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S. HRG. 108–253

PATIENT ACCESS CRISIS: THE ROLE OF MEDICAL LITIGATION

JOINT HEARING

BEFORE THE

COMMITTEE ON THE JUDICIARY

AND THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

EXAMINING THE STATUS OF PATIENT ACCESS TO QUALITY HEALTH CARE, FOCUSING ON THE ROLE OF MEDICAL LITIGATION AND MALPRACTICE REFORM

FEBRUARY 11, 2003

Serial No. J–108–2

Printed for the use of the Committee on the Judiciary and the Committee on Health, Education, Labor, and Pensions

U.S. GOVERNMENT PRINTING OFFICE

85–062 PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
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PATIENT ACCESS CRISIS: THE ROLE OF MEDICAL LITIGATION

TUESDAY, FEBRUARY 11, 2003

U.S. SENATE,
COMMITTEE ON THE JUDICIARY,
AND THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committees met jointly, pursuant to notice, at 2:34 p.m., in Room 106, Dirksen Senate Office Building, Senator Hatch, chairman of the Judiciary Committee, presiding.

Present: Senators Hatch, Specter, Sessions, Cornyn, Gregg, Frist, Alexander, Enzi, Ensign, Leahy, Kennedy, Dodd, Kohl, Feingold, Durbin, Edwards, Murray, Reed, and Clinton.

Senator GREGG. If I could get everybody's attention? There are a lot of things going on today in the Senate, and a lot of members are moving back and forth to the floor with the debate involving Judge Estrada. And I know Senator Kennedy will be arriving soon, as will Senator Hatch, who are both involved in that debate, and Senator Leahy, who is also involved in that debate. We have a number of other members, including the Majority Leader, who are on the way. There are also a number of members who have expressed an interest in participating in this hearing who I am sure will be coming and going as we proceed forward.

Let me outline what is going to happen procedurally in this joint hearing, which we are excited about. We appreciate the opportunity to be here with the Judiciary Committee.

We are going to begin with opening statements from Senator Leahy, Senator Kennedy, Senator Hatch, myself, and should the Majority Leader have time to come over, he will do an opening statement. Then we will hear testimony from the witnesses who are very qualified, and how we deal with patients' access to health care, lawsuits and the costs of lawsuits as they affect the medical industry, medical activities, and patients' abilities to see doctors. We will rotate with 5-minute questioning periods.

We all recognize, I think, just from watching the news, that this issue of patient access to their physicians and the fact that many physicians are finding it difficult to practice because of the costs of their insurance premiums is a significant public policy concern. We have seen the problems in West Virginia where numerous people were unable to see their doctor. One instance I'm aware of involved a janitor who was unable to get adequate attention and had to travel to Kentucky to be seen.

In New Hampshire ob/gyn practitioners have been especially hard hit. It has also been a problem across the country. For example, in northern New Hampshire, where we do not have a lot of ob/gyn doctors, the doctor in that area has found her premium going from $39,000 to $138,000 in 1 year, making it extremely difficult for her to practice and could force her into retirement.

Excessive litigation drives up the cost of health care. Health insurance premiums are increasing at their highest rate in over a decade. Small businesses are particularly hard hit. In New Hampshire, small businesses have seen a 34-percent jump in their premium costs, which limits their ability to expand and create jobs.

The Congressional Budget Office has found that medical litigation reforms would save the Federal Government approximately $14 billion, and savings would be even greater, of course, for private health insurers.

With health insurance being so costly and out of reach for 41 million Americans, it simply makes no sense to allow excessive litigation to continue to eat up more resources in our health care system. Today at least a dozen States are facing urgent patient access crises. Insurance carriers have exited these States at an alarming rate. Physicians, hospitals, nursing homes, and other providers are also in trouble. All but seven of the remaining States have reached "near crisis" status, and it is only a matter of time before the "near crisis States reach full crisis status."

The data is clear about what is driving this crisis: dramatic increases in the size of jury awards, the cost of defending lawsuits, and the frequency of large claims.

Mega jury awards are on the increase. In 1999, the most current year for which we have litigation data, the median award was $800,000, up 34 percent in 3 years.

The number of million-dollar-plus jury awards is on the rise. Now more than half of all awards are over $1 million.

The cost of defending lawsuits is extremely expensive, and too many resources are devoted to defending frivolous lawsuits, as nearly 70 percent of all medical liability claims result in no payments to the plaintiff.

The trial lawyers are using the medical profession, unfortunately, almost as their ATM machines. Left unchecked, this pattern will continue to escalate and deplete the resources of our medical system. Fear of excess litigation also results in substantial indirect costs when physicians practice defensive medicine by ordering additional and unnecessary tests and procedures. And while difficult to measure, some experts believe that the defensive medicine practiced as a result of fear of lawsuits is somewhere between $60 and $108 billion.

Although billions of dollars are spent in our medical liability system in direct and indirect costs, far too few of those dollars actually flow to the patients. Almost 50 percent of the damages awarded in court go to attorney's fees, not to injured patient. And the current system leaves many injured patients with legitimate cases out in the cold.

The solution is to restore balance to the health care system, to ensure fair and timely compensation for patients who are injured by medical negligence. Unlimited compensation for current and fu-

ture medical expenses and loss of wages should be awarded. Quantifiable economic expenses should be awarded. And reasonable compensation for pain and suffering should be awarded. However, the system must also ensure that patients are not denied access—and this is the issue—access on the front end. In order to do that, we must address the acute problem of the excessive litigation and we must address it now.

As the cry for help from patients and physicians grows louder, so too do the excuses for not acting. We have heard it all before. Liability rates aren't increasing significantly. There is no problem. Rates are increasing but it is somebody else's fault. Insurance companies are to blame. State regulators are to blame, or State regulators could do a better job if they would simply pass more regulations. It is bad stock market investments, the business cycle, anticompetitive behavior, so on and so on.

But the facts tell the truth. Insurance rates increase as insurers pay out more in losses and litigation expenses than they collect in premiums. According to an A.M. Best study, the medical liability insurance industry paid out $1.54 in losses for every $1 they collected in premium, and we have a recent study that has been submitted to us, which I will put in the record, from the National Association of Insurance Commissioners which has a similar finding as to the cause of the problem.

[The prepared study was not received by press time.]

Senator GREGG. We must have the courage to just say no to the status quo and yes to the patients. We should act quickly to address the problems that we know are leaving patients without care. At a minimum we should address the litigation lottery that has added to the unpredictability in liability insurance. To ensure there is no gaming of the system, we should ensure that reforms apply across the board to all entities involved in the delivery of patient care. I believe we should look to a model of success such as the California Medical Injury Compensation Reform Act upon which the House bill has been based. We should be open to any additional reforms to the underlying medical liability system, such as encouraging States to adopt patient safety best practices.

There is a lot that can be done to improve this system to allow patients better access to their doctors and allow doctors to actually practice medicine.

At this point, I will yield to the Senator from Massachusetts for his opening statement, if he wishes to make one. Before the Senator arrived, I stated that our procedure was going to be to have an opening statement by yourself, Senator Leahy, Senator Hatch, and the Majority Leader, should he arrive, and then go to questions.

Senator KENNEDY. That is fine. Thank you, Mr. Chairman. Today we are beginning an investigation into the sudden very substantial increases in the cost of medical malpractice insurance which some doctors in a number of States have experienced. And I hope the committee will conduct a thorough and unbiased examination of this problem, one which seeks real solutions.

We must reject the simplistic and ineffective response proposed by those who contend that the only way to help doctors is to further hurt seriously injured patients. Unfortunately, as we saw in

the Patients' Bill of Rights debate, the Bush administration is again advocating a policy which will benefit neither the doctors nor the patients, only the insurance companies. Caps on compensatory damages and other extreme tort reforms are not only unfair to the victims of malpractice, they do not result in a reduction of malpractice insurance premiums.

Placing arbitrary on compensation for noneconomic loss only serves to hurt those patients who have suffered the most severe permanent injury. They are the paralyzed, the brain-injured, and the blinded. They are the ones who have lost limbs, organs, reproductive capacity, and in some cases even years of life. The Bush administration talks about deterring frivolous cases, but caps by their nature apply only to the most serious cases which have been proven in court. A person with a severe injury is not made whole merely by receiving reimbursement for their medical bills and lost wages. Non-economic damages compensate victims for the very real though not easily quantifiable loss in quality of life that results from a serious permanent injury. It is absurd to suggest that $250,000 is fair compensation for a person confined to a wheelchair for life.

Less accountability for health care providers will never lead to better health care. It will not even result in less costly care. The total cost of medical malpractice premiums constitutes less than two-thirds of 1 percent—two-thirds of 1 percent—of the Nation's health care expenditures each year. Malpractice premiums are not the cause of the high rate of medical inflation.

In the past year, there have been dramatic increases in the cost of medical malpractice insurance in States that already have damage caps and other restrictive tort reforms on the statute books as well as in the States that do not. The reason for sky-high premiums cannot be found in the courtroom. Comprehensive national studies show that medical malpractice premiums are not lower on average in States that have enacted damage caps and other restrictions on patients' right than in States without these restrictions. Insurance companies are merely pocketing the dollars which patients no longer receive when tort reform is enacted. Let's look at the facts.

Twenty-three States had a cap on damages in medical malpractice cases in 2001; 27 States did not. The best evidence of whether the cap affects the cost of malpractice insurance is to compare the rates in the two groups of States. The average liability premium in 2002 for doctors practicing in States without caps on malpractice damages was virtually the same as the average premium for doctors practicing in States with caps—31,926 to 30,521.

An examination of the rates for range especially show similar results. There are many reasons why insurance rates vary substantially from State to State. This data demonstrates that it is not States' tort reforms which make the difference. Insurance industry practices are responsible for the sudden steep premium increases which have occurred in some States in the last year. The National Association of Insurance Commissioners studies show that in 2000, the latest year for which data is available, total insurance industry profits as a percent of premium for medical malpractice insurance were nearly twice as high, 13.6 percent, as overall casualty and

property insurance profits, 7.9 percent. In fact, malpractice was a very lucrative line of insurance for the industry throughout the 1990s. Recent premium increases have been an attempt to maintain high profit margins despite sharply declining investment earnings. The industry creates malpractice crisis whenever its investments do poorly.

Doctors, especially those in high-risk specialties whose malpractice premiums have increased dramatically over the past year, do deserve premium relief. That relief will only come as a result of tougher regulation of the insurance industry. When insurance companies lose money on their investments, they should not be able to recover those losses from the doctors they insure. Unfortunately, that is what is happening now. Doctors and patients are both victims of the insurance industry. Only by recognizing the real problem can we begin to structure an effective solution to end unreasonably high medical malpractice premiums.

The CHAIRMAN. We will now turn to the distinguished Majority Leader of the Senate. Senator, if we can have your statement, and then if Senator Leahy gets here, we will go to him next, and I will finally conclude.

Senator FRIST. Thank you, Mr. Chairman. And I will be brief. I want to thank all of the chairmen for holding this timely joint hearing on a matter that is crucial to our Nation's health care system.

Today's hearing in this Congress marks the first step in which I pledge as Majority Leader in the U.S. Senate, to work with my colleagues to develop legislation that is passed by this body and ultimately signed by the President to address a crisis that is just that—a crisis. It was a challenge a couple of years ago, and a problem about 4 years ago. Today, it is a crisis.

The crisis has come today not just in the increasing premiums, but as a result of that we see diminished access for patients. And we all either have been patients or will be patients at some time in our lives. This crisis is a patient access issue. No longer is it doctors that are paying too much money, simply, or having to spend more and more to stay in practice. Now doctors are leaving the profession entirely. They are leaving their specialty. Trauma centers are closing doors. We have seen what happens with slow-downs among physicians who really have no choice. It is an access-to-quality-care issue, and the situation is grave and is worsening daily.

We have all seen the headlines. We have seen the horror stories. They are occurring with increasing frequency: hospitals closing obstetric wards, trauma centers shutting their doors, expectant mothers unable to find an obstetrician because that obstetrician could no longer afford that extra $1,300 per baby in a tax, in essence, to pay for frivolous lawsuits.

Daily we hear about these new stories and new victims. They used to be anecdotes, and now they are a frequent reality. The AMA has listed 12 States now that are in crisis and another 30 States that are near crisis.

As all of you know, I am doctor. I have paid malpractice premiums my entire adult lifetime, and I still pay malpractice premiums even though malpractice has diminished as I am not actively practicing today. It does give me the opportunity to talk to

a number of doctors who are living with this crisis each and every day.

It will be a debate whether it is the insurance companies or the frivolous lawsuits, or the personal injury lawyers who are out looking for cases, creating cases because of the incentives in the system, and that is a debate we will learn from and hopefully have today. But at the end of the day, we need to recognize that we at the Federal level must respond to this crisis.

One of the things which affects me so directly is the fact that highly qualified and committed doctors are leaving their specialties—leaving neurosurgery, leaving obstetrics and the delivery of babies, and going into gynecology or making that the main part of their practice. Doctors are leaving certain States and then moving to another State that already has addressed to some extent some of the malpractice issues that most other States have not yet addressed.

We see doctors dropping vital services today. We have some of the very best doctors, the most highly motivated individuals who go into the profession of medicine to help and to heal and to sacrifice, being able to practice because of these frivolous lawsuits and skyrocketing premiums.

Defensive medicine, we will talk a little bit about that, I am sure. We look at the overall cost of medicine, the cost of the frivolous lawsuits, the incentives that the current system has to have these multi-million-dollar lawsuits today without any sort of control. Skyrocketing premiums ultimately have to be passed on to patients, driving up the cost of health care and health care premiums; and ultimately, putting the overall cost of health care out of reach of people who are right on the border of being able to obtain insurance. Defensive medicine, as a physician, means that if you are constantly worried about a frivolous lawsuit, you end up getting more tests run on patients than necessary.

Action is needed. It is needed now. It is needed in this Congress. I am going to do everything within my power to make sure that we develop a bipartisan bill, which pulls the very best out of all of the ideas that we can pull together, to take that bill to the floor of the U.S. Senate, and to have further debate. At the end of day we must have a bill that will address the issues of access and quality that we know are being affected by these skyrocketing premiums.

The CHAIRMAN. Well, thank you, Senator.

We will go to Senator Leahy, and then I will conclude.

Senator LEAHY. Thank you very much, Mr. Chairman.

I think all of us agree on the basic issue that our health care system is in crisis. Unfortunately, we hear that comment so many times that the force of it actually disappears.

But we do know, as has been stated by everybody here, that dramatically rising medical malpractice insurance rates are forcing some doctors to abandon their practices or to cross Sate lines to find more affordable situations. Patients who need care in high-risk specialties—like obstetrics—and patients in areas already underserved by health care providers—like a lot of rural communities—are often left without any care at all.

Here we are, the United States, the richest, most powerful Nation on earth. We ought to be able to at least ensure access to quality health care to all our citizens. Other countries do. We ought to be able to assure that the medical profession and its members will not be driven from their calling by the manipulations of the malpractice insurance industry.

The debate about the causes of this latest insurance crisis and the possible cures grow very, very shrill. I hope this hearing will be a lot calmer and more constructive.

My concerns are straightforward: one, that we ensure that our Nation's physicians are able to provide the high quality of medical care that our citizens deserve and for which the United States is world-renowned; and also that in those instances where a doctor does harm a patient, that patient ought to be able to seek appropriate redress through our court system.

Now, different States have different experiences with medical malpractice insurance. As we know, insurance remains largely State-regulated industry, so each State ought to work to develop its own solution to rising medical malpractice insurance rates because each State has its own unique problems. Some States, such as my State of Vermont, while we may have problems, we do not begin to face the crisis that so many other States do. One of the reasons is that Vermont's legislature is at work to find the right answers for our State, and some other States are doing the same thing.

But, in contrast, in States such as West Virginia and Pennsylvania and Florida and New Jersey, doctors are walking out of work in protest over the exorbitant rates being extracted from them by their insurance carriers.

The distinguished Majority Leader has said that we should try to find a bipartisan solution, and I agree. I worry, however, that the administration's proposal that is the only thing before us ignores that kind of an effort.

This is a problem in the insurance industry. This can't be laid just on the rest of the tort system. The administration has proposed a plan that would cap noneconomic damages at $250,000 in medical malpractice cases. This is one-size-fits-all. Well, that does not follow the experience in most States. There is nothing to protect true victims of medical malpractice to arbitrarily limit compensation. The medical malpractice reform debate too often ignores the fact that there are people involved—men, women, and children whose lives have been dramatically and sometimes permanently, terribly permanently altered by medical errors.

I look at Linda McDougal, one of our witnesses here today. I will let her speak through her own testimony. But I would ask anybody in this room, after you hear Ms. McDougal, to ask yourself if you would be willing to go through what she did because somebody gave you $250,000. I know that the answer on this panel would be that nobody here would do anything comparable for that, and I can guarantee you, Ms. McDougal, nobody in this room would go through what you did for that.

Now, one problem is that the insurance industry's business model does require legislative correction, and that is its blanket exemption from Federal antitrust laws. They have enjoyed a benefit novel in our marketplace. The McCarran-Ferguson Act permits in-

surance companies to operate without being subject to most of our Federal antitrust laws, and our Nation's physicians and their patients have been worse off because of it. Using this exemption, insurers can collude to set rates that can result in higher premiums than true competition would achieve. And because of this exemption, enforcement officials can't even investigate that collusion. So if we are going to really control rising premiums, then we have to look at this broad exemption in the McCarran-Ferguson Act.

I have introduced the Medical Malpractice Insurance Antitrust Act of 2003, and I want to thank Senator Kennedy and Senator Durbin and Senator Edwards and Senator Feingold and others for cosponsoring it. It modifies the McCarran-Ferguson Act with respect to medical malpractice insurance when we think of some the antitrust offenses—price-fixing, bid-ridding, market allocations. Then you are going to go to the real question of premiums. It wouldn't stop State regulators from looking into this, but there is no reason to continue a system in which the Federal enforcers are stopped from prosecuting the most harmful antitrust violations just because they are committed by an insurance company. They could prosecute anybody else, but not an insurance company.

So I hope we can get together just as we did once before when Senator Hatch and I joined forces in recent years to scale back the antitrust exemption for baseball, and in the Curt Flood Act we eliminated the exemption as it applied to employment relations. If we do the same thing for the insurance industry as we did for baseball, we are all going to be a lot better off.

Thank you.

[The prepared statement of Senator Leahy may be found in additional material.]

The CHAIRMAN. Thank you, Senator.

I have a long statement to make. As a former medical liability defense lawyer, I recognized medical liability as a tremendous problem years ago. In fact, 20 years ago, I suggested that the cost of defensive medicine due to so many frivolous medical liability suits would be at about $300 billion a year. Now, we need defensive medicine, there is no question about it. But it goes way beyond that.

I remember good lawyering encouraged doctors to maintain that historical record demonstrating that they tried everything possible in treating their patients, not just the standard of the community but way beyond the standard of the community. Medicine is not an exact science. Something can go wrong with a patient, so doctors must prepare to face lawsuits.

We will have people who will claim that the insurance industry is what is at fault. Unfortunately, that argument sometimes falls because a lot of doctors have gone to nonprofit, physician-owned insurance companies or mutual companies to be able to bring the prices down and still can't get them down.

We are concerned about doctors who are leaving the profession because they cannot afford to pay the medical liability premiums, and I might add that many of them are obstetricians who are critical in our society. Elaine and I had six children. We have 20 grandchildren and the 21st is on the way, and I sure as heck want my daughters, as I wanted Elaine, to have the best obstetrician that

I could find. But if they are not there, what are women going to do? Are we going to go back to midwives? Which is good, but I think it is probably better to have obstetricians if you can have them.

We have cases where women just don't have access to obstetricians. Some expectant mothers have to travel hundreds of miles to be able to get pre-natalcare and treatment. What are we going to do? Are we going to let this continue on, or are we going to do something constructive about it?

Some States have gone to very rigid methodologies to solve these problems, and they have concluded that it is better over the long run to do it in a way that is very cost-saving and cost-effective even though there will be an occasional injustice.

I don't agree with that. While it is important to reasonably limit a physicians's liability for noneconomic damages. There are tough cases, really bad cases of gross negligence by a doctor or hospital where $250,000 is insufficient compensation for the patient's pain and suffering.

On the other hand, we all know that the vast majority of these suits, and certainly in my experience, were frivolous in nature, should never have been brought. Many of them were brought just to get the defense costs, which are considerable in these kinds of cases. That is what we want to avoid. This is a serious set of problems. We can blame one side or the other. We can blame the doctors. We can blame the insurers. We can blame the patients if you want to. But the fact is we have got to solve this problem. We need physicians to be able to practice. We need them in this modern day, with more and more Federal Government intrusion into the health care industry, to have some degree of independence whereby they can enjoy being in this profession, or some of the best and the brightest are not going to become doctors to begin with. They will go into some other less-intruded-upon professions.

This is a very important hearing because we are going to try and come up with a way of resolving these problems that will keep incentives alive for the best and the brightest to go into the medical profession and, of course, to provide the services that all of us need from time to time when we are in trouble, when we need health care. I hope we can resolve these issues in a bipartisan way. In fact, it must be done in a bipartisan way. I hope we can call upon both sides to work together to get these problems solved.

We are very fortunate to have a physician, a heart surgeon, to be exact, as the Majority Leader in the Senate. I think he understands these matters as well if not better than anybody. I intend to help him. I intend to help my colleagues on the other side to see if we can arrive at a resolution to these problems that will allow great medicine to go forward, allow patients with difficulties to have the best access to medicine, and will take care of the truly bad cases that do arise from time to time where there is no excuse for them arising.

[The prepared statement of Senator Hatch may be found in additional material.]

The CHAIRMAN. Having said all of that, let us introduce our witnesses. Senator, would you care to do that or——

Our first witness will be Laurie Peel. Ms. Peel and her husband Chris are residents of Raleigh, North Carolina. Together, they are the co-owners of the Carolina Wine Company. In addition, they recently opened a restaurant, Vin Laurie, the restaurant "Vin." Laurie is a graduate of UNC, Greensboro. She and her husband have been married since 1998 and have a two-year-old daughter named Grace. We welcome you here, Ms. Peel.

We will then go to Linda McDougal. Linda and her husband Jerry are residents of Woodville, Wisconsin, and both are veterans of the United States Navy. They have three sons, John, Jared and Jacob. Linda is an accountant, and is recovering from a double mastectomy. We welcome you here as well, and we look forward to your testimony, all of you.

Leanne Dyess and her husband Tony own a small business in Vicksburg, Mississippi. Due to a disability suffered in a car accident, Tony Dyess currently lives with his parents who assist in providing for his health care needs. They have two teenage children, a sophomore in high school and a freshman in junior college. We are really pleased to have you here as well. We appreciate you taking time.

Dr. WILBOURN. Dr. Wilbourn attended the University of Mississippi as an undergraduate and received his medical school training at Tulane University School of Medicine. He performed his residency at the University of Tennessee and then returned to Tulane University for specialty training in obstetrics and gynecology. After completing his training, Dr. Wilbourn settled in Las Vegas, Nevada, where he practiced for 12 years, and served as an assistant professor at the University of Nevada School of Medicine. He recently relocated to Belfast, Maine.

Jay Angoff joined the law firm of Roger G. Brown and Associates as "of counsel" in December 2001. He was Missouri Insurance director between 1993 and 1998, director of the U.S. Health Care Financing Administration's Private Health Insurance Group during 1999 and a vice president at quotesmith.com, an Internet insurance broker in 2000 to 2001.

Before moving to Missouri in 1993, he served as deputy insurance commissioner and special assistant to New Jersey Governor Jim Florio as counsel to the National Insurance Consumer Organization as an attorney for Public Citizen and as an antitrust lawyer with the Free Trade Commission.

As Missouri's Insurance director, Mr. Angoff was—am I pronouncing that right, Angoff?

Mr. ANGOFF. Yes, sir.

The CHAIRMAN. Was chairman of the Commission on State Health Insurance and vice chairman of the Missouri Consolidated Health Care Plan. He was also chairman of the National Association of Insurance Commissioners' Committee on Credit Insurance and vice chairman of its Committee on Insurance Availability and Affordability. We are grateful to have you here.

Jose Montemayor currently serves as commissioner of Insurance for the State of Texas. He was first appointed to this position in 1999 by then Governor George W. Bush and is in the process of being confirmed for his third term.

Commissioner Montemayor currently chairs the National Association of Insurance Commissioners' Market Conditions Working Group, which was established to look at issues surrounding medical malpractice insurance and make recommendations to State regulators.

Commissioner Montemayor has been with the Texas Department of Insurance since 1993, where he held the positions of director of Insurer Services and associate commissioner for the Financial Program.

He served in the United States Air Force for 24 years, completing his military career as director for Air Force Security Assistance Program in Latin America. He holds numerous advance degrees, including an MBA in finance and banking, and an MS in logistics and an MA in accounting.

That is pretty impressive. We are glad to have you here.

Lawrence "Larry" Smarr is the chief executive of the Physician Insurers Association of America, a position he has held since 1992. He has led the trade association which has 50 insurance company members, insuring over 700,000 physicians and dentists. During his 10-year tenure as CEO, membership has increased by more than 40 percent, and the association has become the recognized voice of the industry.

From 1979 to 1992, Mr. Smarr served as senior vice president of Government Relations and Research with the Pennsylvania Medical Society Liability Insurance Company. So we are pleased to welcome all of you here. We appreciate the testimony in advance that you are going to give, and we look forward to hearing from you, and hopefully we can gain enough from your testimony to be able to move on and do something constructive about these very serious problems.

Ms. Peel, we will turn to you first.

STATEMENTS OF A PANEL CONSISTING OF LAURIE PEEL, RALEIGH, NORTH CAROLINA; LINDA McDOUGAL, WOODVILLE, WISCONSIN; LEANNE DYESS, VICKSBURG, MISSISSIPPI; SHELBY L. WILBOURN, M.D., ON BEHALF OF THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY, BELFAST, MAINE; JAY ANGOFF OF ROGER G. BROWN AND ASSOCIATES, JEFFERSON CITY, MISSOURI, AND FORMER INSURANCE COMMISSIONER OF MISSOURI; JOSE MONTEMAYOR, COMMISSIONER OF INSURANCE, STATE OF TEXAS, AUSTIN TEXAS; AND LAWRENCE E. SMARR, PRESIDENT, PHYSICIAN INSURERS ASSOCIATION OF AMERICA, ROCKVILLE, MARYLAND

Ms. PEEL. Thank you, Chairman Gregg and Chairman Hatch, for inviting me to testify here today. I am honored to be here.

Since July, when I was asked to participate in a round-table discussion with the President on malpractice reform, I have heard a lot of tragic, really poignant stories on both sides of the issue. My own experience may not be tragic, but I do think it illustrates the difficulties patients across the Nation—and especially women—are experiencing.

I live in a community, Raleigh, North Carolina, which enjoys health care probably as good as, if not better, than any in the coun-

try. I, and my family, all have excellent doctors. Yet, even in Raleigh, when I first had a health care crisis, I had a very hard time finding a doctor who would take me. And when I was lucky enough to find a great one, Dr. John Schmitt, who is here today, he was ultimately driven out of business by overwhelming frustrations with the crippling cost of malpractice insurance. He is now on faculty at UVA School of Medicine.

As he explained in a letter to all of his patients in July of 2002, he could no longer practice medicine the way he wanted to and always had. And that is, frankly, what we should all want from our doctors and maybe even demand.

I first came to Dr. Schmitt under difficult circumstances. I was married less than a year and had just moved to Raleigh and had no Ob/Gyn there. I was 11 weeks pregnant, experiencing complications, which turned out to be a miscarriage, and in need of immediate medical attention. As a high-risk patient, though no Ob/Gyn would take me in. When I got to Raleigh, I called every practice I could find and was told again and again that the practice was full and would not be taking new patients. Fortunately, Dr. Schmitt learned of my plight, called me back and took me in.

I soon discovered he was one of Raleigh's leading Ob/Gyns, yet he had all of the time in the world for my husband and me. In the 5 years that I saw Dr. Schmitt, he helped me through the biggest disappointment in my life, my biggest health scare, and finally helped me realize the greatest joy of any life. In short, my relationship with Dr. Schmitt was everything one could hope for from a doctor. It is also a relationship both he, and all of his patients, would very much like to continue, but we cannot because of the crippling cost of medical liability insurance.

What he must pay to protect himself from the remote possibility of lawsuits—or at least legitimate ones—has prevented Dr. Schmitt from continuing the outstanding practice he had made his life's work, and stories like his are, I believe, truly tragic for us all.

Now, I have seen both sides of the issue in a very real and personal way. My father is a doctor, as are my brother and his wife, but my family has also suffered from medical errors. I do not want, and I do not know any doctor who does, to deny victims of medical errors adequate redress for their injuries. And, certainly, my father, brother and every doctor I know wants to hold the medical profession to the highest possible standards.

But the way to address malpractice cannot be to destroy the possibility of good practice or drive away those doctors, like Dr. Schmitt, who do practice to the very best of their abilities. None of us can afford that. I do not know the solution, but I do urge you to find one. And, Mr. Chairman, I very much appreciate that that is what you are trying to do.

Thank you.

[The prepared statement of Ms. Peel may be found in additional material.]

The CHAIRMAN. Thank you, Ms. Peel.

We will go to Ms. McDougal.

Ms. MCDOUGAL. First, I want to thank Chairman Gregg, Chairman Hatch, and Senators Kennedy and Leahy. I greatly appreciate the opportunity you have given me.

My name is Linda McDougal, and I am a victim of medical malpractice. I am 46 years old. I live with my husband and sons in Woodville, Wisconsin. It is a small Norwegian community in Northwestern Wisconsin. My husband and I are both veterans of the United States Navy. This is my story.

About 8 months ago, in preparation for an annual physical, I went to the hospital for a routine mammogram. I was called back for additional testing and had a needle biopsy. Within a day, I was told I had breast cancer. My world was shattered. My husband and I discussed the treatment options and decided on one that would give me the best chance of living and maximize my time alive with my family. We made the difficult life-changing decision to undergo what we believed was the safest long-term treatment, a double mastectomy, the complete removal of both of my breasts.

Forty-eight hours after the surgery, the surgeon walked in my room and said, "I have bad news for you. You do not have cancer." I never had cancer. My breasts were needlessly removed. The pathologist switched my biopsy slides and paperwork with someone else's. Unbelievably, I was given another woman's results.

The medical profession has betrayed the trust that I had in them. How could the doctors have made this awful mistake? It has been very difficult for me to deal with this. My scars are not only physical, but emotional. After my breasts were removed, I developed raging infections, and I required emergency surgery. Because of my ongoing infections, I am still unable to have reconstructive surgery, and I am nearly 8 months past surgery. I do not know whether I will ever be able to have anything that ever resembles breasts again.

After I came forward publicly with my story, I was told that one of the pathologists involved had a 10-year exemplary performance record and that she would not be reprimanded or disciplined in any way until a second incident occurred. Should someone else have to suffer or perhaps even die before some kind of disciplinary action is taken?

Now there is a proposal to limit the rights of people like me who have suffered permanent, life-altering injuries. Arbitrarily limiting victims' compensation is wrong. Malpractice victims may never be able to work again and may need help for the rest of their lives, and they should be fairly compensated for their suffering. Without fair compensation, a terrible financial burden is imposed on the entire family.

Those who would limit compensation for life-altering injuries say that malpractice victims still would be compensated for not being able to work, meaning they would be compensated for their economic loss. Well, I live in a small town. I did not have any significant economic loss. My lost wages were approximately $8,000, and my hospital expenses of approximately $48,000 were paid for by health insurer. My disfigurement from medical negligence is almost entirely noneconomic.

As you discuss and debate this issue, I urge you to remember that no two people, no two injuries, no two personal situations are identical. It is unfair to suggest that all victims should be limited to the same one-size-fits-all arbitrary cap that benefits the insurance industry at the expense of patients.

Victims deserve to have their cases decided by a jury that listens to the facts of a specific case and makes a determination of what is fair compensation based on the facts of that case. One size does not fit all.

I could never have predicted or imagined in my worst nightmare that I would end up having both my breasts needlessly removed because of a medical error. No one plans on being a victim of medical malpractice, but it happened, and now proposals are being discussed that would further hurt people like me, all for the sake of helping the insurance industry.

I am not asking for sympathy. What happened to me may happen to you or to someone you love. When it does, maybe you will understand why I am telling this story. The rights of ever injured patient in America are at stake. Limiting victims' compensation in malpractice cases puts the interests of the insurance industry ahead of patients who have been hurt, who have suffered life-altering injuries, like loss of limbs, blindness, brain damage, infertility, sexual dysfunction or loss of a child, spouse or parent. Instead of taking compensation away from people who have been hurt and putting it in the pockets of the insurance industry, we should look for ways to improve the quality of health care services in our country, to reduce preventable medical errors, like the one that cost me my breasts, part of my sexuality, part of who I am as a woman.

Medical malpractice kills as many as 98,000 Americans each year, and it permanently injures hundreds of thousands of others. We must make hospitals, doctors, HMOs, drug companies and health insurers more accountable to patients. A good start would be to discipline health care providers who repeatedly commit malpractice. We should make the track records of individual health care providers available to the general public, instead of protecting bad doctors at the expense of unknowing patients.

Limiting victims' compensation will not make health care safer or more affordable. All it will do is add to the burden of people whose lives have already been shattered by medical error. Every patient should say no to any legislation that does not put patients first. I urge you to do the same.

Thank you for your time and consideration.

[The prepared statement of Ms. McDougal may be found in additional material.]

The CHAIRMAN. Thank you so much.

Ms. Dyess, we will turn to you.

Ms. DYESS. Chairman Hatch, Chairman Gregg, Senator Kennedy, distinguished members of the Senate Judiciary and HELP Committees, it is an honor for me to sit here before you this afternoon to open up my life, and the life of my family, in an attempt to demonstrate how medical liability costs are hurting people across the country. While others may talk in terms of economics and policy, I want to speak to you from the heart.

I want to share with you the life of my two children, that my two children and I are now forced to live because of a crisis in health care that I believe can be fixed. And when I leave, and the lights are turned off, and the television cameras go away, I want you and all America to know one thing, and that is that this crisis is not about insurance, it is not about doctors or hospitals or even per-

sonal injury lawyers; it is a crisis about individuals and their access to what I believe is otherwise the greatest health care in the world.

Our story began on July 5th of last year, when my husband Tony was returning from work in Gulfport, Mississippi. We had started a new business. Tony was working hard, as I was. We were doing our best to build a life for our children, and their futures were filled with promise. Everything looked bright. Then, in an instant, everything changed. Tony was involved in a single-car accident. They suspect he may have fallen asleep, though we will never know.

What we do know is that after removing him from the car, they rushed Tony to Garden Park Hospital. He had head injuries and required immediate attention. Shortly thereafter, I received a phone call that I pray no other wife has to ever receive. I was informed of the accident and told that the injuries were serious, but I cannot describe to you the panic that gave way to hopelessness when they told me, "We do not have the specialist necessary to take care of him. We will have to airlift him to another hospital."

I could not understand this. Gulfport is one of the fastest-growing and most prosperous regions in Mississippi. Garden Park is a good hospital. Where, I wondered, was the specialist who could have taken care of my husband?

Almost six hours passed before Tony was airlifted to the University Medical Center, six hours for the damage to his brain to continue before they had a specialist capable of putting a shunt into his head to reduce the pressure on his brain—six unforgettable hours that changed our life.

Today, Tony is permanently brain damaged. He is mentally incompetent, unable to care for himself, unable to provide for his children, unable to live the vibrant, active and loving life he was living only moments before the accident.

I could share with you the panic of a woman suddenly forced into the role of both mother and father to her teenage children, of a woman whose life is suddenly caught in limbo. I could tell you about a woman now who had to worry about the constant care of her husband, who had to make concessions she never thought she would have to make in order to be able to pay for his therapy and care. But to describe this, would be to take away from us the most important point in the value of what I learned.

Senator Hatch, I have learned that there was no specialist on staff that night in Gulfport because of rising medical liability costs had forced physicians in that community to abandon their practices. In that area, in that time, there was only one doctor who had the expertise to care for Tony, and he was forced to cover multiple hospitals, stretching him thin and unable to care for everyone.

Another doctor had recently quit his practice because his insurance company terminated all of the medical liability policies nationwide. That doctor could not obtain affordable coverage. He could not practice, and on that hot night in July, my husband, and our family, drew the short straw.

I have also learned that Mississippi is not unique; that this crisis rages in States all across America. It rages in Nevada, where young, expectant mothers cannot find Ob/Gyns; it rages in Florida,

where children cannot find pediatric neurosurgeons; and it rages in Pennsylvania, where the elderly, who have come to depend on their orthopedic surgeons, are being told that those trusted doctors are moving to States where practicing medicine is affordable and less risky.

The real danger of this crisis is that it is not readily seen. It is like termites in the structure of a house. They get into the woodwork, but you cannot see the damage. The walls of the house remain beautiful. You do not know what is going on beneath the surface, at least not for a season. Then, 1 day, you go to hang a picture or a shelf and the whole wall comes down. Everything is destroyed.

Before July 5th, I was like most Americans, completely unaware that just below the surface of our Nation's health care delivery system, serious damage was being done by excessive and frivolous litigation, litigation that was forcing liability costs beyond the ability of doctors to pay.

I had heard about some of the frivolous cases, and of course the awards that climbed into the hundreds of millions of dollars, and like most Americans, I shook my head and said, "Someone has hit the lottery." But never, I never asked, "At what cost?" I never asked, "Who has to pay for those incredible awards?" It is a tragedy when a medical mistake results in a serious injury. But when that injury, often an accident or an oversight by an otherwise skilled physician is compounded by the lottery-like award, and that award, along with others, make it too expensive to practice medicine, there is a cost, and believe me it is a terrible cost to have to pay.

Like most Americans, I did not know the cost. I did not know the damage. You see, Senator Hatch, it is not until it is your spouse that needs a specialist or you are the expectant mother who needs an Ob/Gyn or it is your child who needs a pediatric surgeon, that you realize the damage that is beneath the surface.

From my perspective sitting here today, this problem far exceeds other challenges facing America's health care, even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we did not have was a doctor, and now no amount of money can relieve our pain and suffering, but knowing that others may not have to go through what we have gone through could go a long way toward helping us heal.

Senator Hatch, I know of your efforts to see America through this crisis. I know it is important to you, and it is important to the President. I know the priority Congress and many in the Senate are placing upon doing something and doing something now. Today, I pledge to you my complete support. It is my prayer that no woman or anyone else anywhere will ever have to go through what I have gone through and what I continue to go through every day with my two children and a husband I dearly love.

Thank you.

[The prepared statement of Ms. Dyess may be found in additional material.]

The CHAIRMAN. Thank you, Ms. Dyess. We appreciate your testimony.

Dr. Wilbourn, we will turn to you.

Dr. WILBOURN. On behalf of the American College of Obstetricians and Gynecologists, an organization representing more than 45,000 physicians dedicated to improving the health care of women, I would like to thank Chairman Hatch and Chairman Gregg for holding this important hearing to examine the medical malpractice liability crisis facing this Nation.

Women across America are asking, "Who will deliver my baby?" ACOG deeply appreciates your leadership and commitment to ending this crisis.

We urge Congress to pass meaningful medical liability reform, patterned on California's MICRA law, and bring an end to the excessive litigation restricting women's access to health care.

My name is Dr. Shelby Wilbourn, and I am an Ob/Gyn, who recently relocated to Belfast, Maine, after 12 years of practice in Las Vegas.

Liability is not about fault or bad practice any more. It is about hitting the jackpot. Even the very best Ob/Gyns have been sued, many more than once. Even doctors who have never been sued are seeing their liability premiums double and triple, not because they are bad docs, but because they practice in a litigation-happy field where everyone is fair game.

Let me cite a perfect example which demonstrates the imbalance of the current tort reform system. That is my story. I finished my residence at Tulane and moved to Las Vegas, one of the first people in my family to go into medicine. My father is a retired master sergeant in the U.S. Air Force, my mother retired from Sears and Roebuck. I was not raised as a physician's son or a wealthy family. I worked very hard and came out of medical school with $186,000 in debt that I was going to have to pay off.

I worked hard in Las Vegas, teaching at the University of Nevada, private practice, seeing 40 patients a day, 20 to 25 deliveries a month, operating and was very happy. For 12 years, I had no lawsuits. I had no claims and no disciplinary actions.

Last year, in March, I was informed by my medical malpractice carrier that my insurance was going to increase from $33,000 to $108,000 a year. This was in a year that I had already had trouble making ends meet and paying the bills of my office at $33,000. On top of that, I was told that the $108,000 would apply if I limited my number of deliveries to less than 125 a year because they considered it risky to do more than that. I was already doing 205 deliveries.

How do I choose which half of my patients to tell them, "I am sorry. I can no longer take care of you. I have hit my limit for the year"?

I was forced into one of three options. I could either get out of medicine, retire, and find something else to do, relocate, I could stop practicing obstetrics, but that is one-half of my job—that is what I trained to do, and that is what I love—or I could start to pick and choose which of my patients got to stay with me and which ones got turned out on the street. I could also have the option to go borrow over $100,000 a year, take the gamble that 1 day the crisis would wear away, and I would be over half a million dollars in debt.

None of those options were acceptable, so I chose to relocate. I looked at positions in the United States where it was less litigious, malpractice was more affordable, and I felt more physician friendly; thus, my relocation to Maine.

When I got ready to leave Las Vegas, I left over 8,000 active patients. Women were in the office crying, bringing dishes to say goodbye. I am still getting phone calls in Maine from these women asking for advice, and I can no longer treat them long distance.

I had a practice of 12 years that was very successful that I could not sell. There were no new Ob/Gyns coming to Las Vegas. They were living faster than you could get one in. There were no residents coming out that wanted to stay in Las Vegas and practice. I took a 12-year business and donated it to the University of Nevada School of Medicine.

I left Nevada because the litigation climate has driven the medical liability premiums to astronomical heights. In 2002, Las Vegas Ob/Gyns paid as much as $141,760 a year, a 49.5-percent increase from 2001. In Clark County, Las Vegas, there are only 160 Ob/Gyns left, that is private, public and resident practitioners, left to deliver an estimated 23,000 babies in 2003. That is an average of 216 babies per Ob/Gyn, which is already over their 125 limit.

Of those Ob/Gyns in Las Vegas who responded to an American College of Ob/Gyns survey last number, 86 percent have changed their practice, such as retired, stopped doing high-risk deliveries, and 30 percent of the Ob/Gyns have stopped doing obstetrics altogether.

Last July, I was privileged to meet with President Bush in North Carolina to discuss the medical liability crisis on a national level. At that time, I had never been named in a lawsuit, a fact that was made known during that round-table discussion.

Within 6 days of my return from meeting the President, I was delivered my first lawsuit. All but one of the physicians who served on the task force to the governor of Nevada received lawsuits within six to 7 days, some multiple. I find that coincidental.

When I left Nevada, my patients, many of whom were with me for 12 years, were forced to find another Ob/Gyn, among a dwindling population of Ob/Gyns in Las Vegas. This is the real issue. Patients around this country are losing access to good doctors and quality health care. The end game of the current system is a society without enough doctors to take care of its citizens. We just cannot let this happen.

Today, we have heard or will hear anecdotes from both sides of this debate, all of which support each side's position. However, the fact remains clear there is a medical liability crisis in this Nation. Who loses in this environment? Women, good doctors, patients, communities, businesses and Americans.

On February 5th, 2003, the House of Representatives took an important first step in ending this crisis when Representatives Greenwood, Cox, DeLay and Sensenbrenner introduced H.R. 5, the Health Act of 2003, with ACOG's full support. H.R. 5 is fair for everyone. H.R. 5 will restore the balance in the health care system that has been hijacked by trial lawyers and meritless lawsuits.

Thank you, Senators Hatch and Gregg, for your leadership on this important issue and for the committee's attention to this crisis.

The College looks forward to working with you as we push for Federal liability reform.

[The prepared statement of Dr. Wilbourn may be found in additional material.]

The CHAIRMAN. Thank you, Doctor.

Mr. Angoff, we will take your testimony now.

Mr. ANGOFF. Thank you, Mr. Chairman and members of the committee. My name is Jay Angoff. I am a lawyer from Jefferson City, Missouri. I was the insurance commissioner of Missouri between 1993 and 1998.

When I was commissioner, Mr. Chairman, we had a great medical malpractice insurance market. Profits were high, rates were low, every year rates either stayed the same or went down. The apparent explanation is that we have very good experience in Missouri. We collect data each year from the insurance companies—I think we have the best data in the country—and that data showed, during the 6 years I was commissioner, new claims filed every year were generally down, the number of paid claims generally went down every year, and the average payment per claim, after accounting for inflation, generally went down.

After I left the Department, the same trends accelerated, particularly between 2000 and 2001, there was a dramatic drop in reported claims, a drop in paid claims, and a drop in payment per claim. This is based on the data the companies submit to us. Yet, despite those drops, malpractice premiums skyrocketed in Missouri, just as they are throughout the country.

That does not seem to make sense, but it does make sense once you understand the underlying characteristics of the insurance business that are responsible for those sudden and dramatic drops. By the way, this is not to blame the insurance industry, this is just the underlying characteristics of the industry that cause it.

No. 1, the investment climate, it is no secret that both the stock market and the bond market are performing terribly. We can quibble about how much insurers invest in stocks and how much they invest in bonds, but the fact is there is no place insurance companies can put their money today where they are going to earn any money. That is reason number one.

No. 2, the cost of reinsurance. The cost of reinsurance was already going up. Reinsurance was the insurance that insurance companies buy themselves for their real high claims. The cost of reinsurance was already going up before the terrorist attacks. After the terrorist attacks, it went up even more for reasons obviously that have to do with international events. Nothing to do with the medical malpractice business.

Reason number three—and this is probably the most important, but it is also the most technical, so I will try to make it simple—when insurance companies say they have a loss, what they mean is they estimate they will pay out a certain amount in the future, not that they have actually paid out that amount.

Mr. Chairman, in your opening statement, you talked about insurance companies paying out $1.54 for each premium they take in, and that is a figure that the insurance industry puts out, and that is accurate based on insurance accounting principles, under which what they call their incurred losses, which seems to the average

person to mean the amount they actually pay out, but under their accounting principles, what it means is the amount that they will project they will ultimately pay out on premiums that they take in, in a given year.

During the last insurance crisis in the mid 1980s, insurance companies projected that they would pay out a whole lot. They had very high loss ratios, numbers similar to the $1.54 that you projected, Mr. Chairman. What they found out when these claims, when it came time to pay these claims, they actually paid out a heck of a lot less, so they had a lot of money left over with which to reduce rates in the nineties. That is one reason rates were slow and profits were so high in the nineties.

The same thing is happening now. Insurers are overinflating the amount that they project they will pay out. In a few years, and I know it is no comfort to doctors now, but in a few years, just as happened after the last insurance crises, it will turn out that these estimates are inflated, they will be able to reduce their rates.

A fourth factor that is responsible, and I do not want to overstate this, but it does have some responsibility, and that is the antitrust exemption for the insurance industry. When times are good, when insurance companies are making lots of money on their investments, the antitrust exemption is irrelevant. Insurance companies do not fix prices then, they cut prices. They are competing like crazy, so the insurance antitrust exemption then is irrelevant.

On the other hand, in times like this, when times are bad, the antitrust exemption allows insurance companies to price without fear. They do not have to worry about being able, they do not have to worry about being prosecuted for pricing collectively. That is not a violation of the law under McCarron-Ferguson, and I will be glad to answer any questions about that after my testimony concludes.

Finally, Mr. Chairman, there are things that can be done, although not all at the Federal level. At the Federal level, the antitrust exemption can be repealed or modified. At the State level, it can be made easier for insurance regulators to roll back and refund excessive rate increases, and, finally, Mr. Chairman, there is the California solution which is a very extreme solution, but in California it worked.

In 1988, the citizens of California enacted a ballot initiative called Proposition 103, which rolled back all property casualty rates by 20 percent, repealed the State antitrust exemption, established prior approval rate regulation. That has had a very positive effect on rates in California. It is an extreme solution, but if nothing else works, it is a solution that can be implemented.

That concludes my statement. I will be glad to answer any questions the committee may have.

[The prepared statement of Mr. Angoff may be found in additional material.]

The CHAIRMAN. Thank you so much.

Mr. Montemayor?

Mr. MONTEMAYOR. Thank you, Mr. Chairman, and good afternoon, members. I am Jose Montemayor. I have the honor of being the commissioner of Insurance for the great State of Texas.

As a member of the National Association of Insurance Commissioners, I also chair that group's Property and Casualty Committee,

and separately a subcommittee or working group looking into the medical malpractice insurance coverage for physicians and other health care providers on a national basis. To that end, we will be having a hearing in March to collect additional data and continue that study.

Today, however, I am presenting for the record a report first provided to the Texas legislature in late 2001 and again updated in 2002 regarding the availability and the affordability of medical professional liability insurance in Texas.

There are a number of theories, Mr. Chairman, regarding the current situation in medical malpractice coverage. However, the sum of our report clearly indicates the loss trends, and what I mean by that is increasing amounts paid for claims or the primary costs or rising costs of medical malpractice insurance. Really, all other costs are a distant second.

This first chart would clearly, it is a 10-year average on a study that we had been conducting just with 15 States. The chart is on the left. It basically shows what happens for every dollar of premium taken in compared to losses in defense expenses associated with claims for that company and their policyholders. And in a State like Texas, you can see—it is the one in the red bar—that we have been paying out approximately $1.60 for every single dollar of premium collected.

What that does, it does affect our profitability, which is the chart on the right, which is basically the net worth of the company after all profits and investment incomes are declared. You can see that on a purely underwriting basis, just dollars in per dollars out, California and Michigan managed to stay profitable over a 10-year period. Once you add investment income back in and compare it to their net worth, almost all States came back to positive, except for Texas, who experienced a negative 2 percent over a 10-year period.

Over a four-year period, those claim costs per doctor—this is all of the claims paid divided by all of the doctors insured—have risen approximately 50 percent, and this is driven by two things; the number of claims called the claim frequency and the amount per claim called the claim severity.

In my own State, we found the problem to be fairly complex, and in some areas we have a high number of frequency, such as in the Lower Rio Grande Valley area—my area of the world—and the reversals in other parts of the State, where the amount per claim is much higher, although the number of claims is lower.

Those loss trends indicate the presence of liabilities which, due to their unpredictability, it has led a number of insurers, first of all, to either discontinue writing the line or go insolvent, and it has cost them, if you go back to the end of 1998 and see what they have had to do with their premiums, basically, to escalate somewhere between 80 and 140 percent over the last 4 years for the major writers in Texas.

With the stock market losses in the last few years and investment income and hard markets, it seemed like reasonable culprits initially. So we undertook an investigation to see exactly what was going on with that. And what we found that nationally all property and casualty companies that specialize in medical malpractice, primarily bonds, into the high 90 percent. The area in blue represents

each of the investment years from 1991 to 2001. The area in yellow, it is the area they held in equities or common stocks, and then there are some holdings in cash and so forth, and this is a natural allocation that has always existed there because of their cash needs and their predictability and ability to get cash.

So, from our perspective, what we found again was losses drove the environment, much more so than any other fundamental reason. It has a much more dramatic effect to have an adjustment in reserves for anticipated claims than it would to lose badly on their equity holdings, and that is the whole purpose of this chart.

What is not in any of these charts, Mr. Chairman and members, can never be conveyed fully through the statistics or the accounts from people who suffer from lack of access to patient care. There are stories from the Rio Grande Valley to the Texas panhandle of how people do not have access to health care.

I have visited with a number of doctor groups who have come to me for help, saying what can we do about our premiums. They are escalating to the point where I can no longer hang in business, where I can no longer do certain procedures, and I am going to have to either withdraw or change my practice to only do less-risky procedures.

So I hope that the attached report that I presented, and the summary charts presented, to the committee today would speak volumes on a simple premise that we do need a balance and reasonable limits on losses to stabilize the medical liability insurance market, and I believe that that will go a long way to alleviate the looming crisis of access to health care.

I would be very pleased to answer any of your questions.

[The prepared statement of Mr. Montemayor may be found in additional material.]

The CHAIRMAN. Thank you so much.

Mr. Smarr, we will turn to you.

Mr. SMARR. Chairman Hatch, Chairman Gregg, and committee members, I am Larry Smarr, president of the Physician Insurers Association of America. The PIAA is an association comprised of professional liability insurance companies owned and/or operated by physicians, dentists and other health care providers.

The 43 PIAA insurance company members can be characterized as health care professionals caring for the professional liability risks of their colleagues, doctors insuring doctors, hospitals insuring hospitals.

Sitting behind me here today is Dr. Warren McPherson, a practicing neurosurgeon from Murfreesboro, Tennessee. Dr. McPherson is the chairman of the PIAA board of directors and also chairman of the State Volunteer Mutual Insurance Company, the largest insurer in Tennessee and Arkansas, and a mutual company owned and operated by the doctors it insures.

We believe that the physician-owned and operated insurance company members of the PIAA currently insure over 60 percent of America's physicians. Let me get right to the issue. Over the past 3 years, medical liability insurers have seen their financial performance deteriorate substantially due to the rapidly rising cost in medical liability claims.

According to A.M. Best, the leading insurance industry rating agency, the medical liability insurance industry incurred a $1.53 in losses and expenses, as we have heard here today, for every dollar of premium they collected in 2001. Best estimates that this number will be $1.41 in 2002 and decline to $1.34 in 2003, primarily due to the rising premiums that the insurance carriers are collecting, and Best also has told us that this statistic would have to go down to $1.14 in order for the industry to break even.

The primary driver of the deterioration in the medical malpractice insurance industry performance has been paid claim severity or the average cost of a paid claim. Exhibit A shows the average dollar amounts paid in indemnity to plaintiffs on behalf of individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9 percent over the past 10 years, as compared to 2.6 percent in the consumer price index.

The data from this exhibit comes from the PIAA data-sharing project, a medical cause-of-loss database which was created in 1985 for the purpose of identifying common trends among malpractice claims which are used for patient safety purposes by the PIAA member companies. To date, over 180,000 claims and suits have been reported to our database.

One very troubling aspect is the proportion of those claims and suits filed which are ultimately determined to be without merit, as shown on Exhibit B. Sixty-one percent of all claims closed in 2001 were dropped or dismissed by the court. An additional 5.7 percent were won by the doctor at trial. Only 33.2 percent of all claims closed were found to be meritorious, with most of these being paid through settlement. Of all claims closed, more than two-thirds had no indemnity payment to the plaintiff. When the claim was concluded at verdict, the defendant prevailed an astonishing 80 percent of the time.

As shown on Exhibit C, the mean settlement amount on behalf of an individual defendant was just over $299,000. Most medical malpractice cases have multiple defendants, and thus these values are below those which may be reported on a case basis.

The mean verdict amount last year was almost $497,000 per defendant, and these are dollars that are actually paid. These are not verdicts that juries render and then get reduced at some point in the future. These are the sum of checks written.

Exhibit D shows the mean expense payment for claims by category of disposition. As can be seen, the cost of taking a claim for each doctor named in a case all the way through trial is fast approaching $100,000.

Exhibit E shows the distribution of claim payments at various payment thresholds. It can be readily seen that the number of larger payments are growing as a percentage of the total number of payments. You can see that the red band at the top is getting larger. Those are claims that are a million dollars or more. Whereas, the green band at the bottom claims, at a far lesser level, are getting smaller in proportion to their number.

This is especially true for payments at or exceeding $1 million, which comprised almost 8 percent of all claims paid on behalf of individual practitioners in 2001, as shown on Exhibit F. This percentage has doubled in the past 4 years.

Unfortunately, I must spend the rest of my time debunking a false premise being propagated by the trial lawyers and a few of their supporters who oppose effective Federal health care liability reform. Contrary to the unfounded allegations of those who oppose effective tort reform, medical malpractice insurers are primarily invested in high-grade bonds and have not lost large sums in the stock market, as Commissioner Montemayor has just explained.

Brown Brothers Harriman, a leading investment and asset management firm, in a recent investment research report states that "Over the last 5 years, the amount medical malpractice companies have invested in equities has remained fairly constant. In 2001, the equity allocation was 9.03 percent."

As Exhibit G shows, medical liability insurance companies, shown in green, invested significantly less in equities than did all property casualty insurers.

Brown Brothers states that the equity investments of medical liability companies had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy. Specifically, the report states that "Since medical malpractice companies did not have an unusual amount invested in equities, and what they did was invest it in a reasonable market-like fashion, we conclude that the decline in equity evaluations is not the cause of rising medical malpractice premiums."

While insurer interest income has declined due to falling market interest rates, when interest rates decline, I think as we all know, bond values increase. This has had a beneficial effect in keeping total investment income level when measured as a percentage of total invested assets.

This is shown on Exhibit H. As you can see, the top line, which is the net investment yield on assets, has remained rather level throughout the last five or 6 years. Thus, the assertion that insurers have been forced to raise their rates because of bad investments is simply not true.

The PIAA firmly believes that the adoption of effective Federal health care liability reform, similar to the California MICRA reforms enacted in 1975, will have a demonstrable effect on professional liability costs. The keystone of the MICRO reforms is a $250,000 cap on noneconomic damages, largely pain and suffering.

These reforms are similar to the provisions of H.R. 4600 passed by the House last year, and scored by the CBO, as providing over $14 billion to the Federal Government and additional savings of $7 billion to the States because tort reform works.

Using annual data published by the National Association of Insurance Commissioners, Exhibit I documents the savings California practitioners and health care consumers have enjoyed since the enactment of MICRA over 25 years ago. As shown, total malpractice premiums reported to the NAIC since 1976 have grown in California by 167 percent, while premiums for the rest of the Nation have grown by 505 percent.

These savings are clearly demonstrated in the rates charged to California doctors, as shown on Exhibit J. Successful experience in California and other States, such as Colorado, make it clear that MICRA-style tort reforms do work without lowering health care quality or limiting access to care.

And as you can see, an Ob-Gyn in California pays almost $55,000 for coverage in Los Angeles. That is a lot of money, but it is not nearly the same amount of money as that same doctor in Miami who pays four times as much.

Legislators are now challenged with finding a solution to the medical malpractice affordability and availability dilemma, a problem long in coming which has truly reached the crisis stage. The increased cost being experienced by insurers who are largely owned or operated by health care providers are real and documented. It is time for Congress to put an and to the wastefulness and inequities of our tort legal system, where only 50 percent of the moneys available to pay claims are paid to indemnify the only 30 percent of claims filed with merit, and the expenses of the remainder.

The system works fine for the legal profession, which is why the trial lawyers and others fight so hard to maintain the status quo.

The PIAA strongly urges members of the Senate to support and pass legislation which will assure full payment of a truly injured patient's economic losses, as well as up to a quarter of a million in noneconomic damages, thereby assuring fair compensation for patients and also assuring Americans that they will be able to receive necessary health care services.

Thank you.

[The prepared statement of Mr. Smarr may be found in additional material.]

The CHAIRMAN. Thank you very, very much, Mr. Smarr.

We are going to go to Senator Gregg first, then Senator Kennedy and then back to me.

Senator GREGG. Mr. Smarr, those statistics which you just presented were rather startling, especially the California experience. Just to clarify, your organization, which insures 60 percent of doctors is a not-for-profit organization; is that correct?

Mr. SMARR. Senator, they are not really not-for-profit because there is no such thing as a not-for-profit insurance company, but there are companies, mostly mutual companies and reciprocals, that are owned and/or operated by the doctors they insure, and they started over two decades ago with the philosophy of——

Senator GREGG. Well, their purpose is not to gouge doctors.

Mr. SMARR. Their purpose is not to what, sir?

Senator GREGG. Is not to gouge doctors, correct?

Mr. SMARR. Absolutely, it is not.

Senator GREGG. In fact, the doctors own——

Mr. SMARR. It is not to gouge doctors.

Senator GREGG. So I am interested in this—can you go back to your chart there, the MICRA chart.

Now, we heard testimony that said that the reason California's rates dropped was because of Proposition 103. As I understand proposition 103, it did not directly impact the malpractice insurance industry. Instead it was MICRA that has driven the drop in the cost of malpractice insurance, and therefore the affordability of doctors to practice in California.

Is that your assessment, also?

Mr. SMARR. It is. Prop 103 was aimed primarily at the auto insurance industry. Malpractice carriers were required to rollback, to provide premium refunds to their insureds, and this was at a 20-

percent level. However, in the consent orders that were made with the Department of Insurance, these refunds of premium were considered as dividends, and at the time the insurers were paying in excess of 20-percent dividends, in any event, and there was no rollback of insurance rates required in these consent agreements.

Senator GREGG. So it is reasonable to presume that the real driver of the affordability of malpractice insurance, and therefore the accessibility of, for example, Ob/Gyns in Los Angeles versus Las Vegas, is the MICRA law.

Mr. SMARR. That is my belief.

Senator GREGG. Commissioner, we received a letter from the National Association of Insurance Commissioners, which was cited as a source by Senator Kennedy in his opening statement, and I believe it is the bench-mark group for the purpose of insurance commissioners, and it addressed this issue of price fixing. I just wondered if you agreed with their assessment from your experience as an insurance commissioner in Texas.

The first question was whether or not the legislation, this would be the legislation introduced by Senator Leahy, presumes that medical malpractice insurance carriers are engaging in price-fixing, bid-rigging and market allocation. And the response of the Association of Insurance Commissioners was "No. To date, insurance regulators have not seen evidence that suggests that medical malpractice insurers have engaged or are engaging in price-fixing, bid-rigging or market allocation," and I emphasize the next sentence. "The preliminary evidence points to the rising costs and defense costs associated with litigation as the principal drivers of medical malpractice prices."

Then, they go on in another answer to say, "Again, the evidence points to high loss ratios, not price-fixing, as the primary drivers of escalating premium costs."

Do you agree with those conclusions?

Mr. MONTEMAYOR. I do, Senator. The bulk of our research points to losses, the checks written to, as a result of claims, as well as defense costs, as being the primary driver of premiums universally across the country. I would agree with that assessment.

Senator GREGG. Is it your experience in Texas that 70 percent of medical malpractice suits are won by doctors?

Mr. MONTEMAYOR. Our experience in Texas is, in fact, even a little higher than that. It is in the mid eighties. Most lawsuits end up with zero payment to the plaintiff, but they do result in additional costs due to the defense costs.

Senator GREGG. That was going to be my question. A previous chart noted that even cases that doctors win still cost $91,000 to litigate. To what extent, are those costs frivolous?

Mr. MONTEMAYOR. I would not be prepared to speak to which percentage of those were frivolous. I mean, I can tell you that of those that did go to trial, the doctor won them 85 percent of the time or so, and the plaintiffs won some 15 percent of the time.

Senator GREGG. Is it reasonable to presume that some percentage of those cases are brought because the plaintiff's attorney believes that, even though they are not going to win the case, they are going to win the costs?

Mr. MONTEMAYOR. That certainly is one of the conclusions that we have reached in looking into this issue.

Senator GREGG. How do we address that, from the standpoint of legislation? Should we make it a "loser pay" situation like the English have?

Mr. MONTEMAYOR. That is a policy matter, Senator. I do not have a good answer for that.

Senator GREGG. To the extent that there has been gross negligence, again, Commissioner, should there be a cap on damages if there is gross negligence or willful negligence, willful misconduct?

Mr. MONTEMAYOR. I will tell you that in speaking to all of our leaders at the State level and all of the other insurance commissioners, I do not think anybody is interested in denying those people that have been, in fact, the recipients of a medical error access to have their grievance redressed. I think the real issue is striking that right balance, in terms of keeping insurance affordable, and available, to all physicians vis-a-vis the cost of the losses associated with it.

One of the methods that was tried in the State of California was, in fact, through caps, and our research shows that they consistently, no matter what specialty we are talking about, they consistently get far better rates in that State than anywhere else. But there or anywhere else, it is all driven by the cost of actually the claims themselves.

Senator GREGG. It seems reasonable to me that if there has been conduct which goes outside the bounds of typical error that you should have a different recovery system.

Mr. MONTEMAYOR. It would seem reasonable, Senator.

Senator GREGG. Is it not also intuitively obvious that if the number of claims that are over a million dollars is increasing faster than any other percentage of the group, that it is really the claims that are driving this problem, not collusion of the insurance companies or loss of revenue from bad investments?

Mr. MONTEMAYOR. Without doubt. All other costs are a distant second. The primary driver of premium levels is, in fact, claims made in defense costs.

The CHAIRMAN. Senator Kennedy?

Senator KENNEDY. Thank you very much.

Mr. Montemayor, you State that investment income is not the real culprit of medical malpractice rate hikes of 80 percent to 140 percent for the major companies in Texas because a preponderance of the investments in bonds. Are you not overlooking the fact that with the interest rates at a nearly 40-year low, the bonds have not been doing very well in recent years?

In fact, I have the document from the Texas Department of Insurance, dated August 15, 2002, which shows that the net investment income is way down for medical malpractice insurance. It steadily dropped from $1.347 billion in 1997 to $1.228 billion in 2000. This is a decline of $120 million. In 2000, they also sustained $441 million in unrealized capital losses. The total yield on their investments has fallen from 8.1 percent in 1997 and 5 percent in 2000.

The reduction in earnings these companies have sustained sounds pretty substantial. Is that not what your department data

shows, and how can you discount it as a cause of the substantial premium increase which Texas doctors are seeing?

Mr. MONTEMAYOR. Without doubt, Senator, the level of investment income has in fact decreased, as you pointed out, due to a lower prevailing interest rate on the bond market. However, the old rates were set on a prospective basis, and what that really, really means is that the level of help you will normally get, in other words, your ability to price it at 117 percent, now means that you have to price it at 110 percent of expected losses in order to break even. The Medical Liability Trust, which is the primary driver or writer in Texas—they write some 10,000 doctors out of the approximately 30,000 doctors that are in practice in Texas—projects that they will need about 10 percent return on income, and it is a Medical Liability Trust. In other words, the level of help is just not there.

Senator KENNEDY. The point about it is you have had a decline of $120 million, $441 million in unrealized capital losses. No one is questioning you have the losses. Someone has to make it up, and it appears to me it is the doctors that are being asked to make it up.

Mr. Smarr, you State in your testimony that the net income for the PIAA companies was only 4 percent in 2000. It fell to minus 10 percent in 2001. By comparison, on page 6, on graph 6 of your testimony, shows that the net income was over 20 percent per year, 1995, 1996, 1997, and was 17 percent in 1998 and 12 percent in 1999. Those are all very good rates. Net income was so strong in those years, because as the graph on page 8 shows, investment income as a percent of premiums, was between 43 and 46 percent. Then in 1999 it dropped to 33 percent. In 2001 it dropped to 31 percent. That is a substantial decline. Companies were taking in one quarter less in investment profits. Is this substantial decline of investment income not the largest factor in the timing and the amount of premium increase we have seen in the last 2 years?

Mr. SMARR. No, Senator Kennedy, I do not believe that it is. Our companies did earn more investment income in prior years because prevailing market interest rates were higher, and that is a fact of life that we have to live with.

Senator KENNEDY. That is just what I am saying. Then you have less. So you have the losses, and you are increasing the premiums on the doctors.

Mr. SMARR. It is not losses, Senator. It is the amount of interest we make.

Senator KENNEDY. Well, whatever way you want to describe it, counting, it is not there. I mean we got the charts just reflect that in terms of it—we do not want to spend the time—whatever way you want to show it, it was not getting the kind of income that you were getting in the previous years.

Mr. SMARR. Yes, sir. I think none of us are getting the kind of investment income.

Senator KENNEDY. We just admitted, this is what the charts show, you had 23 percent, 20 percent in 1996, 1997, 21 percent, 17 percent in 1998, and minus 10 percent in 2001. That is what your charts show.

Let me go to the issue about California, the MICRA. I would like to ask Mr. Angoff if he would interpret the figures on California. I have them here. They are part of your testimony, Exhibit 3. We have heard a great deal about MICRA, about starting in 1976 and how it basically stabilized. Then we see MICRA is upheld by the California U.S. Supreme Court, and we get the largest increases. And then we have Proposition 103, which is the Insurance Reform in 1988, where from 1988 the premiums were in I guess in hundreds of thousands, 663,155, hundreds of thousands, to in 2000, 609, so there is virtually no actually decline.

Can you explain, since we have heard a great deal about from 1976 to 2000 there are really three sets of figures, one where you have stability in premiums earned for the first years. Then a very dramatic, 2 or 3 percent bubble up, and then the stable figures afterwards. What should we know? What do those figures tell us? What were the factors that influenced that, and what should we—how should we take those figures in trying to understand the medical malpractice question?

Mr. ANGOFF. Mr. Smarr is correct that the aggregate increase between 1976 and the present in California is much less than the aggregate increase country wide, but the facts show that that relatively good experience in California is due to Prop 103 for the following reason.

MICRA was tied up in litigation for the first couple of years. The California U.S. Supreme Court finally upheld the two most significant parts of MICRA, the limit on noneconomic damages and the limit on attorneys fees in 1985. A year after the California U.S. Supreme Court upheld those two provisions. Medical malpractice premiums in California rose by 35 percent. Now, does this mean that MICRA caused malpractice premiums to rise? No, that would be pure demagoguery to take that position, and that is not the position that I am taking.

On the other hand, MICRA clearly did not cause malpractice premiums to fall. Malpractice premiums only started falling after Prop 103 was enacted in 1988. In 1988 medical malpractice premiums were 663 million. They went down to 633 million the next year. They kept going down. And even in 2000, 12 years after Prop 103 was enacted, malpractice premiums in California are 609 million, about 10 percent less than they were in the year before Prop 103 was enacted.

Now, Prop 103 did roll back rates by 20 percent, and as I said in my testimony, that is a very extreme measure. It might sound even a little wacky. You cannot just mandate companies to roll back their rates by 20 percent. But the California U.S. Supreme Court upheld that rollback as long as insurers had an opportunity to avoid the rollback if they can show that they cannot earn a fair rate of return with the rollback. So that was upheld by the California U.S. Supreme Court, and in addition, very importantly, Prop 103 did not only roll back rates by 20 percent, which was very important, but it also repealed the State Antitrust Exemption so that in California insurers can share data that will allow them to make prices, set prices more accurately. They can share their past cost data, which is permitted under the antitrust laws, but they cannot get together and agree on future prices which is not permitted.

And then finally, Senator, MICRA also gave doctors and consumers automatic standing to intervene in rate cases before the insurance department. That is, if an insurance company files for a rate increase, under Prop 103 any consumer, any policyholder, including a doctor, can intervene and can try to show why that increase is excessive. So, yes, I think the evidence shows that Prop 103 is what is responsible for the relatively good experience in California.

Senator KENNEDY. Thank you.

The CHAIRMAN. Mr. Smarr, as I understand it, California did stabilize rates while other States were continually going up. Am I wrong about that?

Mr. SMARR. No, Senator, you are correct.

The CHAIRMAN. So that did happen. Let me ask you this. On page 6 of his written testimony, Mr. Angoff suggests that doctors who own and operate the companies that you represent are taking advantage of their colleagues, increasing prices for the wrong reasons to increase profit.

Now help me out with this. Sixty percent of America's doctors are insured by these companies. I have not heard from one doctor that he or she feels that we need legislation to prevent their own doctor-owned insurer from taking advantage of them. Now, who is right here? Are doctors being ripped off?

Mr. SMARR. Senator Hatch, I have not heard from one doctor either that they feel like they are being ripped off by their physician owned or run insurance company. The companies are run very conservatively. They pay dividends to their policy holders, and their core purpose in being, their only purpose in being, is to provide a fair and equitable market for their insurers.

The CHAIRMAN. Well, we all know that the stock market has declined during the last 2 years, but is that what is driving the current medical liability crisis?

Mr. SMARR. No, not at all. The malpractice companies are not largely invested in equities, and there is no way that that could even be considered a prime driver of this crisis.

The CHAIRMAN. Commissioner Montemayor, there are some who suggest that one of the principal reasons for the rise in medical liability rates is the McCarran-Ferguson Act, the antitrust exemption for the insurance industry. Yet on page 5 of his written testimony, Mr. Angoff candidly admits, quote, "The extent to which insurers today are acting in concert to raise prices has not yet been determined," unquote. Now, I am personally not aware of any evidence to suggest that medical liability insurers have reached specific agreements to raise prices. Are you aware of any specific evidence demonstrating that any of the increase in medical liability insurance rates is the result of an agreement or agreements among insurers to fix prices, allocate territories among themselves, or engage in bid rigging? In other words, is there any evidence to suggest that members of the industry are colluding to raise prices?

Mr. MONTEMAYOR. Mr. Chairman, we have come across no such evidence in Texas. To my knowledge, none of my fellow commissioners have come across any such evidence in their State either, and in fact, as my own chart here demonstrated, there is enough variability in terms of what the individual insurance companies operating were doing to sort of lead the indication the other way. In

fact, there is ample evidence that they are not getting together to set those prices.

The primary reason—I cannot overemphasize that enough—for the dramatic increase in premiums is in fact losses, and that, our losses would include not only indemnity payments, but also the duty to defend and defense costs, bar none.

The CHAIRMAN. Mr. Angoff, in your written Statement you write, quote, "Whether or not a State enacted such limitations," unquote, meaning tort reform I take it, quote, "malpractice rates rose during the mid 1980s, fell during the 1990s and are sharply rising today," unquote. Yet the evidence that we have seen today suggests that this is not the case in California. The evidence indicates that the reforms in California stabilized medical liability premiums, and that those premiums have remained substantially lower than the remainder of the country in aggregate since they were enacted.

