity continued to increase. In addition, reinsurance costs rose significantly in relation to the increase in loss costs. The insurance system was able to accommodate even this inexcusable volume of litigation as long as the size of the few valid claims was predictable. Unfortunately, in the past few years there has been an explosion in the cost of individual claims. Texas has seen a \$268,000,000 verdict. A number of states have witnessed verdicts in excess of \$100,000,000. The city of Philadelphia alone has recorded multiple verdicts in excess of \$50,000,000 in just the past two years. Four claims in Arkansas totaled \$98,000,000 in just the past year. According to PIAA data [shown on next chart], during the period 1991 to 2001, the percentage of claims costing in excess of \$1 million dollars increased nearly four-fold. Insurance is not magic. If society expects insurers to pay unlimited awards, it should expect those who are insured to pay corresponding premiums. As premiums rise so must the cost of health care. Since health care today is a zero sum game, these costs increases mean corresponding decreases in access to health care.

### Claim Payments =>\$1 Million PIAA Data Sharing Project



Those are the largest claims. What about the size of the average claim? PIAA data shows that the average indemnity payment in 2001 was more than \$310,000, a 60% increase in the last five years. As the next chart shows, the average malpractice payment is rising precipitously. With it, the sum of the malpractice claims paid rises. In New York and Pennsylvania alone nearly \$1 billion was paid in 2000.

### Average Indemnity Claim Payments PIAA Data Sharing Project



#### THE CURRENT SITUATION

As the new millennium began, insurers who were not able to weather the storm began to experience poor financial results. Expressed differently, a number of companies that felt that they could provide insurance for less than its cost learned the inevitable lesson. Several, such as PHICO, PIE and Reliance, have ceased all underwriting operations. In December of last year, long-time industry leader St. Paul announced that due to unsustainable losses and the "unfavorable tort environment" the company would no longer write new medical liability coverage and it would not renew the policies of its 42,000 physicians, 750 hospitals and 73,000 other health

care providers. Though St. Paul is a commercial carrier and not a member of PIAA, it is telling that the largest company in the industry for the better part of two decades feels that it can no longer afford the risk of insuring the practice of medicine. Companies remaining in the market have had no choice but to take the rate increases necessary to insure survival.

Conning & Co. estimates that malpractice insurers will pay out approximately \$1.40 for every premium dollar collected in 2001 and 2002. Even with the projected rate increases, Conning & Co. still projects insurers will pay out \$1.35 for each dollar collected in 2003 (Conning Report on Medical Malpractice Insurance, April 2002). PIAA data reveals that since 1990, claims costs have risen annually by 6.9%, nearly three times the rate of inflation.

#### IN CONCLUSION

The average claim payment has increased by 60% over the past five years. The cost of the most expensive claims has exploded in a manner that is absolutely unprecedented. If judgments are to be unlimited, then the premiums need to increase accordingly to pay for those judgments. With absolute certainty, this money will be taken out of our healthcare system and compound the severe access to care issues that we all face today.

Several spurious arguments have been put forth by those with an interest in continuing the tsunami of medical malpractice litigation. First, it has been deceptively argued that stock market losses are the real driver of price increases. In fact, investments by insurance companies are highly regulated and controlled by each state department of insurance and closely monitored by the rating agencies. Insurance companies continue to gain funds from their investments and use those funds to offset even higher malpractice premium rates. As income from investments decreases, however, premiums must more closely match losses.

Second, it is argued that insurance companies should have raised rates sooner. There may be some truth to this. However, *it is difficult to understand how having today's sky-high rates earlier would make them more palatable.*

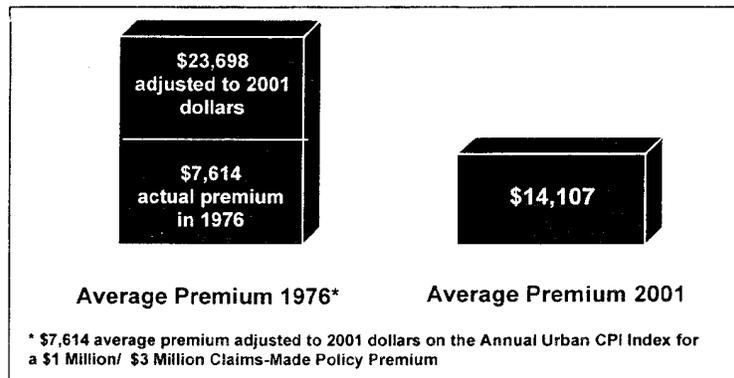
Third, it is argued that insurance companies fail to settle claims when they should, and are therefore, exposed to astronomic jury verdicts. Again, reality is quite different. In most cases, it is the physician, not the company, who must make any settlement decision. Remember that doctors are found to be without fault in approximately 8 out of 10 malpractice trials. Should these cases have been settled?

Finally, there are those who argue for a state run medical liability system. Allow me to point out that the majority of state run malpractice programs have gone bankrupt, or charge premiums that are much higher than those charged by PIAA companies. In New York, premiums are actually set by the Department of Insurance, not by individual companies, and New York rates are among the highest in the nation.

#### THERE IS A "TRIED AND TRUE" SOLUTION

California has 27 years of experience with the MICRA statutes. We know, we do not have to speculate, that tort reform works. Since 1975, The Doctors Company malpractice premium rates in California have decreased by 40% in constant dollars. [See chart below] This is true despite the fact that there has not been and is not today any limit on actual damages awarded.

***MICRA Helps Reduce California  
Medical Liability Premium Rates by 40%***



We know, we do not speculate, that claims settle about 33% faster in California than the rest of the nation because the lottery aspect of non-economic damages has been controlled.

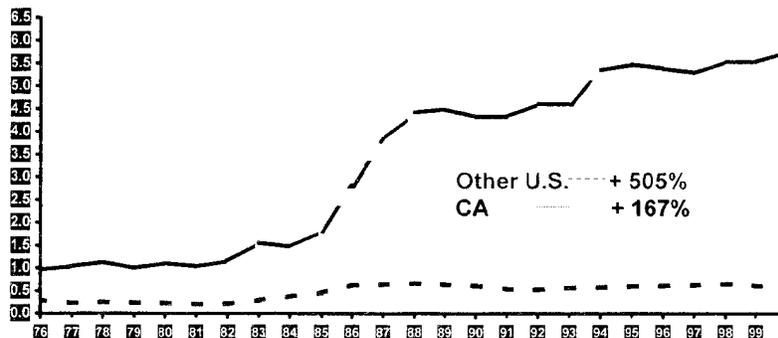
We know, we do not speculate, that even very large judgments can be accommodated by the insurance system because they can be paid on an annual basis over the intended period of compensation, not as a single jackpot.

We know, we do not speculate, that injured patients actually take home a significantly higher percentage of awards in California because there is an upper limit on attorney contingency fees. In many areas, more than 40% of a malpractice award goes directly into the pocket of the plaintiff's attorney. In California, MICRA contains a limitation on this fee. An attorney winning a \$1 million claim must be satisfied with a legal fee of \$221,000.

We know, we do not speculate, that MICRA has not limited access to attorneys. California remains a litigious state and according to The Doctors Company data the frequency of malpractice cases in the state is 50% higher than the national average.

California passed effective tort reforms and its providers have been able to weather this liability crisis well. These same reforms are found in H.R. 4600, the Help Efficient, Accessible, Low-cost, and Timely Healthcare Act of 2002 (the HEALTH Act). The PIAA and The Doctors Company fully support the provisions of this act, which when signed into law, will provide the same protections to patients across the United States as found in California for over a quarter century. The next chart, which was compiled from data reported to the National Association of Insurance Commissioners, speaks volumes about MICRA's effectiveness:

**Savings from MICRA Reforms  
California vs. U.S. Premiums 1976 - 2000**



We thank members of the Committee and their staff for holding this important hearing and inviting us to testify. We look forward to working with you to make the health care liability system fairer for everyone. I will be happy to answer any questions you might have.

Mr. BILIRAKIS. Thank you, doctor.  
Mr. Court.

#### STATEMENT OF JAMIE COURT

Mr. COURT. I'm Jamie Court and I have a few slides. Hopefully, we can put the first one up. I'm Executive Director of the Foundation for Taxpayer Consumer Rights. I deal with patients. I've dealt with probably a couple hundred patients over the years who have been victims of MICRA, the medical malpractice restrictions you're debating for the Nation. This is one of them, and he's the reason I actually came 3,000 miles here today. His name is Steven Olsen. He's 12 in this picture. It was taken last week. He's blind, he's brain damaged. When he was two, he fell on a stick in the woods. He tripped, the stick impaled him. He went to a hospital. They took the stick out. His parents felt he was acting a little weird, rubbing his head. Asked for a CAT scan because his mother had a tumor, she had had a brain tumor before. Thought something was up. They didn't give him the CAT scan, sent him away. He came back, same situation. They wanted the CAT scan. Again, these are doctors driven in an HMO environment to do less for the patient, not exhibit enough caution. Sent him away, he came back. Finally, blind, comatose and as he is today.

A jury awarded \$7.1 million after hearing these facts in non-economic damages for his lifetime of pain and suffering, for his lifetime of darkness for not knowing as a child whether he would be become an executive or a millionaire for a doctor. He'll never have that chance. That's what that compensated him for. And today after that \$7.1 million verdict, it was reduced by a Judge unbeknownst to the jury to \$250,000 for pain and suffering.

A jury foreman found out about it in the newspaper and wrote a letter that's in my testimony that you can read, shocked that a jury in America could be overturned and not know about it.

This child today has lots of problems. His mother had to quit her job. They had to take him over a hundred medical and therapy appointments last year. His life and his family's life is forever altered and he's a victim of MICRA. He is a kid who will never see. And because of a one size fits all cap on compensation, his pain and suffering is valued as the same as anyone else in California. And it was determined by an arbitrary limit set by the legislature.

MICRA has denied victims, not just adequate compensation, but also legal representation. If you are a patient with only non-economic damages, you will not find a lawyer in California. And I urge you to read the patient stories I put together. There are a lot of patients that don't find attorneys and what happens to them—they go on public assistance and the tax payer pays for them when they can't get their injuries compensated. That's what happened to patients. The other aspect of MICRA that I'd like you to consider today is that it does have an effect on HMOs.

The Nation's largest HMO which is Kaiser, and the state's largest HMO, is protected in about 400 lawsuits every year by the

MICRA cap. And in my testimony I've shown some evidence that's come out in newspapers of systemic problems in Kaiser that were never fixed because of the price of those injuries to Kaiser was limited in non-economic damages of \$250,000. There was no incentive for this system to change and Kaiser operates nationally. It covers 6 million California patients. So for 6 million of our 24 million insured, those patients don't have redress.

The final question that I'd like to bring to your attention is for what. And if we can move to the next slide.

What has been the impact overall on MICRA and what I put together here is the NAIC data showing medical loss, these are insurers loss ratios which go across all lines of insurance. And if you can see in California, ever since 1986, was when the Supreme Court said the MICRA cap was legal. You have seen that malpractice insurers consistently have paid out less than 50 cents of every dollar they have taken in in premiums and claims. So less than 50 cents of every premium dollar goes out in claims in California. Next slide, please.

You can also see from this slide that insurers' profits, and it's all in the testimony as well, have been higher than the national average every year since 1986.

Next slide, please. This is all attributable to the fact that was described in the Wall Street Journal Article—the insurance cycle. This is happening against all lines of insurance, not just medical malpractice insurance. I deal with HMOs. Premiums are going up in California by HMOs 30 percent for small businesses. It's happening on home owners. It's happening on other lines of malpractice, and it's because when investments are good, when they're rich, insurers cut their premiums to attract people so they have more capital to make money in the investment markets. And when Wall Street is bad, what happens? They raise their rates to make up for their losses. This is the problem that needs to be addressed—the passing through of investment losses. And that happens in all lines of insurance. If you go to the next slide and the last slide.

This is an article dealing with the malpractice crisis. But it's not for doctors. It's the California Bar Journal in this issue of July 2002. It's for lawyers whose premiums are now going up literally 200 and 300 percent. Why? Because investment losses are driving this crisis. And what I put to this panel is I suspect from the discussion today you would not limit the rights of people who are represented by lawyers to sue them for malpractice as a way of solving this crisis. So if you're not going to do it for lawyers, I ask that you don't do it for medical providers. There are some disputes in numbers.

There's one statistic I'd like to address before stopping. It is the statistic that's been thrown out a few times here about malpractice premiums.

Bob Hunter did do a study that showed, by looking at NAIC premium data, earned premiums, and dividing it by number of doctors in California and then similarly the number of doctors in the United States, and he found malpractice premiums pretty comparable. I mean, not enough to limit victims' rights clearly, not enough of a difference. The data that I've heard today talking

about a 400 percent increase in premiums nationally versus a 150 percent premiums in California since 1976, that deals with a very interesting little quirk that I found out when I was talking to a friend about Hunter's data.

The friend is from the medical establishment and he tells me wait a second. California malpractice premiums you represent are way lower than we know them to be. And that's because a third of the physicians in California, those who are a part of Kaiser Permanente, are self-insured and not counted in that premium data. And similarly, in this premium data from the NAIC that is being talked about today, a third of the premiums are not represented because a third of the doctors are self insured. So thank you for the time.

[The prepared statement of Jamie Court follows:]

PREPARED STATEMENT OF JAMIE COURT, EXECUTIVE DIRECTOR, FOUNDATION FOR  
TAXPAYER AND CONSUMER RIGHTS

'In age where expanding patients' rights has become a national demand, HR 4600 would dramatically contract patients' rights across the nation. This anti-consumer legislation will shield HMOs and providers they influence from legal accountability to the patient for harm they cause.

HR 4600 will deny innocent victims of medical negligence both adequate compensation for their injuries and legal representation for legitimate claims. It will confer substantial financial benefits only on malpractice insurance companies, not the average physician. To the extent that staff model HMOs indemnify their staff and facilities, as the nation's largest HMO does, HR 4600 will also protect HMOs from liability for the harm they cause to patients. The evidence comes from California, where the model for HR 4600 has had these consequences.

Under California's restrictions, malpractice insurers have consistently paid out in claims less than 50% of the premiums they have taken in and made excessive profits. Despite limitations on victims, California doctors' malpractice premiums have been consistent with the national average.

The failed model for this legislation was enacted in California in 1975 as the Medical Injury Compensation Reform Act, or MICRA. In recent years, Californians have been confronted with MICRA's devastating human impact and its failure to achieve its financial goals. The California legislature has tried twice in the last four years to remove MICRA's limits, but have been unsuccessful in the face of lobbying by the insurance industry.

First my testimony will explain the impact of the MICRA provisions also contained in HR 4600 and their draconian consequences for innocent patients. Then, I will address MICRA's impact on malpractice premiums and how insurers in California have seen the only substantial profits from MICRA.

Like HR 4600, MICRA provisions:

- Place a \$250,000 cap on the amount of compensation paid to malpractice victims for their "non-economic" injuries.
- Eliminate the "collateral source rule" that forces those found liable for malpractice to pay all the expenses incurred by the victim.
- Permit those found liable for malpractice to pay the compensation they owe victims on an installment plan basis.
- Impose a short "statute of limitations" on malpractice victims (generally three years).
- Establish a sliding scale for attorneys fees which discourages lawyers from accepting serious or complicated malpractice cases.

I have been contacted over the last ten years by hundreds of patients who are innocent victims of medical malpractice, then further victimized by these MICRA restrictions. The actual experiences of these patients shows the cruel consequences of each MICRA restriction also contained in HR 4600.

CAPPING MEDICAL MALPRACTICE VICTIMS' COMPENSATION CAUSES INNOCENT PATIENTS  
MORE PAIN AND SUFFERING

Like HR 4600, MICRA places a cap of \$250,000 on the amount of compensation paid to malpractice victims for their "non-economic" injuries, no matter how egregious the malpractice or serious the harm.

The MICRA cap is not adjusted for inflation. In order to provide the same level of compensation in today's dollars, the cap would have to be approximately \$800,000. Put another way, the \$250,000 MICRA cap has decreased in value since 1975, when compared to the Consumer Price Index, to approximately \$70,000. Though health care costs—hospital charges, medical fees, etc.—have risen dramatically since 1975, compensation for non-economic damages has been frozen by the statute.

Non-economic injuries include pain, physical and emotional distress and other intangible "human damages." Such damages compensate for severe pain; the loss of a loved one; loss of the enjoyment of life that an injury has caused, including sterility, loss of sexual organs, blindness or hearing loss, physical impairment, and disfigurement.

Applying a one-size-fits-all limit to non-economic damages objectifies and erases the person, considering them as a fixed "thing" for the purposes of law, so that there is no recognition of the uniqueness of their suffering. There is no quicker way to strip an individual of their humanity than to fail to recognize their suffering.

My personal bias on this point springs from the experiences of a friend who today is twelve years old. Steven Olsen is blind and brain damaged because, as a jury ruled, he was a victim of medical negligence when he was two years old. He fell on a stick in the woods while hiking. Under the family's HMO plan, the hospital pumped Steven up with steroids and sent him away with a growing brain abscess, although his parents had asked for a CAT scan because they knew Steven was not well. The next day, Steven Olsen came back to the hospital comatose. At trial, medical experts testified that had he received the \$800 CAT scan, which would have detected a growing brain mass, he would have his sight and be perfectly healthy today.

The jury awarded \$7.1 million in "non-economic" damages for Steven's avoidable life of darkness and suffering. However, the jury was not told of a two decade old restriction on non-economic damages in the state. The judge was forced to reduce the amount to \$250,000. The jurors only found out that their verdict had been reduced by reading about it in the newspaper. Jury foreman Thomas Kearns expressed his dismay in a letter published in the San Diego Union Tribune.

We viewed video of Steven, age 2, shortly before the accident. This beautiful child talked and shrieked with laughter as any other child at play. Later, Steven was brought to the court and we watched as he groped, stumbled and felt his way long the front of the jury box. There was no chatter or happy laughter. Steven is doomed to a life of darkness, loneliness and pain. He is blind, brain damaged and physically retarded. He will never play sports, work, or enjoy normal relationships with his peers. His will be a lifetime of treatment, therapy, prosthesis fitting and supervision around the clock...

Our medical-care system has failed Steven Olsen, through inattention or pressure to avoid costly but necessary tests. Our legislative system has failed Steven, bowing to lobbyists of the powerful American Medical Association (AMA) and the insurance industry, by the Legislature enacting an ill-conceived and wrongful law. Our judicial system has failed Steven, by acceding to this tilting of the scales of justice by the Legislature for the benefit of two special-interest groups...

I think the people of California place a higher value on life than this.

When in San Diego, I often visit Steven and his family. Their struggles are unfathomable to me. In 2001, Steven had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. And his parents say that was a good year because Steven was not hospitalized. Steven's mother Kathy had to leave her job because caring for Steven is a full time job. She has to struggle constantly with the school district for Steven to receive special education classes. One day, Steven ate part of a light bulb, not an uncommon problem for children with brain injuries. He has to be watched constantly. Insurance executives that seek to limit jury awards for the individual's pain and suffering claim society must do so to save money. Yet these executives typically make millions every year without any of Steven Olsen's pain and suffering. Limiting their responsibility for the pain of individuals reduces not only the corporation's accountability, but the worth of the individual to that of a mere object.

Last week, Kathy Olsen said this about Steven: It has been 10 years ago this month when Steven came home from a 5-month life changing stay at the hospital. He was only 2 years old. When he went into the hospital no one asked his party affiliation. He was a casualty of the system. The system that he had no say in. Which lawmakers were looking out for him? Now with all his disabilities he will never see, do things that the average person gets to do in their lifetime, or vote in an election. Please look out for all the Steven Olsens in this great country. Don't let this happen over and over again.

Other California patient cases similar document how the \$250,000 cap on compensation has further victimized innocent victims.

**Patients with permanent injuries are limited to \$250,000, even whenjuries award significantly more compensation, tangible “economic” damages exist (but are unidentified byjuries), and unforeseen “economic” costs arise later.**

Harry Jordan, a Long Beach man, was hospitalized to have a cancerous kidney removed but the surgeon took out his healthy kidney instead. A jury awarded Jordan more than \$5 million dollars, but the judge was required to reduce the verdict to \$250,000 due to California’s cap on “non-economic” damages—plus a mere \$6,000 in “economic costs”. Jordan, who lived for years on 10% kidney function, could no longer work, though the jury (which lawfully can not be notified about the “non-economic” cap) did not take this into account. Jordan’s court costs—not including attorney fees—amounted to more than \$400,000 and his medical bills, that arose after frequently being denied by insurers, totaled more than \$500,000. He paid \$1700 per month in health insurance.

**Arbitrary caps on “non-economic” compensation unfairly discriminate against the suffering of women**—who typically sustain injuries due to medical negligence, such as laceration of the uterus or loss of a new born during child birth, that do not carry high “economic” price tags but involve significant loss. Injuries sustained by homemakers are also unvalued, because they have no “wage loss.” Caps not only deny women victimized by medical malpractice fair compensation and legal representation for their injuries, but subject women to repeat offenders and have been undeterred.

San Andrea Terry McBride lost her unborn baby and her fertility at the hands of a negligent doctor who had injured at least 25 women before her, causing the unnecessary deaths of their babies and the affliction of Cerebral Palsy to 2 children. California’s “non-economic” compensation cap restricted McBride to less than \$250,000 for the loss of her child’s life and her own sterilization (because she suffered no wage loss due to her injuries). The award was even insufficient to cover the cost of an expensive new procedure seeking to restore her fertility.

**Arbitrary caps on “non-economic” compensation unfairly discriminate against the littlest victims, children**—who can not prove significant future wage loss and whose families cannot realistically estimate the expenses they are to incur over the course of a life time.

A six year old Northern California girl paralyzed by negligent medicine was restricted to 250,000 in compensation for her lifetime due to California’s “non-economic” cap because she could not prove any future wage loss.

**Caps on “non-economic” compensation devalue the lives and health of low income patients.** Caps on pain and suffering discriminate against the suffering of low income people whose “economic” basis—wages—are limited. A strictly “economic” evaluation based on wages devalues what victims will create or produce in the future, their quality of life, as well as an injury’s impact on their ability to nurture others. For instance, a laborer may loose his arms due to the exact same act of medical negligence as a corporate CEO, but the CEO would be able to collect millions and the laborer would be closely limited to the \$250,000 cap. A housewife similarly would be limited to the cap no matter the physical or emotional depths of her injury. Caps assign greater value to the limbs and lives of some people than the limbs and lives of others.

The five children of a 32-year old mother, who was unemployed and untrained (therefore had no “economic” value), were left with merely \$250,000 to compensate all of them for their life time after the errors caused their mother’s death during an emergency Caesarean section.

**Caps make taxpayers foot the bill for malpractice.** Malpractice victims receive full compensation only for medical bills and lost wages. But those who are not wage earners—such as seniors, women, and the poor—have no other resource from which to pay for unforeseen medical expenses and basic needs. A cap forces malpractice victims to seek public assistance from state or federal programs funded by taxpayers.

A Los Angeles woman, who sustained severe jaw damage and slight brain damage from an HMO’s misdiagnosis and refusal to treat her, was not represented by an attorney because she was limited in her recovery by California’s cap. As the HMO did not pay for the damage it caused, and would not treat her, the woman was forced to receive government funded Medicare and Supplemental Social Security Income payments for her disability.

## HMO PROTECTION: ENDING DETERRENCE TO HMO ABUSE

The nation's largest HMO, which is also California's largest HMO, is protected by MICRA's cap in California and staff model HMOs like it would be similarly shielded across the nation under HR 4600. Kaiser Permanente has hundreds of cases in its system every year in California for which it is liable for no more than \$250,000 in non-economic damages. In many cases, California's cap system has limited the liability for egregious systemic error to an acceptable cost of doing business, permitting systemic medical negligence to continue undeterred. There is no incentive to systemic problems.

For example, Colin McCaffery was born too large, in Kaiser's Woodland Hills facility with only a nurse-midwife present—although his parents urged that a physician be there because their other children had been born large. As a cost cutting practice, the HMO did not routinely assign doctors to be present during child birth, except for "high risk" cases. Because the nurse-midwife lacked the skill to properly guide Colin out of the birth canal, he was crippled, losing movement in his arms and torso—a rare condition known as Erbs Palsy resulting only from botched deliveries. Due to California's cap on recovery, Colin's family settled for only \$250,000—not enough to compensate Colin or make Kaiser change its practice. Colin's father stated after the case the HMO "still does not provide the option for a doctor when delivering babies. At a clinic for Colin, I saw over 50 babies, all under the age of two, clinging to their parents. None of them were smiling. They all had Erbs Palsy. One little girl around one had such a sad look to her. Her arms, both of them, just dangled lifelessly by her side. " Other similar cases of seriously injured or dead newborns due to the child birth system have emerged in California, but they typically cost Kaiser no more than \$250,000, so there is little incentive for the HMO to change its system.

A recent account from the Los Angeles Times of systemic problems with overcrowding in Kaiser's emergency room show how un-addressed deficiencies have led to many patient deaths from similar circumstances (Charles Ornstein, "Cases Reveal Lapses in Kaiser Emergency Care," Los Angeles January 2, 2002 p.A1) MICRA's cap dramatically limited the HMO's liability in these cases so there was no incentive to change its practices over a ten year period. As the article points out, recently the California Department of Managed Health Care fined Kaiser \$1.1 million for these same systemic problems. "In justifying a \$1.1-million fine against Kaiser, state regulators cited three patient deaths and said the cases demonstrated a pattern of problems in emergency care that has put the HMO's 6 million California members at risk," the Times reported. "Similar problems showed up in at least nine other cases since 1995 . . . in which arbitrators found Kaiser liable for patient injuries or deaths." Had MICRA's shield not protected the HMO, perhaps Kaiser would have had an incentive to change its practices. Under MICRA, deterrence to wrongdoing at Kaiser has been removed.

For HMOs like Kaiser, the \$250,000 cap in MICRA and in HR 4600 allows negligence without consequence. Deterrence to wrongdoing is especially important at HMOs. Arbitrarily applying one-size-fits-all caps to systemic wrongdoing lets HMOs know there is a financial limit to how much they will pay no matter how egregious and irresponsible their conduct. This is *carte blanche* in many cases to throw caution to the wind.

Ironically, proponents of HR 4600 claim it will limit "defensive medicine" procedures. The Congressional Office of Technology Assessment reported in July 1994 that "defensive medicine," procedures purported to be driven by physicians' fears of lawsuits, account for only 8% of medical procedures and may in fact constitute merely preventative, high quality health care. As the OTA stated, fear of lawsuits can often simply make those with the least incentive to be cautious exhibit more caution. This is precisely the incentive HMOs and their doctors and hospitals now need.

## PERIODIC PAYMENTS REWARD CONVICTED WRONG-DOERS AT THE EXPENSE OF MALPRACTICE VICTIMS THEY INJURE

Like HR 4600, MICRA permits defendants found liable for malpractice to pay jury awards on a periodic, rather than a lump sum, basis, if the award equals or exceeds \$50,000 and the defendant requests it. Jury-designated malpractice awards can be restricted by the judge as to the dollar amount paid each period and the schedule of payments. The periodic payment arrangement, once approved by a judge, cannot typically be modified—unless the victim dies earlier than expected, in which case the defendants, rather than the family of the deceased, retain the balance of what they owe.

This provision of MICRA, like HR 4600's provisions, allows the negligent provider or its insurance carrier to control, invest and earn interest upon the victim's compensation year after year. No adjustment is made in the payments to reflect unexpected trends in the inflation rate or changes in the cost of medical care.