Now, I would like you to explain, if you will, the dramatic differences between California and the rest of the United States, between 1985 and 1988?

Mr. ANGOFF. I would be glad to, Mr. Chairman. The difference between California and the rest of the country is that California enacted Prop 103 in 1988, which had the effect of immediately rolling back rates and keeping them at moderate levels since 1988. Missouri, it is demonstrable that MICRA, the cap did not have any effect on limiting malpractice insurance rates, because for example, in my own State of Missouri, Mr. Chairman, we enacted a cap in 1986. it was held constitutional immediately thereafter. Yet we are still having the same problems in Missouri. Doctors are still having 100 percent increases in Missouri, even though we enacted a cap. Other States——

The CHAIRMAN. Now, wait. Is not that cap currently over 500,000, about $550,000?

Mr. ANGOFF. Yes, that is true.

The CHAIRMAN. In other words, it is going up all the time.

Mr. ANGOFF. It is indexed to inflation as most are. But you will, Mr. Chairman, that today, regardless of whether or not a State has a cap, malpractice rates are going way up. It happens to be the case that in my State, based on the data the insurance companies submit to us, litigation is decreasing, not increasing. The average payment per claim is decreasing, not increasing. And despite that, rates have gone up by over 100 percent in a little over a year according to the State Medical Association. So despite the fact that we have good experience, despite the fact that we already enacted a cap, malpractice rates are still dramatically increasing in Missouri. That is why it seems obvious to me, Mr. Chairman, that the cause cannot be the litigation system.

The CHAIRMAN. Let me just ask one more question. I have to head over to the floor. But let me put it this way. Mr. Smarr, we have heard from you that in California the Medical Injury Compensation Reform Act, or MICRA, stabilized medical liability insurance costs. We have heard from Mr. Angoff that Proposition 103, not MICRA, is what worked in California. Now, who is correct? Is it MICRA or Proposition 103 or both?

Mr. SMARR. Chairman Hatch, the Prop 103 argument I think is just totally false. I have here consent agreements which were

signed by physician-owned insurance companies in California, and paragraph 4 of the consent agreement for the NORCAL Mutual Insurance Company, for example, States: A rate rollback obligation is a return of premium, and as such is treated as a policy holder dividend in accordance with customary industry practice.

Now, this rollback as a return of premium was to be paid in 1992. And with respect to the NORCAL Mutual Insurance Company, which I believe is typical, in 1990, NORCAL paid dividends back to its policy holders of 27 percent of premium. In 1991 it paid 26 percent. In 1992, the year the 20 percent as to go back, it paid 31 percent of premium. In 1993 it paid 37 percent of premium back to its policy holders. In 1994, 34 percent and so on. But I have to tell you that NORCAL currently is paying something like 4 percent back to its policy holders because of the deterioration in this loss experience. Prop 103 was not an issue.

The CHAIRMAN. Just one last thing. The Harris poll stated that the fear of being sued has led 79 percent of doctors to order more tests than are medically necessary. In other words, doctors are practicing unnecessary defensive medicine. The same poll stated that 76 percent of the physicians are concerned that malpractice litigation has hurt their ability to provide quality care to patients. Now, I personally believe that that is putting a lot of pressure on insurance rates as well, because of the high cost of defensive medicine.

I remember when we were advising doctors in these matters—it was a long time ago, when I had any type of practice in this area—we just told them: You are just going to have to fill up your history. You cannot afford to just tell a patient with a common cold, take 2 aspirins every 6 hours, drink all the liquids you can, in 6 days, 7 days you will be better, or do not do anything, in 7 days you are going to be better. You are going to have to order respiratory exams, cardiovascular exams, etc., which certainly had the effect of driving up the cost. Is that what you are experiencing?

Mr. SMARR. Well, defensive medicine drives up health care costs, and one estimate issued by the National Bureau of Economic Research is that up to $50 billion a year is spent in the health care system to pay for defensive medicine, and doctors who fear being sued, in case they do not do a test. Every sprained ankle now apparently gets x-rayed because somewhere in a group of 100 sprained ankles there is going to be a fracture that will wait 2 weeks to be diagnosed. And so this fear of being litigated against is forcing doctors to order tests that would otherwise not be necessary.

The CHAIRMAN. Thank you. Mr. Chairman.

Senator GREGG [presiding]. As is our tradition, we will recognize members in order of arrival. Senator Dodd, alternating back and forth, Senator Dodd.

Senator DODD. Thank you very much, Mr. Chairman. I commend both the chairmen for holding this joint hearing. Obviously it is a matter that requires the attention, as I understand it, of both committees. So I appreciate the opportunity to listen to our witnesses.

I want to begin by thanking Laurie Peel and Linda McDougal and Leanne Dyess for being here. It is not easy to come and talk about personal stories, and it takes a lot of courage to do so, and

we are very grateful to all three of you for being here to share your stories with us this afternoon, and you have our deepest sympathies for the difficulties you have been through personally.

Just a couple of questions if I could. One is I would like to ask our two insurance commissioners if I could. People get somewhat confused. If you have an automobile accident, your premiums on your insurance for your automobiles is going to go up. But my neighbors' generally will not. There is not the sense that because people live in the same neighborhood, one has an accident, the other does not, everybody gets a higher premium cost. Why cannot that work here? It seems to what you have got are doctors paying this thing, but our physician from Nevada went through here, had a good record over 12 years, no incidents at all as I understand you, doctor, and yet your premiums went up. Now, I presume there were doctors in Nevada that were subjected to malpractice loss, legitimate ones. You acknowledge that, I presume, there were various cases?

Dr. WILBOURN. Yes. There were.

Senator DODD. Let me just finish the question.

Dr. WILBOURN. I am sorry.

Senator DODD. My point being here, why do we not apply the same standard we do on automobile insurance to medical malpractice insurance?

Mr. ANGOFF. Senator, we could do that. That is something that would have to be done at the State level. But it would make—it has frequently been suggested that the categories of doctors should be broadened so that there are more doctors in a category, thus spreading the risk more broadly, but that within the category doctors' rates should be based on experience. That is, a doctor who had to pay—who was found negligent would be surcharged. A doctor who was found negligent twice would be surcharged even more, and then real high risk doctors would be put into a residual market, which exists in auto insurance for the really bad drivers. The same concept is in place in certain States and it could be put in place in other States, so that there would be what is called a joint underwriting association for doctors who have been found negligent several times, and they would pay higher premiums, but in addition their premiums would be subsidized.

Senator DODD. So in effect, Dr. Wilbourn was driven out of the State of Nevada, not because of anything he did wrong, but because of what some of his colleagues did, and that is why his premiums went up.

Mr. ANGOFF. That can happen. I mean that is happening.

Senator DODD. Want to answer that, Commissioner?

Mr. MONTEMAYOR. Senator, you are on the right trail. I mean everything in property and casualty, which this is, it is frequency and severity, and so the different classes of doctors are somewhat similar to different kinds of vehicles, Ob/Gyn's, family practice, neurosurgeons, etc. And so you look at the probability of them being involved in a claim, and then on average how much the claims have been, and in the most rudimentary of ways you look at both frequency and severity for this period and this period and this period, and you draw a line, and in estimating the future period, just extend it one more. And that is essentially what they do. And they

do have a methodology for surcharging based on individual claims to try to manage that, but it is basically a spreading of risk by like class and kind to some manageable level.

Most of the insurance companies will determine how they set up their territories for rating purposes and so forth, but it is essentially the same type of exercise, Senator.

Senator DODD. In the full disclosure, I represent the State of Connecticut, and we have a small cottage industry called insurance in my State, but I am curious on how these issues work. I will also tell you that my State of Connecticut, we have roughly 13,500 doctors, about 30,000, I think the number is, nurses—in fact we have a shortage of about 11,000 in my State. We have 31 hospitals in the State of Connecticut. And I went back and checked with my insurance companies and my physician groups in Connecticut. We average somewhere around 350 medical malpractice suits each year in the State of Connecticut. And one of the reasons I am told we do is because they have a number of rules in Connecticut. One is that before a claim can be filed, you must have a signature or a document signed by a physician saying that the claim, if proven to be true, would be a legitimate malpractice allegation, and you have got to get that certification before you can go forward. And it seems to have had the positive effect of reducing the number of lawsuits being filed.

I wonder if you might share with us, just from your own experience, what other countries may be doing, what others are doing. I, for one, will tell you, I always wrote the Private Securities Litigation Reform Bill for the U.S. Senate a number of years ago to limit frivolous lawsuits in the securities field. And I wrote along with Bob Bennett the restrictions on tort reform, if you will, of some tort reform, and the Y2K legislation, along with Mike Enzi and others who were involved in that. So I have certainly been supportive in the past of tort reform issues. But I for one believe—and I will tell you very strongly—the idea of putting caps on what people can receive for their pain and suffering is just a nonstarter. I do not know what will happen here, but I guarantee a lot of us will fight that tooth and nail. [Applause.]

Senator DODD. I did not mean to get that—but I think there are other things that can be done.

Senator GREGG. Excuse me, Senator. Actually, demonstrations are not appropriate to hearings. We appreciate that this is an emotional issue and that people like to express themselves, but it is better if we maintain a decorum within the hearing process.

Senator DODD. I would like to just ask if I could what the Connecticut experience, which does not have caps but has instituted these other reforms, it seems to be producing the desired results that people are looking for here. What is being done elsewhere along those lines short of a cap approach that you think may be constructive and positive.

Mr. ANGOFF. Yes. Senator, Missouri has what sounds similar to Connecticut. It has a requirement that there be an affidavit of merit, and lawyers on both sides seem to live fairly well with that.

Senator DODD. What is the effect of that in terms of the number of malpractice claims that are being filed?

Mr. ANGOFF. Well, it is tough proving cause and effect, but as I outlined, the number of claims in Missouri has gone down, both paid and reported. Whether it can be attributed to that, who knows? But the experience of Missouri is good.

Senator DODD. Commissioner from Texas?

Mr. MONTEMAYOR. We have got a similar requirement in Texas, Senator, where an affidavit is required. The number of claims has gone up roughly at the 5 percent level. The severity of the claims has gone roughly at the, I believe 7 or 8 percent level. Combined frequency and severity have made costs go up approximately 11 percent each and every year looking back. But that has been the trend there. But there is a similar requirement in Texas to date.

Senator DODD. And last, Ms. Dyess, could you just tell me——

Senator GREGG. Senator, I think your time has expired. Can you just ask during the second round.

Senator DODD. Just ask one last question if I could.

Just out of curiosity, they are obviously a different set of circumstances, but do you support a cap on pain and suffering? Would you support that?

Ms. DYESS. It really does not matter what I think.

Senator DODD. Well, it does. You are here as a witness.

Ms. DYESS. I would support a reasonable cap, a reasonable cap.

Senator DODD. Thank you.

Ms. DYESS. But you have to understand that I get nothing. I am not suing anybody.

Senator DODD. No, I understand that. I am just curious, knowing what you have been through, whether or not a cap of some $250,000 would be acceptable to you.

Senator GREGG. Senator Alexander.

Senator ALEXANDER. Thank you, Mr. Chairman, and thanks to the witnesses for being here. I had to step outside the hearing room for a few minutes to see someone else, but I have enjoyed the discussion.

Let me focus on one aspect of this crisis and use some facts from our State. The issue that concerns me the most about this crisis is the effect it has had on prenatal health care for expecting mothers. I remember a few years ago when I was serving as Governor. Tennessee had the most prenatal health care problems in the country. One of the things that we wanted to do to change that was to make sure that every expectant mother had a medical home for her child. This meant connecting expectant mothers with doctors who deliver babies. We worked in a voluntary way with doctors, and especially in Memphis and other parts of our State, we were successful. So, it concerns me greatly when I hear from doctors and from communities that many doctors are leaving family practice. It must be very difficult for expectant mothers, especially poor expectant mothers, to have a medical home for their child before the child is born. This problem can have a tremendous effect on our future. I was a Governor who very strongly defended States' rights in this case, and I am a lawyer who respects our profession, but I am now convinced that we have a real problem with runaway lawsuits.

We have talked a good bit about rural areas and how mothers may have to drive a distance to have their baby, but just this morning I was visiting with a delegation from Memphis—the Bap-

tist Memorial Health Care Corporation. They operate 17 hospitals in Tennessee, Arkansas and Mississippi, with 52 affiliated physicians. Their liability insurance bill last year was $2.6 million, and for similar coverage this year is $8.2 million. And I was listening to the discussion about California and the debate back and forth as to what seems to have caused it. At least we have identified the fact that California is different from other States. Tennessee is not a crisis State among those States that were listed today, so we are not as bad as other States, but here are the figures.

In 2002, the medical liability insurance premium for general surgeons in Tennessee was $35,000; 2003, $62,000. For an Ob/Gyn in Tennessee, the medical liability insurance premium was $62,000 in 2002; in 2003, it increased to $160,000. In California medical liability insurance for Ob/Gyns is only $57,000.

I am seeing that at least we have identified something right is happening in California. The issue seems to be what the cause of it can be. I am very skeptical about the idea that the caps on limits and the caps on fees have not been the greater cause of the lower costs in California.

For example, the comment was made that litigation is going down. In our State, Volunteer Mutual Insurance Company insures about 10,000 doctors. There are 2,000 pending medical malpractice lawsuits against these 10,000 doctors.

Mr. Smarr, is it reasonable to you that for every five doctors there should be one medical malpractice lawsuit? Are doctors that negligent? Is this a reasonable circumstance? It seems to me that this represents a condition of runaway lawsuits that require some sort of corrective action.

Mr. SMARR. Senator Alexander, that is not an unexpected statistic, but I the it is unreasonable that there are that many lawsuits, especially since 70 percent of those on average will be found to have no merit.

Senator ALEXANDER. I talked with the chief medical officer at Vanderbilt Medical Center. Dr. John Sergent says that for the first time Ob/Gyn doctors in Tennessee are saying they may be forced out of practice, and we are not a crisis State in Tennessee, according to this list. At the University of Tennessee, Dr. Jim Gibb Johnson says that one third of all residents in training since 1990 have been served with a malpractice suit. That sounds like runaway lawsuits to me. So I welcome the opportunity to have this hearing, and appreciate the emotional feelings on all sides. I am glad to have the California experience, and I hope that as time goes on we can isolate which of the causes made the most difference. It sounds to me like, Mr. Smarr, that you have the better side of the argument, but I will keep listening.

Senator GREGG. I believe Senator Clinton is yielding to Senator Edwards. Senator Edwards.

Senator EDWARDS. Thank you, Mr. Chairman.

Ms. Peel, welcome. We are glad to have my neighbor from Raleigh here testifying today. Appreciate you being here.

Let me go to the question just raised by Senator Alexander, because I think we have to be very careful not to have a complete disconnect about what we are talking about. The President likes to use the term "frivolous lawsuits." I think it is important to distin-

guish between frivolous lawsuits and the remedy that is being proposed here. The remedy, frivolous lawsuits are lawsuits that never should have been brought, that have no merit, where the contentions of the person bringing the case should never have been in the court system. What the President is proposing is that we put a limit on the most serious cases, because what he is suggesting is the way to curb frivolous lawsuits is to limit the rights of the most seriously injured, because they are the only people affected by noneconomic damage caps, which is what we are talking about.

And let me just say to begin with, I think that talking about the lawsuit lottery is not productive. We have people, including some people in this audience, kids that have been paralyzed for life, children who are blinded, who I represented for 20 years. And those families, I promise you, do not think they have won any lottery. They are faced with very, very difficult circumstances, not for a year, not for 5 years, but for 60, 70, 75 years. So I think that is not a good way for us to talk about this issue.

I do believe that the doctors have a serious complaint. I think the question is, what is it that is causing this problem? And there is a difference between cases that should never have been brought and cases where people are very—in many cases, kids, women, senior citizens, have been very seriously injured. Because the cap on noneconomic damages for people who earn a good living, the senators at this table and others, economic damages are not being capped. So if you make a good living, and you have had a huge economic loss as a result, you are going to have a—your recovery will be just fine. It is people like Ms. McDougal, children. These caps on noneconomic damages hit children and seniors and women like a laser, particularly for example a stay-at-home mom who is not working, and as a result has no lost wages or what is commonly talked about as economic damages. So I think we have to be very careful about distinguishing between frivolous lawsuits on the one hand, cases that should never have been brought—and I was interested in Senator Dodd's idea about dealing with doctors on an individual loss basis—and second, cases of people who are very badly hurt, in many cases kids, and putting a limit on their rights. Those two things have nothing to do with one another.

Mr. Smarr, I wanted to ask you a couple of questions if I can. You were testifying about MICRA and whether MICRA has had an effect or whether it is Prop 103 that had an effect in California. I mean I have got from the State insurance commissioner the actual numbers in California as opposed to your chart.

In 1976 the insurance premiums paid in California, the year that MICRA was passed, $228 million. In 1988, $663 million, or an average increase of 24 percent. So over the first 12 years that MICRA was in place, there was an average increase of 24 percent. In 1988 Prop 103 was passed. Between 1988 and 2001, in other words, for the 13 years after passing of Prop 103, insurance premiums went from 663 million to 647 million. They actually went down. So for the first 12 years that MICRA was the law of California, insurance premiums went up 24 percent a year. I doubt that the doctors think that is okay. And after Prop 103 was passed, the insurance premiums actually came down over the course of the next 13 years.

Mr. Angoff, is that your understanding of roughly what happened?

Mr. ANGOFF. Yes, it is, Senator.

Senator EDWARDS. On the issue of cases that should not be brought, so-called frivolous lawsuits, in my State as in your State, Mr. Angoff, we have a requirement, what is called an affidavit of merit. And the idea is that before a case comes to court and gets involved in the court system, we make the lawyers involved thoroughly investigate the case, have the case in fact reviewed by an independent expert in the field to make sure that cases that are actually getting into the court system are cases that have merit. Now, I know that is not a nationwide law. That law only exists in selected places around the country. It exists in North Carolina, and apparently exists in Missouri. I think actually it is a very good idea because we want cases that are going to be in the court system, taking up the court's time, taking up cost.

Commissioner, you talked about some of the costs associated with defensive cases, and those costs are legitimate and acceptable so long as they are cases that are serious, that ought to be in the court system and should have been brought. On the other hand, if there are cases that should not be in the court system—I mean, we would like to find a mechanism to make sure that the cases that get into the court system are actually meritorious and are serious cases like the cases that I described earlier. And whether this is the specific mechanism, I think it is actually a good one, but if there is another better way to do that, we should talk about that because—I can only speak for myself. I did this kind of work for 20 years, almost 20 years, and I did this myself anyway, but it seems to me that we want to make sure that people who are bringing cases have serious legitimate cases that belong in the court system, and some screening mechanism to make sure that that is true I think is reasonable. I do not think it is reasonable—and I agree with Senator Dodd about this—to say to women and kids and senior citizens, who have been paralyzed for life or blinded, we are going to take away your rights. First of all, I do not think there is any cause and effect. I think this testimony today shows absolutely no cause and effect between those two. And I do, I might add, have a little trouble—and Senator Kennedy asked questions about this—accepting the argument which I hear being made, that the fact that the malpractice crisis in the 1980s and this malpractice crisis, which is very real for the doctors, no question in my mind about that, that has no relation to the fact—it is just a pure coincidence that those happen to be times that the market was doing poorly. You know it is difficult for me—I mean I hear all of your use of numbers, but it is just difficult for me to accept that those things have nothing to do with one another.

Senator GREGG. If the senator would not mind concluding his remarks, because we do have others.

Senator EDWARDS. I will conclude there. Let me just say one last thing. I do think that we need to do something about the problems that the doctors are facing. I think these insurance premium increases are serious. I think the place that I differ with some of the witnesses at least is about addressing what the cause of those problems are. And if we can keep cases that should not be in the

system out of the system, I think that is a very good thing and we should figure out a way to do that.

At the same time I still believe that there is a relationship between what is happening in the markets and investment income, which Senator Kennedy asked about, and these premium increases, which clearly are much more than even what you are contending are the increases in payouts.

Thank you, Mr. Chairman.

Senator GREGG. Thank you, Senator.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman. I appreciate having this hearing. I have learned a great deal today. I would ask that a Statement that I have be made a part of the record.

[The prepared statement of Senator Enzi may be found in additional material.]

Senator ENZI. I want to bring a different dimension to some of the discussion here. I am from Wyoming. Wyoming is the least populated State in the Nation. We are one of those two square States out there in the West—we could not exist if the square had not been invented. We are about 300 plus miles on a side, and we have a little over 493,000 people in the State. Our biggest city is 50,000 people. It goes downhill pretty quick from there, so we have a little problem with the number of doctors that we have, and we are considered a risk pool all by ourselves.

I do not have a way to check and see how drastically that affects the insurance rates, but I know that it does. Not only are our obstetricians leaving, a few days ago in the Washington Post, page 2, there was almost a full page article about a doctor in Wheatland, Wyoming, whose insurance premiums just went up above $150,000. He is going to quit his practice.

Now, in Wheatland he delivered all of the kids. He was interviewed at a basketball game in Douglas—that is 60 miles away. He delivered a third of the kids there. In Casper, Wyoming, we have a doctor who is also leaving his practice there. He delivered a third of the kids in that town. That city is just under 50,000. In Torrington, they are losing their only doctor, which means all medicine, not just obstetrics.

So we have got this huge problem. I am willing to consider any kind of a solution. Actually, what I would like to do at the moment I think is join California as part of their risk pool. I guess that is not an option.

We have two insurance companies for doctors. I remember when we had our first child. It was a difficult delivery, came about 3 months early, and consequently, when we were having our second child, there was no doctor in our town. There was only one to begin with, but he was not willing to take on a second child with those kinds of difficulties.

I hope when we are looking for the solutions on this, we will take into consideration those areas of the country that are extremely remote and extremely rural. Dr. Wilbourn comes from a State that is considerably more populated than Wyoming, but is still down on the bottom of the chart. And you described some of the medical liability and patient access problems that are in your part of the

country. Do you think that the crisis you described is less severe in States that have enacted medical litigation reforms?

Dr. WILBOURN. I am sorry. Could you repeat that one more time?

Senator ENZI. Yes. Do you think that the problems you described, the crisis you described, the thing that is getting you out of the field, is less severe in States that have enacted medical litigation reform?

Dr. WILBOURN. I think it is to a great degree. There is a lot of reform that can be done. But when we see these lawsuits go forth and there is no limit to what you might get from a jury, then there is nothing to deter someone from saying, "Let us sue 100 people this week, and maybe one of them will—or maybe they will settle just because they do not want to spend $91,000 defending this case, and we will get something, and I really do not even have to go to the courtroom. I do not have to try this case. I will just get enough in this settlement and that settlement because the insurance companies will do that."

So there is no deterrent to keep the number of suits down. So we get into this situation where more and more suits are filed, the premiums keep, in my opinion, keep going up. Yes, there is a lot of different answers here today as to who thinks it is whose fault. The problem that we have is the doctors are sitting here saying, I do not know who you are going to say whose fault it is, but I cannot practice medicine under these conditions. I cannot pay my malpractice insurance premium. I am left to either go out of business or move somewhere else.

I chose a State that does not seem to be litigious. I jokingly said the other day that in Maine if there is a problem, instead of suing you they just run the snowplow past your driveway so you cannot get out in the morning. [Laughter.]

Dr. WILBOURN. But it does not seem to be as a litigious environment in that State. Perhaps that is why the rates are still affordable. I am greatly concerned. There was just an article in yesterday's Bangor Daily, editorial that was written by the chairman of NEH, New England Health Care Systems that has Pen Bay Hospital in Camden, citing this concern, the increase in insurance that the hospital was having to pay this year for the hospitals that are in Camden, and that he was concerned that the problems that were in New Jersey and Pennsylvania were going to start to move northward into our States, and that perhaps our senators should look at that now before we get to a crisis in Maine.

Senator ENZI. Thank you. And since my time has expired, I will be giving you written questions, including a couple others of you, particularly Mr. Montemayor on his feelings among insurance commissioners for expanding beyond their borders to have bigger risk pools for the liability. So I will send that to you in writing though since I have run out of time.

Dr. WILBOURN. Senator, I will look forward to it.

Senator GREGG. Senator Specter has to leave, so he would like to make a comment for the comment in a couple seconds.

Senator SPECTER. I compliment, Mr. Chairman, on scheduling the hearing, and I have a commitment at 5 o'clock, and I will try to get back to ask questions, but if I do not I will submit them for the record. Thank you very much.

Senator GREGG. Senator Clinton.

Senator CLINTON. Thank you, Mr. Chairman.

And I want to thank all of our witnesses today. I think that the testimony we have heard, particularly from Ms. Peel, Ms. McDougal and Ms. Dyess, put into very stark terms what it is we are here about. And underneath the current of conflicting charts and information and ideas about what should be done, I think there actually is some common interest, or at least I hope so, because as we evaluate the options that are before us, it will not do us or anyone any good if we merely fight ourselves to a draw and point fingers at each other and then nothing changes. And the kind of poignant and painful stories that we hear, not just from the witnesses on the panel, but from the people in the audience and literally around our country will be in vain.

I think, Mr. Chairman, that we have actually made some progress in elucidating these issues today, and for me, we ought to be looking at five different factors as we move forward. Each of them are equally valid, it strikes me.

First. Does any plan that we propose or that anyone were to propose in a State or in the private sector reduce liability insurance premiums for physicians? I think there is unanimity on this panel that we have a problem, and even if it is a problem that ebbs and flows with the economic conditions in the marketplace, it still is a problem, and it is a problem that discourages and deters people from practicing in certain places and from being available.

No. 2. Does any plan that we would consider provide for adequate access to high-risk specialists or the availability of high-risk procedures? I mean it is heartbreaking that Ms. Peel would move to a major city in our country and not be able to find easily a Ob/Gyn to care for his high-risk pregnancy, or that Ms. Dyess's husband would not be taken care of. That we should deal with regardless of the context in which we are concerned, because that is just absolutely unacceptable.

Third. Does any plan reduce the current rates of preventable injuries and damage? You cannot, as a woman, sit and listen to Ms. McDougal's story without just being horrified, and I really thank you for your courage in coming forward. I know that it cannot be easy for you and your family. And we have to ask ourselves what is it we need to do? Because there is a lot of evidence from GAO reports in 1999, from the Institute of Medicine report, that there are problems, there are preventable problems. There is ordinary, if you can call negligence ordinary, and then there are the very rare instances of intentional harm that can be traced to a history of drug or alcohol abuse or other very unfortunate circumstances.

Fourth. In conjunction with reducing the current rates of preventable injury for individual patients, we do not want to do anything, it strikes me, that closes the door on raising larger problems within the medical and health care community. And by that I mean that it was malpractice cases brought on behalf of individual patients that brought to attention issues like IUDs that caused injuries and infertility, or DES which we know was used for trying to prevent problems, but created miscarriages but created birth defects and cancers. And there are many other instances of that. Unfortunately, in our system, given the way our economy and our sys-

tem works, lots of times you do not get the attention you need on these medical procedures and devises in the absence of somebody bringing a lawsuit, and sometimes more than one lawsuit. So as we go forward we have to think to ourselves, Wait a minute. We do not want to do something that inadvertently causes harm and where perhaps a lot of doctors are not aware in one part of the country what is happening in another part of the country until the lawsuits reach a critical mass.

And finally, I am concerned about the kind of catastrophic injuries and the level of compensation that is available, and it does particularly fall on families whose children were injured at birth or had some other kind of difficulty, and therefore you have lifelong care requirements, women who have no income or at least not a very high amount of it, so the economic damages are not significant. And there are those cases where as a society we have to figure out how to deal with them.

So I think, Mr. Chairman, there are many people of good faith on all sides of this issue. This is not, in my view anyway, a either/or, black or white, good guys/bad guys kind of routine, depending upon where you are. But if we can work together to try to figure out what are the questions that we want to have answers for to deal with the legitimate concerns, not the exaggerated ones, not the sky is falling, but really just honestly, what are the problems? How do we sort them out? How do we move forward? Then I think that we actually might be able to make some progress.

I really appreciate the Chairman and his counterpart holding this extraordinary joint meeting to try to air all of these issues.

Senator GREGG. I thank the Senator. Your points are very cogent and right on as far as I am concerned.

Senator Cornyn? You were here first?

Senator ENSIGN. Yes.

Senator CORNYN. I defer to my senior.

Senator GREGG. I was given an incorrect list. I apologize. Senator Ensign.

Senator ENSIGN. Thank you, Mr. Chairman.

First of all, Senator Clinton, I appreciate the spirit in which you offer your comments. I want to start by addressing one of the things that you said. Being a health care professional myself, it is very difficult to legislate better outcomes. It is one of the most difficult things that there is. Each one of the colleges—the American College of Surgeons, the American College of Obstetrics and Gynecology—they all try to police themselves somewhat.

But, Dr. Wilbourn, I think that my profession and your profession, all of them need to do a much better job. However, one of the problems that we also see is that they are afraid at the State board level that they are going to get sued. There is a huge problem that if you police one of your own peers, then you can be sued because you are potentially taking away their livelihood. That is one of the big problems that people are afraid to clamp down on.

Ms. McDougal, you mentioned disciplinary actions of physicians. Again, this is what I am talking about at the State board level. That is something that needs to be addressed, maybe even some tort reform as far as State boards are concerned. You do not want them to be all powerful, but it is very difficult the State boards to

enforce penalties. I am a veterinarian by profession. I see this firsthand. Sometimes I cannot believe some of these people are still practicing. However, after talking to some members on the boards, they are afraid that their livelihood is going to be taken away because of their disciplinary actions. Obviously, there is a serious problem there.

The second thing I want to make a comment on is the point you made about high-risk procedures. This is a very, very serious problem.

In Las Vegas—Dr. Wilbourn, you know this—a lot of the physicians have changed their practice—and you have talked about this—to not take the high-risk pregnancies any more.

And, Ms. McDougal, your story broke my heart as well. You hate to hear these horrible cases where neglect happened. But, I also do not want to hear that because somebody had a child that needed a certain type of care—a high-risk pregnancy—and now there is not a doctor that will take care of them because they cannot afford to risk everything that they had worked their whole life to attain.

Dr. Wilbourn, would you like to address the problem as far as the high-risk procedures?

Dr. WILBOURN. Well, it is just in obstetrics I think anything can be high risk. We were taught in residency the first thing, never trust a pregnant woman. Just when you think everything is going well, something will happen.

There are some factors that we can identify in patients who are pregnant that we know are going to be risk factors. One of the biggest risk factors in a woman's obstetrical care is lack of prenatal care. When that patient has not had access to health care. Therefore, she has not gone to the Ob/Gyn because he was unavailable or she did not have health insurance, and that physician has chosen no longer to take Medicaid. She goes for weeks and weeks and months and months. We do not know if she is anemic so we can correct that. We do not know if there are abnormal testing for genetic abnormalities. We do not have an opportunity to get in early and even avert a possible problem. So now some physicians, when we talk about limiting high-risk obstetrics, a lot of people think that just means I am not going to take care of triplets any more. No. Physicians are saying if you have a due date after this point, in other words, if you are more than 14 weeks or 16 weeks pregnant, I will not see you because I have already missed opportunities early in your pregnancy to avert a potential bad outcome, hence, I will be sued.

So that is another way we have. A limit of access to care has nothing to do with that patient's high risk. We perceive her to be high risk because she has not had care.

Senator ENSIGN. Is it not also true that if you happen to be in an emergency room, such as a physician on call there, and somebody asks you to take a quick look at a patient, once you care for that patient, you cannot fire that patient. Is that not correct?

Dr. WILBOURN. Absolutely. There is a very long process you have to go through in firing a patient. The patient has to be notified verbally, in writing for 30 days. It varies from State to State. I am more familiar with Nevada since I just came from there. But in Nevada you have to send out a letter, return receipt. You have to pro-

vide any care that they need for 30 days until they have adequate time to find another physician. If they happen to be pregnant and show up in labor, you still have to take care of them. It does not matter if they were abusive.

Senator ENSIGN. I hate to interrupt you, but I just want to make one final point. I wish we had more time. Perhaps there is a second round of questioning.

The issue was brought up about investment, and everybody is going back and forth on this issue. What I have not heard addressed is if it is investment income that is now causing the problem. Was it in fact the good returns that allowed the medical liability rates not to increase during the 1990s?

Well, let us say it is the stock market. I am just saying give them their argument—give them their argument that it is investment income. It still does not take away the fact that we are paying out a lot more based on the things that you presented, Mr. Smarr. There are still increased jury award amounts, such as, we are seeing in Nevada. The statistics are very clear in Nevada on the number of huge payment awards, and I imagine around the country they are going up as well. That seems to be certainly a large contributing factor, if not the most important contributing factor.

Mr. SMARR. Yes, Senator, Ensign, I agree with you, and to put it in perspective, actuaries tell us that a 1-percent drop in market interest rates on bonds equates to a 3- to 4-percent increase in premiums. At their height in recent years, long-term bonds are paying 7-8 percent, and they are now down in the 4- to 5-percent range, and so the math is fairly simple to tell that the increase in premiums we are seeing is due not largely to the drop in bond rates, but due to the increase in the cost of the claim.

Senator ENSIGN. Thank you, Mr. Chairman. My time is up.

Senator GREGG. Senator Cornyn?

Senator CORNYN. Thank you, Mr. Chairman.

I want to do as Senator Clinton and Senator Dodd did, and I know really all of us feel the same way in expressing our appreciation to Ms. Peel, Ms. McDougal and Ms. Dyess for coming forward and the courage you have shown talking about your story.

I know Senator Dodd was candid to talk about the fact that a number of insurance companies do business or call their home office in Connecticut, and Senator Edwards, I noticed, talked about the fact that for 20 years he made a living suing doctors and hospitals, and perhaps I need to be candid as well and say I used to be, back when I was a young lawyer, on the other side of that, defending doctors and hospitals. That was a long time ago.

But as much as I have high regard for doctors and hospitals, I have even a greater concern for patients because that includes, of course, all of us.

I wanted to just ask Commissioner Montemayor, since I know him best, being the Insurance commissioner from Texas, who does this crisis of access affect most profoundly? I know, in my travels around the State during the last year, in Corpus Christi, and McAllen, and the Rio Grande Valley, in terms of the socioeconomic stratum that this affects most profoundly, who would that be, Commissioner?

Mr. MONTEMAYOR. Senator, you just put your finger on it. First of all, medical malpractice carriers provide coverage not only for physicians, but also for clinics, also for hospitals and also for nursing homes. In fact, this is where the vast majority of the disruptions began at, but it is pretty much spread throughout the system, and without fail, with the research we have done, some of the very best physician cities, regardless of the specialty, seem to be in places like Sacramento, California. At the worst end of the scale, at four or five times those rates, regardless of the specialty, are places like Miami and Fort Lauderdale. Not very far behind that were places like McAllen, Texas, and Brownsville, Texas.

Senator CORNYN. Would those be the poorest really regions of our State and the most medically underserved?

Mr. MONTEMAYOR. That is correct, Senator. That, in fact, just exacerbates the issue of trying to recruit new physicians and replace retiring ones or those that simply give up the practice.

Senator CORNYN. I know, I think Senator Clinton said it very eloquently, none of us are interested at all in denying people who are injured as a result of the fault of some physician or some person employed by a hospital access to or without a remedy.

I wonder, Ms. McDougal, would you mind, for example, have you filed a lawsuit as a result of your terrible incident that occurred to you?

Ms. MCDOUGAL. At this time, no. I am still experiencing infection, and they cannot continue with my reconstruction until the infections are taken care of. It could be several years.

Senator CORNYN. And without asking you to tell me who the lawyer is and that sort of thing, have you talked to lawyers about the possibility of representing you in a lawsuit?

Ms. MCDOUGAL. Yes, I have.

Senator CORNYN. Can you give us, the committee, an idea of the range of attorney's fee that that lawyer would require in order to represent you, I presume, on a contingent-fee basis.

Ms. MCDOUGAL. That is correct.

Senator CORNYN. What would that percentage be that you have been told would be pretty much what the market does in that area?

Ms. MCDOUGAL. It is 30 percent.

Senator CORNYN. Thirty percent in your part of the country. Well, actually, that is relatively low, compared to some parts of the country. I know, in San Antonio, Texas, my hometown, many lawyers who file these kinds of lawsuits demand 50 percent of the recovery. And, in fact, after the attorney is paid and after the expenses are paid to expert witnesses, court costs and the like, the patient actually gets just pennies on the dollar and is not literally made whole, which is sort of the legal theory that I know sometimes is applied here. The idea is you get full compensation for your injury, but the fact is, under the current system, that does not happen. Is that your understanding?

Ms. MCDOUGAL. Yes. I am a layperson, though.

Senator CORNYN. Sure, I am not asking you to——

Ms. MCDOUGAL. I have no remedy without an attorney.

Senator CORNYN. I am not asking you to explain it. Is that your understanding, though, that basically you would receive what is left over after your lawyer gets paid and after the court costs?

Ms. MCDOUGAL. Yes, it is.

Senator CORNYN. I guess, Mr. Angoff, you testified, I know, in your capacity as a former insurance commissioner, but actually you are a personal injury lawyer, are you not, sir?

Mr. ANGOFF. No, I am not a personal injury lawyer. I am a lawyer specializing in insurance issues. I represent more plaintiffs than defendants, but I do represent defendants and also State insurance departments.

Senator CORNYN. And your firm website lists medical negligence cases as one of the things that you and your firm do for a living?

Mr. ANGOFF. I do not. Some other people in my firm do.

Senator CORNYN. And you typically represent, people in your firm who do those kinds of cases, represent people on a contingent-fee basis; would that be correct?

Mr. ANGOFF. Yes, sir.

Senator CORNYN. Mr. Chairman, I just wonder, just sort of in closing, whether a system that I think as we all want, which leaves no injured person without a remedy, but at the same time as having devastating impact on people who want to give their life to help heal others, physicians and health care providers, and leaves them in such dire straits, but at the same time seems to provide a very healthy rate of return for lawyers, whether the transaction costs associated with getting the money to people who really need it and deserve it are far too high, and perhaps as part of this committee's and this Congress's consideration over what would be the best way to address this, would figure some way that perhaps let doctors and health care providers practice their chosen profession, gave patients access to good-quality health care, provided a full remedy to people who actually were hurt as the result of the fault of others, but at the same time did not result in such huge transaction costs, for which lawyers profit.

Thank you.

Senator GREGG. Thank you, Senator.

Senator Durbin?

Senator DURBIN. Thank you very much, Mr. Chairman, and thank you to the panel. I apologize for having stepped out to go to an Intelligence Committee hearing, but I did read your testimony before I left, and I am sorry I could not be here as you presented it, but I am familiar with what you said to the committee.

Unlike some of my colleagues here who have said that in the past they have defended doctors and others have sued doctors, I have done both. Before I was elected to Congress, I spent 5 years defending doctors in medical malpractice cases and 2 years on the other side, on the plaintiffs' side. So I have seen, at least in my time a few years back, both sides of the equation.

Let me disabuse you from the notion immediately about frivolous lawsuits. If someone walked in my office and said they had a medical malpractice claim, I quickly calculated that I would be spending out of pocket thousands of dollars in preparation of that claim. I was not about to take a flier and run the possibility of contempt for filing a case that made no sense at all and lose money in the process.

In my State, and many others, you are going to file an affidavit with your complaint from another doctor saying you could have a

claim, you could have a cause of action. There is a lot of work that goes into these cases, and people who file frivolous lawsuits should be dismissed, and I doubt that that is the source of the problem here today.

Let me also tell you that I listened to this debate here about contingency fees, and without fail, the people that came into my office when I was an attorney could not have had an attorney any other way. They could not afford to put up $10-, $20-, $30 thousand of their own money after they had gone through a devastating medical injury. They only could operate under a contingency fee, and different lawyers charge different percentages, but many of them run the risk of ending up with nothing when it is all over.

People have argued that this issue is all about doctors, and trial lawyers, and Americans who cannot find medical care because medical malpractice premiums are driving doctors out of business. I think it is about all three of those, but I think it is about three other groups, too. It is about doctors guilty of negligence and reckless misconduct; it is about Americans who are innocent victims of medical malpractice and face a lifetime of pain suffering and death; and it is about insurance companies who have somehow escaped the scrutiny of the White House and many Members of Congress when it comes to this medical malpractice crisis.

These same groups that now argue we should not look at insurance companies as part of the problem also said we should absolve HMOs from liability when they make the wrong decisions as to whether or not you can even qualify for medical care. I do not think that that is consistent with this theory of accountability, which we hear so often in Washington, DC. All of us are held accountable. We should be held accountable in a reasonable way.

I would like to ask Dr. Wilbourn, if I could, you had a personal life experience that was clearly, I mean, demonstrates the problem, where you had to pick up and move from a practice in Nevada to Maine under these circumstances.

Now, you know that since you left, probably, maybe—I do not know how long you left—but since you left Nevada, but they passed a medical malpractice law. Are you aware of the fact that the malpractice insurance companies have said they are not going to reduce premiums even with the caps?

Dr. WILBOURN. Yes, sir, I am aware of that. That special session was called while I was actually meeting with President Bush in High Point. The special session went into effect and the law was passed after I had closed my practice July 31st, but prior to me physically leaving town, as I was trying to put my house on the market.

I was aware that those rates would not go down. We had been told by our liability writers that, number one, do not expect a decrease in rates until a case test has gone through and U.S. Supreme Court has upheld it and, number two, enough exceptions were put into the bill that was passed in Nevada that left enough legal loopholes that they really did not find that it was going to help them at all, as far as costs.

Senator DURBIN. If you look at the States that have imposed caps—I know you have probably gone over this ground, and I will not repeat it—the States that have imposed caps on recovery and

lawsuits for people who are injured and die, those caps really have not resulted in significant differences in malpractice premiums in these States. So what we are doing is limiting the day in court for the person who is a victim and not achieving the goal that we are seeking, affordable medical malpractice insurance so doctors can practice medicine.

I just cannot understand why this administration will not consider looking at insurance companies. Why is it that they cannot be part of the solution here?

Let me ask this of the people on the panel here, you have probably heard of cases, and there have probably been some described here today, do you feel that $250,000 is fair compensation for some of these cases you have heard of? A case that I had of a little baby brought in for baby shots, which every parent does without a second thought, who within days was a quadriplegic, unresponsive because the doctor failed to note that this baby was suffering from a fever and a problem that made a reaction to pertussis, the whooping cough vaccine at the time? Think about that child living 5 years/10 years in that State. Two hundred and fifty thousand dollars, is that enough compensation for the pain and suffering of that child and the family associated with them?

Do you all feel that $250,000 is adequate or generous under those circumstances or the circumstances described by Ms. McDougal? I ask my friends in the insurance industry.

Mr. SMARR. Senator, I do not know if there is any amount that could make a severely injured patient whole, and whether the amount is $250,000 or some other reasonable number, we have reached the point in time where the excessive awards of noneconomic damages have driven malpractice insurance rates to the point where doctors simply cannot practice medicine any more, and if we are going to draw the line at some point, we know that $250,000, which is in effect in California today, and Colorado today, and Kansas today, and a few other States, works, and has kept their premiums down and their doctors practicing in those States.

Senator DURBIN. I know Senator Dodd suggested this, that you start looking at individuals, rating them. People with a bad driving record pay more for auto insurance. We know that 54 percent of the claims are filed against 5 percent of the doctors, and it seems to me that those are the target doctors who should be paying higher medical malpractice premiums, unlike Dr. Wilbourn, who I guess had no experience with medical malpractice liability before his premiums went through the roof.

I also have heard suggestions in other States of kind of a cross-subsidy, where they would say that there would be a certain small amount taken from all specialties to provide some subsidy to those that are higher-risk specialties, but a necessary part of medical practice.

It seems to me that, unless we are willing to honestly talk about the insurance industry and your practices, this is really an exercise in bashing away at trial lawyers, rather than getting to the heart of the problem.

Mr. SMARR. I am glad you brought up the topic of experience rating for doctors, and such does exist. In my own experience in work-

ing in the market in Pennsylvania, the market leader carrier in Pennsylvania has an experience rating program, and yesterday in House testimony in Bucks County, Pennsylvania, the president of that company explained what they were doing.

Essentially, they have a 15-percent discounted premium for physicians that are claim free for a certain period of time. They also have a 5-percent risk management discount for doctors that participate in their risk management programs, and they have the Consent to Rate Program, which is a special mechanism for insureds that have very adverse loss experience, where they asked to consent to a rate that is very much higher-than-normal filed annual rate, and that is filed with the State insurance department.

I think that programs like this are in effect with insurance carriers, the doctor-owned carriers I represent, at least, in States across the Nation.

Senator DURBIN. I think it is a reasonable alternative.

Thank you, Mr. Chairman.

Senator GREGG. Senator Sessions?

Senator SESSIONS. Thank you, Mr. Chairman. I do believe there is a problem. We did some checking in Alabama and the circumstances there. I notice that the chart up there rated Alabama as okay, but it does not appear that all things are going well.

On the question of access, I have two notes. Atmore Community Hospital in Atmore, Alabama, was forced to close its obstetrics program because it could not afford a 282-percent increase in malpractice insurance from $23,000 to $88,000. That is a small hospital, with a $50,000/$60,000-hit. I visited that hospital, and I know the things they are doing to try to deal with a wage index that are hurting smaller hospitals. But I now expect that mothers in that area have to go long distances to hospitals.

One that touched me particularly was an article in the paper, on the 7th of February, in Huntsville, Alabama, about Dr. Sumter Blackman. He thought he had seen everything in his 31 years as a family physician in rural Wilcox County. Nothing prepared him, though, for the epidemic sweeping Alabama's malpractice insurance business. Two of the State's five malpractice insurers, Reciprocal of America and a sister company, Doctors Insurance for Reciprocal Risk Retention Group, are in disarray because of money woes. Another, St. Paul Fire and Marine, has stopped writing premiums in Alabama.

I will not go into the details, but it says Blackman, the Wilcox County doctor, may have to put down his stethoscope this summer. Dr. Blackman is my mother's doctor. He organizes and leads one of the smaller hospitals in the State. He is, if you took a poll of who is the most respected man in that county, it would be Dr. Sumter Blackman. And to think that he is at the point of losing his career over this is not an insignificant matter to me. I do not know what the county would do without him.

The hospital was named J. Paul Jones Hospital, for Dr. Paul Jones, who is one of the finest family practitioners ever, I guess, and they named the hospital for him. This was not a problem he had to deal with in his career, I am sure.

One of the oldest nursing homes, the oldest nursing home in Alabama, has reported to me that their premiums for liability insur-

ance has gone up 865 percent over the last 4 years. Premium costs per bed, according to Bill Roberts, the fine leader of that nursing home, have gone up from $370 in 1979, Mr. Chairman, to $3,204. In other words, he is paying $3,000 per nursing home bed just for liability insurance.

And Jackson Hospital in Montgomery has seen an increase in liability insurance from $591,000 in 1999 to $1 million in 2003. There was a 28-percent increase between 2002 and 2003, and the chart up there says we are doing okay.

So I do not know what the answer is. I sometimes I thought it might be the insurance companies, but, Mr. Smarr, you make a pretty strong case that investments and those matters are really small compared to the hits you are taking on the difference between your premium and what you are paying out.

Are you confident your numbers can withstand scrutiny? As I understood your testimony, there is no doubt in your mind that all of these other problems that have been raised about insurance payments, there is no doubt in your mind that any analysis of your companies will show that they are paying out more than they are taking in, and that is what is causing the crisis?

Mr. SMARR. Senator Sessions, there is no doubt in my mind that at the present time malpractice insurers are incurring losses that are far in excess of the premiums and the investment income they are collecting, and every independent organization that has looked at this, such as the Congressional Budget Office, such as the Department of Health and Human Services, such as the National Association of Insurance Commissioners in its February 7th letter to Chairman Gregg, confirmed this.

The industry is in crisis. A.M. Best, the leading rating agency in this area, confirms this as well. There is no doubt it is being driven by losses.

Senator SESSIONS. Mr. Chairman, that is something we ought to be able to determine pretty conclusively as the time goes by.

I will tell you one thing, it offends me a little bit people say, "Well, you are doing up there to protect the insurance company, you sorry politicians. You talk about reform of the litigation, and it is to protect insurance companies." I do not know about the other Senators, but they do not call me about these issues. They do not really care, I think. The more they pay out, the more people have to have insurance.

But who are calling me are employers who pay insurance for their employees, hospitals and doctors. That is who are calling me, and I am not getting any pressure from any insurance company about this matter, so far as I know. It certainly is not anything like the concern I am hearing from people out there.

I would just say this. There are some concerns about how we do this, what the role of the Federal Government should have in this matter. One thing that is pretty significant to me, Mr. Chairman, is that probably 60 percent or more of health care in this country is paid for by the Federal Government. Would any of you doctors or panelists, Dr. Wilbourn, do you have an opinion of how much of health care is actually funded by the Federal Government, directly or indirectly?

Dr. WILBOURN. No, I would not know that. I think I have heard it mentioned a couple of times today about whether States should handle this problem themselves or whether the Federal Government should be involved, and I would like it if States could handle this problem. It would be nice if all of the States had already handled the problem. We would not even be meeting today. But, obviously, some States can handle the problems and some cannot.

What we have to ask ourselves, as Americans, as patients, just because I am lucky enough to live in California, I cannot take my children to Las Vegas or my wife to Vegas for the weekend for fear that something will happen to her and there is not available care. I can no longer vacation in Florida because there is not a neurosurgeon or Gulfport, Mississippi.

You are restricting my movement around America if I have got certain areas of this country that I do not want to go. There are not enough doctors there, and if we are in a car wreck, the Trauma Center is closed.

So it is a Federal issue when you get down to that.

Senator SESSIONS. Well, you do have, I am told, and I visited 20 or more hospitals/30 or more hospitals in Alabama, they tell me well over 50 percent is Medicare, then you have Medicaid, and then you have veterans and other things that are paid for by the Federal Government. So that is causing me to think that there is, indeed, a Federal interest here that is significant, but certainly an individual tort inside a State, we have traditionally seen as a State matter.

Thank you, Mr. Chairman.

Senator GREGG. Thank you, Senator.

I am going to have to depart, but before I do, I would like to ask unanimous consent that the statement of Senator Grassley be inserted in the record and note that the record will be kept open for 2 weeks for submission.

[The prepared statement of Senator Grassley may be found in additional material.]

Senator GREGG. I especially want to thank the panel.

I am going to turn it over to Dr. Ensign because he had a couple of other questions.

I especially want to thank the panel. It has been an extraordinarily strong panel, in my opinion, and I especially want to thank the folks who have had individual experiences which are extremely moving—Ms. Peel, Ms. McDougal, and Ms. Dyess, and Dr. Wilbourn, who chose Maine, instead of New Hampshire, which I take is a personal——

Dr. WILBOURN. You had no availability in New Hampshire. I checked there. [Laughter.]

Senator GREGG. As a number of Senators said, to come forward and share your story with us is courageous, and it is important, and we thank you for that, and we thank you for the expert testimony we have received from the other members of the panel.

Unfortunately, I have to move on, but I am going to turn the hearing over to Senator Ensign.

Senator ENSIGN [presiding]. Thank you, Mr. Chairman.

Mr. Angoff, I want to start with you on talking about Prop 103 in California, where you credited that that was controlling medical

malpractice premium increases. The 20-percent refund that you talked about, the rollback, was that a one-time rollback or was that year-to-year?

Mr. ANGOFF. No, the 20 percent is a one-time rollback.

Senator ENSIGN. So is a one-time rollback going to be responsible for all of the years of stabilizing the rates?

Mr. ANGOFF. It is not. What is responsible for all of the years of stabilizing rates are the other provisions of Prop 103, particularly two. No. 1, the most significant, Prop 103 repealed the State antitrust exemption for the insurance industry. So that in California, unlike other States, insurance companies can get together, and they can share their past cost data in order to be able to project more accurate rates for the future, but what they cannot do is to agree on rates. In most States, they can. So that I think is the most significant thing in Prop 103 that has kept rates moderate.

The second provision of Prop 103, in addition to the rollback and the antitrust exemption, that has kept rates at moderate levels over the long run is it gave doctors and consumers automatic standing to challenge any proposed rate increase by any property casualty insurer, and because of that automatic standing consumers do intervene and do prevent insurers from raising rates to excessive levels, which would not be the case in other States.

Senator ENSIGN. When you talk about your experience in Missouri, with all of the data that you provided from Missouri, you said there was no increase in the number of claims. In fact, you said it was going down. However, we are hearing from other people that all across the country claims is going up. Do you have different numbers?

Mr. ANGOFF. Yes, I do not doubt that there are differences among States in litigiousness. In Missouri, we are just not a very litigious State.

Senator ENSIGN. Correct, but the rest of the country is experiencing dramatic increases in especially the severity of claims. You saw the chart—do you have that chart that shows the $1 million? It was the top red line, I think, was it not?

That one is good enough. Those are the percentages of million-dollar-plus claims. You can see it, year-to-year, is obviously going to up, and it is almost going up logarithmically.

Mr. ANGOFF. Well, Senator, if you look at Mr. Montemayor's chart of about 15 States, which shows the rate of return of the malpractice industry in each State, it shows a dramatic difference by State. Traditionally—I was a member of the National Association of Insurance Commissioners—traditionally, the NAIC has been very, very strong in insisting that each State has its own market. There are different issues in each State, and that right-hand chart there, Senator, shows that.

It is true that for some reason—I do not know the Texas market well enough to say what it is—for some reason, yes, there is a problem in Texas, but look at all of the other States. Many of those States are not just making adequate rates of return, they are making excessive rates of return. So it just does not make sense for Congress to pass a law which would prohibit injured people from recovering in States where the insurance companies are already making excessive rates of return.

Senator ENSIGN. Could you put up the chart comparing California and Colorado and their rates.

These are the rates. And, Mr. Smarr, maybe you can address this since your company does business all across the country.

Los Angeles, $54,000, as far as for an OB, but if you go up and down the chart, it seems to me that Colorado does not do too badly there, compared to these other rates. As a matter of fact, if you put Nevada in there, and especially Southern Nevada, where some of the bigger claims have been, although Northern Nevada just got their rate increases and from what I have been hearing their rates just took a huge increase, that $54,000 would be a small rate.

Dr. Wilbourn, your experience of the $108,000, I think that that was on the low end of a lot of them. I think a lot of people I have heard from have been up to the $130- $140 thousand range in Nevada.

Dr. WILBOURN. That was quoted to me because I would have discounts; the 5-percent discount for attending educational——

Senator ENSIGN. Right.

Dr. WILBOURN. —and discounts for having no lawsuits, but also the $108- was quoted if I reduced the number of deliveries.

Senator ENSIGN. Right. And, by the way, these numbers are not cheap. I do not think anybody is looking at that. Those numbers are not cheap in the first place. I mean, the Los Angeles and the Denver numbers, those are fairly significant numbers in the first place, let alone when we start getting to the right side of these charts.

But the thing that is most evident to me is that Colorado did not have a Prop 103, and they have had very, very good success.

Dr. Wilbourn, I want to ask you about the part of Colorado's legislation that requires somebody to be an expert in their field to testify. Now, I do not have any statistics on this, but I have heard time and time again from physicians that a common practice has become in fact it is becoming almost an industry, for some physicians out there that only go around and testify. They are not an expert in that field, but trial lawyers know that they can pick them off, bring them in, and they are very convincing. They are becoming professional witnesses, and they are able to convince those juries that they are an expert in areas they are not, so this seems to be a big problem with our legal system today.

Can you comment on that?

Dr. WILBOURN. I sure can. I do not know if you are aware, Senator Ensign, that when I was in Nevada, I sat on the medical-dental screening panel for the State before it was abolished with our last legislative act. For those not aware, many of the Senators today talked about having an affidavit or someone to verify this is an adequate lawsuit, in Nevada, the way it used to work when I was there, if someone sued you, it went to the medical-dental screening panel. At that panel, was three physicians and three attorneys who reviewed the chart for probability of malpractice.

If the panel felt that there was a probability of malpractice, that was the ruling that went out and could be presented in court. If they felt there was no reasonable probability of malpractice, that was the ruling that went out and could be presented in court. And from what I understand, if the panel could not agree, which often-

times happen when you have three attorneys and three physicians in a room together, it went out as no report. This did not keep a case from going to trial. They could still take it.

In that capacity, in reviewing those cases, first of all, it was very rare to have one of the physicians on that panel be someone who was a specialist in that field. We often had to exempt ourself because we knew that person from medical meetings.

But then even when we got into reviewing, their expert witness, the plaintiff's expert witnesses, most, and I will point out that most of the attorneys who served on that panel were plaintiff trial lawyers, they would even make comment about, you know, it must be really bad if this is the only expert witness they could find. They, themselves, recognized that there were very bad expert witnesses that were more or less hired guns—if we give this person enough money, they will raise their hand and swear an oath.

So I agree with you that I think a lot of times there is no legitimacy to who is an expert witness. Many times the expert witness does not even practice in the same field of medicine.

Senator ENSIGN. Thank you. I need to excuse myself. We are going to turn the gavel over to Senator Sessions.

Mr. Montemayor, if you have to excuse yourself for a flight, go ahead and feel free to do that.

Thank you very much for the rest of the panel. I will turn it over to Senator Sessions.

Senator SESSIONS [presiding]. Thank you, Mr. Chairman.

Mr. ANGOFF. May I excuse myself for a flight, too, Mr. Chairman?

Senator SESSIONS. Certainly.

Mr. ANGOFF. Thank you very much.

Senator SESSIONS. At this moment I am the chairman, I guess.

Thank you very much, both of you, for your insightful testimony. It is something that we are going to have to wrestle with. We are going to have to get the facts, and then make some decision about what action, if any, we should take.

Mr. Smarr, you have heard the argument over the Proposition 103. Do you have anything further to add or to raise about that? That was the question that Dr. Ensign asked me to ask you.

Mr. SMARR. Senator Sessions, only to reiterate that Prop 103 was a one-time 20-percent rollback in rates that was to be refunded to California physicians, and it was the only thing that was required of the medical malpractice insurers in California. They did not lower their premiums.

I read from one of the consent agreements, paragraph 2, "The amount specified in paragraph 1 above . . ." which is the 20 percent ". . . including the interest specified therein shall constitute respondent's entire rollback refund obligation pursuant to Insurance Code Section 186101."

Now, the California carriers did not decrease their rates, and they returned the 20 percent as part of their normal dividend process. But one other thing, I mentioned the NORCAL Mutual Insurance Company, during the legal contest of Prop 103, NORCAL actually had two independent rate decreases filed and which were held up by the legal mechanisms of considering whether or not Prop 103 was constitutional.

And so the doctors in California actually did not benefit from the two filings, a reduction of 12 percent and the other was, I believe, a reduction of 2 percent, and so they paid higher premiums because of Prop 103 for a period of a couple years, until this mess could be sorted out.

Senator SESSIONS. I know someone well in a law firm, and they defend hospital and nursing home lawsuits, and Mississippi has passed some reform, and I understand hundreds of lawsuits have been filed in advance of that law becoming effective. So that would indicate to me that there is some impact on litigation.

But, you know, I tend to believe that it is difficult under current circumstances to do away with a contingent fee, in general. Sometimes that is just a necessary part of the system under the way we operate today. But when you have circumstances like asbestos, where we had testimony that only 40 percent of the money paid out by the asbestos companies actually got to the victims, and what we also know is that many, many people are being paid substantial sums of money who were exposed but have never gotten sick. We know there are 200,000-some-odd cases pending. We know that the cost of litigation, and there are great delays in it.

It seems to me that since the asbestos companies have ceased to contend they did not know that asbestos was dangerous and are willing to compensate ill patients, somehow we ought to have a system so if you mesothelioma, cancer or that sort of thing as a result of asbestos, then somebody ought to write you a check, and you should hardly even need a lawyer at all.

Certainly, these large fees could be reduced, and then the asbestos company would have less money to expend on defense, the plaintiffs would have less litigation expense, there would be less delay, and the ill person could be paid.

Does that make sense to you, Mr. Smarr?

Mr. SMARR. Oh, it does, Senator Sessions. And I agree that it is hard to understand how a contingency fee applies to a case where there really is no contingency, where it is a question not of causation, but of damages and how much.

The legislation that the PIAA supports in the House is H.R. 5, which was passed as H.R. 4600 last year in the House. I think Senator Ensign introduced a similar bill in the Senate last year. That has a sliding scale for plaintiff attorney contingency fees, and for example under that provision, and that is similar to the California MICRA provisions, that the contingency fee is 40 percent of the first $50,000, and it slides up until it is 15 percent of amounts over $600,000.

In the case of a million-dollar payment, the plaintiff attorney has to be satisfied with only $220,000 in a contingency fee, but that is better than 40 percent or 50 percent of a million dollars. That provision, we feel, actually tempers the effects of the contingency-fee arrangement and puts more money into the pocket of the patient.

Senator SESSIONS. Well, we need to wrestle with that issue of compensation, and certainly we need to deal with the question of when the defendant knows they did wrong, they know there was an error occurred, they are willing to compensate. There should be a better way of getting prompt compensation under those circumstances.

The question of, as Ms. McDougal raised, pain and suffering, disfigurement, those are matters that are very important, and how we control or limit that I am not sure at this time. I am not sure precisely what role that this Congress should carry out at this time. I would just say this: I have no doubt we do have a crisis because we are trying to wrestle with how to give more health care to more Americans and not have the costs go through the roof. Every year we are dealing with Medicare and Medicaid costs that seem to be going up. More and more people are aging, and they need more health care. We need the absolute most efficient system that this country can provide to get good, quality health care.

And when you see these huge premiums being paid out by hospitals and doctors, those are not expenditures reasonably likely to produce much direct health benefit.

So I think if we could come up with a way to compensate those who truly need it, keep the overall costs down, speed up perhaps that system and at the same time reduce this heavy insurance burden would be good.

I would also ask Dr. Wilbourn if a series of—you know, the theory is that the punitive damages punish, but if you have 10 OBs in a community, and two of them get sued and get hit with big verdicts, what happens to the premiums for all 10 doctors in the community?

Dr. WILBOURN. They all go up.

Senator SESSIONS. They all go up.

Dr. WILBOURN. They all go up.

Senator SESSIONS. So, in effect, if one doctor fails, the way our system works, the punitive damages is not just punishing that doctor, it is punishing innocent doctors, also.

Dr. WILBOURN. Correct.

Senator SESSIONS. So we need to wrestle with our legal system. It has been great for us. The rule of law has preserved our freedoms and provided our strong economy, and I believe we can make some progress on this, and I look forward to working on it.

I thank all of you for your attendance. Is there anything else you would like to add for the record? We will give you some time to do that in writing if you would like.

Dr. WILBOURN. Thank you for having us.

Senator SESSIONS. Thank you very much. It has been a very interesting panel. We are adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

OPENING STATEMENT OF SENATOR LEAHY

Today I am pleased to introduce the "Medical Malpractice Insurance Antitrust Act of 2003" along with Senators Kennedy, Durbin, Edwards, Rockefeller, Reid, Boxer, Feingold, and Corzine. In the deafening debate about medical malpractice, I believe this legislation is a clear and calm statement about fixing one significant part of the system that is broken—skyrocketing insurance premiums for medical malpractice. Our health care system is in crisis. We have heard that statement so often that it has begun to lose the force of its truth, but that truth is one we must confront and the crisis is one we must abate.

Unfortunately, dramatically rising medical malpractice insurance rates are forcing some doctors to abandon their practices or to cross state lines to find more affordable situations. Patients who need care in high-risk specialties—like obstetrics—and patients in areas already under-served by health care providers—like many rural communities—are too often left without adequate care.

We are the richest and most powerful nation on earth. We should be able to ensure access to quality health care to all our citizens and to assure the medical profession that its members will not be driven from their calling by the manipulations of the malpractice insurance industry.

The debate about the causes of this latest insurance crisis and the possible cures grows shrill. I hope today's hearing will be a calmer and more constructive discussion. My principal concerns are straightforward: That we ensure that our nation's physicians are able to provide the high quality of medical care that our citizens deserve and for which the United States is world-renowned, and that in those instances where a doctor does harm a patient, that patient should be able to seek appropriate redress through our court system.

To be sure, different states have different experiences with medical malpractice insurance, and insurance remains a largely state-regulated industry. Each state should endeavor to develop its own solution to rising medical malpractice insurance rates because each state has its own unique problems. Some states—such as my own, Vermont—while experiencing problems, do not face as great a crisis as others. Vermont's legislature is at work to find the right answers for our state, and the same process is underway now in other states. To contrast, in states such as West Virginia, Pennsylvania, Florida, and New Jersey, doctors are walking out of work in protest over the exorbitant rates being extracted from them by their insurance carriers.

Thoughtful solutions to the situation will require creative thinking, a genuine effort to rectify the problem, and bipartisan consensus to achieve real reform. Unfortunately, these are not the characteristics of the Administration's proposal. Ignoring the central truth of this crisis—that it is a problem in the insurance industry, not the tort system—the Administration has proposed a plan that would cap non-economic damages at $250,000 in medical malpractice cases. The notion that such a one-size-fits-all scheme is the answer runs counter to the factual experience of the states.

Most importantly, the President's proposal does nothing to protect true victims of medical malpractice. A cap of $250,000 would arbitrarily limit compensation that the most seriously injured patients are able to receive. The medical malpractice reform debate too often ignores the men, women and children whose lives have been dramatically—and often permanently—altered by medical errors.

The President's proposal would prevent such individuals—even if they have successfully made their case in a court of law—from receiving adequate compensation. We are fortunate in this nation to have many highly qualified medical professionals, and this is especially true in my own home state of Vermont. Unfortunately, good doctors sometimes make errors. It is also unfortunate that some not-so-good doctors manage to make their way into the health care system as well. While we must do all that we can to support the men and women who commit their professional lives to caring for others, we must also ensure that patients have access to adequate remedies should they receive inadequate care.

High malpractice insurance premiums are not the result of malpractice lawsuit verdicts. They are the result of investment decisions by the insurance companies and of business models geared toward ever-increasing profits. But an insurer that has made a bad investment, or that has experienced the same disappointments from Wall Street that so many Americans have, should not be able to recoup its losses from the doctors it insures. The insurance company should have to bear the burdens of its own business model, just as the other businesses in the economy do.

But another fact of the insurance industry's business model requires a legislative correction—its blanket exemption from federal antitrust laws. Insurers have for years—too many years—enjoyed a benefit that is novel in our marketplace. The McCarran-Ferguson Act permits insurance companies to operate without being subject to most of the federal antitrust laws, and our nation's physicians and their patients have been the worse off for it. Using their exemption, insurers can collude to set rates, resulting in higher premiums than true competition would achieve—and because of this exemption, enforcement officials cannot investigate any such collusion. If Congress is serious about controlling rising premiums, we must objectively limit this broad exemption in the McCarran-Ferguson Act.

That is why today I introduce the "Medical Malpractice Insurance Antitrust Act of 2003." I want to thank Senators Kennedy, Durbin, Edwards, Rockefeller, Reid, Boxer, Feingold, and Corzine for cosponsoring this essential legislation. Our bill modifies the McCarran-Ferguson Act with respect to medical malpractice insurance, and only for the most pernicious antitrust offenses: price fixing, bid rigging, and market allocations. Only those anticompetitive practices that most certainly will affect premiums are addressed. I am hard pressed to imagine that anyone could object to a prohibition on insurance carriers' fixing prices or dividing territories. After all, the rest of our nation's industries manage either to abide by these laws or pay the consequences.

Many state insurance commissioners police the industry well within the power they are accorded in their own laws, and some

states have antitrust laws of their own that could cover some anticompetitive activities in the insurance industry. Our legislation is a scalpel, not a saw. It would not affect regulation of insurance by state insurance commissioners and other state regulators. But there is no reason to continue a system in which the federal enforcers are precluded from prosecuting the most harmful antitrust violations just because they are committed by insurance companies.

Our legislation is a carefully tailored solution to one critical aspect of the problem of excessive medical malpractice insurance rates. I hope that quick action by the Judiciary Committee and then by the full Senate, will ensure that this important step on the road to genuine reform is taken before too much more damage is done to the physicians of this country and to the patients they care for. Only professional baseball has enjoyed an antitrust exemption comparable to that created for the insurance industry by the McCarran-Ferguson Act. Senator Hatch and I have joined forces several times in recent years to scale back that exemption for baseball, and in the Curt Flood Act of 1998 we successfully eliminated the exemption as it applied to employment relations. I hope we can work together again to create more competition in the insurance industry, just as we did with baseball.

If Congress is serious about controlling rising medical malpractice insurance premiums, then we must limit the broad exemption to federal antitrust law and promote real competition in the insurance industry.

OPENING STATEMENT OF SENATOR HATCH

First I would like to thank everyone for being here today and especially Chairman Gregg of the HELP committee for agreeing to hold this joint hearing. I know we both believe that this is a very important issue, worthy of our attention and of every effort necessary to find a resolution to this crisis.

Chairman Gregg and I share a deep concern about how this has affected patient care in our home states and across the country. Patient access to healthcare has diminished significantly because out-of-control litigation and frivolous lawsuits have caused medical liability insurance premiums to skyrocket—forcing needed doctors out of practice. During the last two years alone, premiums have increased by as much as 81% according to some insurers. Doctor unavailability is a crisis in 12 states and threatens to become one in at least 30 others. One of our witnesses here today, Leanne Dyess, will tell us how the unavailability of a neurosurgeon tragically impacted her family. We should all be concerned—each one of us runs the risk that necessary care may be unavailable because the doctor we need is no longer able to practice.

Do we really want our healthcare system to be nothing more than a game of Russian roulette—leaving it to chance whether a doctor will be available when we need one? Sadly, that is what is happening. Doctors are leaving specialties in record numbers because they can no longer afford to practice. It is truly the most vulnerable patients, those who need emergency care, specialty surgery or obstetric care who are most severely impacted

I am very concerned about the increasing shortage of doctors in my home state of Utah. A study by the Utah Medical Association

underscores the alarming problem in my state: "50.5 percent of Family Practitioners in Utah have already given up obstetrical services or never practiced obstetrics." One third of the remainder say they plan to stop providing OB services within the next decade. Most plan to stop within the next five years. According to this study: "Professional liability concerns [were] given as the chief contributing factor in the decision to discontinue obstetrical services. Such concerns include the cost of liability insurance premiums, the hassles and costs involved in defending against obstetrical lawsuits and a general fear of being sued in today's litigious environment."

One resident of Salt Lake City, Lois Collins, had to wait six months for a routine OB appointment. Kori Wilhelm related in a recent Washington Post story how she is forced to make a three hour roundtrip to Cheyenne, Wyoming to get specialized treatment that is no longer available in her area, because her own doctor was forced to give up delivering babies. Laurie Peel will testify today about her difficulty in obtaining obstetric care in North Carolina. These are just a few of the many examples of the personal costs of the current situation.

As many of you know, before coming to Congress, I personally litigated medical liability cases—in some cases I represented the plaintiff in others I represented the defendant. I saw first-hand, heart-wrenching cases in which mistakes were made, and I know that we will hear more today about those cases which deserve access to appropriate remedies. But, more often, I witnessed heart-wrenching cases in which mistakes were not made and doctors were forced to expend valuable time and resources defending themselves against frivolous lawsuits.

Let me make one thing perfectly clear. No one believes more than I that victims of real malpractice should be compensated swiftly and appropriately for their losses. But that is not what is going on today. Instead, patients are forced to meander through a complicated and exhausting legal system and often are awarded damages only after years of legal bickering. Moreover, our current medical litigation system resembles a lottery more than it does a system of justice. In some cases, juries award plaintiffs astounding and unreasonable sums in damages. A sizable portion of those awards does not even go to the plaintiff. It goes to the attorneys. The result: to pay for these awards, insurance premiums go up for all doctors, and in some cases insurance becomes completely unavailable. Consequently, doctors cannot practice and patients cannot obtain the care they desperately need.

Every American is impacted by frivolous litigation and the defensive medicine that results. It is not just the frivolous suits that drive up healthcare costs. The unnecessary tests doctors feel compelled to perform increase health care costs also. A recent study by the Department of Health and Human Services indicates that "Excessive liability . . . adds $30 billion to $60 billion annually to Federal Government payments for Medicare, Medicaid . . . and other government programs."

Some will try to point the finger at the insurance industry, claiming that the crisis is false or due to intentional misconduct on the part of insurers. That, in my opinion, is a red herring. There is nothing to suggest that states have been remiss in regulating the

insurance industry, and there are no data to suggest that collusion is the cause of rising malpractice insurance rates.

The National Association of Insurance Commissioners concurs, stating in a February 7, 2003 letter that "[T]he evidence points to high loss ratios, not price-fixing, as the primary driver of escalating premiums." They further state that:

"Non-profit physician owned mutual insurers have developed in response to market availability concerns . . . Careful inspection will show that a mutual insurer is concerned with its policy holders' interests. Since each policy holder is also an owner of the company and the company is a non-profit entity, the goal of the mutual insurer is to deliver medical malpractice insurance to its policyholder/owners as inexpensively as possible. To do otherwise would contradict the goals of the mutual and jeopardize its non-profit status."

I look forward to today's hearing, and our panel of witnesses, in the hope that they will shed some light on these issues. It is time to address this crisis head on, and today's hearing is a first step in that direction.

PREPARED STATEMENT OF SENATOR FEINGOLD

Thank you Mr. Chairman. I want to welcome all of the witnesses this afternoon. In particular, I want to welcome Linda McDougal from my home state of Wisconsin, who has become in a short time one of the best known and most articulate advocates for preserving the rights of victims of medical malpractice to receive adequate compensation through our legal system.