If the defendant enters bankruptcy or simply ceases to pay, the victims are forced to return to court and engage in another lengthy legal proceeding. Another problem is that an inflexible payment schedule leaves the victim without sufficient resources in the event that unanticipated medical or other expenses arise. This is most likely to occur in the years immediately following the injury, when the periodic payments are unlikely to cover the aggregate costs.

**Periodic payments allow wrong-doers to invest and earn interest on the money owed injured victims.** Periodic payment schedules permit convicted perpetrators to control the money owed victims and profit from its use year after year. If the physician happens to fall into bankruptcy due to bad investments, the victim is denied the agreed upon compensation.

**If a patient dies, all payments stop and the victim's family receives nothing.** Wrong-doers are rewarded for causing the most severe, life threatening injuries. If a patient dies, periodic payments cease and the guilty physician is allowed to keep the remainder of their money. Awards do not revert to the next of kin.

**Periodic payments reduce the already limited compensation received by victims, as the value of the verdict diminishes over time due to inflation.** No adjustment is ever made in the payments to reflect the inflation rate or changes in the costs for medical care—which have risen sharply and well above the inflation rate for many years.

**Periodic payments put the burden on the victim to meet their basic needs.** The periodic payment arrangement, once approved, is extraordinarily difficult to modify. If costs of the victim's medical care increases beyond their means, or a special expensive medical technology is made available which the victims require, the injured patient must retain a lawyer to have the schedule modified—and may very well not succeed.

#### CAPPING PLAINTIFF ATTORNEY CONTINGENCY FEES, BUT NOT DEFENSE ATTORNEY FEES, DENIES VICTIMS REPRESENTATION

Like HR 4600, MICRA sets a sliding contingency fee schedule for plaintiffs' attorneys representing victims of medical malpractice. The MICRA fees are limited to 40% of the first \$50,000 recovered; 33 $\frac{1}{3}$ % of the next \$50,000; 25% of the following \$100,000, and 15% of any amount exceeding \$200,000. MICRA does not limit the fees of the defendant's lawyers.

**Only the most seriously injured victims with clear-cut cases to prove can ever find legal representation.** In states with caps on attorney contingency fees for medical malpractice cases (and particularly in states such as California where a victim's pain and suffering compensation is also capped), victims of medical malpractice simply can not find legal representation. It is not cost effective for attorneys to take the vast majority of cases. Says the President of Safe Medicine For Consumers, a California-based medical malpractice survivors group, "The vast majority of individuals who contact us are women, parents of children or senior citizens. 90% of these individuals are unable to pursue meritorious medical malpractice cases because they can not find legal representation on a contingency basis and their savings have been wiped out."

**Limiting plaintiff attorney contingency fees, but not defense attorney fees creates an uneven playing field for victims.** Defendants can typically afford very high priced attorneys who fly special expert witnesses in from out of state. A contingency fee practice demands that a plaintiff's attorney must front the cost of expert witnesses to refute the testimony of experts flown in by the defendant. With caps on fees, such costs become prohibitive for the victim's legal counsel.

**Undermining the contingency fee mechanism contributes to a deteriorating quality of health care and passes costs onto taxpayers.** Left without legal representation in California, victims go uncompensated, and dangerous doctors go undeterred. Taxpayers pay the cost of low income victims' medical care and basic needs through public assistance programs if the physicians responsible for the injuries are not held accountable.

**Undermining the viability of contingency fee mechanism discriminates against low income patients who are most at risk of medical malpractice.** A contingency fee system is a poor patient's only hope of affording an attorney to challenge a negligent physician. Undermining such a system through caps on fees, that reduce incentives for attorneys to take malpractice cases, fails to punish negligence in poor neighborhoods.

IMPOSING A COLLATERAL SOURCE OFFSET FORCES TAXPAYERS AND POLICY HOLDERS TO  
PAY FOR WRONGDOERS' ERRORS

The collateral source rule prohibits defendants charged with negligence from informing the jury that the plaintiff has other sources of compensation, such as health insurance or government benefits, including social security and disability. The purpose of this long-established doctrine is to ensure that the jury holds the defendant responsible for the full cost of the harm the defendant caused by requiring the defendant to pay all the victim's expenses—even if a collateral source has already paid them.

Application of another legal doctrine, known as subrogation, ensures that the collateral source rule does not result in “double recoveries” for injured victims. Under subrogation rights—which are applicable to virtually all health insurance policies, government programs, and workers' compensation systems—the third-party payor of a health or job loss benefit has the legal right to take funds from a malpractice award to reimburse itself for payments it has already made to the malpractice victim. The collateral source rule, in conjunction with subrogation rights, ensures that wrongdoers pay for the full amount of the harm they cause, and that victims do not receive double payments for their injuries. HR 4600's provisions are not necessary because there are already controls on “double recoveries.”

For example, an injured individual's health care coverage usually pays the victim's medical bills. Under the traditional collateral source rule, if the victim sues the wrongdoer for compensation, including payment of medical bills, the defendant cannot tell the jury that the bills have already been paid by another source. However, once the jury makes an award to the victim, including damages for medical care, the health insurer can exercise its subrogation rights, and recover from the defendant (or the victim, if the award has been paid) the amount of money already paid for the victim's medical bills.

As HR 4600 proposes for the nation, MICRA repealed these rules in California. Consequently, in a trial, defendants may introduce evidence of insurance or other compensation obtained by the plaintiff. The jury is further permitted to reduce its award against the defendant by the amount of alternative compensation the victim received or is entitled to. As with the cap on non-economic damages, abolition of the collateral source rule reduces the amount of money the wrongdoer must pay. In effect, responsibility for the harm is transferred to the victim, who purchased the insurance coverage, to the victim's insurer, and/or to taxpayers. Moreover, once the defendant tells the jury about payments made by collateral sources, MICRA prohibits the collateral source from using the subrogation process to obtain reimbursement from the wrongdoer.

**Collateral source offsets will shift billions of dollars per year in malpractice injury costs caused by the negligent onto taxpayers and the health insurance system.** The cost of injuries resulting from medical malpractice total \$60 billion each year according to the Harvard School of Public Health. Instead of wrong-doers bearing the full cost of these injuries, tax-payer funded programs, such as social security, and policy-holder funded health plans, will be forced to pick up the tab.

**A collateral offset forces poor patients onto welfare, while wrong-doers' fortunes will be protected.** Low income victims “entitled” to public assistance payments from taxpayer-funded supplemental social security, social security disability and aid to families with dependent children become government assistance recipients while the wrong-doers earn interest on profits made at the victim's expense.

MICRA'S PROMISES HAVE NEVER MATERIALIZED, DATA SHOWS HR 4600 WILL ENRICH  
ONLY INSURERS

Like HR 4600, MICRA promised drastic reductions in physician malpractice premiums. MICRA was enacted by the California legislature in 1975 in response to rapidly-increasing medical malpractice insurance premiums. The powerful insurance and physicians' lobbies told state legislators that medical malpractice lawsuits and jury awards were responsible for the higher premiums.

Insurance companies threatened that the costs associated with malpractice insurance were rising at such a rate that their only option was to raise health care professionals' liability premiums or to withdraw from the market altogether. Physicians and hospitals emerged as high visibility advocates for the legislation: many opted to “go bare” (practice without malpractice insurance), some discontinued providing certain high-risk procedures, while others threatened to quit.

The crisis, we now know, was created by the “insurance cycle.” This is a well-established phenomenon in which insurers, during bad economic times, raise pre-

miums to cover investment losses after years in which they have lowered premiums (the good economic times) to attract capital for investment. This cycle and its inherent periods of investment losses, then as now, increased malpractice premiums, not lawsuits and claims. Reform then should focus on preventing such insurer investment practices, not restricting victims' rights.

For this reason, data from the National Association of Insurance Commissioners (NAIC) shows MICRA has not significantly lowered physician malpractice premiums compared to the national average and has resulted instead in excessive overhead costs and profit margins for insurers.

Nationally recognized actuary J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under presidents Ford and Carter, compared national malpractice premium trends to those in California. Hunter found that from 1991 to 2000, malpractice premiums in California have stayed close to national premium trends.

- The 2000 average premium per doctor in California was only 8.2 percent below that of the nation (\$7,200.61 vs. \$7,843.75).

- The average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent), than it did in the nation overall (1.9 percent.) According to Hunter, "there is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience."

If there are savings to limiting the rights and recovery of innocent victims of dangerous and culpable doctors, then insurers have not passed them onto physicians. The following table shows Mr. Hunter's analysis.

Year	California Number of Doctors	U.S.A. Number of Doctors	California Medical Malpractice Prem Earned (in thousands)	U.S.A. Medical Malpractice Prem Earned (in thousands)	Average Med Mal Premium Per Doctor California	Average Med Mal Premium Per Doctor U.S.A.
1991	76043	631400	529056	4862170	6957.33	7700.62
1992	76367	652100	526496	5138395	6894.29	7879.77
1993	76411	670300	563004	5174055	7368.10	7719.01
1994	77311	684400	576771	5931898	7460.40	8667.30
1995	78169	720300	597660	6080639	7645.74	8441.81
1996	79048	737800	610003	5992394	7716.87	8121.98
1997	80341	756700	628858	5917038	7827.36	7819.53
1998	81762	777900	652601	6195047	7981.72	7963.81
1999	82872	797600	611785	6155241	7382.29	7717.20
2000	84675	812800	609712	6375401	7200.61	7843.75
1991 to 1999 percent change	3.5	1.9				
1991 to 1999 % change (annualized)	0.4	0.2				

Sources:

Doctors USA: Statistical Abstract of the United States

Doctors CA: California Department of Consumer Affairs

Earned Premiums: NAIC Report On Profit By Line By State

NAIC data also shows that California insurers have, in fact, profited greatly from California patients' pain.

- In most years since the courts ruled that MICRA's cap was constitutional, 1986, California malpractice insurers have paid out in claims less than fifty cents of every dollar they have taken in through premiums (every year since 1989). By contrast, malpractice insurers nationally have typically paid out in claims more than two-thirds of every premium dollar.

- California malpractice insurers' "operating profits" have been higher than the rest of nation since MICRA was implemented, even though many insurers claim to be "not for profit." For non profits, the money taken in from doctors but not paid to victims can also be tied up in excessive overhead, assets and reserves that yield investment profits or in higher legal costs of defending against claims.

The chart below shows this NAIC data taken from Report on "Profitability By Line By State, 1976-2001"

## Loss Ratios for Malpractice

Year	CA Loss ratio: Losses Incurred/ Premiums Earned	CA Profit (\$000)	CA Operating Profit: Profit As a % of Premiums Earned	U.S. Loss Ratio: Losses Incurred/ Premiums Earned	U.S. Profit (\$000)	U.S. Operating Profit: As a % of Premiums Earned
1976	61.9%	3,198	1.4%	47.0%	238,576	20.1%
1977	38.9%	50,638	22.3%	40.4%	315,608	24.1%
1978	41.3%	53,227	21.4%	59.7%	175,510	12.7%
1979	42.1%	59,494	24.9%	68.2%	119,064	8.6%
1980	44.3%	61,241	26.6%	77.8%	90,662	6.8%
1981	61.3%	49,733	24.4%	101.0%	36,959	2.8%
1982	81.8%	19,169	9.1%	113.0%	-65,644	-4.3%
1983	70.5%	45,961	16.0%	104.4%	44,262	2.4%
1984	92.7%	18,358	4.9%	112.1%	187,029	8.8%
1985	80.8%	37,327	8.3%	121.6%	-513,570	-19.3%
1986	68.2%	89,382	14.2%	98.5%	-99,011	-2.6%
1987	63.0%	64,024	10.1%	85.8%	86,459	1.9%
1988	52.4%	137,936	20.8%	75.6%	426,683	8.4%
1989	39.4%	232,467	36.7%	52.6%	1,428,346	27.9%
1990	35.6%	241,699	39.9%	53.9%	1,449,651	29.4%
1991	9.0%	354,997	67.1%	55.7%	1,419,754	29.2%
1992	39.8%	148,998	28.3%	69.5%	1,495,273	29.1%
1993	38.1%	153,137	27.2%	64.6%	1,541,868	29.8%
1994	37.5%	148,807	25.8%	59.3%	1,506,702	25.4%
1995	41.5%	133,388	22.3%	59.3%	1,563,241	25.7%
1996	45.0%	132,262	21.7%	62.9%	1,696,723	28.3%
1997	44.3%	178,933	28.5%	57.8%	1,892,251	32.0%
1998	41.3%	197,932	30.3%	73.0%	1,258,887	20.3%
1999	42.0%	125,494	20.5%	73.9%	874,421	14.2%
2000	45.8%	171,520	28.1%	80.9%	869,373	13.6%

## CONCLUSION

For what? That is the question asked by Californians who understand both the human devastation MICRA has wrought and its financial failures. Enacting similar draconian restrictions federally would fly in the face of the experience of too many California casualties who have suffered needlessly under MICRA for a result that has only benefited malpractice insurers.

The real answer to skyrocketing insurance premiums, which are striking across all lines of insurance, is to regulate the insurers' pricing and accounting practices so that investment losses cannot be passed onto policyholders. Congress should not blame the victim for a crisis created by insurance companies.

Mr. BILIRAKIS. Mr. Hurly.

## STATEMENT OF JAMES HURLY

Mr. HURLY. Chairman Bilirakis, Ranking Member Brown, members of the subcommittee, thanks for inviting me to testify today on behalf of the American Academy of Actuaries. My name is Jim Hurly. I am chairperson of the Academy's Medical Malpractice Subcommittee. The Academy is the public policy and professional organization for actuaries practicing in all specialties within the United States. The Academy is nonpartisan and assists the public policy process through the presentation of clear and objective actual analysis. The Academy also develops and upholds actuarial standards of conduct, qualification, and practice. And for those of you who don't know who an actuary is, he's the guy who evaluates loss data to advise about rates and reserves, those liabilities that companies carry. So what I do is evaluate those loss data and make determinations about what rates need to be charged and what loss reserves need to be held.

I appreciate this opportunity to comment on issues related to the availability and pricing in medical malpractice insurance. In the time available, I would like to highlight a number of key points from my written statement. It may be helpful to start by discussing recent experiences in the medical malpractice line of business. During the 1990's, the medical malpractice line experienced favorable operating results and insurers competed aggressively. Health care providers shared in the benefit of improved loss experience and higher levels of investment income through lower charged premiums.

Recently, however, the cost of medical malpractice insurance has been rising. Rate increases have been precipitated in part by the growing size of claims, more frequent claims in some areas and higher defense costs. The relationship of increasing litigation and increased losses is clear. For example, the size of a medium jury award went to \$1 million in 2000, a jump from roughly \$475,000 in 1996, according to July 2002 Insurance Information Institute Report.

From a financial standpoint, medical malpractice results deteriorated in 1999 and 2000, and they're expected to continue to deteriorate in 2001. These results can be looked at in two component parts, underwriting and investments. The combined ratio is an indication of how the company is doing in its insurance underwriting. A.M. Best Company offers comprehensive data to insurance professionals and tracks these results. For all companies reported in A.M. Best, the combined ratio of 130 percent and 134 percent of the earlier 2 years, respectively, has deteriorated to 143 percent based on preliminary estimates for 2001.

From underwriting, this represents a loss of 43 cents on each dollar of premium earned in 2001. The operating ratio factors in investment income and other costs to reflect the companies bottom line. An operating ratio of 106 percent for 2 earlier years, reflecting a loss of 6 cents on every dollar of premium earned, is expected to deteriorate when 2001 results of the entire industry become available. At these levels, 2001 results will be the worse they've been in 15 years or more, approximating levels on the mid 1980's.

Today the loss environment has deteriorated. Benefits of favorable reserve development appear to be gone and the available investment income offset has declined. In fact, reserve reliability may require increases to cover current ultimate lost obligations.

All said, rates for both insurers and reinsurers need to increase to properly align with current loss and investment income levels. Companies failing to do this jeopardize their surplus base and financial health.

My written statement summarizes the two key drivers of financial results and their effects on operating results and surplus. The chart on display, which appears as chart c in my testimony, demonstrates the fall in that operating income. And this is for a subset of those companies reporting to A.M. Best because all of that data is not summarized yet, so this is a summarization of a significant portion of the companies that are reporting to A.M. Best.

The strong operating results of the earlier years as you can see by the chart in the neighborhood of 20, 25 percent, has declined to a slight profit in 2000 and to a 10-percent loss for 2001.

The next chart which appears as chart d in my testimony demonstrates the decline in surplus for these same companies. Surplus increased through 1999 and it shows the rate of increase, so you're looking at the percent of increase year over year. Surplus increase through 1999 decreased slightly in 2000 and decreased again more significantly in 2001.

Surplus represents a capital base for these insurers. And it's decline reduces the capacity to write new or renewing business and/or absorb losses on business written in prior years. And this includes their opportunity to write business that will become available from companies withdrawing from the market.

I noted earlier the underwriting investment components of financial results. Most malpractice insurers anticipate losing money in their underwriting operations and offsetting the loss with their investments. However, investment income is no longer sheltering the operating loss as reflected in the operating results or bottom line described earlier.

Investment income plays an important role in overall financial results, particularly for insurers and medical professional liability because of the long delay between the payment of premium and payment of losses. Insurers, just for the record, have not suffered investment losses. They've experienced lower rates of returns on those investments. In establishing rates, insurers do not recoup investment losses. Rather, the general practice is to choose an expected prospective rate of return, for example five or six percent, calculate a discount factor, usually producing a credits of rates on the order of 10 to 15 percent. Since interest yields drive this process, when interest yields decrease, rates increase.

In conclusion, I appreciate this opportunity to provide an actuarial prospective on these important issues. I would be glad to answer any questions you may have or provide any additional information that would be helpful to the subcommittee in its deliberations.

[The prepared statement of James Hurley follows:]

PREPARED STATEMENT OF JAMES HURLEY, CHAIRPERSON, MEDICAL MALPRACTICE  
SUBCOMMITTEE, AMERICAN ACADEMY OF ACTUARIES

INTRODUCTION

The American Academy of Actuaries appreciates the opportunity to provide comments on issues related to insurance and the availability and pricing of medical malpractice insurance. The Academy hopes these comments will be helpful as the subcommittee considers related proposals.

This testimony discusses some facts about medical malpractice financial results updated through 2001, contributing factors, and some common misconceptions about the results.

*Then and Now*

During the 1990s, the medical malpractice line of business experienced favorable operating results, and insurers competed aggressively. Healthcare providers shared in the benefit of improved loss experience and higher levels of investment income through lower charged premiums.

Recently, however, the cost of medical malpractice insurance has been rising. Rate increases have been precipitated in part by the growing size of claims, more frequent claims in some areas, and higher defense costs. The relation of increasing litigation and increased loss costs is clear, and the size of a median jury award rose to \$1 million in 2000, a jump from \$474,536 in 1996, according to a July 2002 Insurance Information Institute report.

From a financial standpoint, insurance industry medical malpractice results deteriorated in 1999 and 2000, and are expected to have continued to deteriorate in 2001. For all companies reporting to A.M. Best (an organization offering comprehensive data to insurance professionals), the combined ratio of 130 percent and 134 percent for the earlier two years, respectively, has deteriorated to 143 percent, per A.M. Best preliminary estimates. An operating ratio of 106 percent for the two earlier years, reflecting a loss of 6 cents on every dollar of premium written after considering underwriting and investment results, is expected to deteriorate when 2001 results become available. At these levels, 2001 results will be the worst they have been in 15 years or more, approximating levels of the mid-1980s.

Today, the loss environment has deteriorated, benefits of favorable reserve development appear to be gone, and the available investment income offset has declined. In fact, reserve liabilities may require increases to cover current ultimate loss obligations. All said, rates for both insurers and reinsurers need to increase to properly align with current loss and investment income levels. Companies failing to do this jeopardize their surplus base and financial health.

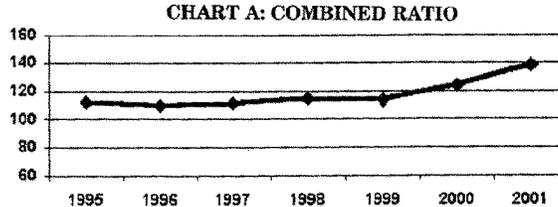
SOME FACTS

Because 2001 insurance industry A.M. Best data is not available, the following discussion is based on results of 30 companies (the 30-Group), primarily physician-owned and/or -operated medical liability insurers. These companies represent about one-third of the exposure reported to A.M. Best. Information is shown for the last seven years.

Results for these companies reflect a slight operating profit (a 96 percent operating ratio, or 4 percent net income relative to premiums) in 2000. However, the results deteriorated to a 10 percent operating loss (a 110 percent operating ratio) for 2001.

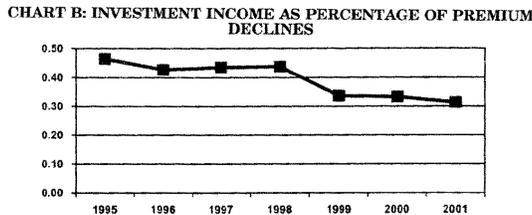
Following are discussion and charts summarizing the two key drivers of financial results and their effects on operating results and surplus.

**CHART A: COMBINED RATIO**



*Driver #1*—Higher combined ratio (defined here as calendar year loss and all loss adjustment and underwriting expenses divided by premium earned). The combined ratio deteriorated by 10 points in 2000 and a further 14 points in 2001. The ratios were 124 percent and 138 percent in 2000 and 2001, respectively. The preceding five years reflect a rather stable 110-115 percent range. The driver in these results is the deterioration of the loss and loss adjustment expense ratio as the underwriting expense ratio remains relatively flat. The earlier years reflect the benefit of significant reserve reductions that have decreased and contributed to the deterioration observed.

**CHART B: INVESTMENT INCOME AS PERCENTAGE OF PREMIUM DECLINES**

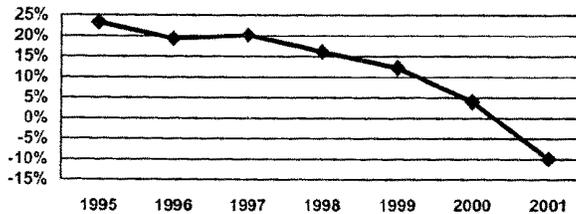


*Driver #2*—Decreased investment income (shown here as pre-tax investment income divided by premium earned). As shown in Chart A, insurers generally spend more money on loss and expense than they collect in premium. This is possible because investment income offsets this underwriting loss. In Chart B, pre-tax investment income is divided by earned premium to estimate the protection provided to offset an underwriting combined ratio in excess of 100 percent. As can be seen from Chart B, this statistic has declined over the measurement period from the mid-40s to the mid-30s, and, in 2001, to 31 percent. This “offset” will continue to decline in the future for two reasons. First, most invested assets are bonds and are affected by recently lower yields, a change that has not been fully felt in current investment income. Second, the premium base is growing due to increased rates, growth in exposure, or both. Invested assets are not increasing as rapidly as premium and, therefore, investment income as a percentage of premium will decline.

*Effect #1*—Net operating income falls (shown in Chart C as a percentage of premium). Net operating income represents the net impact of the combined ratio and investment income ratio, adjusted for other income statement items (primarily policyholder dividends, miscellaneous other income, and federal income tax). The strong operating returns of the early years have been followed by the slight 2000 profit and 10 percent loss for 2001 described earlier.

**CHART C: CALENDAR YEAR OPERATING RESULTS TURN NEGATIVE**

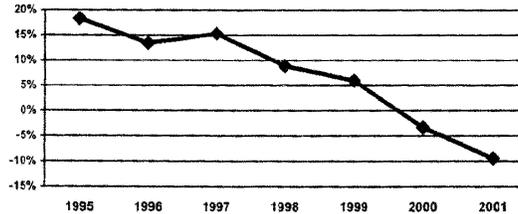
**CHART C: CALENDAR YEAR OPERATING RESULTS TURN NEGATIVE**



*Effect #2*—Surplus declines are shown in Chart D as a percentage change from one year to the next. Surplus increases through 1999, decreases slightly in 2000, and decreases more significantly in 2001. Surplus represents the capital base for these insurers, and its decline in 2000 and 2001 reduces the capacity to write new or renewing business prospectively, and/or absorb adverse loss developments on business written in prior years.

**CHART D: SURPLUS CHANGE TURNS NEGATIVE**

**CHART D: SURPLUS CHANGE TURNS NEGATIVE**



**CONTRIBUTING FACTORS**

There are several factors contributing to the financial results described above. It is probably best to note the factors contributing to the favorable results of the early and mid-1990s and then discuss the changes in these factors today.

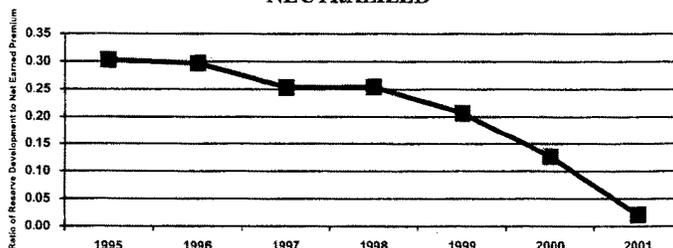
*Factor #1:* Throughout the 1990s, premium rates for the insurance industry as a whole were relatively flat or down in several states. Rates decreased toward the middle and end of the period in comparison to rates at the beginning of the decade. In many cases, rate decreases were a consequence of more significant discounts rather than changes to filed rates.

*Factor #2:* Loss-cost trends (the annual change in the frequency and severity of claims) during this time period were relatively low. Long-term indications suggest a low single-digit change, 3 percent to 5 percent, varying from state to state. This

reflects a lower general economic inflationary environment, and, perhaps more importantly, an equally low medical inflationary index. Rates established at the beginning of the period contemplated higher trends. Companies responded to this emerging data in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others found they needed to increase rates modestly and tried to refine pricing models to improve the equity of their program costs. Many insurers employed combinations of these, with resulting increases in some programs and decreases in others, depending on specific facts and circumstances. However, in general, there was a decline in the adequacy of premiums in this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower in some jurisdictions.

*Factor #3:* Lower than expected loss-cost trends allowed reductions in loss reserves established in anticipation of trends more in line with historically higher levels. As experience emerged, loss reserves for prior years were reduced, contributing to very profitable calendar year results. This evidence emerged gradually as claims settled. Thus, the reductions occurred over a period of years. Loss reserve reductions for prior years lowered current calendar year loss ratios (and thus the combined and operating ratios) during the mid-to-late 1990s, as shown in Chart E. As is clear from the graph, loss reserve development for the 30-Group was not a factor in 2001. From a broader perspective, it appears that the medical malpractice line for the insurance industry as a whole is currently in a deficit position. For example, the industry as a whole had to increase reserves in 2000, and indications are that this also will have occurred in 2001. (Insurance industry results for 2001 are not yet available.)

**CHART E: LOSS RESERVE DEVELOPMENT AS % OF PREMIUM  
NEUTRALIZED**



*Factor #4:* During the 1990s, investment income returns produced a real spread between fixed income rates of return and economic inflation. In addition, the modest equity position of invested assets for the 30-Group combined with fixed income yields to produce significant investment gains, improving overall financial results. These gains increased the investment income ratio (see earlier graph) and improved the operating ratio.

*Factor #5:* Given the financial results of the early-to-mid-1990s, some companies considered expansion into new markets (although they may have had limited information to develop rates), became more competitive in existing markets, and offered more aggressive premium discounts. In most jurisdictions, "discounts" against the manual premium became common, reducing the actual premiums paid by health care providers. Reinsurers likewise reduced rates, competed and covered more exposure but often at lower rates. As a consequence, rates on a coverage year basis became less adequate.