Ms. McDougal, none of us can ever truly imagine the horrible suffering you have endured. All we can do is say that we are terribly, terribly sorry that this happened to you and that we will do everything we can to prevent similar suffering for others who go to their health care providers seeking aid and comfort, not pain or disfigurement.

Mr. Chairman, I hope everyone on these two Senate committees, whether they are here or not, will read or listen to Linda McDougal's testimony and learn about her experience. It is a powerful cautionary note for those of us who are charged with developing and voting on legislation concerning medical malpractice liability and insurance.

Can anyone in this room or on these committees look Linda McDougal or any of the thousands of victims of catastrophic medical malpractice in the eye and say, "$250,000 is all your pain and suffering are worth"? Would any of us be able to tell our wives or our daughters that their damages should be limited to $250,000 if they were the victims of such unspeakable pain and lifelong sadness?

That is the challenge we face Mr. Chairman. There is no question that we have a problem in this country over the cost of malpractice insurance. But the solution cannot be to penalize innocent victims like Linda McDougal, to prolong and extend their suffering by denying them adequate compensation.

We have virtually no evidence that caps on economic damages will actually lower insurance rates. More importantly, I have yet

to hear an explanation of how this is fair to Linda McDougal and others like her.

I regret that we are pursuing this kind of legislation, but I want to sincerely thank you, Ms. McDougal, for the sacrifices you have made to share your story with the committee and the public. I can only hope that we learn the lessons you are trying to teach us.

Thank you Mr. Chairman.

PREPARED STATEMENT OF LAURIE PEEL

Since July, when I was asked to participate in a roundtable discussion with the President on malpractice reform, I've heard a lot of tragic, really poignant stories on both sides of the issue. My own experience may not be tragic, but I think it illustrates the difficulties patients across the nation—and especially women—are experiencing.

I live in a community, Raleigh, North Carolina, which enjoys healthcare probably as good as, if not better than, any in the Country. I, and my family, all have excellent doctors. Yet even in Raleigh, when I first had a healthcare crisis, I had a very hard time finding a doctor who would take me. And when I was lucky enough to find a great one, Dr. John Schmitt, he ultimately was driven out of business by his overwhelming frustrations with the crippling cost of malpractice insurance. (He now is on faculty at UVA School of Medicine). As he explained in a letter to all of his patients in July of 2002, he could no longer practice medicine the way he wanted to, and always had. And that is frankly, what we should all want from our doctors . . . and maybe even demand.

I first came to Dr. Schmitt under difficult circumstances. I was married less than a year and had just moved to Raleigh, and had no Ob/Gyn there. I was 11 weeks pregnant, experiencing complications—which turned out to be a miscarriage—and in need of immediate medical attention. As a "high-risk patient", though, no Ob/Gyn would take me in. When I got to Raleigh I called every practice I could find, and was told again and again that the practice was full and wouldn't be taking new patients. Fortunately, Dr. Schmitt learned of my plight, called me back and took me in.

I soon discovered he was one of Raleigh's leading Ob/Gyns, yet he had all the time in the world for my husband and me. In the five years I saw Dr. Schmitt, he helped me through the biggest disappointment in my life, my biggest health scare, and finally helped me realize the greatest joy of any life. In short, my relationship with Dr. Schmitt was everything one could hope for from a doctor. It's also a relationship both he and all of his patients would very much like to continue. But we can't because of the crippling cost of medical liability insurance. What he must pay to protect himself from the remote possibility of lawsuits (or at least legitimate ones) has prevented Dr. Schmitt from continuing the outstanding practice he had made his life's work. And stories like his are, I believe, truly tragic for us all.

Now, I've seen both sides of this issue in a very real and personal way. My father is a doctor, as are my brother and his wife. But my family has also suffered from medical errors. I don't want—and I don't know any doctor who does—to deny victims of medical errors adequate redress for their injuries. And certainly my father, brother and every doctor I know wants to hold the medical profession to the highest possible standards.

But the way to address malpractice can't be to destroy the possibility of good practice—or drive away those doctors, like Dr. Schmitt, who do practice to the very best of their abilities. None of us can afford that. I don't know the solution, but I do urge you to find one. And Mr. Chairman, I very much appreciate that that's what you're trying to do.

PREPARED STATEMENT OF LINDA MCDOUGAL

First, I want to thank Chairman Gregg, Chairman Hatch, and Senators Kennedy and Leahy. I greatly appreciate the opportunity you have given me. My name is Linda McDougal and I am a victim of medical malpractice.

I am 46 years old. I live with my husband and sons in Woodville, a small community in northwestern Wisconsin. My husband and I are both veterans of the United States Navy. This is my story.

About 8 months ago, in preparation for my annual physical, I went to the hospital for a routine mammogram. I was called back for additional testing and had a needle biopsy. Within a day I was told that I had breast cancer.

My world was shattered. My husband and I discussed the treatment options and decided on the one that would give me the best chance of survival, and maximize my time alive with my family. We made the difficult, life-changing decision to undergo what we believed was the safest, long-term treatment—a double mastectomy.

Forty-eight hours after my surgery, the surgeon walked in my room and said, "I have bad news for you. You don't have cancer."

I never had cancer. My breasts were needlessly removed. The pathologist switched my biopsy slides and paperwork with someone else's. Unbelievably, I was given another woman's results.

I was in shock. My husband was with me in the room and we were reduced to tears. Today, I am still in shock. To some extent, it was easier to hear from the doctor that I supposedly had cancer, than to hear—after both my breasts were taken from me—the fact that I never had cancer. How could the doctors have made this awful mistake?

The medical profession betrayed the trust I had in them.

It's been very difficult for me to deal with this. My scars are not only physical, but emotional. After my breasts were removed, I developed raging infections requiring emergency surgery. Because of my ongoing infections, I am still unable to have reconstructive surgery. I don't know whether I will ever be able to have anything that will ever resemble breasts.

After I came forward publicly with my story, I was told that one of the pathologists involved had a ten-year exemplary performance record, and that she would not be reprimanded or punished in any way until a second "incident" occurred. Should someone else have to suffer or even die before any kind of disciplinary action is taken?

While there are no easy answers, apparently now the insurance industry is telling Congress it knows exactly how to fix what it believes to be the "problem" caused by malpractice—by limiting the rights of people, like me, who have suffered permanent, life-altering injuries.

Arbitrarily limiting victims' compensation is wrong. Malpractice victims that may never be able to work again and may need help for the rest of their lives should be fairly compensated for their suffering. Without fair compensation, a terrible financial burden is imposed on their families.

Those who would limit compensation for life-altering injuries say that malpractice victims still would be compensated for not being able to work, meaning, they would be compensated for their economic loss. Well, I didn't have any significant economic loss. My lost wages were approximately $8,000, and my hospital expenses of approximately $48,000 were paid for by my health insurer. My disfigurement from medical negligence is almost entirely non-economic.

As you discuss and debate this issue, I urge you to remember that no two people, no two injuries, and no two personal situations are identical. It is unfair to suggest that all victims should be limited to the same one-size-fits-all, arbitrary cap that benefits the insurance industry at the expense of patients. Victims deserve to have their cases decided by a jury that listens to the facts of a specific case and makes a determination of what is fair compensation based on the facts of that case.

Recently, I heard a politician on the news argue in favor of limiting patients' compensation. He said insurance companies need the predictability of knowing, in advance, the maximum amount they might have to pay to injured patients. He said lack of predictability makes it hard for insurance companies to run their businesses profitably. We'd all like to be able to count on the predictability that this politician wants for insurers. But life doesn't work that way. My case is a perfect example.

I could never have predicted or imagined in my worst nightmare that I would end up having both my breasts removed needlessly because of a medical error. No one plans on being a victim of medical malpractice. But it happened, and now, proposals are being discussed that would further hurt people like me . . . all for the sake of helping the insurance industry.

I'm not asking for sympathy. What happened to me may happen to you or someone you love. When it does, maybe you will understand why I am sharing my story. The rights of every injured patient in America are at stake. Limiting victims' compensation in malpractice cases puts the interests of the insurance industry ahead of patients who have been hurt, who have suffered life-altering injuries like loss of limbs, blindness, brain damage, infertility or sexual dysfunction, or the loss of a child, spouse or parent.

Instead of taking compensation away from people who have been hurt and putting it in the pockets of the insurance industry, we should look for ways to improve the quality of health care services in our country to reduce preventable medical errors like the one that cost me my breasts; part of my sexuality; and part of who I am as a woman.

Medical malpractice kills as many as 98,000 Americans each year and it permanently injures hundreds of thousands of others. We must make hospitals, doctors, HMOs, drug companies and health insurers more accountable to patients. A good start would be to discipline health care providers who repeatedly commit malpractice. We should make the track records of individual health care providers available to the general public, instead of protecting bad doctors at the expense of unknowing patients.

Limiting victims' compensation will not make health care safer or more affordable. All it will do is add to the burden of people whose lives have already been shattered by medical errors. Every patient should say no to any legislation that does not put patients first. I urge you to do the same.

Thank you for your time and consideration.

PREPARED STATEMENT OF LEANNE DYESS

Chairman Hatch, Chairman Gregg, Senators Leahy and Kennedy, distinguished members of the Senate Judiciary and HELP committees, it's an honor for me to sit before you this afternoon—to open up my life, and the life of my family, in an attempt to demonstrate how medical liability costs are hurting people all across America. While others may talk in terms of economics and policy, I want to speak from the heart.

I want to share with you the life my two children and I are now forced to live because of a crisis in health care that I believe can be fixed. And when I leave and the lights turn off and the television cameras go away, I want you—and all America—to know one thing, and that is that this crisis is not about insurance. It's not about doctors, or hospitals, or even personal injury lawyers. It's a crisis about individuals and their access to what I believe is, otherwise, the greatest health care in the world.

Our story began on July 5th of last year, when my husband Tony was returning from work in Gulfport, Mississippi. We had started a new business. Tony was working hard, as was I. We were doing our best to build a life for our children, and their futures were filled with promise. Everything looked bright. Then, in an instant, it changed. Tony was involved in a single car accident. They suspect he may have fallen asleep, though we'll never know.

What we do know is that after removing him from the car, they rushed Tony to Garden Park hospital in Gulfport. He had head injuries and required immediate attention. Shortly thereafter, I received the telephone call that I pray no other wife will ever have to receive. I was informed of the accident and told that the injuries were serious. But I cannot describe to you the panic that gave way to hopelessness when they somberly said, "We don't have the specialist necessary to take care of him. We need to airlift him to another hospital."

I couldn't understand this. Gulfport is one of the fastest growing and most prosperous regions of Mississippi. Garden Park is a good hospital. Where, I wondered, was the specialist—the specialist who could have taken care of my husband?

Almost six hours passed before Tony was airlifted to the University Medical Center—six hours for the damage to his brain to continue before they had a specialist capable of putting a shunt into his brain to drain the swelling—six unforgettable hours that changed our life.

Today Tony is permanently brain damaged. He is mentally incompetent, unable to care for himself—unable to provide for his children—unable to live the vibrant, active and loving life he was living only moments before his accident.

I could share with you the panic of a woman suddenly forced into the role of both mother and father to her teenage children—of a woman whose life is suddenly caught in limbo, unable to move forward or backward. I could tell you about a woman who now had to worry about the constant care of her husband, who had to make concessions she thought she'd never have to make to be able to pay for his therapy and care. But to describe this would be to take us away from the most important point and the value of what I learned.

Senator Hatch, I learned that there was no specialist on staff that night in Gulfport because rising medical liability costs had forced physicians in that community to abandon their practices. In that area, at that time, there was only one doctor who had the expertise to care for Tony and he was forced to cover multiple hospitals—stretched thin and unable to care for everyone. Another doctor had recently quit his practice because his insurance company terminated all of the medical liability policies nationwide. That doctor could not obtain affordable coverage. He could not practice. And on that hot night in July, my husband and our family drew the short straw.

I have also learned that Mississippi is not unique, that this crisis rages in States all across America. It rages in Nevada, where young expectant mothers cannot find ob/gyns. It rages in Florida, where children cannot find pediatric neurosurgeons. And it rages in Pennsylvania, where the elderly who have come to depend on their orthopedic surgeons are being told that those trusted doctors are moving to States where practicing medicine is affordable and less risky.

The real danger of this crisis is that it is not readily seen. It's insidious, like termites in the structure of a home. They get into the woodwork, but you cannot see the damage. The walls of the house remain beautiful. You don't know what's going on just beneath the surface. At least not for a season. Then, one day you go to hang a shelf and the whole wall comes down; everything is destroyed. Before July 5th, I was like most Americans, completely unaware that just below the surface of our nation's health care delivery system, serious damage was being done by excessive and frivolous litigation—litigation that was forcing liability costs beyond the ability of doctors to pay. I had heard about some of the frivolous cases and, of course, the awards that climbed into the hundreds of millions of dollars. And like most Americans I shook my head and said, "Someone hit the lottery."

But I never asked, "At what cost?" I never asked, "Who has to pay for those incredible awards?" It is a tragedy when a medical mistake results in serious injury. But when that injury—often an accident or oversight by an otherwise skilled physician—is compounded by a lottery-like award, and that award along with others make it too expensive to practice medicine, there is a cost. And believe me, it's a terrible cost to pay.

Like most Americans, I did not know the cost. I did not know the damage. You see, Senator Hatch, it's not until your spouse needs a specialist, or you're the expectant mother who needs an ob/gyn, or it's your child who needs a pediatric neurosurgeon, that you realize the damage beneath the surface.

From my perspective, sitting here today, this problem far exceeds any other challenge facing America's health care—even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we didn't have was a doctor. And now, no amount of money can relieve our pain and suffering. But knowing that others may not have to go through what we've gone through, could go a long way toward helping us heal.

Senator Hatch, I know of your efforts to see America through this crisis. I know this is important to you, and that it's important to the President. I know of the priority Congress and many in the Senate are placing upon doing something . . . and doing it now. Today, I pledge to you my complete support. It is my prayer that no woman—or anyone else—anywhere will ever have to go through what I've gone through, and what I continue to go through every day with my two beautiful children and a husband I dearly love.

PREPARED STATEMENT SHELBY L. WILBOURN, MD.

WHO WILL DELIVER AMERICA'S BABIES?

The Impact of Excessive Litigation

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 45,000 physicians dedicated to improving the health care of women, I thank Chairman Hatch and Chairman Gregg for holding this important hearing to examine the medical liability crisis facing this nation. Women across America are asking, "Who will deliver my baby?" ACOG deeply appreciates your leadership and commitment to ending this crisis.

We urge Congress to pass meaningful medical liability reform, patterned on California's MICRA law, and bring an end to the excessive litigation restricting women's access to health care.

I. Doctors Help Every Day

My name is Dr. Shelby L. Wilbourn and I am an Ob/Gyn who recently relocated to Belfast, Maine after 12 years of practice in Las Vegas, Nevada.

Every day in America, doctors help millions of mothers, children, grandfathers, and sisters live another day, see another birthday, play another game. Every day, beautiful newborns go home with their mother. Every day, there is another breast cancer survivor or a life saved by a highly trained physician.

Doctors help make miracles happen every day in America. This is what makes our American health care system the envy of the entire world. And this is what's at stake in this debate about medical liability reform.

II. Personal Effects of The Medical Liability Crisis on My Practice

Liability isn't about fault or bad practice anymore. It's about hitting a jackpot. Even the very best Ob/Gyns have been sued, many more than once. Even doctors who have never been sued are seeing their liability premiums double and triple—not because they're bad doctor, but because they practice in a litigation-happy field where everyone is fair game.

Let me cite a perfect example, which demonstrates the imbalance of the current tort system. I just recently relocated to Maine after 12 years of practice in Nevada because of the skyrocketing liability insurance premiums in that State. I had a vibrant Ob/Gyn practice, taught at the University of Nevada, and served as a member of the board of the directors of the Clark County Ob/Gyn Society. The Society worked in conjunction with Governor's Task Force on the medical liability crisis.

I left Nevada because the litigation climate had driven the medical liability premiums to astronomical heights. In 2002, Las Vegas Ob/Gyns paid as much as $141,760, a 49.5 percent increase from 2001. In Clark County, there are only 106 Ob/Gyns, private, public, and resident practitioners, left to deliver an estimated 23,000 babies in 2003—an average of 216 babies per Ob/Gyn. Of these, 80 percent no longer accept Medicaid patients because of the threat of litigation coupled with low reimbursement.

Last July, I was privileged to meet with President Bush in North Carolina to discuss the medical liability crisis on a national level. At that time, I had never been named in a lawsuit, a fact that was made known during the roundtable discussion. Within days of my meeting with President Bush, a lawsuit was filed against me. In addition, all but one of the doctors Governor Guinn named to the Task Force in Nevada had lawsuits filed against them within a short period, as well.

When I left Nevada, my patients, many of whom were with me for 12 years, were forced to find another Ob/Gyn amongst a dwindling populaiton of Ob/Gyns in Las Vegas. This is the real issue. Patients around the country are losing access to good doctors and quality health care. The end game of the current system is a society without enough doctors to care for its citizens. We just cannot let this happen.

Today, we have heard, or will hear, anecdotes from both sides of this debate, all of which support each side's position. However, the fact remains clear—there is a medical liability crisis in this nation. Who loses in this environment? Women, good doctors, patients, communities, businesses, and America.

III. 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 affects hospitals, public health clinics, and medical facilities in rural areas, inner cities, and communities across the country.

Now, women's health care is in jeopardy for the third time in three decades. This crisis will only end if Congress acts. 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 percent 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 a few claims with exorbitant award potential, ignoring other claims with merit. Even then, much of a jury award goes straight into the lawyers' pockets; typically, less than half of a medical liability award reaches the patient.

Liability isn't about fault or bad practice anymore. It's about hitting a jackpot. Even the very best Ob/Gyns have been sued, many more than once. Even doctors who have never been sued are seeing their liability premiums double and triple—not because they're bad docs, but because they practice in a litigation-happy field where everyone is fair game.

The liability crisis compromises 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 percent of Americans are concerned about the impact of rising liability costs on access to care.

IV. Women's Health Consequences of Excessive Litigation

The medical liability crisis affects 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 at the Federal level, women's access to health care will continue to suffer.

Expectant mothers can't find obstetricians to deliver their babies. 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 is reduced, depriving women of the proven benefits of early intervention.

Excessive litigation 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, 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.

Medical liability is causing a 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.

Community clinics must cutback services, jeopardizing the millions of this nation's 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.

More women are becoming uninsured. Health care costs continue to increase overall, including the cost of private health care coverage. As costs 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. In 2001, 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. If fewer doctors are available to deliver babies, the crisis becomes even more acute.

V. How Excessive Litigation Compromises the Delivery of Obstetric Care

Obstetrics-gynecology is among the top three specialties in the cost of professional liability insurance premiums. Nationally, insurance premiums for Ob/Gyns have increased dramatically: the median premium increased 167 percent between 1982 and 1998. The median rate rose 7 percent in 2000, 12.5 percent in 2001, and 15.3 percent in 2002 with increases as high as 69 percent, 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 percent of the physician liability market, withdrew from that market last year. 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 filed 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 percent). 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 percent) of claims against Ob/Gyns were dropped by plaintiff's attorneys, dismissed or settled without a payment. Of cases that did proceed, Ob/Gyns won more than 65 percent of the cases resolved by court verdict, arbitration, or mediation, meaning only 10 percent of all cases filed against Ob/Gyns were found in favor of the plaintiff. Enormous resources are spent to deal with these claims, only 10 percent of which are found to have merit. The costs to defend these claims can be staggering and often mean that physicians invest less in new technologies that help patients.

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 percent from 1993 awards, according to Jury Verdict Research of Horsham, Pennsylvania. The median medical liability award jumped 43 percent 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 percent of the claims against obstetricians, is nearly $1 million, but can soar much higher. One recent award in a Philadelphia case reached $100 million. This in spite of the fact that fewer than 10 percent of these cases are found to result from intrapartum hypoxia.

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 percent) of ACOG Fellows have even been sued for care provided during their residency. In 1999, 76.5 percent 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.

This high rate of suits does not equate malpractice. Rather, it demonstrates a lawsuit culture where doctors are held responsible for less than perfect outcome. And in obstetrics/gynecology, there is no guarantee of a perfect outcome, no matter how perfect the prenatal care and delivery.

VI. There Is a Solution

On February 5, 2003, the House of Representatives took an important first step in ending this crisis when Representative Greenwood, Majority Whip Delay, and Judiciary Committee Chairman Sensenbrenner introduced H.R. 5, the HEALTH Act of 2003. ACOG resoundingly supports H.R. 5, important legislation protecting women's access to health care. This legislation is supported by a broad coalition of physicians, health insurers, and businesses.

H.R. 5 caps non-economic damages at $250,000, while still allowing patients full and complete access to the courts. The HEALTH Act safeguards patients' access to health care with common sense measures:

- Allows Complete Recovery of All Economic Damages, Including Current and Future Lost Wages
- Promotes Speedy Resolution of Claims
- Fairly Allocates Responsibility
- Compensates Patient Injury
- Maximizes Patient Recovery
- Ensures Payment of Medical Expenses
- Allows State Flexibility on Non-Economic Damages Caps

H.R. 5 allows for the complete recovery of a person's economic damages, including compensation for medical and rehabilitation costs, current and future "lost" wages, and other economic loss. H.R. 5 is fair for everyone. H.R. 5 will restore the balance in the health care system that has been hijacked by trial lawyers and merit-less lawsuits.

VII. Women's Health Suffers Nationwide

As Ob/Gyns, our primary concern is ensuring women access to affordable, quality health care. It is critical that we maintain the highest standard of care for America's women and mothers. In 2002, ACOG has identified a medical liability crisis in the following nine "Red Alert 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 fac-

tor 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

• 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 Dade and Broward counties in South Florida, where insurers say litigation is the heaviest, annual premiums for Ob/Gyns soared to $210,576—the highest rates in the country, according to Medical Liability Monitor.

• In a recent ACOG survey, 76.3 percent of the Florida Ob/Gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 21.69 percent of Florida respondents indicated that they have stopped practicing obstetrics due to the unavailability and unaffordability of liability insurance.

• The liability situation is so severe the State allows doctors to "go bare" (not have liability coverage), as long as they can 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. Ob/gyns in this State are more likely 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 rose 20 percent to 400 percent in 2002, for various carriers. 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 percent, with an additional 23 percent 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 percent of family physicians deliver babies.

• In a recent ACOG survey, 66.7 percent of the Mississippi Ob/Gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 12.82 percent of Mississippi respondents have stopped practicing obstetrics.

• In Cleveland, Mississippi, three of the six doctors who deliver babies dropped obstetrics 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 by their insurance carriers to delivering 250 babies per year, leaving approximately 500 pregnant women searching for maternity care, reports the Mississippi Business Journal.

• Yazoo City, Mississippi, with 14,550 residents, has no obstetrician.

• A Grenada, Mississippi Ob/Gyn will not take any obstetric patients with a due date after June 15, 2003, leaving two Ob/Gyns to deliver approximately 700 babies a year.

• Natchez, Mississippi, which serves a 6-county population of over 100,000, has only three physicians practicing obstetrics.

• Days before HB2 (legislation aimed at reducing liability insurance costs and improving access to health care) took effect, there was a rush of medical liability lawsuits filed in Mississippi. State Insurance Commissioner George Dale said these

claims will be in the system for a long time and the market for medical liability insurance is not likely to get better any time soon.

• The State's major insurer of hospitals, Reciprocal of America, is facing financial difficulties and recently asked participants to pay $30 million to help keep it afloat, according to the State insurance commissioner's office.

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 percent 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.

• In Las Vegas, Ob/Gyns paid premiums as high as $141,760, a 49.5 percent increase from 2001.

• In the ACOG survey, 86.2 percent of the Nevada Ob/Gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 27.59 percent of Nevada respondents stopped practicing obstetrics.

• As of October 2002, according to Clark County OB/GYN Society, only 80 private practice physicians, 14 HMO physicians, and 12 residents are doing deliveries, totaling 106 doctors. With an estimated 23,000 deliveries expected in Nevada in 2003, each physician will have to deliver 216 babies.

• 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, between 200 and 250 physicians will face bankruptcy, close their offices, or leave 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 escalating medical liability premiums and litigiousness. 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.

• In August 2002, the Nevada Legislature met in Special Session and passed tort reform—AB 1. AB 1 included a partial cap on awards for non-economic damages and a total cap on trauma liability. There has been no significant improvement in the availability of affordable medical liability coverage, according to a September 2002 statement by the Nevada State Medical Association. Most carriers have continued to request and receive approval to raise rates.

• The Nevada tort reform legislation went into effect in January 2003. In December 2002, the frequency of lawsuits filed against health care providers skyrocketed with 170 suits filed in December 2002 (as compared to 8 suits field in 2001).

D. New Jersey

• In the ACOG survey, 75.6 percent of the New Jersey Ob/Gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 19 percent of New Jersey respondents have stopped practicing obstetrics.

• 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 remaining 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 percent to 200 percent 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 percent over the last three years, and 65 percent of facilities report that they are losing physicians due to liability insurance costs.

E. New York

• New York State faces a shortage of obstetric care in many rural regions. Increasing liability insurance costs will only exacerbate these access problems.

• In the ACOG survey, 67 percent of the New York Ob/Gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 19.28 percent of New York respondents have stopped practicing obstetrics.

• In 2002, an Ob/Gyn practicing in New York could pay as much as $115,500 for medical liability insurance, according to Medical Liability Monitor.

• In 2000, there was a total of $633 million in medical liability payouts in New York State, far and away the highest in the country, and 80 percent 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

• In the ACOG survey, 77.4 percent of the Pennsylvania Ob/Gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 21.61 percent of Pennsylvania respondents have stopped practicing obstetrics.

• 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 percent 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 percent to 147.8 percent, 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 percent of medical students who come to the State for a world-class education choose to practice elsewhere, according to the Pennsylvania State Medical Society.

• On April 24, 2002, Methodist Hospital in South Philadelphia announced that it would 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.

• Some tort reform measures passed the State legislature (House Bill 1802) in 2002. However, 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 percent to 20 percent overall reduction in doctors' liability premiums. But with the 50 percent to 100 percent 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

• In the ACOG survey, 67.5 percent of the Texas Ob/Gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 13.79 percent of Texas respondents have stopped practicing obstetrics.

• 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.

• Medical liability insurance premiums for 2002 were expected to increase from 30 percent to 200 percent, 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.

• The Abilene Reporter News reported on October 13, 2002, that the obstetrics unit at Spring Branch Medical Center is set to close December 20, 2002. The hospital's $600,000 premium for labor and delivery liability was set to increase by 67 percent next year. In 2001, 1,003 babies were born at Spring Branch Medical Center.

• According to Governor Rick Perry's office, between 1996 and 2000 one in four Texas physicians had a medical liability claim filed against them. In the Lower Rio Grande Valley, the situation is even worse. In 2002, Valley Ob/Gyns paid liability insurance premiums up to $97,830, a 34.5 percent increase from 2001.

• 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 percent of all Texas physicians had claims filed against them, according to the Texas Medical Examiners Board. Patients filed 4,501 claims, up 51 percent from 1990.

• As many as 86 percent of medical liability claims filed in Texas are dismissed or 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 percent increase in one year.

• Texas has no limits on non-economic 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 percent 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 percent or higher from the year 2000.

• In the ACOG survey, 57.2 percent of the Washington Ob/Gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 15.06 percent of Washington respondents have stopped practicing obstetrics.

• According to the Pierce County Medical Society, some Tacoma specialists reported 300 percent increases.

• Unlike California, Washington has no cap on non-economic 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's office heard 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 the ACOG survey, 82.2 percent of the West Virginia Ob/Gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 23.66 percent of West Virginia respondents stopped practicing obstetrics.

• 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 percent higher than the highest commercial rate, and an additional 50 percent higher for physicians 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.

VIII. Conclusion

Thank you Senator Hatch, Senator Gregg for your leadership on this important issue and for the Committees' attention to this crisis. ACOG appreciates the opportunity to present our concerns for the Committees' consideration. The College looks forward to working with you as we push for Federal liability reform.

PREPARED STATEMENT OF JAY ANGOFF

Mr. Chairman and Members of the Committee: My name is Jay Angoff and I am a lawyer from Jefferson City, Missouri, and a former insurance commissioner of Missouri and deputy insurance commissioner of New Jersey. I appreciate the opportunity to testify here today.

BACKGROUND

Today's medical malpractice insurance crisis is the third such crisis in the last thirty years. The first was in the mid 1970's, and the second was in the mid 1980's. Some States enacted limits on liability—so-called "tort reform"—in response to one or both of those previous crises. But whether or not a State enacted such limitations, malpractice rates rose during the mid-80's, fell during the 90's, and are rising sharply today. The tort system therefore can not be the cause of these periodic insurance crises, and thus enacting tort reform can not reasonably be expected to avert future insurance crises.

For example, during my 1993–98 tenure as insurance commissioner of Missouri, both the number of medical malpractice claims filed and the number of medical malpractice claims paid out decreased: according to the data the medical malpractice insurance companies filed with our department, the number of new medical malpractice claims reported decreased from 2,037 in 1993 to 1,679 in 1998, and the number of medical malpractice claims paid out decreased from 559 in 1993 to 496 in 1998. (See Exhibits 1 and 2.) As might reasonably be expected, medical malpractice insurance rates in Missouri decreased during that time.

After I left the insurance department, the number of malpractice claims paid continued to decrease: from 496 in 1998 to 439 in 2001. And the number of malpractice claims filed decreased even more dramatically: from 1,679 in 1998 to 1,226 in 2001.

Moreover, the average payment per claim rose by less than 5 percent—from $161,038 to $168,859—far less than either general or medical inflation.

Unexpectedly, however, malpractice insurance rates rose sharply last year in Missouri—by an average of almost 100 percent in little over a year, according to a Missouri State Medical Society survey—just as they did in the rest of the country, and just as they did in 1986 and 1975. Insurance rates going up while insurance claims are going down—and Missouri is just one of many States where this phenomenon is occurring—doesn't seem to make sense. But it does make sense, for four reasons.

CAUSES OF INSURANCE CRISES

First, malpractice insurers make money not by taking in more in premiums than they pay out in claims, but by investing the premiums they take in until they pay the claims covered by those premiums. Investment income is particularly important for malpractice insurers because they invest their premiums for about six years, since they don't pay malpractice claims until about six years after they have occurred; insurers pay other types of insurance claims much more quickly. When either interest rates are high or the stock market is rising, a malpractice insurer's investment income more than makes up for any difference between its premiums and its payouts. Today, on the other hand, stocks have crashed and interest rates are near 40-year lows. The drop in insurers' investment income today can therefore dwarf the decrease in their claims payments, and thus create pressure to raise rates even though claims are going down.

Second, just as people buy insurance to insure themselves against risks that they can't afford to pay for or choose not to pay for themselves, insurance companies buy insurance—called re-insurance—for the same reason. For example, an insurer might buy reinsurance to pay an individual claim to the extent it exceeds a certain amount, or to pay all the insurer's claims after its total claims exceed a certain amount. The re-insurance market is an international market, affected by international events, and the cost of re-insurance for commercial lines was already increasing prior to the terrorist attacks. After those attacks, not surprisingly, it increased far more, due to fears related to terrorism (and completely unrelated to medical malpractice).

Third, insurance companies use a unique accounting system—called statutory accounting principals, or SAP—rather than the generally accepted accounting principles (GAAP) used by most other companies. Under this system, insurers increase their rates based on what their "incurred losses" are. "Incurred losses" for a given year, however, are not the amount insurance companies have paid out in that year—although that would be its non-insurance, common-sense meaning—but rather are the amount the insurer projects it will pay out in the future on policies in effect in that year. These projections are, by definition, a guess, under the best of circumstances, i.e., under the assumption that an insurer has no business reason to either overstate or understate them.

Insurers do, however, have reasons for inflating or understating their estimates of "incurred losses." Insurance companies who are thinly capitalized—who have very little cushion, called "surplus" in the insurance industry, beyond the amount they estimate they must pay out in claims—will often understate their "incurred losses" on the reports they file with insurance departments so that they can show a higher surplus on those reports. (It's the job of insurance department auditors to ferret out insurers who are doing this.)

At other times, however—like today—insurers overstate their incurred losses to justify a rate increase. In addition, because increasing their "incurred losses" lowers their income, they also have tax reasons for inflating those estimates. Today, insurers' incurred loss estimates have increased dramatically because they are seeking to recoup the money they have lost on investments—not because the amount they have actually paid out in the past has risen substantially (to the contrary, in Missouri it has actually decreased). When it becomes apparent that the insurers' current loss estimates are too high, insurers will be able to use the amount they estimated they would pay out but did not in fact pay out to reduce premiums or increase profits, or both. This is one reason premiums fell during the 1990's: the "incurred loss" estimates insurers made in the mid-1980's to justify their rate increases during the 1985–86 insurance crisis turned out to be wildly inflated, enabling insurers to use the difference between what they estimated they would pay out and what they actually ended up paying out to both reduce premiums and increase their profits in the 1990's. These same phenomena will inevitably occur after this insurance crisis.

The final factor contributing to periodic spikes in insurance rates is the insurance industry's exemption from the antitrust laws under the McCarran-Ferguson Act.

Unlike virtually all other major industries, insurance companies may agree among themselves to raise prices or restrict coverage, as well as to engage in other anti-competitive activities, with the exception of boycotts, that would otherwise violate the antitrust laws. When times are good—i.e., when investment income is high—the industry's antitrust exemption would seem to be irrelevant. Far from raising prices in concert, insurance companies compete for market share by cutting price. When times are bad, however—and they could hardly be worse than they are today, when both the stock market and the bond market are producing low or negative returns—the antitrust exemption for the insurance industry allows insurers to collectively raise their prices without fear of prosecution. In other industries, fear of such prosecution prevents such collective increases.

The extent to which insurers today are acting in concert to raise price has not yet been determined. Evidence from the mid-1980's insurance crisis, however, supports the conclusion that insurance companies both have collectively raised prices and have used such collective increases to pressure legislators to enact tort reform. For example:

• In December 1984 the Insurance Information launched an advertising campaign which it characterized as an "effort to market the idea that there is something wrong with the civil justice system in the United States." Maher, I.I.I. Launches New Ad Campaign, National Underwriter, Dec. 21, 1984, at 2.

• In June 1985 former GEICO Chairman John Byrne told the Casualty Actuaries of New York that they should quit covering doctors, chemical manufacturers, and corporate officers and directors since "it is right for the industry to withdraw and let the pressure for reform build in the courts and in the State legislatures." Journal of Commerce, June 18, 1985, at 10A.

• In November 1985, the Insurance Information Institute sent a kit on the "civil justice crisis" to insurance executives and agents urging them to tell their policyholders and the media that "insurers have no recourse but to cut back on liability insurance until improvements in the civil justice system will create a fairer distribution of liability, reduce the number of lawsuits, and create a climate in which insurance can operate more predictably."

• The famous Time Magazine cover story announcing the arrival of the insurance crisis appeared in January 1986.

Because of McCarran-Ferguson courts have also consistently been forced to dismiss cases involving either price-fixing among insurers or any other type of collusion falling short of a complete refusal to deal on any terms. See, e.g., Ohio AFL–CIO v. Insurance Rating Board, 451 F.2d 1178 (6th Cir. 1971); Fleming v. Travelers Indem. Co., 324 F.Supp. (D. Mass. 1971). And while the attorneys general of 19 States challenged certain insurer activity under the boycott exception to McCarran in the aftermath of the last insurance crisis, they did not challenge the recommending of rates by the Insurance Services Office (ISO), an insurance industry consortium. The attorneys general explained that "the rate-recommendation function of ISO, although anticompetitive and illegal in any other industry, is not a part of the Attorneys Generals' cases because the insurance industry has a special exemption from the antitrust laws that covers this conduct." Office of the Attorney General of West Virginia, Fact Sheet on the Multi-State Prosecution of Antitrust Violations in the Insurance Industry, March 22, 1988, at 7. Whether any anti-competitive activity that insurers may currently be engaging in is immune from prosecution under McCarran or actionable under the boycott exception to McCarran will likely be determined in the aftermath of the current crisis.

HOW TO PREVENT FUTURE INSURANCE CRISES

What, then, can be done to reduce medical malpractice insurance rates in the short run, and to prevent periodic medical malpractice insurance crises from occurring in the future just as they have occurred in the past? First, Congress should repeal the McCarran antitrust exemption, so that insurers could no longer act in concert to raise prices without fear. A second solution is to give doctors automatic standing to challenge rate increase proposals filed by medical malpractice insurers with State insurance departments. Some malpractice insurers are today owned by doctors, and many doctors have the quaint idea that those doctor-owned insurers are somehow different than other insurers. When doctors own insurance companies, however, they act like insurance executives, not doctors; and they are just as affected by poor investment performance and high reinsurance costs as are other insurers, and just as likely to inflate their incurred loss estimates and take advantage of their antitrust exemption as are other insurers. By hiring an independent actuary at a cost of a few thousand dollars to point out the unreasonableness or irrationality of an insurer's "incurred loss" estimate on which its rate increase request is based,

a State medical association could save its members hundreds of thousands or even millions of dollars in the aggregate.

Third, the States could change their laws to make it easier for insurance commissioners to prevent excessive rate increases. In many States, for example, medical malpractice insurers can raise their rates at will, without getting approval of the insurance commissioner. In other States the insurance commissioner may disapprove a rate only if he first finds that the market is not competitive; by the time the commissioner makes such a finding, however, the damage has already been done.

Fourth, States can authorize and provide start-up loans for new malpractice insurers which would compete with the established insurers. In Missouri, the legislature created such a company to write workers compensation insurance in 1993, when workers comp rates were increasing dramatically even though workers comp claims were not, and that company has been a success: it charged rates that were based on experience rather than inflated "incurred loss" estimates, which forced the other insurers to do the same; it paid back its loan from the State well ahead of schedule; and it now is a significant player in the workers comp market. The key to its success is the fact that it competed with the established insurers for all risks, including the most profitable; the established carriers had sought to limit its mission to insuring only the worst risks. If a State establishes a new medical malpractice carrier and authorizes it to compete with the established carriers for all doctors' business then that insurer should help drive medical malpractice rates down just as the Missouri State-authorized workers comp insurer has helped drive workers comp rates down.

Finally, there is the California 20 percent solution. In 1988, California voters narrowly approved a ballot initiative, Proposition 103, which not only repealed California's antitrust exemption for insurance companies and gave both doctors and consumers automatic standing to challenge insurers' proposed rate increases, but also mandated that insurance companies roll back their rates. The California Supreme Court upheld substantially all of Proposition 103, including the rollback, modifying it only to the extent necessary to permit insurers to avoid the rollback if they could demonstrate that they would be unable to earn a fair rate of return if their rates were rolled back. Few insurers could prove this, and as a result medical malpractice premiums in California fell sharply in the years immediately after Prop 103 was enacted, and even today are lower than they were in the year before Prop 103 was enacted. While a mandatory rollback sounds—and is—extreme, what California tells us is both that it is constitutional and that it works. Some doctors argue that what has caused rates to fall in California is a law limiting the non-economic damages that injured people can recover that the California Supreme Court held constitutional in 1984. But in the first full year after the law was upheld, premiums rose by 35 percent. Premiums did not begin to fall until Prop 103 was enacted in 1988 and declared constitutional a year later. (See Exhibits 3 and 4.)

WHAT INSURERS THEMSELVES SAY ABOUT INSURANCE CRISES

To be sure, the current sharp and apparently irrational increases in insurance rates have created pressure to enact limitations on liability, based on the understandable rationale that if the amount injured people can recover from insurance companies is limited, insurance companies will pay out less money to such people, and they will pass at least some of those savings on to policyholders. I have explained that such limitations do not make sense because the other factors which cause insurance rates to fluctuate, such as investment income and the cost of reinsurance, have a much greater impact on the premium dollar than could any plausible limitation on the amount injured people could recover.

In addition, Missouri and many other States did enact such limitations after the insurance crisis of the mid-1980's, or the insurance crisis of the mid-1970's, yet rates are rising today in those States just as they are rising in States that did not enact such limitations—even if, as in Missouri, litigation is decreasing, not increasing.

But perhaps the best evidence that litigation does not cause insurance rates to rise—and conversely, that limiting litigation will not cause insurance rates to drop—is what two of the biggest medical malpractice insurance companies said themselves after the last insurance crisis. Florida reacted to that crisis by limiting non-economic damages for all injuries to $450,000, and limiting liability in four other respects. After the law was passed, the insurance commissioner required all medical malpractice insurers to refile their rates to reflect the effect of the five major limitations on liability the State had just enacted. In response, Aetna Casualty and Surety conducted a study, attached as Exhibit 5, that concluded that none of those limitations would reduce insurance rates. In particular, Aetna concluded

that the $450,000 cap on non-economic damages would have no impact on Aetna's claims costs "due to the impact of degree of liability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff."

The St. Paul Fire and Marine Insurance Company—which at the time was the largest malpractice insurer in the nation—conducted a similar study, attached as Exhibit 6. That study analyzed 313 claims it had recently closed and found that 4 of those 313 claims would have been affected by the limitations enacted in Florida, "for a total effect of about 1 percent savings." The St. Paul further explained that the 1 percent savings estimate probably overstates the savings resulting from the new restrictions. And it specifically emphasized that "the conclusion of the study is that the non-economic cap of $450,000, joint and several liability on the non-economic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice."

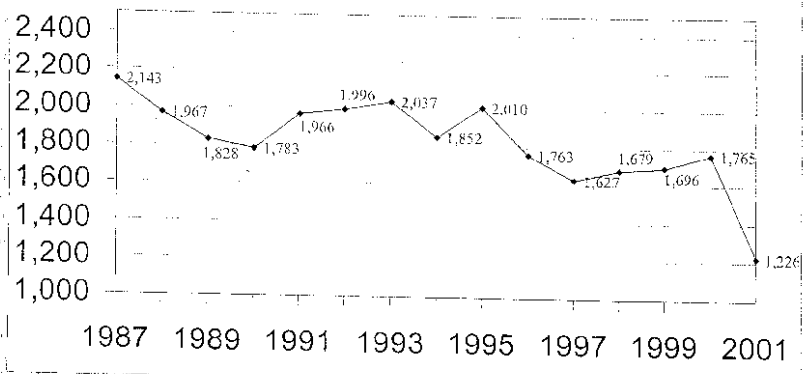
What the Aetna and St. Paul studies may really be telling us—since they prepared those studies to justify their refusal to reduce their rates after limitations on liability were enacted—is that even if such limitations might reduce the amount insurers pay out, insurers don't pass on any savings to policyholders. More important, however, even if they did pass on any such savings, they would be insignificant compared to the other factors affecting malpractice rates. Perhaps that is why after the last insurance crisis the chairman of the Great American West Insurance Company told an audience of insurance executives that tort reform "will not eliminate the market dynamics that lead to insurance cycles," and warned them that "we must not over-promise—or even imply—that insurance cycles will end when civil justice reform begins." See "Don't Link Rates to Tort Reform, Insurance Executive Warns Peers," Liability Week, Jan. 19, 1988, at 1.

CONCLUSION

In conclusion, over the long run the medical malpractice insurance industry is substantially more profitable than the insurance industry as a whole: during the 10-year period 1991–2000, according to the National Association of Insurance Commissioners, its return on net worth has been more than 40 percent greater than the industry average, and its loss ratio has been 6 percentage points lower than the industry average, i.e., it has paid out in losses six cents less on the premium dollar than have all property/casualty insurers. (See Exhibit 7.) Despite this long-run above-average profitability, however, medical malpractice insurance rates, for the reasons I have described, fluctuate substantially—both up and down. The reforms I have outlined can both reduce those fluctuations and, particularly if the insurance industry's antitrust exemption is repealed, reduce the level of malpractice rates over the long run. In contrast, limitations on liability have been demonstrated to do neither.

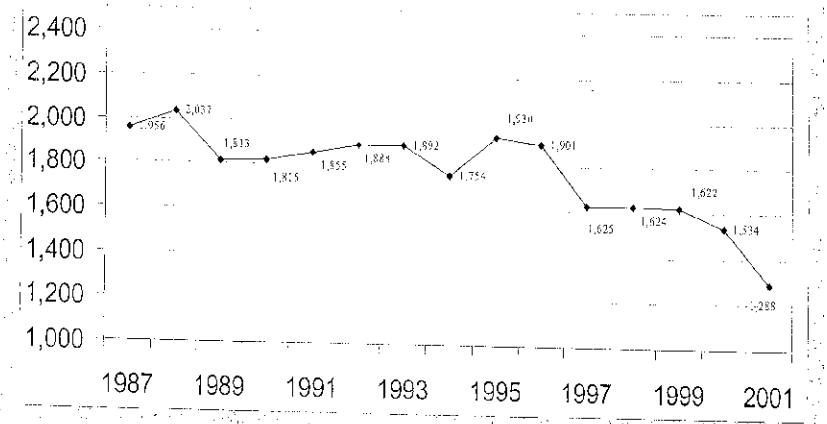
I would be happy to answer any questions the committee may have.

MISSOURI MEDICAL MALPRACTICE REPORTED CLAIMS, 1987 - 2001



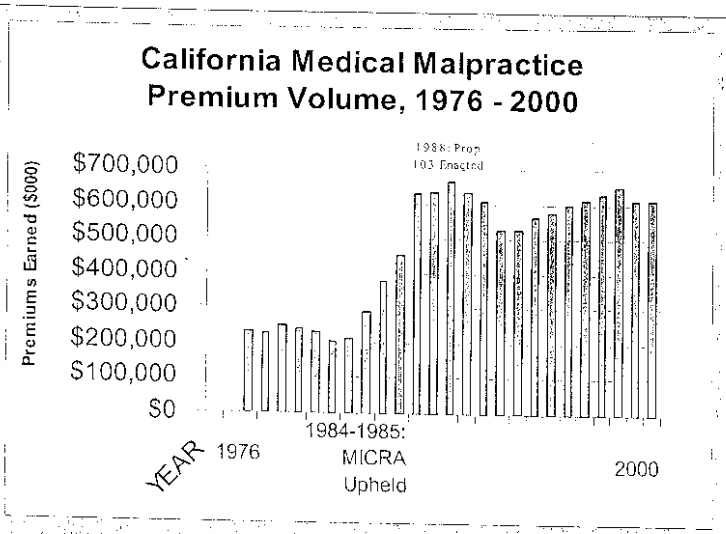
Source: 2001 Missouri Medical Malpractice Insurance Report

MISSOURI MEDICAL MALPRACTICE CLOSED CLAIMS, 1987 - 2001



Source: 2001 Missouri Medical Malpractice Insurance Report

CALIFORNIA MEDICAL MALPRACTICE PREMIUM VOLUME
1976 - 2000



Source: NAIC, Profitability By Line By State, 1977-2001

CALIFORNIA MEDICAL MALPRACTICE PREMIUM VOLUME
1976 - 2000

YEAR	PREMIUMS EARNED $000
1976	228,451
1977	227,077
1978	248,724
1979	236,932
1980	230,230
1981	203,825
1982	210,652
1983	287,256
* 1984	374,681
**1985	449,727
1986	629,448
1987	633,903
***1988	663,155
1989	633,424
1990	605,762
1991	529,056
1992	526,496
1993	563,004
1994	576,771
1995	587,660
1996	610,003
1997	628,858
1998	652,601
1999	611,785
2000	609,712

* MICRA's collateral source and periodic payment provisions upheld by California Supreme Court
** MICRA's cap on damages and limits on plaintiff's attorney's fees upheld by California Supreme Court
*** Prop 103 enacted
Source: NAIC, Profitability By Line By State, 1977-2001

MEDICAL MALPRACTICE v. ALL P/C LINES
1991 - 2000

	Loss Ratio	Return on Net Worth
Medical Malpractice	60.1	12.1
All Lines	66.9	8.3

Source: NAIC, Profitability By Line By State, 2001

Commercial Insurance Division
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123

August 8, 1986

FCC-86-2172

FORMS AND CONTRACTS

Honorable Bill Gunter
INSURANCE COMMISSIONER
Florida Department of Insurance
Tallahassee, FL 32301

ATTN: Mr. Charlie Gray, Chief
Bureau of Policy and Contract Review

Dear Mr. Gray:

RATE REVISION
CONTRACTORS LIABILITY POLICY PROGRAM
THE AETNA CASUALTY AND SURETY COMPANY
THE STANDARD FIRE INSURANCE COMPANY
THE AUTOMOBILE INSURANCE COMPANY OF HARTFORD, CONNECTICUT

In accordance with your Insurance Laws, our Companies file a revised liability rate level which results in an overall selected premium increase of 17.2% with an annual premium effect of $622,250.

Our Companies' decision to revise rates results only after a thorough and comprehensive analysis. We evaluated our experience, market conditions, tort reform, and other relevant factors as they affect the establishment of adequate rate levels. The enclosed exhibits prepared by actuarial unit are submitted in support of our rate filing decision, and demonstrate that the resultant rates are neither excessive, inadequate, nor unfairly discriminatory.

We propose to implement this filing with respect to all policies written on or after January 1, 1987. So as to not delay the filing of our rate level decision, revised rate pages will be forwarded under separate cover when available.

A stamped, self-addressed envelope is enclosed for your convenience in responding.

Sincerely,

Thomas L. Rudd

Thomas L. Rudd, Superintendent
Insurance Department Affairs - Commercial Lines

BODILY INJURY CLAIM COST IMPACT OF FLORIDA TORT LAW CHANGE

Summary

The following table summarizes the expected impact of the new Florida law on bodily injury claims costs (including Allocated Loss Adjustment Expenses). The impacts shown were developed from data gathered via a special claim study conducted by the AEtna. The claim study and the analysis are detailed in the succeeding sections of this memorandum.

Impact of Tort Law Changes

Impact of Tort Law Changes

Tort Law Change	Line of Business: Products Bodily Injury	Line of Business: All Other General Liability
Collateral Source Offset	0	(0.4%)
Joint & Several	0	0
Limitation of Noneconomic Damages to $450,000	0	0
Punitive Damages	0	0
Future Economic Damages over $250,000 Paid at Present Value	0	0

All Other General Liability includes the bodily injury liability portion of package policies, SMP Section II, and monoline General Liability policies. The analysis as shown is based solely on AEtna data and, therefore, is applicable only to AEtna's book of business.

Claim Study

The attached special claim analysis form, designed to gather data on the impact of the tort reforms, was completed by experienced Branch Office claim personnel. Claims eligible for analysis were selected according to the following criteria:

1. Commercial Casualty claims (excluding National Accounts business) for policy years 1981 through 1985
   a. reported prior to January 1, 1986
   b. open as of May, 1986
   c. closed during the last six months

2. All claims in category (1) with indemnity payments or reserves over $25,000 were analyzed (total of 55 claims).

3. Fifty closed claims with indemnity of less that $25,000 were randomly selected.

The completed forms were reviewed for internal consistency prior to coding and analysis.

Collateral Source Analysis

Exhibits I and II detail the analysis of the revision in the collateral source rules. Exhibit I is for claims over $25,000 indemnity. Exhibit II is for claims under $25,000 indemnity.

Exhibit I shows that since the right of subrogation exists for many collateral sources available to the plaintiff, the economic losses incurred are not expected to be substantially reduced due to the law change. Furthermore, current AEtna claim settlement practices recognize, in part, the existence of collateral sources as part of the negotiating process used in arriving at a mutually satisfactory damage value with the plaintiff.

Exhibit II shows that for claims under $25,000, no additional savings are expected due to the change in Florida law.

Joint and Several Analysis

Exhibit III details the analysis of joint and several additional payments made by AEtna. Total joint and several payments were 4.5% of indemnity payments over $25,000. A review of each claim generating additional payments due to joint and several liability indicated no reduction in those payment due to the interaction of economic damages sustained by the plaintiff, the percentage of liability assigned to AEtna's insured, and the policy limits purchased.

Analysis of Limitation of Noneconomic Damages to $450,000

Nine claims had the potential for coming under the new limitation for noneconomic losses. The nine cases were identified on the basis of full liability value--not our insured's share of the liability. Data in the above format allowed for a review of whether total claim value could be reduced and whether such a reduction would impact on AEtna's incurred claim cost.

The review of the actual data submitted on these cases indicated no reduction of cost. This result is due to the impact of degree of disability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff; all seemed to reduce the expected noneconomic component of damages to less than $450,000.

Analysis of Punitive Damages

Only two cases were found where punitive damages had an impact on the claim settlement value. The total impact was estimated at less than $15,000 or less than 0.1% of total indemnity payments. Consequently, it appears that there will be no impact on AEtna's claim values due to changes in the allocation of the punitive damages awarded.

Analysis of Installment Payment of Future Economic Damages Over $250,000

Ten claims had the potential for coming under this section of the law. The review of individual cases indicated no net savings to AEtna for the following reasons:

1. interaction of policy limits, past economic losses, and future economic losses
2. settlement value of the case
3. apparent implicit recognition of the periodic nature of future damages

Overall Summary

The expected net reduction in claim costs is based on an analysis of AEtna claims. As such, the analysis is applicable only to AEtna's book of business.

Due to the level of detail of the historical claim data, informed claim judgement was required in some instances to ascertain some of the detail required for the analysis. The judgement, if any, was exercised by experienced claim adjustors and is implicit in the analysis.

The analysis shown represents the best estimate of future cost reductions if the law as currently structured remains in effect. However, the sunset provision of the law takes effect in four years. Furthermore, the law applies only to cases filed under the law, and the Florida statute of limitations is four years. Consequently, it is possible that any plaintiff who might be severely impacted by the provisions of the law would delay filing until after the law expires. If this situation arises, then the expected reductions will be lower than those indicated in this memorandum.

SAVINGS FROM TORT REFORM ACCORDING TO ST. PAUL:

"The conclusion of the study is that the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice."

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM

In 1986, Florida passed a number of changes to the tort system. We have reviewed the tort changes and their potential effect on our medical professional liability experience. Our review is based on a study of over 300 Florida closed claims. The total effect of the bill based on this evaluation was very small.

Evaluation:

Of the 313 closed claims that were studied, only four claims would have been effected by the law for a total effect of about 1% savings. (Exhibit A) Furthermore, all of these savings would have been eliminated if the courts had assigned only 10% more of the blame on our insureds than our claim department had estimated. It's highly likely that there would have been no savings on these claims had the bill been in effect. (Exhibit B)

Our study covered all of our Florida physicians, surgeons and hospital claims that closed in 1983 and 1984. Economic loss was determined based on the plaintiff's medical loss, weekly wage, and time lost from work. These losses were reduced for the time value of money.

We added the noneconomic loss cap to the total economic losses. The cap is $450,000 times the portion of negligence assigned to our insured. We compared this maximum award under the new law to the amount that the St. Paul actually paid on behalf of our insured.

The conclusion of the study is that the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice.

Comments on other provisions of the bill:

a. Collateral source offset

The medical malpractice provisions prior to this act provided for subrogation against collateral providers. The effect of this subrogation would be similar to the effect of the collateral source rule. Therefore, the net effect of eliminating the subrogation and allowing collateral sources is negligible.

b. Itemization of Damages

Damages were itemized in our evaluation of this tort reform and no savings were shown. They are probably already implicitly itemized by either juries or our claim department when settling claims. We expect no savings from this provision.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM
(Continued)

c. Frivolous Suit Protection

This provision can either work for or against us depending on who wins the case. No savings are expected from it.

d. Additur/Remittitur

This provision can also work for or against us. No savings are expected.

e. Punitive Damages

The legislation reduces the monetary incentive for punitive damage cases, but not total award amounts. Since these cases often have a retaliatory incentive, no savings are expected.

f. Timing of Effects

The tort changes made in Florida apply to losses occurring on or after July 1, 1986. On a claims-made policy, they will effect only the portion of our expected losses with accident date after July 1, 1986. This will impact the equivalent of our first year losses.

g. Conclusion

The tort law changes effective July 1, 1986 in Florida will, hopefully, have a positive impact on loss costs for occurrences after that date. However, to forecast the effect is highly speculative. Our evaluation of prior losses showed little or no savings under key provisions of the law and our analysis of other provisions show no expected savings. Our best estimate is no effect from the tort changes.

It can be hoped that the adoption of these tort changes will have an intangible effect on society, and further work to mitigate future loss trends. However, the trends in medical malpractice have been very high. The effect of the reform needs to be very strong to stem such trends.

Medical Professional Liability
State of Florida

Exhibit A

FLORIDA STATE TORT REFORM EVALUATION

EFFECT OF NONECONOMIC DAMAGES CAP, APPORTIONMENT OF LIABILITY, AND MANDATORY STRUCTURED SETTLEMENTS

FLORIDA PHYSICIANS' AND SURGEONS' DATA

LOSS SEVERITY	1984 INCURRED LOSS & LAE	PROJECTED PERCENTAGE SAVINGS	PROJECTED LOSS DOLLAR SAVINGS
EMOTIONAL	$759,362	0.0%	$0
TEMPORARY	$5,867,384	0.0%	$0
PERMANENT PARTIAL	$12,424,121	0.0%	$0
PERMANENT TOTAL	$8,347,000	0.0%	$0
DEATH	$9,337,688	4.5%	$420,196
TOTAL	$36,735,155	1.1%	$420,196

COUNTRYWIDE PHYSICIANS' AND SURGEONS' DATA

LOSS SEVERITY	1985 INCURRED LOSS & LAE	PROJECTED PERCENTAGE SAVINGS	PROJECTED LOSS DOLLAR SAVINGS
EMOTIONAL	$8,217,941	0.0%	$0
TEMPORARY	$81,499,529	0.0%	$0
PERMANENT PARTIAL	$110,004,377	0.0%	$0
PERMANENT TOTAL	$90,695,313	0.0%	$0
DEATH	$99,481,842	4.5%	$4,476,683
TOTAL	$379,899,002	1.2%	$4,476,683

Medical Professional Liability
State of Florida

Exhibit B

FLORIDA CLOSED CLAIM STUDY

CLAIMS PRODUCING SAVINGS UNDER JULY 1,1986 LEGISLATION

LOSS SEVERITY	ECONOMIC LOSS	INSURED NEGLIGENCE	INDEMNITY PAYMENT	NONECONOMIC CAP	PROJECTED SAVINGS
TEMPORARY	$0	0%	$66	$0	$66
TEMPORARY	$0	0%	$194	$0	$194
DEATH	$10,000	3%	$38,375	$11,250	$17,725
DEATH	$5,000	25%	$350,000	$112,500	$232,500

CLAIMS PRODUCING SAVINGS UNDER JULY 1,1986 LEGISLATION
ASSUMING 10% GREATER LIABILITY ASSIGNED TO INSURED

LOSS SEVERITY	ECONOMIC LOSS	INSURED NEGLIGENCE	INDEMNITY PAYMENT	NONECONOMIC CAP	PROJECTED SAVINGS
TEMPORARY	$0	10%	$66	$45,000	$0
TEMPORARY	$0	10%	$194	$45,000	$0
DEATH	$10,000	13%	$38,375	$56,250	$0
DEATH	$5,000	35%	$350,000	$450,000*	$0

* INSURED LIABILITY EXCEEDS CLAIMANT LIABILITY

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company

SAVINGS FROM TORT REFORM ACCORDING TO AETNA:

"IMPACT OF TORT LAW CHANGES

Tort Law Change	Line of Business: Products Bodily Injury	Line of Business: All Other General Liability
Collateral Source Offset	0	(0.4%)
Joint & Several	0	0
Limitation of Noneconomic Damages to $450,000	0	0
Punitive Damages	0	0
Future Economic Damages over $250,000 Paid at Present Value	0	0"

Physician Insurers Association of America
2275 Research Blvd., Suite 250,
Rockville, MD 20850
Telephone (301) 947-9000 - Fax (301) 947-9090

STATEMENT

OF THE

PHYSICIAN INSURERS ASSOCIATION OF AMERICA

Presented by
Lawrence E. Smarr, President
Physician Insurers Association of America

Before a joint hearing of the

United States Senate
Judiciary Committee
And
Health, Education, Labor and Pensions Committee

Regarding:
Patient Access Crisis: The Role of Medical Litigation

February 11, 2003

STATEMENT
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PHYSICIAN INSUERS ASSOCIATION OF AMERICA

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February 11, 2003

INTRODUCTION

Chairman Hatch, Chairman Gregg, members of the Judiciary and H.E.L.P. Committees, I am Lawrence E. Smarr, President of the Physician Insurers Association of America (PIAA). Thank you for allowing me the opportunity to appear before you today and speak about the impact of medical litigation on patient access to health care.

As we all know, professional liability insurance premiums for doctors and hospitals are rapidly rising in many states to levels where they cannot afford to pay them. These increased premiums are caused by the ever-increasing size of medical liability insurance payments and awards. The unavoidable consequence is that physicians are moving away from crisis states, reducing the scope of their

practices, or leaving the practice of medicine altogether. Likewise, hospitals are being forced to close facilities and curtail high-risk services because they can no longer afford to insure them.

DOCTORS INSURING DOCTORS

The PIAA is an association comprised of professional liability insurance companies owned and/or operated by physicians, dentists, and other health care providers. Collectively, our 43 domestic insurance company members insure over 300,000 doctors and 1,200 hospitals in the United States and our nine international members insure over 400,000 health care providers in other countries around the world. The PIAA member insurance companies can also be characterized as health care professionals caring for the professional liability risks of their colleagues - doctors insuring doctors, hospitals insuring hospitals. We believe that the physician owned/operated company members of the PIAA insure over 60% of America's doctors. Unlike the multi-line commercial carriers, medical liability insurance is all that the PIAA companies principally do, and they are here in the market to stay.

The PIAA was formed 26 years ago at a time when commercial insurance carriers were experiencing unanticipated losses and exited the market, leaving doctors, hospitals and other health care professionals no choice other than to form their own insurance companies. A quarter century has passed, and I am proud to say that the insurers who comprise the PIAA have become the driving force in the market, providing stability and availability for those they insure.

When the PIAA and many of its member companies were formed in the 1970's, we faced a professional liability market not unlike that which we are experiencing today. At that time, insurers, all of which were general commercial carriers, were experiencing rapidly increasing losses, which caused them to consider their continuance in the market. Many of the major carriers did indeed

exit the market, leaving a void that was filled by state and county medical and hospital associations across the country forming their own carriers. Again we see the commercial carriers, such as St. Paul, exiting the market. But, this time, the provider owned carriers are in place and are indeed providing access to insurance and stability to the market.

Unfortunately, the recent exodus from and transformation of the market is of such a magnitude that the carriers remaining do not have the underwriting capacity to take all comers. Facing ever-escalating losses of their own, many of the carriers remaining in the market are forced to tighten their underwriting standards and revise their business plans with regard to their nature and scope of operations. This includes the withdrawal from recently expanded markets, which adds to the access to insurance problem caused by carriers exiting altogether.

My goal here today is to discuss what the PIAA sees as the underlying causes of the current medical liability crisis. I want to stress that I believe that this situation should be characterized as a medical liability crisis, and not a medical liability insurance crisis. The PIAA companies covering the majority of the market are in sound financial condition. The crisis we face today is a crisis of affordability and availability of insurance for health care providers, and more importantly, the resulting growing crisis of access to the health care system for patients across the country.

INSURANCE INDUSTRY UNDERWRITING PERFORMANCE

Medical liability insurance is called a long-tail line of insurance. That is because it takes on average two years from the time a medical liability incident occurs until a resulting claim is reported to the insurer, and another two and one-half years until the average claim is closed. This provides great uncertainty in the rate making process, as insurers are forced to estimate the cost of claims

which may ultimately be paid as much as 10 years after the insurance policy is issued. By comparison, claims in short-tail lines of insurance, such as auto insurance, are paid days or weeks after an incident.

Over the past three years medical liability insurers have seen their financial performance deteriorate substantially due to the rapidly rising cost of medical liability claims. According to A.M. Best (Best), the leading insurance industry rating agency, the medical liability insurance industry incurred $1.53 in losses and expenses for every dollar of premium they collected in 2001. While data for 2002 will not be available until the middle of this year, Best has forecast that the industry will incur $1.41 in losses and expenses in 2002, and $1.34 in 2003. The impact of insurer rate increases accounts for the improvement in this statistic. However, Best also calculates that the industry can only incur $1.14 ½ in losses and expenses in order to operate on a break-even basis. This implies that future rate increases can be expected as the carriers move toward profitable operations.

The physician owned/operated carriers that I represent insure a substantial portion of the market (over 60%). Each year, an independent actuarial firm (Tillinghast Towers-Perrin) provides the PIAA with a detailed analysis of annual statement data filed by our members with the National Association of Insurance Commissioners (NAIC). This analysis is very revealing with regard to the individual components of insurers financial performance.

Exhibit 1 below details the operating experience of 32 physician owned/operated insurance companies included in the analysis. A widely relied upon insurance performance parameter is the combined ratio, which is computed by dividing the losses and expenses incurred by insurers by the premiums they earn to offset these costs. For these companies, this statistic has been deteriorating (getting larger) since 1997, with major increases being experienced in 2000 and 2001.

EXHIBIT 1

FINANCIAL RATIOS TO NET PREMIUMS EARNED

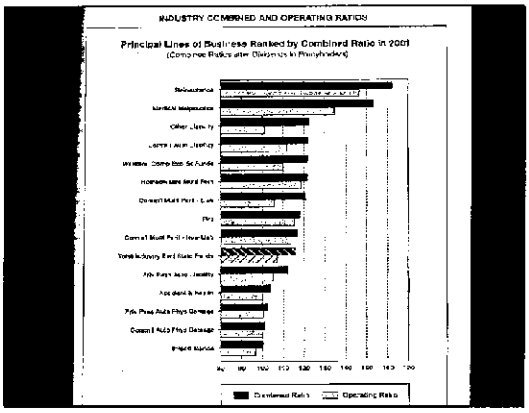
	1995	1996	1997	1998	1999	2000	2001
Loss & LAE	95%	92%	91%	92%	91%	103%	116
Underwriting Exp	15	17	19	22	22	21	22
Combined Ratio	110	109	111	114	113	124	138
PH Dividends	8	8	7	6	6	5	3
Adj Comb Ratio	119	118	118	120	119	129	141
Net Inv Income	49	44	45	43	34	33	31
FIT	7	7	6	6	2	1	-1
Net Income	23	20	21	17	12	4	-10

Source: Tillinghast Survey of PIAA Companies NAIC Filings

For calendar year 2001, the combined ratio (including dividends paid) was 141, meaning that total losses and dividends paid were 41% more than the premiums collected. Even when considering investment income, net income for the year was a negative ten percent. This follows a meager 4 percent net income in 2000. This average experience is indicative of the problems being experienced by insurers in general, and demonstrates the carriers' needs to raise rates to counter increasing losses. All of the basic components of the combined ratio calculation (loss and loss adjustment expense, underwriting expense) have risen as a percentage of premium for all years shown. The only declining component has been dividends paid to policyholders.

To compare this group of PIAA companies with the industry, Exhibit 2 is taken from the 2002 edition of *Best's Aggregates and Averages*. This shows that medical malpractice is the least profitable property and casualty line of insurance in 2001, following reinsurance, which has been greatly impacted by the World Trade Center losses. The adjusted combined ratio for the entire industry is 153, as compared to 141 for the PIAA carriers represented on Exhibit 1.

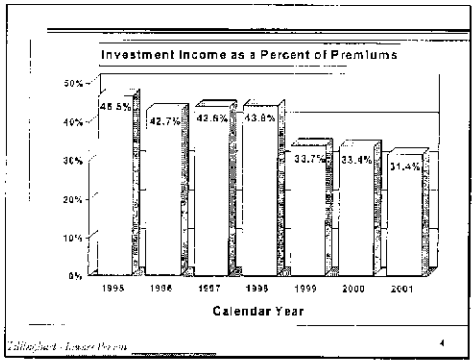
EXHIBIT 2



THE ROLE OF INVESTMENT INCOME

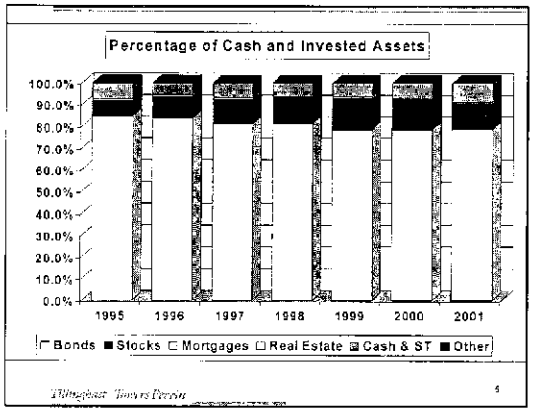
Investment income plays a major role for medical liability insurers. Because medical liability insurance is a "long tail" line of insurance, insurers are able to invest the premiums they collect for substantial periods of time, and use the resulting investment income to offset premium needs. As can be seen on Exhibit 3, investment income has represented a substantial percentage of premium, and has played a major role in determining insurer financial performance. However, investment income as a percentage of premium has been declining in recent years primarily due to historic lows in market interest rates.

EXHIBIT 3



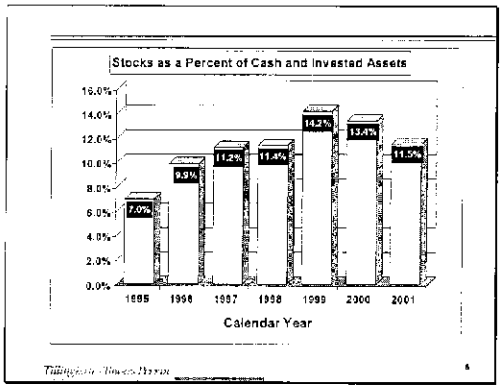
Contrary to the unfounded allegations of those who oppose effective tort reforms, medical liability insurers are primarily invested in high grade bonds and have not lost large amounts in the stock market. As can be seen in Exhibit 4, the carriers in the PIAA survey have been approximately 80% invested in bonds over the past seven years.

EXHIBIT 4



As shown on Exhibit 5, stocks have averaged only about 11% of cash and invested assets, thus precluding major losses due to swings in the stock market. Unlike stocks, high grade bonds are carried at amortized value on insurer's financial statements, with changes in market value having no effect on asset valuation unless the underlying securities must be sold.

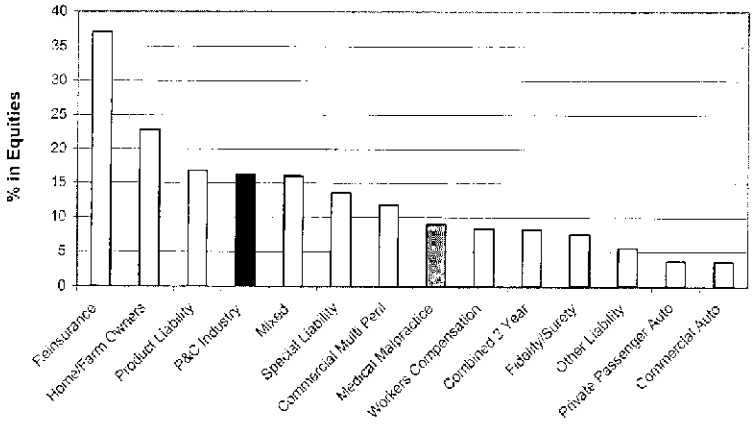
EXHIBIT 5



The experience of the PIAA carriers is confirmed on an industry-wide basis through data obtained from the NAIC by Brown Brothers Harriman, a leading investment and asset management firm. Brown Brothers reports that "Over the last five years, the amount medical malpractice companies has invested in equities has remained fairly constant. In 2001, the equity allocation was 9.03%." As Exhibit 6 shows, medical liability insurers invested significantly less in equities than did all property casualty insurers.

EXHIBIT 6

P&C Equity Allocation 2001



Source: Brown Brothers Harriman & Co., Insurance Industry Asset Allocation Study using NAIC data

Brown Brothers states that the equity investments of medical liability companies "...had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy.

The Brown Brothers report further states:

Since medical malpractice companies did not have an unusual amount invested in equities and what they did was invested in a reasonable market-like fashion, we conclude that the decline in equity valuations is not the cause of rising medical malpractice premiums.[1]

[1] Did Investments Affect Medical Malpractice Premiums? Raghu Ramachandran, Brown Brothers Harriman, January 2003.

While insurer interest income has declined due to falling market interest rates, when interest rates decline, bond values increase. This has had a beneficial effect in keeping total investment income level when measured as a percentage of total invested assets. This is shown in Exhibit 7 below. Thus, the assertion that insurers have been forced to raise their rates because of bad investments is simply not true.

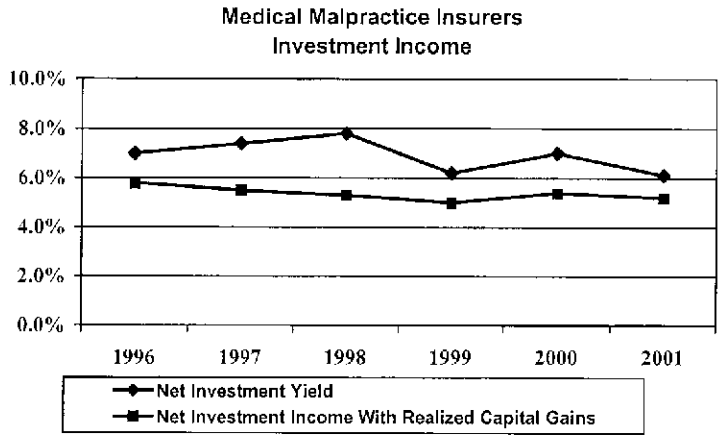


EXHIBIT 7

Source: A.M. Best Aggregates & Averages, 1997 through 2002 Editions, (Predominantly Medical Malpractice Insurers).

THE INSURANCE CYCLE

Opponents of effective tort reform claim that insurance premiums in constant dollars increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the industry's investment performance. The researchers at Brown Brothers also tested this theory, and found no correlation between changes in generally accepted economic parameters (Gross Domestic

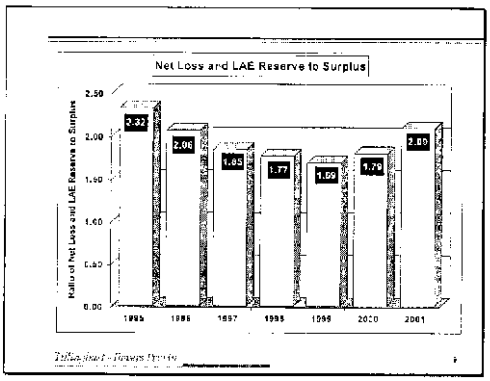
Product (GDP) and 5-year treasury bond rates) with direct medical liability premiums written. In fact, Brown Brothers conducted 64 different regression analyses between the economy, investment yield, and premiums, and found no meaningful relationship. The report produced by Brown Brothers states:

> *Therefore, we can state with a fair degree of certainty that investment yield and the performance of the economy and interest rates do not influence medical malpractice premiums.*[2]

INSURER SOLVENCY

A key measure of financial health is the ratio of insurance loss and loss adjustment expense (amounts spent to handle claims) reserve to surplus. This ratio has deteriorated (risen) for the PIAA carriers since 1999 to a point where it is approximately two times the level of surplus, as shown on Exhibit 8 below.

EXHIBIT 8



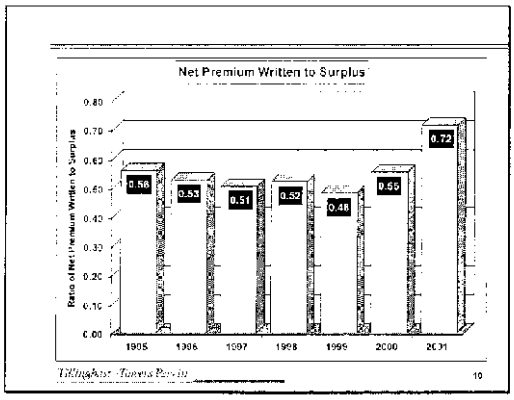
[2] Did Investments Affect Medical Malpractice Premiums? Raghu Ramachandran, Brown Brothers Harriman, January 2003.

The relationship between reserves (amounts set aside to pay claims) and surplus is important, as it is a measure of the insurer's ability to contribute additional amounts to pay claims in the event that original estimates prove to be deficient. At the current approximately two-to-one ratio, these carriers in aggregate are still in sound financial shape. However, any further deterioration in surplus due to underwriting losses will cause a deterioration in this important benchmark ratio indicating an impairment in financial condition. Under current market conditions, characterized by increasing losses and declining investment interest income, the only way to increase surplus is through rate increases.

Net premiums written as compared to surplus is another key ratio considered by regulators and insurance rating agencies, such as A.M. Best. This statistic for the companies in the PIAA survey has also been deteriorating (rising) since 1999, showing a 50% increase in the two years ending in 2001. The premium-to-surplus ratio is a measure of the insurer's ability to write new business. In general, a ratio of one-to-one is considered to be the threshold beyond which an insurer has over-extended its capital available to support its underwritings.

As can be seen on Exhibit 9, this statistic has also deteriorated, and the carriers in aggregate are approaching one-to-one. As the carriers individually approach this benchmark, they will begin to decline new risks, causing further availability problems for insureds. Rate increases the carriers are taking also have an impact on this important ratio as well as new business written.

EXHIBIT 9



THE CAUSE OF THE CRISIS

The effects described in the previous pages were caused by the convergence of six driving factors making for *the perfect storm*, as follows:

- Dramatic long term paid claim severity rise
- Paid claim frequency returning and holding at high levels
- Declining market interest rates
- Exhausted reserve redundancies
- Rates becoming too low
- Greater proportion of large losses

The primary driver of the deterioration in the medical liability insurance industry performance has been paid claim severity, or the average cost of a paid claim.

EXHIBIT 10

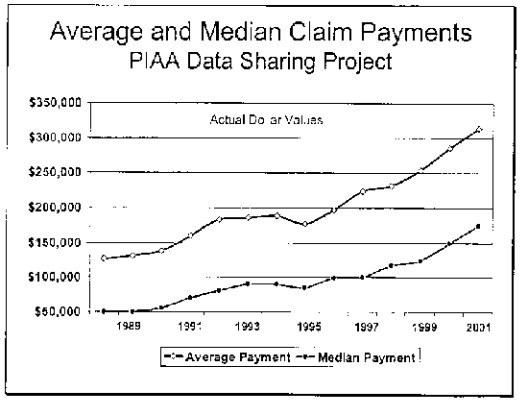
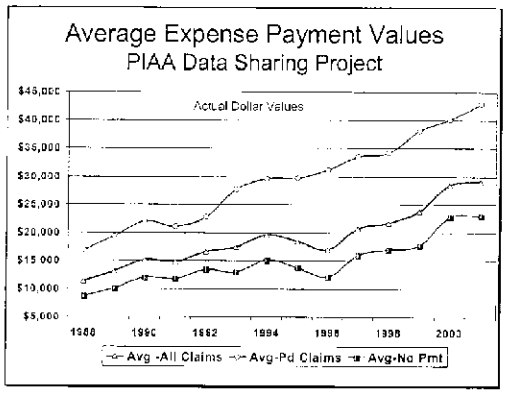


Exhibit 10 shows the average dollar amount paid in indemnity to plaintiffs on behalf of individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9% during this period, as compared to 2.6% for the Consumer Price Index (CPIu). The data for Exhibit 10, as well as that for slides which follow, comes from the PIAA Data Sharing Project. This is a medical cause-of-loss database, which was created in 1985 for the purpose of identifying common trends among malpractice claims. PIAA member companies use the database for risk management and patient safety purposes. To date, over 180,000 claims and suits have been reported to the database.

Allocated loss adjustment expenses (ALAE) for claims reported to the Data Sharing Project have also risen at alarming rates. ALAE are the amounts insurers pay to handle individual claims, and represent payments principally to defense attorneys, and to a lesser extent, expert witnesses. Average amounts paid for three categories of claims are shown below. As can be seen, the average amount spent for all claims in 2001 has risen to just under $30,000.

EXHIBIT 11

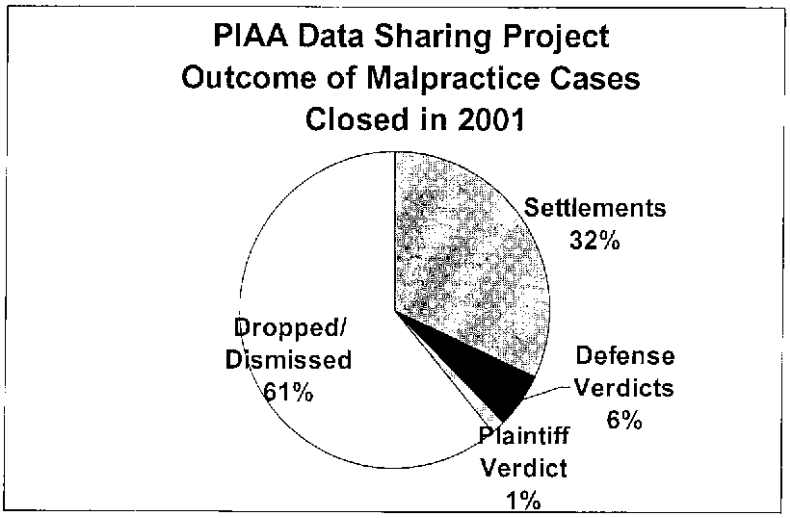


One very troubling aspect of medical malpractice claims is the proportion of those filed which are ultimately determined to be without merit. Exhibit 12 shows the distribution of claims closed in 2001 as reported to the PIAA Data Sharing Project. Sixty-one percent of all claims filed against individual practitioners were dropped or dismissed by the court. An additional 5.7% were won by the doctor at trial. Only 33.2% of all claims closed were found to be meritorious, with most of these being paid through settlement. Of all claims closed, more than two-thirds had no indemnity payment to the plaintiff. When the claim was concluded at verdict, the defendant prevailed an astonishing 80% of the time. This data clearly shows that those attorneys trying these cases are woefully deficient in recognizing meritorious actions to be pursued to conclusion.

Analyses performed by the PIAA have shown that of all premium and investment income available to pay claims, only 50% ever gets into the hands of truly injured patients, with the remainder being principally paid to attorneys, both plaintiff and defense. Something is truly wrong with any system that consumes

50% of its resources to deliver the remainder to a small segment of those seeking remuneration.

EXHIBIT 12



A review of the average claim payment values for the latest year reported to the PIAA Data Sharing Project (2001) is revealing. As shown on Exhibit 13, the mean settlement amount on behalf of an individual defendant was just over $299,000. Most medical malpractice cases have multiple defendants, and thus, these values are below those, which may be reported on a per case basis. The mean verdict amount last year was almost $497,000 per defendant.

EXHIBIT 13

PAYMENT VALUES – 2001

As of 09/04/02

Mean Indemnity Payment	**$310,215**
Mean Settlement	**$ 299,003**
Mean Verdict	**$ 496,726**

Exhibit 14 shows the mean expense payment for claims by category of disposition. As can be seen, the cost of taking a claim for each doctor named in a case all the way through trial is fast approaching $100,000.

EXHIBIT 14

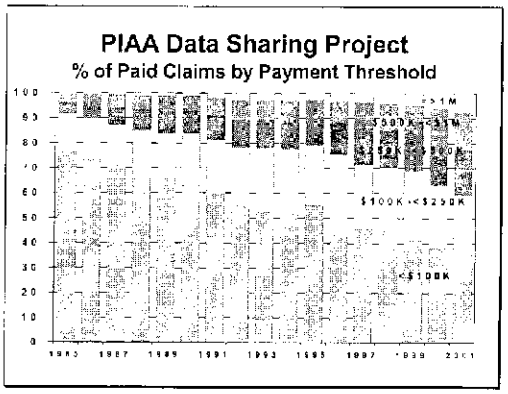
PAYMENT VALUES – 2001

As of 09/04/02

Mean Indemnity Payment	**$310,215**
Mean Expense Payment	**$ 28,801**
Won at Trial	**$ 85,718**
Lost at Trial	**$ 91,423**
Settled	**$ 39,891**
Dropped/Dismissed	**$ 16,743**

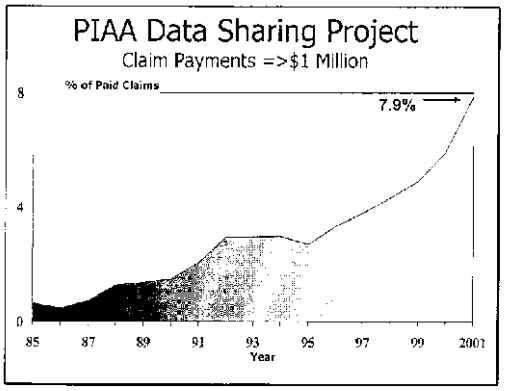
Exhibit 15 shows the distribution of claims payments at various payment thresholds. It can be readily seen that the number of larger payments are growing as a percentage of the total number of payments.

EXHIBIT 15



This is especially true for payments at or exceeding $1 million, which comprised almost eight percent of all claims paid on behalf of individual practitioners in 2001 (Exhibit 16). This percentage has doubled in the past four years, and clearly demonstrates why insurers are facing dramatic increases in the amounts they have to pay for reinsurance. While medical liability insurers are reinsured by many of the same companies having high losses from the World Trade Center disaster, their medical liability experience was rapidly deteriorating prior to September 11, 2001.

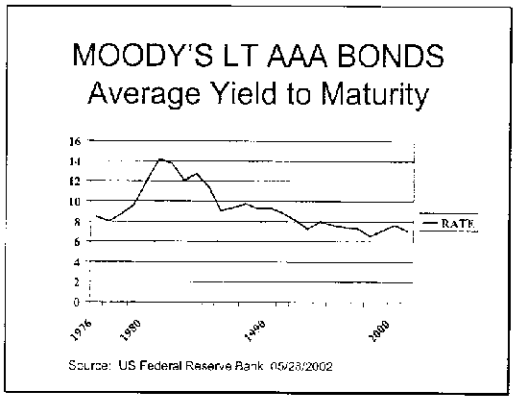
EXHIBIT 16



In addition to rising claim severity, like all other investors, medical liability insurers have faced declining market interest rates. Eighty percent of PIAA insurers' investments are placed in high-grade bonds. Exhibit 17 shows the long-term decline in high-grade bond earnings. As can be seen, this is not a recent phenomenon, but a long term trend.

Critics of the medical liability insurance industry say that insurers' reliance on investment income to offset premiums has caused turmoil in the marketplace, implying that the use of investment income is a bad thing. Nothing could be further from the truth. If insurers did not ever use investment income to offset premium needs, then rates would always be 30 – 40% higher than otherwise necessary. The role market interest rates play in determining pricing in medical liability insurance (and other lines as well) is a fact of life which we cannot control.

EXHIBIT 17



THE ANSWER

Medical liability insurers and their insureds have faced dramatic long-term rises in paid claim severity, which is now at historically high levels. Paid claim frequency (the number of paid claims) is currently remaining relative constant, but has risen significantly in some states. While interest rates will certainly rise and fall in future years, nothing has been done over the past three decades to stem the ever-rising values of medical malpractice claim payments or reduce the number of meritless claims clogging up our legal system at great expense – except in those few states that have effective tort reforms. In many states not having tort reforms, costs have truly become excessive, and insurers are forced to set rates at levels beyond the abilities of doctors and hospitals to pay. States having tort reforms, such as California, provide a compelling example that demonstrates how such reforms can lower medical liability costs and still provide adequate indemnification for patients harmed as a result of the delivery of health care.

The following reforms are those which the PIAA advocates be adopted at the federal level, which we also feel should be the standard for any state reforms enacted. They are based on the reforms found in the Medical Injury Compensation Reform Act (MICRA) which became effective in California in 1976 and which have been successful in compensating California patients and ensuring access to the health care system since their enactment.

EXHIBIT 18

Health Care Liability Reform

- **$250,000 cap on non-economic damages**
- **Collateral source offsets**
- **Periodic payment of future damages**
- **1/3 year statute of limitations/repose**
- **Joint and several liability**
- **Contingency fee limits**

The keystone of the MICRA reforms is the $250,000 cap on non-economic damages (pain and suffering) on a per-incident basis. Under MICRA, injured patients receive full compensation for all quantifiable damages, such as lost income, medical expenses, long-term care, etc. In addition, injured patients can get as much as one-quarter million dollars for pain and suffering. Advising juries of economic damages that have already been paid by other sources serves to reduce double payment for damages. An important component of MICRA is a reasonable limitation on plaintiff attorney contingency fees, which can be 40% or

more of the total amount of the award. Under MICRA, a trial lawyer must be satisfied with *only* a $220,000 contingency fee for a $1 million award.

A Gallup poll published on February 5, 2003 by the *National Journal* indicates that 57% of adult Americans feel there are too many lawsuits against doctors, and 74% feel that we are facing a major crisis regarding medical liability in health care today. Seventy-two percent of respondents favored a limit on the amount that patients can be awarded for their emotional pain and suffering. Only the trial lawyers and their front groups disagree, seeing their potential for remuneration being reduced. Especially displeasing to them is MICRA's contingency fee limitation, which puts more money in the hands of the injured patient (at no cost reduction to the insurer).

The U.S. House of Representatives adopted legislation containing tort reforms similar to MICRA, including a $250,000 cap on non-economic damages, for the seventh time in September of last year. HR 4600, known as the HEALTH Act, was introduced and adopted on a bi-partisan basis. The Congressional Budget Office (CBO) conducted an extensive review of the provisions of HR 4600, and reported to Congress that if the reforms were enacted, "...premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

The CBO found that HR 4600 reforms would result in savings of $14.1 billion to the federal government through Medicare and other health care programs for the period 2004 – 2012. An additional $7 billion of savings would be enjoyed by the states through their health care programs. The CBO's analysis did not consider the effects that federal tort reform would have on reducing the incidence of defensive medicine, but did acknowledge that savings were likely to result.

EXHIBIT 19

CBO Scoring of HR 4600

September 24, 2002

$14.1 Billion Savings 2004 – 2012

$7 Billion Savings to the States 2004 - 2012

"...premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

The US Department of Health and Human Services published a report on July 24, 2002, which evaluated the effects of tort reforms in those states that have enacted them. As stated in Exhibit 20, HHS found that practitioners in states with effective caps on non-economic damages were currently experiencing premium increases in the 12 – 15% range, as compared to average 44% increases in other states.

EXHIBIT 20

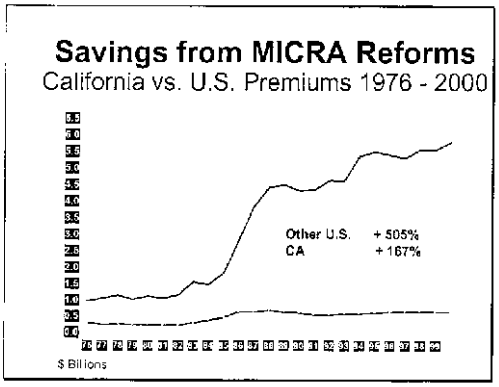
USDHHS

Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System
July 24, 2002

"States with limits of $250,000 or $350,000 on non-economic damages have average combined highest premium increases of 12 – 15%, compared to 44% in states without caps..."

Annual data published by the National Association of Insurance Commissioners (NAIC) also documents the savings California practitioners and health care consumers have enjoyed since the enactment of MICRA over 25 years ago. As shown in Exhibit 21, total medical liability premiums reported to the NAIC since 1976 have grown in California by 167%, while premiums for the rest of the nation have grown by 505%. These savings can only be attributed to MICRA.

EXHIBIT 21



These savings are clearly demonstrated in the rates charged to California doctors as shown in Exhibit 22. Successful experience in California and other states makes it clear that MICRA style tort reforms do work without lowering health care quality or limiting access to care.

EXHIBIT 22

2002 Rates- $1mil/3mil Coverage

(as reported by Medical Liability Monitor)

	LA[1]	Denver[2]	Chicago[3]	Phila[4]	Miami[5]
IM	11,164	9,845	26,404	18,429	56,153
GS	36,740	34,644	68,080	82,157	174,268
OB/ Gyn	54,563	30,905	102,640	100,045	201,376

1 The Doctors Company
2 COPIC Insurance Company
3 ISMIE Mutual Insurance Company
4 Pennsylvania Medical Society Liability Insurance Company
5 First Professional Insurance Company

PROP 103 HAD NO EFFECT ON CALIFORNIA MEDICAL LIABILITY PREMIUMS

In an effort to derail desperately needed tort reforms as described above, the Association of Trial Lawyers of America and related individuals and groups have stated that the beneficial effects of MICRA as shown on Exhibit 21 are due to Proposition 103, a ballot initiative passed in 1988 aimed primarily at controlling auto insurance costs. The ballot initiative passed by a 51% majority vote, with voters in only 7 of California's 58 counties approving the measure. The major changes made by Prop 103 include:

- Making the insurance commissioner of California an elected, rather than appointed, official;
- Giving the insurance commissioner authority to approve rate changes before they can take effect;
- Requiring insurers to reduce rates by 20 percent for two years from their levels on November 8, 1987;
- Requiring auto insurance companies to offer a 20 percent "good driver discount."
- Requiring auto insurance rates to be determined primarily by four factors;
- Allowing for payment of "intervenor fees" to outside groups that intervene in hearings conducted by the Department of Insurance[3].

[3] Ironically, the Proposition 103 Enforcement Project headed by Harvey Rosenfeld, a self-proclaimed consumer advocate who led the fight for the adoption of Prop 103, has received almost $1.5 million in intervenor fees through 1997. In total, "consumer organizations" and

Medical liability insurers were not the intended target of Prop 103, but were covered by the resulting regulations. However, Prop 103 did not have any substantive effect on medical liability insurance rates. Prop 103 did have the effect of freezing most insurance rates in California until as late as 1994.[4] This all came at a time when medical liability insurers across the nation were seeing their rates level off or even decline. One major California medical liability insurer, the NORCAL Mutual Insurance Company, actually had two rate decrease filings (-2%, -12%) which had been made with the department of insurance in 1990 and 1991 held up until the conclusion of legal challenges and exemption issues were resolved. NORCAL reached a consent agreement with the California Department of Insurance in November of 1991, at which time its rate decreases were granted. NORCAL was specifically permitted to declare a one-time 20% return of premium for policyholders insured between November 8, 1988 and November 8, 1989 as a dividend and was not required to reduce its rates as a result of Prop 103. As NORCAL had already paid dividends exceeding 20% during the period in question, no monies were returned to policyholders as a result of Prop 103. The experience of other California physician owned companies was similar to that of NORCAL. Even if California medical liability insurers had been required to reduce rates by 20%, this in no way could explain the wide gap in experience shown on Exhibit 21.

CONCLUSION

Increasing medical malpractice claim costs, on the rise for over three decades, have finally reached the level where the rates that insurers must charge

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individuals have received over $7.1 million in intervenor fees and administrative costs through 1997. Source: Personal Insurance Federation of America, www.pifc.org/insurance/prop103.html.

[4] Background on Insurance Reform – A Detailed Analysis of California Proposition 103. www.consumerwatchdog.org/insurance/fs/fs000159.php3.

can no longer be afforded by doctors and hospitals. These same doctors and hospitals cannot simply raise their fees, which are limited by government or managed care companies. Many doctors will face little choice other than to move to less litigious states or leave the practice of medicine altogether.

Legislators are now challenged with finding a solution to the medical liability insurance affordability and availability dilemma – a problem long in coming that has truly reached the crisis stage. The increased costs being experienced by insurers (largely owned/operated by health care providers) are real and documented. It is time for Congress to put an end to the wastefulness and inequities of our tort legal system, where only 50% of the monies available to pay claims are paid to indemnify the only 30% of claims filed with merit and the expenses of the remainder. The system works fine for the legal profession, which is why trial lawyers and others fight so hard to maintain the status quo.

The PIAA strongly urges members of the Senate to pass effective federal health care liability reform, thereby stopping the exodus of health care professionals and institutions which can no longer afford to fund an inequitable and inefficient tort system which benefits neither injured plaintiffs or the health care community.

Patient Access Crisis: The Role of Medical Litigation
Joint Hearing
Statement of Senator Judd Gregg

February 11, 2003

Our health care system is facing a crisis. Physicians across the nation, especially those in high risk specialties, are being driven out their states or out of practice because of sky-rocketing medical liability insurance premiums. This alone may be cause for alarm or legislative action, but there is much more to this story.

A hospital janitor in West Virginia falls and breaks his hip. In the course of his treatment, he learns he has a tumor on his spine and is told he needs to see a neurosurgeon for treatment. He calls four in his community, but none will see him, citing the risky nature of condition and liability insurance concerns. He tries to get appointments with surgeons in three or four neighboring communities, but runs into the same problem. Even the University Medical Center will not take him as a patient. After contacting more than a dozen surgeons, he eventually he finds a surgeon who will see him. But this surgeon is in another state, more than three hours away by car. This is a difficult drive for a man who has spinal trouble and just had hip surgery. This is not a hypothetical case. It's a true story.

A woman in North Conway New Hampshire is pregnant with her first child. North Conway is a rural area without great wealth. It's winter time and roads are icy and covered with snow. Midway through her pregnancy this woman learns that her ob/gyn will soon be forced to retire because she can no longer afford to maintain her medical practice since her insurance premiums increased from $38,000 to $139,000 in just one year. The pregnant woman tries to find a new ob/gyn, but there are few in the area and none willing to take on a new patient, especially one with a high risk pregnancy. What is this woman to do? Wait for the first labor pain and hope that there is not a blizzard when she gets into her car to drive across the state? This is not a hypothetical case. It's a true story.

Some of our witnesses today have similar stories. These are not isolated cases. Indeed, this is a growing, national problem. Patients all across the nation are being denied access to quality health care because of the growing medical liability crisis.

- According to the American College of Obstetricians and Gynecologists, one in eleven obstetricians has been forced to scale back their practices, and one in six have begun to refuse high risk cases.

- The University Medical Center in Las Vegas, Nevada, was forced to close its trauma center for 10 days last year, forcing patients, in need of urgent care, to travel as much as five hours for care.

- In Delaware county, near Philadelphia, more than 40 doctors left the state or stopped practicing in 2001 because of high liability insurance costs.

Today twelve states are facing an urgent patient access crisis. Insurance carriers have exited these states at an alarming rate. Physicians are being forced to move to other states, retire early, or close their practices altogether. Hospitals, nursing homes and other providers are also in trouble. All but 7 of the remaining states have reached "near crisis" status. It's only a matter of time before the "near crisis" states reach full crisis status.

The data are clear on what's driving this crisis. Soaring liability premiums can be directly attributed to excessive litigation. Fueled by dramatic increases in the size of jury awards, the cost of defending lawsuits, and the frequency of large claims, liability insurance costs have been increasing at alarming rates since the late 1990s.

In recent years, the size of jury awards has increased to astronomical amounts. The average award rose 76% between 1996 and 1999, according to the Jury Verdict Research Series. In 1999,, the most current year for which we have litigation data, the median award was $800,000, up 34% in only three years.

The number of million dollar plus jury awards is on the rise, increasing 45% between 1998 and 1999. Now, more than half of all awards are in excess of $1 million.

The cost of defending lawsuits is very expensive, and too many resources are devoted to defending frivolous cases. Nearly 70 percent of all medical liability claims result in no payment to plaintiffs. Yet, the median cost of defending a case, where the jury rules the defendant not guilty, was $66,767 in 2001, according to the American Tort Reform Association. Ob/gyns have the most suits filed against them, but win 7 out of 10 cases closed, according to a survey by the American College of Obstetrics and Gynecology.

Trial lawyers are using the medical professionals as their own personal ATM machines. Left unchecked, this pattern will continue to escalate and deplete the resources of our medical system. Fear of excessive litigation also results in substantial indirect costs when physicians practice "defensive medicine" by ordering additional and unnecessary tests and procedures. While difficult to measure, some experts believe defensive medicine could increase the cost of health care by 5 to 9 percent. This is worth about $60 to $108 billion to our health care economy. In addition to monetary costs, defensive medicine also takes a human toll when defensive medicine jeopardizes quality of care and patient safety.

The system is broken. It has become easier to sue a doctor than get an appointment. Although billions of dollars are spent in our medical liability system in direct and indirect costs, far too few patients reap the benefits. Almost 50% of damages won in court go to attorneys fees, not the injured patient. And the current system has flawed incentives that encourage attorneys to pursue only those cases that are likely to produce exorbitant damage awards while leaving many injured patients with legitimate cases out in the cold.

The solution is to restore balance to the health care system. The solution should ensure fair and timely compensation for patients who are injured by medical negligence. It should provide unlimited compensation for current and future medical expenses and lost wages, and reasonable

compensation for pain and suffering. But it must also must ensure that patients are not denied access to care on the front end. In order to do that, we must address the acute problem of excessive litigation, and we must address it now.

As the cry for help from patients and physicians grows louder, so too are the excuses for not acting. We have heard it all before. Liability rates aren't increasing significantly. There's no problem. Rates are increasing, but it's somebody else's fault. Insurance companies are to blame. State regulators are to blame, or state regulators could do a better job if we they simply passed more regulations. It's bad stock market investments, the business cycle, or anti-competitive behavior. And on and on.

But the facts tell the truth. Insurance rates increase as insurers pay out more in lost claims and litigation expense than they collect in premium. According to A.M. Best, the medical liability insurance industry incurred $1.53 in losses and expenses for every dollar of premium collected in 2001. This has been happening for several years. While it's convenient to blame insurance companies, state insurance regulators, the nation's front line experts, say that "the preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices." Indeed, insurance regulators are concerned that "due to extremely high loss ratios, the concern has been with rate inadequacy." (Feb. 7, 2003 letter from the National Association of Insurance Senator Judd Gregg; letter attached).

We must not overlook the experience of hospitals across the country either. Because most hospital systems self-fund their liability risk, there is no insurance company to blame. Nevertheless, hospitals across the nation are experiencing liability losses that are just as dramatic as it is for those who buy insurance.

We should not be distracted by those who seek to deflect attention from their alliances with the lawyer industry by laying blame where it does not belong. We should not be tempted by those who deny there is a problem. We should not be confused by those who seek to muddle the issue with numbers that don't add up or half-baked theories. We should not be distracted by red herring solutions that do nothing to address the underlying problem.

Instead, we must have the courage to just say no to the status quo and yes to patients. We should act quickly to address the problems that we know are leaving patients without care. At a minimum, we should address the litigation lottery that has added to unpredictability in liability insurance. To ensure there is no gaming of the system, we should ensure that reforms apply across the board to all entities involved in delivery care to a patient. We should look to models of success, such as California's Medical Injury Compensation Reform Act (MICRA). And we should be open to any additional reforms to the underlying medical liability system, such as encouraging states to adopt patient safety best practices. However, our first priority should be to act quickly, before more patients are denied care.

BILL FRIST

U.S. SENATE MAJORITY LEADER • TENNESSEE

FOR IMMEDIATE RELEASE
February 11, 2003

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Health, Education, Labor and Pensions Committee and the Judiciary Committee
"Patient Access Crisis: The Role of Medical Litigation"
Statement by U.S. Senator Bill Frist, M.D.

I thank Chairman Hatch and Chairman Gregg for holding this timely hearing on a matter that is so critical to our nation's health care system. This is only the first step for the Senate in addressing what is a clear and growing problem.

America is indeed in the midst of a health care crisis that is impeding access to care. This crisis is caused by out of control medical litigation costs, and the victims are the patients who are seeing their access to quality care threatened and, in some cases, disappear entirely. The situation is grave, and it is only getting worse.

We've all seen the headlines and heard the horror stories - hospitals closing obstetric wards; trauma centers shutting their doors; expectant mothers unable to find an obstetrician; doctors dropping services, moving to states that have enacted reform or retiring early. And the headlines go on and on....Almost daily it seems there are fresh stories and new victims. In fact, the problem has become so severe that in June of last year the AMA listed 12 states that were in a state of crisis and 30 other states that were near crisis.

I talk with my medical colleagues about this particular problem frequently. In fact, many doctors consider the current medical litigation system the greatest threat they face to providing patients with affordable, quality care. At first the problem of skyrocketing medical litigation costs presents doctors with uncomfortable choices, but in the end it's the patients and the rest of the country that suffer when their skills and services are lost.

What makes this situation so tragic is that highly qualified and committed doctors are literally being forced from the fields of medicine that they so cherish. We are not talking about a few bad doctors, but rather the very best men and women in their profession who have devoted their professional lives to healing others. They do not want to drop vital services, leave already underserved areas, refuse to see expectant mothers or refuse to give emergency care, but the current situation gives them no other choice.

It is difficult to comprehend that we have a system that actually penalizes or even prohibits quality doctors from helping the underserved or simply treating pregnant women. We should be encouraging these health care professionals, not forcing them from their practices. Clearly, this system needs reform.

(cont)

In addition to threatening access to quality care, our current medical litigation system adds dramatically to the overall cost of health care by forcing doctors to practice defensive medicine. All doctors must be careful and prudent in providing care, but should not be threatened by excessive litigation into taking expensive and unnecessary steps. This does not improve care or help patients – it only increases costs. A recent federal report indicates that reasonable litigation reform could save the country at least $60 billion annually in health care costs.

Action is needed now before the crisis spreads further. Meaningful, comprehensive medical litigation reform can provide for fair and equitable compensation for those negligently injured and ensure patient access to quality care. I'm encouraged that we can work in a bipartisan manner to enact meaningful reform that brings balance to our medical litigation system and puts the interest of patients first.

Again, I thank the Chairmen for having this hearing, and I assure them and the American public that the full Senate will address this crisis soon.

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STATEMENT FOR THE RECORD OF SENATOR MICHAEL B. ENZI

SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS JOINT HEARING WITH THE SENATE COMMITTEE ON THE JUDICIARY

"PATIENT ACCESS CRISIS: THE ROLE OF MEDICAL LITIGATION"

FEBRUARY 11, 2003

Thank you Chairman Gregg and Chairman Hatch for holding this hearing today on such a critical issue. Thank you also to the panel members, who are sharing your time, expertise and experience with us today.

Today we will be discussing a very complex problem. But our focus is not -- and should not be -- doctors versus trial lawyers versus insurance companies.

Our focus is patients. For them, there are two main issues we need to address. The first is ensuring that everyone has access to affordable and high-quality healthcare services. The second is ensuring that patients who are injured by medical errors or malpractice are compensated fairly.

Both of these goals are compromised by our tort system. The current state of medical litigation does not provide injured patients with fair and appropriate compensation, and it does little to encourage systematic responses to medical errors. At the same time, skyrocketing medical liability insurance premiums are raising the cost of healthcare for all and curtailing access to healthcare services, particularly for people in rural and frontier areas like Wyoming.

Last week, the Washington Post ran a story about how the medical liability crisis is affecting Wyomingites. There are only two firms left in Wyoming who provide liability insurance to physicians, and the premiums for doctors in Wyoming are two to four times more expensive than those for doctors in California. It's hard enough to recruit physicians to Wyoming as it is. Huge liability insurance premiums don't make it any easier.

As a result of this, Wheatland and the surrounding communities just lost their only obstetrician. His insurance company went bankrupt, and the last two companies serving Wyoming are not writing new policies for obstetricians.

A woman with a complicated pregnancy now has to make almost a three-hour round-trip drive to Cheyenne to get the specialized treatment she needs. This puts her life and the life of her baby in great danger.

This is the price we all pay for a system that encourages frivolous lawsuits and unlimited damages. We need to put a stop to it.

I wish this story was just an isolated instance, but it's not.

Let's take a look at another town in Wyoming. Torrington is actually luckier than many communities. It has a general surgeon. But Torrington almost lost its only surgeon because of rising medical liability insurance premiums.

This surgeon has been in practice in Torrington for 20 years. He also has been trying for the last 10 years, without success, to recruit another surgeon to join him. One of the main reasons he hasn't been successful in his recruitment is that the cost of medical liability insurance is more than he could afford to pay a new surgeon!

Still another example is Casper, Wyoming, where one of the remaining obstetricians in the town is considering whether or not to leave his practice because his new insurance premium is too high. This doctor delivers 30 percent of the babies in Casper, including a large percentage of babies born to mothers who are Medicaid beneficiaries. These mothers simply cannot be expected to pay more to cover the costs of his liability insurance.

These examples highlight the problem we're facing. It's not just about lawsuits and insurance rates. It's about people who can't get the medical attention they need. It's about communities without doctors to serve them. That's why this hearing is so important.

The question is what do we do to solve this patient access crisis?

First, we need to develop a system where injured patients get their just compensation. As it applies to medical litigation, our current legal system is random and inequitable. The standards for determining negligence are vague and uncertain, and the monetary awards granted by juries are highly subjective and variable.

Furthermore, for every dollar paid in malpractice insurance premiums, only 40 cents in compensation is actually paid to the injured - the rest goes for legal fees, insurance company administration, court costs, and the like.

The major beneficiaries of the tort system are the trial lawyers, not the injured patients. Who really bears the costs? We all do, in the form of higher health insurance premiums, greater out-of-pocket payments and higher taxes.

A 1996 study in the *Quarterly Journal of Economics* estimated that limiting unreasonable awards for non-economic damages could reduce healthcare costs by 5 to 9 percent within three to five years of adoption without adversely affecting quality of care. This could save up to $108 billion in healthcare costs each year. These savings would lower the cost of health insurance and permit up to 4.3 million more uninsured Americans to obtain coverage.

Our first step toward fixing this broken system should be to pass legislation to reform medical litigation by

- ensuring compensation that covers patients' economic damages, such as medical bills, lost wages, future earnings, rehabilitation, and custodial care;
- placing a reasonable cap on subjective non-economic and punitive damage awards;
- reserving punitive damages for cases that justify them;
- deducting collateral sources of compensation from plaintiffs' damage awards;
- limiting attorney contingency fees on a sliding scale; and
- providing a reasonable statute of limitations on claims.

Next, we should continuing working toward comprehensive patient-safety legislation that replaces the status quo with a system that encourages the prompt disclosure of preventable medical errors. This new system also should contain mechanisms for catching and correcting medical errors to improve the quality and consistency of care.

Let's face it – many medical errors are the result of problems in the healthcare system, not individual negligence. The tort system doesn't encourage physicians, hospital administrators, or anyone else to admit openly to mistakes and to correct the systemic problems that are the root causes of most medical errors. Until we replace the tort-system lottery with a system that promotes accountability and innovation instead of discouraging it, we're not going to raise the overall standard of care.

We also ought to encourage states to develop better alternatives to litigation. Some states already have experimented with using alternative dispute resolution, such as arbitration and mediation, to resolve medical liability claims. Other states have tried limited no-fault plans for particular injuries, which award compensation through the administrative process, rather than through the courts. These innovations deserve a closer look.

The best solution to the patient access crisis would be to develop a system that reduces the number and severity of medical errors and provides fair compensation to patients injured by them. Medical litigation reform is the necessary first step toward that system.

Medical litigation reform will control costs by reducing the pressure on medical liability insurance premiums and on the need for physicians to practice "defensive medicine." By controlling costs, medical litigation reform will improve access to healthcare in areas already suffering from shortages of physicians and other healthcare professionals. Medical litigation reform also will reduce healthcare costs paid by all Americans in the forms of higher insurance premiums, out-of-pocket payments and taxes.

Finally, medical litigation reform will encourage providers to learn from their mistakes and to prevent them in the future. This will improve the quality of care for all.

Controlling costs, improving access, and improving the quality of care are the three keys to a better healthcare system. I hope that this hearing brings us closer to harmonizing our legal system with these goals.

Thank you, Messrs. Chairmen.

**STATEMENT BY SENATOR EDWARD M. KENNEDY
AT A JOINT HEARING OF THE
HELP and JUDICIARY COMMITTEES
ON MEDICAL MALPRACTICE
(February 11, 2003)**

Today, we are beginning an investigation into the sudden, very substantial increase in the cost of medical malpractice insurance which some doctors in a number of states have experienced. I hope the Committees will conduct a thorough and unbiased examination of this problem, one which seeks real solutions.

We must reject the simplistic and ineffective responses proposed by those who contend that the only way to help doctors is to further hurt seriously injured patients. Unfortunately, as we saw in the Patients' Bill of Rights debate, the Bush Administration is again advocating a policy which will benefit neither doctors nor patients, only insurance companies. Caps on compensatory damages and other extreme "tort reforms" are not only unfair to the victims of malpractice, they do not result in a reduction of malpractice insurance premiums.

Placing arbitrary caps on compensation for non-economic loss only serves to hurt those patients who have suffered the most severe, permanent injuries. They are the paralyzed, the brain-injured, and the blinded. They are the ones who have lost limbs, organs, reproductive capacity, and in some cases even years of life. These are life-altering conditions which deprive a person of the ability to engage in many of the normal activities of day to day living. It would be terribly wrong to take their rights away. The Bush Administration talks about deterring frivolous cases, but caps by their nature apply only to the most serious cases which have been proven in court.

A person with a severe injury is not made whole merely by receiving reimbursement for their medical bills and lost wages. Noneconomic damages compensate victims for the very real, though not easily quantifiable, loss in quality of life that results from a serious, permanent injury. It is absurd to suggest that $250,000 is fair compensation for a person confined to a wheelchair for life.

Caps are totally arbitrary. They do not adjust the amount of the compensation ceiling with either the seriousness of the injury, or with the length of years that the victim must endure the resulting disability. Someone with a less

serious injury can be fully compensated without reaching the cap. However, a patient with severe, permanent injuries is prevented by the cap from receiving full compensation for their more serious injuries. The person with a life-altering injury is only permitted to receive a relatively small portion of the compensation to which he or she is entitled.

Caps discriminate against younger victims. A young person with a severe injury such as paralysis must endure it for many more years than an older person with the same injury. Yet, that young person is prohibited from receiving greater compensation for the many more years he will be disabled. Is that fair?

Caps on noneconomic damages discriminate against women, children, minorities, and low income workers. These groups often do not receive large economic damages for lost earning capacity. Thus, noneconomic damages are particularly important to fairly compensate these vulnerable populations. For example, women who are homemakers and caregivers for their families sustain no lost wages when they are injured, so they only receive minimal economic damages. Yet, ignoring the value of the work they do within the home would violate the most basic family values.

Less accountability for health care providers will never lead to better health care. It will not even result in less costly care. The total cost of medical malpractice premiums constitutes less than two-thirds of one percent (0.66%) of the nation's health care expenditures each year. Malpractice premiums are not the cause of the high rate of medical inflation. Over the last 15 years, the cost of health care rose more than twice as fast as the cost of malpractice insurance.

The White House and other supporters of caps have argued that restricting an injured patient's right to recover fair compensation will reduce malpractice premiums. But, there is scant evidence to support their claim. In fact, there is substantial evidence to refute it. In the past year, there have been dramatic increases in the cost of medical malpractice insurance in states that already have damage caps and other restrictive tort reforms on the statute books, as well as in states that do not. No substantial increase in the number or size of malpractice judgements has suddenly occurred which would justify the enormous increase in premiums which many doctors are being forced to pay. The reason for sky-high premiums cannot be found in the courtroom.

Comprehensive national studies show that medical malpractice premiums

are not lower on average in states that have enacted damage caps and other restrictions on patient rights than in states without these restrictions. Insurance companies are merely pocketing the dollars which patients no longer receive when "tort reform" is enacted.

Let's look at the facts. Twenty-three states had a cap on damages in medical malpractice cases in 2001. Most have had those statutes for a substantial number of years. Twenty-seven states did not have a cap on malpractice damages in 2001. The best evidence of whether such caps effect the cost of malpractice insurance is to compare the rates in those two groups of states. Based on data from the Medical Liability Monitor on all fifty states, the average liability premium in 2002 for doctors practicing in states without caps on malpractice damages was virtually the same as the average premium for doctors practicing in states with caps ($31,926 v. $30,521). There are many reasons why insurance rates vary substantially from state to state. This data demonstrates that it is not a state's tort reform laws which make the difference.

An examination of the rates for a range of specialties reinforces this conclusion:

- the average liability premium in 2002 for doctors practicing internal medicine was actually less (2.8%) for doctors in states without caps on malpractice damages ($9,552) than in states with caps on damages ($9,820). Internists actually pay more for malpractice insurance in the states that have caps.

- the average liability premium in 2002 for general surgeons was almost identical for doctors in states without caps ($33,016) and states with caps ($33,157). Surgeons are paying the same regardless of the state's tort laws.

- the average liability premium for OB/GYN physicians in 2002 was less than 10% more for doctors in states without caps ($53,163) than states with caps ($48,586), a relatively small difference.

This evidence clearly demonstrates that capping malpractice damages does not benefit the doctors it purports to help. Their rates remain virtually the same. It only helps the insurance companies earn even bigger profits.

Since malpractice premiums are not effected by the imposition of caps on

recovery, it stands to reason that the availability of physicians does not differ between states that have caps and states that do not. AMA data shows that there are 233 physicians per 100,000 residents in states that do not have medical malpractice caps and 223 physicians per 100,000 residents in states with caps. Looking at the particularly high cost specialty of obstetrics and gynecology, states without caps have 29 OB/GYNs per 100,000 women while states with caps have 27.4 OB/GYNs per 100,000 women. Clearly there is no correlation.

If a national cap on noneconomic compensatory damages were to pass, it would sacrifice fair compensation for injured patients in a vain attempt to reduce medical malpractice premiums. Doctors will not get the relief they are seeking. Only the insurance companies, which created the recent market instability, will benefit.

Insurance industry practices are responsible for the sudden, dramatic premium increases which have occurred in some states in the last year. The explanation for these premium spikes can be found not in legislative halls or in courtrooms, but in the boardrooms of the insurance companies themselves.

A National Association of Insurance Commissioners study shows that in 2000, the latest year for which data is available, total insurance industry profits as a percentage of premiums for medical malpractice insurance was nearly twice as high (13.6%) as overall casualty and property insurance profits (7.9%). In fact, malpractice was a very lucrative line of insurance for the industry throughout the 1990's. Recent premium increases have been an attempt to maintain high profit margins despite sharply declining investment earnings.

Interest earned on premium dollars is particularly important in medical malpractice insurance because there is a much longer period of time between receipt of the premium and payment of the claim than in most lines of casualty insurance. The industry creates a "malpractice crisis" whenever its investments do poorly. The combination of a sharp decline in the equity markets and record low interest rates in the last two years is the reason for the sharp increase in medical malpractice insurance premiums. What we are witnessing is not new. The industry has engaged in this pattern of behavior repeatedly over the last thirty years.

Doctors, especially those in high risk specialities, whose malpractice premiums have increased dramatically over the past year do deserve premium

relief. That relief will only come as the result of tougher regulation of the insurance industry. When insurance companies lose money on their investments, they should not be able to recover those losses from the doctors they insure. Unfortunately, that is what is happening now.

Doctors and patients are both victims of the insurance industry. Excess profits from the boom years should be used to keep premiums stable when investment earnings drop. However, the insurance industry will never do that voluntarily. Only by recognizing the real problem can we begin to structure an effective solution that will bring an end to unreasonably high medical malpractice premiums.

Statement of Senator Grassley on Medical Malpractice Reform, February 11, 2003

Mr. Chairman, I thank you for calling this important hearing. Anyone who doesn't have their head in the sand knows that this an extremely urgent problem facing physicians and hospitals nationwide, and this hearing is a useful first step toward resolving the problem. The bottom line is that our medical malpractice system is on life-support, and the prognosis isn't good unless we step in.

I've always believed that medical malpractice liability laws should provide adequate compensation for those who are truly injured, while reducing frivolous lawsuits. But the plain fact is that medical industry is in a state of crisis. Doctors are closing down their businesses because malpractice insurance coverage costs have become prohibitive. As I'll discuss in a moment, this is happening in Iowa.

The plain truth is that many trial lawyers see the current system as a litigation lottery. More and more frivolous lawsuits are being filed, driving up costs for everyone. And the big rewards are going primarily to the trial lawyers, not the victims. Lawyers are taking advantage of the system, claiming that it is to the benefit of the consumer – but that isn't the case. It's just plain wrong for lawyers to take sometimes up to 60% of an award that is supposed to help a victim. When it comes to patients and those harmed because of lawsuits, the people harmed - not the lawyers - should get most of the money from a lawsuit. We need to look at dealing with unreasonably large attorneys fees and ensure that the victim gets most of the award.

And we need to limit run-away juries from awarding enormous verdicts that do not reflect reality. Verdicts should fully compensate for economic damages and, where appropriate, provide reasonable compensation for non-economic damages, but they shouldn't be permitted to run so out of control as to chase good doctors out of business. That hurts us all.

Moreover, the price of malpractice insurance coverage has sky-rocketed so high that it has become prohibitive for doctors in certain states; the result is that they are forced to leave the business or move to places that have a better tort reform system, and lower insurance rates. But that means that consumers are left without doctors, and the remaining doctors are overloaded with patients. This is

happening in my own state of Iowa, where rural families are finding it harder and harder to find a doctor to deliver their babies.

In Manchester Iowa, the only two O-B-G-Y-Ns at the Strawberry Point Family Medical Center perform almost one-third of the region's 190 childbirths each year. One of the doctors has been there for many years, the other a few. When the younger doctor joined the practice six years ago, insurance was just over $13,000 for each doctor. By 2001 it rose to about $45,000. But just last year, their insurance company tacked a $77,000 tail and other charges on each doctor's annual premium because the younger doctor, performing unrelated emergency room services that the hospital requires him to perform, had been sued.

Well, these insurance price hikes – for a lawsuit totally unrelated to the O-B-G-Y-N work that either doctor does – brought each doctor's annual premium up to $237,000, and was just too much for the young doctor to afford. He moved to another state where insurance costs less, leaving the community with but one doctor to perform its births. And now the ER is down one doctor, too. If other doctors in the area can't pick up the slack, residents will have to drive 75 miles for medical treatment. That's just not right.

So runaway verdicts drive up premiums and drive out doctors – and the losers are you and me. The system is broken, and my constituents are paying dearly. We need a fix, and we need it fast.

We shouldn't allow this litigation lottery to go on any more, nor should we let the trial lawyers take the majority of a victim's recovery. We need a fairer and more balanced approach for the consumer and the victim.

I think we can fix this problem with a careful, balanced approach. As the Chairman and many members of this committee know, this is just the approach we took in S.274, the Class Action Fairness Act of 2003. In that bill, cosponsored by Senators Kohl, Hatch, Carper, Specter, Miller, Chafee and Lugar, we seek to ensure that the legal system guarantees that plaintiffs have full access to the courts and get treated fairly, but that incentives are curbed so that lawyers and corporations can't game the

system to gouge plaintiffs, consumers and companies. I know that Chairman Hatch shares my strong desire that the Class Action bill will soon become law, and I look forward to an early markup of that bill. And I'm hopeful that we can broker a similar fix for the medical malpractice problem.

In conclusion, I hope that the witnesses have come with solutions that promote a more fair judicial system that provides free access to the courts, but that stops greedy lawyers from driving doctors out of business – a result that hurts us all. I look forward to hearing from this distinguished panel of witnesses, and I thank you for your time.

STATEMENT OF SENATOR LARRY E. CRAIG
"PATIENT ACCESS CRISIS: THE ROLE OF MEDICAL LITIGATION"
Joint hearing
by the Senate Committee on Judiciary
and the Senate Committee on Health, Education, Labor, and Pensions
February 11, 2003

I thank our two Chairmen and Ranking Members of Judiciary and HELP for holding this important hearing today.

Ensuring Americans' access to affordable, adequate health care is one of the most pressing challenges before the Congress. In my State of Idaho and much of the Intermountain West, the access question is complicated by our still-wide open spaces and sparse populations. Idaho has 2100 doctors serving a population of just over a million, which is dispersed over 83,557 square miles. Many communities have only one doctor or health care facility; some have none. Loss of a doctor or facility can be catastrophic to a community, but it can be fatal to patients needing acute care, who may have to travel hundreds of miles to reach the nearest neighboring town. And let me point out that traveling in Idaho is not like jumping on the D.C. beltway – roads in some parts of the state are impassable when there are rockslides or heavy snow, and there usually are few, if any, alternate highway routes to choose.

Yet in Idaho today, doctors are telling me that they are forced to make tough choices about where and who they serve, and they blame the medical litigation crisis – both for creating problems in obtaining malpractice insurance and for forcing them to practice defensive medicine. It is my understanding that three companies providing this insurance have pulled out of my state; another has imposed a twenty percent across-the-board cost increase and adds surcharges on top of that, depending on a practitioner's specialty.

Clearly, we need to get to the bottom of this problem and find a way to address it.

Let me confess in advance that I have a bias. I have in the past supported medical liability litigation reform, and I will continue to do so. I am troubled by a trend in litigation that goes well beyond helping victims obtain relief for their injuries – a trend that more closely resembles a shakedown. I believe there are ways to curb abuses of the legal system in this area, while still ensuring that legitimate claims are satisfied.

To that end, we need to have a better understanding of the repercussions of this kind of litigation, so that we can better tailor our legislative solutions.

With that, I look forward to hearing from our witnesses today, and again thank Chairman Hatch, Chairman Gregg, Senator Leahy, and Senator Kennedy for this opportunity.

Statement of Rep. Dave Weldon, MD (FL-15)
February 21, 2003

I appreciate this opportunity to provide testimony to your Committee on the critical need for medical malpractice reform.

Before being elected to Congress, I practiced internal medicine for 15 years. Since coming to Congress I have seen the rampant increase in medical malpractice premiums and the adverse impacts this is having on patient care and the practice of medicine. Last year I voted for the HEALTH Act, H.R. 4600, and I have joined in cosponsoring H.R. 5, which seeks to bring about responsible medical malpractice reforms.

Since 1976, California has operated under a medical liability system that has kept malpractice premiums under control. Conversely, over the past two years premiums for Florida physicians have increased between 25% and 400%.

Quality of Care Is at Stake

Some would like to minimize the importance of this debate as simply an argument between doctors and lawyers, but anyone who has scratched the surface realizes the very serious implications this issue has on the quality of care for patients. Our failure to address this issue has monumental consequences for the American people and not only will erode the quality of care, but will continue to drive up the costs of medical care, making insurance unaffordable for more Americans.

Patients are suffering today. Seven hospitals in Florida have closed their delivery rooms, denying pregnant women the option of delivering their baby closer to home. Hundreds of the most experienced doctors across this nation have closed their doors and retired from medicine due to the highly litigious culture and the high costs of renewing medical malpractice premiums. What gets lost on the public, is that younger physicians are losing their mentors, as the most experienced doctors retire. This is having a dramatic though unqualtifiable affect on the practice of medicine. Younger doctors learn from the experience of their older more experiences peers, but with the rapid retirement of these physician mentors, patients will no longer be able to benefit from the most experienced specialists. Moreover, studies have shown that one-third of physicians have chosen not to enter a particular specialty due to increased liability exposure in particular fields.

Diverting Resources for Defensive Medicine – Cost to Medicare

As a physician, I know first hand about the urge to practice defensive medicine. No doctor wants to be second-guessed by a lawyer in a courtroom, so tests are often ordered just to make sure. The down side of defensive medicine is that valuable, limited resources are diverted and used in a manner to practice defensive medicine rather than to provide services that might be much more useful to individual patients and society as a whole.

For example, studies on Medicare have shown that the MICRA reforms in California have played a significant role in keeping the costs of medicine as well as holding down the cost of malpractice premiums. Malpractice premiums across the country have increased by 505% since 1976. However in California, premiums have increase only about $167%, 70% below the rate of increase seen across the rest of the nation. In an important study published in 1996 - "Do Doctors Practice Defensive Medicine," *Quarterly Journal of Economics*, May 1996 - Daniel Kessler and Mark McClellan found that Medicare could save over $600 million per year in heart disease alone if California's MICRA reforms were in place across the nation. Most importantly, that study found comparable care and morbidity, but significantly fewer tests and procedures. In other words, while there was significant cost savings in California, the quality of care was in no way compromised.

Clearly, this study demonstrates that defensive medicine is real, that defensive medicine provides no better medical outcomes, and that defensive medicine adds significantly to the cost of medicine for Medicare, private health insurance and other medical coverage. Is it no wonder that we have such difficulty finding the means to pay for enhanced Medicare benefits? I believe that enacting medical malpractice reforms would free up dollars in the Medicare program to ensure the solvency of the Medicare trust fund, enhance benefits, provide better reimbursements, and provide support for a prescription drug benefit for seniors.

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STATEMENT OF THE HONORABLE JAMES C. GREENWOOD
SUBMITTED FOR THE RECORD FOR THE JOINT HEARING
THE SENATE HEALTH, EDUCATON, LABOR & PENSIONS COMMITTEE &
THE SENATE JUDICIARY COMMITTEE
"PATIENT ACCESS: THE ROLE OF MEDICAL LITIGATION"
FEBRUARY 11, 2003

WE HAVE COME THIS MORNING TO THE FRONT LINES OF A CRISIS. TODAY WE WILL EXPLORE, EXAMINE AND CONFRONT THE MEDICAL LIABILITY INSURANCE CRISIS.

THE WORD "CRISIS" IS OFTEN THROWN AROUND IN WASHINGTON DC BUT LET ME TELL YOU SOMETHING THAT FITS THIS TERM, UNDER ANY DEFINITION: FROM DECEMBER 21 UNTIL JANUARY 3 OF THIS YEAR, FOR THIRTEEN DAYS, THE TRAUMA CENTER OF ABINGTON HOSPITAL, IN ABINGTON, PA CLOSED ITS DOORS BECAUSE THE DOCTORS STAFFING THIS CRITICAL FACILITY COULD NOT OBTAIN THE AFFORDABLE MEDICAL LIABILITY INSURANCE THEY NEEDED TO PRACTICE. FOR THOSE THIRTEEN DAYS, FUNDAMENTAL PROTECTIONS TO THE HEALTH AND THE LIVES OF THE FAMILIES IN THIS AREA CEASED TO EXIST. HOW HAVE WE COME TO THIS?

THE PURPOSE OF THIS HEARING IS TO HELP THIS COMMITTEE -- AND THE PUBLIC -- LEARN AND UNDERSTAND THE EVENTS AND FORCES CONTRIBUTING TO THE GROWING INABILITY OF PEOPLE ACROSS THE COUNTRY TO FIND A DOCTOR. WHAT IS MORE, WE NEED TO UNDERSTAND WHY AMERICANS IN MANY STATES CAN NO LONGER GO ABOUT THEIR DAILY LIVES KNOWING THAT IF THE WORST HAPPENS - THE DOCTOR IS IN PLACE AND ON CALL.

IN THE PHILADELPHIA REGION WE HAVE A SPECIAL OBLIGATION AND A PROUD LEGACY TO PROTECT. SINCE 1751, WHEN THE FOUNDERS OF PENNSYLVANIA HOSPITAL, BENJAMIN FRANKLIN AND DR. THOMAS BOND, OPENED THE DOORS TO THE NATION'S FIRST HOSPITAL, WE HAVE BEEN A LEADER IN HEALTH CARE. EVEN TODAY, ALMOST ONE IN SEVEN DOCTORS IN THE UNITED STATES DID SOME PART OF THEIR MEDICAL TRAINING IN PHILADELPHIA, WHICH IS HOME TO A HOST OF EXCELLENT MEDICAL SCHOOLS AND INSTITUTIONS.

BUT THE SIGNS APPEAR OMINOUS AND THIS LEGACY IS THREATENED. RECENTLY, METHODIST HOSPITAL IN SOUTH PHILADELPHIA, WHICH HAS SERVED THAT COMMUNITY FOR MORE THAN 100 YEARS WAS FORCED TO CLOSE ITS OBSTETRICS PRACTICE. WHY? AND WHAT HARDSHIPS HAVE BEEN VISITED UPON THE EXPECTANT MOTHERS WHO COUNTED ON THOSE SERVICES?

THIS CRISIS AFFECTS MORE THAN JUST PATIENTS AND DOCTORS. IN AN ENERGY AND COMMERCE OVERSIGHT AND INVESTIGATION SUBCOMMITTEE HEARING I CHAIRED ON THIS CRISIS IN MY HOME DISTRICT ON FEBRUARY 10, 2003 WE HEARD FROM TWO HOPSITALS AND TRAUMA CENTERS OPERATING IN SOUTHEASTERN PENNSYLVANIA, ST. MARY MEDICAL CENTER AND ABINGTON HOSPITAL ABOUT THE PROBLEMS GROWING DAY-BY-DAY TO FIND AND RETAIN THE PHYSICIANS NEEDED BY THESE FACILITIES TO KEEP OPEN THEIR DOORS.

I AM DEEPLY SADDENED AND ANGERED THAT THIS CRISIS IS HAVING PERMANENT AND LONG-TERM EFFECTS: WEAKENING HOSPITALS, DEBILITATING MEDICAL SCHOOLS, REDUCING THE NUMBER OF DOCTORS WHO PRACTICE, AND DESTABILIZING HEALTH CARE INSTITUTIONS - ALL TO THE DETRIMENT OF THE PEOPLE DESPERATELY IN NEED OF SKILLED MEDICAL TREATMENT.

AGAIN I ASK: WHY? THAT IS THE QUESTION WE SEEK TO ANSWER HERE TODAY.

LET ME TELL YOU WHAT I KNOW SO FAR. THE ACCESS TO HEALTH CARE HAS BEEN RESTRICTED BECAUSE THE INDIVIDUALS AND INSTITUTIONS DELIVERING THAT CARE CANNOT FIND THE AFFORDABLE INSURANCE REQUIRED TO PRACTICE MEDICINE. INSURANCE COMPANIES ARE RAISING THEIR RATES ACROSS THE STATE AND TURNING DOWN DOCTORS LOOKING TO FIND NEW POLICIES.

WHAT IS HAPPENING TO INSURERS? INSURANCE COMPANIES SET THEIR PREMIUMS BASED ON THEIR RISK - THE AMOUNT THEY ESTIMATE THEY WILL HAVE TO PAY. YOU WOULD NATURALLY EXPECT TO PAY MORE TO INSURE A $50,000 HOME THAN A $500,000 HOME. WHAT DO YOU THINK AN INSURANCE COMPANY WOULD SAY TO SOMEONE WHO WANTED TO INSURE A HOUSE, BUT COULD NOT TELL THE VALUE EXCEPT THAT IT COULD BE WORTH EITHER $10,000 OR MILLIONS? PENNSYLVANIA MEDICAL LIABILITY INSURERS FACE A SIMILAR QUANDARY. THEY SIMPLY CANNOT MAKE REASONABLE BUSINESS DECISIONS OF THEIR RISK WHEN THEY DON'T KNOW WITH EACH PASSING YEAR WHAT JURIES WILL AWARD.

IN THE PAST 3 YEARS, ACCORDING TO A RECENT WALL STREET JOURNAL EDITORIAL, JURIES IN PHILADELPHIA HAVE AWARDED MORE IN MEDICAL DAMAGES THAN THE ENTIRE STATE OF CALIFORNIA. IN 2000, PENNSYLVANIA HAD 19 AWARDS INDIVIDUALLY EXCEEDING $5 MILLION.

IN LIGHT OF THIS, CAN WE BEGIN TO UNDERSTAND WHY PENNSYLVANIA INSURERS, FACING THE UNPREDICTABILITY OF PENNSYLVANIA COURT VERDICTS, CONTINUE TO INCREASE THEIR RATES? CAN WE THEN SEE

WHY PENNSYLVANIA'S LARGEST PHYSICIAN INSURER THIS YEAR RAISED ITS PREMIUMS AN AVERAGE OF 54%? DOES THIS HELP US START TO RECOGNIZE WHY 72% OF PENNSYLVANIA DOCTORS, ACCORDING TO A 2001 SURVEY, DEFERRED THE PURCHASE OF NEW EQUIPMENT OR THE HIRING OF NEW STAFF BECAUSE OF MALPRACTICE COSTS? AND NOW CAN WE SEE WHY, SINCE JANUARY 2001, MORE THAN 900 PENNSYLVANIA PHYSICIANS HAVE CLOSED THEIR PRACTICE, MOVED OUT OF STATE OR REFUSED TO DO HIGH-RISK PROCEDURES?

I ASKED "WHY" EARLIER. LET'S TRACE THE PROBLEM BACK TO THIS FACT: INSURERS CANNOT PROPERLY, REASONABLY AND COMPETITIVELY OFFER INSURANCE TO MEDICAL PROVIDERS BECAUSE OF AN UNPREDICTABLE TORT SYSTEM PRONE TO "JACKPOT" AWARDS.

NO ONE WILL ARGUE THAT PATIENTS INJURED BY THE NEGLIGENCE OF A MEDICAL PROVIDER DO NOT DESERVE COMPENSATION - BUT WE HAVE LOST ALL SENSE OF PROPORTION IN THE AREA OF NON-ECONOMIC, INTANGIBLE DAMAGES. HOW DO WE PUT A PRICE TAG ON SUFFERING, LOSS OF ENJOYMENT OF LIFE, OR EMBARRASSMENT? A JURY OF PEERS IS THE BEST AND FAIREST SYSTEM OF JUSTICE WE HAVE. THEY MAKE DECISIONS OF PROFOUND IMPORTANCE EVERY DAY ACROSS THE COUNTRY BASED FIRST ON THE RULE OF LAW BUT SECOND ON THEIR SENSE OF JUSTICE.

BUT WE MUST ASK: WHAT INFORMS, WHAT CREATES THIS SENSE OF JUSTICE AND GIVES IT PROPORTION? HOW HAVE WE SET BENCHMARKS FOR PUTTING A DOLLAR VALUE ON ANOTHER PERSON'S PAIN OR EMBARASSMENT? ARE WE GUIDED BY THE AMOUNTS WE SEE IN SENSATIONAL HEADLINES OR ADVERTISEMENTS OF LAWYERS TRUMPETING HUGE RECOVERIES? ARE WE GUIDED BY THE WOMAN WHO WON MILLIONS FOR SPILLED MCDONALD'S COFFEE? WHERE EVER WE FOUND THAT PRICE TAG WE HANG ON ANOTHER'S SUFFERING - IT IS CLEAR THAT ALL SENSE OF PROPORTION SEEMS TO HAVE BE LOST.

REASONABLE CAPS ON SUCH SUBECTIVE DAMAGES, IN MY ESTIMATION, WHEN TEAMED WITH A SPECIFIC PACKAGE OF OTHER REFORMS, WILL BRING JURIES, VERDICTS AND INSURANCE RATES BACK TO EARTH.

I HAVE RECENTLY INTRODUCED LEGISLATION IN THE HOUSE DESIGNED TO ADDRESS THIS ROOT PROBLEM. HOWEVER, I AM READY TO WORK WITH MEMBERS ON BOTH SIDES OF THE AISLE, IN BOTH CHAMBERS TO ACHIEVE A SOLUTION THAT WILL BE SIGNED INTO LAW BY THE PRESIDENT.

AGAIN, THANK YOU TO THE TWO COMMITTEES FOR HOLDING THIS JOINT HEARING.

Statement of Rep. Peter DeFazio on Medical Malpractice Insurance submitted to a Joint Hearing of the United States Senate Health, Education, Labor, and Pensions Committee and Judiciary Committee

February 11, 2003

Chairman Gregg, Chairman Hatch, Ranking Member Kennedy, Ranking Member Leahy, and distinguished members of the Senate HELP and Judiciary committees, thank you for accepting my testimony on this important issue.

All across my state of Oregon and throughout the country, skyrocketing medical malpractice insurance rates have tremendously decreased access to and affordability of health care.

The one-sided House Republican bill proffered before the 107th Congress—H.R. 4600, the "Help Efficient Accessible Low-Cost Timely Healthcare (HEALTH) Act"—written at the behest of the insurance industry, supposedly addressed the problems with malpractice insurance and passed the House last September by a vote of 217-203. Wisely, the Senate did not act on this flawed legislation before Congress adjourned last December. But, the congressional leadership in both chambers and the President have indicated a desire to pass legislation this year, so I'm sure the debate will continue. It's my sincere hope that both chambers will act in the best interest of *all* Americans and arrive at a solution that avoids the public relations legislation rammed through last year.

I have a number of reservations that need to be addressed in any legislation that Congress crafts to provide relief to physicians from outrageous medical malpractice premiums. I'm extremely concerned about reports of physicians in my district being forced to close down their practices because of sudden rate hikes in their malpractice premiums—on top of the unfair Medicare reimbursement rate cuts that physicians have already had to sustain. Although some would say that the total solution is a simple capping of non-economic damages, in my opinion, other steps are necessary to address this recurring problem.

A front-page, investigative report by the Wall Street Journal on June 24, 2002, concluded, "while malpractice litigation has a big effect on premiums, insurers' pricing and accounting practices have played an equally important role." The legislation preferred by the President and congressional Republicans ignores these problems. The article reported that some groups like the American College of Obstetricians and Gynecologists "for the first time [are] conceding that carriers' business practices have contributed to the current problem." You may remember hearing about the nation's second largest insurer, The St. Paul Companies, deciding to exit the medical malpractice line at the end of 2001. While much was made of the payments they made in malpractice cases (nearly $3.37 million in Oregon), a little reported fact was that St. Paul lost over 32 times that amount—$108 million—when Enron declared bankruptcy.

This "crisis" in medical malpractice insurance is really a cyclical event. There were malpractice crises in the 1970s, the 1980s, and even in the early 1990s. When the economy is strong and their investments boom, malpractice insurers slash prices and write risky policies. When the economy sours, insurers scramble to raise premiums and limit coverage putting undue pressure on physicians and their practices. As the Wall Street Journal reported:

> following a cycle that recurs in many parts of the business, a price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims...Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year...[i]n at least one case, aggressive pricing allegedly crossed the line into fraud.

In each "crisis" the insurance industry has presented "tort reform" as the solution. However, there's no evidence to suggest that there's a cyclical nature to malpractice litigation. It seems to me that the aggressive pricing strategies, questionable accounting practices, and poor investments are all significant factors contributing to the current "crisis" that cannot be ignored.

As insurance is the only major industry that is exempt from antitrust laws, a more effective and long-term solution will be one that addresses the non-competitive and price-fixing nature of the industry, and examines its investment strategies.

That's why I recently reintroduced a legislative package of three bills that I first introduced last Congress to address the high cost of medical malpractice rates. The first bill, H.R. 446, will create the Emergency Malpractice Liability Insurance Commission to study all the factors that cause wildly fluctuating insurance costs, propose solutions for dampening the effects of the insurance premium cycle, and present ways to bring relief to physicians from high premium rates.

I have also reintroduced H.R. 447, the Improved Medical Malpractice Information Reporting and Competition Act to strengthen and increase the transparency of the National Practitioner Data Bank (NPDB). The NPDB would be run out of a new Office of Health Care Competition Policy at the Department of Health and Human Services. This office would improve public access to and widen the scope of information gathered on medical malpractice lawsuits and medical malpractice insurance. It would also support states by compiling and analyzing national trends in liability insurance.

Finally, I have reintroduced H.R. 448, the Insurance Competitive Pricing Act. This legislation would ensure that insurance companies don't engage in anticompetitive activities using the McCarran-Ferguson Act—which exempts insurance companies from antitrust laws—as cover. My bill would partially repeal the McCarran-Ferguson Act to remove this unfair and unintended antitrust exemption.

The bottom line is the Republican proposal (as embodied in H.R. 4600 in the 107th Congress) doesn't address the underlying causes of the malpractice insurance "crisis."

Even the experience in California, which instituted a $250,000 cap for non-economic damages under the Medical Injury Compensation Reform Act (MICRA), hasn't shown that caps keep premium rates low. In fact, premiums in states with caps on non-economic damages are not significantly different from those without them. In 2001, in the specialties of internal medicine and general surgery, premiums were over 2 percent higher in states with caps than those that didn't have caps. For the specialty of obstetrics and gynecology, states with caps had premiums only around 3 percent lower than those without caps on non-economic damages. Last year, internal medicine premiums were 62 percent lower in Oregon, which doesn't have a cap on non-economic damages, than in California, which does. Similarly, obstetrics and general surgery premiums were nearly 50 percent lower in Oregon than in California.

The fact that opponents of insurance reform fail to realize is that malpractice premiums in California increased by 190 percent during the first 12-years following enactment of the $250,000 MICRA cap. It took California's Proposition 103 to stabilize malpractice premium rates. Proposition 103 was an insurance reform measure that increased consumer protections with a short-term rate freeze and prohibition of arbitrary cancellation/non-renewal if policy holders didn't violate a checklist of three items—non-payment, fraud, or increased risk. In fact, California's MICRA model is really no model at all. Since 1998, premiums in California have risen 37 percent compared to the nationwide average of just 5.7 percent.

I am also concerned about federal legislation trampling over state constitutions. You may know that in 1994 the Oregon Court of Appeals ruled the $500,000 cap on non-economic damages was unconstitutional. This was upheld by a 1999 decision from the Oregon Supreme Court. In May 2000, Oregon voters resoundingly defeated Ballot Measure 81 by 74 to 21 percent. This measure would have capped damages on any civil action. Passing legislation like H.R. 4600 would conflict with Oregon's constitution and the will of Oregon voters.

As many of my colleagues already know, this is a complex and emotional issue; one that goes to a physician's ability to engage in their profession and livelihood and to the consumer's right to seek redress for their grievance. I hope there will be enough political will in the 108th Congress to find a comprehensive solution to stop these cyclical crises that unfairly affect physicians and bring relief to an already ailing health care system.

Statement of

Paul Strauss

United States Senator

District of Columbia (Shadow)

Submitted for the Record of the

JOINT HEARING OF THE

COMMITTEE ON THE JUDICIARY

AND

THE COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

Patient Access Crisis: The Role of Medical Litigation

Tuesday, February 11, 2003

2:30 P.M.

Room 106, Dirksen Senate Office Building

I would like to thank both of these prestigious committees for having a hearing on this important issue and allowing me to enter a statement into the record on behalf of my constituents, the great citizens of the District of Columbia. Chairman Gregg and Hatch, Ranking Members Kennedy and Leahy, I stand

firmly against all attempts to limit what a jury can award victims of medical malpractice

The issue is clear: if we set limits on the sums that juries can award, we tear away at the very fabric of our legal system. Trials by jury are a hallmark of American democracy, guaranteed by the constitution. Denying juries the ability to award large sums of money in the most egregious medical malpractice cases is akin to not allowing them to sentence criminals to the maximum penalties in the most egregious criminal cases. No one would agree with maximum sentences for criminals as low as are being proposed for medical malpractice. Is $250,000 sufficient damage for someone who has lost their vision, their ability to walk or their ability to take care of themselves?

I share the sadness of my fellow Senators and others who are witnessing doctors forced out of practice due to escalating premiums, but the cause of these escalating premiums is not increasing jury awards. Allow me to share some facts. The cost of malpractice insurance represents only 3.2 percent of the average doctor's total revenue and these insurance costs have risen only 4.4 percent over the past year. Doctors have felt this increase more noticeably because of decreases in reimbursements from HMOs and government health programs. There is a medical crisis in this country, but it is a crisis of patient coverage and payment to doctors and not a crisis of so-called "out of control" juries.