*Factor #6:* Loss-cost trends, particularly claim severity, began to pick up toward the latter part of the 1990s. The number of large claims (sometimes very large) increased, but even basic limits analyses (eliminating the distortions of very large claims) began to move upward. This, coupled with the cumulative effect of the low loss-cost trend and rate activity in the earlier part of the decade, produced rate indications that were moving up significantly in many states. Insurers are moving to eliminate competitive discounts.

*Factor #7:* Aggregate loss reserve levels were reconciled to the lower loss-cost trends, resulting in no further reductions in 2001 (and for the insurance industry, requiring an addition to prior reserve levels). In fact, the upward loss-cost pressure noted above calls into question whether current reserve levels will be adequate to meet ultimate loss costs. Results to date for the 30-Group reflect little or no strengthening in the aggregate, although results vary on a company-by-company basis.

*Factor #8:* Rates of return on invested assets declined, and equity values fell. In addition to the fact that this affected interest earnings on existing assets, it also affected the expectation for investment earnings used to offset needed prospective premium levels. Rates established using an interest rate assumption of 6 percent rather than 7 percent were 3 to 4 percent higher (assuming no changes in other rate components) due to the multiplier effect of investment income. Moving to even lower yields compounds the impact.

*Factor #9:* Reinsurers' experience deteriorated as their results were affected by the increased claim severity and pricing changes in the early-to-mid-1990s. Since reinsurers generally cover the higher layers of exposure, their results were disproportionately impacted by claim severity increases. This, coupled with the broadly tightened reinsurance market after the events of September 11, 2001, caused reinsurers to substantially increase rates and tighten terms of reinsurance for medical malpractice.

#### FREQUENT MISCONCEPTIONS

In closing, it would be helpful to address some frequent misconceptions about the insurance industry and medical malpractice insurance coverage.

*Misconception 1: "Insurers are increasing rates because of investment losses, particularly their losses in the stock market."*

Investment income plays an important role in the overall financial results of insurers, particularly for insurers of medical professional liability, because of the long delay between payment of premium and payment of losses. Insurers have not suffered investment losses, but they have experienced a decline in their portfolio rates of return. The vast majority of invested assets are fixed-income instruments. Generally, these are purchased in maturities that are reasonably consistent with claim payments. Losses from this portion of the invested asset base have been minimal, although the rate of return available has declined. Equities are a much smaller portion of the portfolio (for this 30-Group, representing about 15 percent of invested assets). After favorable performance up through the latter 1990s, there has been a decline in the last few years, contributing to less favorable investment results and overall operating results. Thus, investment returns are still positive, but the rates of return have been adversely affected by equity declines and lower fixed income investment yields.

In establishing rates, insurers do not recoup investment losses. Rather, the general practice is to choose an expected prospective rate of return (e.g., 5 percent or 6 percent) and calculate a discount factor (usually producing a credit to rates on the order of 10 percent to 15 percent). This means the insurer is expecting to have an underwriting loss that will be offset by investment income. Since interest yields drive this process, when interest yields decrease, rates increase.

*Misconception 2: "Companies operated irresponsibly and caused the current problems."*

Financial results for medical insurers have deteriorated. Further, some companies made underwriting and rate decisions that have resulted in adverse financial results, including insolvencies. A significant portion of this adverse experience is emerging on business written in newly entered markets by companies that attempted to expand in the mid-to-late 1990s. In addition, companies became too aggressive in discounting premiums for existing business.

Additionally, while one can argue about whether companies were imprudent in past pricing behavior, today's rate increases reflect a reconciliation of rates and current loss levels, given available interest yields. There is no added cost for past mispricing. Thus, although the competitive, soft market pricing delayed reconciliation of rates and loss levels, the "current problem" reflects current data.

*Misconception 3: "Companies are reporting losses to justify increasing rates."*

This is a false observation. Companies are reporting losses primarily because claim experience is worse than anticipated when prices were set. It is clear that companies, having gone through the 1990s reporting very profitable results, would not suddenly have decided that, in order to get more profits, they would report losses to increase rates. Further, several companies have suffered serious adverse consequences given these financial results, including liquidation or near liquidation. For example, the St. Paul Cos., formerly the largest writer of medical malpractice insurance, is now in the process of withdrawing from this market.

The Academy appreciates the opportunity to provide an actuarial perspective on these important issues and would be glad to provide the subcommittee with any additional information that might be helpful.

Mr. BILIRAKIS. Thank you very much, Mr. Hurly.  
Mr. Plunkett? Please proceed, sir.

#### STATEMENT OF TRAVIS PLUNKETT

Mr. PLUNKETT. Thank you, Mr. Chairman and thank you to the chairman and Mr. Brown and members of the subcommittee for the opportunity to offer our comments on this very important issue. I'm Travis Plunkett. I'm the Legislative Director with the Consumer Federation of America.

For the third time in less than 30 years, Congress and State Legislators are grappling with the problem of fast rising medical malpractice rates. As we've just heard, insurers insist a sharp increase in large, unwarranted jury verdicts is to blame for the crisis.

But research by our Director of Insurance, Robert Hunter, shows that insurers are pointing fingers when they should be looking in the mirror. It is the hard insurance market and the insurance industry's own business practices that are largely to blame for the rate shock that physicians have experienced in recent months.

Our research shows several trends that are relevant to the debate about malpractice rates. First is we've already heard, these rate hikes aren't occurring in a vacuum. Commercial insurance rates are rising overall depending on the size of the account and type of insurance. The problem is caused by a classic turn in the economic cycle of the industry, and I'd ask that the insurance cycle slide be put up—sped up, but not caused by the terrorist attacks.

There are been three malpractice crises since the early 1970's, in the mid-1970's, the mid-1980's, and right now. As the graph shows, these crises have coincided precisely with the bottom of the insurance cycle each time this has occurred, with the one exception in 1992, that would be payouts for Hurricane Andrew losses. This appears to be so far, this crisis, the mildest of the three events in terms of price increases and coverage unavailability. Even with the withdrawal of the largest malpractice insurer, Saint Paul, from the market.

According to the National Association of Insurance Commissioners, there are three major causes of this kind of steep underwriting cycle.

First, a large loss shock. Second, changes in interest rates. Third, underpricing in soft markets. Lower interest rates and underpricing have already been in place for quite some time. September 11 provided the shock loss in an achingly painful way. But the cycle had turned before the 11th in late 2000.

As I mentioned, a significant part of the problem is underpricing, and I'd like to turn now to exhibit a.

This shows that the average malpractice premium per doctor barely climbed from 1991 to 2000—1.9 percent, which is really a 32.5 percent drop if medical inflation is factored in. That means it would take a rate increase of 48 percent to bring premium rates in 2000 back to the 1991 level.

Our research shows that medical malpractice as well as a percentage of national health care expenditures is quite low. It's a fraction. It's about 66 cents over the last decade for every \$100 of national health care cost. Thus, the maximum potential savings if you eliminate all rights for injured patients to seek legal redress

would be under 60 cents on a \$100 medical bill. I say under 60 cents because the year 2000 cost was about 56 cents.

Regarding claims in the last decade, let us note that only one in four person, as you've heard, get any payment at all. I'd like to turn to exhibit c. Each closed claim in America which includes all million dollar verdicts averaged \$27,824 for the decade ending December 31, 2000. Notice I'm talking about the decade, not the most recent year where data on claims is clearly insufficient. This includes costs for insured defense and claims adjustment. The figures over the decade showed virtually no growth in closed claims.

Now why do we talk about closed claims? Because they include those costs you've heard so much about today. They include the cost for the zero claims. They include the cost for paying out those claims and defending against those claims. It's important to note that. If you talk just about claims that are paid, and the number we have in our chart over a decade is average \$112,000, this number doesn't include costs for defensive claims settled, adjudicated or otherwise closed with no payment. So you have to look at both. You have to look at both the closed claims and those that are paid.

The conclusion we've drawn from this data is that the insurance cycle and the practices of the insurance industry themselves are the key culprits in the rate shock that physicians, hospitals, and patients are grappling with. Unfortunately, each time the cycle turns from soft to a hard market, the response by insurers is extremely predictable.

They shift from inadequate under pricing to unconscionable over pricing. They cut back on coverage and then they blame large jury verdicts for the problem. Insurers seem to expect Congress and the American public to swallow the dubious line, that trial lawyers have managed to time their million dollar jury verdicts to coincide precisely with the bottom of the insurance cycle three times in the last 30 years. That just doesn't seem plausible. And as you've heard from others the insurance cycle is quite complicated and you can't boil it down simply to a question of losses involving jury verdicts.

A lot is at stake in this debate. As you've already heard, the IOM report demonstrates that far too many Americans face the serious possibility of an injury or even death due to medical mistakes in the hospital. Their range, on medical errors, was either the eighth leading cause of death in the country ahead, of AIDs and breast cancer, or the fourth leading cause of death in the country, depending on how you calculate the numbers and what study you look at.

Mr. BILIRAKIS. Please summarize, Mr. Plunkett.

Mr. PLUNKETT. Absolutely. Some medical errors are directly attributable to physician negligence and some aren't. But the point is it that there are serious implications here if you roll back legal rights. And before you move tort reform legislation, I urge you to look at these insurance issues very closely, get the facts, and look at the role the insurance industry has played in the predicament that we all find ourselves in right now. Thank you.

[The prepared statement of Travis Plunkett follows:]

PREPARED STATEMENT OF TRAVIS PLUNKETT, LEGISLATIVE DIRECTOR, CONSUMER  
FEDERATION OF AMERICA

Good morning. I am Travis Plunkett, legislative director for the Consumer Federation of America. CFA is a non-profit association of more than 290 organizations

founded in 1968 to advance the consumer interest through advocacy and education. Ensuring the provision of fairly priced and adequate insurance has been one of our core concerns since CFA's inception.

I would like to thank Chairman Bilirakus, Ranking Member Brown and the other members of the Subcommittee for the opportunity to offer our comments on this extremely important issue. For the third time in less than thirty years, Congress and State legislators across the country are grappling with the problem of fast-rising medical malpractice rates. Insurers insist that a sharp increase in large, unwarranted jury verdicts is to blame for the crisis. As a result, lawmakers on this Subcommittee and in a variety of states are considering legislation to place further limits on the legal rights of Americans who have been harmed or killed by medical malpractice.

But research by actuary and CFA Director of Insurance J. Robert Hunter shows that insurers are pointing fingers when they should be looking in the mirror. It is the "hard" insurance market and the insurance industry's own business practices that are largely to blame for the rate shock that physicians have experienced in recent months. CFA has found that:

- Medical malpractice rates are not rising in a vacuum. Commercial insurance rates are rising overall.
- The rate problem is caused by the classic turn in the economic cycle of the industry, sped up—but not caused by—terrorist attacks.
- Insurers have under-priced malpractice premiums over the last decade. It would take a 50 percent rate hike to increase inflation-adjusted rates to the same level as existed ten years ago.
- Further limiting patients' rights to sue for medical injuries would have virtually no impact on lowering overall health care costs. Medical malpractice insurance costs as a proportion of national health care spending are miniscule, amounting to less than 60 cents per \$100 spent.
- Insurer losses for medical malpractice have risen slowly in the last decade, by just over the rate of inflation.
- Malpractice claims have not "exploded" in the last decade. Closed claims—which include claims where no payout was made—have remained constant, while paid claims have averaged just over \$110,000.
- Medical Malpractice profitability over the last decade has been excellent, at just over 12 percent, despite a decline in profits in the last two years.

#### I. PUTTING MEDICAL MALPRACTICE INSURANCE RATES INTO CONTEXT: INSURER PRACTICES AND THE INSURANCE CYCLE

##### *A. Commercial Insurance Rates Overall Are Rising*

To put price increases in insurance anywhere in America today into context, you have to be aware of a general tendency toward higher rates nationally. According to data released by the Council of Insurance Agents (CCIA) and Brokers,<sup>1</sup> commercial premiums are increasing quickly. According to estimates made by CFA based upon the CCIA data for the 12-month period ending December 31, 2001, average prices rose as follows: Small Commercial Accounts +21%; Mid-size Commercial Accounts +32%; and Large Commercial Accounts +36%.

The worst hit are, not surprisingly, "terrorist target" risks, such as skyscrapers. According to the CCIA survey, CFA calculates the average increases over the last year by line of insurance as: Business Interruption +30%; Construction +46%; Commercial Cars +28%; Property +47%; General Liability +27%; Umbrella Liability +56%; and Workers' Compensation +24%.

Interestingly, the broad rate increases are occurring even when terrorism is excluded. The market shows all the earmarks of a classic cycle bottom, which is discussed in some detail below.

##### *B. There is a Classic "Hard" Cycle Nationally—with Prices Rising Accelerated by the Events of September 11th*

Insurance is a cyclical business. This is particularly true in the medical malpractice insurance business. In the mid-1970s, the country experienced the first liability insurance crisis. In this case, the crisis was particularly acute in product liability insurance and medical malpractice insurance.

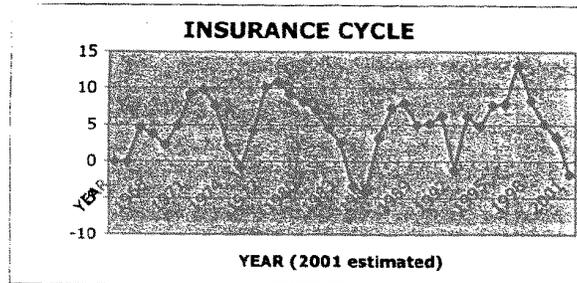
At the mid-70s cycle low, the industry's rate of return was "2.6% in 1975," rose "to 19.7% in 1977, a gain of almost 17 points in the course of only two years. The industry's rate of return then fell by more than 17 points over the next 7 years to

<sup>1</sup> 4th Quarter 2001 Survey, released January 2002.

1.9% in 1984, the nadir of that soft market. During the subsequent hard market, profits once again shot up—to 15.4%” (by 1987).<sup>2</sup>

The mid-1980s crisis was in commercial liability generally, hitting municipalities, day care centers, environmental liability, medical malpractice and many other liability risks and lines. *Time* magazine had a cover story called “Sorry America, Your Coverage is Cancelled.”

Two charts below show the cyclical nature of insurance.<sup>3</sup> The first chart, “Insurance Cycle” shows the operating income as a percentage of premium from 1967 to 2001. The operating income of the industry falls below zero four times on the chart—in 1975, in 1984 and 1985, in 1992, and in 2001 (the last number estimated by CFA).



The 1992 data point was not a classic cycle bottom, but reflected the impact of Hurricane Andrew and other catastrophes in that year.

The 1975 and mid-80s bottoms were both classic cycle bottoms with very sizeable price increases and coverage availability problems immediately following the bottom. Consider the mid-80s cycle turn: between 1977 and 1984, insurance premiums had “... actually declined (by) 4.4% ... from 1984 to 1987, net premiums written increased 63.3% ...”<sup>4</sup>

The price increases in this cycle turn began in late 2000.<sup>5</sup> The rate of change was accelerating upward before September 11th. The terrorist attacks sped up the price increases into what some seasoned industry analysts see as gouging.<sup>6</sup> Many examples of unjustified price increases have surfaced in the last few months.<sup>7,8</sup>

Gouging usually does occur as the cycle turns.<sup>9</sup> The evidence is very strong that what we are experiencing is a classic underwriting cycle turn into a “hard,” from a prolonged “soft,” market.

According to the National Association of Insurance Commissioners, “... underwriting cycles may be caused by some or all of the following factors:

<sup>2</sup>*Cycles and Crises in Property/Casualty Insurance: Causes and Implications*, edited by Cummings, Harrington and Klein, NAIC, 1991. Page 11.

<sup>3</sup>Both of these charts use data from A. M. Best and Co., *Aggregates and Averages*, 2001 edition for all years except 2001, where CFA made estimates of the results based on current information.

<sup>4</sup>*Cycles and Crises in Property/Casualty Insurance: Causes and Implications*, edited by Cummings, Harrington and Klein, NAIC, 1991. Page 8.

<sup>5</sup>“The Big Question For 2002: Will Hard Market Last Long?” By Sean F. Mooney, *National Underwriter*, January 7, 2002 edition.

<sup>6</sup>“...there is clearly an opportunity now for companies to price gouge—and it’s happening... But I think companies are overreacting, because they see a window in which they can do it.” Jeanne Hollister, consulting actuary, Tillinghast-Towers Perrin, in, “Avoid Price Gouging, Consultant Warns,” *National Underwriter*, January 14, 2002.

<sup>7</sup>“As Insurers Hike Prices, State Regulators Consider Reducing Regulatory Authority,” Consumer Federation of America, December 5, 2001.

<sup>8</sup>“We’ve seen premiums go up as much as 40-70 percent,” says [Jenny] Jones [CEO of Elkins/Jones insurance brokerage]. She points out that commercial buildings which now pay five or six cents per square foot for insurance need to budget for costs to go up to as much as seven or eight cents a foot. She says the increases could be across the board for all types of properties. Single family housing developers could be sharply affected, she notes, citing one homebuilder whose liability premium doubled at the November 11 renewal.” “Large Insurance Premium Increases in 2002 as September 11 Ricochets Through Industry, Expert Advises,” *Business Wire*, January 3, 2002.

<sup>9</sup>“To be sure, the market began firming in 2000. But the Sept. 11 terrorist attacks sent insurance prices skyrocketing far beyond the estimates of increases that earlier were being attributed to a normal hard cycle.” “Year in Review,” *Business Insurance*, December 24, 2001.

1. Adverse loss shocks...unusually large loss shock...may lead to supra-competitive prices.
2. Changes in interest rates...
3. Under pricing in soft markets..."<sup>10</sup>

Prior to September 11th, the industry had been in a soft market since the late 1980s. The usual six to ten year economic cycle had been expanded by the amazing stock market of the 1990s. No matter how much they cut their rates, the insurers wound up with a great year when investing the float on the premium in this amazing market (the "float" occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer—e.g., there is about a 15 month lag in auto insurance). Further, interest rates were relatively high in recent years as the Fed focused on inflation.

But, in the last two years, the market turned with a vengeance and the Federal Reserve cut interest rates again and again. Item 2 above had occurred well before September 11th.

Item 3 above, the low rates, were also apparent. The chart, "Insurance Cycle," shows the operating profit drop from about 13% of premium in 1997 to about 3.5% of premium in 2000.

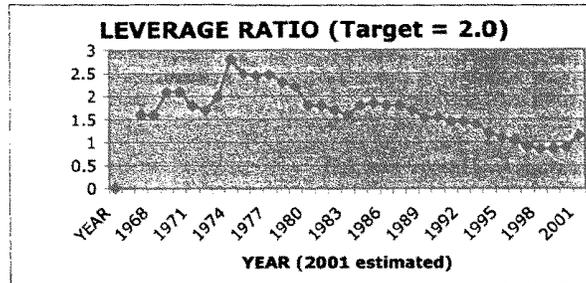
So, before September 11th, the cycle had turned, rates were rising and a hard market was developing. An anticipated price jump of 10% to 15% in 2001 was predicted by CFA and confirmed by the Insurance Information Institute.

Item 1, the shock loss was all that was missing. September 11th provided that in an achingly painful way.

However, the increases are mostly due to the cycle turn. The price increases were sped up by the terrorist attack, collapsing two years of anticipated increases into a few months, but the bulk of the increases are not related to pricing for terrorism, per se. This is a classic economic cycle.

The question we hear a lot of debate about is how long the hard market can last. Given the amazing inflow of capital, can the prices hold for long? While the jury is still out on that question, there are some factors that make it seem likely that the hard market will be brief. They include:

- The capital inflow in excess of the after-tax terrorism loss,
- The relatively overcapitalized position of the industry as shown in the chart, "Leverage Ratio," below,
- The availability of alternative risk mechanisms to the larger client risks, the insureds with the biggest price hikes,
- The pattern of risk managers blaming insurers, not the terrorism event, for renewal problems, and shopping for better deals.<sup>11</sup>



A "leverage ratio" is the ratio of net premiums written (i.e., after reinsurance) to the surplus, the amount of money the insurer has to back up the business; assets less the liabilities. Surplus is not reserves, which are liabilities set up to cover claims. The leverage ratio has always been the key measure of insurer strength.

The rule of thumb used for decades by insurance regulators and other experts in determining solidity is the so-called "Kenny<sup>12</sup> Rule" of \$2 of premium for each \$1 of surplus as safe and efficient use of capital. Some now say that this rule is antiquated, given the new level of catastrophe possible, but new ways of spreading the

<sup>10</sup> *Cycles and Crises in Property/Casualty Insurance: Causes and Implications*, edited by Cummings, Harrington and Klein, NAIC, 1991. Page 339.

<sup>11</sup> "Risk Managers Blame Insurers for Renewal Woes," *National Underwriter*, January 14, 2002

<sup>12</sup> Named after a famous insurance financial writer, Roger Kenny.

risk, such as securitizing it, may offset this. CFA still believes a 2:1 ratio is safe. But even those proposing a lower ratio do not go below 1.5:1. The NAIC uses a 3:1 ratio as the standard for determining if an individual insurer warrants solvency inspection.

When the cycle turned in the mid-70s, the premium/surplus ratio was as high as 2.8 to 1. This was a dangerously high average ratio since many insurers exceeded the 3:1 NAIC problem ratio. When the mid-80s cycle turned, the ratio was as high as 1.8 to 1—a relatively safe level. In today's cycle turn, CFA projects the ratio for 2001 year-end to be about 1.2 to 1, extremely safe and, indeed, overcapitalized.

## II. THE FACTS ABOUT MEDICAL MALPRACTICE CLAIMS AND LOSSES

As the lengthy explanation above demonstrates, the practices of the insurance industry itself are to largely to blame for the wildly gyrating business cycle of the last thirty years. Each time the cycle turns from a soft to a hard market the response by insurers is predictable: they shift from inadequate under-pricing to unconscionable over pricing, cut back on coverage and blame large jury verdicts for the problem. It is particularly appalling to see a crisis caused by insurer action being blamed, by the very insurers that caused the problem, on others. Insurers seem to expect legislators and the American public to swallow the dubious line that trial lawyers have managed to time their million-dollar jury verdicts to coincide precisely with the bottom of the insurance cycle three times in the last thirty years. Medical malpractice insurance rates are now rising fast. Insurers tell the doctors it is the fault of the legal system and urge them to go to state legislatures or to Congress and seek restrictions on the rights of their patients. Physician associations, unfortunately, are only too willing to accept this faulty logic.

Although rates are obviously now increasing, medical malpractice insurance losses are not “exploding” and have actually declined by one significant measure. CFA's Director of Insurance, J. Robert Hunter, conducted an actuarial analysis of medical malpractice insurance using the most recent insurance data available from the National Association of Insurance Commissioners and A.M. Best and Company. He found the following:

1. **Inflation-adjusted medical malpractice premiums have declined by one-third in the last decade.** Exhibit A shows that the average medical malpractice premium per doctor barely climbed from \$7,701 in 1991 to \$7,843 in 2000, an increase of 1.9 percent. Rates in constant 2000 dollars have declined by 32.5 percent, when the medical care services Consumer Price Index is taken into consideration, it would take a rate increase of 48 percent to bring premium rates in 2000 back to the 1991 price level. This chart points to insurer pricing practices (e.g. under-pricing during a soft market followed by a sharp increase in premiums as the market has hardened) as a key culprit in the rate shock that many physicians are now experiencing.
2. **Medical malpractice as a percentage of national health care expenditures are a fraction of the cost of health care in this nation.** Over the last decade, for every \$100 of national health care costs in the United States, medical malpractice insurance cost 66 cents. In the latest year (2000) the cost is 56 cents, the second lowest rate of the decade. Exhibit B shows that malpractice premiums as a share of health costs have declined from .95 percent in 1988 to .56 percent in 2000. Medical malpractice insurance is actually an amazing value as it covers all medical injuries for about one-half of one percent of all health costs. Moreover, this chart shows that proposals to further limit patients' rights to sue for medical injuries have little, if any, value in terms of lowering overall health care costs. The maximum potential savings of eliminating all rights for injured patients to seek legal redress would be under 60 cents on a \$100 medical bill.
3. **There is no “explosion” in the severity of medical malpractice claims.** Only about one in four persons who bring a claim (24.6%) get any payment at all. Each closed claim in America—which includes all million-dollar verdicts—averaged only \$27,824 for the decade ending December 31, 2000. This includes costs for insurer defense and claims adjustment. The figures over the decade showed no growth in average paid claim. If one looks at average payout just for claims with payments (as opposed to all closed claims) the average loss was \$112,987. This includes costs for defense of claims settled, adjudicated or otherwise closed with no payment, thereby overstating the cost per claim paid. (See Exhibit C.)
4. **Medical malpractice insurance losses have risen very slowly.** Incurred losses, including loss adjustment expense (LAE) has risen by one-half of one percent over the last decade on a per-capita basis more than medical inflation.

(See Exhibits A and C.) Furthermore, Exhibit D shows that medical malpractice losses haven't come anywhere close to approaching or exceeding premiums, as they did in the early 1980s. In other words, losses have increased on a fairly regular, predictable basis, like most goods and services subject to inflation. The problem, as pointed out in 1 above, is that premiums have not kept up with losses.

**5. Medical Malpractice profitability over the last decade has been excellent.**

Despite a decline in profitability in the last three years, the average return on net worth for medical malpractice lines was still a handsome 12.3% over the last decade. (See Exhibit E.)

### III. SOLUTIONS

Both the states and Congress must act to deal with the true source of the malpractice insurance price increases: insurer pricing practices and the volatile insurance cycle. As usual with insurance issues, state regulators must take the lead. CFA has called on the National Association of Insurance Commissioners to thoroughly investigate rate hikes in both personal and property/casualty lines and to consider a number of specific reforms to freeze or rollback unwarranted rate hikes and to prevent rate shock in the future. States can also take steps to spur private market development of increased insurance alternatives (such as captive insurance companies, risk retention groups, purchasing groups and the creation of new mutual insurance companies) and to increase the availability of insurance through public resources (such as joint underwriting associations and insurance facilities.)

The states could also act to provide relief to the medical specialists, such as obstetricians and neurologists, who bear the brunt of medical malpractice costs. The problem, from an insurance point-of-view, is that the risk is too concentrated on too few providers. The highest risk patients, who have illnesses or conditions where a slight provider error can cause grave harm or death, are usually "referred up" from general practitioners and internists to specialists. For example, only the very worst risks of all bad backs in a particular state end up being treated by neurosurgeons. Yet a few neurosurgeons bear the full cost of these risks; none of the risk is borne by referring physicians. This risk should be spread somewhat, because non-specialist physicians benefit financially from this structure (lower risk patients are less costly in malpractice terms.) States should consider requiring insurers to impose a "high-risk referral" fee on all physicians, that could then be adjusted upward for risk depending on the class of practitioner and used to lower insurer costs in the highest-risk classes.

**Congress could act to address rising malpractice rates by creating a national reinsurance facility.** All insurers writing medical malpractice would be members of the facility. Members would cede the premiums and claims over a set catastrophic amount to the facility. The facility would take all risk over this retention and would charge an actuarially-based premium for this coverage. The premium would NOT be allowed to fluctuate downward during the economic cycle of the medical malpractice insurance market, thereby serving to stabilize the premium cycle as well as make insurance more readily available through spreading the cost of large injuries to a national base. The reinsurance plan would have to be administered by a federal agency—the Department of Health and Human Services is probably the best bet—but there would be no taxpayer funding. Cost of premiums and of program administration would be paid out of the premiums ceded to the facility. HHS would utilize the data generated on these catastrophic claims to report to Congress on ways to decrease medical errors and malpractice.

There have been three medical malpractice crises, in the mid-1970s, the mid-1980s and currently. This appears to be (so far) the mildest of the three events in terms of price increases and coverage unavailability, even with the withdrawal of malpractice insurer St. Paul from the market.

The crises are caused by the economic cycle of the insurance industry. The cost of claims has been relatively flat, of the order of \$110,000 per claim closed with payment and under \$30,000 per claim closed when those claims closed without payment are included in the averages (as they must be since the adjustment expense for such claims is included in the data).

Thus, in order to control the periodic malpractice insurance rate flare-ups, the cycle must be controlled. This requires the discipline of a regulator to do a very difficult thing, keep prices somewhat higher than competition would dictate during the "soft" phase of the cycle and escrow the excess to help when the "hard" phase sets in.

The "hard" phase is related to reinsurance becoming unavailable or high priced. This is why a national reinsurance facility makes sense. Further, if the facility is

regulated by the federal government, the government would have incentives to make sure that rates remained actuarially sound and stable throughout the cycle and would be able to use the data on large claims for risk reduction research.

## IV. CONCLUSION

A lot is at stake in this debate. The 1999 report regarding medical errors by the Institute on Medicine (IOM) demonstrates that far too many Americans face the serious possibility of an injury, or even death, due to medical mistakes in the hospital. Using the IOM's low estimate of 44,000 deaths per year, medical errors are the eighth leading cause of death in this country, ahead of breast cancer and AIDS. The IOM's high-range estimate of 98,000 deaths a year would make medical errors the fifth leading cause of death, more than all accidental deaths.<sup>13</sup> Of course, some medical errors are directly attributable to physician negligence and some are not, but the IOM report clearly demonstrates the serious implications of rolling back the legal rights of Americans who have been harmed or killed by malpractice. If Congress gets it wrong, the pain and suffering incurred by many families across the country will only increase.

Before this Committee rushes through tort reform legislation, I urge you get to get the facts. As the evidence I've presented you with today shows, insurers have only themselves to blame for the predicament they—and physicians and patients throughout the country—face.

## EXHIBIT A: MEDICAL MALPRACTICE PREMIUMS 1991-2000

Year	U.S.A. Number of Doctors	U.S.A. Medical Malpractice Premm Earned (in thousands)	Average Med Mal Premium per Doctor U.S.A	Medical Care Services CPI-U 7/1 of Year	Med Mal Average Premium at 2000 Dollars
1991 .....	631400	4862170	7700.62	176.1	11614.33
1992 .....	652100	5138395	7879.77	189.7	11032.50
1993 .....	670300	5174055	7719.01	202.6	10119.30
1994 .....	684400	5931898	8667.30	212.6	10828.01
1995 .....	720300	6080639	8441.81	223.5	10031.97
1996 .....	737800	5992394	8121.98	231.9	9302.27
1997 .....	756700	5917038	7819.53	238.7	8700.74
1998 .....	777900	6195047	7963.81	246.5	8580.88
1999 .....	797600	6155241	7717.20	254.6	8050.62
2000 .....	812800	6375401	7843.75	265.6	7843.75
1991 to 2000 Percent Change .....	50.8	-32.5			
Rate increase required to bring 2000 to 1991 price level .....	48.10%				

Sources:  
 Doctors USA: Statistical Abstract of the United States  
 Earned Premiums: NAIC Report on Profit By Line By State  
 Medical Care Services Inflation: Bureau of Labor Statistics

## EXHIBIT B: RATIO OF MEDICAL MALPRACTICE PREMIUM COSTS TO NATIONAL HEALTH CARE EXPENDITURES

Year	Direct Plus Assumed Medical Malpractice Premiums Earned <sup>1</sup>	National Health Expenditures <sup>2</sup>	Medical Malpractice Premium as a % of Health Costs
1988 .....	\$5322	\$562,000	0.95
1989 .....	5379	623,900	0.86
1990 .....	5157	699,400	0.74
1991 .....	5015	766,800	0.65
1992 .....	5127	836,500	0.61
1993 .....	5367	898,500	0.60
1994 .....	5896	947,700	0.62
1995 .....	6207	993,700	0.66
1996 .....	6190	1,042,500	0.59
1997 .....	6402	1,092,400	0.59
1998 .....	6559	1,146,000	0.57
1999 .....	6703	1,211,000	0.55

<sup>13</sup> *To Err is Human, Building a Safer Health System*, Institute of Medicine, National Academy of Sciences; November, 1999.

EXHIBIT B: RATIO OF MEDICAL MALPRACTICE PREMIUM COSTS TO NATIONAL HEALTH CARE EXPENDITURES—Continued

Year	Direct Plus Assumed Medical Malpractice Premiums Earned <sup>1</sup>	National Health Expenditures <sup>2</sup>	Medical Malpractice Premium as a % of Health Costs
2000 .....	7360	1,311,000	0.56
<b>TOTAL .....</b>	<b>\$56,062</b>	<b>\$8,463,400</b>	<b>0.66</b>

<sup>1</sup> Best's Aggregates and Averages, 1998 and 2001 Editions. Figures in millions of dollars. Using direct plus assumed slightly overstates the size of medical malpractice premiums.

<sup>2</sup> U.S. Department of Health and Human Services web site.

EXHIBIT C: MEDICAL MALPRACTICE CLAIMS BY AMERICANS 1991-2000

Year	Claims closed with payment	Claims closed without payment	USA number of doctors	Claims w/pay per 100 doctors	Total claims closed per 100 doctors	Percent of total claims with payment	Paid losses and LAE expense (000)	Average loss for all claims closed	Average loss for paid claims only
1991 .....	30841	75348	631400	4.9	16.8	29.0	3089412	29093.52	100172.24
1992 .....	31079	82737	652100	4.8	17.5	27.3	3270128	28731.71	105219.86
1993 .....	32821	87728	670300	4.9	18.0	27.2	3438042	28519.87	104751.29
1994 .....	31147	92788	684400	4.6	18.1	25.1	3696608	29826.99	118682.63
1995 .....	31237	94180	720300	4.3	17.4	24.9	3903960	31127.84	124978.71
1996 .....	30522	92888	737800	4.1	16.7	24.7	3641179	29504.73	119296.87
1997 .....	24326	79178	756700	3.2	13.7	23.5	2560484	24738.02	105257.09
1998 .....	17835	67094	777900	2.3	10.9	21.0	2488737	29303.74	139542.30
1999 .....	10419	50363	797600	1.3	7.6	17.1	1192560	19620.28	114460.12
2000 .....	3035	22280	812800	0.4	3.1	12.0	204248	8068.26	67297.53
<b>TOTAL .....</b>	<b>243262</b>	<b>744584</b>	<b>7241300</b>	<b>3.4</b>	<b>13.6</b>	<b>24.6</b>	<b>27485358</b>	<b>27823.53</b>	<b>112986.65</b>

EXHIBIT D: PREMIUMS EARNED AND LOSSES INCURRED 1976-2000

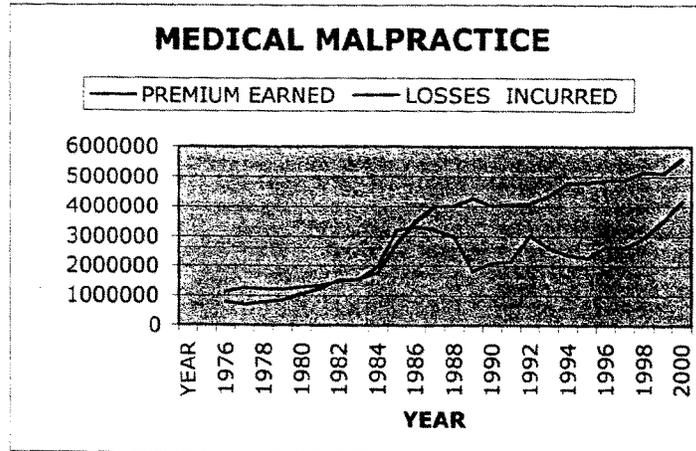


EXHIBIT E: MEDICAL MALPRACTICE INSURANCE PROFITABILITY 1991-2000

PROFITABILITY DATA—RETURN ON NET WORTH

Year	National Return
1991 .....	15.9
1992 .....	15.5
1993 .....	15.3

EXHIBIT E: MEDICAL MALPRACTICE INSURANCE PROFITABILITY 1991-2000—Continued  
 PROFITABILITY DATA—RETURN ON NET WORTH

Year	National Return
1994 .....	13.7
1995 .....	12.7
1996 .....	12.6
1997 .....	12.6
1998 .....	7.6
1999 .....	5.1
2000 .....	5.4
Average ROR .....	12.3

Source: Profitability By-Line, By-State, National Association of Insurance Commissioners, 2000 Edition.

Mr. BILIRAKIS. Thank you, sir.  
 Mr. Schwartz. Your mike, please.

**STATEMENT OF VICTOR E. SCHWARTZ**

Mr. SCHWARTZ. Chairman Bilirakis, Ranking Member Brown, members of the committee I appreciate your inviting me here today to talk about the medical malpractice crisis. I've studied liability law as a law professor. I've practiced law for the plaintiff's side for 15 years. The past 22, I've been on the defense side. I also chair the Public Policy Group at Shook, Hardy, & Bacon. I served as General Counsel to the American Tort Reform Association, but today my views are my own, not that of the association or any member.

One reason why the committee thought it would be important for me to testify today is that some quotes of mine have been put before this committee and the Judiciary Committee, that medical malpractice liability reform in H.R. 4600 will do no good. Those quotes were taken from statements I've made about another bill which had no limits on damages. When I heard about this, I felt actually good. In Washington, first you're not quoted, then you're quoted. Then you're misquoted. Then you're quoted out of context. That's when you've made it, so I thought there was something satisfactory about that, but I thought I should clear it up.

The bill is going to limit damages to \$250,000 pain and suffering is going to ultimately have an effect on insurance. I don't think the bill should be passed simply to limit insurance costs. I don't think that's right. I think the first thing with tort reform that it should be fair and it should be balanced.

A bill such as H.R. 4600 can limit insurance costs because it limits the amount of payouts. Some members pointed this out. You don't need to study tort law for 3 decades to figure that out.

Mr. Deutsch, other members raised the issue why not let States do it. My view about medical malpractice has been that the States should do it. The problem is, and it was adverted to by some of the witnesses, that State tort reform, in key States that you're looking at, like Arizona, Nevada, Illinois, Ohio, has been decimated by State Supreme Courts holding these laws unconstitutional under State constitutions. When they do that, there is no way you can get a review of the decisions because they use State constitutions and you cannot get to the Supreme Court. Even the Washington Post calls it judicial nullification. The Harvard Law Review has roundly

criticized these decisions. We've done an article on it. We'll submit it to the committee for the record. But the answer to the question of why not let the States do it, is it's been shown that the States can't do it. And a handful of States can undermine the total national picture.

Mr. BILIRAKIS. If you would submit that article to the committee and without objection, it will be part of the record.

Mr. SCHWARTZ. We will.

Mr. BILIRAKIS. Thank you.

Mr. SCHWARTZ. Another myth is that someone that insurers are all going to go to the bank and create a big raid once you pass this bill. This committee back in 1981, then in 1986, passed the Federal Risk Retention Act. It was not mentioned by anybody today. I'll bring it to your attention because it's extremely relevant.

If insurers do not really reflect the savings that would be brought about by your bill, doctors have a ready alternative. They can self insure or they can group together and purchase insurance on a group basis. The Doctor's Company, which is a principal insurer, is a mutual. It's owned by the doctors. So they're not there to cheat their members or not pass along savings brought by tort reforms.

The final thing, and I've heard it many times, is that the tort reform won't be effective, it won't do any good. I heard the same thing about the General Aviation Recovery Act in 1994, which was signed by Bill Clinton, which limited the liability in a constructive way of the general aviation industry. I was told in the Senate Room that they would be papier maché airplanes that fall out of the sky, that nothing would happen.

Well, let me share with you what happened and we will submit an article that shows this. This Congress passed a tort reform. It's the only real Federal tort reform that affects a substantial business in the United States. It brought back Piper. It brought back Cesna. It produced 25,000 jobs and there has not been one Member of Congress on either side of the aisle that sought to repeal that bill, because they know if they did they would be in the paper for repealing a bill that was effective.

So civil liability reform of this type can be effective. It can achieve the goals you wish. I'd be happy to answer any questions that you might have. I realize there's a limited amount of time, but I would value answering questions because there were a lot of things said this morning that really deserve a clear, concise answer.

[The prepared statement of Victor E. Schwartz follows:]

PREPARED STATEMENT OF VICTOR E. SCHWARTZ, SENIOR PARTNER, SHOOK, HARDY & BACON, L.L.P.

Thank you, Mr. Chairman, and members of this Committee, for your kind invitation to testify today about the medical malpractice liability crisis.

By way of background, I wish to share with you that I have practiced and taught in the area of liability law for over three decades. For almost fifteen years, while teaching, I worked exclusively for injured parties. Since 1980, I have been affiliated with law firms that have primarily defense practices. I am now a senior partner at Shook, Hardy & Bacon, L.L.P. and chair its Public Policy Group. I am senior author of the Nation's leading torts casebook, and have had the privilege to serve on each of the Advisory Committees in the American Law Institute's project that is restating the law of torts for this new century.

I serve as General Counsel to the American Tort Reform Association (ATRA), but the views that I am sharing today are my own, not those necessarily shared with members of ATRA or of the various medical groups that are seeking this reform.

One reason why some members of the Committee thought it would be helpful for me to testify here today is because purported quotes that I made about the medical liability system and medical malpractice have been placed before this Committee by other witnesses. When I read these quotes, it reminded me of a wise insight given to me by my former minister, Burt Sikkelee. In his sermons, he admonished our congregation that "something not in context is pretext." In that regard, it has been suggested that my views are that a bill such as H.R. 4600 would do nothing to reduce the burgeoning insurance rates and premiums faced by physicians and other medical providers throughout our Nation. This suggestion is simply not true. I have attached a letter regarding this issue we sent to Mr. Nadler, your colleague on the Judiciary Committee. I would like to take a moment to share my response with you.

Some of the comments that have been quoted to you were made about a completely different piece of legislation that contained no strict limits on the amount of damages a plaintiff would receive. Instead, these comments related to a product liability bill considered by this body in 1998. That 1998 bill contained general principles of tort law and sought to provide a badly needed balance between plaintiffs and defendants in our legal system.

Again, that 1998 bill did *not* contain provisions for strict limits on damages which ultimately help reduce insurance rates. Reducing insurance rates is an important consideration, but it is not and should not be the sole guiding light for enacting tort reform.

First and foremost, tort reform should be fair and balanced, and meet the needs of both plaintiffs and defendants. If it is not fair, it is not good.

Having studied the subject of torts from both perspectives of the court aisle, I believe that tort reform can be fair to both plaintiffs *and* defendants and that tort reform can achieve stability in the insurance market. Meaningful reforms such as those in H.R. 4600 will help bring a degree of predictability and fairness to the civil justice system that is critical to solving the growing medical access and affordability crisis.

#### WHY NOT LET THE STATES DO IT?

When it comes to the specific area of medical malpractice, in the past I have believed that this should be the exclusive function of the States. Medical malpractice insurance rates are often set on a state-by-state basis, where state controls could lower costs. That good premise and that good practice has been upended in recent years, because when States have passed balanced medical malpractice reforms, they have been nullified by state courts under obscure portions of very lengthy and prolix State Constitutions.

I am submitting to this Committee a law review article that was authored by my colleague, Leah Lorber, and myself that was recently published in the *Rutgers Law Review*,<sup>1</sup> and ask that it be made a part of the record. The article demonstrates that these decisions do not represent sound State Constitutional law, and also that they trespass on the Federal Constitution itself. It is very pertinent to note that not one of these decisions held a state medical malpractice law unconstitutional under the Constitution of the United States; they would be upheld under that Constitution.

The state courts that have nullified state tort reform are in key areas, such as Arizona, Illinois, and Ohio, all of which have situations that cry out for medical malpractice reform.

In Arizona, for example, USA Today reports that the medical liability crisis has forced the maternity ward in Bisbee, Arizona, to close its doors. Expectant mothers must drive more than a half hour to the nearest town to deliver.<sup>2</sup> In Ohio, a general surgeon named Dr. Joan Palomaki was scheduled to close her practice on June 30, the day before the price she paid for medical liability insurance would have jumped 80 percent, to about \$45,000 a year.<sup>3</sup> Dr. Palomaki had spent 25 years performing biopsies, lumpectomies, mastectomies and other breast surgeries. Had she chosen to

<sup>1</sup> See Victor E. Schwartz & Leah Lorber, *Judicial Nullification of Civil Justice Reform Violates the Fundamental Federal Constitutional Principle of Separation of Powers: How to Restore the Right Balance*, 32 *Rutgers L. J.* 907 (2001).

<sup>2</sup> See Steve Freiss, *Malpractice gets costlier; Insurance rate hikes put doctors in a bind*, USA Today, Apr. 9, 2002 at D7.

<sup>3</sup> See Roger Mezger, *Insurance costs force doctors to quit*, The Plain Dealer, Feb. 18, 2002, at A1.

stay in medicine, Dr. Palomaki said she would have had to clock 1,000 office visits—half a year’s work—just to cover the cost of insurance.<sup>4</sup>

State court decisions to nullify legislative medical malpractice reforms trespass on the needs of others, a fact that can be readily appreciated by members of this Committee. For decades, this Committee has upheld both the principles and purposes of the Commerce Clause of the Constitution of the United States. Wayward action by a few courts in a few states should not undermine national goals, which is to have fair and balanced tort law, and affordable liability insurance.

At this point in time, the medical malpractice liability crisis is best handled at the federal level, with uniform principles, giving states some options to address provisions, such as the cap on pain and suffering damages, where state policy may provide rules that are appropriate for the individual state. This is the approach that is taken under H.R. 4600.

#### THE MYTH THAT INSURANCE COMPANIES WILL REAP THE PROFITS OF REFORM

I have read statements by the Center for Justice & Democracy and other organizations that suggest that if reform is enacted, either it will not be effective or if it is, that the benefits of tort reform will be wrenched away from doctors’ hands by commercial insurance companies. This is another myth that I wish to dispose of today.

Back in 1981 and then again in 1986, I worked with members of this Committee to support the Federal Risk Retention Act. Those members of this Committee who served at that time will recall that I sought the enactment of risk retention, so that if a tort reform were enacted into law, we could assure all Americans that the benefits of that reform would go to those who need it—the doctors and, in turn and in this instance, the very important needs of the patient who seeks and needs medical care at affordable cost. If commercial insurers were to reap and hold profits that arose from tort reform, the Federal Risk Retention Act would provide a ready vehicle for doctors’ groups to form their own insurance pool or band together to form insurance purchasing groups to shop among commercial insurers for a better price. There already is in existence The Doctors Company and other mutual insurance groups that can help guard against that possibility.

It has been noted that on occasion when state tort reforms have been enacted, insurance premiums for doctors did not immediately drop. From what I have suggested, that is wise rate-setting policy by commercial, mutual or doctor-owned insurance companies. We now know that state reform may last for a very short period of time, up until it is nullified by a state supreme court. If an insurance company, again a commercial or mutual company, were to lower reserves based on a tort reform that would be subject to nullification, doctors, patients and our Nation would not be well served.

#### CAN TORT REFORM BE EFFECTIVE?

It has been strongly suggested by the Center for Justice & Democracy and other organizations that bills such as H.R. 4600—or tort reform in general—are not effective. I heard the very same argument from other groups in 1993, when we sought enactment of the General Aviation Revitalization Act, signed into law on August 17, 1994 by President Bill Clinton. This was an act to address a crisis that occurred in general aviation. The crisis had some interesting similarities to that faced by physician insurers. The tort system had gone haywire, and was driving the general aviation industry out of business; Piper, Cessna and other companies had stopped producing planes. The promise of tort reform was that it would bring back stability within the industry. I am pleased to share with you today a very important fact: a promise made was a promise kept. Those companies are now back in business; over 25,000 jobs have been created.<sup>5</sup> We will submit to this Committee an article to be published in the *Journal of Air Law and Commerce*<sup>6</sup> that details the effectiveness of federal tort reform.

A bill such as H.R. 4600 can have appropriate and salutary benefits for patients, doctors and the medical system in the United States. Doctors are leaving practice because insurance is unaffordable. Specialists such as OB/GYNs are particularly hit hard. Even professionals who are merely providing care for patients, such as nurs-

<sup>4</sup>See *id.*

<sup>5</sup>See General Aviation Manufacturers Association, *Five Year Results: A Report to the President and Congress on the General Aviation Revitalization Act* (1999).

<sup>6</sup>See Victor E. Schwartz & Leah Lorber, *The General Aviation Revitalization Act: How Rational Civil Justice Reform Revitalized an Industry*, *J. of Air L. & Com.* (forthcoming 2002).

ing homes, have seen insurance soar and have had to go without insurance or close their doors.

CONCLUSION

I have kept my remarks brief because my points, which while I believe are important are very simple. Tort reform should be enacted if it is fair and balanced. A bill such as H.R. 4600, which seeks to achieve that balance, will have an important effect on insurance rates, just like MICRA had positive impacts in California, and the General Aviation Revitalization Act of 1994 had beneficial effects for the aviation industry in America.

The commercial insurance industry will not steal greater profits for benefits that should go to all Americans. That will not take place, but if it ever does, we have a guardian at the gate: doctor mutuals and the Risk Retention Act, to ensure that the benefits of this legislation will help all Americans.

It is true that there is one group that will steadfastly oppose this legislation under any and all scenarios, those who earn their living by suing people. If I still earned my living that way, I would be concerned about it too. The medical malpractice crisis is pervasive. The needs of our country should be put first, and this Committee should move forward this legislation as soon as possible.

Thank you for your attention.

Mr. BILIRAKIS. Thank you, Mr. Schwartz.

We have three votes, and I think it would be wise to break. You haven't had lunch, too. I was able to grab a piece of pizza in the other room. But in any case, we'll break, for three votes which constitutes a good half hour, so maybe you all can take a break. I apologize. I'm sorry for those who aren't accustomed to doing this, this is routine up here, unfortunately. We have these votes so we got to make them. We will return right after the third vote in a half hour or so.

[Brief recess.]

Mr. BILIRAKIS. Mr. Hurly, you are the chairperson of the Medical Malpractice Subcommittee within the American Academy of Actuaries, right? I think that was a yes.

Mr. HURLY. Yes, sir.

Mr. BILIRAKIS. Let's see, you weren't hired. You're not being paid for testifying here today?

Mr. HURLY. No.

Mr. BILIRAKIS. Is an actuary ordinarily hired by an association or by a company or whatever the case may be to give answers to various questions?

Mr. HURLY. Frequently, yes. My capacity here today is as a member of the American Academy, I chair the committee that I described, the Medical Malpractice Subcommittee of the American Committee, and therefore it's part of a voluntary participation as a member of the Academy that I'm here today.

Typically, my job is I'm a consulting actuary, so I do work for companies or self-insured programs, hospitals and things like that that would be interested in sorting out what their medical liability is.

Mr. BILIRAKIS. Okay, your submittal here, your written statement, which certainly is professionally done, in charts a, b, c, d, contributing factors, introduction, then and now, et cetera, et cetera. All that was done by you in conjunction with your testimony here today. Is that right?

Mr. HURLY. That is correct.

Mr. BILIRAKIS. That is correct. So you were not asked to do that by either the American Medical Association or medical profession by the insurance profession, by the majority up here?

Mr. HURLY. No, actually I started to draft a document that was like this awhile ago at the request of some folks who were interested in getting an overview of what was going on and that just formed the basis for this, but this was written specifically for this purpose.

Mr. BILIRAKIS. Sir, you were in the audience. God knows you were in the audience for all those hours just waiting patiently.

Mr. HURLY. I remember that, yes.

Mr. BILIRAKIS. And you heard Dr. Roberts testifying about his rates having doubled and how he's heard that they will doubling again next year, that sort of thing. Why are insurance commissioners of the States allowing something like that to happen?

Mr. HURLY. Well, as you know, the regulators in the States have, depending on the State law, the opportunity either to approve prior to the implementation of rates or review after the implementation of rates whether the rates are adequate, not excessive, and not unfairly discriminatory.

Mr. BILIRAKIS. That is inconsistent. In other words, some States require them to approve them before they go into effect and others do it after the fact?

Mr. HURLY. That's correct. Depends on the law of the State in question. In the case of West Virginia, it's a prior approval State, and so rates need to be filed in advance. They are subject, if they are greater than 10 percent to a rate hearing which is open to the public and is held under the auspices of the Insurance Commissioner of the State. In the case of West Virginia, there is an actuary retained by the State to review the filing that's made and then finding of fact made by the Hearing Officer based on the request for a rate change. So they're subject to the review of State regulators and their approval.

Mr. BILIRAKIS. All right. In your experience, how would you say the State insurance commissions, regulators function? Do they—do some function in your eyes better than others in terms of allowing increases in terms of decreases? I don't know if they do decrease at all in lieu of the fact there may be some documentation to show loss in other words or whatever reduction in claims, etcetera. Do some reduce?

Mr. HURLY. If the question is do some State regulators reject the rate increases that are filed and adjust them to lower levels, the answer is yes, they do. In the case of West Virginia, for example, the rate increases and then filed by the most significant writer in that State had been reduced the last couple of times that they've made filing. So they'd win for a rate increase of 25 percent and that would get 15 approved by the State. So the State is looking at these rate applications carefully and making a determination. And some States are more aggressive and more particular about that than others. Others believe the market should be allowed to operate and may not be as, I guess, careful in reviewing those.

Mr. BILIRAKIS. Do any of them on their own volition look at the rates? For instance, is it only when an application is made by an insurance company that they would take a look at them? Or lets

say, for instance, do any of them take a look and say, well claims have dropped? You know, whatever all that data is for the past year or whatever and they therefore are going to decrease the rates? Does that happen at all?

Mr. HURLY. As a practical matter, once rates are filed and approved, they stay in place as a general proposition until a company comes in and requests a change in those rates, whether they be a reduction or an increase, those rates would stay in place until such times the company would file again.

Mr. BILIRAKIS. All right, now the rates in West Virginia that have doubled for Dr. Roberts, have you looked at those at all? You haven't had an opportunity to look at those, come to any personal conclusion as to whether they were right in doing so or right in looks like maybe doubling them again or whatever?

Mr. HURLY. I can't speak to the specifics about that particular rate application. I've done work on malpractice exposure in the State of West Virginia, but I have not reviewed that particular rate analysis. I do believe there was a correct statement of how the BRIM program works, and that it is a State run facility and how those rates were determined. But I can't speak to the actual rates.

Mr. BILIRAKIS. Many members of the minority, Mr. Brown and others, and I'm really not at all displeased that they have, because the intent here is to do what's right. Yes, I think the original focus was intended and has been on the legislation and on the litigation and that sort of thing. But they brought in this insurance business and what not, and we would be wrong to not look at the overall picture. But the insurers statement, insurers are increasing rates because of investment losses particularly their losses in the stock market. Now I know you've covered this in your written statement, very briefly though. Right, wrong? Possible, impossible?

Mr. HURLY. The answer is no. They cannot increase rates in response to prior losses in the stock market or in their investments. They can't recoup investment losses in pricing prospectively for coverage that they will provide in the future. From actuarial standpoint, it's an actuarial standard of conduct. You can't do that. You make prices prospectively considering what you think is going to be in place prospectively, not based on your investment losses from prior periods.

Mr. BILIRAKIS. All right, you say they can't do that because of the violation of actuarial standards. Do any of them do that? Might any of them have done that?

Mr. HURLY. Not to my knowledge, not that I have seen, no.