In fact the notion of "out of control" juries is as much of a misnomer as the idea of "frivolous lawsuits." There are no frivolous lawsuits. The suits that make

it to trial are the most extreme cases. As a case in point I submit to you the fact that plaintiffs drop 10 times more cases than they pursue. Those who file lawsuits are not money hungry and seeking a "payday," they are injured people looking for damages in return for their losses. I urge you to find more than a handful of these cases where $250,000 is sufficient for the damages caused. More often than not, juries award fair sums. They are not "out of control."

As further evidence of how legal system has hurt doctors, proponents of caps in malpractice cases claim that there has been an epidemic of lawsuits in recent years. In fact, in the five years between 1995 and 2000 the number of new medical malpractice claims declined by about four percent. In 1995 there were a little over 90,000 claims. In 2000 the number of claims was under 86,500. This information is according to the National Association of Insurance Commissioners (NAIC).

Proponents of medical malpractice reform also claim that rising costs of physician insurance has led to higher prices of health insurance premiums. But medical malpractice awards have risen at a slower rate than health insurance premiums. Furthermore, the amount that doctors pay in malpractice insurance has risen at half the rate of over all medical inflation. This means that while their rates have increased, the overall cost of medical care has risen proportionally more. Juries cannot be blamed for this increase. Who is to blame then? The answer is simple. The insurance companies.

Throughout the last decade doctors benefited from artificially low premiums caused by the insurance companies desire to increase their market

share. Recent increases in premiums have taken rates to where they would have been had insurance companies made incremental increases. Reckless management by insurance companies and not reckless judgments by jurors is the major cause of the recent rise medical malpractice premiums. If anything we should be debating placing caps on the premiums that companies can charge.

For all of the reasons outlined I would, therefore, like to state for the record that I oppose any attempt to limit jury awards for medical malpractice law suits. It is unethical to take away the rights of juries to use their judgement to decide, based on the facts presented to them in a court of law, how much money to award victims of medical malpractice.

I would like to once again thank the committees, chairmen, and ranking members for giving me the opportunity to present testimony for the record on the behalf of my constituents. The issue at hand is an important one to all Americans including the citizens of the District of Columbia. I would like to thank my staff, including Jonathan Fiedler and Matthew Helfant in preparing this testimony.

Alliance of Specialty Medicine

A Coalition of 13 Medical Societies Representing Over 160,000 Physicians in the United States

For more information contact: Katie Orrico, American Association of Neurological Surgeons
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Statement

of the

Alliance of Specialty Medicine

Before the

Senate Judiciary Committee
and
Health, Education, Labor, And Pensions Committee

On the Subject Of

"Patient Access Crisis: The Role of Medical Litigation"
Tuesday, February 11, 2003

American Academy of Dermatology Association, American Association of Neurological Surgeons/
Congress of Neurological Surgeons, American Association of Orthopaedic Surgeons,
American College of Cardiology, American College of Emergency Physicians,
American College of Osteopathic Surgeons, American College of Radiology,
American Gastroenterological Association, American Society for Clinical Pathology,
American Society of Cataract and Refractive Surgery, American Urological Association,
National Association of Spine Specialists, and Society of Thoracic Surgeons.

Patient Access Crisis: The Role of Medical Litigation

The Alliance of Specialty Medicine, a coalition of 13 medical organizations representing over 160,000 specialty care physicians in the United States, appreciates the opportunity to comment on the impact that our current medical litigation system is having on patient access to medical care. While our nation is facing myriad problems with various other elements of our health care system, none is as pressing and immediate as the current medical liability crisis.

And it is a crisis. The media now report on a daily basis that the situation has become so critical that many physicians are forced to limit services, move to other states where the medical liability system is more stable, or retire altogether. Much of the "face" of this crisis has centered around the great difficulties that pregnant women are having in finding obstetricians to deliver their babies, but the simple truth is that this is a problem that potentially affects all of our citizens: the mother whose little boy has fallen off of the jungle gym and needs an orthopaedic surgeon to fix his broken arm; the teenager who has been in a serious car accident and needs a neurosurgeon to treat his severe head injury; the woman who needs a pathologist to evaluate her Pap smear to screen for cervical cancer; the elderly man who has a poor heart and needs a cardiologist or cardio-thoracic surgeon to unblock a clogged artery or replace a failing valve; the woman who has a family history of breast cancer and needs a radiologist to perform a mammography to make sure she is cancer free; the business man who needs a gastroenterologist to treat his ulcer; the man who needs a urologist to screen for prostate cancer; and the list goes on and on.

Cause of the Crisis: The Current Medical Litigation System is Out of Control

The root cause of this problem is quite simple: the unrestrained escalation of jury awards and settlements, in even a small number of medical liability cases, is driving up doctors' liability insurance premiums and is forcing some insurance companies out of business altogether. This problem is making it difficult, and sometimes impossible, for doctors to obtain affordable liability insurance so they can remain in practice. Adding to this is the fact that doctors distrust and fear the medical litigation system, causing them to alter the way they deliver medical care to their patients, and in some cases this fear is causing doctors to cease practicing altogether. There is a wide body of evidence to substantiate these conclusions:

- **Medical Liability Awards are On the Rise**

  Medical liability awards have been growing steadily, and according to Jury Verdict Research data, from 1994 to 2000 the median jury award rose by 176 percent. The number of mega-verdicts is also on the rise, with the proportion of million dollar plus awards increasing dramatically over this same time period. In 1996, 34 percent of all jury awards exceeded $1 million. Four years later, the number of million dollar awards increased to 52 percent, and the average jury award in 2000 was nearly $3.5 million.

- **Medical Liability Insurance Premiums are Skyrocketing**

  It is clear that the increasing number of multi-million dollar jury awards is driving up the costs of medical liability insurance and insurance companies are now paying out approximately $1.40 for every premium dollar collected. Obviously, this is not sustainable, and this trend is

population ages and requires more medical care from an increasingly shrinking pool of practicing doctors.

- When the practice of medicine becomes so uninviting, fewer and fewer of our nation's best and brightest will want to become doctors, thus jeopardizing our country's status as one of the finest health care systems in the world.

Scope of the Crisis: A National Problem that Requires a Federal Solution

Those who oppose federal legislation to address this crisis cite various reasons to support their contention that this is not a national problem that merits a federal solution. In particular, they note that the regulation of insurance and health care are generally state issues, and therefore principles of Federalism preclude federal legislation to address this problem. They are, however, wrong. The undisputed truth is that this problem now touches nearly every American and a federal solution is therefore a national imperative. As the following demonstrate:

➢ **Nearly All States are Facing a Medical Liability Crisis**

The AMA has identified 12 states that are in a medical liability crisis for all physicians. These include: Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia. However, for many high-risk specialties, like neurosurgery and orthopaedic surgery, the situation is even more widespread than the AMA reports. A 2002 national survey of neurosurgeons identified 25 states that are in a severe medical liability crisis, with an additional 12 states in potential crisis. In addition to those identified by the AMA, the crisis states for neurosurgery include: Alabama, Arkansas, District of Columbia, Illinois, Kentucky, Missouri, New Hampshire, North Carolina, South Carolina, Rhode Island, Tennessee, Utah and Virginia.

➢ **Every American Pays for the Costs of the Current Medical Litigation System**

According to the U.S. Department of Health and Human Services (HHS), in its report entitled, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System," the current medical litigation system imposes enormous direct and indirect costs on the health care system. These costs are passed on to all Americans in the form of increased health insurance premiums, higher out-of-pocket medical expenses and higher taxes. The report estimates that enacting federal medical liability legislation could save between $60-108 billion in health care costs each year. These savings would in turn lower the cost of health insurance and make health care more affordable and available to many more Americans.

➢ **Federal Medical Liability Reform Will Save the Federal Government Money**

Each year, the Federal Government pays for the increased costs associated with the current medical litigation system through various health care programs, including Medicare, Medicaid, Community Health Centers and other health care programs for veterans and members of the armed forces. The Department of Health and Human Services estimates that the direct cost of medical liability insurance coverage and the indirect cost of defensive medicine, increases the Federal Government's costs of these health programs by $28.6 to $47.5 billion each year. In

the above referenced report, HHS estimates that if reasonable limits were placed on non-economic damages, it would reduce Federal Government spending by $25.3 to $44.3 billion per year. The Congressional Budget Office (CBO), in its cost estimate of HR 4600, the HEALTH Act of 2002, confirms that passage of federal medical liability reform legislation that includes a cap on non-economic damages will increase federal tax revenues, and at the same time reduce the costs of federal health care programs.

➢ **States Face Significant Barriers to Implementing Medical Liability Reforms**

Many states face barriers – some legal and some political -- to enacting effective medical liability reform laws. Some states, including Texas, Florida, Ohio and Pennsylvania, have enacted medical liability reform laws, only to have their state Supreme Courts strike them down as unconstitutional. New laws passed by Mississippi and Nevada face certain court challenge, and it will be years before it is determined whether these laws pass state constitutional muster. Finally, in some other states, this issue has become a political one, with Republicans generally on the side of reform and Democrats against it, effectively killing any chances for passage. As a consequence, despite the increasing medical liability crisis in many of these states, they are effectively powerless to act to effectively solve the problem.

Solution to the Crisis: Medical Liability Reform Legislation Patterned After California's MICRA

Fortunately, Congress does not need to start from scratch and identify and implement a solution that is untested. Faced with a similar crisis in the early 1970's, the state of California, with bipartisan support, enacted the Medical Injury Compensation Reform Act or MICRA. The key elements of MICRA include:

- Providing full compensation for all economic damages, including medical bills, lost wages, future earnings, custodial care and rehabilitation;
- Placing a fair and reasonable limit of $250,000 on non-economic damages, such as pain and suffering;
- Establishing a reasonable statute of limitations for filing a lawsuit;
- Allowing for periodic payments of damages rather than lump sum awards; and
- Ensuring that the bulk of any award goes to the plaintiffs, not attorneys

The clear and simple truth is that MICRA works. For nearly three decades, this law has ensured that legitimately injured patients get unfettered access to the courts and receive full compensation for their injuries, while at the same time providing stability to the medical liability insurance market to ensure that doctors can remain available to care for their patients. Consider the following points:

➢ **MICRA Fully Compensates Injured Patients**

First and foremost, under MICRA, patients receive full compensation for legitimate injuries resulting from medical negligence. Detractors of federal reform legislation are attempting to obfuscate the facts by scaring the public and policymakers into believing that injured patients will only receive a maximum of $250,000 to compensate them for their injuries. This is simply not the case. Patients receive full compensation for all of their quantifiable needs, with up to an additional $250,000 for non-economic damages, such as pain and suffering. To demonstrate

this fact, the Californians Allied for Patient Protection recently compiled a sample of total awards (including both economic and non-economic damages) provided to injured patients. For example:

December 2002
$84,250,000 total award
Alameda County
5 year-old boy with cerebral palsy and quadriplegia because of delayed treatment of jaundice after birth.

October 2002
$59,317,500 total award
Contra Costa County
3 year-old girl with cerebral palsy as a result of birth injury.

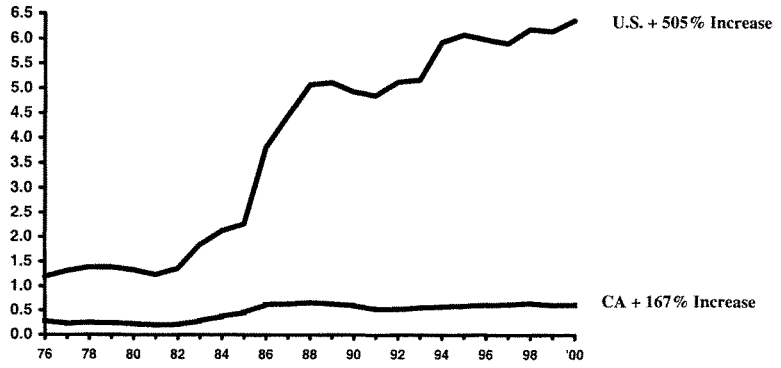
July 2002
$12,558,852 total award
Los Angeles County
30 year-old homemaker with brain damage because of lack of oxygen during recovery from surgery.

November 2000
$27,573,922 total award
San Bernardino County
25 year-old woman with quadriplegia because of failure to diagnose a spinal injury.

➢ **MICRA Significantly Minimizes Premium Increases**

Opponents of reform cite statistics that over the past several years, premiums for doctors in California have also been rising; thus proving that MICRA does not have any impact in holding down the costs of medical liability insurance. While it is true that premiums are on the rise in nearly all states, including California, the rate of increase of premiums for California doctors is significantly lower than in other states, and over time, MICRA has, in fact, stabilized medical liability insurance premiums as compared to the rate of increase in the rest of the country. As the following chart demonstrates, from 1976 to 2000, premiums for physicians in California have risen only 167 percent as compared to an increase of 505 percent for the entire United States.

Premium Growth: California vs. U. S. Premiums 1976-2000



Source: NAIC Profitability Study, 2000

Data collected from high-risk medical specialties from 2000 to 2002 also validate these trends. For example, according to a nationwide survey of neurosurgeons, the national average premium increase for California neurosurgeons was 39 percent as compared to 63 percent for neurosurgeons in the entire country. In addition, the same survey clearly demonstrated that the rate of increase for an individual neurosurgeon in Los Angeles, California, as compared to other neurosurgeons who practice medicine in crisis states where there are no reforms in place, is significantly lower. The average rate of increase for the neurosurgeons in these non-reform states was 143 percent as compared to just 8 percent in Los Angeles, CA.

State/City	2000	2002	Percentage Increase
Los Angeles, CA	**$ 48,000**	**$ 52,000**	**8%**
West Palm, FL	58,000	210,000	262%
Cleveland, OH	75,675	167,941	122%
Oaklawn, IL	110,000	282,720	157%
Philadelphia, PA	90,000	190,000	111%
New York, NY	154,890	251,126	62%

Source: American Association of Neurological Surgeons /Congress of Neurological Surgeons Nationwide Survey April 2002

The Alliance does acknowledge that despite the successful reforms contained in MICRA, the average medical liability claim in California has outpaced the rate of inflation. This is in large part due to the fact that economic damages are not limited under MICRA and have grown as a component of medical liability claims. Notwithstanding this, however, the undisputed fact remains that MICRA prevents runaway juries from awarding outrageous awards for subjective, arbitrary and often unquantifiable non-economic damages, which allows insurance companies to adequately predict future lawsuit awards, bring stability the health care delivery system.

- **Federal Government Validates that MICRA Works**

U.S. Government experts agree that MICRA does in fact hold down the costs of medical liability insurance, and over the years there have been a number of studies that have identified MICRA's $250,000 cap on non-economic damages as a critical element in stabilizing premium costs. For example, dating back to September 1993, the former U.S. Office of Technology Assessment (OTA), in a report entitled, "Impact of Legal Reforms on Medical Malpractice Costs," concluded that caps on damages were consistently found to be an effective mechanism for lowering medical liability insurance premiums. Most recently, the previously referenced HHS report, "Confronting the New Health Care Crisis" and the CBO cost estimate report of the HEALTH Act, came to the same conclusion.

Justification for Federal Reform Legislation: Americans Overwhelmingly Support a MICRA-Style Solution

Americans are becoming acutely aware of the impact that this crisis is having on our nation's health care system, and overwhelmingly favor having Congress pass legislation to reform the current medical liability system and create one that balances the rights of patients to seek and obtain appropriate compensation for injuries caused by medical negligence against the right of all our

citizens to have continued access to medical care. Two recent polls clearly demonstrate this support. In January 2003, Gallup conducted a poll on this issue and found the following:

- Americans believe that the medical liability insurance issue is either a major problem (56%) or a health care crisis (18%);
- 72 percent favor passing a law that would limit the amount that patients can be awarded for their emotional pain and suffering; and
- 57 percent responded that they think patients bring too many lawsuits against doctors

This Gallup poll confirms the findings of last year's Wirthlin Worldwide study conducted for the Health Care Liability Alliance (HCLA), which found that:

- 78 percent of Americans are concerned that skyrocketing medical liability costs could limit their access to care;
- 73 percent favor a federal law that guarantees injured patients full payment for lost wages and medical costs and reasonable limits on awards for "pain and suffering" in medical liability cases; and
- 48 percent believe the number of medical liability lawsuits against doctors is higher than justified

Conclusion

We have reached a very important juncture in the evolution of the U.S. health care system. At a time when lifesaving scientific advances are being made in nearly every area of health care, patients across the country are facing a situation in which access to health care is in serious jeopardy. Thus, as the Congress deliberates the many facets of this issue, the Alliance urges you to continue to keep in mind that this issue is not about doctors, lawyers and insurance companies. Rather, it is about patients and their ability to continue to receive timely and consistent access to quality medical care. By reforming the medical litigation system, the crisis will ultimately be abated. Patients are calling for reform. Doctors are calling for reform. President Bush is calling for reform. The House of Representatives is calling for reform. And the Alliance now urges the Senate to heed these calls and, at a minimum, pass MICRA-style medical liability reform legislation so all Americans are able to find a doctor when they most need one. Ultimately, when the question "Will your doctor be there?" is asked, the answer must be an unqualified yes.

Thank you for considering our comments and recommendations. The Alliance of Specialty Medicine, whose mission is to improve access to quality medical care for all Americans through the unified voice of specialty physicians promoting sound federal policy, stands ready to assist you on this and other important health care policy issues facing our nation.

AMERICAN ACADEMY *of* ACTUARIES

United States Senate
Committee on Health, Education, Labor, and Pensions
Committee on Judiciary

Hearing on
"Role of Litigation in Patient Access to Care"

Statement of James Hurley, ACAS, MAAA
Chairperson, Medical Malpractice Subcommittee
American Academy of Actuaries

February 11, 2003

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INTRODUCTION

The American Academy of Actuaries appreciates the opportunity to provide comments on issues related to patient access to health care and, in particular, the availability and pricing of medical malpractice insurance. The Academy hopes these comments will be helpful as Congress considers related proposals.

This testimony discusses what is driving medical malpractice premium increases and the prognosis for future changes, tort reform, potential impacts on physicians and patients, and some discussion of insurance company practices.

MEDICAL MALPRACTICE – WHAT HAPPENED?

The medical malpractice insurance marketplace is in serious turmoil after an extended period of reported profitability and competitiveness during the 1990s. This turmoil began with serious deterioration in financial results, continued with some consequences of these results and, at least at this point, gives rise to an uncertain future. Industry-wide financial results reflect a 2001combined ratio (the measure of how much of a premium dollar is dedicated to paying insurance costs of the company in a calendar year) that reached 153 percent and an operating ratio (reducing the combined ratio for investment income) of about 135 percent; the worst results since separate tracking of this line of business began in 1976. Projections for 2002 are for a lower combined ratio of approximately 140 percent and probable lesser improvement in the operating ratio. This follows 1999 and 2000 operating ratios of 106 percent.

The consequences of these poor financial results are several. Insurers have voluntarily withdrawn from medical malpractice insurance (e.g., St. Paul, writer of approximately nine percent of total medical malpractice insurance premium in 2000) or have selectively withdrawn from certain marketplaces or segments of medical malpractice insurance. In addition, several insurers have entirely withdrawn due to poor financial results (e.g., Phico, MIIX, Frontier, Reciprocal of America). Overall, premium capacity has been reduced by more than 15 percent. These withdrawals fall unevenly across the states and generally affect those identified as jurisdictions with serious problems more severely than others.

Capacity to write business would have decreased even more if not for the fact that much medical malpractice coverage is written by companies specializing in this coverage, some of whom were formed for this specific purpose.

The future outlook is not positive, at least in the short term. Claim costs are increasing more rapidly now than they were previously. Further, the lower interest rate environment would require higher premium rates, even if losses were not increasing. The combined effect is that there are likely to be more poor financial results and additional rate increases.

WHAT IS DRIVING PREMIUM INCREASES?

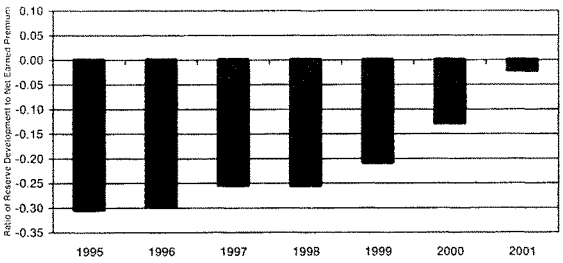
Background

Today's premium increases are hard to understand without considering the experiences of the last decade. Rates during this time period oftentimes stayed the same or decreased relative to the beginning of the period due to several of the following factors:

- Favorable Reserve Development--Ultimate losses for coverage years in the late 1980s and early 1990s have developed more favorably than originally projected. Evidence of this emerged gradually over a period of years as claims settled. When loss reserves for prior years were reduced, it contributed income to the current calendar years, improving financial results (i.e., the combined and operating ratios). That was the pattern during the middle to late 1990s for 30 provider-owned medical malpractice insurers whose results are shown in Chart A. What is evident from that chart is that favorable reserve development (shown as a percentage of premium) was no longer a significant factor in 2001 for these insurers as the effect approached zero. In contrast to the experience of these provider-owned insurers, the prior-year reserves for the total medical malpractice line of business actually deteriorated in 2000 and in 2001.

- Low Level of Loss Trend--The annual change in the cost of claims (frequency and severity) through most of the 1990s was lower than expected by insurers, varying from state to state and by provider type. This coincided with historically low medical inflation and may have benefited from the effect of tort reforms of the 1980s. Rates established earlier anticipated higher loss trends and were able to cover these lower loss trends to a point. As a result, rate increases were uncommon and there were reductions in several states. This was justified in part because the rates established at the beginning of the last decade proved too high, inasmuch as carriers had assumed higher loss trends.

CHART A: LOSS RESERVE DEVELOPMENT AS PERCENTAGE OF PREMIUM



Insurers responded to the emerging favorable loss trend in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others increased rates modestly and tried to refine pricing models to improve overall program equity. In general, however, premium adequacy declined in this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower, particularly in some jurisdictions.

- High Investment Yields--During the 1990s, investment returns produced a real spread between fixed income rates of return and economic inflation. Counter to what some may believe, medical malpractice investment results are based on a portfolio that is dominated by bonds with stock investments representing a minority of the portfolio. Although medical malpractice insurers had only a modest holding of stocks, capital gains on stocks also helped improve overall financial results. These gains improved both the investment income ratio and the operating ratio.

- Reinsurers Helped--Many medical malpractice insurers are not large enough to take on the risks inherent in this line of insurance on their own. The additional capacity provided by reinsurers allows for greater availability of medical malpractice. Similar to what was happening in the primary market, reinsurers reduced rates and covered more exposure, making the net results even better.

- Insurers Expanded Into New Markets--Given the financial results of the early-to-mid-1990s, some insurers expanded into new markets (often with limited information to develop rates). They also became more competitive in existing markets, offering more generous premium discounts. Both actions tended to push rates down.

What Has Changed?

Although these factors contributed to the profitability of medical malpractice insurance in the 1990s, they also paved the way for the changes that began at the end of the decade.

- Loss Trend Began to Worsen--Loss cost trends, particularly claim severity, started to increase toward the latter part of the 1990s. The number of large claims increased, but even losses adjusted to eliminate the distortions of very large claims began to deteriorate. This contributed to indicated rate increases in many states.

- Loss Reserves Became Suspect--As of year-end 2001, aggregate loss reserve levels for the industry are considered suspect. Reserve reductions seem to have run their course. As mentioned earlier, the total medical malpractice insurance industry increased reserves for prior coverage year losses in 2000 and 2001, although results vary on a company-by-company basis. Some observers suggest that aggregate reserves will require further increases, particularly if severity trends continue or intensify.

- Investment Results Have Worsened--Bond yields have declined and stock values are down from 1990s highs. The lower bond yields reduce the amount of expected investment earnings on a future policy that can be used to reduce prospective rates. A one percent drop in interest rates can be translated to a premium rate increase of two to four percent (assuming no changes in other rate components) due to the several year delay in paying losses on average. A two and one-half percent drop in interest rates, which has occurred since 2000, can translate into rate increases of between five percent and ten percent.

- The Reinsurance Market Has Hardened--Reinsurers' experience deteriorated as their results were affected by increased claim severity and pricing changes earlier in the decade. Because reinsurers generally cover the higher layers of losses, their results are disproportionately influenced by increases in claim severity. This, coupled with the broadly tightened reinsurance market after 9/11, has caused reinsurers to raise rates substantially and tighten reinsurance terms for medical malpractice.

The bottom line is that these changes require insurers to increase rates if they are to preserve their financial health and honor future claim payments.

WHAT ABOUT TORT REFORM?

Some states enacted tort reform legislation after previous crises as a compromise between affordable health care and an individual's right to seek recompense. The best known is the Medical Injury Compensation Reform Act or MICRA, California's tort reform package. Since MICRA's implementation in 1975 California has experienced a more stable marketplace and lower premium increases than have most other states.

Tort reform has been proposed as a solution to higher loss costs and surging rates. Many are suggesting reforms modeled after California's MICRA, although some have cautioned against modifying the MICRA package. The Academy, which takes no position for or against tort reforms, has previously reviewed and commented on this subject. Based on research underlying the issue, we observe the following:

- A coordinated package of tort reforms is more likely than individual reforms to achieve savings in malpractice losses and insurance premiums.
- Key among the reforms in the package are a cap on non-economic awards (on a per-event basis and at some level low enough to have an effect; such as MICRA's $250,000) and a mandatory collateral source offset rule.
- Such reforms may not assure immediate rate reductions, particularly given the size of some increases being implemented currently, as the actual effect, including whether or not the reforms are confirmed by the courts, will not be immediately known.
- These reforms are unlikely to eliminate claim severity (or frequency) changes but they may mitigate them. The economic portion of claims is not affected if a non-economic cap is enacted. Thus rate increases still will be needed.
- These reforms should reduce insurer concerns regarding dollar awards containing large, subjective non-economic damage components and make the loss environment more predictable.
- Poorly crafted tort reforms could actually increase losses and, therefore, rates.

EFFECTS ON PHYSICIANS AND PATIENTS

Besides commenting on the drivers of premium increases, the committee requested we also comment on the effects these changes are likely to have on physicians and patients.

The cost of medical malpractice insurance is an expense to a physician. In the past, an increase in a physician's expenses such as medical malpractice insurance could be passed on through increased fees. This did not diminish the shock of a large rate increase but did mitigate the financial effect to physicians' practices. Today, the ability to pass on these costs is constrained, at least in the short run, because the majority of physicians' payments come from regulated or negotiated rate payers.

The financial elements of the physicians' income and their changes in recent years are wide-ranging and varied. Property and casualty actuaries, who conduct rate and reserve analysis for medical malpractice insurance, do not normally delve into the areas of reimbursements, practice expenses, or the like. However, with the help of our health insurance actuary colleagues, we have investigated the physician reimbursement portion of health care in an effort to place the medical malpractice insurance price increases in perspective. What we have done is a simple approach, to demonstrate what can happen under a range of reasonable scenarios.

Beginning with 2001 physician expense information, as it relates to gross revenues, we determined the implied physician net income (including benefits and retirement funding). We separately identified a trend for the expenses into 2003 and the gross revenues to the beginning of 2003. This "trending" was assumed to be the same for all specialties, although variations might have existed. The resulting effect on a physician's practice net income was shown. From these results, a few broad conclusions were made:

- In states where medical malpractice insurance rate increases are most severe (we assumed rates increasing 200 percent during the two-year period), there is a clear and significant pattern that shows physician practice income materially down from prior 2001 levels (before potential 2003 increases in reimbursements). For example, under these assumptions, an OB/GYN who received a seven percent increase in commercial reimbursements in 2002 would still see about a 22 percent reduction in practice income from 2001 levels, prior to any increases (or decreases, as proposed for Medicare) in 2003 reimbursement rates.

- In states where medical malpractice insurance rate increases are most severe, the magnitude of the effect appears to correlate with the level that medical malpractice insurance costs represent to the total practice gross revenues. The higher this percentage, the more adverse the effect.

- In moderate states (in terms of rate increases), where medical malpractice insurance costs have increased at lower double-digit levels (we assumed rates increasing by 30 percent), a physician's net income still can be adversely affected in most cases, but the magnitude is not nearly as large.

- In moderate states, there appears to be some correlation to the level of Medicare activity by specialty. In other words, those specialties with a greater portion of their revenue coming from Medicare are harder hit than others. Other factors contribute as well. For example, the relatively higher percent of Medicaid and self-paid are a primary cause for the family practice results to reflect a sizeable reduction in practice income, despite a relatively low Medicare percentage.

These calculations are necessarily rough, but serve as a litmus test of physician-raised concerns about the combined affect of revenue and expense changes. Thus, while not conclusive, they do suggest that the economic circumstances are such that physicians may legitimately question whether to continue practicing medicine, or whether to provide services on a reduced basis. Such changes may effect healthcare quality and patient access to healthcare.

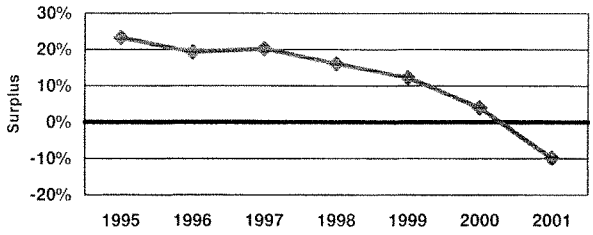
ARE INSURERS AT FAULT? - THE ROLE OF INVESTMENTS, UNDERWRITING AND COMPETITION

Some allege that medical malpractice insurers caused the current downturn through too rapid and reckless expansion. Given the positive results of the early 1990s, some carriers expanded into new markets and some offered more generous discounts in existing markets. But before assigning blame, it is important to consider the nature of the business and the circumstances of the last several years.

To obtain a better understanding of why medical malpractice insurance rates are rising, we focus on the results of 30 specialty insurers that are primarily physician owned or operated and that write primarily medical malpractice business. Their results reflect the dynamics of the medical malpractice line. This sample represents about one-third of the insured exposures in the United States.

These insurers, which achieved more favorable financial results than that of the total industry, showed a slight operating profit (four percent of premiums) in 2000. This deteriorated to a ten-percent operating loss in 2001 (see Chart B).

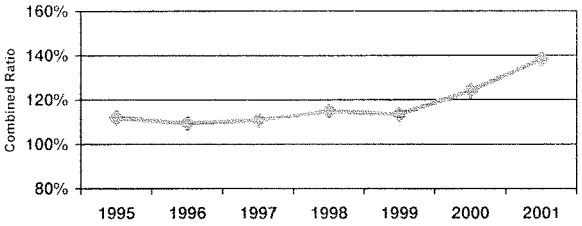
CHART B: CALENDAR YEAR OPERATING RESULTS TURN NEGATIVE



There are two key drivers of these financial results:

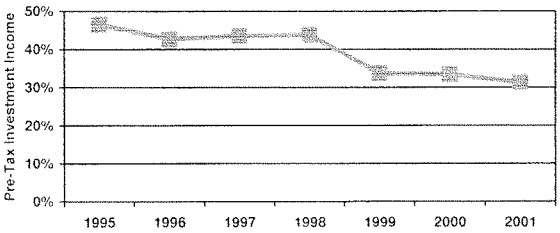
- Insurance Underwriting--For these companies, a simplified combined ratio was calculated by dividing calendar year loss and loss adjustment and underwriting expenses by premium. The combined ratios were 124 percent and 138 percent in 2000 and 2001, respectively. That means in 2001, these insurers incurred $1.38 in losses and expenses for each $1.00 of premium. The preceding five years were fairly stable, from 110 percent to 115 percent. Deterioration of the loss and loss adjustment expense ratio drove these results; the underwriting expense ratio remained relatively constant (see Chart C).

CHART C: COMBINED RATIO



- Investment Income--Pre-tax investment income (including realized capital gains and losses) derives from policyholder-supplied funds invested until losses are paid as well as from the company capital ('surplus'). The ability of investment income to offset some of the underwriting loss is measured as a percentage of earned premiums. This statistic declined during the measurement period from the mid-40 percent to the mid-30 percent level and, in 2001, to 31 percent (see Chart D).

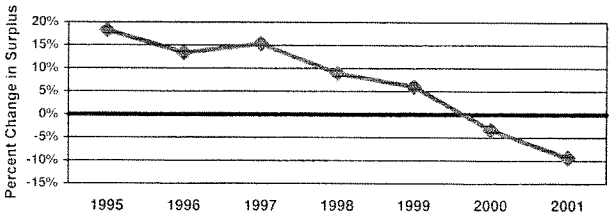
CHART D: INVESTMENT INCOME AS PERCTANGE OF PREMIUM DECLINES



This offset will continue to decline because (i) most insurer invested assets are bonds, many of which were purchased before recent lower yields, and interest earnings do not yet fully reflect these lower yields; and (ii) the premium base is growing due to increased rates and growth in exposure. Invested assets are not increasing as rapidly as premium and, therefore, investment income as a percentage of premium will decline.

The effect of these results on surplus is reflected in Chart E, which shows the percent change in surplus from one year to the next. Surplus defines an insurer's capacity to write business prospectively and to absorb potential adverse loss development on business written in prior years (see Chart E).

CHART E: SURPLUS CHANGE TURNS NEGATIVE



Insurers have some responsibility for the magnitude of today's price corrections, but this should be viewed in the context of the circumstances during the 1990s and through today. Given the positive results of the early 1990s, some carriers were very aggressive in expanding into new markets or in competing heavily for business in existing markets. This activity continued for several years, until signals of deteriorating claim cost trends appeared, favorable reserve development disappeared, reinsurance prices increased, and investment returns declined. The collision of a competitive market

and these adverse events has been dramatic and would have been difficult to predict. Nonetheless, conditions have changed and, like all businesses, insurers must respond accordingly in order to maintain their financial viability.

Medical malpractice insurance is a challenging line of business to underwrite successfully and is written, primarily, by insurers who specialize in it. It is a risky line of business given its characteristics because of low frequency and high severity claims, with long delays in the reporting and payment of claims. Even with the best of information, rates may be incorrect. This inherent pricing uncertainty can result in some insurers becoming optimistic and very competitive. If conditions deteriorate, or their assumptions prove to be incorrect, adverse financial results along with significant price increases can occur.

With respect to investments, insurers tend to be conservative because of regulatory restrictions on allowable investments, and because of the underwriting risk they face. For example, the group of medical malpractice insurers discussed earlier invests only 15 percent of their assets in equities. The other investments are composed largely of fixed income investments. Changes in stock values are, therefore, important but not critical to insurers' financial health . Insurers are more dependent on sustained interest income on bonds, which have been adversely affected by recent declines in yields.

Given the nature of their assets, therefore, insurers do not generally realize serious investment losses when the stock market declines. Further, past investment results do not make their way directly into the process of setting rates. Insurers adjust their rates for expected prospective investment yields, in conformity with insurance code and well-defined actuarial principles. The ratemaking process is a

forward-looking process intended to estimate prospective claim losses, expenses, profit, and investment income; it does not contemplate recoupment of past losses. Furthermore, given the competitive nature of the insurance business with its low barriers to entry, it would be very difficult for any company to maintain a recoupment provision for long without inviting new players into the market.

Regarding the regulation of insurance rates, we understand a bill has been introduced recently that prohibits price fixing, bid rigging, or market allocations in providing medical malpractice insurance. In discussions with colleagues and other industry representatives and based on our extensive industry experience, we understand that the vast majority of states view all these activities as illegal. Further, the behavior of the market historically and today is indicative of a competitive market with significant entries and exits, winners and losers, and significant variability in financial results, which does not seem consistent with a market engaging in collusive practices.

In addition, it is important for the insurance industry to be allowed to share certain types of information. It is likely that some damage could be done to the market if the law precluded some useful activities like industry-wide data collection, the development of common policy forms, and other activities that actually enhance competition and make insurance coverage more available.

The Academy appreciates the opportunity to provide an actuarial perspective on these important issues and would be glad to provide the committees with any additional information that might be helpful. For further information, please contact Greg Vass, Senior Policy Analyst, at 202-223-8196.

National
Medical Liability
Reform Coalition

Statement
of the
National Medical Liability Reform Coalition
to the
Senate Committee on Health, Education, Labor and Pensions
and the
Senate Judiciary Committee
on
Patient Access Crisis: The Role of Medical Litigation
February 11, 2003

Chairman Gregg, Chairman Hatch, Senator Kennedy, Senator Leahy, members of the committees, 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, dentists, 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 *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. According to a September 25, 2002, report by the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, many neurosurgeons are no longer performing high-risk neurosurgical procedures in order to lower their professional liability costs and to minimize their risk of suit. Forty-three percent of those neurosurgeons surveyed have, or are considering, restricting their practice.

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.

According to an American College of Emergency Physician study, 95% of emergency medicine physicians experienced liability premium increases over the past two years. Liability premiums in some states have risen more than 200%. Emergency physicians are often included in lawsuits involving hospital patients because many patients are now admitted through the emergency department. Though the emergency physician may have provided outstanding care, he or she may be included in the suit simply because they "touched" the patient.

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

Testimony of Christian Shalgian

Chairman of the Health Coalition on Liability and Access

Submitted to the Joint Hearing of the Senate Judiciary Committee and the Senate Committee on Health, Education, Labor and Pensions

February 11, 2003

"Patient Access Crisis: The Role of Medical Litigation"

Thank you for the opportunity to submit testimony to this important hearing. My name is Christian Shalgian, and I serve as Chairman of the Health Coalition on Liability and Access (HCLA). Our coalition includes more than fifty organizations representing doctors, hospitals, health care liability insurers, pharmaceutical companies, health care insurers, employers and health care consumers. Our members are committed to preserving access to health care for the American people – access that is threatened by an ongoing crisis in our nation's health care liability system. *More and more Americans aren't getting the care they need when they need it, because our medical liability system has turned into a lawsuit lottery where a few win and the rest of us lose. We strongly believe common sense federal reforms are urgently needed to preserve patients' legal rights and protect affordable patient care.*

Too Many Meritless Lawsuits and Jackpot Jury Awards Cause the Crisis

The current crisis has been fueled over the past several years by the frequency and severity of medical liability cases filed in the nation's courts. Too many meritless lawsuits and excessive jury verdicts have hurt patients and doctors, burdened taxpayers, and threatened the viability of our nation's health care system. The crisis has been marked by skyrocketing jury awards to plaintiffs in cases that come to trial. Between 1996 and 1999, the average jury award in medical liability cases jumped 76 percent.[1] In 1985, fewer than one in a hundred medical liability claims resulted in payments of more than $1 million; today, nearly one in 13 payments exceeds $1 million. The potential for lottery-sized jury awards has prompted some doctors and insurance companies to settle lawsuits before they go to court – even when they are not at fault. This trend just encourages lawyers to file more lawsuits. Most of the cases filed lack merit: more than 60 percent are dismissed or dropped, and only 7 percent ever even come to trial.[2] Yet the prospect of what has been called "jackpot justice"[3] has led to an ever-growing number of frivolous claims.

Senator John Edwards (D-NC) recently said that the filing of frivolous medical liability cases "results in clogging up the courts, results in increased costs, and it means that people who should never have been brought into court are brought into court."[4] We completely agree. Yet even when lawsuits are completely lacking in merit, they cost thousands of dollars to defend. The threat of a lawsuit can drive up a doctor's insurance

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[1] Source: U.S. Department of Health and Human Services, July 24, 2002
[2] Source: Physicians Insurers Association of America, December 9, 2002
[3] Source: Liz Carroll, Mississippi State Medical Association, *Washington Post*, November 23, 2001
[4] Source: ABC's *This Week*, January 5, 2003

premiums, even if a case is never filed. As a result, doctors across the nation are facing staggering increases in medical liability premiums – that is, if they can find coverage at all. In 2001, twelve states saw premium hikes of 25 percent or more.[5] Rates for some specialists have increased in some areas by as much as 300 percent.[6] And in December, 2002, one of the nation's largest medical liability insurers – the St. Paul Companies – stopped providing medical liability insurance for doctors in any state, leaving 10 percent of the nation's doctors looking for an alternate insurer.

More and More Americans Suffer

As The Crisis Grows Progressively and Rapidly Worse

As insurance becomes unaffordable, and in some cases unobtainable, the delivery of medical care to patients is disrupted. Residents of a dozen states – Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia – have been hardest hit so far. Nearly 56 percent of Blue Cross/Blue Shield plans in these states are refusing some high-risk procedures, and nearly one-third of the physicians in these states are moving their practices.[7] The American Medical Association reports that the problem is rapidly spreading, with more than 30 states facing a "looming" crisis. Access to health care nationwide is being compromised as doctors – especially physicians in high-risk specialties that have been frequent targets of lawsuits -- are forced to drop vital services, postpone the purchase of new equipment, relocate their practices, and in some cases abandon medicine altogether. A recent survey

[5] Source: *American Medical News*, January 7, 2002
[6] Source: *National Journal*, January 18, 2002
[7] Source: BlueCross/BlueShield Association, January 15, 2003

of Pennsylvania doctors found that 72 percent say they have postponed purchases of advanced medical equipment in order to pay rising medical liability premiums.[8]

The Broken Liability System Hurts Women Most

Women's access to care is being seriously threatened by the current crisis. According to a report published in *Self* magazine "over the last four years, malpractice insurance rates for ob/gyns have jumped as much as 150 percent, prompting record numbers of obstetricians – about 1 in 11 nationwide – to scale back their services to gynecology only."[9] An OB can expect to be sued roughly three times over the course of his or her career, and although more than half the claims against ob/gyns are dropped or settled without payment, the average award amount in an OB liability cases has doubled in the last ten years, now hitting $400,000 per case. Today, in the absence of any reform in the medical liability system, one in six ob/gyns refuse high-risk cases. As a result, women are experiencing increasing difficulty getting access to prenatal care, screenings for reproductive cancers, diabetes, and other serious health risks.[10]

Some doctors who are willing to provide high-risk obstetrical services are finding that there are no insurers in the marketplace who can provide them with the medical liability coverage they need. A recent report in the *Washington Post* described the dilemma of Dr. Willard Woods, the only obstetrician serving the residents of three Wyoming counties. Dr. Woods was forced to stop delivering babies this year when his insurance provider declared bankruptcy. Only two other companies sell medical liability insurance

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[8] Source: Karen Ignagni, *Knight-Ridder/Tribune*, January 21, 2002
[9] Source: *Self*, April 2002

in Wyoming, and neither was willing to take on an additional obstetrical practice. Dr. Woods was able to get coverage for his gynecological practice, but his annual premium is $116,000, three times what he paid a year ago. The expectant mothers he used to care for, however, must now travel to Cheyenne, a three-hour round trip, to receive specialized prenatal and delivery care.[11]

The Broken Liability System Hurts Access

by Driving Up Health Care Costs for Every American

Although women's access to health care is most severely impacted by the current crisis, the costs are borne by all health care consumers. The rising cost of medical liability coverage is pushing up the cost of physician services across the board, especially in high-risk specialties. These higher costs are borne by patients in the form of higher premiums, out-of-pocket expenses, and deductibles for health care consumers. The current situation leads some doctors, mindful of the growing possibility of a lawsuit, to practice defensive medicine, which also in turn drives up health care costs. An April, 2002 survey of physicians revealed that nearly 4 out of 5 (79 percent) have ordered more tests than were medically needed due to fear of litigation. 76 percent of all physicians surveyed believe that concern about litigation has hurt their ability to provide quality care in recent years.[12]

Taxpayers, too, bear the burden of the medical liability crisis. The federal government, through its funding of Medicare, Medicaid and other programs, pays an additional $28 to

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[10] Source: American College of Obstetricians and Gynecologists, March 7, 2002
[11] Source: "Insurance Crisis Hits Hard on Prairie," *Washington Post*, February 3, 2003

$47.5 billion per year for health care due to the costs of medical liability coverage and defensive medicine.[13] The nonpartisan Congressional Budget Office estimates that medical liability reform would save the federal government nearly $12 billion per year in lower health care expenditures and generate an additional $2.4 billion in federal tax revenues.[14]

Medical Liability Reform is the Proven Solution

It's clear that the current system of medical liability is deeply flawed. The time for reform is long overdue. That's why HCLA strongly supports comprehensive legislation to reform the medical liability system and ensure access to care.

The bill we support, H.R. 5, was introduced in the House of Representatives last week by Congressman Jim Greenwood (R-PA) and 68 cosponsors. A similar bill passed the House in the107th Congress with bipartisan support. Known as the HEALTH Act, it includes reforms designed to promote access to care for patients who are now threatened with the loss of vital medical services, and to keep health care affordable for all Americans.

The HEALTH Act is modeled on a successful medical liability reform effort in California which brought an end to a liability and access crisis in that state nearly thirty years ago, and for decades has spared California doctors and patients the medical liability woes other states are facing. It puts in place reasonable guidelines to limit the kind of arbitrary, non-economic damage awards that are a significant cause of the medical liability crisis, and it

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[12] Source: "Fear of Litigation Study," Harris Interactive, April 2002
[13] Source: US Department of Health and Human Services, July 24, 2002

reins in the runaway attorneys' fees that provide an incentive for trial lawyers to file meritless lawsuits. The California experience has demonstrated the wisdom of these reforms – since passing liability reforms nearly three decades ago, California's medical liability premiums have increased less than half as fast as those in the rest of the country. California doctors pay some of the lowest medical liability insurance premiums in the nation.[15]

Under the HEALTH Act, injured patients would be fully and fairly compensated, without any limit, for any and all economic losses, including past and future medical expenses, loss of past and future earnings, loss of the use of property, costs of repair or replacement, the economic value of domestic services, and the loss of employment or business.

However, non-economic damages – which include compensation for subjective losses such as pain, suffering, inconvenience, emotional distress, loss of society and companionship -- would be limited to $250,000. This cap has proven fair and effective in California. The HEALTH Act also provides guidelines for punitive damages. These guidelines state that punitive damages could go up to $250,000 (over and above the economic and non-economic damages award), or double the amount of the economic damages award, whichever amount is higher.

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[14] Source: Congressional Budget Office, September 24, 2002
[15] Source: The California Story, CAPP, 2002

The HCLA also supports important reforms included in the HEALTH Act which prevent double payments for the same expense; ensure that defendants are responsible for only their share of the injury; allow for periodic payments of future damages over $50,000; encourage speedy resolution of claims, and limit plaintiff attorney contingency fees.

It's important to note that the HEALTH Act would create the federal floor for many of the reforms necessary to stabilize our medical liability system, while also protecting states' rights by allowing states to have the flexibility they need. For example, California and other states have already instituted reforms that mirror some or all of the provisions in the Act. If passed, the HEALTH Act would impose a cap of $250,000 on non-economic damages in states that currently have no cap – but all states would be free to pass their own, different caps – even higher ones.

Unless the critical reforms included in the HEALTH Act are enacted, the nation's health care system will remain a lottery for lawyers – and health care consumers and providers will pay the price.

Most Americans Support Federal Medical Liability Reform

The American people strongly support reform of the medical liability system. A Gallup poll conducted earlier this month found that three-quarters of the adults surveyed believe rising medical liability insurance rates in health care today are a "crisis" or a "major problem." Seventy-two percent supported a limit on the amount patients can be awarded for their emotional pain and suffering.

The issue of medical liability reform should not be a partisan issue. The HEALTH Act is supported by Republicans and Democrats alike. President Bush has strongly endorsed reforms like those included in the HEALTH Act. In a recent speech in Scranton, Pennsylvania he urged Congress to act in a bipartisan fashion to pass these reforms without delay. The HCLA is ready to work with members of Congress on both sides of the aisle to quickly enact effective and proven reforms in the health care liability system to keep health care available and affordable. We look forward to working with the Committee members to achieve that goal.

Statement of

Mary R. Grealy
President
Healthcare Leadership Council

Committee on Health, Education, Labor, and Pensions
Committee on the Judiciary

Joint Hearing
"Patient Access Crisis: The Role of Medical Litigation"

February 11, 2003

Mr. Chairman, our liability system is broken. If it is not fixed soon, it will break our health care system as well.

One of the founding principles of the Healthcare Leadership Council (HLC) – which represents the CEO's of the nation's leading health care companies and organizations – is that patients should have access to high quality health care. Skyrocketing liability costs threaten patient access to quality care. This is no longer simply about lawyers and doctors. This is about patients.

The cost of excessive jury awards is causing staggering increases in medical liability premiums. Between 1996 and 1999, average jury awards in medical liability cases have increased by 76 percent. These spiraling increases add directly to the cost of health care, contributing significantly to premium costs and the growing number of uninsured Americans.

Just as harmful to patients and consumers, however, are the indirect costs of the crisis. Patients are increasingly "paying" for excessive litigation by losing access to medical specialists such as obstetricians and surgeons. An estimated 1 in 11 obstetricians/gynecologists say they have strictly limited their services solely to gynecology due to the malpractice crisis. In some areas, the situation is far worse. In Miami, average annual malpractice premiums for Ob-Gyns are $210,578, while the average salary for an Ob-Gyn in Florida is $118, 435. In

Wyoming, premiums average $116,000, while average salaries for Ob-Gyns are $108,700.

As medical malpractice insurance rates skyrocket – or become unavailable – medical specialists such as neurosurgeons, orthopaedic surgeons and obstetricians/gynecologists are leaving states such as Pennsylvania, Mississippi, West Virginia, New Jersey, Florida and others. While these states have been in the news lately, the crisis goes far beyond the 13 "crisis" states. It is estimated that as many as 30 other states are in "near crisis" and will soon join the ranks of states where patient access is endangered.

Patients also are losing access to nearby hospitals, trauma centers, and other facilities as a result of the crisis. Patients are subjected to, and pay for, unnecessary tests and procedures as physicians must practice "defensive medicine." In addition, patients ultimately are the ones who suffer when new drug therapies and medical technologies are not developed due to litigation or the fear of it.

The cause of the liability crisis is clear. Medical malpractice insurance rates are set prospectively. These rates are set primarily on the basis of projections of jury awards. This trend line is in one direction: straight up. Solving the cost problem requires dealing with the size and unpredictability of these awards. The bottom line is that medical malpractice premiums cannot keep up with claims. A typical state is Oregon, where a Governor's task force reported that medical liability insurers paid out $71 million in losses and defense costs, while receiving $50 million in premiums over the same period. In Ohio, medical malpractice insurers are losing $1.62 for every $1 in premiums. Clearly these trends are unsustainable and will drive more physicians out of practice.

The only proven way to bring these costs under control – while actually enhancing patients' ability to recover economic damages for injuries – are reforms which include capping non-economic and punitive damages, establishing reasonable levels for attorneys' fees, and setting fair share rules for joint and several liability.

HLC strongly supports these and other reforms embodied in the Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003 (H.R. 5). HLC urges the Committee and the Senate to pass H.R. 5 or similar legislation.

We stand ready to work with you to address this growing crisis.

STATEMENT OF BARBARA HURST

If anyone had asked me back in August of 1990 when I was just starting my career in private practice obstetrics and gynecology, whether I was planning to stop the obstetric portion in just 8 years, I would have said they were crazy. I hadn't spent 4 years in college, 4 years in medical school and 4 years in OB-Gyn residency training to then walk away from 50% of what I had worked my whole adult life to do. But when the opportunity presented itself in 1998 that is exactly what I did. I was planning to leave my previous group practice and had the choice whether to continue obstetrics; I chose not to. The "malpractice" or liability insurance issue was not the only reason I made the change to a gynecology-only practice but it was a major consideration in a difficult decision.

In 1998 when I decided to stop OB, there was no particular liability insurance crisis in Utah as did exist in other areas of the country. The cost of liability insurance for my specialty has always been in the highest grouping and I accepted that as part of the cost of doing business. Insurance premiums had gradually increased over the years I practiced to $2200 per month ($26,400/year) at the end of 1998. However, health insurance remuneration for my professional services declined steadily in the same time period, and continues to do so now. Office overhead expenses go up every year. Despite a thriving, busy practice, my income peaked in 1992 and declined thereafter. Not the typical course one might expect for a professional career. But what made me wonder if it was worth it was not just the literal cost. The emotional, psychological and physical costs of working your hardest and providing excellent care to your patients and still getting sued are enormous. Patients sometimes say things like, "The doctor has insurance, it's no big deal to sue her, it's not personal." They are wrong. I spent more than a decade to become a well-trained physician. There were many times that I worked 100 hours a week. I went without sleep. I went without meals. I missed my baby's first steps, family holidays and children's birthday parties to attend to my patients. I find that very personal.

I've been sued four times. One case was a patient who was unhappy with her cesarean section scar, even though I had explained and documented carefully why I needed to make the incision I did: her baby's position in the womb was a dangerous one called back-down transverse lie. That term strikes fear in every OB's heart because of the potential risks to the baby.

Another case involved a patient who used an appropriately prescribed medication incorrectly and had some transient discomfort but no long-term problems. Incidentally, her condition was cured.

I've had two OB cases brought against me, both involving twin pregnancies which are, by definition, high risk. In one situation, the pregnancy was managed successfully and the patient delivered at term, but one of the babies developed problems immediately after birth. I was eventually dropped from that case, after years of discovery and depositions and tremendous stress. In the other case, the patient presented in advanced labor and delivered her twins three months early; one of the children has severe handicaps because of prematurity, the other did quite well. This case dragged on for 8 years, ultimately went to arbitration, and was decided in my favor.

There was no malpractice in any of these cases. What did exist were unrealistic and unreasonable expectations on the patients' parts and indeed sadness and heartbreak and overwhelming medical and financial concerns for some of these families—but it wasn't my fault.

Technically I've never "lost" a case although I feel I lost a lot. The real cost of defending even ridiculous things like not liking a scar can be determined precisely, but the emotional trauma of having your training and judgment and motivation dragged through the mud cannot be calculated. Ultimately I came to the sad conclusion that it wasn't worth it to continue OB when I changed my practice. I loved what I did, I genuinely cared for my patients and I was good at it, but the overall equation didn't add up.

Ironically, I got to pay an additional $56,000 for the privilege of stopping obstetrics: I had to buy "tail" insurance to cover the 8 ½ years of deliveries I had done because the statute of limitations runs to adulthood in those babies. Fortunately my insurance company allowed me to pay this over two years or I would not have been able to afford to quit.

When my last patient delivered in February 1999, my liability insurance premium was about $3600 per month ($43,200/year). It had been $2200 in December ($26,400/year), two months earlier. The next month, practicing gynecology only (including surgery) it dropped to $775 ($9300/year). But 1999 was the beginning of a growing liability insurance problem in Utah, which now approaches crisis proportions. In the last two years, premiums have increased 50%. My gynecology only premium is now $3500 per month ($42,000 per year) and my obstetric colleagues are paying more than $71,000 per year. When I quit obstetrics my patients were disappointed and inconvenienced, but there were plenty of obstetricians in the Salt Lake City area I could refer to. There has been a shortage of OB's in rural areas for many years but this problem will likely worsen everywhere. In a recent survey of Utah Ob-Gyn's, 25% reported they were planning to quit practice within the next five years. And with the dramatic increase in liability premiums this year, I know many are accelerating their plans. Who is going to care for all these patients?

Good, conscientious, well-trained, experienced and devoted doctors are burning out and leaving this specialty. Most physicians really do go into medicine with the noble desire of wanting to help people, but the toll this profession exacts can be crushing. Without some relief, more and more will decide that it just isn't worth it.

Barbara Hurst MD

Barbara Hurst, MD
Salt Lake City, Utah
7 February 2003

J. Charles Rich
2397 East 1300 South
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Medical Liability Insurance, Neurological Surgery and Early Retirement

I have just turned sixty-seven, am in perfect health and have enjoyed a productive career as a neurosurgeon. Recently completed terms as president of our national spokes-organization, the American Association of Neurological Surgeons (1996-97) and as Chief Medical Officer of the Salt Lake 2002 Winter Olympic Games (1997-2002) were positive, rewarding experiences. My familiarity with the intricacies and subtleties of neurosurgery are such that I could continue to make a substantial contribution to that surgical discipline. In more than three decades of neurological surgery clinical practice, my liability insurance carrier (UMIA) has never, to my knowledge, had to pay any settlement monies on my behalf nor have I been involved in a malpractice trial. UMIA would probably agree that I have been something of a bargain from their standpoint.

I am, however, fully retired and completely out of clinical practice for a reason. The present process of medical liability insurance coverage for neurosurgeons bears resemblance to a high-stakes poker game. The ante, just to stay in, is not only high but keeps going higher. My insurance premium for this past year would have been $80,000. For one who wanted to slow down and had a demonstrably low-risk practice, the decision was unavoidable. I truly cannot afford to stay in the game as it is presently being played.

A wise academic once observed, "The entire field of economics can be summarized in four words: people respond to incentives. Everything else is commentary." It would be difficult to devise more perverse disincentives than those presently operative for the practicing neurological surgeon. All of us understand how to avoid risk of medical liability and litigation.

One can assume responsibility of care only for straightforward, non-complex cases. Problem: those cases where operative intervention carries with it real, tangible risk of an untoward result represent precisely those patients most in need, in order to preserve neurological function, of that surgical intervention.

Also, one can arrange his or her private practice to assume an elective-surgery cases only, suburbs located, nine-to-five practice and studiously avoid covering urban hospital emergency rooms with their trauma services, nighttime and tertiary/quaternary level care needs for disposition problematic referrals. It is common knowledge that the latter category of practice carries with it a differential likelihood of becoming entangled in medical liability claims and, inevitably, with litigation. Problem: what if every neurosurgeon responded appropriately to the incentives the present system has in place? None would choose to be involved in the second category of practice. The incentives are crystal clear.

You all have priced me out of the market. It is my hope that you can make some constructive changes to the present perverse, counterproductive system of medical liability insurance. If not, many others are going to follow my lead.

J. Charles Rich, MD

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WORLD WIDE WEB
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February 7, 2003

Honorable Judd Gregg
Chairman
Committee on Health, Education,
Labor, and Pensions
United States Senate
Washington, DC 20610-6300

Dear Chairman Gregg:

On behalf of the National Association of Insurance Commissioners (NAIC), I am pleased to respond to your letter of January 31, 2003 requesting information on medical malpractice insurance. Many states are experiencing escalating premium costs for this critical insurance coverage for doctors, while also encountering problems of availability and insufficient capacity to support a healthy competitive market.

State insurance commissioners share the concerns you and other Members of Congress are raising about improving the availability and affordability of medical malpractice insurance. We are vested with the responsibility of protecting the rights of consumers and assuring that insurers remain financially solvent and able to meet their claims obligations. While the recent trends in some states over limited availability and escalating premiums make oversight critical, we would caution that any reforms be considered carefully, especially in recognition of reforms already enacted in several states.

In September 2002, we established a Market Conditions Working Group to look at these issues more closely and based upon that review make recommendations to regulators. The working group has scheduled a public hearing on Saturday, March 8, 2003. We are hopeful this hearing and other efforts will help guide state and federal policymakers as they work to explore potential solutions. We will look forward to sharing with you the results of this hearing.

Our responses to the questions in your letter are as follows:

(1) Are medical malpractice insurance rates subject to state law prohibitions on excessive, inadequate, or unfairly discriminatory rates?

Almost all states have rating laws for property and casualty insurance, including medical malpractice. These rating laws require that insurance rates not be excessive, inadequate, or unfairly discriminatory.

(2) If a state determines that a rate is excessive, inadequate, or unfairly discriminatory, does the insurance regulator have the authority to reject or modify such a rate?

If a state receives a filing from an insurer that contains a rate that is believed to be out of compliance with the statutory rating standards, there are remedies available to address the problem. The most common regulatory approach available to insurance regulators is the ability to order a hearing on the non-complying rate. In states with prior approval laws, the commissioner generally has authority to disapprove the non-complying rate, however the insurer is generally provided an opportunity for a hearing if it disagrees with the commissioner's decision. Only in rare instances does an insurance commissioner have authority to unilaterally modify a filed rate. Because of extremely high loss ratios in many states, regulator concerns have been with rate inadequacy, and not excessiveness or unfair discrimination.

(3) If states do have this authority, can you provide any examples where a state insurance regulator has rejected or modified an excessive or unfairly discriminatory medical malpractice insurance rate?

We are not aware of any recent state actions in this regard. State insurance regulators generally do have the authority to prevent anti-trust activities by insurers. These state laws are based on the NAIC model rating laws, which contain the following provisions.

> "No insurer or advisory organization shall attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market or engage in a boycott, on a concerted basis, of an insurance market."
>
> "No insurer shall agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to facilitate the reporting of statistics to advisory organizations, statistical agents or the commissioner. The fact that two or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, prospective loss cost, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists."
>
> "No insurer or advisory organization shall make any arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of unreasonably restraining trade or lessening competition in the business of insurance."

States generally have adopted the NAIC model law provisions or equivalent provisions, thus comparable authority currently exists. Again, due to extremely high loss ratios, the concern has been with rate inadequacy.

(4) The Leahy legislation presumes that medical malpractice insurance carriers are engaging in "price fixing, bid rigging, and market allocation." Does the NAIC, or any of your members have evidence that medical malpractice insurance carriers are engaging in these types of criminal behaviors? If so, could you detail that information for us?

No. To date, insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation. The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices. A July 2002 report prepared by the Department of Health and Human Services also cites the impact of litigation and defense costs on this line of insurance.

(5) Notwithstanding the McCarran-Ferguson exemption from federal anti-trust laws, do state insurance regulators and attorneys general have the authority to prevent "price fixing, bid rigging or market allocations" under current state law? If so, could you explain the deficiencies in those laws and provide us with proposed remedies?

As noted in the previous question, states have strong laws that prohibit price-fixing and anti-competitive practices by insurers. The sharing of loss data among insurers is permitted, however, because it is necessary to encourage competition by giving potential new entrants to the marketplace and smaller insurers enough underwriting and rate-setting information to enter and remain viable in the medical malpractice marketplace. Again, the evident points to high loss ratios, not price-fixing, as the primary driver of escalating premiums.

(6) What percentage of the medical malpractice insurance market is composed of non-profit physician-owned mutuals? What incentive or incentives, if any, do you think these types of medical malpractice carriers face that would cause them to engage in "price fixing, bid rigging or market allocations?"

Non-profit physician-owned mutual insurers have developed in response to market availability concerns. Since the owners of these mutuals are also the customers, it would appear on the surface that market allocation might be occurring. Careful inspection will show that a mutual insurer is concerned with its policyholders' interests. Since each policyholder is also an owner of the company and the company is a non-profit entity, the goal of the mutual insurer is to deliver medical malpractice insurance to its policyholder/owners as inexpensively as possible. To do otherwise would contradict the goals of the mutual and jeopardize its non-profit status

(7) Finally, if the Leahy legislation were to be enacted, would it lower the underlying medical malpractice claims costs and stabilize medical liability insurance premiums? If yes, in what way would it do so?

No, we do not believe enactment of the Leahy legislation as originally drafted would change the underlying costs of malpractice claims or premiums. We now understand this language is being modified. The reason insurers are not writing, or are pulling back from medical malpractice insurance, is because there are many other lines of insurance that offer more opportunities for profit at a lower risk. The uncertainties and historical return in this line of business lead many commercial insurers to commit capital in other lines of commercial insurance. It is our experience this market will remain volatile in some states until such time as claims costs stabilize.

Finally, while we are seeing difficult market conditions in some states, it is by no means widespread in all states. Like all insurance markets, medical malpractice insurance markets vary from state to state. However, the cost drivers in all states are closely linked to claims losses.

I hope this information is helpful, and we look forward to being of assistance as your Committee continues its review of these issues. The NAIC and its members stand ready to provide whatever data and resources we have available to help Congress and the states improve the market for medical malpractice insurance.

Sincerely,

Mike Pickens
Commissioner of Insurance, Arkansas
President, NAIC

Statement of Sister Mary Roch Rocklage, RSM

Good Afternoon, my name is Sr. Mary Roch Rocklage. I am Chairperson of Sisters of Mercy Health System, a Catholic health system with 20 hospitals in Missouri, Oklahoma, Kansas, Arkansas and Texas. I have been a Sister of Mercy for 43 years. From 1969 to 1979, I was the Chief Executive Officer of St. John's Mercy Medical Center, a 1,166 bed facility in St. Louis, Missouri. From 1986 to 1999, I was Chief Executive Officer of Sisters of Mercy Health System. I have been Chairperson of the Health System since 1986. This year I am serving as Immediate Past Chairperson of the American Hospital Association.

Much attention has been paid, and properly so, to the burdens imposed on physicians by runaway malpractice lawsuits. As a former hospital and health system executive and current health system Board member, I can state that these lawsuits are also imposing a significant burden on hospitals and their ability to serve their communities.

In recent years Sisters of Mercy Health System has seen its liability costs escalate dramatically. Like many health systems, we are largely self-insured for our malpractice exposure. We also purchase excess coverage to cover catastrophic claims. This is an efficient, cost-effective way to address the Health System's malpractice exposure. The Health System's hospitals pay for this coverage through annual assessments.

In 1995 the Health System's overall liability coverage cost $8 million. In 2000 it was $11.4 million and this year it was 17.7 million. On average across the Health System,

this amounted to $1,892 per bed in 1995 and $4,047 per bed in 2003, an increase of 214%. But this average per bed cost does not tell the full story. A hospital's share of the Health System's liability coverage cost is determined by the hospital's liability exposure. In other words, those hospitals that have the greatest liability exposure bear the greatest burden. So, for example, our facilities in Arkansas, where malpractice pay outs have been, by comparison, modest, paid into the Health System's program on average $387 per bed, in 1995 and $1,544 per bed in 2003. In contrast, Mercy Health Center, our facility in Laredo, Texas, paid $4,051 per bed in 1995 and over $16,998 per bed in 2003 as a result of the malpractice climate in south Texas.

Our facility in Laredo is a good example of the severe burden that runaway malpractice exposure can impose on a hospital. The Sisters of Mercy's service to the Laredo community began in 1894, when the first Mercy Hospital was opened. Mercy Health Center today has 292 inpatient beds and a wide range of outpatient programs to serve a rapidly growing community of nearly 200,000 residents. A new medical campus, constructed at a cost of $140 million, was opened in 1999, and represents the Sisters' ongoing commitment to Laredo.

Since its beginning, Mercy has served as the access point for health services to residents of Laredo and the surrounding communities, regardless of their ability to pay. With no public hospital and few public health services available in the area, Mercy has assumed the burden of providing care to the region's indigent population. In fiscal year 2002, ending June 30, 2002, Mercy Health Center provided more than $25.5 million in actual

charity care to patients unable to pay for health services, and another $44 million in unreimbursed Medicaid services, for a total of $69.5 million.

Community Benefits

The services provided by Mercy extend beyond its hospital walls. In FY 2002, Mercy Health Center's costs of providing community benefits — above and beyond its charity care spending and Medicaid write-offs — totaled more than $2.4 million. Combined with Mercy's charity care spending and Medicaid write-offs, Mercy Health Center provided in FY 2002 charity care and community benefits totaling $71.9 million.

Mercy's Malpractice Liability Challenge

For more than 100 years, the Sisters of Mercy and Mercy Health Center have worked to meet the health care needs of Laredo and the surrounding community, and to manage critical threats such as rising numbers of uninsured residents and shortages of health care workers. Today, Mercy Health Center is challenged by its most serious threat: a rising number of malpractice claims that put at risk the investment the Sisters of Mercy has made in the Laredo community.

The Texas State Board of Medical Examiners reports over 4,000 malpractice claims were filed in Texas in 2001, which is a 64% increase from 1989. While this reflects a significant increase statewide, the trend is even more dramatic in Laredo where the number of malpractice claims filed increased 238% between 1989 and 2001. These

statistics paint a bleak picture for hospitals and other medical professionals who seek malpractice insurance and attempt to practice in this litigious environment. The *Dallas Morning News* (January 20, 2002 "Malpractice Rates Take Feverish Leap") reported that 7 out of 10 physicians in south Texas have claims asserted against them.

Mercy Health Center paid over $30 million into the Health System's liability program for the years 1999 to 2003. As burdensome as these payments have been, they are far less than what Mercy Health Center would have paid had it purchased commercial insurance. Remarkably, even with the large payments that Mercy Health Center has made over the years, the Health System has paid out $23.5 million more than Mercy Health Center has paid into the Health System's liability program. This deficit will have to be made up in future years, thereby imposing an even greater burden on the hospital.

Mercy Health Center's malpractice burden significantly reduces its ability of Mercy to provide indigent care and otherwise provide services to the Laredo community. In addition, this runaway malpractice exposure discourages Mercy from offering new, sophisticated services to the community.

Sisters of Mercy Health System and all of its 20 hospitals are strong supporters of malpractice reform.

Women's Health Consequences Without Medical Liability Reform

The American College of Obstetricians and Gynecologists (ACOG) applauds Senators Rick Santorum (R-PA), Jon Kyl (R-AZ), Orrin Hatch (R-UT), Judd Gregg (R-NH), and Don Nickles (R-OK) for their leadership in addressing the medical liability crisis facing this nation. ACOG strongly supports Senate Majority Leader Bill Frist's, MD (R-TN) and Senate Majority Whip Mitch McConnell's (R-KY) message that federal liability reform – such as HR 4600, the bipartisan HEALTH Act of 2002 – must be passed by Congress. A national solution to the acute problems in the nation's medical liability system, problems that threaten the availability of physicians to deliver babies and health care to women is of the utmost importance.

Without medical liability reform and a resolution of the crisis, there are serious repercussions such as:

Fewer Obstetric Providers

Experience demonstrates that obstetrics providers—confronted with substantially higher costs for liability coverage—will stop delivering babies, reduce the number they do deliver, further cut back or eliminate care for high-risk patients, the uninsured, and the underinsured.

Rural Crisis

Women in underserved rural areas have historically been particularly hit hard by the loss of obstetric providers. With the economic viability of practicing obstetrics already marginal due to sparse population, low insurance reimbursement for pregnancy and growing managed care constraints, an increase in liability insurance costs will force rural physicians to stop delivering babies.

Community Clinic Cutbacks

Also hurt without Medical Liability Reform will be the nation's 39 million uninsured patients—the majority of them women and children—who rely on non-profit licensed community clinics for health care. Unable to shift higher insurance costs to patients, these clinics have no alternative to but to care for fewer people.

Less Prenatal Care

With fewer obstetric providers, women's access to early prenatal care will be reduced. Greater availability of prenatal care over the last several decades has resulted in the country's lowest infant mortality rates. Without Medical Liability Reform, providers' ability to maintain this standard will be threatened because the cost of insurance places a major additional strain on our maternal health care system.

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Less Preventive Health Care

As premiums increase, women's access to general health care—including regular screenings for reproductive cancers, high blood pressure and cholesterol, diabetes, and other serious health risks—will decrease without a cap. These services are routinely provided by community clinics, ob-gyns, and family physicians. However, as these providers retire early and restrict the scope of their practices, the supply of health care resources will not be able to meet the growing demand for preventive health care.

More Uninsured

Last year 11.7 million women of childbearing age were uninsured. Without Medical Liability Reform, a greater number of women ages 19 to 44 will move into the ranks of the uninsured. Without this legislation, health care costs will continue to increase, which will discourage employers from offering benefits. Many women who 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 poverty guidelines.

STATEMENT OF THE

AMERICAN COLLEGE OF PHYSICIANS – AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE SENATE COMMITTEE ON JUDICIARY AND THE SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

"Patient Access Crisis: The Role of Medical Litigation"

February 11, 2003

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 Senate Committee on Judiciary and the Senate Committee on Health, Education, Labor, and Pensions for holding this important hearing on a subject matter that has more relevance today than ever before. Of the College's top priorities for 2003, 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 Chairmen Orrin Hatch and Judd Gregg, Ranking Members Patrick Leahy and Edward Kennedy, and other members, for holding this important hearing to discuss how limitless litigation can and has begun to restrict patient access to health care in this country.

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 in 2000-2003. 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. Unfortunately, rates continue to rise dramatically with no sign of the market beginning to stabilize.

While obstetricians, surgeons and other high-risk specialists have been hit hard, internists have been one of the hardest hit specialties -- having seen a record nearly 50 percent average increase over the last two years. In some cases, physicians, even those without a track record of lawsuits, cannot find an insurance company willing to provide coverage. These physicians are being forced to decide whether to dig deeper and pay the 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. Frontier and Reliance are also gone. Other commercials, 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 in which they extended sales.

The Perfect Storm

At a time when the market is squeezing physician and hospital margins, the rise in professional liability insurance may be the deciding factor that contributes to whether physician offices and emergency rooms keep their doors open. Recently, the costs of delivering health care have been driven by increased costs of new technologies; increased costs of drugs that define the standard of care acceptable for modern medicine; the rising costs of compliance under increasing state and federal regulation; the low reimbursement rate under Medicare and Medicaid; and the declining fees from managed care have all been contributing factors that have affected patient access to health care.

Unquestionably, there is real potential that rising insurance rates ultimately will reduce access to care for patients across the country. Indeed, press accounts on a daily basis are demonstrating exactly that from coast to coast. Physician offices and emergency rooms have been closing their doors all across the country due to the exorbitant costs. The states most severely hampered by the spiraling out-of-control rates are: Florida, Georgia, Illinois, Michigan, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. 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 resulted in only band-aid approaches to the more 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 – a fact 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 been introduced to help curb the spiraling upward trend in malpractice premiums. **H.R. 5, the "Help Efficient, Accessible, Low Cost, Timely Health Care" (HEALTH) Act of 2003, will attempt to 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 the 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 damages 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 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 providers 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 statue 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 an injured patient's award, 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 (33 1/3%) 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 largely 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 an increase in patient access to care. During this recent malpractice insurance crisis, California's rates have changed only slightly, while other states have spiraled to out of control levels. ACP-ASIM strongly supports the elements contained in MICRA. Further, we believe that any legislation proposed must include these basic, proven elements in order to assure the stabilization of malpractice premiums.