Mr. BILIRAKIS. Okay. There are others. My time is really up, but companies operated irresponsibly and caused the current problems. Companies are reporting losses to justify increasing rates, etcetera. We've heard that all day today, that sort of thing. And I don't disagree. I would raise the questions where any of that is possible, possibly in the process of others questioning I might have an opportunity to get at that.

Mr. Brown, to inquire.

Mr. BROWN. Thanks, Mr. Chairman. We noted earlier that, and I come back to this because I'm still sort of intrigued by this, this question really is for you, Mr. Schwartz, I think that on page 10 of H.R. 4600, there's language the amount of punitive damages

awarded in health care lawsuit may be up to as much as two times the amount of economic damages awarded, on and on. So I come back. I want to make sure I understand this, and you have great expertise in tort law, obviously. If it means that someone so that candid, if a doctor harms Ken Lay, the punitive damages are higher than if the doctor harms in exactly the same way and the same body part or the same injury, whatever, the woman that empties the waste basket in Ken Lay's office. It strikes me as peculiar in a country that sort of put the 3/5ths rule which is in our Constitution behind us that some human beings are only worth 3/5ths of another human being. This isn't economic damages of what you're going to earn. This is to punish the provider that made the—committed the negligent act.

Is this something we see in tort law? I'm not a lawyer and I'm hardly an expert in tort law. Is this a common sort of thing in our law?

Mr. SCHWARTZ. No, it isn't common. Most States don't have caps or limits on punitive damages. Some do. And there's a variety of ways to treat them. The Supreme Court has said in one opinion, and there are many opinions on this—we probably don't want to get in depth. At some point, the ratio of punitives to compensatories could be so extreme that it's close to the line of being unconstitutional. And the court has talked about four to one and five to one. But there the court was talking about compensatory damages which include both economic damages and damages for pain and suffering.

Mr. BROWN. Do you support this part of that bill to—

Mr. SCHWARTZ. Do I personally support it?

Mr. BROWN. Yes.

Mr. SCHWARTZ. I think one has to make sure that punishment is adequate for a defendant and I would want to give some thought to this. I wasn't really asked to comment on the details of the bill and I've not supported ratios in the past that would be based on punitives to purely economic losses. So the answer would be that is not something I've supported in the record, no.

Mr. BROWN. I appreciate that. I wasn't really here to talk about 4600 either and—

Mr. SCHWARTZ. I want to mention one thing because you asked a lot of questions about it and I thought your questions, I'm surprised you're not a lawyer because your questions were really many of them on the mark. And that is economic losses versus non-economic losses. Believe me, this is a complex thing. There are a lot of things in the law that are economic losses, somebody who is not a lawyer wouldn't think of as economic losses. For example, somebody who is at home, a house wife or house husband, they're not earning anything. So one might think they have no economic losses. But that's not the way it is if you're a plaintiff's lawyer. I used to be able to jack those things up to \$60,000, \$70,000, \$80,000 a year. I'd break down on a chart everything that the woman, it was mostly women at the time, did, to cooking, nursing care. So I can build their economics up very high.

With a child, as somebody mentioned a child earlier, you can take the child and you bring in neighbors and people who knew

him or her, show his promise of economic losses in the future and build him up very, very substantially.

So some of the remarks about the focus on economics are probably misplaced, or that people haven't tried cases. So that the distinction that's made in the bill is an honest distinction. You're not leaving somebody high and dry simply because they may not, at that point in time, have a job. And a final point on this, is that the California statute was not going to work miracles. Once the plaintiffs' lawyers, and I was one, they do good work. They're smart. They readjust. Figured out what the situation was. They moved a lot of things that used to be deemed pain and suffering into economic losses. So sure MICRA saved money, but it didn't save a huge ton because thing that had previously been regarded as pain and suffering damages were put into economic losses, and I think the record should reflect that.

Mr. BROWN. Thank you. I have one question, Mr. Plunkett. One of the witness's referenced the departure of St. Paul from the malpractice market. Are there other reasons why St. Paul left the market?

Mr. PLUNKETT. I don't know. I know that they were the largest provider of malpractice insurance. I actually don't know much about their departure from the market.

Mr. ANDERSON. Perhaps if I could offer a partial explanation of that. I am at least somewhat familiar with it. St. Paul lost more than a billion dollars in the year 2001 in excess claims costs over and above the premium. Not investment market losses, not stock market losses; it lost more than a million dollars in actual paid, it had losses, in excess of approximately a billion dollars in excess of the amount of premium that it collected.

Really what St. Paul was saying, that despite the fact that it was the largest carrier of malpractice insurance in the United States for the better part of 2 decades, that the insurance market had become so unpredictable in the United States, that they, despite 2 decades of work in the industry, were unable to predict what adequate premiums would be. And they were unwilling to put their shareholders at risk.

Mr. BROWN. They lost tens of millions of dollars on Enron too, did the not?

Mr. ANDERSON. I don't know what they lost in Enron. I know what they lost in medical malpractice which I thought was the subject of the hearing. They lost more than a billion dollars in paid claims in excess of the premium taken in the year 2001. They didn't choose to exit other lines of insurance. They chose to exit malpractice insurance.

Mr. PLUNKETT. Mr. Brown, since the subject has been brought up, let me mention this. There had been concerns that St. Paul moved too fast to expand into too many States, to take advantage of the positive environment in the 1990's for medical malpractice insurance and that they overreached. In particular, that they underpriced premiums, and then when losses started increasing moderately, they started increasing. They weren't in a position to deal well with that financially.

Mr. BROWN. Thanks, Mr. Chairman.

Mr. NORWOOD [presiding]. Mr. Greenwood to inquire.

Mr. GREENWOOD. Thank you, Mr. Chairman. I want to quickly follow up on something. There's been an awful lot of talk throughout this hearing about blaming the insurance industry and saying the real reason we have these outrageous rates is because the insurance industry lost so much money in the stock market that they had to make it up. Now is there a grain of truth to that?

Mr. ANDERSON. Barely and probably actually less than a whole single grain. Insurance is a highly regulated industry, and insurance company investments are regulated carefully and in detail by both insurance commissioners and the National Association—

Mr. GREENWOOD. Since my time is very brief and I have a lot of questions less than a half a grain. Mr. Hurly, you said that they can't recoup, that the State insurance commissions don't allow insurance companies to put into their rates past losses, right? It wouldn't make a jot of difference if St. Paul or anybody lost \$100 million to \$200 million in Enron or anywhere else in terms of how they set their rates. Is that you've testified?

Mr. HURLY. Yes.

Mr. GREENWOOD. Mr. Schwartz, is it possible that there's anything built into the rate of an insurance company that has anything in your opinion, that has anything to do with past losses in the insurance industry, excuse me, in the investment market?

Mr. SCHWARTZ. If the insurance commissioners are doing their job, no.

Mr. GREENWOOD. Mr. Plunkett, do you disagree with these other three gentlemen on that point?

Mr. PLUNKETT. Sadly, yes. Investment income affects reserves. Reserves affects operating income. The combination there is especially potent for medical malpractice because you have a longer lag time for medical malpractice, a pay out period of 6 years than you do for other types of insurance. So it actually does have an impact.

Mr. GREENWOOD. Mr. Anderson, Mr. Hurly, would you care to refute or agree with Mr. Plunkett in that regard?

Mr. ANDERSON. Investment income does not affect reserves. Reserves are set based on the actual anticipated value of a case. It has nothing to do with investment income. Any decrease in investment income is simply money that is no longer available to subsidize the premiums of medical malpractice insurance.

Mr. GREENWOOD. Mr. Hurly, is Mr. Plunkett right or is Mr. Anderson right?

Mr. HURLY. I would agree with Dr. Anderson.

Mr. GREENWOOD. Mr. Anderson is right. Okay. So Mr. Hurly, what goes into, what are the components of a rate that a company gets to charge a premium that gets a charge? We know that they don't even, in that premium is less than they expect to pay in payouts, right?

Mr. HURLY. That's generally correct, yes.

Mr. GREENWOOD. So that premium, so then out of their future investments they have to get all their operating costs and any profit. Is that correct?

Mr. HURLY. Well, that's not always the case. What they'll do is they'll build a rate that includes lost costs and expenses of operating their company. In general, though they anticipate that they're going to lose money, the combined costs of operating the

company and paying losses is going to be greater than the premium they collect and they offset that with investment income. But it may be that the loss ratio is like 90, 95 percent on an undiscounted basis and expenses are 20, 25 percent, something like that.

Mr. GREENWOOD. There's a draft Democratic bill that's called the Medical Liability Insurance Crisis Response Act of 2002 that I think is going to be offered up as an alternative to H.R. 4600. One of the things that they proposed to do is freeze in medical malpractice insurance rates, effective on the date of enactment, rates would be frozen at the level of January 1, 2002 until 6 months after the filing of the Commission Report.

What would a 6-month freeze in insurance premium, what would be the impact of that, Mr. Anderson? Dr. Anderson?

Mr. ANDERSON. Well, I think it would be devastating. I think we've heard allegations before the committee today that the malpractice industry was derelict for not raising rates sooner, which is a notion that I find very difficult to understand. It's hard to know why having today's sky high malpractice rates sooner would make them more palatable.

Mr. GREENWOOD. The bill also provides, says this—preventing medical malpractice insurers from exiting the market. Any insurer who exits the medical malpractice insurance market must also stop offering all types of insurance.

Mr. Hurly, what do you think about that?

Mr. HURLY. I think it's peculiar. I don't see that as a—

Mr. GREENWOOD. That's kind of an understatement, isn't it?

Mr. HURLY. Yes, I think so. I don't want to use poor legal terminology here. I'm not a lawyer, but it sounds almost confiscatory and sort of binding the company to do something that's inconsistent with good financial activity.

Mr. GREENWOOD. Mr. Plunkett, since you don't support the tort reform approach, do you concede that the rates are outrageously high in places like Pennsylvania? You agree with that, don't you?

Mr. PLUNKETT. We have a rate problem in some States. Absolutely.

Mr. GREENWOOD. A rate problem. Now, you don't think the tort reform is the way to solve the rate problems, so could you outline for us what insurance reforms you think would solve this problem?

Mr. PLUNKETT. Absolutely. We've proposed a number of items at the State and the Federal level. And some of them are unique and recognize the problem; for instance, that the high risk specialties you've heard about so much today, the obstetricians and the neurologists, some of the specific problems that they face. For example, in the written testimony as you have probably seen, we suggest that the States consider a sort of a fee based on risk that would be adjusted, which—

Mr. GREENWOOD. What fee?

Mr. PLUNKETT. It would be a fee that insurance companies would assess, that they would assess it on all physicians. It would be based on the risk of the specialty, so a higher fee for a higher risk—

Mr. GREENWOOD. What's the difference between a higher fee and a higher premium?

Mr. PLUNKETT. It could possibly mean that for general practitioners and internists and those who are practicing much lower malpractice rates at this current time, but are doing what we call referring up. The problem with some of these specialties is that they're seeing patients who are of the highest risk, because neurologists and neurosurgeons are having referred up to them from other practitioners, patients who if there's a minor error—

Mr. GREENWOOD. You would have the family doctor pay higher insurance rates to lower—

Mr. PLUNKETT. The family doctor, Mr. Greenwood, is actually benefiting from the medical malpractice structure a little bit. So I'd have them pay a little bit. Yes, absolutely. And that would actually deal with some of the problems that we've heard today where we have obstetricians leaving practice. Where we have neurologists who are facing medical malpractice insurance premiums that are extremely high. It would be a slight subsidy for those high risk specialties recognizing that all physicians are part of the care that these patients get. Only some of them are taking the risk.

Mr. GREENWOOD. My time is expired, but I invite you to come to Pennsylvania and you'll find out that there are no physician categories that aren't gouged as it is. And there's no room to simply transfer the premiums downward to the family practices. They're already struggling.

Thank you, Mr. Chairman.

Mr. NORWOOD. Mr. Stupak, you're recognized for 5 minutes.

Mr. STUPAK. Thank you, Mr. Chairman.

Dr. Anderson, you talked a lot about St. Paul and I believe you said that St. Paul was the, business was exclusively medical malpractice but everything I've seen—

Mr. ANDERSON. I didn't say that.

Mr. STUPAK. You didn't say that. Okay. Ten percent of their business is medical malpractice. Ninety percent is insuring others. So when they lost \$108 million on Enron, it had to be picked up somewhere. We're not saying it was in the medical malpractice field, but somewhere. If you lose money, next year you got to pick up that loss somehow, right?

Mr. ANDERSON. That's your testimony. That's not my testimony. What I pointed out was that St. Paul lost more than a billion dollars in medical malpractice paid lawsuits. They chose not to exit other lines of business to limit their loses. They chose to exit the sale of medical malpractice insurance.

Mr. STUPAK. And St. Paul, between 1992 and 1997 released \$1.1 billion from the reserves, reserves that were set aside. They released it, which certainly hurt their malpractice business and made their bottom line and their profit look very well. But if you have a run of claims, it's going to hurt you if you release \$1.1 billion from your reserves.

Mr. ANDERSON. I'm sorry sir, but that logic is incorrect. I can talk to you about it in detail if you'd like me to take the time.

Mr. STUPAK. Well, sir, I refer you to the Wall Street Journal article, June 24, 2002, because that's exactly what they reported as happen and that's what caused sort of a run under claims for medical malpractice.

Mr. ANDERSON. I think it would be a great mistake for this committee to accept the article in the Wall Street Journal as representing fair, appropriate, and balanced evaluation of the situation before it today.

Mr. STUPAK. Well, if you look at also their statements for those years, like last year they had \$1.8 billion where 10 percent come from medical malpractice. If you look at their financial statements and go back and see what happened, I think would verified the Wall Street Journal article.

Anyway, moving right on. Mr. Schwartz, you know about the Medical Liability Monitor magazine?

Mr. SCHWARTZ. I've heard of it. It is not something that I have read, sir.

Mr. STUPAK. Is it a credible source for a magazine?

Mr. SCHWARTZ. I have no idea. It's not something that is in my reading box every week.

Mr. STUPAK. And you have not relied on it then?

Mr. SCHWARTZ. No, I have not sir.

Mr. STUPAK. The Medical Liability Monitor indicates that States without caps on damages and States with caps on damages, the premiums are actually about the same. So the caps found in 4600 here, how is that going to reduce the malpractice premiums?

Mr. SCHWARTZ. Well, I can't evaluate a source that I don't know anything about. I've been working in tort law for 30 years and I've never heard of that journal.

Mr. STUPAK. Well, then you can't dispute it either.

Mr. SCHWARTZ. Well, I just would say that where you have, there's a certain common sense approach to all of this, that if you limit damages in tort law to \$250,000 you do a number of things that are going to reduce costs. No. 1, obviously if a verdict—work with me on this. Before the thing is law, a jury can come back with a million dollars pain and suffering. Afterward, it can only come out with \$250,000. Ninety-five percent, or 97 percent in some instances of these cases are settled. Now I've been in a lot of settlement negotiations. Hundreds. And if there is a cap in a State, whether I'm on the plaintiff's side or the defense side, the perimeters of the settlement are going to be narrowed. They just are. So I don't know what this periodical showed, but as a matter of common sense, it should reduce cost.

Mr. STUPAK. The common sense is based on assumption based upon your experience, right?

Mr. SCHWARTZ. That's all I have, sir.

Mr. STUPAK. Well, than tell me this. Then tell me this. Michigan, which did pass medical malpractice with caps very similar to 4600, but yet the AMA still lists them as one medical malpractice crisis States. If these caps work so wonderful, and we've been at it about 10 years now, the verdicts would be through the system, why is Michigan still a crisis State?

Mr. SCHWARTZ. Well, it could be and one has to look at the Michigan verdicts and the Michigan experience that after a period of time, plaintiff's lawyers were able to shift enough costs into economic loss so it didn't make any difference. I haven't studied it, but I would say that would be the answer. And I haven't labeled Michigan as a crisis State. Michigan law, overall, is pretty fair. It's a

good court and it isn't a State that at least comes to my mind as being a crisis State.

Mr. STUPAK. Well, Michigan premium recoveries are \$85,000, this is based upon National Practitioners Data Base. Michigan, the medical malpractice pay out based on 2000 is \$85,000, where rest of the Nation is \$125,000. So they're actually about \$40,000 or almost a third less, but yet they're still considered a crisis. So you have less pay outs. You have the caps. But yet they are still in crisis.

Mr. SCHWARTZ. I would want to see what the criteria for crisis are.

Mr. NORWOOD. Thank you very much, Mr. Stupak.

Now I'll recognize Mr. Cox for 5 minutes.

Mr. COX. Thank you, Mr. Chairman.

Let me begin with Mr. Plunkett. Earlier, on the first panel, Lauren Townsend with the Coalition for Consumer Justice answered a question concerning trial or contributions to the Coalition for Consumer Justice, indicated that a significant portion of that organization's funding comes from trial lawyers. In California, the trial lawyers have changed their name to the Consumer Lawyers of California. Can you tell me whether or not the Consumer Federation of America takes trial lawyer money?

Mr. PLUNKETT. No, I can't tell you.

Mr. COX. Oh, you cannot tell me?

Mr. PLUNKETT. I don't know. But I can tell you this—

Mr. COX. How can we find out the answer to that question? I only ask this in the interest of full disclosure. Obviously, we have insurers sitting here, we have stakeholders, we have physicians and so on. And if we have lawyers being represented indirectly then we know that too.

Mr. PLUNKETT. Okay, here's what I can tell you. We have an annual awards dinner every year. Mr. Schwartz is a regular attendee. I think on occasion trial lawyers—

Mr. COX. I'm sorry, Mr. Plunkett. I'm asking a really direct question.

Mr. PLUNKETT. Not that I know of.

Mr. COX. Do you disclose your finances publicly? Is there a way for Congress or the public to find out who funds the Consumer Federation of America?

Mr. PLUNKETT. We can give you our annual report just like we will to anybody.

Mr. COX. Does that include that information of where the money comes from?

Mr. PLUNKETT. I don't know. I haven't looked at it recently.

Mr. COX. All right. Well, thank you for that non-answer.

Mr. PLUNKETT. The truth is if there's any, it's—

Mr. COX. I'm sorry, Mr. Plunkett.

Mr. PLUNKETT. Less than half of a percent. There's your answer.

Mr. COX. Actually, that's a very direct answer. So the answer is—

Mr. PLUNKETT. Well, why I tried to say Mr. Cox but—

Mr. COX. Half of a percent—

Mr. PLUNKETT. We have an annual awards dinner. That's the only time when we accept outside contributions. So if there's a per-

centage, it's tiny, tiny, tiny, and it's probably equivalent to what Mr. Schwartz here contributes.

Mr. COX. I'm sorry, outside contributions. And what are the other contributions?

Mr. PLUNKETT. Say, foundation grants and contributions from our members.

Mr. COX. And might those members include trial lawyers?

Mr. PLUNKETT. No, they don't.

Mr. COX. They're forbidden from contributing?

Mr. PLUNKETT. Members of the Consumer Federation include legitimate consumer groups. They include other members such as a credit unions and public power entities and our association. But we don't include trial lawyers.

Mr. COX. We'll try and figure out exactly where that all comes from so we know exactly what interests are being represented. But I appreciate that.

Dr. Anderson, the Doctor's Company which is a significant insurer in the State of California, my State, has been in the market throughout that malpractice crisis when Jerry Brown was Governor, when the democratic legislature enacted MICRA and he signed it into law. And you're still around in California. You haven't left. My understanding is the following, and please correct me if I'm wrong, that in constant dollars, the 1976 premiums on average for malpractice in California were \$23,000 and that today, the average premium, or at least in 2001 the average premium was \$14,000. Is that right?

Mr. ANDERSON. That is correct in constant dollars, yes.

Mr. COX. So in other words the premium is less now than it was a quarter century ago.

Mr. ANDERSON. That is correct.

Mr. COX. And that experience I take it is not unique to California, but is experienced in other States with similar kinds of tort reform?

Mr. ANDERSON. Absolutely true. Whenever we do an apples to apples comparison, we find the same thing. Colorado has precisely the same experience, Indiana has the same experience. States that have effective tort reforms have effective decreases in premium. The reason that the Medical Liability Monitor and the Consumer Federation of America and the Center for Justice and Democracy don't seem to be able to get hold of the fact that limits on non-economic damages decrease rates is because they're making fish to bicycle comparisons. The cap that we're talking about here is a \$250,000 cap on non-economic damages. Where ever that cap has been used results are dramatic. Obviously, they would be less dramatic if you have a million dollar cap. They will be less dramatic if you have a cap on punitive damages because punitive damages are rarely, if ever pled in medical malpractice cases. I point out that in general, punitive damages are not insurable, because insuring an illegal act is considered a moral hazard.

Mr. COX. Dr. Anderson, what is the nature of the law in California, what are the provisions, I mean, the main provisions of it.

Mr. ANDERSON. MICRA has four principal provisions. One is—

Mr. COX. I'm sorry, did I say California? I meant to say Colorado.

Mr. ANDERSON. Colorado has very similar reforms to California, generally limiting total medical liability damages to approximately a million dollars.

Mr. COX. And in Colorado, where the experience base is 1986 to 2002, the premium in constant dollars is \$30,000 back in 1986 and \$11,000 in 2002. Is that right?

Mr. ANDERSON. Yes, that's correct.

Mr. COX. So it's again lower by over 60 percent.

Mr. ANDERSON. Yes, sir.

Mr. COX. Now what year did Colorado enact this reform?

Mr. ANDERSON. 1986.

Mr. COX. So over the period of time since these reforms have been in place, not only have premiums not gone up, but they've been reduced by over 60 percent?

Mr. ANDERSON. In constant dollars, yes sir.

Mr. COX. I'm sorry, Mr. Chairman? I'm being informed that my time is up. I apologize to the other witnesses for not being able to ask more questions.

Mr. NORWOOD. But don't leave, we'll go around again.

Mr. Strickland, you are recognized for 5 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman. One of the reasons I think we have witnesses before this committee is to pick your brains and get your judgments, your best opinions. And we've heard here today something that really bothers me greatly. And that has to do not with the economic damages as such and not with the non-economic damages as such, but with the punitive damages, which are damages that are for the sole purpose of punishing or deterring inappropriate behavior. And we've been told that this bill allows in the area of punitive damages an amount two times the amount of the economic damages up to \$250,000, whichever of the two is greater.

Now I think that means that if you are a relatively poor person and you have been subject to bad behavior so that punitive damages are called for, that you've got the possibility perhaps of getting a little bit of money. But if you are a very successful, high income individual and you qualify for punitive damages, you have the possibility of getting a whole lot of money. I'm just interested in your opinion. And I'd like for you to tell me if you would as you go down the table there. Do you think this is fair?

Dr. Anderson?

Mr. ANDERSON. Punitive damages are rarely pled in medical malpractice.

Mr. STRICKLAND. But when they are. When they are, this is a theoretical question but, I'm trying to get at your best judgment and perhaps your values, I don't know.

Mr. ANDERSON. What this would imply is that punitive damages should be proportionate to the injury. This is a way of making that—

Mr. STRICKLAND. But it's based on the economic damages. It's not based on the severity of the injury as such.

Mr. ANDERSON. I beg to differ, sir. There is no limitation on actual damages as has been pointed out in previous testimony.

Mr. STRICKLAND. But this is based not on non-economic damages, but on economic damages which means that a person of low income

is going to receive less in terms of punitive awards than the person of high income.

Is that fair when the purpose of punitive damages is to deter bad behavior?

Isn't it appropriate that we have at least an equal punishment for bad behavior directed toward a poor person as we would have directed toward a wealthy individual?

Mr. ANDERSON. If the sole purpose of punitive damage is to punish the offender, it would have no relationship to whom they are paid, sir.

Mr. STRICKLAND. It would have no relationship to what, sir?

Mr. ANDERSON. To whom they are paid. If society wishes to use—

Mr. STRICKLAND. But the amount would, would it not? The amount would have a deterrent effect.

Mr. BROWN. Would the gentleman yield?

Mr. STRICKLAND. I would.

Mr. BROWN. Does this mean if a physician or physical therapist or whatever is working on a wealthy person providing some service that they're going to be a lot more careful because punitive damage will be higher, than if they're working on the wealthy person's maid, where they do injury to that person, punitive damages will be very little?

Mr. STRICKLAND. Reclaiming my time, I hope that's not the answer.

Dr. Anderson, could I get a yes or no or a I don't know answer from you to that question? I've given you three choices, yes, no, or I choose not to say.

Mr. ANDERSON. I'm sorry, sir. I don't find the question to be something that I can answer.

Mr. STRICKLAND. Do you not understand the question, sir? I'll explain it again if you do not understand it.

Mr. ANDERSON. Go ahead.

Mr. STRICKLAND. If you are a poor person and you are injured and the jury awards punitive damages, you're going to get less if you are a poor person than if you are a wealthy person.

Can you understand that?

Mr. ANDERSON. I understand your words. It is not necessarily the case.

Mr. STRICKLAND. Let's assume it is the case.

Mr. ANDERSON. That's your answer.

Mr. STRICKLAND. I don't think you want to answer me, sir, so we're going to move on. Next.

Mr. HURLY. As a representative of the American Academy, I'm not speaking on behalf of the Academy.

Mr. STRICKLAND. Sure, I understand that, sir.

Mr. HURLY. But it seems to me that punitive damages don't tend to be dealt with in medical malpractice cases because they're, in a lot of cases, not allowed.

Mr. STRICKLAND. But when they are, when they are should a poor person get less than a wealthy person? In your judgment sir. I'm just asking for your judgment.

Mr. HURLY. My personal judgment is that it should be not mitigated by whether they're poor or rich.

Mr. STRICKLAND. Thank you, sir. Mr. Hurly?

Mr. PLUNKETT. Plunkett.

Mr. STRICKLAND. Oh, I'm sorry, Mr. Plunkett.

Mr. PLUNKETT. Well, as with Mr. Brown, I'm also not an attorney. So I'm going to give you, we have also not taken a formal position on the Greenwood Bill because we're still looking at it. But in general, we are wary of this kind of tort reform. So here's your general answer. It doesn't make much sense to me to base punitive damages on the income of the person who's suing. Punitive damages should be based on the deterrent value.

Mr. STRICKLAND. Thank you. Next.

Mr. SCHWARTZ. I was asked that question by Mr. Stupak when you were out of the room. That's not an approach that I would advocate. I think there should be reasonable limits on punitive damages. I hate to see this bill sidetrack on what, as a practical matter, is a non-issue because as some of the witnesses testified, punitive damages rarely come in med. mal.

Mr. STRICKLAND. I know, but I want to tell you this single issue just bothers me greatly.

Mr. SCHWARTZ. I can understand that and hopefully—there's really three things here and it's very confusing although this morning having the 5 hours there allowed me to stop and think which once in a while I do. I had a good day, so I thought about it. There's three things going on here and everybody keeps mixing them up.

One, is there a problem? And there seems to be at least some consensus that there is a problem for some of the doctors.

Mr. STRICKLAND. There is.

Mr. SCHWARTZ. No. 2, whether this particular bill would be effective in addressing that problem. And there is considerable debate among the members as whether it would or not; whether in California it has worked or it has not worked. I think it's worked. That's my view.

And the third, which goes to your question, that last question. And that is, whether the contents of this bill are fair. And I think it might be helpful over time, as you talk among yourselves to keep those three things separate, because that third part I would say that's not an approach that I would advocate on punitive damage reform, which I believe in. And that goes to the part three.

Mr. NORWOOD. Mr. Strickland, your time is up I'm sorry to say.

Mr. Buyer, you're recognized for 5 minutes.

Mr. BUYER. Thank you. Mr. Schwartz, I want to thank you for your testimony. I'm relating to you. There are more thoughts, though, that we have examining this. I immediately came toward you in your thoughts when you spoke about States' rights, because that's where I am. And so I am concerned about the commerce clause and its applicability here and the Federal Government being involved in States' issues.

Federal Government, you know, reality is over the years depending upon whatever party is in control here in this town, we pick and choose. We really do. We don't like to admit that, but we do. We pick and chose when we should intervene and we're all politicians and we can justify just about anything.

So I'm interested in a reply about the constitutional question. The other is with regard to punitives. I'll just put on my lawyer's cap. Punitives really are in my opinion are about the punishment. And it has no idea about justice is completely blind. They have no idea about the face of that individual nor care about their well-being or economic standing. It was the conduct. So I'd just say to my colleague, Mr. Strickland isn't here, I guess he's moved. I guess I don't get as emotionally excited as you did on this one because I agree with you on it, but anyway, that's just the way punitives works out there as I know it, in the two States that I practiced in.

So I'm interested about the constitutional question. With regard to Mr. Anderson and Mr. Hurly, question for you is this idea on I have looked at, I cited to it earlier, this trend in 2001 rates for physicians, medical professional liability insurance. And as I look at all these increases in rates through all the jurisdictions of States, and those of whom have some type of cap, and they all got—it's a hybrid out there. And since you have the Doctor's Company, you're dealing with a lot of different ones.

But my question is to you those States that have made some form of an attempt, has there not been some form of an impact upon those premiums? Okay, so I've got a list of questions for both of you and Mr. Schwartz. And I hate to put it that simply, but we'll start with Dr. Anderson first.

Mr. ANDERSON. I think that's a very important point. Speaking for the Doctor's Company, but in general this is true for all the PIAA companies that insure in multiple States, it's very important to point out that the average rate increase in the United States in the year 2000 is about 10 percent. Doctor's Company actually less than that. In the 2001, it's between 10 and 20 percent. The astronomically high rates that are now being demanded are solely being demanded in areas where there is unlimited liability in which we have now entered a new era of nine figure hundreds of million of dollars a malpractice suit. So this is not a problem in every venue. It is only a problem in venues which now have unlimited damages.

I would point out that even in the State of Nevada, there is a big difference between rates in Clark County, which is exceptionally litigious with a very active plaintiffs' bar, and Reno, which is much less so. And the rates fairly reflect that difference.

Mr. BUYER. Why was it in Pennsylvania when the legislature increased the physicians' primary limits, then all of a sudden premiums increased also by 69 percent.

Mr. ANDERSON. I'm sorry, sir, I missed the question.

Mr. BUYER. In Pennsylvania it looks at though the legislature increased the physicians' primary limits up to \$500,000/\$1.5 million fund surcharge. And then also we also had these insurance premiums just skyrocket in Pennsylvania even though they have caps and a compensation fund.

Mr. ANDERSON. Because the liability picture in Pennsylvania has gone, because there was no check and really is to this day, no check on the limitation for damages in Pennsylvania, more or less out of the clear blue sky, the State of Pennsylvania has now entered a new era of \$50 and \$100 million malpractice verdicts.

As I pointed out, the city of Philadelphia alone in the last year has had four verdicts in excess of \$50 million. That is an enormous

burden to be placed on the limited number of physicians who carry that burden. It also means that any insurance company trying to set future rates must now be aware of what the upper limit of risk is. The alternative is to have the company go bankrupt.

I would point out that most of the companies whose names have been put before the committee already went bankrupt during the time when financial returns in the investment markets were highest. It didn't go bankrupt because they made bad mismanagement decisions or mismanaged investment funds. They went bankrupt because they thought they had a mechanism for pricing their insurance at less than the cost of the actual claims.

Insurance is not magic. Insurance companies cannot manufacture money. They must adjust premiums to match risk or they will not survive and patients will have no indemnity and physicians will have no insurance.

Mr. BUYER. Mr. Chairman, I see the lights have come on. I'd appreciate it though if Mr. Hurly and Mr. Schwartz could have the opportunity to answer those questions.

Mr. HURLY. As far as tort reforms, which is the second question you asked, I don't think Dr. Anderson addressed that. I think one of the clearest examples we have of the impact of tort reforms is the body of tort reforms that were passed in the mid 1980's which once they fed in through the system and companies began to get a feel for what their impact was going to be because companies will tend to defer until they figure out whether the tort reforms are going to be upheld, whether they're going to be effective and to measure that, companies did decrease the rates as they went into the decade of the 1990's, and that's part of the reason why rates went down during that timeframe. St. Paul, for example, I happened to run across a piece of paper, they reduced rates in 30 States in 1989 on average of 15, 20 percent across each of these States, and it was largely due to the impact of the implementation of these tort reform and the change in social consciousness, because tort reforms do have an impact on losses and companies will respond when indicated by adjusting the rates for the most part.

I think that is true and I agree with what Dr. Anderson said about the situation with the pricing. One thing about the Pennsylvania pricing that you mentioned, it's not clear from what you said whether you reflected the fact that when you increase the limits of coverage, you need to increase the price that's paid. And in the State of Pennsylvania they've iterated up their coverage over time from \$200- to \$300- to \$400- to \$500,000 as the primary limit. And part of that rate increase may have been the steps, part of the stepping process up to that limit of coverage, but I don't know that from what you said. So that notwithstanding, Pennsylvania has seen a deterioration in its loss experience and rates are responding to that deterioration.

Mr. SCHWARTZ. Mr. Buyer, there's an article written by former Judge Bork and actually a young man at the American Enterprise Institute, which I don't think is a liberal think tank, showing the commerce clause's effect in tort law. It's a good study. It's at 3 Harvard Journal of Law and Public Policy. And Judge Bork and his colleague show how the commerce clause today would be impacted

by the things that were discussed this morning, that medical malpractice crisis is not really isolated to one State.

The costs also that are borne by this are borne by this government and by laws passed by this Congress. So they make the argument that this is an area where the Congress of the United States can act.

Now, I agree with you around this great institution, States' rights is often in the eyes of the beholder. So merely because the commerce clause allows this, that doesn't mean that it should be done. The reason I think it should be considered very, very seriously is State tort reform right now is Russian Roulette. You never know whether a particular act is or is not going to be held unconstitutional, because it really depends on the vagaries of who's sitting on a State court.

In Ohio, they nullified a tort reform. In California, they didn't. In Florida, a lower court, they did. So how can one operate in something as serious as medical mal with that going on?

Moreover, if I were running an insurance company and a State passed a medical malpractice cap, I would not touch my reserves or my rates and premiums until I knew whether or not the issue would be held constitutional or not and that can take 4 or 5 years.

Mr. NORWOOD. Thank you, Mr. Buyer.

Mr. Schwartz, you're referring to it is found in States, various States, unconstitutional according to the State constitution.

Mr. SCHWARTZ. That's correct, sir. In State constitutions, and we'll submit this article to you. I just started to read them 10 years ago. I didn't read them in law school. They can be two or three hundred pages in length, and they have clauses in them that are extremely malleable. Something like open courts. An open courts provision to a Judge could say, well, the court should be open 24 hours a day. Or if you touch \$1 of compensatory damages, it's unconstitutional. And unfortunately for both sides, these decisions seemed to have reflected the elected Judge constituency who elected him.

So if he or she were elected by the business community, they're upheld as constitutional. If he or she were elected by our friends in the plaintiffs' bar, it's held unconstitutional. And that's where State tort reform is left right now, and it is not a pretty picture.

Mr. NORWOOD. Mr. Deal, you're recognized for 5 minutes.

Mr. DEAL. Thank you, Mr. Chairman. First of all, let me go back to the punitive damages issue that Mr. Strickland addressed and perhaps another point of view. In my State, and although I've been out of the practice of law now for 10 years by virtue my position here, our State passed an unusual provision. I say unusual, perhaps it's affected other States, and that is because punitive damages are, by their very nature, not really intended to compensate the victim, but rather to punish and therefore take on more of a criminal type fine approach rather than reimbursement or restitution, in products liability cases, our State I believe now requires that either two thirds or three fourths of that will be paid to the State. And as I recall, the challenge to this constitutionality has been upheld.

So Mr. Greenwood, I might suggest we might think about, in terms of punitive damages, having a portion of punitive damages

aesthete to the State to be used to help States pay the cost of their Medicaid program.

Mr. STRICKLAND. Would the gentlemen yield?

Mr. DEAL. Sure.

Mr. STRICKLAND. You know, that seems fair to me if the amount was the same regardless of the income of the individual. It's the discrimination that goes between—

Mr. DEAL. Reclaiming my time. I understand the point that you're trying to make. The point though also is that sometimes the amount of compensatory damages is not always based on the financial status of the alleged victim. In most times, it is based primarily on the extent of damage and injury, not the financial condition of the individual. Financial condition of the individual would primarily be an ingredient only when you're trying to calculate lost earnings or lost wages. And that, of course, has to have an actual factual basis for making that calculation.

Going back to something else, though. I would like Mr. Schwartz, and I thank you for being here today. I think all of us would like to know what effect these State statutes fixing caps have actually had in real terms on reducing the cost of medical malpractice insurance. And one of the procedural things that I have run across is, that in most instances, the jury is not advised of the existence of caps before they make their awards. Is that generally true?

Mr. SCHWARTZ. That's generally true, and the reason that that's done is there is a belief that if they knew what the cap was, that they would always award the cap. Now that belief may or may not be true, but when these issues are lobbied, one reason they're not told about it is that they always would move to the top of the ladder. Again, I'm not saying they would do it, but that's the reason that's put in the law so they're not informed.

Mr. DEAL. Does anybody have any information that indicates how much of jury verdicts that actually been written off as of a result of the caps? In other words, they return verdicts in excess of the caps but because they did not know the caps, the Judge was required to write off those verdicts.

Does anybody have any information as to how much those amounts might be? And if they are known, what effect would the write offs have on premiums had they not had the caps?

Mr. ANDERSON. The total amount is significant, which again proves the efficacy of the caps. The reason why there is no readily available figure is because the majority of medical malpractice claims in which there is recognized liability are settled. They don't go to court. Settlements do not break out the difference between economic and non-economic damages. But the settlements do reflect the upper limit of risk. In other words, a State like Texas which has a \$268 million verdict, your settlement costs will be higher than in a State like California where such a verdict will not have been paid.

Mr. DEAL. I recognize that any time you're negotiating something it's based on what is your achievable end in the long run.

Mr. Schwartz, if you would walk us through some other things, too. And these are procedural issues. Just as you don't tell the jury about the statutory caps, the debate is ongoing about collateral sources as to whether or not an injured plaintiff would have dis-

closed to the jury of course, what other collateral sources had paid for medical expenses, etcetera, and whether or not mandatory offsets should take place.

The argument on the other side is if you're going to do that, why not disclose to that same jury what the limits of liability of the insurance policy that the defendant is carrying also has so that they can take all of these outside sources into account.

Would you sort of walk us through the debates that have surrounded all of that?

Mr. SCHWARTZ. Lot of complicated things there, but in some States they do let the jury know about the collateral sources. And then let them make the judgment as to whether or not the plaintiff should, and it really is a false thing, have double recovery or not, whether they should know about it. I agree with that, actually.

I think that the juries are otherwise left to speculate about it, and they already know that a lot of people have insurance. So they might as well be informed. The reason that, and you have to go, I'll conclude with this the reason for each rule.

I gave you the reason for the rule on the \$250,000. The reason for the collateral source rule is that a wrong doer is not supposed to benefit from the fact that the plaintiff has been prudent or has been paid by a source other than the defendant. That is the reason for the rule. Now, wrongdoing varies. Some people are more heinous than others. So my feeling on that issue is let them make a decision as to whether or not the defendant's conduct is so bad that the collateral source shouldn't be considered. So that's my position on that.

Mr. DEAL. Do you know of any States that have allowed information to be made known to the jury as to the liability coverage of the defendant through his insurance policy?

Mr. SCHWARTZ. No, I do not.

Mr. DEAL. I believe my time is up.

Mr. NORWOOD. I now recognize myself for 5 minutes and then do you wish to have a closing statement, Mr. Brown?

Mr. BROWN. I agree with that. You probably have said enough.

Let me—Mr. Schwartz, first let me say I have liked a lot of words you have used today. Fair and balanced, common sense. And with that in mind let me ask all of the panelists. Are there any of you out there that truly believe in your heart that not having some limit on non-economic damages would not improve the health care system in lower premiums? Any of you think that's wrong?

Mr. BROWN. I think that is correct, sir.

Mr. PLUNKETT. Once again, our expertise is on the insurance side, but for all those out there who aren't here, it won't improve the health care system for those who are not able to live their lives—

Mr. NORWOOD. We're on my time. Yes or no would have been find. Your answer is no.

Mr. PLUNKETT. You have my answer, Mr. Chairman.

Mr. NORWOOD. Is there any limit on non-economic damages that you could settle or live with?

Mr. PLUNKETT. Well, I think there might be, Mr. Chairman, but we think that it has to be analyzed based on a real sense of what's happening. If you think that jury verdicts are exploding or out of

control, if you rely only on jury verdict research, the firm that is the source for much of this information and as described in that Wall Street Journal story acknowledges huge gaps in their information. If you don't understand the insurance cycle, then you're going to come to the wrong conclusion of what has to happen.

Mr. NORWOOD. The stories that I've heard today, the comments, the opinions, it's all over the board. I don't know whose got what State right anymore than you do. But it is all right for me to say there is perhaps somewhere a limit that you can agree to that might help reduce premium costs.

Mr. PLUNKETT. If it's based on a real sense of what's happening and not based on this kind of warfare that goes on at the State level and the congressional level. If it looks at the insurance industry and jury verdicts and closed claims and claims that are paid for the and the whole bit that I mentioned, we haven't ruled it out, no.

Mr. NORWOOD. Okay, good. Are you a lawyer?

Mr. PLUNKETT. No, I'm not.

Mr. NORWOOD. Just curious.

Mr. Schwartz, I want you if you would to take a minute and explain to me something that I have been told by a lot of people around this town now for at least the last year. And that's about economic damages.

Are the courts just totally wrong in their awards on economic damages or does that actually work? Nobody has ever suggested anywhere there be any type of cap on economic damages.

Do patients actually receive economic damages or do they need this other amount of money called pain and suffering?

Mr. SCHWARTZ. Well, that's a question that has been debated for almost ages. In terms of needs, you used an interesting word there—need. When it comes to worker compensation, if somebody is hurt in the work place, they don't get any pain and suffering damages. They get their needs. They get their medical costs and a percentage of their loss of wages under our Social Security System disability. They do not get pain and suffering. Under auto no fault, they don't. So if we're focusing on need in the sense of what do I really need to survive, pain and suffering is not needed.

However, you're in the middle of this crazy tort system. And a professor back in 1914 wrote an article that probably told the truth as much as anything else. The one third of the costs are going to lawyers when you recover. So the person doesn't get 100 percent of their need. So some damage for pain and suffering, he said, and for the record the man's name is Terry on Negligence and I read all this stuff and helped me understand what a new idea is versus an old idea.

The pain and suffering damages actually make up, according to Terry, for the amount that the person is having to pay to his lawyer, or her lawyer, which is about one third. I think the sort of underground explanation for pain and suffering is that.

There was an article written by the dean of Washington Law School, a very brilliant man named Cornelius Peck, who studied whether pain and suffering damages do any good. I give this gentleman a million dollars in pain and suffering. Does he feel any better? Does he have any less pain? When he wakes up in the

morning, is the fact that his arm is not there, does he feel better about it because he has the money?

Well, Professor Peck concluded no, he doesn't. And that there really is no relationship between the amount of money and how people feel. So that's as best as I can do with respect to that questions.

Mr. NORWOOD. Well, on a \$50 million verdict, surely that can't then be pain and suffering just to pay the lawyer. There's a lot of other money.

Mr. SCHWARTZ. That's right. If you're getting in the \$50 million range, but an economic loss can possibly get up there. It's difficult, but you can get there. Remember with economics, and I think one thing that I would say from listening this morning, I felt that the economic quotient to the verdict was down played too much.

Economic losses today, with a good plaintiff's lawyer and boy they vary, sir. You got a good one helping you. He or she is going to get those economics up because many, many things can translate into market value today. And every piece of medical equipment, every aid, everything you could have done before that you can't do now can be measured in terms of economic losses.

And I think the way the definition is in your bill, I don't know whose bill it is has been criticized, I think the bill does a very nice job, a good job, of defining what is economic and what is non-economic. So it has guidelines to courts as to dividing these two areas. Because believe me, if you, if this ever were to become law, what I would be doing, and what all the lawyers would be doing, is arguing what's on which side of the line. I know that may seem a little abstract, but that's what occurs every day. And the bill does a very good job on that. I'm just saying, in summary, that the economic portion of this bill should not be down played. It is a significant component of awards.

Mr. NORWOOD. Well, what if we just had unlimited economic damages? No non-economic damages, but just pay the lawyers.

Mr. SCHWARTZ. Well, that would be a very intriguing thing. And if Terry's spirit is up in the sky somewhere, I don't think any tort person gets into heaven, but there may be another place where they go, sort of a special tort place, that he would be very pleased because that's what he recommended in 1914.

Mr. NORWOOD. Well, how do you feel about that?

Mr. SCHWARTZ. I don't think that's a bad idea. I think that's a very intriguing idea.

Mr. DEAL. Will the chairman yield?

Mr. NORWOOD. Ye sir.

Mr. DEAL. If I might follow up on that, we have Federal statutes whereby we allow the Judge to fix compensation for the attorneys. The one that comes that my mind is in the wage discrimination cases in which if the plaintiff is successful, than the Trial Judge has the ability to consider what the records are, the costs, etcetera, and fix compensation for the attorney. It would be interesting to see whether or not the insurance companies would like that one.

Mr. SCHWARTZ. Well, that is a very intriguing thing. I have the feeling, while my friends in ATLA don't like this bill, if you did that I would be running out of the building at the end of the hearing.

Mr. NORWOOD. Just quickly, you do believe patients are compensated for their medical damages?

Mr. SCHWARTZ. Absolutely.

Mr. NORWOOD. Very well in most cases?

Mr. SCHWARTZ. Yes, as long as they again, the lawyers that do med. mal., plaintiffs' lawyers. First, you'd be surprised. There's not that many of them. This is not automobile fender bender stuff. This is hard stuff on either side. The cases are hard to win and you have to be very talented and I'm thinking of a man in this jurisdiction, a former ATLA president Berry Nase, a superb lawyer to whom I've referred many cases. And he will make sure that every medical cost to the nearest dime from now to the projected life of that individual, is recovered by that individual. And every possible loss of wages is covered by that individual. And any other economic loss is compensated to that individual. So the answer is yes, they are fully compensated under our tort system, if they have the benefit of having a good lawyer. In a medical malpractice, most of the plaintiffs' lawyers know what they're doing because it is both an art and a science.

Mr. ANDERSON. Mr. Chairman, if I may, I'd like to add to that answer. Mr. Court previously cited the Olsen cases, an example of MICRA not working. And in fact, really quite the contrary is true. The Olsen child was awarded \$17 million as a 2-year-old child in lost wages. So that I think this is a rather outstanding example of the fact that plaintiffs' lawyers are quite skilled at transferring economic damages, non-economic damages over to the non-economic damages.

Also, I'd like to clarify that despite Mr. Court's testimony, the principal defendant in that case was not a faceless HMO. The principal defendant in that case was the University of California, San Diego and the verdict was funded by the tax payers of the State.

Mr. NORWOOD. Thank all of you. This has been—Mr. Brown?

Mr. BROWN. I'm just asking unanimous consent, particularly since Ms. Visco had to leave for a train and Mr. Court had to fly back to California that any questions that any of us would submit on either side to either those two witnesses or any of the other half dozen or so.

Mr. NORWOOD. Absolutely. I wanted to ask both of them some questions. That's great.

Mr. BROWN. Mr. Schwartz, even though I'm not a lawyer, you sound like you'd be a good school professor to the point that I almost want to go to law school.

Mr. SCHWARTZ. Well, I appreciate that I was for many years, I was told not to mention this, but I do have this book called Schwartz on Torts and I will give a discount to any member who is here.

Mr. NORWOOD. Well, all that, of course, presumes that any law school would have, Mr. Brown.

We do appreciate—

Mr. GREENWOOD. Mr. Chairman, if Mr. Brown would agree to go to law school, I think we could take up a collection for tuition.

Mr. BROWN. Only if I went full time.

Mr. NORWOOD. I appreciate all of you coming and I want to ask Mr. Greenwood, since it is his bill, to close our hearing for us.

Mr. GREENWOOD. Well, thank you, Mr. Chairman. I think Mr. Schwartz put it very well when he said there are three things we have to consider and that is there a problem. Do the tort reform provisions in H.R. 4600 solve the problem, go a long way to solve the problem? And three is adjust.

I think you're correct that this hearing and any reasonable observation would conclude we got huge problems. And in Pennsylvania, to which I can speak most clearly, it is of unimaginable consequence. I do not know what we're going to do for health care in the very near future, if we don't do something. And it's beyond the reach of the Pennsylvania legislature because we a constitutional prohibition against caps. So that there is a crisis only the blind would miss. That caps, and tort reform, reduce premiums significantly, I

think, also, is frankly beyond dispute. All you have to look at is California, Indiana, and the other States. You put caps on it a Federal level, you will reduce the cost of these premiums and you will solve the problem.

The only question that I think that the subject to real honest dispute is the fairness question. Is it fair? Do we treat plaintiffs fairly enough in this legislation? And for instance, is the deriving punitive of damages as a function of economic damages. Is that fair? Is it fair to people of different economic levels? And I think we ought to continue to work on that. I look forward to working with Democrats on this committee who want to a bipartisan solution to the crisis. I think it's possible.

I'm open to adding insurance reforms if they're real. But frankly, I haven't seen any evidence from our hearing today that there's anything we can do—much to be done on that side that's going to fix the problem. So I think fundamentally we need to find out if whether we can come to terms on what's fair from one side of the aisle to the other, and I'm going to try very hard for the rest of the summer to accomplish that, Mr. Chairman.

Mr. BROWN. Mr. Chairman, I didn't know we were doing opening statements again. I've never seen this kind of end of a hearing when one guy on the other side gets to make another statement. You start off this hearing with an assumption that all of the problem, by the name of the hearing, all of the problem rests with trial lawyers. Not questions of fairness, no representation from patients, and I am just a little surprised that this hearing has been run in that direction. I will close with that.

Mr. NORWOOD. Hearing adjourned.

[Whereupon, at 4:32 p.m., the hearing was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION

On behalf of the American Academy of Dermatology Association (AADA), the largest dermatologic association with approximately 14,000 physician members around the world, I appreciate the opportunity to share with you our views regarding health care litigation reform. The AADA is very concerned with the current medical malpractice insurance marketplace and requests that the subcommittee favorably act on H.R. 4600, the "Help Efficient, Accessible, Low Cost, Timely Health Care 'HEALTH' Act of 2002." The current crisis poses a serious threat to the availability of, and access to, quality health care for all patients.

Since January, Frontier, St. Paul Global Health Care, PHICO and Reliance have all left the medical liability insurance market. As a result, liability premiums are

now rising for medical specialties not typically associated with high risk, adding to the financial pressures placed on all practicing physicians.

Physicians across the country have been reporting that they are unable to obtain medical liability insurance. Dermatologists, in particular, have reported that premium increases in certain parts of the country are making it difficult for them to remain viable at a time when all practice efficiencies have been implemented. In some areas, only one insurer remains, forcing physicians to face an all or nothing proposition.

While patient access to care is being threatened in a number of states, there are six states where the crisis for dermatologists is most severe: Florida, Mississippi, Nevada, Pennsylvania, Texas and West Virginia. The AADA is working with dermatology societies in these states, along with their State medical associations, to provide support for their efforts to procure state-level remedies; however, many states are not in session right now and few can agree on the proper course to pursue. For those states that have already enacted medical malpractice legislation, H.R. 4600 would not pre-empt their laws, the legislation only applies to states that have gaps in their laws or have not succeeded in passing legislation.

In 2001, eight states saw two or more liability insurers raise their rates by at least 30 percent. This year, physicians in Texas have witnessed skyrocketing insurance rates of over 50 percent. Mississippi is expected to lose over 400 physicians this year due to the ongoing medical liability crisis. In the first three months of 2002, medical jury awards in Mississippi have reached upwards of \$27 million. Furthermore, Nevada Governor Kenny Guinn has been forced to call a special session of the legislature to respond to the closing of the states only trauma center due to the lack of affordable liability coverage.

A primary cause of this emerging crisis is the unrestrained escalation in jury awards that are a part of our judicial system. The reality of being sued is evident in all corners of our health care delivery system. A recent Harris Interactive study (The Fear of Litigation Study—The Impact on Medicine) for Common Good illustrates the detrimental impact our litigious society has on those who provide care to patients.

The study shows, among other things, that more than three-fourths (76%) of physicians believe that concern for medical liability litigation has hurt their ability to provide quality care in recent years, and nearly all physicians feel that unnecessary or excessive care is provided because of litigation fears. It also shows that an overwhelming majority of physicians (83%) do not trust the current system of justice to achieve a reasonable result to a lawsuit.

Federal legislation is vital to ensuring that physicians provide appropriate care to their patients without fear of litigious action. The present instability of our medical malpractice insurance marketplace is already hampering patient access to care in some states. H.R. 4600 contains much needed medical liability reforms that are similar to those remedies that have kept the market stable in California since 1975, while continuing to ensure that patients who have been injured through negligence are fairly compensated.

According to Medical Liability Monitor, the gap between medical liability insurance rates in California and those in the largest states that do not limit non-economic awards is substantial and growing. One national insurance company (The Doctors Company) recently reported a 93 percent difference in average rates between obstetrician/gynecologists in California (with MICRA reforms) and Nevada (with no MICRA-type reforms).

Yet H.R. 4600 would continue to protect injured patients by allowing unlimited economic damages with additional non-economic damages of up to \$250,000. In addition, this bill would eliminate joint and several liability so that damages are allocated fairly and in proportion to a party's degree of fault.

The American Academy of Dermatology Association strongly believes the time to act is now. Inaction would put American's in jeopardy of not receiving the health care services they need and deserve. We urge Congress to enact H.R. 4600 to ensure the stability and viability of our nation's health care system.

On behalf of our 14,000 members, thank you for your consideration of our views.

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#### PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

This statement is submitted to the Energy and Commerce Committee on behalf of the 93,500 members of the American Academy of Family Physicians. This hearing entitled, "Harming Patient Access to Care: The Impact of Excessive Litigation" is timely. The current lack of professional liability insurance does threaten patient access to care in some states. The current trend of increasing insurance premiums

drive up the cost of health care and force physicians to drop certain services when they cannot afford professional liability insurance.

#### FAMILY PHYSICIANS AFFECTED BY THE LACK OF MEDICAL LIABILITY INSURANCE

Medical liability insurers have left the medical insurance market in the past year in alarming numbers. One reason for this exodus is the unpredictable rise in jury awards that exist in states without adequate tort reforms. According to the Physician Insurers Association of America (PIAA), the last decade has seen a dramatic increase in awards in excess of \$1 million even while the number of suits filed has remained the same. As a result of a few record-breaking cases, insurers find it more difficult to predict their risk.

The remaining insurers have been forced to raise rates or to refuse new applications for insurance. Family physicians are beginning to experience difficulty in finding insurance companies to provide liability insurance or are receiving renewal notices with double-digit and triple-digit increases for the second year in a row.