Conclusion

ACP-ASIM is pleased that the Senate Committee on Judiciary and the Senate Committee on Health, Education, Labor, and Pensions agreed to conduct this joint hearing to address the serious problem of soaring medical malpractice premiums that physicians are facing across the country. **We strongly urge the Committees to pass the common sense reforms similar to those contained in the HEALTH Act that would allow for greater access to care, while adequately compensating injured patients.** We appreciate the opportunity to present our views.

Statement for the Record

of the

American Medical Association

to the

Committee on Health, Education, Labor and Pensions
and the
Committee on the Judiciary
United States Senate

RE: Patient Access Crisis: The Role of Medical Litigation

February 11, 2003

On behalf of our physician members, the American Medical Association (AMA) appreciates the opportunity to provide written testimony regarding an issue that is seriously threatening the availability of and access to quality health care for patients.

There is something terribly wrong when thousands of physicians in several states feel compelled to leave their patients, to leave the work they love doing, and attend legislative rallies in their respective state capitals just to get noticed. There is something terribly wrong when patients have to by-pass the nearest hospital because the specialists who used to care for them have stopped practicing, eliminated certain procedures, or moved out of state because of the liability mess. There is something terribly wrong when dedicated professionals, who have trained for years, want to give up the work of a lifetime and retire. There is something terribly wrong when medical students make decisions about residency training based upon the legal climate in various states. Physicians across the country are making decisions now, and more and more patients are wondering, "will their doctor be there?" We must act now to fix our broken medical liability system.

OVERVIEW

In his State of the Union Address two weeks ago, President Bush stressed that we all are threatened by a legal system that is out of control. The President stated that "Because of excessive litigation, everybody pays more for health care and many parts of America are losing fine doctors." The President's remarks are substantiated in several recent government and private sector reports—reports making clear that the medical liability litigation system in the United States has evolved into a "lawsuit lottery," where a few patients and their lawyers receive astronomical awards and the rest of society pays the price as access to health care professionals and services are reduced.

The crisis facing our nation's medical liability system has not waned—in fact, it is getting worse. Escalating jury awards and the high cost of defending against lawsuits, even frivolous ones, have caused medical liability insurance premiums to reach unprecedented levels. As a result, a growing number of physicians can no longer find or afford liability insurance.

Virtually every day for the past year there has been at least one major media story on the plight of American patients and physicians as the liability crisis reaches across the country. Access to health care is now seriously threatened in states such as Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. And, a crisis is looming in more than 30 other states. Emergency departments are losing staff and scaling back certain services such as trauma units. Many obstetrician/gynecologists and family physicians have stopped delivering babies, and some advanced and high-risk procedures (such as neurosurgery) are being postponed because physicians can no longer afford or even find the liability insurance they need to practice.

We must bring common sense back to our court rooms so that patients have access to their emergency rooms, delivery rooms, operating rooms, and physicians' offices.

THE LITIGATION SYSTEM IS CAUSING THE CRISIS

The primary cause of the growing liability crisis is the unrestrained escalation in jury awards that are a part of a legal system that in many states is simply out of control. While there have been several articles published since the mid-1990s indicating that increases in jury awards lead to higher liability premiums, in the last year a growing number of government and private sector reports show that increasing medical liability premiums are being driven primarily by increases in lawsuit awards and litigation expenses.

According to 2001 Jury Verdict Research data, in just a one year period (between 1999 and 2000), the median jury award increased 43 percent. Further, median jury awards for medical liability claims grew at 7 times the rate of inflation, while settlement payouts grew at nearly 3 times the rate of inflation. Even more telling, however, is that the proportion of jury awards topping $1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top $1 million, and the average jury award has increased to about $3.5 million.

In a July 2002 report prepared by the U.S. Department of Health and Human Services (HHS), the federal government concluded that the excesses of the litigation system are threatening patients' access to health care. HHS reports that insurance premiums are largely determined by the litigation system. The report states that the litigation system is inherently costly, unpredictable, and slow to resolve claims. The cost just to defend a claim averages over $24,000. The fact that about 70 percent of claims end with no payment to the patient indicates the degree to which substantial economic resources are being diverted from patient care to fruitless legal wrangling.

Even when there is a large award in favor of an injured patient, a large percentage of the award never reaches the patient. Attorney contingent fees, added with court costs, expert witness costs, and other "overhead" costs, can consume 40-50 percent of the compensation meant to help the patient.

On September 25, 2002, HHS issued an update on the medical liability crisis. This update reported on the results of a survey conducted by Medical Liability Monitor (MLM), an independent reporting service that tracks medical professional liability trends and issues. According to MLM, the survey determined that the crisis identified in HHS's July report had become worse. HHS reported that:

> The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage. Premiums are spiking across all specialties in 2002. When viewed alongside previous double-digit increases in 2000 and 2001, the new information further demonstrates that the litigation system is threatening health care quality for all Americans as well as raising the costs of health care for all Americans.

The update further highlighted that liability insurance rates are escalating faster in states that have not established reasonable limits on unquantifiable and arbitrary non-economic damages. HHS reported that:

> . . . 2001 premium increases in states without litigation reform ranged from 30%-75%. In 2002, the situation has deteriorated. States without reasonable limits on non-economic damages have experienced the largest increases by far, with increases of between 36%-113% in 2002. States with reasonable limits on non-economic damages have not experienced the same rate spiking.

HHS also compared the range of physician liability insurance premiums for certain specialties in California, which has established reasonable limits on awards for non-economic damages, to the premiums in states that have not enacted similar limits. The results reveal how excessive awards for non-economic damages affect premiums. For example, in 2002 OB/GYNs in California paid up to $72,000. In Florida, which does not limit non-economic damage awards, OB/GYNs paid up to $211,000.

In Florida, as indicated in the example just given, medical liability premiums are among the highest in the nation. The situation in Florida has become so dire that Governor Bush created a special Task Force to examine the availability and affordability of liability insurance. This Task Force held ten hearings over a five month period and received extensive testimony and information from numerous, diverse sources.

or interest rates, on the other hand. In addition, on February 4, 2003, BBH released an addendum to this study that analyzed National Association of Insurance Commissioners (NAIC) data to determine whether investment gains by medical liability insurance companies declined in the recent bear market. BBH asked the question: "Did medical malpractice companies raise premiums because they had come to expect a certain percentage gain that was not achieved due to market conditions?" BBH determined that the decline in equities (which are a small percentage of insurance company investments) was more than offset by the capital gains by bonds (which make up a substantial part of insurance company investments) due to a decline in interest rates. BBH concluded that "investments did not precipitate the current crisis."

BBH's findings are corroborated by other recent reports. On September 25, 2002, HHS released an update on the medical liability crisis addressing claims by trial lawyers that the crisis is caused by the management practices of the insurance industry. HHS concluded that such claims are not supported by facts, stating "Comparisons of states with and without meaningful medical liability reforms provide clear evidence that the broken medical litigation system is responsible." A summary of medical liability insurer annual statement data in AM Best's Aggregates & Averages, Property-Casualty, 2002 edition shows that the investment yields of medical malpractice insurers have been stable and positive since 1997. AM Best reports that medical liability insurers have approximately 80% of their investments in the bond market. Recent NAIC data show that physicians' medical liability insurance premiums between 1976-2000 have risen 167% in California (which established effective liability reforms in 1975) compared to 505% in the rest of the United States.

Public Citizen's misdirected claims are a disservice to patients who are losing access to health care services, and an affront to the physicians and other health care professionals who dedicate their lives to healing and caring for the sick and working to find ways to improve the quality of care. America's medical liability crisis is too serious and the consequences of inaction too grave for the public and Congress to use anything but the facts to make decisions about reform. In short, Public Citizen's claims are counterproductive to the debate on resolving the medical liability crisis.

ACCESS TO CARE IS AT RISK

The most troubling aspect of the current medical liability litigation system is its impact on patients. Unbridled lawsuits have turned some regions in our country—and in several cases entire states—into risky areas to be sick, because it is so risky to practice medicine. Due to large jury awards and the burgeoning costs of defending against lawsuits (including frivolous claims), medical liability insurance premiums are skyrocketing. As insurance becomes unaffordable or unavailable, physicians are being forced to leave their practices, stop performing high-risk procedures, or drop vital services—all of which seriously impede patient access to care.

Five states—Georgia, Florida, New Jersey, Pennsylvania, and West Virginia—illustrate the crisis many states are experiencing and the problems many other states will face if effective tort reforms are not enacted.

Because hospitals finance large portions of their liability insurance with self-insurance (in Baylor's case, over 77% this year), and that data generally is rolled into hospital financials that are not available routinely to the public, it is difficult to access data and research and compare. But it is relevant directly to the policy decisions Congress is considering.

As I mentioned previously, over 77% of Baylor's liability cost is self-insurance reserves. Actuaries and auditors, applying conservative and strict guidelines, calculate the amount of cash reserves that must be put aside and used solely for the intended purpose (to pay for defense costs and liability payments). With no standards for juries, routine $10 million judgments and settlements, and a benchmark of $269 million on the books, self-insurance reserves must, under GAAP, be sufficient to meet that potential liability exposure.

There are no insurance companies to regulate. The few that are willing to write "umbrella" coverage simply will exit the US market altogether if they are forced to commit financial suicide and be subject to unlimited exposure in every health care case. In the Texas environment, physicians cannot obtain significant amounts of coverage; most of the physicians on Baylor's staff can only obtain $200,000 per case coverage, with $600,000 annual aggregate. If the average judgment exceeds $2.1 million (1999), and the average physician can obtain only $200,000 in insurance, hospitals and other facilities are paying roughly 90% of the average judgment. Those judgments are funded through self-insurance pools and are taken directly from the health care system. Finally, it has been reported that outside of California, 57% of the average judgment goes to the personal injury lawyers, his retained experts and publicist, leaving only 42% of the award to the plaintiff. That means over $1.2 million per average judgment is going to personal injury attorneys and their favored experts, and not the injured party.

Baylor University Medical Center is one of three trauma centers serving all of Dallas. One of those centers, Methodist Hospital, recently lost their last neurosurgeon because of the cost of his liability insurance. Methodist has been responsible for more than 12% of the trauma patients in Dallas. Without full-time neurosurgery available, Methodist will not be a full participant in the trauma service for Dallas. With Parkland (a governmental hospital with government immunity from liability) and Baylor routinely full, 12% of the trauma patients for all of Northeast Texas no longer have access to trauma services on many days. Baylor and Parkland are now left to carry the burden of all those head traumas, and Baylor has been unsuccessful in recruiting additional neurosurgeons to support the trauma service. Baylor only has five neurosurgeons left, and they provided emergency trauma services to over 312 emergency patients last year, in addition to operating their private practice. Baylor has only two orthopedic trauma surgeons, and they provided trauma care to over 1,067 patients last year. Recent attempts to recruit an additional ortho trauma surgeon failed when the physician compared the cost of medical liability insurance in Dallas and the cost for that insurance in San Diego, where he had a competing offer. San Diego families obtained another orthopedic trauma surgeon, while the referral center for all of Northeast Texas and parts of Oklahoma struggles to meet the

GEORGIA

- Although she is in her first year of medical school at Medical College of Georgia, the controversy has already caused Thandeka Myeni, 26, to reconsider her preference for obstetrics, one of the specialties hardest hit by the increases. "I definitely think it could be discouraging," she said. (*The Augusta Chronicle*, Nov. 13, 2002).

- Evans Memorial, a rural hospital in Claxton, decided to "go bare"—have no coverage at all—instead of paying what it considered an exorbitant premium. Only one insurer offered a malpractice policy for the hospital and its nursing home, and the annual premium for $1 million coverage would have been $581,000, up from $216,000 last year. "We just thought it was outrageous," said Eston Price, Evans Memorial administrator. (*The Atlanta Journal-Constitution*, Oct. 7, 2002).

- The largest hospital in the state's health system has bought a new policy—with a deductible of $15 million—covering 953-bed Grady Memorial, a nursing home and clinics. On each paid claim below that mark, Grady is responsible for every dollar. The $15 million deductible starts again with each claim. "Grady faces open-ended liability," said Timothy Jefferson, Grady Health System executive vice president and chief counsel. (*The Atlanta Journal-Constitution*, Oct. 7, 2002).

- Knowing that malpractice premiums were rising for everyone in the industry, Ty Cobb Health System CEO, Chuck Adams earmarked enough money for a 100 percent increase. The bill arrived by fax this summer, just 24 hours before a check was due. Not only was the insurance company increasing his deductible tenfold, but the premium jumped from $553,000 to $3.15 million – a 469 percent increase. "We were numb," said Adams, who eventually got an extension and another cheaper policy at $1.65 million. "There goes our expansions, like a renovation of the Hart County Emergency Room." (*The Atlanta Journal-Constitution*, Aug. 11, 2002).

- "Dr. Edmund Wright, a Fitzgerald family practitioner who performed Caesarian sections, has given up that part of his practice. His premiums quadrupled to $80,000 in 2002 and would have been $110,000 if he had continued the surgical delivery procedure. Wright said, "I don't know if I really want to do this anymore." (*The Atlanta Journal-Constitution*, Aug. 11, 2002).

- Insurance costs are rising so high and so quickly because of medical malpractice lawsuits that many doctors are quitting medical practice, said Michael Greene, who has a family practice in Macon. The problem is increasing so fast that Georgia will soon face a critical shortage of physician, Greene said. "It hasn't hit with a tidal wave yet, but the waves are beginning to lap at the shore," Greene continued. (*The Macon Telegraph*, Aug. 3, 2002).

- David Cook, executive director of the Medical Association of Georgia, said the malpractice crisis is driving more doctors into early retirement. "One-third of doctors 55 and older say they plan to reduce their hours or get out altogether," he said. "These are physicians at the peak of their diagnostic powers." (*The Times (Gainesville)*, July 17, 2002).

PENNSYLVANIA

- Dr. Anthony Clay never thought he would have to leave Philadelphia. He has spent his whole life there—growing up and attending college, medical school, and residency to become a cardiologist. He treats families he has known since boyhood. He likes knowing where his patients live, work, and shop. All nine of his siblings still live there. But, Dr. Clay is leaving his practice in Philadelphia this spring because of surging malpractice insurance rates. He is starting over in Delaware, where his insurance costs will drop from roughly $70,000 a year to $8,000. "It's been terrible," said Dr. Clay, 40. "In this field, you've been with the patient, and also the family, in some of their most life-defining moments - in the throes of a heart attack with no blood pressure. Wrongly or rightly, the patient credits you with being there when they weren't doing so well. You realize you've created a bond. I take that very seriously." (*Baltimore Sun*, February 5, 2003).

- Brian Holmes, MD, is only one of an estimated 18 percent of Pennsylvania neurosurgeons to have left the state, retired, or limited their practices because of the medical liability crisis. "It saddened me to move, but I had no choice. It was either move or go out of business." (*Philadelphia Business Journal*, Sept. 25, 2002).

- After 25 years of practice, OB/GYN Michael Horn, MD, stopped delivering babies in 2002 because of the fear of getting sued. "It's just the potential, the not knowing if someone will seek an outlandish reward. I don't want to expose myself or my family." (*Burlington County Times*, Oct. 2, 2002).

- Medical students are less likely to seek residencies in Philadelphia, and residents are less likely to stay and practice in the area because of "prohibitively high" medical liability insurance rates, according to Jefferson Medical College professor Stephen L. Schwartz, MD. (*Associated Press*, Oct. 4, 2002).

- OB/GYN Lawrence Glad, MD, used to deliver about 500 babies a year—40 percent of all the babies born in Fayette County annually. After his premiums skyrocketed from $57,000 to $135,000, however, he closed his practice in the fall of 2002. (*Pittsburgh Business Times*, Nov. 18, 2002).

- Mercy Hospital chief of surgery Charles Bannon, MD, has watched numerous physicians leave Scranton and Lackawanna County—creating a shortage of surgeons, fewer medical school applications and residencies. "It will take generations to get back the quality of medicine in Philadelphia." (*Scranton Times*, Nov. 20, 2002).

FLORIDA

- Women are facing waiting lists of four months before being able to get an appointment for a mammogram because at least six mammography centers in South Florida alone have stopped offering the procedure as a result of increasing medical liability insurance premiums. "This trend is troubling. There are a growing number of older people and less and less people to provide mammograms," said Jolean McPherson, a Florida spokeswoman for the American Cancer Society. (*South Florida Sun Sentinel*, Nov. 4, 2002).

- Aventura Hospital in South Florida closed its maternity ward and cited $1,000 in insurance premiums for each delivery as the prime factor. Aventura is one of six maternity wards to close in recent months. Now, patients will be forced to drive to other counties and other facilities. "There may be waits getting into a labor-room floor," said OB/GYN Aaron Elkin, MD. (*Miami Herald*, Oct. 19. 2002).

- "Without a doubt, access to health coverage is being affected. Some of our emergency rooms are losing their effectiveness," said Dr. Greg Zorman, neurosurgery chief at Memorial Regional Hospital in Hollywood. His unit gets several patients a week from smaller ERs that have lost neurosurgery coverage. (*South Florida Sun Sentinel*, February 5, 2003).

- Port Charlotte cardiologist Leonardo Victores, MD, left for Kansas in the face of medical liability premiums that were going to increase 100 percent. "He's moving to Kansas because that state has caps on malpractice awards," said colleague Mark Asperilla, MD. (*Sun Herald*, Jan. 1, 2003).

- Despite having no malpractice claims or disciplinary actions on his record, Lakeland OB/GYN John Kaelber, MD, was forced to close his practice and leave the state in the wake of insurance premiums that doubled. (*Lakeland Ledger*, Nov. 21, 2002).

- More than 50 Bradenton patients had to postpone elective surgeries and more than 100 office visits were canceled because two physicians were unable to obtain liability insurance. The insurer may leave the state altogether. (*Bradenton Herald*, Jan. 24, 2003).

- After recently receiving notice of a premium spike coming in July 2002, Vladimir Grnja, MD, decided that he would "go bare" and drop all medical liability insurance coverage. Rates for the Hollywood, FL radiologist were to rise to $112,000 from $35,000 a year (a 220% increase), mainly because of litigation over mammograms. "No doctor wants to go bare," said Dennis Agliano, MD, chairman of the Florida Medical Association's special task force on the Florida medical liability crisis. But with significant premium hikes in Florida for specialties like OB/GYN, neurosurgery, thoracic surgery, radiology and even primary care, "some doctors have no choice," he says. Some neurosurgeons in South Florida, are paying a $200,000 premium for coverage of

$250,000 per occurrence, making insurance practically meaningless. The Florida Medical Association reports that more than 1,000 doctors in Florida have no medical liability insurance. Doctors in West Virginia and Ohio are also reportedly going bare. (*Modern Physician*, April 1, 2002).

WEST VIRGINIA

- General surgeon Gregory Saracco, MD, only 49 years old, was forced to borrow money twice in 2002 to pay $73,000 for his liability insurance. His premiums for 2003 are expected to rise to $100,000. He is considering leaving West Virginia and while he has taken time away from his practice this year to decide what his options are, he said "my job is to help people—I couldn't drive past an accident on the road and not stop. I don't know any doctor that could." (*Associated Press*, Jan. 2, 2003).

- Although orthopedic surgeon George Zakaib, MD, was raised and went to school in Charleston, WV, he and his family left because of the state's medical liability crisis. Dr. Zakaib's premiums had increased to $80,000 plus $94,000 in "tail" coverage. (*Charleston Daily Mail*, July 27, 2002).

- Fourth-year medical school student Jennifer Knight isn't sure she'll stay in West Virginia. The Charleston Area Medical Center says fewer medical students are applying to its residency programs, and fewer students are applying to Marshall University's medical school. "I think the problem is, we have too many frivolous lawsuits," said Ms. Knight. (*Sunday Gazette-Mail*, Nov. 24, 2002).

NEW JERSEY

- A multi-physician practice in Teaneck, NJ was forced to layoff employees and reduce the number of deliveries it performed because of professional liability insurance premium increases of more than 120 percent. "All of my colleagues are experiencing the same pressures," said George Ajjan, MD (*Bergen Record*, May 22, 2002).

- One out of every four hospitals—nearly 27 percent—has been forced to increase payments to find physicians to cover Emergency Departments. Physicians are increasingly reluctant to take on such assignments because of the greater liability exposure. Hospitals report that more and more physician specialties are being hit by the crisis. While a previous New Jersey Hospital Association survey in March 2002 found that OB/GYNs and surgeons were primarily affected, the new survey finds a deepening impact for neurologists/neurosurgeons, radiologists, orthopedists, general practitioners and emergency physicians. (New Jersey Hospital Association, Jan. 28, 2003 news release).

- "We have as much to lose as they have," said Joan Hamilton, a patient who attended a recent rally in New Jersey in support of her physician. (*Bergen Record*, Oct. 6, 2002).

OTHER STATES

The crisis may be spreading to **CONNECTICUT**, as evidenced by the recent decisions of 28 OB/GYNs to stop delivering babies. Some OB/GYNs in Connecticut are paying between $120,000-$160,000 per year in insurance premiums, according to state medical society executive Tim Norbeck. Connecticut already is on a "watch" list issued by the American College of Obstetricians and Gynecologists. (*Hartford Courant*, Jan. 3, 2003). The average payment made by one of Connecticut's major insurers to resolve a claim rose from $271,000 in 1995 to $536,000 in 2001. OB/GYN Jose Pacheco's, MD, insurer stopped offering medical liability insurance and he had to seek another carrier. However, because of the high cost of new insurance—estimated around $60,000—combined with "tail" coverage of $80,000, Dr. Pacheco retired after a 27-year career. (*Hartford Courant*, Nov. 17, 2002).

Cardiologist Dr. Donald Copley, member of the Buffalo Medical Group in **NEW YORK** and an officer of the Erie County Medical Society says, "I've watched sadly as valued colleagues have left Erie County and even the profession. A competent young specialist recently quit doing high risk diagnostic procedures to become a business consultant. Several local obstetricians have stopped delivering babies to reduce their insurance expenses. A half dozen nationally-known doctors have quietly left Western New York. The number of doctors leaving Erie County last year doubled from the previous year, a trend that continues in 2002. (*Buffalo Business First*, April 15, 2002).

Eight of 55 OB/GYNs in Springfield, **MASSACHUSETTS** [which has broad exceptions to the state limits on non-economic damages] will no longer be offering Obstetrics care to their patients because of sharply escalating liability insurance costs. "I got into obstetrics because it's a very happy specialty. But there comes a point where you can't make ends meet," said James Wong, MD, one of two OB/GYNs at a western Massachusetts clinic giving up delivering babies. "The real issue is runaway juries," according to Barry Manual, MD, who serves as insurer ProMutual's chairman, and said the number of $1 million-plus claims paid out doubled between 1990 and 2001. (*Boston Globe*, Jan. 8, 2003).

Dr. John Schmitt, a **NORTH CAROLINA** obstetrician left his private practice in Raleigh to take a position with the University of Virginia's medical school. He decided to take the Virginia job after his annual malpractice insurance costs rose from $18,000 to $45,000 in the past year. Former patient Laurie Peel said, "He was a great doctor. When you are a woman, you try to find a gynecologist who will take you through lots of things in life. I suffered a miscarriage. You develop a relationship with your doctor. To lose someone like that is very hard." (*Charlotte Observer*, Jul. 25, 2002).

Liability costs for **TEXAS** physicians skyrocketed as much as 300 percent in some regions and for some specialties. As a result, there is only one neurosurgeon serving 600,000 people in the McAllen area. In the past two years, four South Texas patients with head injuries died before they could be flown out of the area for medical

attention. As reported in a July 10, 2002, article in *The Courier*, a community family practice clinic in Conroe (just north of Houston) was recently forced to turn away half of its normal patient load because its liability insurance provider would not provide coverage while "highly lawsuit-risky obstetrics training was conducted."

In **NEVADA** more than 30 private-practice OB/GYNs have left the state in 2002 and another 20 are poised to leave in 2003. About half of the OB/GYNs in the state are actively interviewing for positions out of state. "Right now it's almost impossible to recruit an obstetrician in Las Vegas," said University Medical Center obstetrician, Warren Volker, MD. (*Las Vegas Sun*, Sept. 27, 2002). Long-time obstetrician, Frieda Fleischer, MD, gave up obstetrics because her premiums rose from $30,000 annually to $80,000. "So far, I've had about 40 pregnant patients to refer elsewhere and it's been tough." Fleischer's office manager, Dawna Gunning adds, "What do you do when you have patients coming to your door crying and saying they cannot find a doctor and you've called every colleague?" (*Las Vegas Review Journal*, Jan. 10, 2003). The story of a woman who had to wait six months to have suspicious lumps removed from her uterus and ovaries because she couldn't get an appointment for the surgery illustrates that pregnant women are not the only patients affected by the exodus of Las Vegas obstetricians in recent months. (See, *Las Vegas Review Journal*, Nov. 5, 2002).

Obstetricians in **MISSISSIPPI** worry about what is going to happen to their patients who face longer trips to the hospital while already in labor. Women who used to walk or make a short drive for both prenatal visits and delivery now face a 45-minute drive. Of the seven doctors in Kosciusko that were practicing obstetrician/gynecologists last year, three will still be delivering babies by January. Right now, pregnant women who are considered high-risk, such as someone with diabetes, can't be treated at the Kosciusko Medical Clinic because it is too risky for physicians. (*The Clarion-Ledger*, Aug. 26, 2002.). Neurologist Terry Smith, MD said he has applied with 14 companies, and Medical Assurance is his last hope to find coverage before his current policy expires on Aug. 4. His premium will go from $55,000 a year to potentially $150,000 with a $132,000 tail to his old insurer. "I'm looking at writing a check for $300,000," said Smith, who does brain surgery at three hospitals in Jackson and Harrison counties. (*Associated Press*, July 11, 2002).

Rural families in John Day, Hermiston, and Roseburg counties, **OREGON** have either lost obstetric care or have seen services drastically reduced. (*The Business Journal of Portland*, Jan. 10, 2003). Only by dropping obstetrics were two Hermiston physicians able to afford their liability insurance premiums. "It's something you don't like to tell patients," said Doug Flaiz, MD. (*The Oregonian*, Oct. 29, 2002). "No one with $100,000 in debt from medical school wants to start a practice in a place where they could find themselves completely broke and having to pick up and go somewhere else to start all over again," said Rosemari Davis, CEO of Willamette Valley Medical Center, who has seen three of her center's family practitioners stop delivering babies. (*The News Register*, Jan. 28, 2003).

A 10-physician OB/GYN group in Columbia, **SOUTH CAROLINA** had to take out a $400,000 loan this year to continue to provide OB services *and* pay malpractice premiums. In rural Oconee County, just four doctors deliver babies now, down from 11 physicians one year ago. A family practice group in Seneca was forced to drop OB coverage for four of their six physicians because of skyrocketing premiums. There are currently a total of four physicians in Seneca treating pregnant women. A solo practitioner practicing geriatrics in Charleston has had to quit treating patients in nursing homes because of high premiums.

THE PRACTICAL SOLUTION

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as devastating or worse to patients and their families than injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation.

This compensation should include, first and foremost, full payment of all out of pocket "economic" losses. The AMA also believes that patients should receive reasonable compensation for intangible "non-economic" losses such as pain and suffering and, where appropriate, the right to pursue punitive damages.

Unfortunately, our medical liability litigation system is neither fair nor cost effective in making a patient whole. Transformed by high-stakes financial incentives, it has become an increasingly irrational "lottery" driven by open-ended non-economic damage awards. A 2002 study by Tillinghast-Towers Perrin shows that our tort system, in general, is an extremely inefficient mechanism for compensating claimants—returning less than 45 cents on the dollar to claimants and only 20 cents of tort cost dollars to compensate for actual economic losses. This study also reveals that the cost of our tort system is significantly higher than other countries and almost twice the average.

To ensure that all patients who have been injured through negligence are fairly compensated, the AMA believes that Congress must pass fair and reasonable reforms to our medical liability litigation system that have proven effective. Toward this end, **we strongly urge Congress to pass the "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act,"** a bipartisan bill that would bring balance to our medical liability litigation system. We applaud Senator Ensign for introducing this bill in the last Congress and look forward to working with all Senators to pass such legislation this year.

The major provisions of the HEALTH Act would benefit patients by:

- Awarding injured patients unlimited economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);

- Awarding injured patients non-economic damages up to $250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in this bill;

- Awarding injured patients punitive damages up to two times economic damages or $250,000, whichever is greater;

- Establishing a "fair share" rule that allocates damage awards fairly and in proportion to a party's degree of fault; and

- Establishing a sliding-scale for attorneys' contingent fees, therefore maximizing the recovery for patients.

These reforms are not part of some untested theory—they work. The major provisions of the HEALTH Act are based on the successful California law known as MICRA (Medical Injury Compensation Reform Act of 1975). MICRA reforms have been proven to stabilize the medical liability insurance market in California—increasing patient access to care and saving more than $1 billion per year in liability premiums—and have reduced the time it takes to settle a claim by 33 percent. MICRA is also saving California from the current medical liability insurance crisis brewing in many states that do not have similar reforms. In fact, according to MLM, as discussed above, 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.

MICRA-type reforms are effective, especially at controlling non-economic damages. Several economic studies substantiate this point. One study looked at several types of reforms and concluded that capping non-economic damages reduced premiums for general surgeons by 13% in the year following enactment of MICRA, and by 34% over the long term. Similar results were shown for premiums paid by general practitioners and OB/GYNs. It was also shown that caps on non-economic damages decrease claims severity (Zuckerman et al. 1990).

Another study published in the *Journal of Health Politics, Policy and Law* concluded that caps on non-economic damages reduced insurer payouts by 31%. Caps on total damages reduced payouts by 38% (Sloan, et al. 1989). Another study concluded that states adopting direct reforms experienced reductions in hospital expenditures of 5% to 9% within three to five years. If these figures are extrapolated to all medical spending, a $50 billion reduction in national health spending could be achieved through such reforms (Kessler and McClellan, *Quarterly Journal of Economics*, 1997).

Further, as discussed above, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress) asserts caps on non-economic damages have been extremely effective in reducing the severity of claims and medical liability premiums. Conversely, a 1996 American Academy of Actuaries study shows that medical liability costs rose sharply in Ohio after the

Ohio Supreme Court overturned a liability reform law in the 1990s that set limits on non-economic damages. (Ohio recently enacted a new liability reform law.)

Furthermore, three-quarters of Americans understand the detrimental effect that excess litigation has on our health care system. A 2002 survey conducted by Wirthlin Worldwide shows that the vast majority of Americans agree we need common sense medical liability reform. Among the findings:

- 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.
- 73 percent support reasonable limits on awards for "pain and suffering" in medical liability lawsuits.
- More than 76 percent favor a law limiting the percentage of contingent fees paid by the patient.

These findings are consistent with the results of a Gallup poll released on February 5, 2003, show that 72% of those polled favor a limit on the amount patients can be awarded for pain and suffering.

CONCLUSION

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an erosion in access to care because their physicians can no longer find or afford liability insurance. The reasonable reforms of the HEALTH Act have brought stability in those states that have enacted similar reforms.

By enacting meaningful medical liability reforms, Congress has the opportunity to increase access to medical services, eliminate much of the need for medical treatment motivated primarily as a precaution against lawsuits, improve the patient-physician relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emotional, of health care liability litigation. The modest proposals in the HEALTH Act answer these issues head on and would strengthen our health care system.

The AMA appreciates the opportunity to testify on the adverse effect that our current medical liability litigation system imposes on patient access to health care and urges Congress to pass the HEALTH Act.

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John J. Castellani
President

Patricia Hanahan Engman
Executive Director

February 11, 2003

The Honorable Orrin G. Hatch
Chairman
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

The Honorable Judd Gregg
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, D.C. 20510

Dear Chairman Hatch and Chairman Gregg:

The Business Roundtable (BRT) strongly supports legislation to reduce the cost of medical liability insurance in the United States, and we applaud you for holding joint hearings on this important issue.

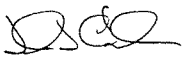
The BRT is an association of chief executive officers of leading U.S. companies. BRT members acting on behalf of their more than 25 million employees and family members are the single-largest set of private purchasers of health care services and insurance in the nation. Increasing health care costs are adversely affecting our employees and their family members.

Rising medical liability costs are having a negative impact on the delivery of health care services. As a result of soaring medical liability premiums, health care access is being diminished. In addition, excessive health care litigation is driving up health care costs through "defensive medicine" practices. In the end, many of these rapidly escalating costs are being shifted to employers and employees.

We support common sense reforms that address some of the more troublesome aspects of our legal system. For example, we support court reforms that place limits on non-economic and punitive damages, as well as alternative methods to resolve legal disputes, such as arbitration and mediation. Uniform standards should be set so that individuals who have been maliciously or intentionally harmed should recover punitive damages. We also believe that injured plaintiffs should receive a majority of any judgment awarded. A reasonable cap on attorneys' fees is fair and ensures that awards that are designed to compensate a patient for injuries are used for the benefit of that person.

Access to quality, cost-effective health care services for all Americans is an important effort – and curbing unnecessary medical liability litigation is critical. With rising health care costs, we can no longer afford the unintended costs of our current tort system. Therefore, we encourage you to move forward with legislation that will reduce transaction costs, stem the rise in health care costs and improve accessibility.

Sincerely,



John J. Castellani

STATEMENT OF

VICTOR E. SCHWARTZ, ESQ.

BEFORE A

JOINT HEARING OF THE
SENATE JUDICIARY AND SENATE
HEALTH, EDUCATION, LABOR AND PENSION COMMITTEES

on

TUESDAY, FEBRUARY 11, 2003 2:30 p.m.

HEARING TITLED:

PATIENT ACCESS CRISIS: THE ROLE OF MEDICAL LITIGATION

Thank you, Mr. Chairman, and members of the Committees, for your kind invitation to submit comments today about the health care 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 on behalf of claims made by 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 I 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.

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 <u>and</u> that tort reform can achieve stability in the insurance market. Meaningful reforms 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.

While excessive litigation poses a problem for all health care providers, the liability crisis faced by long-term care facilities is particularly acute. While some individual nursing homes have engaged in improper conduct and deserve sanctions, the nursing home industry as a whole has been faced with dramatic and unprecedented increases in liability insurance premiums because of a growing number of lawsuits that result in huge settlements and excessive jury awards.

Driving some of these lawsuits is the misuse of both state and federal safety compliance regulations and also state residents' rights laws as standards of medical care. As a result, funds that should go to patient care are diverted to pay for expensive liability insurance coverage. Liability insurers have fled the long-term care market. Nursing facilities in some areas of the country are now forced to go without insurance. Some are unlikely to be able to keep their doors open. Already more than 1 in 10 skilled nursing facilities have sought bankruptcy protection, and others have simply closed their doors.[1]

Why Not Let The States Do It?

When it comes to the specific area of health care liability, I believed in the past that this should be the exclusive function of the States. Health care

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[1] *See, e.g.*, Letter from American Health Care Association to Rep. Dennis J. Hastert, Oct. 4, 2000.

liability insurance rates are often set on a state-by-state basis. State controls can lower costs. That good premise and that good practice has been upended in recent years, because when States have passed balanced health care liability reforms, they have subsequently been nullified by state courts under obscure portions of very lengthy and prolix State Constitutions.

I am submitting to these Committees a law review article that was authored by my colleague, Leah Lorber, and myself that was recently published in the Rutgers Law Review.[2] I ask that it be made a part of the record. The article demonstrates that these decisions do not represent sound State Constitutional law, and 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. As that article clearly demonstrates, they would be upheld under that Constitution.

Apart from avoiding this practice of judicial nullification, another reason for federal action is to address the crazy quilt pattern of state health care liability laws, which causes doctors and other health care liability providers to move where tort liability rules are clear.

Some state courts have looked to other statutory standards relating to health care to allow claims against nursing homes that are not limited by medical liability reforms. While these decisions may be understandable as a

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[2] *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).

legal matter, they do impede the goal of reducing the cost of liability for health care providers. In this regard, federal health care liability reform must address the growing problem of the litigation misuse of alternative state laws, discussed below, to pursue what are essentially medical negligence cases against long-term care providers.

Patient care lawsuits filed against hospitals and physicians typically are based on allegations of medical malpractice and fall under the corresponding state statute. But, in addition to medical malpractice claims, lawsuits against nursing home providers may include causes of action based on nursing home patient protection laws, elder abuse laws, breach of contract, and negligent hiring and supervision. In some states, at least some of these causes of action are subsumed in medical malpractice actions and are subject to the rules governing such lawsuits. But in other states, courts have found these allegations to be separate and independent from medical malpractice claims. Thus, their inclusion in a lawsuit generally means that the long-term care provider cannot be protected from excessive verdicts by the liability controls in state medical malpractice statutes.

For example, in Florida, one of two states with the highest cost per occupied bed of general and professional liability insurance costs,[3] the state Supreme Court ruled in December that a lawsuit under the state's Patients Bill of

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[3] AON Risk Consultants, Inc., Long Term Care General Liability and Professional Liability Actuarial Analysis 11 (2002).

Rights law[4] did not plead a medical malpractice case – although the lawsuit alleged that the nursing home patient failed to receive "adequate and appropriate health care."[5] As a result, the plaintiff did not have to abide by medical malpractice pre-suit requirements designed to screen out frivolous claims.

Also troubling is that some of these alternative state laws may include what appear to be vague and undefined requirements about the quality of care to be given to patients -- without regard for what the professional standard of care is and whether providers met that professional standard of care. The Florida statute regarding the provision of "adequate and appropriate health care" is one such example.[6] In Texas, the other state with the highest per bed loss costs, the state Patients' Bill of Rights allows claims for failure to provide a resident with "a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident."[7] Texas law specifically exempts cases involving claims for injury to the elderly from the 1995 Texas tort reform punitive damages limits.

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[4] Fla. Stat. § 400.022 (1997).

[5] *Integrated Health Services, Inc. v. Lang-Redway*, 2002 WL 31769252, *5 (Fla. Dec. 12, 2002) (statute provides its own standard of "adequate and appropriate health care" so medical negligence standard and corresponding pre-suit requirements are inapplicable). After the accrual of the cause of action in *Lang-Redway* arose, the Florida legislature determined that future residents' rights claims (accruing on or after May 15, 2001) should not be considered medical malpractice claims. *See* 2001 Fla. Sess. Law Serv. Ch. 2001-45 §7 (West 2001).

[6] A Florida appeals court has ruled that the statutory language is not unconstitutionally vague. *See Beverly Enterprises-Florida, Inc. v. McVey*, 739 So. 2d 646 (Fla. App. 1999), *reh'd denied, rev. denied.*

[7] Texas Health & Safety Code § 247.064(b)(1)) (2002).

The scope of a Senate bill on health care liability reform should encompass these "alternative" health care liability laws to allow our legal system to return to an objective analysis of the risks and liabilities of providers, insurers and consumers in a medical environment. If health care liability protections are piecemeal rather than comprehensive, this would lead only to shifting the blame away from doctors and toward non-doctor medical defendants. Nursing home providers will be faced with a substantial increase in the already staggering load of cases. It would augment, not solve, the true liability problem.

On a separate but related topic, I would like to note that excessive lawsuits against long-term care providers are facilitated by the improper use of publicly released quality data. Information collected to help improve patient care and ensure Medicare and Medicaid compliance is instead misused to create a "history" of deficiencies at a facility that plaintiff's attorneys seek to introduce as evidence in order to bolster their negligence claims. Admitting such data into evidence when it has nothing to do with the incident alleged forces nursing facilities into the untenable position of defending a case that attacks the history of the nursing home instead of one that seeks compensation for the individual plaintiff's claim.

Both the government and employers are seeking greater disclosure of quality data. This disclosure would help identify areas in need of improvement and encourage providers to exchange information about innovative ways to improve patient care. It also will help consumers make more informed choices about their long-term care needs. The nursing home industry has been a pioneer

in this area. In October 2002, the industry launched an effort in conjunction with the Centers for Medicare and Medicaid Services to make public benchmark "quality measures" for every facility in the Nation.

Because this is an effort to improve the overall public health, this data should not be admissible in court unless the plaintiff can prove that the data is directly related to the negligent act alleged. This will permit plaintiffs to obtain recoveries for legitimate claims, as those do not turn on the overall past practices of a nursing facility. It also will encourage the full and complete sharing of information. Laws directed at encouraging the spread of information are compromised when they are turned around and used to create liability in the tort system.

There is a plethora of precedent in existing law for keeping such information out of evidence: the common-law "self-critical analysis" privilege and Federal Rules of Evidence barring the introduction of evidence of subsequent remedial measures, evidence of prior similar acts, and character evidence. Codifying these legal principles with regard to nursing homes is the best way to ensure that the principles are uniformly applied throughout the Nation. Courts may rule subjectively, and contingency fee personal injury lawyers can be extraordinarily creative in fashioning excuses for the admission of otherwise prohibited evidence that will help their case.

The Myth That Insurance Companies Will Reap the Profits of Reform

I have read statements by some 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 Congress to support the Federal Risk Retention Act. Those Members 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. Fund reserves that would be needed to pay claims would not be there.

Can Tort Reform Be Effective?

It has been strongly suggested by some organizations tort reform is 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 health care liability 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.[8]

Well-crafted federal legislation can have appropriate and salutary benefits for health care practitioners in the United States. Doctors are leaving practice because insurance is unaffordable. Specialists such as OB/GYNs are particularly hit hard. Nursing homes have seen insurance soar and have had to go without insurance or close their doors. But nursing homes and other health

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[8] *See* General Aviation Manufacturers Association, *Five Year Results: A Report to the President and Congress on the General Aviation Revitalization Act* (1999).

care liability professionals should be where they are needed – not where tort laws, and therefore, insurance rates, are most favorable.

Conclusion

I have kept my comments brief because my points, which while I believe are important, are very straightforward. Tort reform should be enacted if it is fair and balanced. Legislation that 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 legislative vehicle must take into account all potential theories of liability for health care claims, including "alternative" laws targeting specific health care providers.

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 were attempted, 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.

Thank you for reading this statement.

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February 24, 2003

The Honorable Orrin Hatch
Chairman
Committee on the Judiciary
United States Senate
224 Dirksen Senate Office Building
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The Honorable Judd Gregg
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate
428 Dirksen Senate Office Building
Washington, D.C. 20510

Re: February 11, 2003, hearing on "Patient Access Crisis: The Role of Medical Litigation."

Dear Chairmen Hatch and Gregg:

You held a most worthwhile and needed hearing on February 11, 2003, on "Patient Access Crisis: The Role of Medical Litigation." As you recognized at the hearing, the crisis in medical liability litigation is a major public policy issue that requires Congressional attention. One of the issues discussed at the hearing was whether limits on noneconomic damages will adversely affect women, especially those who do not work outside the home, and children. It was asserted by some that such limits would leave those persons without compensation because they receive no economic damages. This assertion does not comport with the reality of actual trials. I have previously addressed this issue during the hearing that was held on July 17, 2002, by the Subcommittee on Health of the House Energy and Commerce Committee on H.R. 4600, the Help Efficient Accessible Low-Cost Timely Healthcare Act of 2002. I have found, however, that this argument that continues to be put forth by opponents of limits on noneconomic damages, regardless of how many times it is answered. For that reason, I am writing this letter to you and ask that it be made part of the record of your February 11, 2003, hearing.

The principal assertion put forth by those who argue that caps on noneconomic damages discriminate against women and children is that the economic damages of women who work as homemakers and children are often low because the income of homemakers and children is small or nonexistent. Those who make this argument do not know or have ignored the practicalities of litigation. These critics fail to recognize that the concept of economic loss includes the value of the services an individual provides to a family, and the future earnings of a child.

While it is true that lost wages are one aspect of economic damages, they are not its only measure. If a woman homemaker is injured, someone must be paid to do all of the things that she formerly did for her family, specifically child care, meal planning and preparation, family transportation, household administration, cleaning, and often economic planning for the family. Each of those losses constitute *economic* damages and would be *fully compensated* even if a cap on noneconomic damages were in place. In some cases, the loss of educational, physical and moral training and guidance provided to children can also be included within economic damages. *See, e.g., Wentling v. Medical Anesthesia Services,* 701 P. 2d 939, 947 (Kan. 1985) (a wrongful death action in which the Supreme Court of Kansas upheld an award to the family of the decedent of $786,166.64 in economic damages for the decedents services as "dietitian, chauffeur, buyer, cook, dishwasher, housecleaner, laundress, nurse, and others" and the loss of care and guidance to the children that would have been provided by the decedent). *See also DeLong v. County of Erie*, 455 N.Y.S.2d 887 (4th Dept. 1982) *dismissal denied* 460 N.Y.S. 2d 526, and *aff'd*, 60 NY2d 296 (N.Y. 1983)(a wrongful death action in which the court permitted expert testimony valuing the decedent's services to her family at $527,659). The compensation for these losses can reach many thousands of dollars for each year the woman plaintiff is unable to perform these multiple important functions.

In the case of children, many courts have allowed the significant recovery for loss of future earnings based on testimony about the probable future income of the child. *See* 2 JACOB A. STEIN, STEIN ON PERSONAL INJURY DAMAGES TREATISE § 6.23 (3rd ed. Supp. 2002) (citing cases). Two of the cases therein provide examples of the extent to which children can recover for future lost earnings. In one case, a New York court affirmed a jury's $3 million award to a child plaintiff for lost future earnings. In another case, the West Virginia Supreme Court of Appeals affirmed a jury's $1.75 million award for an infant's lost future earnings. As these two examples demonstrate, children who have not yet earned an income can nevertheless be compensated for the loss of future earnings.

Another argument that has been made against limits on noneconomic damages is that they discriminate against women because they limit the ability to compensate for the reality that women, on average, have lower incomes than men in comparable positions. *See, e.g.,* Lisa Ruda, Note, *Caps on Noneconomic Damages and the Female Plaintiff: Heeding the Warning Signs,* 44 CASE W. RES. L. REV. 197, 232 (1993). This argument reflects a misunderstanding of the purpose of noneconomic damages. Noneconomic damages, as their name suggests, exist to compensate plaintiffs for the non monetary losses associated with injuries, such as physical pain suffering, mental anguish, and emotional distress. *See* VICTOR E. SCHWARTZ, ET AL., PROSSER, WADE AND SCHWARTZ'S CASES AND MATERIALS ON TORTS at 534-535 (10th ed. 2000). The purpose of noneconomic damages is to compensate each individual according to his or her injuries, not to "even out" the differences between plaintiffs who may have similar injuries yet differing economic losses. Thus, the fact that women make less money than their male counterparts, while regrettable, is not an issue that can or should be redressed through awards of noneconomic damages in tort law.

In conclusion, the arguments used to support the claim that limits on noneconomic damages discriminate against women and children are grounded either in a misunderstanding of the available economic damages for women and children, or in a misguided attempt to address inequalities in pay by inflating economic damages.

Best regards,

Victor E. Schwartz

cc: Ranking Minority Member of the Committee on the Judiciary Leahy
Ranking Minority Member of the Committee on Health, Education, Labor and Pensions Kennedy
Senator Clinton
Senator Edwards

Statement of the Coalition for Affordable and Reliable Health Care (CARH)
Joint Hearing on "Patient Access Crisis: The Role of Medical Litigation"
Before the Senate Committee on the Judiciary and the Committee on Health Education Labor and Pensions
February 11, 2003

It's an honor for me to submit testimony on behalf of the Coalition for Affordable and Reliable Health Care (CARH), an organization dedicated to working with Congress and the Administration to address the medical liability crisis currently undermining patient care in America. As chairman of the coalition, and also as Sr. Vice President and General Counsel of Baylor Health Care System in Dallas, Texas, I want to express my appreciation – and the gratitude of others – for the time and attention Congress is giving this critical issue.

The media and policy makers like to describe the current crisis you are evaluating as an "insurance" crisis, a "medical malpractice" crisis, a "trial lawyer crisis" or a "physician crisis". The truth is that each of these is a mischaracterization. The crisis is not about doctors, hospitals, lawyers, or insurance companies. The crisis is about the dramatic reduction in health care services available to individuals, especially those individuals in the most vulnerable condition: mothers and infants, those who need trauma care, and the elderly. It is a crisis that threatens their access to the finest hospitals and technology available. Their access is being threatened because it is hospitals, not insurance companies and not physicians, that pay the vast majority of the liability costs drained from the health care system and transferred to a relative few personal injury lawyers. Hospitals, not their excess insurance carriers, not the malpractice carriers of physicians, bear the greatest burden of the liability costs, which have caused this crisis. Hospitals pay these awards from reserves typically placed in self-insurance trusts and captive insurance companies (wholly owned corporations which are not designed to make a profit, but to provide a mechanism to access umbrella reinsurance). The amount of these reserves is set by actuaries, who take into account all relevant factors (other than a profit motive) including loss experience, average judgments reported in the area, the size and scope of services of the organization, and the organization's direct experience. Then auditors, applying stringent Generally Accepted Accounting Principles, typically seek to require the hospitals to increase those reserves, to be even more conservative.

Unfortunately, aggressive personal injury lawyers and juries without standards have put a strain on America's hospitals' ability to self insure or ability to obtain excess reinsurance. They have made it virtually impossible to price, with any level of confidence, insurance coverage for hospitals, physicians and nursing homes. This leaves communities without physicians, hospitals without the resources to employ nurses and purchase the latest technologies, and worst of all, leaves patients without access to health care.

Consider these facts, and the comparison of Baylor Health Care System's self-insurance funding requirements and excess reinsurance costs, with those of a hospital group in California. For fiscal year (FY) 2003, Baylor's self-insurance funding is $47 per patient

day. Baylor's total hospital liability cost is $61 per patient day, when we include the cost of reinsurance for claims in excess of $10 million per claim. In other words, Baylor must self-insure the first $10 million of every claim, and our actuaries and auditors require us to fund this potential liability in our self-insurance fund (a wholly owned captive insurance company). Baylor pays additional dollars ($14 per patient day) to commercial carriers for the excess reinsurance. Last year, only two companies out of all the companies we contacted in the US, Bermuda, London, Germany and Switzerland were even willing to offer this excess reinsurance coverage, and only if we assumed this first $10 million of exposure per claim.

Compare this trend and these per bed liability costs with those of a respected group of hospitals located in California. The total liability cost per patient day for these hospitals is approximately $35 per patient day, including both self-insurance and commercial reinsurance. These California hospitals can get reinsurance for claims in excess of $5 million, 50% less than Baylor. Like the physicians, who pay 70-90% less than their colleagues in Texas for medical liability costs, this data shows the dramatically lower costs paid by hospitals in California than hospitals in Texas. This is proof that California's civil justice system works to compensate fairly those injured and deserving, without bankrupting and eliminating access to health care.

Because of the exposure to large judgments and settlements common in Texas, commercial insurance carriers are unwilling to provide excess "umbrella" reinsurance to Baylor, unless Baylor assumes the first $10 million of liability in every case. The only stop loss coverage we could obtain this past year was set at $30 million, meaning Baylor must lose $30 million before a commercial carrier will fully insure claims in excess of that amount. We are told that we may not be able to retain that stop loss limit this year. This reflects the carriers' respective assumptions that Baylor's liability exposure on any given case is close to $10 million and that their total liability exposure for all cases in a given year is closer to $30 million.

What is causing the actuarial increase in self-insurance funding and the fear of the catastrophic carriers? The answer is very simple. The average judgment in Texas health care liability cases increased from $472,982 in 1989 to over $2.1 million in 1999, an increase of almost 450%. The average award for non-economic damages has grown from $318,000 in 1989 to over $1.4 million in 1999. Thus a staggering 66% of all health care liability awards in Texas are determined by juries with no standards provided to them and are more than 200% of the actual economic harm caused to the party.

Reported judgments and settlements paid by hospitals in Texas routinely exceed $10,000,000 and in 2002, a jury awarded over $269 million in one case. When an actuary looks at these trends and an insurance company considers the latest benchmark (in Dallas' unfortunate case, $269 million), their only hope of accuracy is to be extremely conservative and the risk of loss far exceeds any potential profit that can be attained by writing coverage in Texas.

Among the many findings in its report released on January 29, 2003, the Governor's Task Force found that the level of liability claims paid was the main cause of the increases in medical liability insurance rates. The Task Force ultimately concluded that "the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages."

Further, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress), which included a limitation on non-economic damages, asserts that:

> CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 4600 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law.

These are just a few examples of growing evidence that reveal that out-of-control jury awards are inexorably linked to the severe increases in medical liability insurance premiums. It is clear that corrective action through federal legislation is urgently needed.

Public Citizen and other trial lawyer supported groups claim that soaring medical liability insurance premiums are the result of declining investments in the insurance industry, and that liability reforms do not stabilize the insurance market. Beyond the reports discussed above, several authoritative and credible studies reveal Public Citizen's claims to be misleading, based on flawed analysis, and contrary to the facts.

The report on which Public Citizen bases most of its speculations, produced under the direction of J. Robert Hunter for the advocacy group Americans for Insurance Reform (AIR), is flawed in a number of ways. The AIR/Hunter study purports to prove that there is no current explosion in medical liability insurance payouts, and that the explosion in medical liability insurance premiums is due to the insurance underwriting cycle. While medical liability insurance premiums, medical liability award payouts, and tort law factors differ across states, the premium and payout data presented in AIR's report are at the national level. One cannot use national data to draw valid conclusions about how state-specific changes in premiums may be related to state-specific changes in payouts. Conclusions about what has or has not caused recent premium escalation without accounting for the state-level factors listed above are unsupportable.

Last month, Brown Brothers Harriman & Co. (BBH) released a report ("Did Investments Affect Medical Malpractice Premiums?") that analyzed the impact of insurers' asset allocation and investment income on the premiums they charge. BBH concluded that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of the U.S. economy,

demand. Baylor University Medical Center delivered more than 4,221 babies last year, many of them for mothers with "complications" who needed a perinatologist (a highly trained OB/GYN specialist). The one, and I repeat one, perinatologist at Baylor has provided all that care. Our clinical demand suggests we need at least two more. We have been searching for years, but the liability exposure with respect to complicated births, often times resulting from mothers who have had no pre-natal care, makes medical liability insurance coverage virtually out of reach for these specialists, especially when the physician has 21 years of exposure for liability for each delivery.

For Baylor, when you add the increase in liability costs for the physicians employed by an affiliate of the System and the increase in liability cost for the hospital operations, it exceeds a $20 million increase.

What could Baylor do with that $20 million?

Baylor can operate the largest neonatal intensive care unit in the Southwest, a unit that treated more than 1,000 neonates last year, over 50% of which were on Medicaid or had no insurance coverage at all. With that $20 million, Baylor could employ an additional 390 registered nurses per year. With that $20 million, Baylor could install and operate for a year, a computer physician order entry system across all 12 hospitals. With that $20 million, we could buy 9 PET scanners or 250 mammography units and decrease the wait times and increase access to these technologies that are so important to early detection of cancers.

How does Baylor continue its mission of providing care to all who seek access, regardless of their ability to pay? Baylor cannot raise our rates overnight on our Medicare patients, but those reimbursement levels will in future years reflect some portion of the $20 million increase this year, and the additional increase next year, and the next—unless the law is changed. Baylor thus has to increase rates on managed care members. We ran the calculations, and a 10% increase in our outpatient managed care rates results in about $20 million of additional reimbursement. That 10% increase goes straight to fund the increased self-insurance and reinsurance costs, and eventually ends up in the pocket of the personal injury lawyers and their high paid experts.
Where do we get the money to pay for new nurses or needed pay raises for the almost 15,000 caregivers we employ? Where do we get the money to pay for the latest pharmaceuticals and medical devices and drug eluding stints for our Medicare patients? Where do we get the money to pay for the increased cost of blood products? Where do we get the money to prepare for bio-terrorism? Where do we get the money to pay for new additional nurses and CPOE technology, both of which almost all agree are solutions that help improve patient safety and reduce medical errors? Where do we get the money to install electronic medical record technology, technology that can make a patient's entire medical history instantly available to a caregiver, but which is enormously expensive because of all of the security and encryption and hardware and training required? Where do we get the money to provide continuous training and quality

assurance programs? Where do we get the resources to provide another $120 million in uncompensated charity care this year?

One state solved this crisis 27 years ago. Individuals injured by medical negligence should be compensated once, fully, for their out of pocket economic injuries. But public policy should establish a value for pain and suffering, not citizens who are paid $10 per day for their compulsory service, who are provided no training, and who are provided only part of the facts and no objective guidance for determining these emotion packed awards. No one can honestly and in good faith dispute the fact that hospitals and physicians have a fraction of the liability cost in California that their counterparts have in Texas, Florida, Pennsylvania, New York, Arizona, West Virginia, Arkansas, New Jersey, Nevada, Mississippi, Alabama, and Georgia. Insurance companies must act within the boundaries of fair consumer practices, but they can't be forced to provide insurance at prices that won't cover their exposure.

In conclusion, Congress can adopt a proven solution. Congress can adopt a $250,000 cap on non-economic damages, and the other components of the California model of civil justice that has proven so successful.

Thank you.

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Statement for the Record of the Dartmouth-Hitchcock Medical Center

before the Health, Education, Labor, & Pensions Committee

of the United States Senate

Hearing on

Patient Access Crisis: The Role of Medical Litigation

February 11, 2003

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present a statement for the record on the impact of medical litigation on the delivery of health care services. I am John C. Collins, the Chief Executive Officer of Dartmouth-Hitchcock Clinic, Lebanon, New Hampshire. Dartmouth-Hitchcock Clinic, Mary Hitchcock Memorial Hospital, and Dartmouth Medical School are components of Dartmouth-Hitchcock Medical Center (DHMC), committed to patient care, teaching, and research. We serve a population of 1.5 million people across several states, in care sites ranging from the academic medical center campus in Lebanon, to small rural physician practices in Vermont and New Hampshire, to larger clinic sites in New Hampshire's major cities. These combined locations accounted for nearly 100,000 days of inpatient service, more than 1.4 million outpatient visits and over $10 million of charity care provided in 2001-2002.

With more than 5000 employees, DHMC is one of the largest employers in the region. Besides the 300 residents and fellows in DHMC's 34 graduate medical education programs and 300

medical students, the main campus also has more than 400 faculty physicians and over 1000 registered nurses. Mary Hitchcock Memorial Hospital is a member of the Dartmouth-Hitchcock Alliance (DHA), a group of health care organizations that includes tertiary care (MHMH), large and small community hospitals, a community mental health center, and a home health agency. The reasons for forming DHA were many, including improving the coordination of cost-effective, quality care for patients and controlling the cost of health care.

The Dartmouth-Hitchcock professional liability insurance program, which provides insurance, claims management, quality assurance, quality improvement, and loss prevention services to its covered institutions, has a long and successful history. In 1977, the DHMC institutions created what was at that time a unique self-insurance arrangement. Pooling their financial resources, they organized a single professional liability (medical malpractice) and comprehensive general liability insurance program to cover all medical center staff and employees (including physicians, nurses, allied health professionals, students, and volunteers), and foster cooperation among the insureds by encouraging quality improvement initiatives, loss prevention programs and the joint defense of claims. Since that time, the Dartmouth-Hitchcock self-insured program has continued to evolve to keep pace with changes in the malpractice litigation environment and to reflect the quality improvement and patient safety developments within the health care system.

The insurance program coordinates primary coverage, reinsurance through its captive subsidiary insurance company, and commercial excess insurance for catastrophic losses, which goes into effect only when the self-insured limits are exhausted. Insured providers play a pivotal role in both the prevention of liability exposure and the active defense of claims that are asserted.

Underlying the success of the program is a strong emphasis on risk management, which allows us to quickly identify and investigate adverse events, fairly compensate valid claims and firmly defend meritless claims or those involving unreasonable monetary demands. As the professional liability environment deteriorates, it will be challenging for Dartmouth-Hitchcock to continue to support its mission and simultaneously divert resources to fund its self-insurance program and purchase excess coverage.

FINANCIAL CONCERNS

Even with a strong financial foundation and prudent investment management, professional liability insurance programs such as DHMC's are facing difficult times in the insurance marketplace. For example, in the current insurance renewal year, total DHMC costs increased 49% over the prior year. This represents the actuarially determined funding for the risk retained by Dartmouth-Hitchcock, and the cost of the excess coverage itself. The excess premiums rose 70% at the same time the market required Dartmouth-Hitchcock to retain $4 million per claim...up from $2.5 million the prior year. Health care institutions and providers in New Hampshire and other parts of the country have seen their professional liability insurance premiums rise --- in some cases as much as 400% --- or had difficulty finding any coverage. The upcoming renewal cycle is not expected to show any improvement in availability or in the stabilization of costs. Recent indications from brokers in London and domestically are that the "hard" market will be with us for the foreseeable future and that professional liability insurance pricing will continue to rise at unacceptable and unsustainable levels.

This situation is not merely a reflection of insurance company investment practices and the stock market, as professional liability insurers face tight controls on what type of investments they may utilize. Professional liability insurers take in premiums to cover anticipated losses that may occur in the future. Claims that come in have money allocated to them based on projections of what a jury might award in a certain type of case and what the case may cost to defend over a period of time. This information goes into the process used by actuaries and others responsible for determining premiums, and financial auditors. A large jury award in a breast cancer case, for example, can influence both the number of new claims that may be filed in the future, as well as the amounts required to be allocated to them. Claims filed maintain an allocation for the costs of resolving the case until they are closed, which can take several years. When DHMC compared the five years from October 1997 to October 2002, the average amount paid per claim had increased 91%. This is reflective of an increased volume of cases needing investigation and defense to resolve, although most of these do not end up before a jury.

RECRUITMENT AND RETENTION CONCERNS

In addition to the monetary consequences of the current professional liability insurance climate, patient care services are likely to suffer as recruitment and retention of staff becomes more difficult. The potential for some hospitals to curtail services due to an inability to recruit physicians and other health care providers to a particular geographic area is real. And, with more health care dollars being required to cover professional liability insurance premiums, spending for improvements in institutional systems and technology that would promote increased patient safety may be postponed. This is likely to produce a cycle of more adverse events in patient care, with a continued influx of liability claims, and an ongoing escalation of professional

liability costs. Individuals enter the health care field because they want to contribute to saving lives and to improve the health status of the people they serve. If we do not remedy the current situation, capable individuals will take their talents to other fields – to the detriment of all who will need health care in the future.

We appreciate the opportunity to offer testimony on the impact of medical litigation on the delivery of health care services. We look forward to working with members of the committee to help address this important issue.

Statement of

Rodney C. Lester, CRNA, PhD
President of the American Association of Nurse Anesthetists (AANA)

to the

Senate Health, Education, Labor and Pensions Committee
&
Senate Judiciary Committee

on

Roles of Litigation in Patient Access to Care

February 11, 2003

Chairman Gregg, Chairman Hatch, Senator Kennedy, and Senator Leahy, I am Rodney C. Lester, CRNA, PhD, President of the American Association of Nurse Anesthetists (AANA). I appreciate the opportunity to submit for the record a statement on issues surrounding medical liability reform, which are the most challenging facing healthcare today.

For those of you who may be unfamiliar with the AANA, we represent approximately 30,000 Certified Registered Nurse Anesthetists (CRNAs) across the United States. In the administration of anesthesia, CRNAs perform virtually the same functions as anesthesiologists and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations' facilities, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer approximately 65% of the anesthetics given to patients each year in the United States. CRNAs are the sole anesthesia provider in at least 65% of rural hospitals which translates into anesthesia services for millions of rural Americans.

CRNAs have been a part of every type of surgical team since the advent of anesthesia in the 1800s. Until the 1920s, nurses almost exclusively administered anesthesia. In addition, nurse anesthetists have been the principal anesthesia provider in combat areas in every war the United States has been engaged in since World War I. CRNAs provide anesthesia services in the medical facilities of the Department of Defense, the Public Health Service, the Indian Health Service, the Department of Veterans Affairs, and countless other public and private entities. Given the current state of affairs with Iraq and Afghanistan, it is not surprising that our deployed forces depend greatly upon the services and skills of CRNAs.

You may be aware of the widely publicized nursing shortage. While we do not have enough rank and file nurses there is an increasingly acute shortage of CRNAs. Quite simply, there are not enough CRNAs to fulfill the demand. Our NewsBulletin tends to be chock full of advertisements for vacant positions. Quite simply if the rest of the economy was similar to the employment situation for CRNAs, our nation would be at full employment.

Hardly a day goes by for most anesthesia practices when a CRNA is not called by an employment recruiter attempting to entice them into seeking additional pay at another group or hospital. Practices are offering bonuses, attractive benefits, and higher pay in order to recruit CRNAs.

We graduate approximately 1,000 students per year and it is not enough to fill the demand. Our Foundation has recently funded a manpower shortage study and its results are expected shortly.

How are CRNAs different from anesthesiologists?

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists receive medical education while CRNAs receive a nursing education. However, the anesthesia part of the education is very similar for both providers, and both professionals are educated to perform the same clinical anesthesia services. CRNAs and anesthesiologists are both educated to use the same anesthesia processes and techniques in the provision of anesthesia and related services. The practice of anesthesia is a recognized specialty within both the nursing and medical professions. Both CRNAs and anesthesiologists administer anesthesia for all types of surgical procedures, from the simplest to the most complex, either as single providers or in a "care team setting".

What is our experience on malpractice insurance?

For the past several years, CRNAs have relied largely on two main major malpractice carriers – St. Paul and TIG. On December 12, 2001, AANA

Insurance Services – a wholly owned subsidiary of the AANA -- was notified by the St. Paul Companies that it would exit this market and would seek to sell their malpractice book and eventually transition out of the medical malpractice market. We were advised that this difficult decision was based upon "its anticipated worst annual loss in its 148-year old history." The St. Paul further stated that the decision is part of an overall plan "that will put St. Paul on sound financial footing so that they can continue serving their thousands of customers in their other businesses." Their news release goes into more detail concerning losses relative to its losses in malpractice, other insurance lines and those associated with the September 11 terrorist attack.

AANA Insurance Services worked to prepare and assist its policyholders in this transition period and kept them informed of developments relative to their continuing insurance coverage.

The AANA and AANA Insurance Services Staff prepared strategies to respond to this situation proactively to assure a smooth transition for our members insured through St. Paul. We contacted our other carrier at the time, TIG Insurance, to seek support from them assessed other potential medical malpractice carriers to assure that our members have more than one choice for professional liability insurance as we have in the past.

While we were aware that St Paul Companies were experiencing difficulties along with the rest of the insurance industry, we – along with many other providers and perhaps the general public – were surprised by the sudden decision to withdraw completely from the medical malpractice market. St Paul stated that they would do everything possible to make the transition smooth. We had an excellent relationship with the St. Paul and this transition continues.

Following this announcement, we worked even closer with TIG Insurance Company to ensure a smooth transition for the policyholders of AANA Insurance Services. A few months ago, TIG Insurance Company announced it would no longer be providing medical malpractice insurance. Coverage for CRNAs through TIG will not be available after June 30, 2003. TIG's announcement comes almost exactly a year after St. Paul's announcement that it was withdrawing from the medical malpractice marketplace.

On Monday, December 16, 2002, Fairfax Financial Holdings Limited announced that it would be restructuring TIG. Fairfax, the parent company of TIG, is a financial services holding company which, through its subsidiaries, is engaged in property, casualty and life insurance, reinsurance, investment management and insurance claims management.

As part of the restructuring, TIG indicated that it will be discontinuing its program business. Program business, a specialty of TIG's that represents a majority of its business, is defined as insuring large groups of insureds with very similar

characteristics. According to Fairfax, TIG's program business was not meeting Fairfax's financial expectations. Unfortunately, all of TIG's medical malpractice business, including the coverage it provides to CRNAs, falls into this program business category.

It should be noted that medical malpractice only accounted for 25% of TIG's program business and TIG's CRNA program was only a small part of the medical malpractice business. AANA has been informed by Fairfax representatives that the decision to restructure TIG was based neither on the performance of its medical malpractice business in general or its CRNA business in particular.

It is no secret that the number of insurance companies willing to offer medical malpractice coverage has shrunk dramatically over the past few years. Although it's of little consolation, there are many classes of healthcare providers who are facing even greater insurance challenges than CRNAs. While TIG's decision is disappointing, it is not surprising considering the current medical malpractice environment.

Unlike when St. Paul exited from the medical malpractice marketplace, TIG's withdrawal won't be as immediate. TIG will continue to offer both new and renewal policies to AANA members through June 30, 2003. After June 30, 2003, TIG will not provide coverage to new applicants.

Currently AANA Insurance Services provides coverage for members through CNA Insurance Company. It is our understanding that CNA has been approved to do business in 43 states and the District of Columbia. CNA is awaiting approval in the states of Alaska, Nebraska, Nevada, New Hampshire, New York, Vermont and Washington. AANA Insurance Services expects CNA to have approval in all these states by June 30, 2003.

Obviously this has become extremely troubling to our members. While we have an excellent relationship with CNA Insurance Company, CRNAs are increasing concerned that with only one major medical malpractice carrier remaining, issues of coverage could become problematic. It should be noted that unless a CRNA had a particular issue with claims or licensure, coverage could easily be found, whether it was with St. Paul or TIG. That remains relatively true today with the CNA Insurance Company. But with more carriers leaving the marketplace, what does that do to providers? More importantly, what does it mean to patients and consumers? How do we attract more carriers to this market? Without major reforms, will carriers have any reason to go into the market?

Patient Safety

Given the strong safety record of CRNAs, we had no reason to believe then, nor do we now, that there was any nexus between the decision of either St. Paul or TIG to exit the medical malpractice market due to bad claims from CRNAs.

America's CRNAs are committed to advancing patient safety so that actual instances of malpractice are reduced. These commitments including active membership in the cross-disciplinary National Quality Forum (NQF) and the National Patient Safety Foundation (NPSF), closed-claims research that transforms tough cases into educational and practice improvements, and the most stringent continuing education and recertification requirements in the field of anesthesia care. With CRNAs providing two-thirds of all U.S. anesthetics, the Institute of Medicine reported in 1999 that anesthesia is 50 times safer today than 20 years ago.

Our Dilemma

Educational programs that prepare nurse anesthetists rely solely on hospitals, surgery centers and even office based surgical practices to provide students with the required clinical experiences to enable them to become competent anesthesia providers. These healthcare facilities rely on surgeons and other high-risk specialties for their patient admissions. As these high-risk specialties leave, operating rooms close and patients have less access to needed care, and students have less access to patients for clinical training.

Looking at Pennsylvania as an example, the hospitals and surgeons who are part of a healthcare system located in Southeast Pennsylvania have seen their primary premiums increase more than 60 %, their CAT fund increase more than 30%, and their excess premiums increase more than 600%, all within the last year.

The Medical Professional Liability Catastrophe Loss Fund (commonly referred to as the CAT Fund) was established to ensure that victims of medical malpractice are compensated and that medical malpractice insurance is available to health care providers. Health care providers (physicians, surgeons, podiatrists, hospitals and nursing homes) are required to carry a set minimum amount of primary coverage. The health care providers then must pay a surcharge to the CAT Fund in order to fund a layer of insurance above the primary insurance coverage. Failure to comply with this requirement may result in revocation of one's license.

This is reflective of what other healthcare systems in Pennsylvania are experiencing. In addition that system has seen its high-risk specialty physicians relocate out of Pennsylvania or give up the surgical part of their practice. Each time a physician closes his/her office or reduces practice, employees of their practice lose their job. Fewer high-risk specialists mean fewer cases requiring anesthesia are performed. These are exactly the specialties that nurse anesthesia educational programs rely on to provide their students with the required clinical cases.

As surgeons leave the state or reduce surgery because they can not afford the malpractice insurance there are fewer surgical cases, operating rooms are closed, daily operating room schedules are prolonged, overtime costs increase, hospitals' earn less money, layoffs occur and hospitals close. This directly affects patients' access to needed and timely care, and the ability of our educational programs to provide the necessary clinical experiences to educate nurse anesthetists. If this trend continues unabated, nurse anesthesia educational programs (and other healthcare educational programs) will face accreditation issues, declines in student enrollment and delays in graduation as they struggle to find enough clinical experiences for their students. All of this occurring during a time when there is a critical shortage of anesthesia providers nationwide to provide care to an older and sicker population.

The medical malpractice crisis affects all levels of society. Unlimited individual awards for pain and suffering will severely limit the availability and access to care for the majority. The value we place on timely and complete access to care for all our citizens is reflected in our allowance of an individual's unlimited right to take precedence over the needs of all our people. To insure a healthy society, we must insure access to health care even if it means we place limits on a single category of damages to the individual.

If carriers continue to leave the market and if there should be in difficulty obtaining coverage, it could ultimately mean a slow down for hospitals in providing surgeries. In addition, when CRNAs are employed by hospitals or group practices, these entities have to pick up the tab. If increasing rates continue to become an issue, hospitals will increasingly have to make difficult choices. In those rural hospitals where CRNAs are the sole anesthesia provider, hospitals have no choice if they wish to keep their doors open.

That is why the AANA supports medical liability reform. Many can point an accusatory finger as to why carriers exit the market. However, it makes no sense for an insurer to remain in a market if it cannot do so profitably. High costs and runaway juries and large malpractice awards have become unrealistic and disproportionately high. This is not to say that providers, be they nurses or physicians, should not be held responsible for their actions. All providers must take responsibility. And those providers who may be disproportionately responsible for rate hikes because they have had more than one claim must increasingly take responsibility for their actions as do the nursing and medical boards regulating providers. But by the same token, awards have become too high and many insurers have decided that with the unpredictability of determining how to insure a risk that is seems to be increasingly incalculable, they simply exit the market.

In the last Congress, the AANA was pleased to support Rep. Jim Greenwood's (R-PA) legislation, H.R. 4600. The HEALTH Act would permit individuals to recover unlimited economic damages and allow for non-economic damages or

"pain and suffering" up to $250,000. The states would have the flexibility to establish or maintain their own laws on damage awards. Other provisions in the HEALTH Act address the percentage of damage awards and settlements that go to injured patients as well as allocate damage awards fairly and in proportion to a party's degree of fault and works to decrease the time it takes for a case to settle or go to trial. Similar legislation will be considered in the 108th Congress.

Ultimately, it will be incumbent upon insurers, providers, and yes the trial lawyers to work together to find a common solution that works for consumers and patients.

Thank you for the opportunity to share our views on medical liability reform.

Statement of the
American Health Care Association
National Center for Assisted Living

Before a
Joint Hearing of the
Senate Judiciary and Senate Health, Education,
Labor and Pension Committees

Tuesday, February 11, 2003 2:30 p.m.

Hearing Titled:

Patient Access Crisis: The Role of Medical Litigation

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 that patient access to quality long-term care is safeguarded, and we consider the enactment of comprehensive health care liability reform a crucial step towards ensuring care of the vulnerable elderly and disabled is protected.

With this goal in mind, AHCA and NCAL ask that you support the following measures:

- *Straightforward, fair and comprehensive limits on medical liability awards that fully cover "alternative" state laws exploited by some to bring standard medical negligence cases against nursing homes.* Comprehensive protections are essential to restoring a degree of predictability and fairness to the civil justice system that will serve both patients' and caregivers' best interests.
- *Stop the misuse of publicly released quality data to create liability in the tort system.* Long term care has been a leader in developing and releasing benchmark "quality measures" that help consumers make informed choices about where to seek care and also improve the overall public health. This valuable data should not be admissible in court unless the plaintiff can prove the data is directly related to the negligent act they are alleging.
- *Require a reasonable burden of proof for punitive damages.* AHCA and NCAL take a hard line against poor nursing and assisted living facility care and believe such medical care should not be tolerated. Punitive damages should be reserved for egregious cases where it is proven that the medical defendant intended to injure the claimant for a reason unrelated to the provision of medical care.
- *Limit plaintiffs' attorneys' contingency fees in health care actions.* Attorneys, rather than their injured clients, currently receive the lion's share of awards in health care liability cases. In long term care, nearly all of these dollars are being siphoned directly out of the publicly funded Medicare and Medicaid programs. Almost half (47%) of total long term care claims costs go to plaintiff and defense attorneys' fees – and plaintiffs' attorneys claim approximately three out of every four of those

dollars. We urge the Senate to consider reasonable limits on the size of the contingency fee attorneys can charge in health care liability actions.

- *In the House, AHCA and NCAL have endorsed The Help Efficient, Accessible, Low Cost, Timely Health Care Act (The HEALTH Act) of 2003*. This bipartisan legislation incorporates many of the balanced policies outlined above. We look forward to working with the Senate to introduce and pass similar common sense medical liability reforms.

The Problem

While excessive litigation poses a problem for all health care providers, the liability crisis faced by long term care facilities is particularly acute. While some homes have engaged in improper conduct and deserve sanctions, the long term care profession as a whole has been faced with dramatic and unprecedented increases in liability insurance premiums due to a growing number of lawsuits that result in huge settlements and unwarranted jury awards.

Driving many of these lawsuits is the misuse of both state and federal safety compliance regulations and also state patients' rights laws as standards of medical care. State legislatures never intended these laws to replace medical liability tort law, but they have been used with increasing frequency by the plaintiff's bar to bring standard medical malpractice claims against nursing homes.

Forty-two states now have such laws on the books, of which 18 establish a separate cause of action exclusively against nursing homes based on patient protection laws, elder abuse laws, breach of contract, and negligent hiring and supervision. In these states, courts have found these allegations to be separate and independent from medical malpractice claims, and thus the long-term care provider is not protected from excessive verdicts by the standard liability controls offered health care providers in state medical malpractice statutes. For example, claims brought under these statutes may be decided without regard to what the professional standard of care is and whether the provider met that standard.

It is essential that the scope of a Senate bill on health care liability reform encompass these "alternative" causes of action to allow our legal system to return to an objective analysis of the risks and liabilities of providers, insurers, and consumers in a medical environment. Piecemeal reforms would only shift the blame away from doctors toward non-physician medical defendants, further inflating the number of cases filed against nursing home providers and exacerbating the access and availability problem.

Annual premium increases – the average U.S. nursing home paid $240,352 more in premium in 2001 compared to 2000 – have forced nursing facilities in large areas of the country to go without insurance coverage at all. Fifty-five percent of Texas nursing facilities are operating without liability insurance, according to the Texas Department of Human Services. In some states, coverage isn't available for any price. Last month, the Arkansas State Insurance Department announced that there is currently not a single insurer in the state that is writing new liability policies for Arkansas nursing homes. This is not a tolerable state of affairs from the standpoint of patients or caregivers.

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 seniors. 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.

The AON Report

New research by AON Risk Consultants, Inc. shows that national trends in General Liability and Professional Liability (GL/PL) losses for long term care 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 nursing home 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.

AHCA and NCAL again commend Chairman Hatch and Chairman Gregg and both the Judiciary and HELP committees for examining this issue and its impact on the frail elderly and the disabled who rely on long-term care.

United States Senate

WASHINGTON, DC 20510

February 26, 2003

The Honorable José Montemayor
Commissioner of Insurance
P.O. Box 149104
Austin, TX 78714-9104

Dear Commissioner Montemayor:

Thank you for testifying before the Senate Committee on Health, Education, Labor and Pensions and the Senate Committee on the Judiciary on the February 11th hearing entitled, "Patient Access Crisis: The Role of Medical Litigation." We appreciate you taking the time out of your schedule to share your thoughts with us.

We are pleased to have your input on the various issues regarding this important health policy matter. Your comments and suggestions will assist us in addressing these serious patient access challenges in the months ahead.

We have attached a series of follow-up questions that we would like to include in the record along with your responses. We would appreciate receiving your written responses by March 5th. Please e-mail your responses to Rebecca Seidel (Rebecca_Seidel@judiciary.senate.gov) and Kim Monk (Kim_Monk@labor.senate.gov).

Again, we were honored to have the opportunity to discuss these matters with you. We look forward to receiving your responses to the attached questions.

Sincerely,

Orrin G. Hatch
United States Senator

Judd Gregg
United States Senator

Attachment
cc: Edward M. Kennedy, USS
Patrick J. Leahy, USS

Commissioner Montemayor

1. There was much discussion at the hearing about whether Proposition 103 actually had any impact in California. Regardless of whether Prop. 103 actually had any effect California, can you please comment on whether a mandatory, across-the-board rate rollback in every state would solve the current medical malpractice crisis, especially in light of the NAIC's concern that current rates may inadequate? How would such a rollback impact the availability of carriers in the Texas market?

2. Senator Kennedy cited data from the Texas Department of Insurance from August 15, 2002, to support the assertion that "the net investment income is way down for medical malpractice insurance," and that there had been "a decline of $120 million," implying that this was a significant loss and is the driving factor in the current medical liability crisis. Is it not the case, however, that this data in fact indicates that insurance companies are still realizing a profit from investment income and consequently other factors have created the current crisis? Specifically, as I understand it, investment income was $1.347 billion in 1997, and in 2000 it was still $1.228 billion. Thus, the insurance industry did not suffer a loss of $120 million between 1997 and 2000, but it in fact realized a profit of $1.228 billion in 2000, it is just that this profit was not as large as it had been in prior years, is this not correct? Is it not also the case that the reason the insurance industry has had to raise rates, notwithstanding the positive revenue it has realized from investment income, is because the losses it has suffered from increased litigation costs have far outpaced the positive investment income the insurance industry has realized?

3. There seemed to be some confusion at the hearing about the degree to which declining investment returns and interest rates may have contributed to he current crisis. Can you please clarify what factors your state allows insurance companies to use in setting their rates? Specifically, do you allow insurance companies to set rates to recoup past investment losses or declining returns? If not, what tools do you, as an insurance commissioner, have at your disposal to evaluate proposed rates and take action if you feel they are inappropriate? For instance, does your department employ actuaries to review rates? Are the rate-setting rules and practices in Texas similar to other states?

4. Senator Edwards said he is opposed to caps on damages but would support policies that address frivolous litigation. Based on your experience in Texas, would legislation that addresses the frequency of claims but not the severity sufficiently address the current problem?

5. For purposes of medical liability insurance, could a state like Wyoming take action to join the insurance pool of another state with a more reasonable medical litigation system such as California? If so, what actions would have to be taken? If not, what state or federal laws or regulations would stand in the way?

Commissioner Montemayor, continued

6. As a state insurance commissioner, do you believe legislation that says medical malpractice insurers are subject to federal antitrust regulations prohibiting price fixing, bid rigging, and market allocation, as Senators Leahy and Kennedy are proposing, have any impact on the current crisis? Are you aware of any price fixing or illegal anti-competitive behavior that is currently taking place currently in your state? In general, do states have the necessary tools to regulate insurance practices that may be anti-competitive?

7. Mr. Angoff suggested that modifying the existing McCarran-Ferguson antitrust exemption is necessary to prevent medical malpractice insurers from relying on rate recommendations from insurance services offices (ISOs) whose "rate-recommending function" enables insurers to engage in price-fixing and other illegal, anti-competitive behavior. Do ISOs make specific rate recommendations? If not, what impact, if any, would this fact have Mr. Angoff's suggestion that insurers to, as he claims, engage in price fixing and such behavior is facilitated by ISOs?

Texas Department of Insurance
Commissioner of Insurance, Mail Code 113-1C
333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-463-6464 telephone • 512-475-2005 fax • www.tdi.state.tx.us

Jose Montemayor

March 5, 2003

The Honorable Orrin G. Hatch
United States Senator
United States Senate
Washington, DC 20510

The Honorable Judd Gregg
United States Senator
United States Senate
Washington, DC 20510

Dear Senator Hatch and Senator Gregg:

Thank you for your letter of February 26, 2003, and allowing me the opportunity to answer your follow-up questions as they relate to my testimony on February 11, 2003, at the hearing entitled "Patient Access Crisis: The Role of medical Litigation."

1. In my opinion, a mandatory, across-the-board rate rollback in every state would not solve the current medical malpractice crisis if the underlying cause of the problem in these states is the same as Texas'. A rate rollback by itself may bring rates down in states where writing medical malpractice insurance is an excessively profitable business. In the case of Texas, medical malpractice has not been profitable. As I've mentioned in my testimony, I believe that the medical malpractice crisis in Texas is primarily driven by deteriorating loss experience. A mandatory rate rollback in this case absent any other changes, such as those that would reduce insurance losses, would make insurers even more unprofitable. It is hard to think that any insurer would want to do business in such an environment.

2. Insurance companies are still realizing a profit from investment income, even after considering realized and unrealized capital gains / losses. The $1.228B billion for 2000 you cited is the net investment income. It only considers dividends, real estate, and interest income (from bonds, cash, etc.). It would not include realized or unrealized capital gains / losses, that is, losses (or gains) due to a drop (or gain) in the value of their stock and bond portfolios. Even taking into account investment losses due to changes in the value of their stock and bond portfolios, companies still realized a net investment profit of $1.167 billion in the year 2000 ($1.228B investment income + $380M realized capital gains - $441M unrealized capital losses). In summary, yes it is true that the total investment gain just wasn't as large as it has been in previous years. While the drop in investment income contributes to the problem in that it's a reduction of income, we believe the most significant driving factor for increases in rates is increased claim costs.

3. Companies can consider the following items when setting their rates in Texas: past and prospective loss and expense experience, a reasonable margin for profit and contingencies, investment income, and dividends to policyholders or members (Texas Insurance Code Article 5.15-1). In the context of insurance, "loss" refers to claim costs and "expense" refers to items such as operating expenses, commissions to agents, and premium taxes. We do not allow companies to set rates to recoup past investment losses. The rate setting process is prospective in nature, that is to say, rates are set to cover expected future payments / expenses and expected future investment returns. In general, expected future payments are determined by examining past experience and trying to project that into the future. Specifically, with regard to investment returns, expected future investment income (interest, dividends and real estate income) is usually based on a short-term (3-5 years) average of past investment income returns. Expected future capital gains (realized and unrealized) is usually based on a longer term average (10 to 15 years) due to its volatility from year to year. The bottom section of Table A11 of my testimony shows how these combined averages have changed from 1998 to 2000. In 1998, the total yield was 7.0%; in 2000 the total yield was 6.8%.

4. Based on a recent study we've done, in Texas, over 85% of claims are closed with no indemnity payments. In all likelihood, to the extent there are frivolous claims, many if not all would be found in this group. In my opinion, focusing on the frivolous claim issue as well as other loss control mechanisms would address the current problem in Texas.

5. I believe most state insurance pools are creations of the state legislatures. Therefore, I assume that any change to allow for pooling among states could be made by changing state laws. From a policy standpoint, however, it would be unlikely for any state that has a relatively stable medical litigation system to want to join with another where the tort system is significantly different and perhaps more volatile and would lead to higher insurance losses. This would in effect cause the insureds in the former to subsidize the rates of latter.

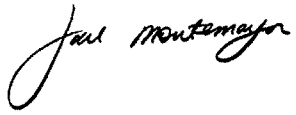
6. As mentioned earlier, I believe the problem in Texas is driven largely by loss experience. In addition, medical malpractice has historically been an unprofitable line in Texas for insurers. I do not see how subjecting medical malpractice to federal antitrust regulations would have an impact on the situation in my state. I am not aware of any price fixing or illegal anti-competitive behavior that is currently taking place in Texas. In fact, the Texas Insurance Code contains a provision, Article 21.21 Unfair Competition and Unfair Practices that gives me the necessary tools to regulate practices that may be anti-competitive. I suspect that most states would have similar law.

7. In Texas, ISO files an advisory loss costs filing, which provides the combined loss experience of several companies. Some insurers use these loss costs – but not an actual ISO rate - as a basis to set their own rates by factoring their individual expense needs. As far as we know, most rate-regulated medical malpractice insurers writing in Texas do not rely on ISO's loss costs to develop their rates. Thus, for this state, I

would not put a lot of weight on the assertion that insurers are engaging in price fixing and that such behavior is facilitated by ISO.

I am at your pleasure should you wish to discuss this further.

Sincerely,



José Montemayor, CPA
Commissioner of Insurance

xc: The Honorable Edward M. Kennedy, USS
The Honorable Patrick J. Leahy, USS

United States Senate

WASHINGTON, DC 20510

February 26, 2003

Mr. Jay Angoff, Esq.
Of Counsel, Roger G. Brown and Associates
216 East McCarty Street
Jefferson City, MO 65101

Dear Mr. Angoff:

Thank you for testifying before the Senate Committee on Health, Education, Labor and Pensions and the Senate Committee on the Judiciary on the February 11th hearing entitled, "Patient Access Crisis: The Role of Medical Litigation." We appreciate you taking the time out of your schedule to share your thoughts with us.

We are pleased to have your input on the various issues regarding this important health policy matter. Your comments and suggestions will assist us in addressing these serious patient access challenges in the months ahead.

We have attached a series of follow-up questions that we would like to include in the record along with your responses. We would appreciate receiving your written responses by March 5th. Please e-mail your responses to Rebecca Seidel (Rebecca_Seidel@judiciary.senate.gov) and Kim Monk (Kim_Monk@labor.senate.gov).

Again, we were honored to have the opportunity to discuss these matters with you. We look forward to receiving your responses to the attached questions.

Sincerely,

Orrin G. Hatch
United States Senator

Judd Gregg
United States Senator

Attachment
cc: Edward M. Kennedy, USS
Patrick J. Leahy, USS

Answers by Jay Angoff to February 26, 2003 follow-up questions from Senator Hatch and Senator Gregg

#1.

Q: In your testimony, you spoke extensively of Missouri's experience with medical malpractice insurance and tort reform. Was your testimony before the committees on behalf of the state of Missouri, or does Missouri's current insurance commissioner, Scott Lakin, endorse your testimony?

A: My testimony was not on behalf of the state of Missouri: I am a lawyer in private practice. I do not know whether Missouri's current insurance commissioner endorses my testimony.

#2.

Q: It was clear from your testimony you have extensive knowledge of Proposition 103 in California. Were you involved in that effort in any way? If so, please explain your role.

A: I was involved in the effort to pass Prop 103: I helped draft Prop 103, and I helped in the campaign to enact Prop 103.

#3.

Q: You are recommending that Congress repeal the limited antitrust exemption for insurers. You suggest in your written testimony, and I quote, that "the extent to which insurers today are acting in concert to raise prices has not yet been determined." I take this to mean that you believe medical liability insurers are in fact colluding to raise prices. What current evidence do you have that such behavior is taking place?

A: I am presently evaluating several cases involving allegations of collusion among insurers during the current crisis. Unfortunately, there is a history of collusion among insurers–both medical malpractice insurers and other insurers–during previous insurance crises. See, e.g., St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531 (1978) (agreement among St. Paul and three other malpractice insurers not to write medical malpractice insurance for doctors insured by St. Paul); Hartford Fire Ins. Co. v. California, 509 U.S. 764 (1993) (agreement among insurers and reinsurers to refuse to do business using the traditional "occurrence" commercial general liability policy). See also U.S. v. South-Eastern Underwriters Assn., 322 U.S. 533 (1944) (agreement by insurers not to deal with customers or agents of competitors who refused to join price-fixing conspiracy).

#4A.

Q: You have suggested that modifying the existing McCarran-Ferguson antitrust exemption is necessary to prevent medical malpractice insurers from relying on rate recommendations from insurance services offices (ISOs) whose "rate-recommending function" enables insurers to engage in price-fixing and other illegal, anti-competitive behavior. Are you aware that ISOs do not make specific rate recommendations and haven't done so for the past 10 years? Thus, what impact, if any, would this fact have on your suggestion that insurers engage in price-fixing and such behavior is faciliated by ISOs?

A: I am aware that ISO has not recommended final rates in many lines for the past 10 years. Instead, ISO has recommended "prospective loss costs," which is the final rate minus the ISO-recommended expense factor. Agreement on prospective loss costs--which is ISO's projection of what it expects ultimate actual loss costs to be--is just as anti-competitive as is agreement on final rates. As the Supreme Court has stated, "genuine competitors...do not submit the details of their business to the analysis of an expert, jointly employed, and obtain from him a 'harmonized' estimate of the market as it is and as, in his specially and confidentially informed judgment, it promises to be be." American Column & Lumber Co. v. United States, 257 U.S. 377, 410 (1921).

4B.

Q. Would you provide specific examples of instances where you believe medical malpractice insurers engaged in price-fixing which was faciliated by ISO?

A. Yes. Any time two or more insurers raise their rates by substantially the same amount recommended by ISO, it is fair to say that the ISO recommendation may have faciliated such increases.

5.

Q. In your testimony you reference, but do not provide the citation, for a case where 19 attorneys general challenged insurance companies for engaging in "certain insurer activity." You seem to imply that the activity was anti-competitive behavior in the medical malpractice arena. However, our understanding is this case was not related to medical malpractice insurance, but rather dealt with environmental coverage issues and the Supreme Court rejected the allegation of an illegal boycott. Can you please clarify this and provide a citation if you are referring to another case?

A. The case to which I was referring, which I apologize for not having cited, is Hartford Fire Ins. Co. v. California, 509 U.S. 764 (1993). It dealt with allegations that reinsurers and insurers had collectively refused to do business using the traditional "occurrence" commercial general liability form and had thereby agreed to restrict coverage. The Supreme Court did not

reject the allegation of an illegal boycott. To the contrary, the Supreme Court unanimously held that the allegations in the complaint could be construed as an illegal boycott. Justice Scalia and Justice Souter disagreed as to the breadth of the boycott exception to McCarran--Justice Scalia, writing for himself and four other members of the Court, construed it much more narrowly than did Justice Souter, writing for the remainder of the Court–but both opinions agreed that the attorneys-general had alleged illegal boycotts.

United States Senate

WASHINGTON, DC 20510

February 26, 2003

Mr. Lawrence E. Smarr
Physician Insurers Association of America
2275 Research Boulevard
Suite 250
Rockville, MD 20850

Dear Mr. Smarr:

Thank you for testifying before the Senate Committee on Health, Education, Labor and Pensions and the Senate Committee on the Judiciary on the February 11th hearing entitled, "Patient Access Crisis: The Role of Medical Litigation." We appreciate you taking the time out of your schedule to share your thoughts with us.

We are pleased to have your input on the various issues regarding this important health policy matter. Your comments and suggestions will assist us in addressing these serious patient access challenges in the months ahead.

We have attached a series of follow-up questions that we would like to include in the record along with your responses. We would appreciate receiving your written responses by March 5th. Please e-mail your responses to Rebecca Seidel (Rebecca_Seidel@judiciary.senate.gov) and Kim Monk (Kim_Monk@labor.senate.gov).

Again, we were honored to have the opportunity to discuss these matters with you. We look forward to receiving your responses to the attached questions.

Sincerely,

Orrin G. Hatch
United States Senator

Judd Gregg
United States Senator

Attachment
cc: Edward M. Kennedy, USS
Patrick J. Leahy, USS

Physician Insurers Association of America
2275 Research Blvd., Suite 250, Rockville, MD 20850
Telephone (301) 947-9000 • Fax (301) 947-9090

March 13, 2003

Honorable Orrin G. Hatch and Honorable Judd Gregg
United States Senate
Washington, DC 20510

Dear Senator Hatch and Senator Gregg:

Thank you for providing the PIAA the opportunity to testify at the February 11, 2003 joint hearing of the Senate Judiciary and HELP Committees. We are very pleased that the Senate is considering the issue of adopting federal health care liability reform, and are willing to support your efforts to enact effective legislation in any way we can.

In your February 26, 2003 letter, you present several follow-up questions and request our answers for inclusion in the record. We are pleased to respond to each of the 8 questions, as follows:

Question 1: Can you please describe how insurers generally establish the bounds of their risk pools with respect to geography and risk/specialty. For instance, in a particular state, are premiums based on claims losses for providers in just one state? Do multi-state carriers establish multi-state pools? Also, are different specialities groups pooled together?

Answer: In general, insurers evaluate the loss experience of their risks by geographic territories and groupings of similar risks. For medical malpractice insurers, the largest geographic territory can be expected to be a state, and for most insurers, counties within a state showing similar loss characteristics are grouped into territories. Malpractice premiums would be based on the loss experience in each geographic territory. Multi-state carriers are required by each state to submit rates (for providers in that state) based on the loss experience and risk in that state.

Physician risks are also grouped into risk classifications comprised of medical specialties having similar loss characteristics. Thus, a typical carrier within a state may have apportioned that state's counties into several rating territories and the various types of medical specialists into as many as eight or nine rating classifications.

Question 2A: Please explain the effects of California's Medical Injury Compensation

Reform Act (MICRA) and Proposition 103 on medical liability insurance premiums in California as compared to the remainder of the United States, between 1975 and 2003.
(A time line showing differences in premiums and the timing of legislation enactment, Supreme Court action etc. would be helpful)

Answer: The California domiciled insurance company members of the PIAA firmly believe that MICRA (effective in 1976) has had a major and demonstrable effect on medical liability insurance premiums charged in California. The effect is shown on Attachment 1, as utilized at the February 11, 2003 hearing. While Prop. 103 was enacted in 1989, its constitutionality was challenged resulting in changes to rate freeze provisions. Furthermore, a methodology to implement the rate rollback was not determined until after the November elections in 1990 when the first elected Insurance Commissioner took office.

Question 2B: MICRA was enacted in 1976 and was upheld by the California Supreme Court in 1985. California's Proposition 103 was enacted in 1989. Between 1985 and 1989, medical liability premium trend in California was fairly steady whereas rates increased exponentially in the remainder of the United States during the same interval. Was the difference due to MICRA? What, if any effect, did Proposition 103 on premiums?

Answer: Prop. 103 required insurers to "roll back" their rates to 20% below those charged on November 8, 1987 and freeze the rates at that level for one year. It is critical to note that insurers did not automatically comply with the provisions of Prop. 103. Instead, insurers negotiated consent orders with the Department of Insurance regarding how they would each individually meet the requirements of the law. As indicated on Attachment 2, the first insurer (not just the first medical liability insurer) to reach such an agreement and voluntarily comply with Prop. 103 was the NORCAL Mutual Insurance Company, a medical malpractice insurer member of the PIAA.

NORCAL's consent order, (Attachment 3), does not stipulate that this insurer must roll back its rates. The consent order does stipulate in paragraph D1 that NORCAL "...shall authorize a rollback refund equal to 20% of the premium paid by each policyholder for calendar year 1989." The rates being charged in 1989 were identical to those in effect on November 8, 1987. An additional amount was added as interest to the refund.

Paragraph D2 states that this refund "...shall constitute Respondent's entire rollback refund obligation pursuant to Insurance Code Section 1861.01." Paragraph D4 states that "The rate rollback obligation is a return of premium and

as such is treated as a policyholder dividend in accordance with customary industry practice." Nowhere in the consent order is NORCAL required to reduce its rates by any amount. The refund dividends were to be paid back in 1992 as credits against 1992 premiums. In 1992, NORCAL paid a 31% dividend credit to its policyholders, which included the 20% "Prop. 103 commitment" referenced in the consent order. In fact, dividends paid in all years 1989 through 1995 exceeded 20% in each year. Thus, Prop. 103 had no effect on NORCAL's premium rates.

I have contacted the executive management of other major insurers in California (Southern California Physicians Insurance Exchange (now known as SCPIE), The Doctors' Company, and the Medical Insurance Exchange of California). Each of these companies had similar consent orders and state that their rates were not affected by Prop. 103. The consent orders of SCPIE and The Doctors' Company are also attached. Thus, Prop. 103 cannot explain the positive loss experience and level premiums in California.

Question 2C: The key component of Proposition 103 is a rate rollback. Regardless of whether Prop. 103 actually had any effect California, can you please comment on whether a mandatory, across-the-board rate rollback in every state would solve the current medical malpractice crisis, especially in light of the NAIC's concern that current rates may be inadequate? How would such a rollback impact the availability of carriers in a market?

Answer: A mandatory rate rollback in every state would only exacerbate the already negative financial results of insurers. If such were to occur, we would undoubtedly see carriers further tighten their underwriting controls with respect to medical specialty and geographical location leaving more providers unable to find insurance. Additional carriers may choose to leave the market all-together if they are not able to generate sufficient premiums to offset their losses. This would also have an effect on reinsurers, who depend upon the primary carriers' abilities to set their rates in relationship to their losses.

Question 3: Please explain the proportional effects of medical liability litigation (liability exposure, payment for claims etc.), the business cycle, and declining investment returns on medical liability insurance premiums during the last several years.

(A bar graph showing the proportion of each to total costs would be helpful). A comparison of costs and revenue would also be helpful)

Answer: The table shown below depicts the proportional effect of each element of

insurers' financial performance on profitability. This table was derived by actuarial firm Tillinghast - Towers Perrin from the 2001 annual statements of 32 physician owned/operated insurance carriers (the 2002 update will be available in two weeks).

Table 1

As can be seen, insurers' claims losses expressed as a percentage of premium, (stable during the 1995 - 1999 period) rose sharply during 2000 and 2001 (25% cumulatively). That tracks when most insurers began raising premium rates. At

FINANCIAL RATIOS TO NET PREMIUMS EARNED

	1995	1996	1997	1998	1999	2000	2001
Loss & LAE	95%	92%	91%	92%	91%	103%	116
Underwriting Exp	15	17	19	22	22	21	22
Combined Ratio	110	109	111	114	113	124	138
PH Dividends	8	8	7	6	6	5	3
Adj Comb Ratio	119	118	118	120	119	129	141
Net Inv Income	49	44	45	43	34	33	31
FIT	7	7	6	6	2	1	-1
Net Income	23	20	21	17	12	4	-10

Source: Tillinghast Survey of PIAA Companies NAIC Filings

the same time, investment income available to offset these increasing costs declined by 3% of premium. While net income in 1999 was 12% of premium, it has gone down to a loss of 10% in 2001. The so-called business cycle effect (weather, inflation, stock market, catastrophic loss) which impact insurers in other lines is not an issue for medical malpractice insurers. As medical malpractice insurers are primarily invested in high grade bonds (80%), stock market performance is not a major concern, as highlighted in the recent Brown Brothers Harriman report.

Question 4: There seemed to be some confusion at the hearing about the recent investment experience of your member companies. Can you please summarize the degree to which investment experience impacts premiums? Specifically, do state insurance regulators allow insurance companies to set rates based on past investment losses? If not, what is the role of States and State Insurance Commissioners in preventing insurance companies from doing this?

Answer: State insurance regulators closely monitor the investment decisions of

insurers. Each insurer must report to state insurance departments those investments bought, sold and held by investment type on an annual basis through Schedule D of the annual statement blank. The format for this report is proscribed by the National Association of Insurance Commissioners (NAIC). Each state insurance department regulates the type and amount of investments by type which an insurer can hold. In many cases, the allocation to stocks is limited. Please see attachment 4 for a state-by-state analysis prepared by the American Insurers Association. State insurance departments specifically do not permit insurers to set future rates based on poor past investment performance. Furthermore, medical liability premiums are set using the "Principles Regarding Property and Casualty Insurance Ratemaking" as adopted by the Casualty Actuarial Society which states: "II. Principle 4: A rate is reasonable and not excessive, inadequate or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer." Rates must be set according to expected future costs and income streams, to include expected future investment income. Attachment 4 also details state insurance department regulation of insurance rates, where rate filings are subject to review and/or approval in each state. As investment income is a major component of rates, this element is always included in any review.

Question 5: Dr. Wilburn testified that doctors in some states are practicing without medical liability insurance, or "going bare," as you put it. Doctors at the hospital in Riverton, Wyoming are considering going without insurance as well. I'm sure that their hospital administrators do not want this to happen, but they can't afford to lose the services of any of their 20 doctors on staff.

Do you think doctors going without liability insurance is a realistic solution to this problem? How does the tort system help patients if doctors are going without insurance?

Answer: Allowing doctors to go bare will not do anything to curb the escalating costs of paid claims. If doctors do go without insurance, they expose their personal assets. Even if a doctor is successful in shielding his/her assets through transfer to a spouse or other means, this will not reduce the amount of awards and settlements in malpractice suits. Plaintiff lawyers will look to other defendants to make up the difference. Hospitals become the deep(er) pocket in these cases, which is somewhat ironic, as hospitals now routinely require doctors with privileges to maintain malpractice insurance. This is also an accreditation requirement of the JCAHO. I cannot imagine a scenario where large numbers of doctors would be permitted to practice without insurance or some self-indemnification mechanism (such as posting a bond). But, if this did occur, patients would obviously have fewer dollars available to indemnify them, and the

process would likely be longer and more complicated. Insurance provides an efficient mechanism for the administration and payment of claims. Collecting settlements and awards from individuals who would by nature do everything they could to limit their exposure would be a nightmare, both for the patient and the doctor. This would undoubtedly slow down the settlement process as defendants try to avoid financial devastation, which could occur from only one claim.

Question 6: Senator Edwards said he is opposed to caps on damages but would support policies that address frivolous litigation. Based on the claims experience of your member companies, would legislation that addresses the frequency of claims but not the severity sufficiently address the current problem?

Answer: The PIAA does not track whether or not a claim made against a doctor is frivolous. However, we know that they often do exist, especially in cases where the plaintiff attorney names any health care provider even remotely involved in a case in order to increase the amount of insurance available for recovery. We know from our data that 61% of all claims filed are dropped or dismissed, and another 6% are won at court (2001 data). The claims that are dropped or dismissed cost about $17,000 each to defend, and those won at trial cost almost $86,000. Removing a significant number of these claims from the system would undoubtedly produce savings. Of the 5,983 closed claims reported to the PIAA Data Sharing Project in 2001, 4,149 were closed without an indemnity payment to the plaintiff (dropped, dismissed or won at trial). While a few of these claims may have not resulted in an indemnity payment due to poor representation on part of the plaintiff's lawyer, almost all of them are considered to be without merit. In aggregate, these claims cost $94.2 million to defend. This compares to the $568.9 million paid in indemnity for the 1,834 paid claims. Thus, an approximate 50% reduction in expenses for non-meritorious claims is equivalent to an 8% reduction in total indemnity. This is not a negligible amount, but it pales in comparison to the savings which can be expected from the entire MICRA package of reforms which includes a $250,000 cap on non-economic damages. A cap of $250,000 on non-economic damages was recently estimated to result in a decrease of 21% of the total indemnity paid in Florida. A real benefit of reducing the number of meritless claims is the relief this would bring to the court system, making the adjudication of claims with merit more expeditious and getting money into the hands of patients truly injured in the health care system faster.

Question 7: Mr. Angoff suggested that modifying the existing McCarran-Ferguson antitrust exemption is necessary to prevent medical malpractice insurers from

relying on rate recommendations from insurance services offices (ISOs) whose "rate-recommending function" enables insurers to engage in price-fixing and other legal, anti-competitive behavior. Do ISOs make specific rate recommendations? If not, what impact, if any, would this fact have on Mr. Angoff's suggestion that insurers engage in price fixing and such behavior is facilitated by ISOs?

Answer: The Insurance Service Office (ISO) is an independent statistical agency which collects insurance premium and loss data. There are three such agencies in the United States of which I am aware, and the ISO is by far the largest. The existence of such agencies is enabled by McCarran-Ferguson. This allows insurers to pool historical data which is used to measure the amount of loss costs and adequacy of premiums for various lines and markets throughout the country. While Mr. Angoff views this as anti-competitive and "rate fixing," the opposite is actually true. The information provided by statistical agencies allows insurers access to data which permits them to compete in new geographical markets or in areas where they do not have adequate historical data to make their own rates. While large insurers are more likely to have extensive data of their own, small insurers rely on industry data to help them determine the rates they must charge in order to compete. If such data was not available, these insurers might not compete in new markets, and if they did, they would actually have to charge more to compensate for the additional uncertainty they would have to accept.

I understand that the process as described above is used in many lines of insurance, such as private passenger auto. But, it does not apply to medical malpractice insurance. The PIAA recently conducted a survey of its 43 domestic insurance company members to determine the extent of usage of independent statistical agencies information in the rate making process. Of the 27 responses received thus far, we know that 11 companies do report premium and loss data to an independent statistical agency, largely the ISO. Many of these companies do this because their respective state laws or regulations require them to report to such an agency. Only two carriers receive any information back from an independent statistical agency, which is limited to periodic bulletins and circulars. All 29 carriers responding indicated that they do NOT use statistical reporting agency data in the determination of their rates. The carriers use a combination of their own historical data, data gleaned from the rate filings of other insurers, and the recommendations of independent actuaries. Thus, the repeal of McCarran-Ferguson would have no effect on the rate making processes of medical malpractice insurance carriers. It would, understand, have a significant effect on other lines of business where pooled data is of value in supporting a competitive marketplace.

Mr. Angoff's suggestion that malpractice insurers engage in price fixing and that such behavior is facilitated by statistical agencies is refuted by the facts. In its February 7th letter to Senator Gregg, the NAIC states that "insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation." We are amazed that anyone would believe such assertions made by Mr. Angoff without a shred of proof to support them.

Question 8: Senator Kennedy asked you whether the fact that insurance companies did not make as much money from their investments in some years as they had in others was the "largest factor" in premium increases. Is it not true, however, that the largest factor in premium increases is the dramatic increase in jury verdicts and settlement costs? Is it also not the case that the profits from investment income have helped to offset the losses that insurance companies have had to incur from increased litigation, and that it is the fact that the increase in litigation costs have far outpaced insurance companies profits from investments that has forced insurance companies to raise premiums?

Answer: Insurers rely on investment income to offset the need for premium. Many independent sources, such as A.M. Best and Brown Brothers Harriman have confirmed the fact that medical malpractice insurers are mainly invested in high grade bonds and have not lost large amounts in the stock market. As indicated on Table 1 (see response 3), physician owned/operated insurers earned 31 cents for every dollar of premium they collected in 2001. All other things remaining equal, premiums would have to be 31% higher in 2001 if this investment income did not exist to produce the same bottom line result (a 10% loss).

Senator Kennedy noted that these companies were making more investment income as a percentage of premium in prior years (49% in 1995), and concluded that this had a lot to do with the escalation in premiums we are seeing in the market today. The fact is that insurers have been able to keep their net investment income stream rather level over the past 5 years, in the 5 - 6% of invested asset range using a combination of interest income and capital gains. While market interest rates have declined, bond values have increased, offsetting the reduction in interest income to the extent that insurers are able to liquidate bonds in their portfolios.

With investment income declining slightly due to declining interest rates at the same time that premiums are going up, the ratio of investment income to premium can only decline, and insurers can do nothing to little to change this unless they take additional market risk to improve potential earnings. Under

today's conditions with rapidly rising loss costs, this would be an imprudent thing to do.

As shown on Table 1, insurers' losses expressed as a percentage of premium, stable during the 1995 - 1999 period, have risen sharply during 2000 and 2001 (25% cumulatively). At the same time, investment income available to offset these increasing costs has declined by 3% of premium. While net income in 1999 was 12% of premium, it has gone down to a loss of 10% in 2001. Increasing claim expense, while admittedly not offset as much by investment income in the past, is the principle driver of the current crisis.

On behalf of the 43 domestic insurance company members of the PIAA which insure over 60% of America's doctors, as well as dentists, hospitals and other health care providers, I thank you for the opportunity to respond to these questions and stand ready to supply any additional input you may require. Rapidly escalating medical malpractice costs have created a health care access crisis in America, and we thank you for your efforts to find a reasonable solution through federal health care liability reform.

Sincerely,

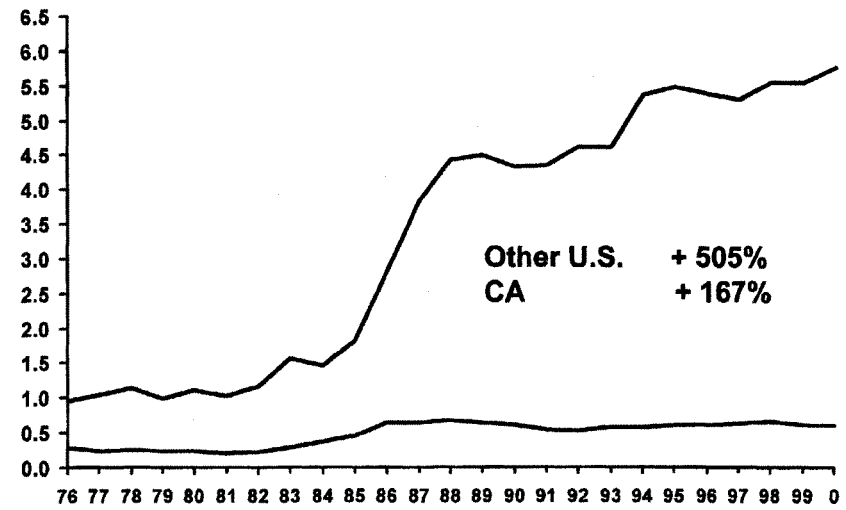
Lawrence E. Smarr
President

attachment

Attachment 1

Savings from MICRA Reforms

California vs. U.S. Premiums 1976 - 2000



$ Billions

Source: NAIC Profitability By Line By State

Attachment 2

California Department of Insurance
John Garamendi, Commissioner
News Release

FOR IMMEDIATE RELEASE:
October 9, 1991

CONTACT:
Bill Schulz/Elena Stern
213/736-2381

FIRST INSURANCE COMPANY TO VOLUNTARILY COMPLY WITH PROPOSITION 103

NORCAL Mutual Agrees to 20 Percent Policyholder Refund Totalling $19.9 Million

In the first action of its kind, NORCAL Mutual Insurance Company has agreed to voluntarily comply with the rollback provisions of Proposition 103 enacted by California voters nearly three years ago, and will return to policyholders a 20 percent rebate totalling $19.9 million, announced Insurance Commissioner John Garamendi.

"NORCAL Mutual has wisely decided to fulfill the letter and spirit of Proposition 103, place the interests of its policyholders first, and put their rollback liability behind them," said Garamendi. "While NORCAL Mutual is a unique company with a specialized niche market, I hope their decision will serve as an example to other insurers that Proposition 103 can be fully, fairly and quickly implemented."

According to a stipulation between NORCAL Mutual and the Department of Insurance, the company will pay a refund of $15,316,000 and an additional estimated $4,558,972 in interest. The rebate is based on the company's 1989 total premiums of $76,581,000, plus interest calculated at 10 percent since May 8, 1989 (the date the California Supreme Court upheld the legality of Proposition 103).

Refunds will be paid to policyholders of the company between November 8, 1988 and November 8, 1989. Current policyholders will receive four quarterly installment credits applied to their 1992 premium. If no longer insured by the company, policyholders will receive the entire refund by March 31, 1992.

The San Francisco-based mutual insurance company provides medical malpractice coverage to physicians and, as a mutual company, is owned by the doctors it insures. NORCAL Mutual has 9,000 policyholders in California.

.. August 15, Garamendi announced that Californians are owed a total of $2.5 billion in ..position 103 rebates. On Monday, October 7, Governor Wilson over-ruled his administration's prior rejection of Garamendi's new emergency regulations that trigger the rollbacks mandated by Proposition 103.

The Department of Insurance is now in the final stages of determining the rollback amounts each insurance company will be required to rebate their policyholders.

On October 16, Garamendi will announce the first of numerous individual company rollback amounts to be rebated to California policyholders.

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Attachment 3

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John Garamendi, Commissioner
News Release

OR IMMEDIATE RELEASE:
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BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of the Rate Rollback and Refund Obligation of NORCAL Mutual Insurance Company, Respondent.	File No. REB-2754 STIPULATION AND CONSENT ORDER

The Department of Insurance of the State of California (the "Department") and Respondent NORCAL Mutual Insurance Company ("Respondent") stipulate as set forth herein.

RECITALS

A. Insurance Code Section 1861.01 was enacted by the voters of California on November 8, 1988 as a part of initiative measure Proposition 103. That section, as subsequently modified on May 8, 1989 by the California Supreme Court in CalFarm v. Deukmejian (1989) 48 Cal.3d 805), requires insurers writing specified lines of property and casualty insurance in California to reduce rates and make certain refunds to policyholders. The determination of a constitutionally permissible manner in which to accomplish these rollbacks and refunds has been the subject of administrative and judicial proceedings.

B. The Department claims that, under its specific circumstances, Respondent is obligated to roll back its rates and refund premiums collected for policies in force between November 8, 1988 and November 8, 1989. Respondent denies that it has any such obligation.

C. It is in the best interests of Respondent and Respondent's policyholders to resolve these issues promptly and without further expense. Additionally, Respondent desires a prompt resolution to its rollback liability.

D. The Department wishes now to resolve this matter as regards Respondent, without the need for further hearing or administrative action, except as provided herein. It is in the best interest of the Department and the People of the State of California that this matter be resolved in this manner.

THEREFORE, THE DEPARTMENT AND RESPONDENT STIPULATE AS FOLLOWS:

1) Respondent's Board of Directors in 1991 shall authorize a rollback refund equal to 20% of the premium paid by each policyholder for calendar year 1989. Respondent's 1989 paid premium was $76,581,000 under overall rate levels identical to those prevailing on November 8, 1987, requiring a rollback refund of $15,316,200. Respondent shall pay 10% simple interest on this amount covering the period of time beginning May 8, 1989 until such time as either the entire rollback refund has been paid or the last quarterly credit has been applied as set forth in paragraph 3, below. Interest is $4,558,972 assuming refunds are timely made for a total rollback refund obligation of $19,875,172.

2) The amount specified in paragraph 1, above, including the interest specified therein, shall constitute Respondent's entire rollback refund obligation pursuant to Insurance Code

Section 1861.01. Specifically, in the event of a change in the laws or regulations governing the rollback refund obligations of insurers subject to Proposition 103, or of any other change which might otherwise have affected Respondent's rollback refund obligation, neither the Commissioner nor Respondent shall be entitled to an adjustment in the rollback refund obligation provided for herein.

3) The rollback refund obligation shall be paid to each policyholder issued or renewed a policy by Respondent between November 8, 1988 and November 8, 1989. Where such policyholders are still insured by Respondent, Respondent shall pay the rollback refund obligation by applying it in four quarterly installments as a credit against 1992 premium; however, in the event that 1992 premium is less than the amount of the rollback refund obligation for any such policyholder, the rollback refund obligation in excess of the 1992 premium shall be paid by check no later than December 31, 1992. Where such policyholders have died, retired, become disabled or otherwise will not pay premium to Respondent in 1992, the rollback refund obligation shall be paid by check no later than March 31, 1992.

4) The rate rollback obligation is a return of premium and as such is treated as a policyholder dividend in accordance with customary industry practice. The rollback shall be separately reported as a voluntary rollback refund under Proposition 103.

5) Respondent's rate rollback exemption application filed May 31,

1989 is withdrawn. Respondent's annual rate filings for 1990 and 1991 are hereby granted interim approval by the Department.

6) The rollback refund obligation provided for herein shall not constitute a fine, penalty or adverse administrative action.

7) Upon the execution of this agreement, the Insurance Commissioner shall give notice to the public that, within 20 days of the date of the notice any consumer or his or her representative may request a hearing in which this agreement, or any part of it, may be challenged. That notice shall include a copy of this agreement and this agreement shall not become final until either the expiration of the 20-day period or the disposition of any hearing held thereon, whichever is later.

8) Respondent shall comply with all terms and conditions of this agreement on or before December 31, 1992.

9) Respondent shall submit quarterly compliance reports commencing with the last day of the calendar quarter in which the order adopting this agreement is entered and until all terms and conditions of this agreement are satisfied. These reports shall include, at a minimum, (1) total principal and interest amounts refunded by check, total principal and interest amounts credited to policyholder accounts, and (2) the names, last known addresses and principal and interest amounts due policyholders whom Respondent has been unable to

locate.

10) Respondent shall make disclosure of its rollback plan in its Annual Statement to the Insurance Commissioner of the State of California and in its Annual Report to Members.

11) Respondent shall provide, within a reasonable time, any information requested by the Department regarding Respondent's rollback refund obligation.

12) Respondent shall dismiss all pending administrative and judicial actions challenging the Commissioner's rate rollback regulations.

13) Respondent shall escheat all unpaid rollback refunds to the State of California in compliance with applicable California law.

14) Nothing contained herein shall limit the Commissioner's ability to bring any actions that he may deem necessary to enforce other provisions of law relating to Respondent or its rates, rating plan, rating system or underwriting rules.

Date: 10/4, 1991

NORCAL Mutual Insurance Company

By: Albert C McCarvill

Title Pres/CEO

Date: 10/4, 1991

JOHN GARAMENDI
Insurance Commissioner
State of California

BY: Steven Miller

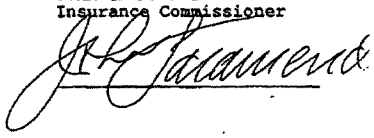
Steven Miller
Deputy Commissioner

ORDER

The terms of the foregoing stipulation are hereby adopted as the order of the Insurance Commissioner of the State of California in the above-entitled matter.

Date: 12/3/, 1991

JOHN GARAMENDI
Insurance Commissioner



Attach St H4

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Alabama	Rates may not be unreasonably high, inadequate or unfairly discriminatory. Rates must be approved by the DOI, subject to a 30-day deemer. 27-13-1 et seq.	An insurer may invest no more than 10% of its assets in all stock obligations; investments are limited to solvent U.S. or Canadian institutions that have not defaulted in the payment of principal and interest on any of their fixed interest obligations during the five preceding years, and that have continuously paid the dividends provided for by outstanding preferred stock, if any, during the five preceding years. 27-41-1 et seq.
Alaska	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be on file with the DOI for 15 days before they become effective. 21.39.010 et seq.	Insurers must balance the following investment objectives: (1) preservation of principal; (2) assuring reasonable diversification as to type of investment, issuer and credit quality; and (3) achieving an adequate within the bounds of prudent investment principles. An insurer may not invest more than 10% of its admitted assets in stocks, nor more than 5% of its admitted assets in any one security. 3 AAC 21.201 et seq.; 3 AAC 21.375
Arizona	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI within 30 days after becoming effective. 20-341 et seq.	Investments must be approved or authorized by an insurer's board of directors; an insurer may invest no more than 20% of its assets in stocks, and no more than 10% of its assets in any one stock. 20-531 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Arkansas	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be on file with the DOI for a waiting period of 20 days before they become effective, and will be deemed approved unless disapproved within the waiting period. 23-67-201 et seq.	Investments must be authorized by insurer's board; may invest no more than 5% in any one stock or 25% of all assets in stocks generally; limitations placed on acquisition of medium and lower grade investments. 23-63-801 et seq.
California	Rates may not be excessive, inadequate, or unfairly discriminatory. The commissioner shall consider whether the rate mathematically reflects the insurance company's investment income. Rates must be filed with the DOI and approved by the commissioner prior to their use, subject to a 60-day "deemer" provision. Ins. 1861.05	Insurers may invest assets (in an amount equal to its required minimum paid-in capital) only in specified securities; excess fund investments are also regulated; insurers must file a report with the Insurance Commissioner disclosing material acquisitions and dispositions of assets. Ins. 1170 et seq.
Colorado	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI concurrent on or before their effective date. 10-4-401 et seq.	An insurer may invest no more than 20% of its admitted assets in lower or medium grade obligations, no more than 10% in lower grade obligations, and no more than 3% in lower grade obligations rated five or six by the NAIC's Securities Valuation Office. 10-3-213 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Connecticut	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI on or before their effective date. 38a-663 et seq.	Insurer may not invest more than five per cent of admitted assets in obligations of any single institution other than high yield obligations; nor more than one per cent of admitted assets in high yield obligations of any one institution or more than ten per cent of admitted assets in the aggregate in such obligations. 38a-102 et seq.
Delaware	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI, and are subject to review. T. 18 §2501 et seq.	Insurer may not place more than 10% of its assets in a single investment, and may not hold more than 50% of the voting stock of a single corporation; nor may an insurer invest more than 10% of its assets in lower grade obligations. T. 18 §1301 et seq.
District of Columbia	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI prior to use. 31-2701 et seq.	Insurers may not invest in stocks that have not paid dividends during the previous five years, or in bonds for which interest payments have been defaulted during that period. Insurers must file a report with the Insurance Commissioner disclosing material acquisitions or dispositions of assets within 15 days after the end of the calendar month in which the transaction occurs. 31-2502.18; 31-1001 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Florida	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI at least 90 days before the effective date, and not implemented during the review period. Alternatively, rates may be filed no later than 30 days after the effective date, though such filings are subject to an order to return portions of rates found to be excessive. 627.062	Limited to "eligible investments" (i.e., interest-bearing, entitled to receive dividends, not in default); must be authorized or approved by insurer's board or authorized committee; insurers must maintain investments in a amount equal to their entire reserves and minimum statutorily required surplus; diversification requirements are specifically indicated. 625.301 et seq.
Georgia	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI at least 45 days prior to the effective date. Overall increases of 25% or more within any 12-month period require an examination of the insurer, and increases of between 10% and 25% may result in a discretionary examination. 33-9-1 et seq.	Insurer investment strategies subjected to specified standards of prudence, including diversification; Commissioner may order insurer to make changes to comply with these standards; only particular classes of investments, in specified proportions, are eligible for support of an insurer's outstanding liabilities; medium and lower grade investments may only constitute a specified percentage of an insurer's admitted assets. 33-11-50 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Hawaii	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be approved by the DOI, subject to a 30-day deemer. 431:14-101 et seq.	Investments must be approved by an insurer's board of directors; records for each transaction -- signed by an officer -- must be maintained; an insurer may invest no more than 10% of its admitted assets in any one stock, and may not invest in obligations of an insolvent corporation. 431:6-101 et seq.; 431:6-404 et seq.
Idaho	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI within 30 days after becoming effective. 41-1401 et seq.	Insurers may only invest in securities entitled to receive dividends, and may not be purchased above market price; an insurer may invest no more than 10% of its admitted assets in any one stock. 41-701 et seq.
Illinois	Rates may not be excessive, inadequate, or unfairly discriminatory. Every company writing medical liability insurance shall file with the Director of Insurance the rates and rating schedules it uses for medical liability insurance. This filing shall occur at least annually and as often as the rates are changed or amended. 215 ILCS 5/155.18	Insurer's board must adopt a written plan for acquiring and holding investments, including guidelines regarding quality, maturity and diversification; insurer may not place more than 5% of its admitted assets in a single investment, and is restricted to certain types of high and medium grade investments. 215 ILCS 5/126.1 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Indiana	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the Commissioner and are effective upon filing, though they are subject to review and public inspection. 27-1-22-1 et seq.	Insurers may not hold any investment that is not authorized by state law, other than obligations issued under the Farm Credit Act of 1971. 27-2-6-1
Iowa	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI on or before their effective date. 515F.1 et seq.	An insurer's investment program must take into account the safety of the company's principal, investment yield and growth, stability in the value of the investment, and liquidity necessary to meet the company's expected business needs, and investment diversification (i.e., no more than 10% of an insurer's capital and surplus may be invested in any one stock). 515.35
Kansas	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI on or before their effective date. 40-951 et seq.	An insurer's investments must be approved by a majority of its board of directors; any corporation invested in must have been in existence for at least five years; an insurer may invest no more than 25% of its admitted assets in securities, nor more than 15% of same in any one stock. 40-2a01 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Kentucky	Rates in a non-competitive market may not be excessive, inadequate, or unfairly discriminatory. Rates in a non-competitive market must be filed not later than 30 days prior to their effective date. Rates in a competitive market within a flex band of ±25% must be filed not later than 15 days after their effective date. Prior approval is required for rates exceeding the 25% flex band. 304.13 051	Insurer's board to adopt written plan for engaging in investment practices that specifies guidelines as to the quality, maturity and diversification of investments, to assure that the investments and investment practices are appropriate for the business conducted by the insurer, its liquidity needs, and its capital and surplus; insurers generally may not invest in securities for the benefit of officers or directors. 304.7-010 et seq.
Louisiana	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be approved by the DOI, subject to a 45-day deemer. 22:1401 et seq.	An insurer may invest no more than 25% of its admitted assets in securities, nor more than 5% of same in any one security; similar constraints apply to investments in insurer investment pools. 22:841 et seq.
Maine	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI not less than 30 days prior to the effective date. T.24-A §2301 et seq.	An insurer may not acquire any high-yield or medium grade obligations of any institution if the aggregate amount of all such obligations exceeds the lesser of 20% of its admitted assets or its surplus as to policyholders; further limitations are placed on the acquisition of lower-grade investments as rated by the Securities Valuation Office. T.24-A §1101 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Maryland	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI on or before their effective date. Ins. §11-201 et seq.	An insurer may not invest more than 10% of its admitted assets in any one stock, nor in the securities of an insolvent corporation, nor in an investment that the Commissioner finds is against public policy or designed to evade a prohibition of the investment limitations. Ins. §5-601 et seq.
Massachusetts	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed at least 15 days prior to their proposed effective date, and the Insurance Commissioner may delay the effective date for an additional 90 days beyond the normal 30 day discretionary period established for other lines of insurance. Ch. 175A §1 et seq.	Insurer's board must authorize all investments; Insurers may not invest more than 20% of admitted assets in medium and low grade investments, nor more than 1% or ½%, respectively, in individual medium or low grade investments. Ch. 175 §63 et seq.
Michigan	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be approved by the DOI, subject to a 15-day deemer. 500.2401 et seq.	An insurer may invest no more than 20% of its assets in obligations that are not in 1 of the top 2 numbered classifications of bonds reported in the insurer's annual financial statement on a form approved by the commissioner; nor may insurer invest more then 5% of its assets in any one security. 500.901 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Minnesota	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI on or before their effective date. 70A.01 et seq.	An insurer's investment program must take into account the safety of company's principal, investment yield and growth, stability in the value of the investment, the liquidity necessary to meet the company's expected business needs, and investment diversification (i.e., no more than 5% of an insurer's admitted assets may be invested in any one stock). 60A.11 et seq.
Mississippi	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI at least 30 days prior to the proposed effective date. Filing will be deemed approved unless disapproved within the waiting period. 83-2-1 et seq.	Investments limited to stocks that have earned a certain percentage of par value during three of the past five years; an insurer may not invest more than 10% of its admitted assets in any one stock. 83-19-51

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Missouri	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI within ten days after becoming effective. 379.315 et seq.	An insurer's board of directors must adopt a special written plan for making investments in lower or medium grade obligations; an insurer may invest no more than 20% of its admitted assets in such obligations, including no more than 10% in obligations rated 4, 5 or 6 by the NAIC's Securities Valuation Office and no more than 3% in obligations rated 5 or 6. 375.1075
Montana	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the Insurance Commissioner. 33-16-201 et seq.	Investments must be authorized by an insurer's board of directors; no more than 10% of an insurer's assets may be invested in any one stock, nor may an insurer invest more than 20% of admitted assets in medium and lower grade investments (or more than 10% in lower grade investments) 33-12-101 et seq.; 33-12-301 et seq.
Nebraska	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates are subject to the prior approval of the Commissioner, and may be deemed approved within 30 days after filing. 44-7501 et seq.	An insurer's board of directors must adopt a written plan specifying the quality, maturity and diversification of investments; an insurer may not invest more than 5% in a single obligation, a percentage that decreases as the obligation's Securities Valuation Office valuation decreases. 44-5101 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Nevada	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI for approval, and must be approved or disapproved no later than 60 days after filing. 686B.010 et seq.	Investments must be authorized by an insurer's board; no more than 10% of an insurer's assets may be invested in any one stock; no more than 20% of an insurer's assets in "other corporate obligations." 682A.010 et seq.
New Hampshire	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI prior to their effective date. T.XXXVII §414:1 et seq.	Insurers may only invest in securities rated in one of the highest four generic lettered rating classifications, or awarded a "yes" rating by the Securities Valuation Office; restrictions are placed on an insurer's ability to invest in financial futures, put and call options, and options and futures contracts. T.XXXVII §402:27 et seq.
New Jersey	Rates may not be unreasonably high or inadequate for the safety and soundness of the insurer, and may not unfairly discriminate between risks involving essentially the same hazards and expense elements. Rating systems must be filed with the DOI; filings will be deemed approved unless disapproved within 90 days. 17:29A-1 et seq.	Strict parameters are placed on an insurer's ability to invest in investment pools (e.g., only highly-rated obligations, requirements regarding pool management); Commissioner may disallow non-complying investments. 17:24-1 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
New Mexico	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI for approval, and must be approved or disapproved no later than 60 days after filing. 59A-17-1	Investments must be authorized by an insurer's board of directors; an insurer may not invest more than 10% of its assets in any one obligation, nor hold more than 10% of the outstanding voting stock of any corporation. 59A-9-1 et seq.
New York	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be approved by the Commissioner, subject to a 30-day deemer. Ins. §2301 et seq.	At least 60% of an insurer's required minimum capital or surplus must be invested in guaranteed obligations of the United States or direct obligations of the state; securities must generally be rated A or higher (or the equivalent thereto) by a recognized securities rating agency recognized by the superintendent, and must have been given the highest quality designation by the NAIC's Securities Valuation Office. Ins. §1401 et seq.
North Carolina	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the Insurance Commissioner prior to their stated effective date. 58-40-1 et seq.	Investments must be authorized by an insurer's board of directors; all stock investments may not exceed 25% of an insurer's admitted assets, and may not exceed 3% of that amount with respect to a single investment. 58-7-165 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
North Dakota	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI for approval, and must be approved or disapproved no later than 60 days after filing. 26.1-25-01	An insurer's directors who make or authorize a non-conforming investment are personally liable to the stockholders for any loss occasioned thereby; investments must be authorized by an insurer's board of directors; all stock investments may not exceed 25% of an insurer's admitted assets, and may not exceed 3% of that amount with respect to a single investment. 26.1-05-18 et seq.
Ohio	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI on or before the effective date. 3935.01	An insurer may not invest more than 5% of its admitted assets in any one stock; nor may an insurer generally hold more than 25% of the stock of any corporation. 3925.05 et seq.
Oklahoma	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be approved by the DOI, subject to a 30-day deemer. T.36 §901 et seq.	An insurer may invest no more than 20% of its admitted assets in preferred or guaranteed stocks, nor more than 10% of same in any one security; investments must be authorized or approved by an insurer's board of directors. T.36 §1601 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Oregon	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI on or before their effective date; rates must be filed prior to that date if the average annual rate level increase or decrease exceeds 15%. 737.205 et seq.	An insurer's investment program must take into account the safety of the principal of the insurer, investment yield and return, stability in the value of the investment, liquidity necessary for expected business needs of the insurer, and investment diversification according to standards established by rule. 733.510 et seq.
Pennsylvania	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI for approval, subject to a 30-day deemer. 40 P.S. 1181 et seq.	Eligible investments are specified by statute, with limitations as to percentages of an insurer's capital and surplus that may be invested in, e.g., particular partnerships; Commissioner may order a company to limit or withdraw from certain investments. 40 P.S. 653
Rhode Island	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI for approval, subject to a 30-day deemer. 27-6-1 et seq.	Insurers must balance the following investment objectives: (1) preservation of principal; (2) assuring reasonable diversification as to type of investment, issuer and credit quality; and (3) achieving an adequate within the bounds of prudent investment principles. An insurer may invest no more than 10% of its admitted assets in certain obligations reported on the annual statement. 27-11.1-1 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
South Carolina	Rates may not be excessive or unreasonable. Rates must be filed with the DOI for approval, subject to a 60-day deemer. 38-73-910 et seq.	An insurer may invest no more than 5% of its admitted assets in a single investment, nor more than 20% of such assets in medium and lower grade investments; restrictions placed on insurer participation in investment pools. 38-12-10 et seq.
South Dakota	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be approved by the DOI, subject to a 30-day deemer. 58-24-1 et seq.	Investments must be dividend or income-paying, and may not be purchased above market value; an insurer may not invest more than 5% of its assets in any one stock; nor may an insurer hold more than 10% of the outstanding voting stock of any one corporation. 58-27-1 et seq.
Tennessee	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be approved by the DOI, subject to a 30-day deemer. 56-5-310 et seq.	An insurer may not invest more than 3% of its admitted assets in any one stock, or more than 25% of same in all stocks; the aggregate net earnings of the issuer must meet certain criteria. 56-3-401 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Texas	Rates must be reasonable, adequate, and not unfairly discriminatory. Rates must be filed with the Commissioner and may be disapproved following a hearing. Ins. Art. 5.13 et seq.	Insurer's board must adopt written investment plan that specifies diversification of investments designed to reduce the risk of large losses; investments in particular types of instruments limited to specified percentages of admitted assets; restrictions placed on insurer participation in investment pools. Ins. Art. 2.10 et seq.
Utah	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI within 30 days after becoming effective. 31A-19a-101 et seq.	An insurer may invest no more than 35% of its assets in preferred stocks or more than 25% in common stocks, nor more than 10% in any single security. 31A-18-101 et seq.
Vermont	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed not later than 15 days after the effective date. T. 8 §4682 et seq.	An insurer may invest no more than 5% of its admitted assets in a single investment, and must comply with applicable regulations addressing investments in lower and medium grade obligations. T. 8 §3461 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Virginia	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the State Corporation Commission on or before their effective date. 38.2-2000 et seq.	An insurer's investments in medium and lower grade obligations may not exceed 20% of its admitted assets (figure is 10% for lower grade obligations, 3% for such obligations rated five or six by the Securities Valuation Office, and 1% for such obligations rated six by the SVO). 38.2-1400 et seq.
Washington	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI for approval, subject to a 30-day deemer. 48.19.010 et seq.	An insurer may invest no more than 4% of its assets in any one stock, may not hold more than 10% of the outstanding common shares of any one corporation, and may not invest in an insolvent corporation. 48.13.010 et seq.
West Virginia	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI at least 90 days before they become effective, and the Commissioner may extend this period for an additional 30 days upon written notice that additional time is needed to consider the filing. 33-20B-1 et seq.	Investments must be authorized or approved by insurer's board; an insurer may invest no more than 5% of its admitted assets in a single investment; restrictions placed on classes of securities in which an insurer may invest. 33-8-1 et seq.

STATE REGULATION OF MEDICAL MALPRACTICE RATES AND INVESTMENTS

State	State Rating Law	Regulation of Investments
Wisconsin	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates must be filed with the DOI within 30 days after they become effective. 625.01 et seq.	The commissioner may impose reasonable and temporary restrictions upon the investments of an individual insurer, including prohibition or divestment of a particular investment. An insurer's investments are subject to special quality and diversification requirements for five years after obtaining a certificate of authority. 620.01 et seq.
Wyoming	Rates may not be excessive, inadequate, or unfairly discriminatory. Rates in a non-competitive market must be approved by the DOI, subject to a 30-day deemer. 26-14-101 et seq.	An insurer may not invest more than 5% of its assets in any one stock, nor may an insurer hold more than 10% of the outstanding voting stock of any corporation; securities must be dividend-bearing and may not be purchased above market value. 26-7-101 et seq.

March 6, 2003

Answers to Questions for the Record

February 11, 2003 Hearing
Patient Access Crisis: The Role of Medical Litigation

Senate Committee on Health, Education, Labor and Pensions
And
Senate Committee on the Judiciary

Dr. Shelby Wilbourn, FACOG
On behalf of the
American College of Obstetricians and Gynecologists

1. Why are underserved areas particularly hard hit by excessive litigation?

In rural and underserved areas, the loss of even one ob-gyn or one nurse midwife often means a devastating loss of access to care for many women. Many states, including Wyoming, already have too few women's health care providers, including ob-gyns. In many rural states, women already have to travel long distances to see a doctor and women already have trouble finding doctors to take their cases.

Typically, rural ob-gyns are also the source of primary health care, including regular cancer screenings, treatment of menopause and its symptoms, and other women's health care conditions. These important health care services, too, are often lost when an ob-gyn leaves the community.

Communities, too, lose when an ob-gyn practice closes. Businesses, schools, growing families all depend on having doctors to care for health needs. Without community doctors, women and families have to rely on hospital emergency departments for regular health care.

Does our medical litigation system impede systematic efforts to enhance patient safety?

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Our current fault-based system creates serious and troubling disincentives to report errors and develop new systems to better ensure patient safety. Very few bad outcomes are the result of malpractice. Even the best doctors and best care cannot guarantee no bad outcomes.

When an adverse event occurs, the best thing that can happen for patients is for doctors and hospitals to examine the situation carefully, honestly, and openly to determine if anything could be done in the future to help ensure that a similar situation doesn't happen again. But this kind of open and careful examination nearly impossible in today's litigious environment.

2. Is going without liability insurance a realistic solution to this problem?

Doctors going without insurance shows how desperate doctors are to continue practicing in the face of this crisis. It certainly is not a solution to the crisis.

The tort system is only designed to win money awards for patients – money that doesn't exist if doctors go bare – not to increase access, weed out bad doctors, or create better patient safety systems.

3. Would legislation that addresses the frequency of claims, but not the severity sufficiently address the current problem?

Both the frequency and severity of lawsuits need to be addressed. Huge and unpredictable awards, however, are what cause the unpredictability in the insurance market and drive up liability premiums – and ultimately health care premiums – for everyone.

In New Jersey, for example, there were five awards of $1 million or more between 1997 and 2001. In 2002 alone, there were 5 awards of $1 million or more.

Frequency is also a problem. This year in Louisiana, for example, the number of lawsuits filed is increasing sharply, even though there's no evidence of a decrease in the quality of care or of increases in doctor error.

Statement of Jose Montemayor
Commissioner of Insurance, Texas
U.S. Senate Joint Hearing
Committee on Health, Education, Labor and Pensions
Committee on the Judiciary
February 11, 2003

Good afternoon Chairmen and Members; I am Jose Montemayor. I have the honor of being the Commissioner of Insurance for the great state of Texas. As a member of the National Association of Insurance Commissioners, I chair that group's Property and Casualty Committee, and separately, a working group looking into medical malpractice insurance coverage for physicians and other health care providers on a national basis.

Today, I am presenting for the record a report first provided to the Texas Legislature in late 2001 and updated in 2002, regarding the availability and affordability of medical professional liability insurance in Texas. There are a number of theories regarding the current situation in medical malpractice coverage; however, the sum of the report clearly indicates that loss trends – increasing amounts paid for claims – are the primary cause of rising costs in medical malpractice insurance. All other causes are a distant second.

Many states, especially Texas, are writing at significant losses. Texas has $1.60 in losses for every dollar in premium. This trend has affected net worth, with Texas carriers realizing a negative return of 3.3% for 2000, and a negative 2% return for the ten year period.

Over a four-year period, the claims costs per doctor have increased 50%. This is driven by claim frequency as well as claim severity. In my own state, we have an increasing number of claims per physician in the lower Rio Grande Valley. The reverse holds true in the other parts of the state where the amount per claim is higher though the frequency is lower.

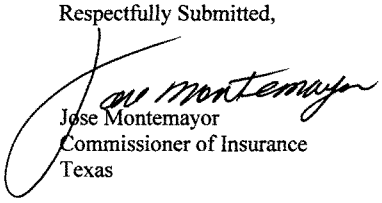
These loss trends indicate the presence of liabilities which, due to their unpredictability, result in pricing increases of 80% to 140% for the major writers in Texas. With the stock market losses of the last few years, investment income and hard markets seem like reasonable culprits; however, a review of how insurance carriers invest their funds indicates that a preponderance of investments is in bonds. This investment allocation is natural for the industry as it attempts to stabilize cash flow.

What can never be fully conveyed in the statistics, though, are the accounts from people who suffer from lack of access to patient care. There are stories from the Rio Grande Valley to the Texas Panhandle of how people do not have access to care, not for lack of means, but for lack of willing providers. It has reached the point where good providers can no longer afford to practice medicine, or limit their accessibility, because of rising premiums. In my own state, doctors have only four carriers to choose from, down from seventeen a few years ago. This trend stifles the advancement of medicine and undermines the human infrastructure of our communities.

The attached report and summary charts presented to the Committees today speak volumes on a simple premise: balanced and reasonable limits on losses will stabilize the medical liability insurance market and will go a long way to alleviate the looming crisis of access to health care.

I would be very pleased to answer your questions.

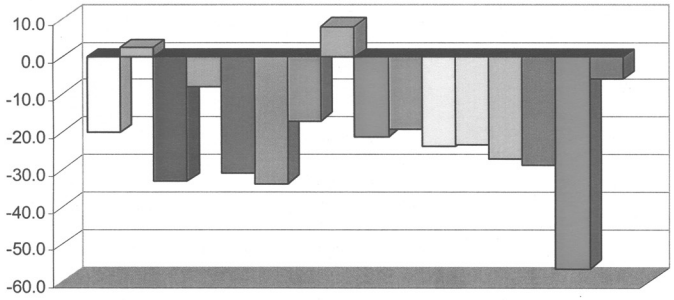
Respectfully Submitted,



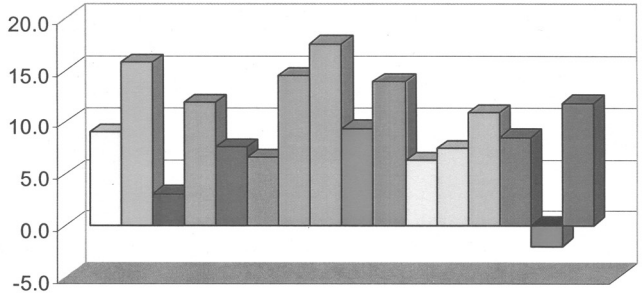
Jose Montemayor
Commissioner of Insurance
Texas

TEXAS DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE INSURANCE [1]
Calendar Years 1991 - 2000

UNDERWRITING PROFIT
AS A PERCENT OF DIRECT PREMIUMS EARNED



PERCENTAGE RETURN ON NET WORTH

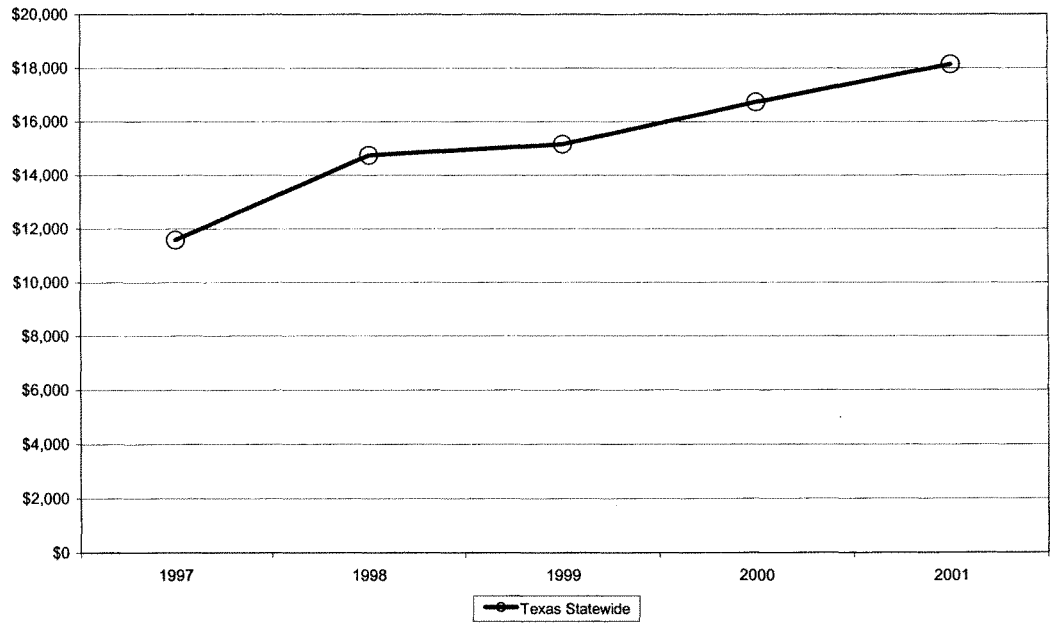


Arizona	California	Florida	Georgia
Illinois	Maryland	Massachusetts	Michigan
New Jersey	New York	North Carolina	Ohio
Pennsylvania	Tennessee	Texas	Virginia

Source: 2000 NAIC Profitability Report

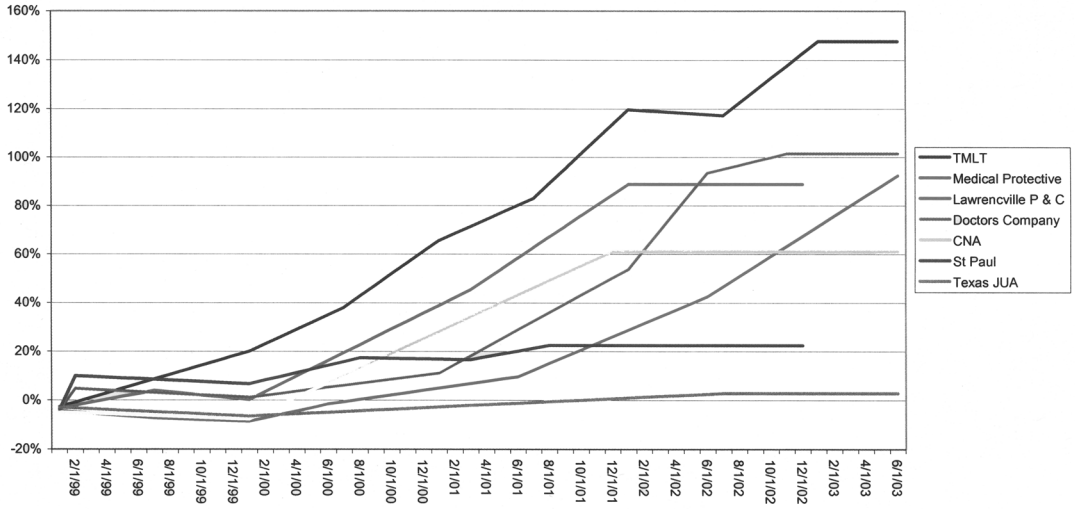
[1] The NAIC report does not include TMLT, which does not report data to the NAIC.