For example, in Florida, 40 medical liability companies were writing medical liability insurance five years ago. Today, there are six companies and two of them will not accept new applications. Family physicians are experiencing increases of medical liability insurance rates anywhere from 35 percent up to 300 percent based on location and scope of practice. In Pennsylvania, there were 25 medical liability insurers in 2000. Currently, there are ten and only one is accepting new applications. Over the last two years, family physicians in Pennsylvania have received a 30 percent increase on average in liability insurance premiums and premiums increases are expected to be at least that expensive for 2002.

State laws, hospital accreditation and managed care contracts all require physicians to carry medical liability insurance. If family physicians cannot afford insurance coverage, they must choose between shutting down their practice altogether or restricting the range of services they provide. For family physicians in rural settings, this usually means being forced to stop delivering babies or providing prenatal care due to mounting liability premiums.

#### FAMILY PHYSICIANS' DECISION TO DELIVER RURAL MATERNITY CARE

According to data from the Health Research and Services Administration (HRSA), family physicians are more likely than other primary care physicians to practice in rural areas. Rural family physicians are much more likely to provide maternity and prenatal care, although both the fear of litigation and the unavailability or affordability of liability insurance are beginning to force some physicians into limiting the services they provide.

The need for national tort reform has also been clear to family physicians for over ten years. The following excerpt from a study published in the *Western Journal of Medicine*, June 1991, entitled, *Tort Reform and the Obstetric Access Crisis* by Rosenblatt, R. et al., may signal what lies ahead as the next liability crisis looms:

The data are remarkably similar for the four states [Washington, Alaska, Montana, and Idaho]. As in other studies, physicians reported that issues related to medical malpractice are the most powerful factors influencing their collective decisions to continue basic practice. The cost of medical malpractice insurance is the most important factor, often exceeding the fiscal capacity of family physicians to continue to offer this service. To this economic decision is added the difficult-to-qualify—but no less important—emotional effects of a climate in which obstetric malpractice suits are perceived as increasingly common and increasingly expensive.

Although all four states did enact some tort reform in the 1980s, none of them enacted a package of tort reforms such as California's Medical Injury Compensation Reform Act of 1975 (MICRA). The MICRA reforms have already brought stability and fairness to the California legal system for the past 27 years. Californians Allied for Patient Protections (CAPP), a major consumer group supportive of MICRA, have found that legal disputes in California are settled 23 percent faster than the national average. At the same time, the number of suits filed in California matches the national average. In 1998, the Congressional Budget Office estimated that tort reforms such as those effective in California would result in savings of \$1.5 billion over ten years.

#### AAFP SUPPORT FOR H.R. 4600

The American Academy of Family Physicians supports The Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002 (H.R. 4600) because it would bring the same rational reforms contained in MICRA to all states' professional liability systems. Given what researchers have shown in the past concerning

the impact of high insurance costs on patient access, the AAFP supports federal legislation to stabilize the medical tort reform systems in the states. According to Kenneth S. Abramowitz, in the *New York Times* (September 9, 2001), "The rising cost of malpractice coverage is becoming one of the most important factors driving inflation for physicians' services."

The AAFP supports several provisions of The HEALTH Act in particular. H.R. 4600 would require that a party pay damages only to the extent that the party was liable for the harm caused. Family physicians provide primary care (comprehensive and coordinated care for all life stages and both genders). Because they are the overall medical managers for a vast number of patients in the U.S., with responsibility for making referrals to subspecialists, family physicians need the protections of joint and several liability reforms to ensure that they are not held responsible for the clinical decisions of others.

H.R. 4600 would limit attorneys' fees ensuring that a larger proportion of the award actually goes to the patient who was harmed. According to PIAA, less than two percent of paid claims exceeded \$1 million in 1991. By the year 2001, that number increased to seven percent. However, with contingency fees taking upwards of forty percent of a settlement, average citizens who seek redress in court will end up with only a tiny portion of the award. This provision ensures that they are treated fairly after they leave the courthouse.

H.R. 4600 includes a cap on non-economic damages. The Office of Technology Assessment drafted an analysis of tort reforms in 1993 entitled, "Impact of Legal Reforms on Medical Malpractice Costs." That report found that the one reform shown to consistently reduce medical liability costs was a cap on non-economic damages. While economic losses, such as lost wages, medical expenses and rehabilitation costs are fully compensated, non-economic damages reflect the monies collected for intangible losses.

#### CONCLUSION

The Academy appreciates the opportunity to address the Energy and Commerce Committee regarding the impact of excessive litigation on patient access to care.

We look forward to working with the Committee to find a workable solution for patients and physicians. We believe that the reforms contained in H.R. 4600 are fair both to legitimately harmed parties and to medical professionals.

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#### PREPARED STATEMENT OF AMERICAN ACADEMY OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY, INC.

Chairman Bilirakis, Ranking Member Brown and members of the Subcommittee, the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) is pleased to submit this statement for the record of the Energy and Commerce Subcommittee on Health's hearing on this country's growing medical liability insurance crisis. AAO-HNS, representing more than 10,000 otolaryngologist—head and neck surgeons across the country, is the national medical association of physician specialists dedicated to the care of patients with disorders of the ears, nose and throat and related structures of the head and neck. We are often referred to as ENT physician specialists.

In a growing number of states across the country, including Florida, Ohio, Oregon, Pennsylvania and West Virginia, the ability to obtain medical liability insurance has become either increasingly cost-prohibitive or is simply unavailable. Physicians who find it too expensive to maintain their practices appear to be retiring early or moving to states with less costly premiums. As this trend continues, access to quality health care for patients in many communities and neighborhoods is seriously jeopardized.

Today, practicing physicians face burdensome regulatory requirements, rising practice costs and decreasing reimbursements. These problems are compounded by increasing medical liability premiums, which are forcing physicians to practice "defensive medicine," reduce the number of services and stop performing high-risk procedures in an attempt to keep their practices afloat and avoid litigation. The money physicians could use to purchase the latest medical technology or hire another physician is often diverted to pay the skyrocketing insurance premiums. Ultimately, increasing medical liability premiums are forcing physicians to devote a greater amount of time and energy away from their number one priority—providing quality health care to their patients.

While numerous states continue to suffer from the tightening grip of increasing medical insurance premiums, one state has insulated itself and today remains relatively protected by the high premium costs. In 1975, as a result of soaring liability

premiums, California passed the Medical Injury Compensation Reform Act (MICRA). The legislation has helped the state of California maintain manageable control of insurance premiums and stabilize the industry to the benefit of physicians and patients alike. The AAO-HNS believes that in order to create nationwide stability in the medical liability insurance system, while continuing to protect the ability of patients to be compensated when injured by an act of negligence, *Congress must pass fair and equitable tort reform. To that end, we urge Congress to pass the Help Efficient, Accessible, Low-Cost Timely Health Care "HEALTH" Act of 2002 (H.R. 4600), introduced by your colleague Representative Greenwood.* The legislation includes provisions similar to those passed in MICRA that would limit non-economic damages, provide periodic payment for future damages and establish a reasonable statute of limitations. Amending the federal health liability laws through this legislation is a positive step towards ensuring patient access to physicians when and where they need care.

The AAO-HNS is pleased that the Subcommittee is addressing the important issue of reforming the medical liability crisis that is plaguing physicians across the country. We welcome the opportunity to work with the Subcommittee to ensure passage of meaningful legislation that will give physicians access to affordable insurance and not further jeopardize a patient's access to quality health care.

Thank you for the opportunity to submit this statement.

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PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS

On behalf of the American Association of Orthopaedic Surgeons (AAOS), representing 18,000 board-certified orthopaedic surgeons throughout the United States, we are pleased to offer a statement to the House Energy and Commerce Committee, Subcommittee on Health. We thank Chairman Bilirakis and members of the subcommittee for holding this important hearing and believe the time is right to address problems with the current tort system. AAOS supports the adoption of federal measures that will permit orthopaedic surgeons to better provide high quality services at reasonable costs to their patients. Without action, we fear patient access to specialty care will be threatened.

Across the country, surgical practices and emergency rooms are closing or reducing their hours of availability to patients due to substantially increased rates of professional liability insurance and an unavailability of insurers willing to provide coverage.

Last year, commercial carriers in eight states raised their rates by more than 30 percent, and another 12 states increased premiums by more than 25 percent. In some states, high-risk specialists have had their insurance cancelled or not renewed. Our physicians are finding their premiums being raised by 200-300 percent—even without ever having a claim filed against them. Patient care has suffered further because physicians must increase their patient load in order to afford increased coverage rates, while at the same time reduce the amount of time dedicated to each individual. It has become difficult for orthopaedists to provide the kind of care and attention they would like to provide their patients.

This situation was brought to light most dramatically in Nevada, when the University Medical Center Level 1 trauma center in Las Vegas—the only trauma center in southern Nevada—was forced to close for 10 days beginning July 3. Fifty-six orthopaedists resigned from the trauma center because of concerns with escalating medical liability premiums and coverage issues. Although the governor of Nevada has called a special legislative session to try to develop a long-term solution, it is clear that without action, residents of southern Nevada, as well as neighboring states served by the trauma center will lack critical specialty care in the meantime.

In addition to Nevada, throughout the country, there are startling statistics regarding the cost of practicing medicine in today's current legal environment. For instance:

- At Temple University in Philadelphia, Pennsylvania, faculty have been unable to recruit orthopaedic fellows to fill slots that have remained open for two years, despite the qualified specialists that receive training at the University.
- Health care providers in the Kansas City area experienced 25 percent to 100 percent increases in medical liability insurance rates, after both the St. Paul Cos. and Chicago Insurance Co. withdrew from the medical malpractice market, and PHICO Insurance Co. declared bankruptcy. The three companies provided malpractice coverage to about one-fourth of the physicians in Missouri.
- A survey done by North Mississippi Health Services found that 15 percent of the company's doctors are considering early retirement and 30 percent are considering jobs in other states because of legal issues. The survey also revealed that

80 percent of the doctors who have found affordable liability insurance are practicing “defensive medicine,” performing extra tests to create a record that can be used in case of a lawsuit.

In a recent survey conducted by the AAOS, we learned that two-thirds of the respondents indicated that the cost of their professional liability has affected their practice. Physicians are limiting the scope of their practice, ordering more tests and turning away from providing charity care. They are retiring or leaving certain states altogether just to survive. As the population continues to age, we are gravely concerned of the consequences of less access to quality orthopaedic care.

Physicians need relief. One possible solution is H.R. 4600—the “Help, Efficient, Accessible, Low-cost, Timely Health Care (HEALTH) Act of 2002,” introduced by Representative Greenwood (R-PA) and several others, including Representatives Chris Cox (R-CA), John Murtha (D-PA), Patrick Toomey (R-PA), Collin Peterson (D-MN), Dave Weldon (R-FL), Charles Stenholm (D-TX), Chip Pickering (R-MS), Ken Lucas (D-KY) and James Moran (D-VA). This bipartisan legislation safeguards patients’ access to care through reasonable, comprehensive, and effective health care liability reforms. AAOS supports the provisions contained within the HEALTH Act and believes a significant measure of relief can be achieved if it is adopted.

Importantly, the HEALTH Act addresses several critical inconsistencies within the current system. H.R. 4600 sets reasonable limits on noneconomic damages and implements a system of several liability, in which the physician is liable only to the extent he or she is responsible, thus ensuring a more fair allocation of responsibility. Another key principle protects payment of all medical expenses yet supports the allowance for periodic payment of future damage awards. This important provisions ensures that a physician need not risk bankruptcy, and therefore provide no compensation to the patient. The legislation also allows for the timely resolution of claims.

These reforms work in states that have adopted them. Similar legislation passed in California in the mid-1970’s resulted in a stabilization of the professional liability situation. However, not every state has enacted legislation. Federal legislation is needed to bring uniformity to this situation.

At the same time, an additional measure of relief could be found within the insurance industry itself. Congress may want to consider examining possible insurance reforms. It may prove helpful to assess the rising cost of insurance and what role the marketplace plays in setting rates. We believe Congress should carefully examine all possible reasons for the sudden rate increases and devastating market withdrawals.

Thank you again, Chairman Bilirakis, and Representative Brown, for holding this hearing. Continued patient access to specialty care will be compromised if steps are not immediately taken to address liability concerns. We look forward to working with you on this issue.

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PREPARED STATEMENT OF AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM)—representing 115,000 physicians and medical students—is the largest medical specialty society and the second largest medical organization in the United States. We congratulate the Subcommittee on Health for holding this important hearing on a subject matter that has more relevance today than ever before. Of the College’s top priorities for 2002, addressing the health care liability crisis and its impact on access to care is one of the most critical to our members. ACP-ASIM thanks Congressmen Michael Bilirakis, Chairman of the Subcommittee, Sherrod Brown, Ranking Member of the Subcommittee, and other members, for holding this hearing to discuss how excessive litigation is impacting patient access to health care.

BACKGROUND

Doctors across the country are experiencing sticker shock when they open their medical malpractice insurance renewal notices—if they even get a renewal notice. After more than a decade of generally stable rates for professional liability insurance, physicians have seen costs dramatically increase between 2000 and 2002. And in some areas of the country, premiums have soared to unaffordable levels. According to the *Medical Liability Monitor*, in mid-2001, insurance companies writing in 36 states and the District of Columbia claim to have raised rates well over 25 percent. With the new rate assessments coming in July 2002, rates are expected to increase even further.

While obstetricians, neurosurgeons and other high-risk specialists have been hit hard, internists have been one of the hardest hit specialties—having seen a record 45 percent increase in the last three years. In some cases, physicians, even those without a track record of lawsuits, could not find an insurance company willing to provide coverage. These physicians are being forced to decide whether to dig deeper and pay a steeper bill, change carriers, move out of state, or retire from the practice of medicine.

Of these options, changing carriers may not even be an alternative. Finding replacement coverage won't be as easy as it was in a buyer's market. Companies writing professional liability coverage are fleeing or being chased from the market. As an example, St. Paul Companies, which insures doctors in 45 states and is the second largest medical underwriter in the country, announced late in 2001 that it no longer would write medical liability policies. It plans to phase out coverage as physicians' contracts expire over the next 18 to 24 months. Also, Frontier and Reliance are gone. Other commercial insurers, such as PHICO, CNA and Zurich, are significantly cutting back. Even some provider-owned insurers, committed to this market by their founders, are pulling back from some states.

#### THE PERFECT STORM

At a time when the market is squeezing physician and hospital margins, the rise in professional liability insurance may be the factor that determines whether physician offices and emergency rooms keep their doors open. There are other contributing factors that have limited patient access to health care: the cost of delivering health care driven by increased cost of new technologies; increased cost of drugs deemed necessary to meet the standard of care; the rising cost of compliance under increasing state and federal regulation; the low reimbursement rates under Medicare and Medicaid; and the declining fees from managed care.

Unquestionably, there is real potential that rising insurance rates ultimately will reduce access to care for patients across the country. Indeed, daily press accounts from coast to coast are demonstrating exactly that. Physician offices and emergency rooms have been closing their doors all across the country due to the exorbitant costs of liability coverage. The states most severely affected by the spiraling out-of-control rates are: West Virginia, Florida, New York, Georgia, Illinois, Washington, Ohio, Texas, Nevada, Michigan, Pennsylvania, and Oregon. Several other states are just beginning to feel the impact.

Some states have tried to address the dramatic increase in professional medical liability insurance rates with very little success. At best, attempts by the states to solve this problem have not addressed the underlying problem: the escalation of lawsuit awards and the expense of litigation has led to the increase in medical liability premiums. This fact has resulted in many patients not receiving or delaying much needed medical care—facts Congress can no longer ignore. ACP-ASIM strongly believes that Congress must act to stabilize the market to avoid further damage to the health care system.

#### RELIEF FOR PHYSICIANS FROM SOARING MALPRACTICE PREMIUMS

Federal legislation has finally been introduced to help curb the escalating trend in malpractice premiums. **H.R. 4600, the "Help Efficient, Accessible, Low Cost, Timely Health Care" (HEALTH) Act of 2002, will safeguard patient access to care, while continuing to ensure that patients who have been injured through negligence are fairly compensated. ACP-ASIM strongly endorses this legislation as a means to stabilize medical liability insurance market and bring balance to our medical liability litigation system.** The HEALTH Act achieves this balance through the following common sense reforms:

- Limit on pain and suffering (non-economic) awards. This requirement limits unquantifiable non-economic damages, such as pain and suffering, to no more than \$250,000.
- Unlimited recovery for future medical expenses and loss of future earnings (economic) damages. This provision does not limit the amount a patient can receive for physical injuries resulting from a provider's care, unless otherwise restricted by state law.
- Limitations on punitive damages. This requirement appropriately raises the burden of proof for the award of quasi-criminal penalties to "clear and convincing" evidence to show either malicious intent to injure or deliberate failure to avoid injury. This provision does not cap punitive damages, rather, it allows punitive damages to be the greater of two times the amount of economic damages awarded or \$250,000.

- Periodic payment of future damages. This provision does not reduce the amount a patient will receive. Rather, past and current expenses will continue to be paid at the time of judgment or settlement while future damages can be funded over time. This ensures that the plaintiff will receive all damage awards in a timely fashion without risking the bankruptcy of the defendant.
- Elimination of double payment of awards. This requirement provides for the jury to be duly informed of any payments (or collateral source) already made to the plaintiff for his/her injuries.
- A reasonable statute of limitation on claims. This requirement guarantees that health care lawsuits will be filed no later than 3 years after the date of injury, providing health care professionals with ample access to the evidence they need to defend themselves. In some circumstances, however, it is important to guarantee patients additional time to file a claim. For example, the legislation extends the statute of limitations for minors injured before age 6.
- A sliding scale for contingency fees. This provision will help discourage baseless and frivolous lawsuits by limiting attorney incentives to pursue meritless claims. Without this provision, attorneys could continue to pocket large percentages of injured patient awards, leaving patients without the money they need for their medical care. The sliding scale would look something like this:
  - Forty percent (40%) of the first fifty thousand dollars recovered
  - Thirty-three and one-third percent (33⅓%) of the next fifty thousand dollars recovered
  - Twenty-five percent (25%) of the next five hundred thousand dollars recovered
  - Fifteen percent (15%) of any amount recovered in excess of six hundred thousand dollars
- Proportionate liability among all parties. Instead of making a party responsible for another's negligent behavior, this requirement ensures that a party will only be liable for his or her own share. Under the current system, defendants who are only 1 percent at fault may be held liable for 100 percent of the damages. This provision eliminates the incentive for plaintiff's attorneys to search for "deep pockets" and pursue lawsuits against those minimally liable or not liable at all.
- These common sense recommendations have been proven to work. The HEALTH Act is based on provisions contained in the California Medical Injury Compensation Reform Act (MICRA). Since its enactment in the mid-1970's, the MICRA reforms have helped reduce the overall costs of medical malpractice and have contributed to the increase in patient access to care. During this recent malpractice insurance crisis, California's rates have changed only slightly, while rates in other states have escalated to out of control levels.

#### CONCLUSION

ACP-ASIM is pleased that the Subcommittee agreed to conduct this hearing to address the serious problem of soaring medical malpractice premiums that physicians are facing across the country. **We strongly urge the Subcommittee to pass the common sense reforms contained in the HEALTH Act that allow greater access to care, while adequately compensating injured patients.** We appreciate the opportunity to submit this statement for the record.

#### PREPARED STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

The American Dental Association (ADA), a professional organization that represents more than 140,000 licensed dentists in the United States, believes that federal legislation is needed to remedy the root cause of excessive liability insurance premiums, which can and do threaten patient access to health care services.

To address this problem, the ADA supports H.R. 4600, the "Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002." This legislation, sponsored by Representative Jim Greenwood (R-PA), would reduce liability costs that are burdening the health care delivery system without compromising the legal rights of persons truly injured as the result of malpractice. H.R. 4600 would:

- encourage the speedy resolution of claims through implementation of a 3-year statute of limitations on health care-related injuries in most cases;
- provide for a \$250,000 limit on noneconomic damages;
- ensure that each party shall be liable only for the amount of damages that should be allocated in direct proportion to his or her responsibility;
- place express limits on contingency fees that can be collected by plaintiff's counsel;
- permit introduction of information concerning collateral source benefits;

- state that future damages may be paid by periodic payments; and
- permit state statutory limits on compensatory and punitive damages to remain in effect, regardless of whether they are greater or smaller than the limits provided in the Act.

The ADA is concerned that the current sharp increases in malpractice premiums are adversely affecting access to medical services, and could soon also affect dental services. Some medical specialties are seeing increases of up to 100 percent in liability insurance premiums. As a result, some physicians are no longer providing procedures that would put them at risk of liability suits, and some are moving to areas with lower insurance rates or, retiring early. The ADA hopes that congressional action will stem this tide.

Many insurers cite the skyrocketing amounts of jury awards in medical liability cases as their rationale for premium increases. According to Jury Verdict Research's report, "Medical Malpractice: Verdicts, Settlements and Statistical Analysis", the median national jury award in medical liability claims jumped 43% in one year—from \$700,000 in 1999 to \$1 million in 2000. H.R. 4600 would place fair, reasonable limits on such awards.

While the practice of dentistry differs profoundly from medicine, insurance premiums are still a concern for dentists and should be of concern to dental patients and third party payers, such as private sector employers and federal and state governments. Some dental liability insurance experts predict that dentists will face a substantial growth in premiums within 3 to 5 years. Significant increases in the cost of dental malpractice coverage will necessarily make oral health care services more expensive. With more than 50 percent of all dental expenditures paid out-of-pocket by the dental consumer, any unnecessary increases in dental costs could make dental care less attainable for many Americans. And because of the progressive nature of dental disease, those who choose to forgo care as a result of increased costs will face the unfortunate fact that untreated dental disease almost certainly worsens over time.

In addition to recommending the passage of H.R. 4600, we would be remiss if we did not also request that Congress seek additional ways to prevent the filing of frivolous lawsuits. We believe that an effort must be made to differentiate between the legitimate claims of injured parties and those filed by people who want to play the system.

To better understand our concerns you must understand that, for a health care provider, nothing is more devastating than an allegation that he or she has harmed, rather than helped, a patient. When one prides oneself on an ability to provide sound dental care to a patient, and one's reputation in the community rests on that ability, a public claim to the contrary—regardless of how flimsy or misguided—takes a toll.

Fundamentally, all any health care provider has to offer is a reputation based upon the level of care provided. It is this reputation, even more than the time and money that must be needlessly expended to defend oneself against a frivolous suit, that is at risk when someone looks to make some easy money by filing a frivolous malpractice lawsuit. We ask that Congress seek ways to prevent such suits from getting filed. For example, some states require that a plaintiff in a malpractice suit obtain a certificate of merit—an affidavit from an independent professional that a standard of care was not met—before a case can proceed.

Dentists have worked hard to deliver the best dental care in the world while struggling to keep it affordable. Frivolous lawsuits and increased liability premiums could jeopardize these efforts, resulting in more expensive dental care for all: patients, employers, and public health programs such as Medicaid.

Mr. Chairman and members of the committee, thank you for providing the ADA with this opportunity to discuss our views on much needed liability reform. We look forward to working with you on this issue.

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PREPARED STATEMENT OF AMERICAN HEALTH CARE ASSOCIATION AND THE NATIONAL CENTER FOR ASSISTED LIVING

On behalf of the American Health Care Association and the National Center for Assisted Living, we thank you for holding this important hearing in order to hear from providers and patients alike regarding the issue of medical liability reform. We commend you for bringing light to an issue that has a significant impact on patient access to care and services.

We support you for your efforts to introduce and work for passage of legislation that is pro-patient and will bring common sense reforms to our medical liability laws. AHCA and NCAL support legislative efforts to ensure patient access to quality

long-term care is safeguarded, and we consider the bill you have put forth as an important step towards ensuring care of the vulnerable elderly and disabled is protected. AHCA has endorsed The Help Efficient, Accessible, Low Cost, Timely Health Care Act (The HEALTH Act) of 2002. This bipartisan legislation is co-sponsored by Rep. James Greenwood, Rep. Christopher Cox, Rep. John Murtha, Rep. Patrick Toomey, Rep. James Moran, Rep. Collin Peterson, Rep. Charles Stenholm, Rep. Ken Lucas, Rep. Charles (Chip) Pickering, Rep. Dave Weldon and over 80 others.

#### THE AON REPORT

New research by AON Risk Consultants, Inc. shows that national trends in General Liability and Professional Liability (GL/PL) losses are increasing at an alarming rate. In the five-year period between 1990 and 1995 costs more than doubled from \$240 per bed to \$590 per bed. Since 1995 costs have quadrupled to an estimated \$2,360 per bed. The countrywide increases are the results of an explosion in litigation that started in a handful of states and is spreading to a multitude of regions throughout the country. This increase in litigation is raising the number of claims individual long-term care operators are incurring each year. In addition, the average size of each claim is steadily going up across the country at annual increases well ahead of inflation. In many states, the increase in liability costs is largely offsetting annual increases in Medicaid reimbursements.

Some specific facts revealed by the AON study include:

- The average long term care GL/PL cost per annual occupied skilled nursing bed has increased at an annual rate of 24% a year from \$240 in 1990 to \$2,360 in 2001. National costs are now ten times higher than they were in the early 1990's.
- The long-term care operators represented in this study report \$1.9 billion in GL/PL liability claims incurred between 1990 and 2001. The expected ultimate cost of claims incurred in this period is \$3.7 billion, taking into consideration the claims in the pipeline and the as yet to be determined outcomes of open cases.
- These same providers, who represent only 26% of the providers in the United States, are projected to incur \$1 billion in GL/PL claims in 2002 alone. Extrapolated to a national basis, this exposure is a multi-billion dollar a year cost to the nursing home industry.
- The average size of a GL/PL claim has tripled from \$67,000 in 1990 to \$219,000 in 2001.
- Florida and Texas were leaders in driving the increase in GL/PL costs for the long-term care industry. With trends during the 1990's in the range of 25% to 35% a year, costs in these two states have risen to close to \$11,000 per bed in Florida and \$5,500 per bed in Texas.
- Numerous states across the country are indicating similar annual trends including Georgia (50%), West Virginia (50%), Arkansas (45%), Mississippi (40%), Alabama (31%), and California (29%). With current costs in these states up to \$3,300 per bed, it won't take long at these annual trend rates to reach Florida level loss costs.
- GL/PL claim costs have absorbed 20% (\$3.78) of the \$18.47 increase in the country wide average Medicaid reimbursement rate from 1995 to 2000.
- Almost half of the total amount of claim costs paid for GL/PL claims in the long-term care industry is going directly to attorneys.

#### ACCESS

AHCA believes that a landslide of lawsuits and the associated insurance affordability and availability crisis endangers patient access to quality care. Access to care is at risk if insurance is not available or so expensive it is unobtainable. According to AON Risk Consultants, Inc., insurance markets have responded to this claim crisis by severely restricting their capacity to write long term care GL/PL insurance. Insurance companies continue to exit the marketplace and cannot provide coverage when faced with this magnitude of losses, explosion in growth of claims, and extreme unpredictability of results. Some states have laws that require long term care facilities to carry insurance as Florida now does. Facilities unable to obtain insurance as required by their states face a crisis in their ability to continue to serve patients.

An alarming reality revealed by the AON report is Medicaid reimbursement increases are being offset by increasing costs of insurance premiums. Increased Medicaid funds as provided by Governors and state legislatures, were intended to help increase the quality of care for seniors in nursing homes, but instead the new funds are substantially consumed by rising insurance costs. Critical health care dollars are being diverted out of patient care for the nation's poorest and most vulnerable sen-

iors. We ask that you take steps to maintain the funding that Congress and the states' intended for quality long-term care for seniors.

Additionally, we ask that you consider additional safeguards for long-term care including limiting the evidentiary use of documents designed for ensuring Medicare and Medicaid compliance, limiting the use of self-reported data used to improve care, and specifically codifying under the law the extension of these legal protections to assisted living settings.

AHCA and NCAL again commend Chairman Bilirakis and the Energy and Commerce Health Subcommittee for examining this issue and its impact on the frail elderly and the disabled who rely on long-term care.

The following letter is from a patient of a nursing home in Tavernier, Florida:

MARGARET LIMERICK  
48 HIGH POINT ROAD, TAVERNIER, FL 33040  
July 17, 2001

The Honorable MIKE BILIRAKIS  
Chairman, Health Subcommittee  
House Committee on Energy and Commerce  
Room 2125 Rayburn House Office Building  
Washington, DC 20515

DEAR CHAIRMAN BILIRAKIS: My name is Margaret Limerick but my friends call me Louise, please feel free to call me Louise. I live in Plantation Key Convalescent Center in Tavernier, FL for almost a year now. In my life-time, I have been married twice, have a wonderful daughter Bonnie who I am very close with. Have a super granddaughter who is an airline pilot for American Airlines. I graduated from High School and attended trade school. I worked in a Physicians office and as a travel agent. I loved my travel agent job and to travel myself. I had great opportunities after WWII. Our company started the first Travel Agencies in Cuba, Bahamas, and Miami. I thoroughly enjoyed when I "island hopped" with tours of 20-25 people and acted as their tour guide. It was a great opportunity to meet so many different people. I treasure all of those memories and would be glad to tell you more. I was born in West Virginia and grew up in Virginia, but have enjoyed the Florida key for some time now. Although I never planned on going to a skilled nursing facility (who does?) I needed one. Tracy Greene administrates my facility. I think she and her staff do a great job of making life not only a little easier for my family and I, but pleasant. If I had to need a nursing facility, this is the one for me!

I count on my caregivers for support and care although I am lucky enough to do a lot for myself. Not all are as lucky as I am. I have heard about the number of lawsuits. With more comes increases in expenses and I am aware that insurance is really hard to get for this and other facilities. I wonder if it keeps going up that some facilities, will close and the residents might have to move. In my case, if this facility closed I would have to move at least an hour away to the next one at best. I see the time that some staff spend to address lawsuits (they make copies, and review, and sort, and mail, and call their attorney, etc.) and I have heard our home does not have as many as some. Lawsuits take important staff time away from the residents. I know that no one is perfect and maybe some times there are situations that have to be looked at. I can't quote these numbers but have seen the paper, TV spoken with our Administrator, Risk Manager, my family, etc. to learn this.

I think that we live in a great Country, but wonder if people have forgotten that we who live here now are citizens, paid taxes, have lives, enjoy families, and so forth. I think that the answer is for our government to step in and deal with this problem today. I think our congress should pass legislation that will stop the large number of lawsuits today or we may not have enough facilities tomorrow. This worries me greatly, as I will soon be one of four generations when my granddaughter and her husband make me a great grandmother this August.

I urge you Sir, please don't let us lose our home(s).

Sincerely,

MARGARET "LOUISE" LIMERICK

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PREPARED STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION

Chairman Bilirakis and Members of the Subcommittee, the American Osteopathic Association (AOA) and its 47,000 members nationwide appreciate the opportunity to submit comments on this issue. The AOA, like each group here today, is very concerned with the instability of the nation's professional liability insurance market,

and the escalating premiums that have resulted. We agree with the Committee that excessive litigation is harming patients access to care.

#### BACKGROUND

As you know Mr. Chairman, the medical liability insurance system has severe problems. Physicians, hospitals, and other health care providers face increases in their liability insurance coverage that range from 30% to 300%. Dramatic increases in jury awards have forced numerous liability insurance providers to no longer write policies in certain states or geographical areas. This trend makes it difficult for thousands of physicians, to secure liability insurance coverage. The dramatic increase in liability insurance premiums and lack of available coverage are forcing physicians around the country to make impossible decisions: do they limit the services they provide their patients; do they cease to perform certain high-risk procedures; do they move to a different state that has enacted real reforms, do they "self-insure" through bonds or lines of credit, or, do they simply close their practices? The AOA believes that physicians should not be forced to make these decisions. Furthermore, we believe that when physicians are forced to make these decisions, the patients that we serve suffer the greatest consequences.

The current medical liability crisis is creating significant "access-to-care" problems across the country. It is well documented that physicians in several states are being forced to limit services, move to neighboring states, or close their practices as a result of the medical liability crisis in their states. This departure of physicians threatens patient access to quality health care. Furthermore, since hospitals are also impacted, the problem is expanded, putting patient access to essential health care services at serious risk.

It is important to note that this is not simply a "specialist" problem. The crisis has a devastating impact upon the nation's primary care providers, including family physicians such as myself. Additionally, if a rural or underserved community loses a primary care provider, the access to care issue is compounded since that community likely lost its only physician.

Mr. Chairman, there are other entities facing severe problems as a result of this crisis. Our nation's osteopathic and allopathic medical schools, teaching hospitals, and teaching clinics also face dramatic increases in their liability insurance premiums. A majority of our 19 colleges of osteopathic medicine and our teaching programs have experienced dramatic increases in premiums.

As you know, medical schools and teaching institutions are essential elements of our health care delivery system. Not only do they educate and train future physicians, they also provide essential health care services to indigent patients. When medical schools and teaching hospitals are forced to increase spending on their medical liability coverage, they must find budget offsets. In an effort to reduce overall spending, they curtail spending on academic programs and/or limit services to patients. This type of action not only damages the educational process, but it also greatly limits access to health care for our most vulnerable citizens.

#### THE PROBLEM

Statistics and history allow us to understand that the professional liability insurance crisis begins when physicians in a state or region face limited availability of professional liability insurance coverage. Availability problems typically originate when insurance companies refuse to provide coverage to physicians in certain states or geographic areas, leave the medical liability market, or become insolvent. A major factor in an insurance company's decision to write policies in a particular state is the stability of that state's tort system. States that face the worst availability problems are the same states that have seen dramatic increases in the number and severity of jury awards in the past few years. Jury awards have skyrocketed in the past 10 years. A report by Jury Verdict Research demonstrates that jury awards and settlements doubled from 1995 to 2000. The median award in 1995 was \$500,000. Five short years later it was over \$1 million and the upward spiral in jury awards continues.

Affordability is a byproduct of availability. With fewer and fewer insurance companies willing to write policies, physicians must pay more for coverage. Companies that do elect to provide coverage do so at much higher prices. A multi-specialty practice in Boca Raton was recently informed that its insurance premiums, currently \$80,000 per year, would rise to \$2.5 million--an increase of over 3,000 percent. A radiologist in Southeast Florida who specializes in the reading of mammograms was recently informed that his premiums would increase from \$30,000 to \$120,000.

The final phase is risk-management. In an effort to obtain affordable coverage, physicians are forced to conduct risk assessments of their practices. As a result of

these assessments, physicians limit services and eliminate high-risk procedures in an effort to secure affordable premiums. In many cases, physicians are unable to find a company willing to underwrite a policy or provide affordable coverage. The only recourse is to close their practices or move to a different state.

#### SOLUTION

Mr. Chairman, the AOA is committed to quality health care and improving patient safety. We fully support initiatives that seek to decrease medical errors and adverse events. Programs of continuing medical education, the Healthcare Facilities Accreditation Program that works to enhance and enforce quality standards at all hospitals in which osteopathic medicine is practiced, along with other initiatives designed to improve quality and safety of care demonstrate this commitment. We will continue these efforts that begin in our osteopathic medical school and continue throughout our member's careers.

The AOA recognizes that in a small percentage of cases, injuries due to negligence do occur. We also recognize that these injuries can have devastating impact upon the patients and their families. The AOA fully supports an individual's right to seek fair compensation when injured as a result of substandard care. The AOA fully supports patients receiving appropriate reimbursement for "economic" losses, including current and future medical expenses, lost wages, and other economic factors. Unfortunately, our medical liability litigation system is ineffective in making a patient whole. Recent studies suggest that less than 50 cents of every dollar awarded goes to the injured patient.

Comprehensive medical liability insurance reform legislation must be passed this year. This issue, if left uncorrected, will have significant and devastating consequences into the foreseeable future.

The AOA strongly supports the "Help, Efficient, Accessible, Low-Cost, Timely, Health Care Act of 2002" (H.R. 4600). We urge Congress to pass this bipartisan legislation now. H.R. 4600 is based on the health care liability reforms enacted in California under the Medical Injury Compensation Reform Act (MICRA) of 1975.

For over 25 years, MICRA has demonstrated that patients' rights can be protected at the same time that medical liability costs are kept stable. A recent study shows the impact of the MICRA laws on medical liability premiums. Premiums in 2002 for a family physician in Los Angeles County, California are approximately \$12,000. Premiums for a family physician in Dade County, Florida are approximately \$52,000. This trend is consistent across all specialties and subspecialties. Mr. Chairman, we believe the only explanation for this dramatic difference in premiums is the simple fact that California has meaningful medical liability laws.

The AOA, through its Council on Federal Health Programs, endorsed six basic principles that we believe, when enacted together, will stabilize the medical malpractice insurance market and ensure patients have access to health care without limiting injured patients access to compensation. Each of these provisions is included in the HEALTH Act. The AOA endorsed principles are: a uniform statute of limitations, a cap on non-economic damages, collateral source payment offsets, periodic payment of future damages, joint and several liability reforms, limitation of plaintiff attorney contingency fees.

The AOA is not alone in its support for medical liability insurance reforms. Seventy-five percent of Americans questioned in a new Wirthlin Worldwide survey believe that excess litigation has a detrimental effect on our health care system. Conducted for the Health Care Liability Alliance (HCLA), of which AOA is a member, the survey shows that 71 percent of Americans agree that a main reason health care costs are rising is because of medical liability lawsuits, 78 percent say they are concerned about access to care being affected because doctors are leaving their practices due to rising liability costs, and 73 percent support reasonable limits on awards for "pain and suffering" in medical liability lawsuits. A majority of Americans support common sense medical liability reforms.

#### CONCLUSION

Without effective reforms, our medical liability litigation system will continue to destabilize the medical liability insurance market, increase health care costs, and limit patients' access to quality health care.

I feel it also important to highlight other factors that contribute, on a secondary level, to this issue. We are all aware that reimbursements to physicians by third party payers, Medicare, Medicaid, and other entities are decreasing or have been "flat" for a number of years. Although we firmly believe the liability crisis is independent of the reimbursement issue, we do believe that they jointly contribute to a decrease in access for our patients. Physicians can no longer afford to offer care

at dramatically reduced prices and, as a result, they are no longer accepting Medicaid and/or Medicare patients.

The AOA appreciates the leadership you and other Members of the Committee demonstrated in June by approving the "Medicare Modernization and Prescription Drug Act of 2002" (H.R. 4954). That legislation takes initial steps to restore reimbursements to physicians and hospitals, and the AOA appreciates your efforts.

We also feel that we must address the role of insurance companies in the current crisis. We understand that the insurance industry has made choices to leave the medical liability market based upon out-of-control court systems and the escalating payments awarded by juries in medical liability cases. We also recognize that there is a growing sentiment to examine the industry with eye to systemic change. The AOA welcomes any ideas or solutions to the current crisis that promise to increase the availability of companies willing to write policies and decrease the cost of medical liability insurance for our members. We believe that this will guarantee patients continued access to quality medical care. We also must stress that we do not view insurance reform as a replacement for meaningful tort reforms. Tort reforms must be approved and if Congress feels that there is a need to address the insurance industry, it should be in addition to the approval of H.R. 4600.

The "litigious environment" surrounding physicians will continue to lead them to the practice of defensive medicine in an effort to eliminate future lawsuits. This type of behavior only increases the cost of health care for the patient and our society.

Physicians, hospitals, nursing homes, medical schools, and patients across the country realize that the current medical liability situation is unacceptable. Unless the escalating costs of the current medical liability system are addressed at a national level, patients in many states will be forced to deal with a shortage of health care providers. The HEALTH Act would provide the same reforms on the national level that have brought stability to states that have enacted similar reforms.

By passing the HEALTH Act, Congress can increase access to medical services, eliminate the practice of defensive medicine, improve the patient-physician relationship, improve patient safety, and slow the wasteful use of health care dollars.

The AOA and our members stand ready to work with you, Mr. Greenwood, and all Members of Congress to ensure that osteopathic physicians can continue to provide high quality care to our patients across the nation.

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#### PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR CLINICAL PATHOLOGY

On behalf of the 151,000 pathologists, clinical scientists, medical technologists and technicians represented by the American Society for Clinical Pathology, thank you for the opportunity to submit a statement for the hearing record on the medical liability system and its impact on access to health care.

As an organization representing the pathology and laboratory medicine team, we are involved in many aspects of the health care system, including cancer screening. We are concerned over the 16,000 new cases of cervical cancer that are diagnosed annually. Unfortunately, approximately 4,800 women die from cervical cancer each year.

More women (80%) die of cervical cancer because they have never had a Pap smear or they have not had a Pap smear in the last five years than those that die of a misread Pap smear. The Pap smear is directly attributable to a 70% decline in deaths due to cervical cancer in the last 50 years. With annual screening, the chance of developing cervical cancer can be reduced to less than 1%.

Pap smears have an irreducible false negative rate (10%-40%) due to sampling errors on the part of health care providers and screening errors occurring in laboratories. According to a March 1997 report in the *Archives of Pathology and Laboratory Medicine*, the continued availability of Pap cancer screening test is threatened by lawsuits because the legal system demands a zero error rate which is mathematically unachievable even in the most competent professional hands.

Changes must be made to the current liability system so that patients continue to have access to critical tests, such as the Pap smear. We believe the Help Efficient, Accessible, Low Cost, Timely Health Care Act of 2002, or "HEALTH" Act, will assist in taming the growing concern over the professional liability crisis in this country and ultimately improve patient access to care.

*July 17, 2002*

The Honorable MICHAEL BILIRAKIS, *Chairman*  
*Subcommittee on Health*  
*Committee on Energy and Commerce*  
*2125 Rayburn Building*  
*Washington, D.C. 20515*

DEAR CHAIRMAN BILIRAKIS: I write on behalf of the American Society of Anesthesiologists (ASA) to thank you for having scheduled today's oversight hearing on health care litigation reform. ASA is a national medical specialty organization of some 37,000 physicians or other scientists engaged or specially interested in the practice of anesthesiology.

A study released by the Institute of Medicine in December 1999 refers repeatedly to the specialty of anesthesiology as having assumed a patient safety leadership role over the past two decades. Since the late 1970s, this specialty has achieved a 50-fold decrease in anesthesia mortality, from about one death in every 5,000 anesthetics to less than one death in 250,000 anesthetics. In ASA's judgment, this radically improved mortality rate was principally the result of a multifaceted effort by ASA, at a total approximate cost of \$15 million. The purpose of this effort was:

- to determine the causes of adverse anesthesia-related events,
- to focus the attention of anesthesia providers on those causes and the ways in which to avoid them,
- to establish national practice parameters designed to raise the quality of anesthesia care in all locations,
- to foster continuing research on additional means to improve patient safety, and
- to insist that nonphysician anesthesia providers be supervised by a physician.

A major byproduct of this ASA patient safety initiative has been, until the very recent past, a significant decline or stabilization in the cost to anesthesiologists of professional liability insurance. As the risks attendant upon anesthesia care declined, so also did the cost of professional liability insurance for members of our specialty.

Regrettably, this pattern of declining or stable liability premiums has now ended, and members of our specialty are now experiencing radically escalating premiums in most states—and indeed, as widely reported, our members in a number of states have this year encountered extreme difficulty in obtaining any insurance coverage at all. We believe this state of affairs is in part attributable to changes in reserve and investment policies of professional liability insurers, but without question it is equally do to the explosion, both in size and frequency, of professional liability awards in general.

ASA firmly believes that any patient injured as a result of the delivery of substandard medical care is entitled to be fairly compensated for his or her loss. The difficulty, however, is that under the laws of many states, the extent of an injured patient's loss is simply unrestrained by common sense or any reasonable measure of actual loss.

For this reason, although ASA will continue aggressively to pursue its successful patient safety initiatives, ASA has joined other medical organizations in supporting the Help Efficient Accessible Low-cost Timely Healthcare Act of 2002 (HEALTH) (H.R. 4600) introduced by Mr. Greenwood, a member of this Subcommittee. ASA believes that passage of this proposed legislation represents the one true hope at the federal level for bringing some semblance of sanity back to the medical liability insurance scene.

Again, we are grateful to you for shedding light on this important issue through the scheduling of these hearings, and to Mr. Greenwood for his authorship of the HEALTH bill.

Sincerely,

BARRY M. GLAZER, M.D.  
*President*

ROBIN A. BLEIER  
 P.O. BOX 1116, CRYSTAL BEACH, FL 34681  
*July 19, 2002*

The Honorable MIKE BILIRAKIS  
 Chairman, Health Subcommittee  
 House Committee on Energy and Commerce  
 Room 2125 Rayburn House Office Building  
 Washington, DC 20515

DEAR CHAIRMAN BILIRAKIS: Thank you sir for taking the time to read my letter. My name is Robin Bleier. I have worked in health care in some way shape or form since 1982 (virtually half my life). I am writing this letter as for the first time in my career I am afraid of the future for those entrusted in our care. Although we do not know each other personally I have worked with Dr. Bilirakis at St. Mark Village in Palm Harbor in the mid 90's as a former Director's of Clinical Services. I stand for now what I did then, quality care and services that I would want my family member to have. I am writing you for help to stop this runaway train before it becomes to late.

I see the "liability crisis" as the pivotal problem. Obviously legal is tied to perception of the public. The current state of legal/insurance affairs is amazing not only me but also my professional counterparts in this and other states. The company I serve is a small one. We have only five SNFs and a hospital organization. We care for and employ approximately 1200 people. I serve as the Chief Operating Officer but started in the field as a nursing assistant and love my roots of care giving. To this day, I find time weekly to provide some kind of physical and or psychosocial assistance to some of our patients/residents to assure my connection to people is not lost so that our processes and system reflect this.

The time we spend addressing legal issues is out of proportion and getting steeper by the week. Obviously time translates into labor, thus time with the patient/resident. In Florida, we have steep staffing requirements. In one sense the government demands we have more nursing staff. The public and advocacy groups saw as good. But the time that the legal efforts require takes some of that back. The time facility that administrative staff and corporate staff spend away from the patient/resident (to pull, review, copy, records, just to start) is huge. I can not see how this helps improve "quality" patient/resident care, services, and outcomes. I think we all know that perceptions are reality. When JACHO surveys a hospital they receive a report card after the visit. Often the score is 90% or more. That means up to 10% was not acceptable. The public sees 90% as an "A" and of course "A's" are good. In the SNF world we get a CMS 2567. This is a deficiency report and it says that right on it. Deficiencies are negative thus "bad". Some facilities get very few and low level deficiencies assigned to them. Who wants to be bad and who wants to buy bad things?

In closing, I think that we all need to realize that punitive action does not result in QUALITY and that should be what we all want. Quality is different for all but costs money to have. Please help my patients/resident. Please stop this runaway train!

Very Sincerely Yours,

ROBIN A. BLEIER, RN, CLC, CDON, HCRM

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PREPARED STATEMENT OF THE NATIONAL MEDICAL LIABILITY REFORM COALITION

Chairman Bilirakis, Ranking Member Brown, members of the subcommittee, the National Medical Liability Reform Coalition appreciates this opportunity to submit for the hearing record a statement noting how excessive litigation negatively impacts patients' access to health care.

The National Medical Liability Reform Coalition (NMLRC) is an alliance of associations representing nurses, advanced practice nurses, physicians, hospitals, health plans, long-term care providers, and other parties dedicated to improving the nation's system for resolving healthcare liability claims.

There is a growing concern that the healthcare liability crisis in this country is compromising patient access to care. The goals of the system are to fairly, expeditiously, and cost-effectively compensate injured patients and deter unsafe practices. Unfortunately, the current system does not accomplish these goals.

Limitless liability negatively affects access to health care. According to the Mississippi State Medical Society, 90 percent of the obstetricians in Mississippi and 75 percent of the general, orthopedic and emergency surgeons have been sued. *Every single* neurologist in Mississippi with more than ten years of experience has been

sued. As a result, few Mississippi towns under 20,000 residents have a physician who will deliver babies.

The Institute of Medicine issued a report entitled, "*Medical Professional Liability and the Delivery of Obstetrical Care*," in which it recommended alternatives to the current tort system. In the mid-70s through the mid-80s, the link between diminished access to medical care for patients and the rise in liability premiums was clear. A strong economy and stock market held this link in abeyance through most of the 1990s, but this complex link is reemerging as a health care access problem—especially in rural areas and especially for those on Medicaid. The National Commission to Prevent Infant Mortality stated over a decade ago that there is a link between physicians dropping pregnancy-related care because they could no longer afford the professional liability insurance required to provide this service and a loss of access to medical care for women.

Reports from across the country indicate that access to medical care is affected by the healthcare liability crisis, including the closing of trauma centers. The *Associated Press* reported on July 13, 2002, that Nevada's only top-level trauma center, the University Medical Center in Las Vegas, reopened 10 days after it shut down because of soaring malpractice insurance rates. "The county-run trauma center closed July 3 after all but one of the medical center's 58 orthopedic doctors resigned because they said they couldn't afford rising malpractice insurance premiums. Physicians say some medical malpractice insurance premiums have jumped from \$40,000 to \$200,000 annually. To put the trauma center back in business, 10 to 15 private practice orthopedic surgeons agreed to become Clark County employees for 45 days, meaning they will be covered by the hospital's \$50,000 liability cap." The Governor of Nevada is expected to call a special session of the legislature by the end of July to address this problem.

The *Los Angeles Times* reported, "Already, specialists are becoming harder to find around the country and trauma centers that treat life-threatening emergencies are closing." Other major news outlets, such as ABC and CBS, are reporting similar findings.

For the past 11 years, *Medical Liability Monitor* has annually surveyed underwriters for the premium rates for general surgery and obstetrics-gynecology. According to the editor, Carol Golin, because of rapidly rising insurance premiums, this is the first year in which the newsletter will conduct a second survey (USA Today, December 4, 2001, *Soaring Malpractice Premiums Stun Many Doctors*). According to that survey, some states have experienced unusually large liability insurance rate increases: Florida, Mississippi, Ohio, Pennsylvania, Tennessee, Texas, West Virginia. These premium increases are leading to the closing of physician practices and health care facilities in these states. In turn, patients who live in smaller or isolated communities in these states are the first to feel the loss of a physician's office or nursing home.

Additionally, AON Risk Consultants, Inc. performed an actuarial analysis of the trends in general liability/professional liability for nursing homes. The study found that the liability costs per nursing home bed have increased at an annual rate of 24% a year from \$240 in 1990 to \$2360 in 2001. Claim costs have absorbed 20% of the Medicaid reimbursement increase nursing homes have received since 1995. This shows dollars earmarked for patient care are instead offset to pay for increased liability insurance premiums.

As of January 2002, major medical liability insurance underwriters, Frontier, St. Paul Global Health Care, PHICO and Reliance, have all left the market or have become insolvent. "In 2001, eight states saw two or more liability insurers raise rates by at least 30 percent last year. Physicians in more than a dozen states saw one or more insurers take a 25 percent or higher rate increase." (AMA News, January 7, 2002, *Professional Liability Insurance Rates Go Up; Doctors Go Away*) Anticipated percentage increases range from the low to upper double digits for those companies that continue to write this insurance product.

Some states are recognizing the link between high professional liability insurance premiums and the resulting loss of access to medical care. Pennsylvania's Attorney General, Mike Fisher, sent a letter to Chief Justice Stephan Zappala of the Pennsylvania Supreme Court in which he wrote,

"Pennsylvania is facing a potential health care crisis due to the unaffordability and unavailability of medical professional liability insurance. Insurers have requested increases for 2002 as high as 20 percent on the heels of 20 to 60 percent hikes in 2001... In recent months, two of the states largest insurers stopped issuing medical malpractice insurance. Doctors are retiring early, relocating their offices to neighboring states or discontinuing their practices. Hospitals are faced with the possibility of closing trauma units. Perhaps the most important consequence is the rising cost of health for all Pennsylvanians."

Pennsylvania is not alone. For example, according to the Mississippi State Medical Society, premiums for pregnancy-related care liability insurance have risen from 20 percent to 400 percent. According to a *Washington Post* article, November 23, 2001, “Waldemar ‘Lanny’ Prichard, [a family physician in Indianola, MS] said he would stop delivering babies next year unless he gets a break on his malpractice insurance bill . . . Prichard’s premium for the coming year: \$70,000. His gross salary last year: \$72,000.” The article goes on to cite the lack of physicians willing to deliver babies in rural Mississippi. “Three of six doctors in Cleveland, MS who deliver babies ended that part of their practice in October because of the increase in premiums. Greenwood (Mississippi) soon will go from four to two. Yazoo City, which has 145,550 residents, has no one practicing obstetrics.”

In Florida, 40 medical liability companies were writing medical liability insurance five years ago, today there are six companies left and two of those companies will not accept new applications. According to the American Academy of Family Physicians, family physicians are experiencing increases of medical liability insurance rates anywhere from 35 percent up to 300 percent based on location, scope of practice, and prior claims.

In the early 1970s, a medical liability insurance crisis gripped California. Liability premiums soared more than 300 percent because of more frequent and severe liability claims and larger jury awards. Many physicians—including high-risk specialties such as obstetrics and neurosurgery—were forced to close their doors, either unable to obtain insurance or unable to afford inflated rates. In 1975, California enacted the Medical Injury Reform Act (MICRA), a comprehensive legislative package of tort reforms that addressed this concern.

As a result, California’s patients and physicians are largely unaffected by national increases in insurance rates. While U.S. premiums increased 505% from 1976 to 1999, California premiums increased only 168%. According to the Doctors’ Company, medical liability lawsuits in California settle in 1.8 years. The same lawsuits in states without limits on non-economic damages settle in an average of 2.4 years, or 33% longer.

To achieve health care access, NMLRC believes that Congress should enact a package of effective tort reforms, similar to California’s MICRA, including:

- limit on pain and suffering (non-economic) awards;
- periodic payment of future damages;
- elimination of double payment of awards;
- a reasonable statute of limitations;
- a sliding scale for contingency fees; and
- proportionate liability among all parties.

These reforms, which are embodied in HR 4600, the Help Efficient, Accessible, Low Cost, Timely Health Care Act of 2002, will meet the intended goals of the system by allowing greater access to care, adequately compensating injured patients, and allowing quicker resolutions.

Again, thank you for the opportunity to share these views.

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American Academy of Dermatology Association; American Academy of Facial Plastic and Reconstructive Surgery; American Academy of Family Physicians; American Academy of Ophthalmology; American Academy of Otolaryngology—Head and Neck Surgery; American Academy of Pediatrics; American Association of Blood Banks; American Association of Health Plans; American Association of Homes—and Services for the Aging; American Association of Neurological Surgeons; American Association of Nurse Anesthetists; American Association of Orthopaedic Surgeons; American College of Cardiology; American College of Nurse-Midwives; American College of Obstetricians and Gynecologists; American College of Osteopathic Emergency Physicians; American College of Osteopathic Family Physicians; American College of Physicians—American Society of Internal Medicine; American College of Radiology; American Dental Association; American Gastroenterological Association; American Health Care Association; American Insurance Association; American Medical Group Association; American Osteopathic Association; American Society for Clinical Pathology; American Society for Reproductive Medicine; American Tort Reform Association; American Urological Association; Cleveland Clinic; Congress of Neurological Surgeons; Healthcare Leadership Council; Hospital & Healthsystem Association of Pennsylvania; Medical Group Management Association; and VHA Inc.