TEXAS DEPARTMENT OF INSURANCE
PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE DATA CALL 2002
TOTAL AVERAGE INDEMNITY AND DEFENSE COST PER PHYSICIAN
Including All Mass Tort Except Phen-Fen Claims



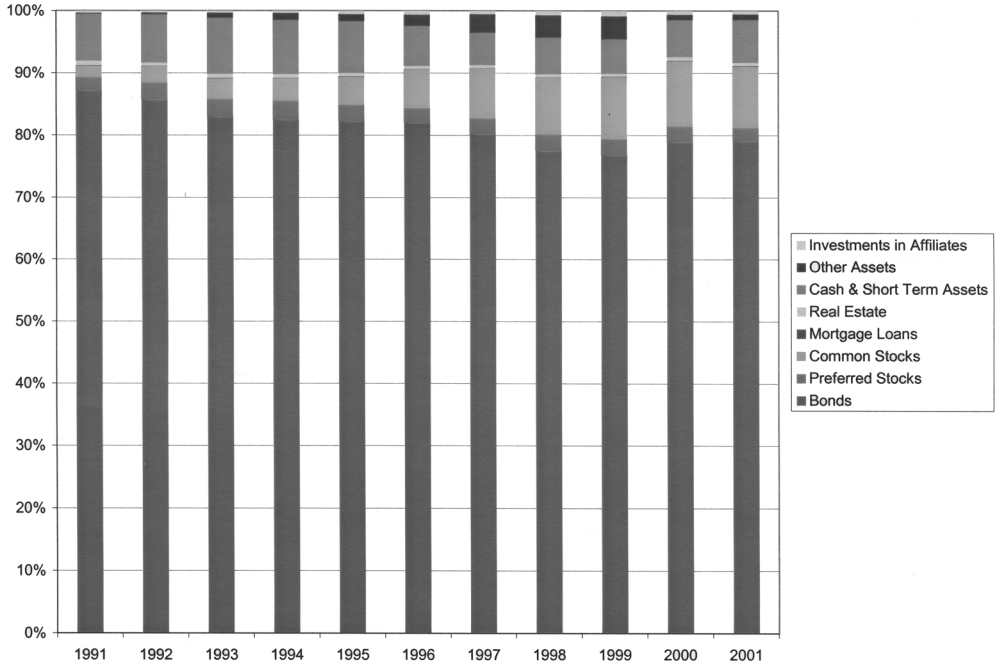
Source: TDI Physicians and Surgeons Medical Malpractice Data Call 2002

TEXAS DEPARTMENT OF INSURANCE
ESTIMATED PHYSICIAN AND SURGEON MEDICAL MALPRACTICE RATE CHANGES
Filed Rate Level Relative to Rates in Effect on 12/31/1998



Source: Insurance company rate filings filed in Texas

TEXAS DEPARTMENT OF INSURANCE
SUMMARY OF INVESTABLE ASSETS DISTRIBUTION
MEDICAL MALPRACTICE PREDOMINATING COMPANIES



Source: Bests Aggregates and Averages 2002 – 1992 Editions

Legislative Briefing
to the
Senate Committee on Finance
Subcommittee on Rising Medical Costs

Regarding
Medical Malpractice Insurance

Senator Robert Duncan, Chair

José Montemayor, CPA
Commissioner of Insurance
September 5, 2002

Texas Department of Insurance
MEDICAL MALPRACTICE INSURANCE: Overview and Discussion

I. Background

A. Medical Liability Insurance - Who and What it Covers

- Medical liability insurance covers a healthcare professional for errors and omissions arising from the practice of the insured's professional specialty.
- Coverage for nursing homes will become mandatory effective September 1, 2003. Other healthcare providers are not legally required to purchase coverage but hospitals and HMO's typically require minimum amounts and proof of coverage.
- Approximately 35,618 physicians currently practice in Texas.[1]

B. Types of Companies Writing Coverage in Texas[2]

1. Licensed (Admitted) Insurers
   - Policyholders with companies licensed by TDI have Guaranty Fund protection in the event of insolvency.
   - The Commissioner of Insurance must approve policy forms before being used (prior approval). Rates must be filed with TDI before being used (file and use).

2. Texas Medical Liability Trust (TMLT)
   - Statewide trust association of self-insured physicians.
   - No Guaranty Fund protection for policyholders in the event of insolvency. Policyholders are asked to contribute when an increase in trust surplus is needed.
   - Rates and policy forms are not regulated.
   - Largest writer in Texas with approximately 10,000 doctors covered.

[1] Source: State Board of Medical Examiners, as of January 2002.
[2] Additional information on companies and coverage can be found in Appendix 1, page 24.

3. Risk Purchasing Groups (RPGs)
   - Individuals or firms of like characteristics that share similar insurance needs and use group purchasing power to obtain malpractice insurance and benefits.
   - Guaranty Fund protection is available to RPGs who buy insurance from licensed insurers with a surplus in the amount of $25,000,000 or more, but not available if insurance purchased from a surplus lines carrier.
   - Although licensed insurers underwriting purchasing groups are subject to the same legislatively mandated provisions as licensed insurers, they are not required to file forms and rates for the RPG. Neither forms nor rates are regulated for surplus lines carriers.

4. Risk Retention Groups (RRGs)
   - An RRG is an insurer that retains and insures the malpractice risk group of like or similar insureds.
   - Policyholders are not protected by the Guaranty Fund in the event of insolvency.
   - Policy forms and rates of RRGs are not filed with TDI.

5. Surplus Lines Insurers
   - Not licensed but deemed eligible by TDI to provide coverage for insureds that are unable to obtain insurance from licensed insurers. Coverage can only be placed in surplus lines after a specially licensed agent has made a diligent effort to place coverage with a licensed insurer.
   - No Guaranty Fund protection for policyholders.
   - Surplus lines rates and policy forms are not regulated by TDI.

6. Texas Medical Liability Insurance Underwriting Association (JUA)
   - Requires insureds to provide evidence of rejection by two licensed insurers.
   - Policyholders are not protected by the Guaranty Fund. Policyholders and JUA member insurance companies may be assessed to maintain solvency.
   - Policy forms and rates of the JUA are regulated by TDI.
   - Physician policy count: Approximately 1000 as of 7/31/02, up from approximately 143[3] on 06/30/01.
   - In July 2002, the JUA Board adopted claims-made policies with additional coverage for prior acts resulting in more policy choices for physicians coming into the JUA. Additionally, the Board adopted lower premium rates for certain specialties.

[3] As the JUA's Physician and Surgeon policies include dentists, this estimate is extracted from the 168 physician and surgeon policies issued.

- While the JUA offers an immediate solution with regard to availability, the more attractive policies and lower rates for certain specialties can be viewed only as a stopgap measure for addressing the present problem of skyrocketing medical malpractice insurance rates and a shrinking number of carriers.

C. Recap of 1993 and 1995 Tort Reform Measures in Texas

The 73rd and 74th Texas Legislatures enacted several laws addressing tort reform. The cumulative effect of the tort reform rate rollbacks is that medical malpractice rates are 17.2 percent lower than they would have been without reform. This number is derived from information companies reported to TDI regarding actual rate rollbacks and tort reform savings. It includes all medical malpractice lines combined, i.e. hospitals, physicians, dentists, nurses, etc.

II. Discussion of the Texas Medical Malpractice Market

A. Companies Writing Medical Malpractice Policies in Texas

Given the diverse types of companies writing medical malpractice insurance, we do not have comprehensive information on the distribution of business for this market, such as premium volume and the number of doctors insured by the various insurers. On April 12, 2002 TDI sent a survey to all insurers known to provide medical malpractice insurance in order to obtain this information.

TDI obtained responses from approximately 70 entities writing medical malpractice insurance during 2001, accounting for roughly 29,000 physicians. Based on this information, approximately ⅓ of the market files their rates and forms, for review and approval respectively.

Type of Carrier	2001 Market Share
Licensed Admitted Carriers (excluding JUA)	31.2%
Texas Medical Liability Trust	34.5%
Risk Purchasing Groups	26.8%
Risk Retention Groups	2.9%
Surplus Lines Insurers	3.6%
Texas Medical Liability Insurance Underwriting Association (JUA)	1.0%[4]

Based on information obtained in the survey, the following insurers write the majority of coverage for individual physicians and group practices (detailed information can be found in the Appendix on page 41):

- American Physicians Insurance Exchange
- The Doctors' Company
- The Medical Protective Company
- Texas Medical Liability Trust (TMLT)
- Texas Medical Liability Insurance Underwriting Association (JUA)

Notes:

1. Some companies/groups provide coverage subject to company underwriting, i.e., group practices only, etc.
2. Health Care Indemnity (HCI) is not included as they write exclusively for HCA and its affiliates. Only doctors that are employed with HCA would be eligible for coverage with HCI.

[4] This figure represents the JUA's market share during 2001, not their current market share. Due to the JUA's recent large policy growth, their market share has increased dramatically since 2001.

2. Companies announcing withdrawal or otherwise non-renewing medical professional liability insurance:

Company	Estimated Number of Insured Physicians Affected
American Healthcare Indemnity (SPCIE Holdings, Inc.)	69
American Healthcare Specialty Insurance Co. (SCPIE Holdings, Inc.)	35
Chicago Insurance Company / Interstate / Fireman's Fund	1,840
Clarendon	No estimate available
First Professionals Insurance Company (FPIC)	*
Frontier Insurance Co.	814
Lawrenceville Insurance Co. (A MIIX Company)	2,176
Legion Insurance Co.	No estimate available
PHICO Insurance Co.	308
St. Paul Insurance Cos.	600
Western Indemnity Insurance Co. (Subsidiary of Frontier Insurance Co.)	613
	Total: 6,455

* FPIC filed a withdrawal plan, however, they have indicated that the majority of policies affected will be absorbed by another insurer.

The first of these companies to non-renew policies began doing so in March 2001. The withdrawals should be complete by December 31, 2003.

B. Recent Rate Changes by Major Insurers

A comparison of recent rate filings by Texas insurers shows a significant increase in rates charged Texas healthcare providers over the last three years. Refer to Table 1 and Chart 1 on pages 6 and 7.

Table 1 includes the major medical malpractice insurers in Texas. Because this comparison covers a four-year period, the list includes some insurers that have ceased writing.

Chart 1 shows the average rate change per company over a four-year period, but it does not compare the actual rates charged. Therefore, a company that shows a 100 percent increase may not have higher rates than those whose rates increased by 50 percent.

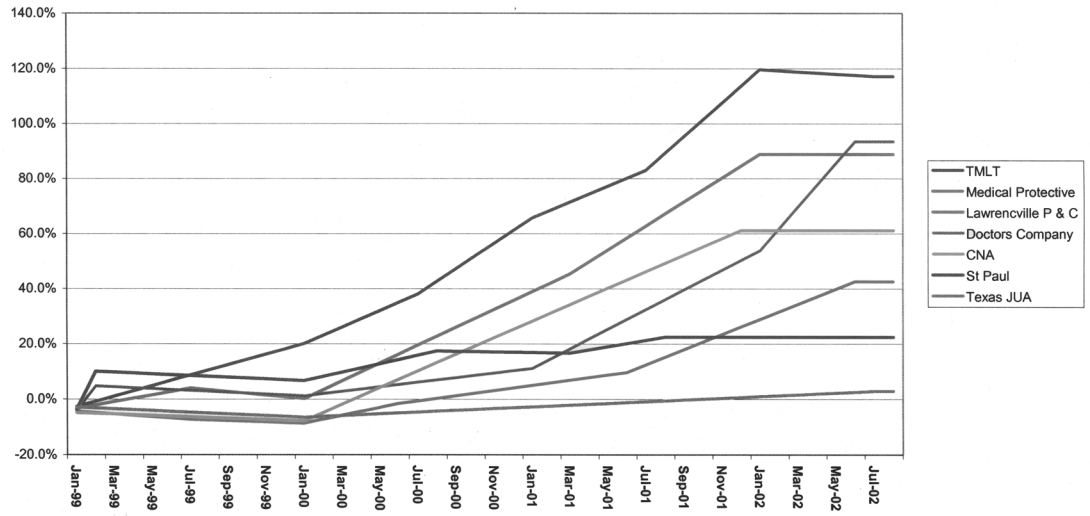
Table 1
ESTIMATED PHYSICIAN AND SURGEON MEDICAL MALPRACTICE RATE CHANGES[5]

Company / Group	Effective Year of Rate Change				1999 - 2002 TOTAL
	2002	2001	2000	1999	
The Texas Medical Liability Trust[a]	18.7%	32.6%	41.9%	-2.7%	117.2%
The Medical Protective	30.0%	11.4%	6.1%	-7.2%	42.6%
Lawrenceville Property and Casualty / MIIX[b]	30.0%	45.0%	-3.6%	4.0%	88.9%
The Doctors' Company	74.2%	9.8%	-3.4%	4.7%	93.5%
PHICO[c]	0.0%	83.4%	-3.3%	-3.2%	71.7%
Continental Casualty / CNA[d]	74.7%	0.0%	-3.0%	-4.9%	61.2%
The St. Paul[e]	0.0%	4.4%	6.7%	10.0%	22.5%
Texas JUA	10.0%	0.0%	-3.7%	-2.9%	2.9%

[a]Rate change in some cases are a rough estimate
[b]Lawrenceville filed its plan to withdraw from the Texas market in March 2002
[c]Company is in liquidation
[d] Company writings have decreased significantly in recent years
[e]Company is withdrawing from Medical Malpractice countrywide

[5] Shows the average rate change per company over a four-year period (1999 - 2002), but it does not compare the actual rates charged.

Chart 1
ESTIMATED PHYSICIAN AND SURGEON MEDICAL MALPRACTICE RATE CHANGES[6]
Rate Level Relative to Rates in Effect on 12/31/1998



[6] Shows the average rate change per company over a four-year period (1999 - 2002), but it does not compare the actual rates charged.

C. Loss Analysis

TDI issued a special data call August 15, 2001 to the top 15 writers of medical liability insurance requesting information regarding loss development, claims, exposures by policy limit, class code and count.

The data call collected statistics on loss trends in the state as a whole and also specific loss trends in certain regions of the State.

Some regions lack statistical credibility because of the low numbers of physicians insured and/or claims.

TDI's analysis reveals the following:

- The average annual loss change as a percent of premiums (i.e. the average claim cost per insured physician) was approximately +15 percent over the five-year period 1996 through 2000. In some parts of the state, claim frequency causes the increase. In other regions, the problem is severity. (Refer to Chart 2 on page 9) [7]

- Nearly the entire increase in claims frequency occurs in the Lower Rio Grande Valley, where the number of claims filed is growing at a rate of 60 percent per year (Region B)[8]. This increase in frequency is primarily due to Hidalgo County. (Refer to Chart 3 on page 10) [9]

- Due to a large increase in small claims in Hidalgo County, the corresponding claim severity is down sharply in the Lower Rio Grande Valley (-25 percent). However, in other parts of the state, such as San Antonio and Dallas, claim severity is driving the increase in costs. (Refer to Chart 4 on page 11) [10]

What this all means is that the cost to an insurance company to insure a doctor in Texas has been increasing significantly in recent years.

This analysis includes information through the year 2000. On May 31, 2002, the Department issued a data call for loss experience data up to 2001. The analysis of this data should be available by the end of September.

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[7] Detailed information can be found in the Appendix on page 36.
[8] Region Boundaries can be found in the Appendix on pages 33-34.
[9] Detailed information can be found in the Appendix on page 37.
[10] Detailed information can be found in the Appendix on page 38.

Chart 2
TDI PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE SPECIAL DATA CALL 2002
PROJECTED UNLIMITED COST PER INSURED PHYSICIAN
Excluding Phen-Fen Claims

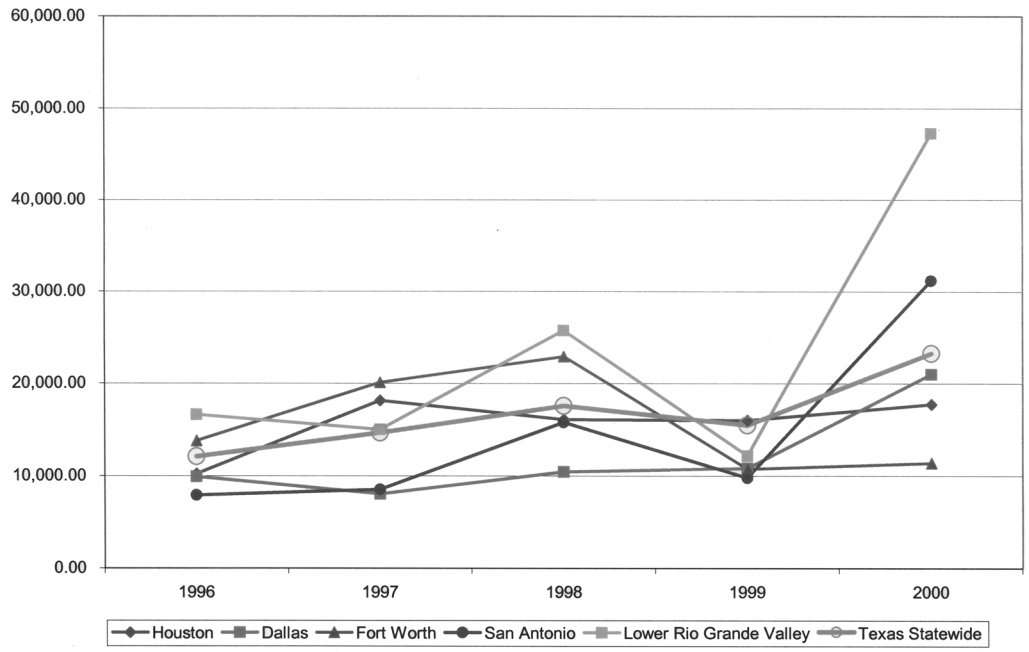


Chart 3
TDI PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE SPECIAL DATA CALL 2002
PROJECTED NUMBER OF REPORTED CLAIMS PER 100 INSURED PHYSICIANS
Excluding Phen-Fen Claims

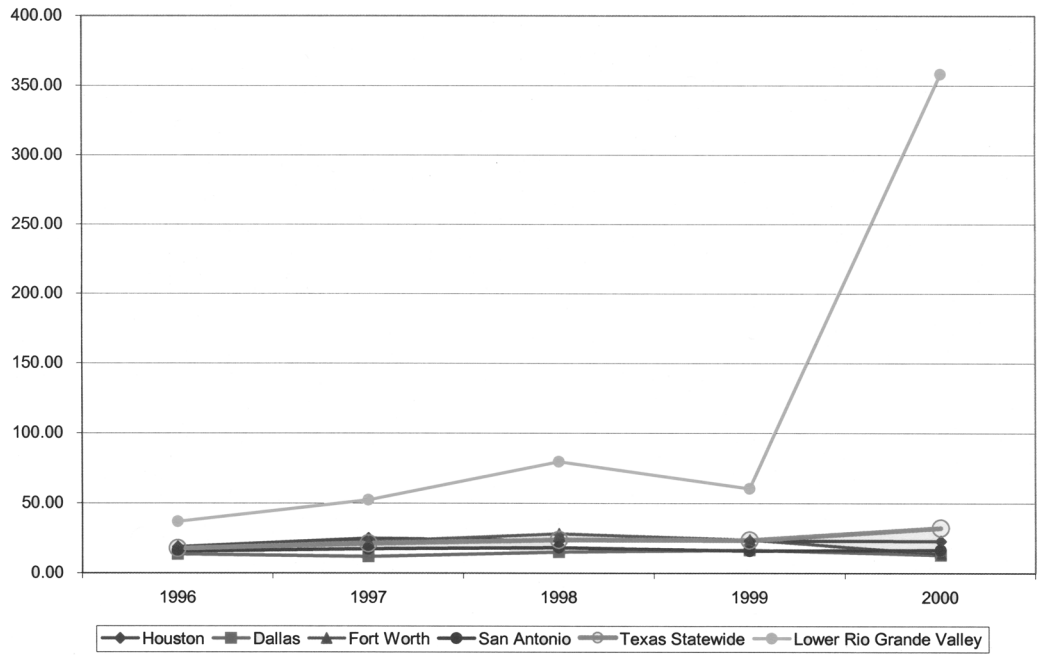
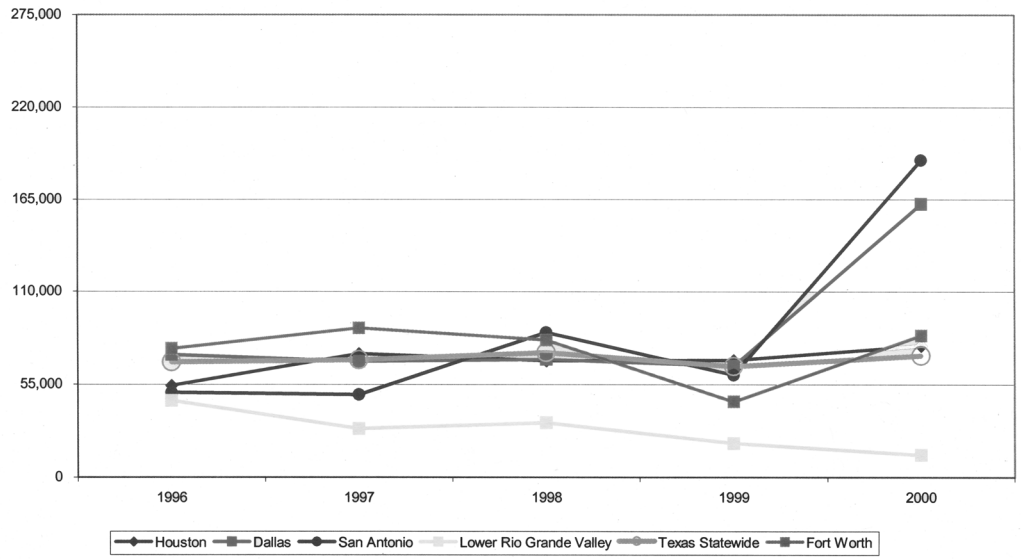


Chart 4
TDI PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE SPECIAL DATA CALL 2002
PROJECTED UNLIMITED COSTS PER REPORTED CLAIM
Excluding Phen-Fen Claims



D. Texas Regional Rate Comparison

The geographical difference in loss experience is reflected in the premiums doctors pay in various parts of the State. Table 2 shows that, on the average, doctors in the Valley and along the border pay the highest rates and those in the Panhandle pay the lowest rates. This pattern exists throughout the different specialties.

Table 2
TEXAS MEDICAL MALPRACTICE FILED RATES FOR SELECTED SPECIALITIES[11]
MATURE CLAIMS MADE WITH $1,000,000 / $3,000,000 LIMITS OF LIABILITY
Sorted from Highest Premium City to Lowest Premium City

City	County	Emergency Medicine Major Surgery	Orthopedic Surgery (Non-Spinal)	Neurosurgery	Anesthesiology
McAllen	Hidalgo	$47,909 - $69,131	$79,007 - $93,516	$143,201 - $116,822	$32,915 - $46,730
Brownsville	Cameron	$47,909 - $69,131	$79,007 - $93,516	$143,201 - $116,822	$32,915 - $46,730
El Paso	El Paso	$40,302 - $62,244	$46,059 - $93,516	$83,482 - $164,946	$23,029 - $46,730
Houston	Harris	$29,240 - $70,045	$46,059 - $107,089	$83,482 - $164,946	$23,029 - $58,112
Beaumont	Jefferson	$29,240 - $62,244	$46,059 - $85,670	$83,482 - $164,946	$23,029 - $46,730
Corpus Christi	Nueces	$35,820 - $56,075	$40,938 - $85,670	$74,199 - $116,822	$20,469 - $46,730
Dallas	Dallas	$30,470 - $56,075	$38,390 - $85,670	$83,482 - $116,822	$21,755 - $46,730
Laredo	Webb	$35,820 - $62,244	$40,938 - $93,516	$74,199 - $164,946	$20,469 - $41,174
Austin	Travis	$32,961 - $56,075	$40,938 - $85,670	$74,199 - $116,822	$20,469 - $46,730
Lubbock	Lubbock	$25,645 - $56,075	$36,450 - $85,670	$67,818 - $116,822	$18,708 - $46,730

[11] Detailed information can be found in the Appendix on page 27.

III. Comparison with Other States

TDI obtained information detailing how Texas compares with 14 other states in terms of the cost of medical malpractice insurance and profitability of the medical malpractice line of insurance.

The 14 states were selected on the basis of premium volume. Thirteen of the states were able to provide premium information. Maryland, the remaining state, was unable to submit complete information. The material provided contains the information collected thus far.

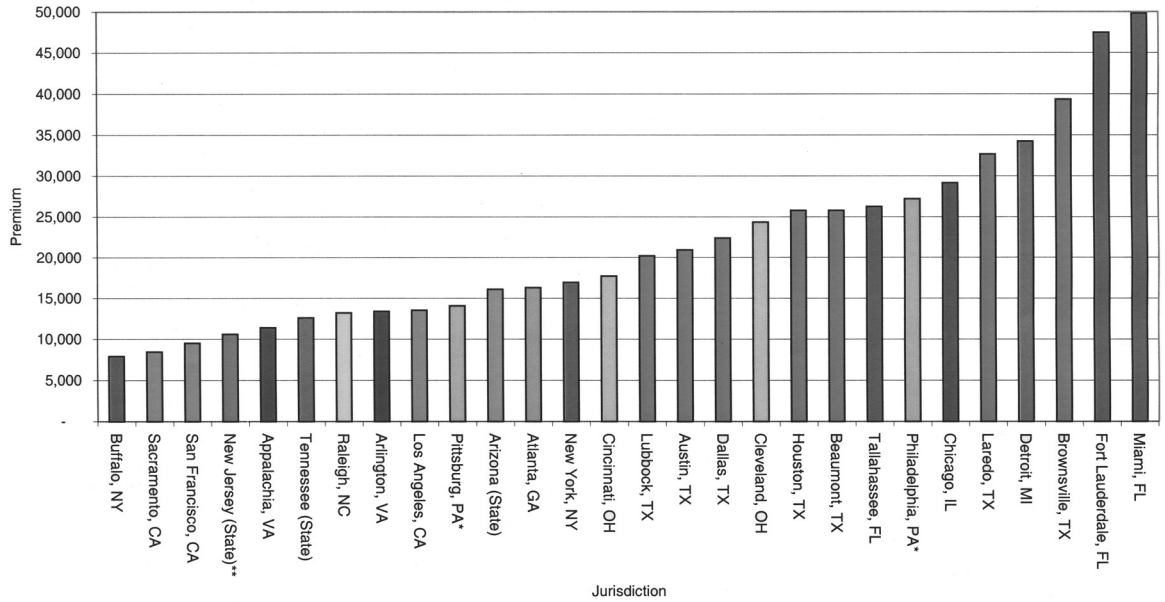
A. Rates in Other States

The states providing rate information are: California, Florida, Arizona, Michigan, Pennsylvania, New York, New Jersey, Ohio, Virginia, Illinois, Georgia, Tennessee and North Carolina. Analysis shows several clear trends. California and Arizona appear to have lower rates than Texas, while Florida has higher rates. No clear trends are identifiable when Texas' rates are compared with Michigan's. (Refer to Charts 5 - 8 on the following pages) [12]

The rate comparison is based on actual rate filing information for the top three medical malpractice carriers in each state. The weighted average rate is based roughly on the premium volume of the three top medical malpractice carriers in each state. Note that medical malpractice insurers are generally regional carriers. Therefore, the same insurers in the various states are not being compared.

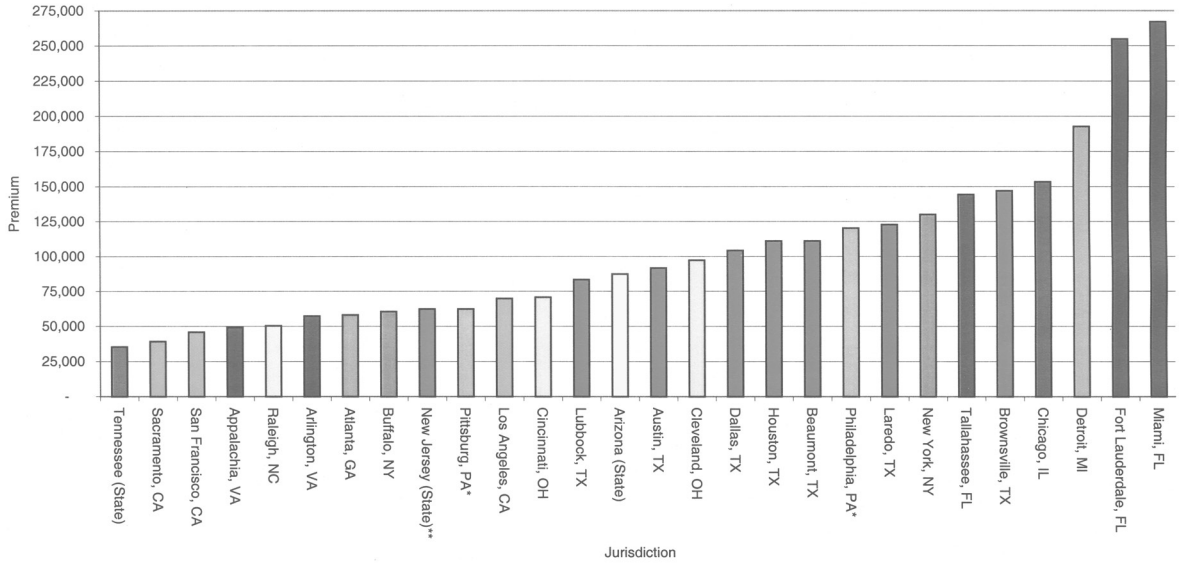
[12] Detailed information can be found in the Appendix on pages 28-32.

Chart 5
MEDICAL MALPRACTICE RATE COMPARISON
SPECIALTY: ANESTHESIOLOGY
Mature Claims Made 1,000,000 / 3,000,000 Limits of Liability (No Deductible)



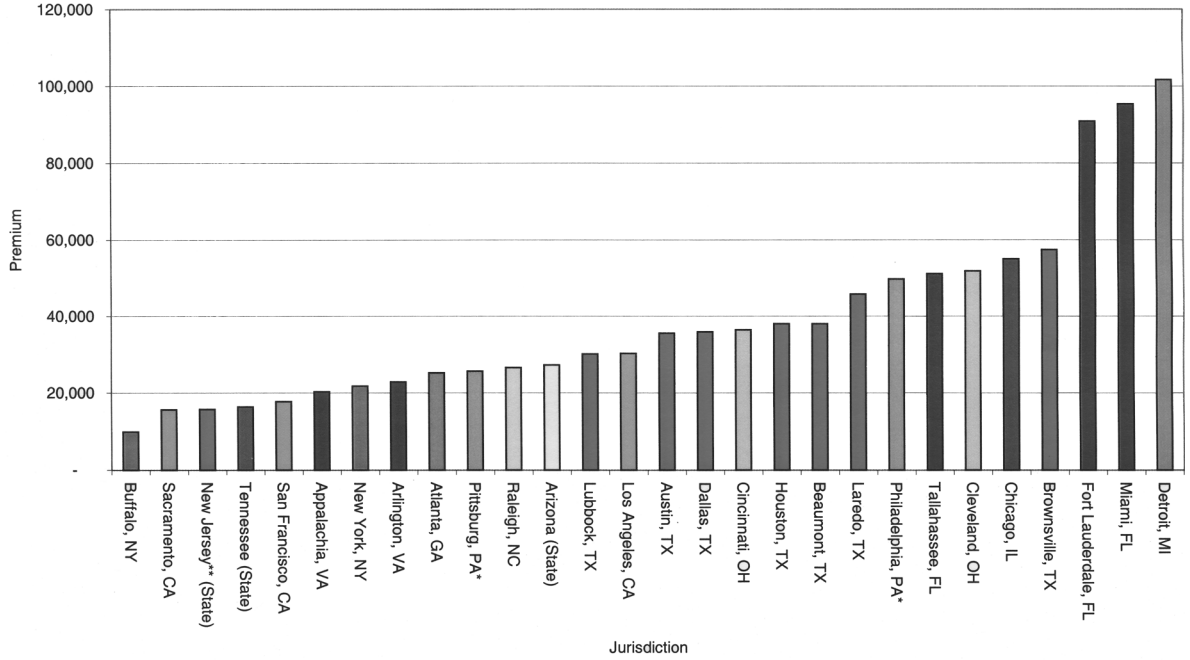
* Limits are 1.2M/3.6M. Companies only write up to 500K/1.5M. A State Cat Fund covers the excess to 1.2M/3.6M on a "pay as you go" basis.
** NJ uses a merit rating system.

Chart 6
MEDICAL MALPRACTICE RATE COMPARISON
SPECIALTY: NEUROSURGERY
Mature Claims Made 1,000,000 / 3,000,000 Limits of Liability (No Deductible)



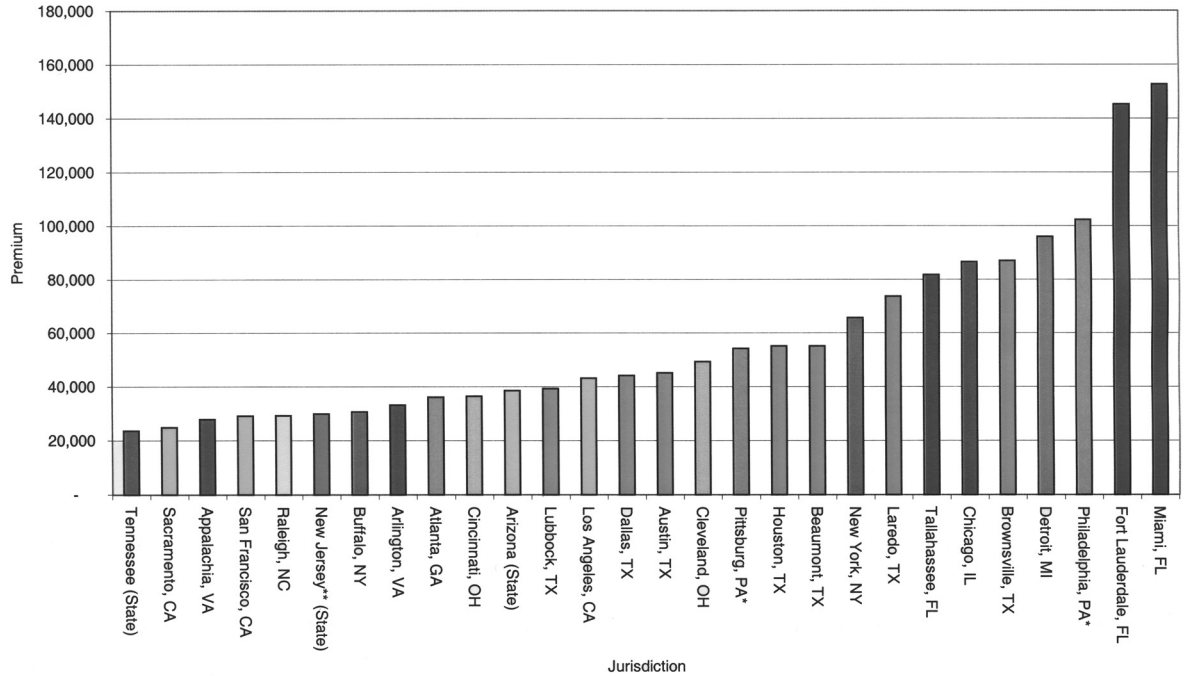
* Limits are 1.2M/3.6M. Companies only write up to 500K/1.5M. A State Cat Fund covers the excess to 1.2M/3.6M on a "pay as you go" basis.
** NJ uses a merit rating system.

Chart 7
MEDICAL MALPRACTICE RATE COMPARISON
SPECIALTY: EMERGENCY MEDICINE - SURGERY
Mature Claims Made 1,000,000 / 3,000,000 Limits of Liability (No Deductible)



* Limits are 1.2M/3.6M. Companies only write up to 500K/1.5M. A State Cat Fund covers the excess to 1.2M/3.6M on a "pay as you go" basis.
** NJ uses a merit rating system.

Chart 8
MEDICAL MALPRACTICE RATE COMPARISON
SPECIALTY: ORTHOPEDICS - SURGERY
Mature Claims Made 1,000,000 / 3,000,000 Limits of Liability (No Deductible)



* Limits are 1.2M/3.6M. Companies only write up to 500K/1.5M. A State Cat Fund covers the excess to 1.2M/3.6M on a "pay as you go" basis.
** NJ uses a merit rating system.

B. NAIC Profitability Information

Medical malpractice insurance in Texas is the least profitable for insurance companies, compared with the other top fifteen states, based on the 2000 NAIC *Report on Profitability By Line By State.* [13]

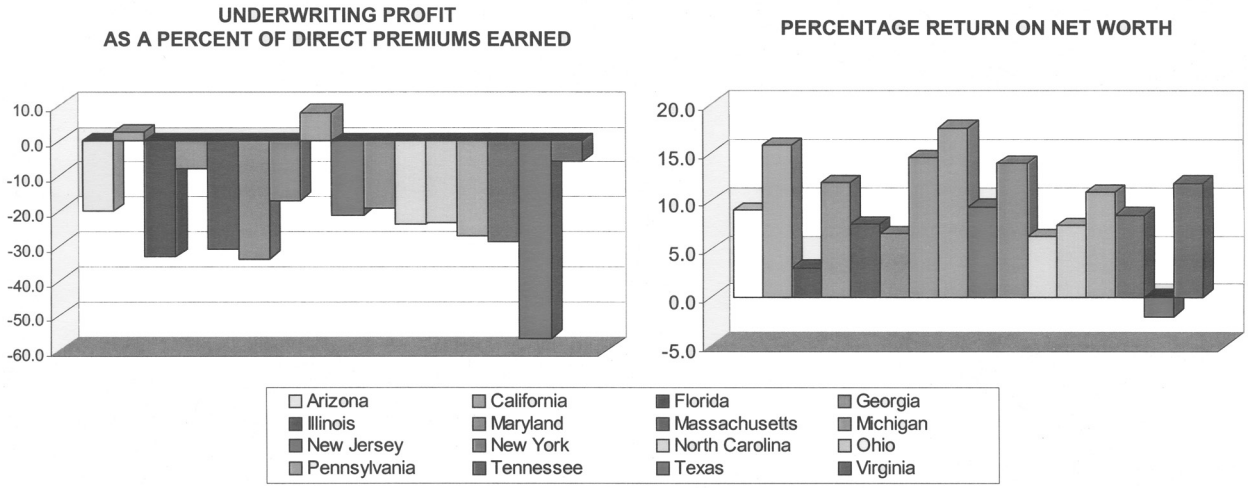
For all measures of profitability, including Underwriting Profit and Return on Net Worth, Texas ranks last over the ten year period of 1991 through 2000. Under these market conditions, it will be very difficult for Texas to retain or attract medical malpractice insurers.

- *Underwriting Profit* is premiums less losses and expenses as a percentage of the premium. It does not include income from investments or federal taxes.
- *Return on Net Worth* is the return to the insurance company "investors" and is analogous to a return on any investment (e.g. savings account, a bond, etc.). It includes income from all sources and reflects all federal taxes.

Refer to Chart 9 (following) and Tables A7 and A8 in the Appendix (pages 39-40) for more detailed information.

[13] The NAIC report does not include TMLT, which does not report data to the NAIC.

Chart 9
MEDICAL MALPRACTICE INSURANCE[14,15]
Calendar Years 1991 - 2000



Source: 2000 NAIC Profitability Report

[14] Detailed information can be found in the Appendix on pages 39-40.
[15] The NAIC report does not include TMLT, which does not report data to the NAIC.

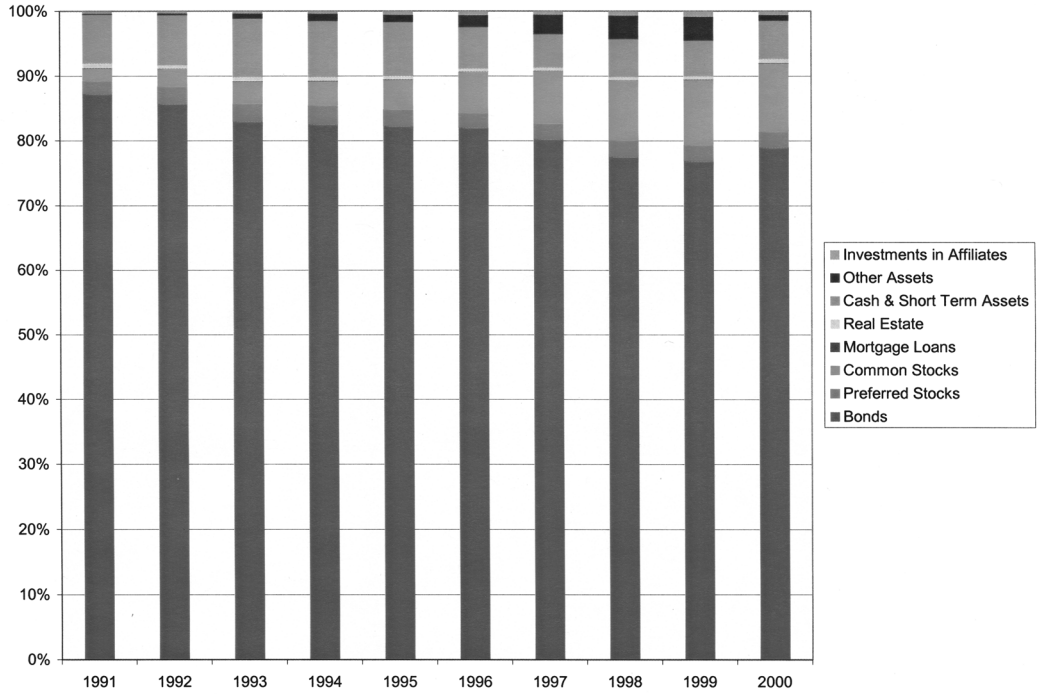
IV. Investment Distribution

A. Insurers with Medical Malpractice Predominating (Source: Bests Aggregates and Averages)

- At the end of 2000, bonds accounted for approximately 80 percent of invested assets.
- Common and preferred stocks account for approximately 13 percent of invested assets.
- Company's investment income is affected more by changes in interest rates and the market value of bonds, than changes in the stock market.
- In ratemaking, generally a long-term average, such as ten years, of capital gains will be used in determining company investment returns.
- Loss in the stock market (either realized or unrealized) will primarily affect company surplus/equity rather than (investment) income. Changes in surplus due to stock market losses could be dwarfed by changes in the surplus due to reserve changes.
  e.g., If these companies suffered a 50 percent drop in the value of their stock portfolio, this would be equivalent to a 10 percent reserve deficiency. A 10 percent reserve deficiency is not an extraordinary event.
- Unrealized capital losses were $440 million in calendar year 2000. Net underwriting losses were $1 billion in calendar year 2000.
- TDI examined the investments of three top insurance carriers in Texas (TMLT, Medical Protective and APIE) and their stock holdings are even less than the industry aggregates provided.
- In summary: Underwriting losses are the major factor influencing rates.
- We expect 2001 figures to be available by the end of September.

See Chart 10 (following) and Table A11 (Appendix, page 45) for additional detail.

Chart 10
SUMMARY OF INVESTABLE ASSETS DISTRIBUTION
Medical Malpractice Predominating Companies



Source: Bests Aggregates and Averages 1992 - 2001 Editions

V. Future Actions

There are many theories as to the reasons for the serious insurance market condition in affordability and availability of medical malpractice insurance. TDI is in the process of collecting additional data and gathering information to assess these theories. TDI will mail a comprehensive closed claims survey within the next several weeks and also plans to review tort laws of other states. Due to the comprehensive nature of this project, the Department anticipates completing the final analysis by the end of the year. TDI will keep you informed of the progress.

APPENDIX

Appendix 1

Medical Liability Insurance - Who and What it Covers

It is insurance that covers a healthcare provider for errors or omissions arising from the practice of the insured's professional area.

These policies include defense costs and generally cover claims for medical error or neglect even if they are false or groundless. Intentional and criminal acts are not covered, although some policies may provide defense until the nature of the underlying act is determined.

Types of Companies Writing Coverage in Texas

Licensed (Admitted) Insurers - The malpractice insurance forms and rates of licensed insurers are regulated by the Texas Department of Insurance (TDI).

TDI reviews malpractice policies offered by licensed insurers to see that they contain the following legislatively mandated provisions for healthcare provider liability insurance:

- minimum ninety days notice of non-renewal or premium increase, including written reasons for non-renewal;
- notice that the insurer may not cancel coverage after 90 days from the effective date of the policy; and,
- no surcharge for claims may be assessed unless the claims have been paid.

Policies are reviewed by TDI for restrictive provisions not in accord with public policy, and to ensure that claims-made policies have provisions for tail or run-off coverage.

Insureds obtaining malpractice insurance from a licensed insurer are protected by the Guaranty Fund in the event a licensed insurer becomes insolvent.

Texas Medical Liability Trust (TMLT) - Established under provisions of legislation enacted in 1977 that provides for a statewide association of physicians to create a self-insurance trust. The Texas Medical Association formed TMLT in 1978. By statute, only members of the founding association may join.

TMLT files its rates and policy forms with TDI for information purposes only. TMLT submits an audited annual financial statement to TDI for review. The Trust, however, does not participate in the Guaranty Fund and insureds are not protected by it.

Risk Purchasing Groups (RPGs) - Formed under the provisions of the federal Liability Risk Retention Act (LRRA) of 1986, a purchasing group is comprised of individuals or firms of like characteristics who share similar insurance needs. The eligibility criteria for members of a purchasing group are set by the LRRA. Once formed and registered with the State of Texas, the group may use its purchasing power to obtain malpractice insurance and benefits that may not be otherwise available.

If a purchasing group buys insurance from a licensed insurer, it may be eligible for Texas Guaranty Fund protection. In order for the policyholder to be eligible, the licensed company must have capital and surplus of at least $25,000,000 at the time of policy issue. Potential insureds must be advised if the purchasing group is not eligible for Guaranty Fund protection.

Although licensed insurers underwriting purchasing groups do not file policy forms for approval, policies are subject to legislatively mandated provisions listed above for licensed insurers.

Rates and policy forms of surplus lines insurers underwriting purchasing groups are not regulated and policyholders are not covered by the Guaranty Fund.

Risk Retention Groups (RRGs) - Also formed under the provisions of the federal Liability Risk Retention Act (LRRA), these groups do not purchase commercial insurance policies for members' protection, but retain the risk within the group. Because a risk retention group is an insurer, however, it may purchase reinsurance. This is a form of insurance (not available to the general public) that companies purchase to cede part of their risk or spread losses over several years. To be registered in Texas, a risk retention group must be licensed or legally domiciled in its home state.

The rates and policy forms of risk retention groups are not regulated and risk retention groups are not covered by the Guaranty Fund.

Surplus Lines Insurers - Insurance not available through licensed insurers may be placed with eligible surplus lines insurers. These insurers must be licensed in their home country or state to sell the kind of insurance they sell in Texas and they must also be on the Texas eligible list to conduct insurance business in Texas. Only a specially licensed surplus lines agent may place a risk with a surplus lines insurer after making a diligent effort to find a licensed insurer to issue the policy.

There is no Guaranty Fund protection in the event of insolvency. Rates and policy forms are not regulated and the policy may be more restrictive than policies subject to TDI review. Additionally, Texas laws regarding notice of cancellation, non-renewal or premium increases do not apply, defense costs could be included within the limit of liability, tail or nose coverage may not be available, and, in some cases, a surplus lines insurer can cancel before a policy's renewal date.

Texas Medical Liability Insurance Underwriting Association (JUA) - Formed in 1975 according to legislation to insure physicians and other eligible healthcare providers who cannot obtain insurance in the voluntary market. JUA member companies consist of all insurers authorized to write and engaged in writing liability insurance in Texas.

TDI regulates the policy forms and rates of the JUA. Although it does not participate in the Guaranty Fund, JUA member insurance companies and policyholders may be assessed to maintain solvency.

Table A1
TEXAS MEDICAL MALPRACTICE FILED RATES FOR SELECTED SPECIALITIES
MATURE CLAIMS MADE WITH $1,000,000 / $3,000,000 LIMITS OF LIABILITY
Sorted from Highest Premium City to Lowest Premium City

City	County	Emergency Medicine Major Surgery	Orthopedic Surgery (Non-Spinal)	Neurosurgery	Anesthesiology	General Surgery
McAllen	Hidalgo	$47,909 - $69,131	$143,201 - $116,822	$79,007 - $93,516	$32,915 - $46,730	$71,200 - $109,668
Brownsville	Cameron	$47,909 - $69,131	$143,201 - $116,822	$79,007 - $93,516	$32,915 - $46,730	$71,200 - $109,668
El Paso	El Paso	$40,302 - $62,244	$83,482 - $164,946	$46,059 - $93,516	$23,029 - $46,730	$46,059 - $109,668
Houston	Harris	$29,240 - $70,045	$83,482 - $164,946	$46,059 - $107,089	$23,029 - $58,112	$46,059 - $109,668
Beaumont	Jefferson	$29,240 - $62,244	$83,482 - $164,946	$46,059 - $85,670	$23,029 - $46,730	$46,059 - $109,668
Corpus Christi	Nueces	$35,820 - $56,075	$74,199 - $116,822	$40,938 - $85,670	$20,469 - $46,730	$40,938 - $77,400
Dallas	Dallas	$30,470 - $56,075	$83,482 - $116,822	$38,390 - $85,670	$21,755 - $46,730	$46,059 - $77,400
Austin	Travis	$32,961 - $56,075	$74,199 - $116,822	$40,938 - $85,670	$20,469 - $46,730	$40,938 - $77,400
Laredo	Webb	$35,820 - $62,244	$40,938 - $93,516	$74,199 - $164,946	$20,469 - $41,174	$34,144 - $69,542
Lubbock	Lubbock	$25,645 - $56,075	$67,818 - $116,822	$36,450 - $85,670	$18,708 - $46,730	$34,144 - $70,092

City	County	Family Physician No Surgery	Obstetrics / Gynecology Surgery	Psychiatry	Ophthalmology No Surgery	Internal Medicine No Surgery
McAllen	Hidalgo	$21,430 - $28,250	$92,326 - $131,601	$18,142 - $27,477	$12,686 - $20,608	$26,334 - $29,640
Brownsville	Cameron	$21,430 - $28,250	$92,326 - $131,601	$18,142 - $27,477	$12,686 - $20,608	$26,334 - $29,640
El Paso	El Paso	$16,469 - $27,477	$73,118 - $131,601	$12,626 - $27,477	$10,979 - $20,608	$16,469 - $29,640
Houston	Harris	$16,469 - $34,346	$62,318 - $131,601	$12,626 - $34,346	$10,979 - $25,761	$16,469 - $34,346
Beaumont	Jefferson	$16,469 - $27,477	$62,318 - $131,601	$12,626 - $27,477	$10,979 - $20,608	$16,469 - $29,640
Corpus Christi	Nueces	$14,638 - $27,477	$64,988 - $93,457	$11,222 - $27,477	$8,953 - $20,608	$14,638 - $27,477
Dallas	Dallas	$15,124 - $27,477	$59,221 - $93,457	$12,618 - $27,477	$8,625 - $20,608	$16,469 - $27,477
Austin	Travis	$14,638 - $27,477	$64,164 - $93,457	$11,222 - $27,477	$8,953 - $20,608	$14,638 - $27,477
Laredo	Webb	$12,680 - $13,589	$42,710 - $83,450	$10,257 - $12,560	$8,044 - $12,156	$12,680 - $18,795
Lubbock	Lubbock	$12,680 - $27,477	$42,710 - $93,457	$10,257 - $27,477	$8,044 - $20,608	$12,680 - $27,477

Note:
The above rates are base rates only. Other credits and surcharges may apply on an individual physician basis.

Table A2
PHYSICIANS RATE COMPARISON

Specialty	Arizona (entire State)		Los Angeles, CA		Sacramento, CA	
	RANGE	AVG*	RANGE	AVG*	RANGE	AVG*
Neurosurgery	$87,416 - $87,416	$87,416	$66,228 - $83,716	$69,957	$29,328 - $48,394	$39,165
Obstetrics & Gynecology - Surgery	$50,361 - $50,361	$50,361	$58,588 - $65,389	$60,222	$25,944 - $37,801	$32,698
Orthopedics - Surgery	$38,571 - $38,571	$38,571	$40,367 - $53,446	$43,216	$18,048 - $30,897	$24,896
General Surgery	$38,571 - $38,571	$38,571	$35,664 - $49,436	$39,360	$15,792 - $28,579	$22,927
Emergency Medicine - Including surgery	$27,347 - $27,347	$27,347	$29,720 - $32,048	$30,322	$13,160 - $17,575	$15,666
Anesthesiology	$16,124 - $16,124	$16,124	$11,888 - $16,867	$13,548	$5,264 - $10,372	$8,462
Family Practice - No surgery	$12,752 - $12,752	$12,752	$10,536 - $17,781	$12,796	$5,264 - $10,279	$7,245
Internal Medicine - No surgery	$12,752 - $12,752	$12,752	$11,888 - $14,744	$12,535	$5,264 - $8,523	$6,915
Ophthalmology - No surgery	$10,512 - $10,512	$10,512	$7,490 - $11,825	$8,958	$3,682 - $6,836	$4,761
Psychiatry - No surgery	$8,378 - $8,378	$8,378	$6,368 - $10,262	$7,802	$2,820 - $5,932	$4,375

Specialty	San Francisco, CA		Broward County, FL (Ft. Lauderdale)		Miami, FL	
	RANGE	AVG*	RANGE	AVG*	RANGE	AVG*
Neurosurgery	$39,772 - $48,394	$45,900	$204,087 - $264,754	$254,827	$233,235 - $278,829	$267,064
Obstetrics & Gynecology - Surgery	$34,349 - $39,408	$37,432	$150,746 - $190,016	$179,396	$172,277 - $201,376	$188,306
Orthopedics - Surgery	$25,742 - $30,897	$29,170	$102,043 - $173,573	$145,336	$116,618 - $183,949	$152,710
General Surgery	$23,988 - $28,579	$26,827	$81,171 - $164,437	$137,637	$92,764 - $174,268	$144,292
Emergency Medicine - Including surgery	$16,262 - $19,988	$17,795	$55,659 - $109,625	$90,960	$63,609 - $116,179	$95,430
Anesthesiology	$7,996 - $10,372	$9,524	$30,934 - $54,812	$47,490	$35,352 - $58,089	$49,791
Family Practice - No surgery	$6,191 - $10,279	$9,005	$29,511 - $45,677	$39,621	$33,725 - $48,408	$41,618
Internal Medicine - No surgery	$6,957 - $8,523	$8,105	$29,511 - $45,677	$39,621	$33,725 - $48,408	$41,618
Ophthalmology - No surgery	$3,682 - $6,836	$5,980	$20,352 - $36,542	$29,355	$22,945 - $38,726	$30,883
Psychiatry - No surgery	$4,284 - $5,932	$5,291	$18,316 - $27,406	$24,481	$20,932 - $29,045	$25,693

*Weighted average

Table A2 (continued)
PHYSICIANS RATE COMPARISON

Specialty	Tallahassee, FL		Atlanta, GA		Chicago, IL	
	RANGE	AVG*	RANGE	AVG*	RANGE	AVG*
Neurosurgery	$122,439 - $155,738	$144,369	$50,103 - $63,532	$58,160	$145,240 - $215,179	$153,782
Obstetrics & Gynecology - Surgery	$90,439 - $103,825	$101,540	$35,033 - $48,973	$43,397	$88,928 - $162,819	$98,734
Orthopedics - Surgery	$61,221 - $94,333	$81,787	$31,415 - $39,280	$36,134	$74,437 - $136,638	$86,621
General Surgery	$48,699 - $89,368	$77,426	$25,266 - $33,138	$29,989	$59,016 - $105,222	$65,298
Emergency Medicine - Including surgery	$33,394 - $59,579	$51,151	$25,266 - $25,266	$25,266	$46,696 - $101,484	$55,068
Anesthesiology	$18,559 - $28,789	$26,263	$11,521 - $19,523	$16,322	$25,756 - $54,169	$29,161
Family Practice - No surgery	$17,705 - $24,824	$22,336	$6,686 - $9,745	$8,521	$18,540 - $26,789	$19,967
Internal Medicine - No surgery	$17,705 - $24,824	$22,336	$6,686 - $9,745	$8,521	$22,060 - $31,722	$23,499
Ophthalmology - No surgery	$12,210 - $19,860	$16,485	$6,686 - $9,745	$8,521	$13,264 - $26,789	$14,840
Psychiatry - No surgery	$10,989 - $14,895	$13,820	$5,361 - $7,887	$6,877	$13,264 - $21,572	$14,103

Specialty	Wayne County, MI (Detroit)		New Jersey (State)		Buffalo, NY	
	RANGE	AVG*	RANGE	AVG*	RANGE	AVG*
Neurosurgery	$176,103 - $209,558	$192,831	$56,822 - $67,953	$62,388	$53,972 - $80,287	$60,551
Obstetrics & Gynecology - Surgery	$115,628 - $140,917	$128,273	$41,427 - $50,440	$45,934	$36,273 - $60,095	$42,229
Orthopedics - Surgery	$94,356 - $97,697	$96,027	$27,118 - $32,760	$29,939	$27,020 - $41,785	$30,711
General Surgery	$97,464 - $107,139	$102,302	$30,401 - $33,213	$31,807	$19,713 - $32,077	$22,804
Emergency Medicine - Including surgery	$97,697 - $105,763	$101,730	$14,691 - $16,834	$15,763	$9,555 - $11,023	$9,922
Anesthesiology	$32,201 - $36,319	$34,260	$9,246 - $12,010	$10,628	$6,965 - $10,796	$7,923
Family Practice - No surgery	$30,613 - $36,319	$33,466	$6,208 - $8,308	$7,258	$5,221 - $11,326	$6,747
Internal Medicine - No surgery	$31,152 - $45,761	$38,457	$9,431 - $10,896	$10,164	$6,803 - $9,462	$7,468
Ophthalmology - No surgery	$20,957 - $31,234	$26,096	$6,208 - $7,601	$6,905	$2,219 - $4,665	$2,831
Psychiatry - No surgery	$17,574 - $19,249	$18,412	$4,386 - $4,621	$4,504	$2,219 - $3,804	$2,615

*Weighted average

Table A2 (continued)
PHYSICIANS RATE COMPARISON

Specialty	New York, NY		Raleigh, NC		Cincinnati, OH	
	RANGE	AVG*	RANGE	AVG*	RANGE	AVG*
Neurosurgery	$121,463 - $132,902	$130,042	$24,672 - $61,597	$50,396	$60,269 - $80,100	$70,798
Obstetrics & Gynecology - Surgery	$89,319 - $90,915	$89,718	$27,068 - $65,717	$48,059	$46,400 - $60,817	$53,237
Orthopedics - Surgery	$63,215 - $66,535	$65,705	$19,759 - $38,457	$29,277	$27,067 - $43,017	$36,468
General Surgery	$48,528 - $48,543	$48,539	$15,918 - $37,393	$29,929	$34,524 - $43,017	$38,918
Emergency Medicine - Including surgery	$16,677 - $23,529	$21,816	$15,918 - $32,474	$26,645	$23,754 - $65,477	$36,475
Anesthesiology	$16,333 - $17,151	$16,947	$7,494 - $16,569	$13,241	$12,850 - $21,534	$17,730
Family Practice - No surgery	$12,857 - $17,135	$13,927	$3,979 - $8,890	$7,562	$7,641 - $12,650	$9,693
Internal Medicine - No surgery	$14,315 - $16,751	$16,142	$3,979 - $10,930	$7,913	$8,683 - $12,757	$10,884
Ophthalmology - No surgery	$5,463 - $7,057	$5,862	$3,979 - $8,361	$6,715	$6,138 - $9,874	$6,973
Psychiatry - No surgery	$5,463 - $5,755	$5,536	$3,184 - $8,361	$6,287	$6,230 - $9,874	$7,704

Specialty	Cleveland, OH		Philadelphia, PA		Pittsburg, PA	
	RANGE	AVG*	RANGE	AVG*	RANGE	AVG*
Neurosurgery	$76,358 - $140,350	$97,326	$108,973 - $137,434	$120,310	$58,687 - $67,734	$62,478
Obstetrics & Gynecology - Surgery	$58,133 - $100,691	$72,920	$97,953 - $103,110	$100,952	$46,750 - $55,627	$52,292
Orthopedics - Surgery	$39,411 - $70,948	$49,378	$87,850 - $108,973	$102,373	$45,462 - $58,687	$54,254
General Surgery	$43,017 - $74,227	$53,278	$86,732 - $87,080	$86,928	$42,179 - $46,874	$45,181
Emergency Medicine - Including surgery	$34,486 - $140,776	$51,879	$45,638 - $56,779	$49,769	$24,579 - $29,290	$25,715
Anesthesiology	$16,063 - $37,238	$24,355	$25,930 - $28,813	$27,218	$13,941 - $14,873	$14,093
Family Practice - No surgery	$9,552 - $21,375	$13,419	$18,628 - $26,844	$21,575	$10,032 - $12,585	$10,984
Internal Medicine - No surgery	$10,854 - $21,375	$14,778	$18,628 - $26,844	$22,172	$10,032 - $13,311	$11,290
Ophthalmology - No surgery	$6,230 - $16,418	$9,744	$8,494 - $11,438	$9,351	$4,574 - $5,898	$4,918
Psychiatry - No surgery	$6,230 - $16,518	$10,481	$12,086 - $19,452	$13,583	$5,804 - $10,025	$7,036

*Weighted average

Table A2 (continued)
PHYSICIANS RATE COMPARISON

Specialty	Tennessee (State)		Dickinson County, VA (Appalachia)		Arlington, VA	
	RANGE	AVG*	RANGE	AVG*	RANGE	AVG*
Neurosurgery	$26,880 - $37,970	$35,419	$46,926 - $51,449	$49,188	$51,449 - $63,414	$57,432
Obstetrics & Gynecology - Surgery	$21,120 - $40,396	$35,963	$46,926 - $47,648	$47,287	$47,648 - $63,414	$55,531
Orthopedics - Surgery	$14,016 - $26,008	$23,250	$25,561 - $30,275	$27,918	$25,561 - $40,912	$33,237
General Surgery	$16,704 - $26,863	$24,526	$25,561 - $30,276	$27,918	$25,561 - $40,912	$33,237
Emergency Medicine - Including surgery	$16,305 - $16,704	$16,397	$15,137 - $25,561	$20,349	$20,256 - $25,561	$22,909
Anesthesiology	$6,912 - $14,322	$12,618	$11,353 - $11,472	$11,413	$11,472 - $15,342	$13,407
Family Practice - No surgery	$3,840 - $6,753	$6,083	$7,569 - $9,446	$8,508	$9,446 - $10,228	$9,837
Internal Medicine - No surgery	$4,800 - $5,939	$5,677	$7,569 - $9,446	$8,508	$9,446 - $10,228	$9,837
Ophthalmology - No surgery	$3,264 - $5,939	$5,324	$6,055 - $6,074	$6,065	$6,074 - $8,182	$7,128
Psychiatry - No surgery	$3,840 - $4,864	$4,628	$6,055 - $7,716	$6,886	$7,716 - $8,182	$7,949

Specialty	Austin, TX		Cameron and Hidalgo County, TX (Brownsville)		Dallas, TX	
	RANGE	AVG*	RANGE	AVG*	RANGE	AVG*
Neurosurgery	$74,199 - $116,414	$91,665	$143,201 - $164,946	$147,014	$83,482 - $116,414	$104,210
Obstetrics & Gynecology - Surgery	$64,164 - $92,880	$69,110	$92,326 - $131,601	$109,802	$59,221 - $92,880	$69,134
Orthopedics - Surgery	$40,938 - $59,305	$45,150	$79,007 - $93,516	$87,015	$38,390 - $59,305	$44,211
General Surgery	$40,938 - $77,400	$48,275	$71,200 - $109,668	$79,703	$46,059 - $77,400	$54,275
Emergency Medicine - Including surgery	$32,961 - $43,930	$35,607	$47,909 - $69,131	$57,487	$30,470 - $43,930	$35,930
Anesthesiology	$20,469 - $23,040	$20,952	$32,915 - $41,174	$39,351	$21,755 - $23,040	$22,394
Family Practice - No surgery	$14,638 - $17,215	$15,999	$21,430 - $28,250	$26,269	$15,124 - $18,778	$17,422
Internal Medicine - No surgery	$14,638 - $20,919	$16,869	$26,334 - $29,640	$27,501	$16,469 - $20,919	$18,291
Ophthalmology - No surgery	$8,953 - $10,809	$10,163	$12,686 - $19,829	$18,409	$8,625 - $10,979	$9,498
Psychiatry - No surgery	$11,222 - $16,505	$14,073	$18,142 - $23,394	$21,999	$12,618 - $21,389	$17,006

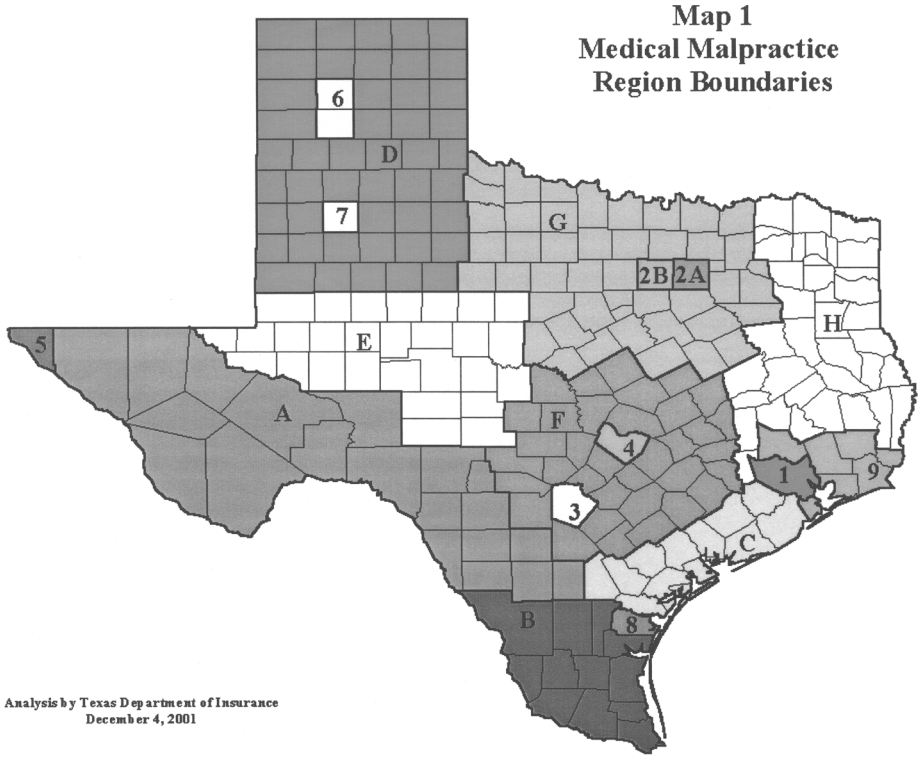
*Weighted average

Table A2 (continued)
PHYSICIANS RATE COMPARISON

Specialty	Houston, TX		Jefferson County, TX (Beaumont)		Laredo, TX	
	RANGE	AVG*	RANGE	AVG*	RANGE	AVG*
Neurosurgery	$83,482 - $164,946	$111,008	$83,482 - $164,946	$111,008	$74,199 - $164,946	$122,863
Obstetrics & Gynecology - Surgery	$62,318 - $131,601	$76,490	$62,318 - $131,601	$76,490	$64,988 - $131,601	$88,649
Orthopedics - Surgery	$46,059 - $84,029	$55,176	$46,059 - $84,029	$55,176	$40,938 - $93,516	$73,691
General Surgery	$46,059 - $109,668	$58,320	$46,059 - $109,668	$58,320	$40,938 - $109,668	$66,379
Emergency Medicine - Including surgery	$29,240 - $62,224	$38,062	$29,240 - $62,244	$38,062	$35,820 - $62,244	$45,828
Anesthesiology	$23,029 - $32,915	$25,779	$23,029 - $32,915	$25,779	$20,469 - $41,174	$32,688
Family Practice - No surgery	$16,469 - $21,430	$18,926	$16,469 - $21,430	$18,926	$14,638 - $26,334	$21,505
Internal Medicine - No surgery	$16,469 - $29,640	$20,157	$16,469 - $29,640	$20,157	$14,638 - $29,640	$22,736
Ophthalmology - No surgery	$10,979 - $13,915	$12,703	$10,979 - $13,915	$12,703	$9,758 - $19,829	$15,233
Psychiatry - No surgery	$12,626 - $25,093	$19,687	$12,626 - $25,093	$19,687	$11,222 - $23,394	$18,346

Specialty	Lubbock, TX	
	RANGE	AVG*
Neurosurgery	$67,818 - $104,595	$83,367
Obstetrics & Gynecology - Surgery	$42,710 - $83,450	$54,662
Orthopedics - Surgery	$36,450 - $53,284	$39,314
General Surgery	$34,144 - $69,542	$40,599
Emergency Medicine - Including surgery	$25,645 - $39,470	$30,202
Anesthesiology	$18,708 - $21,502	$20,192
Family Practice - No surgery	$12,680 - $13,589	$13,061
Internal Medicine - No surgery	$12,680 - $18,795	$13,842
Ophthalmology - No surgery	$8,044 - $12,156	$10,417
Psychiatry - No surgery	$10,257 - $12,560	$11,530

*Weighted average


Map 1
Medical Malpractice
Region Boundaries
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2A
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Analysis by Texas Department of Insurance
December 4, 2001

Table A3
MEDICAL MALPRACTICE REGION BOUNDARIES

Territory	Counties		
1	Harris		
2A	Dallas		
2B	Tarrant		
3	Bexar		
4	Travis		
5	El Paso		
6	Randall, Potter		
7	Lubbock		
8	Nueces		
	Galveston	Liberty	Orange
9	Chambers	Hardin	Montgomery
	Jefferson		
	Brewster	Jeff Davis	Real
	Crockett	Kinney	Reeves
	Culberson	LaSalle	Terrell
A	Dimmit	Maverick	Uvalde
	Edwards	McMullen	Val Verde
	Frio	Pecos	Zavala
	Hudspeth	Presidio	
	Brooks	Jim Hogg	Starr
B	Cameron	Jim Wells	Webb
	Duval	Kenedy	Willacy
	Hidalgo	Kleberg	Zapata
	Aransas	Goliad	Refugio
	Bee	Jackson	San Patricio
C	Brazoria	Live Oak	Victoria
	Calhoun	Matagorda	Wharton
	Fort Bend		

Territory	Counties		
	Armstrong	Fisher	Lamb
	Bailey	Floyd	Lipscomb
	Borden	Gaines	Lynn
	Briscoe	Garza	Moore
	Carson	Gray	Motley
	Castro	Hale	Ochiltree
	Childress	Hall	Oldham
D	Cochran	Hansford	Parmer
	Collingsworth	Hartley	Scurry
	Cottle	Hemphill	Sherman
	Crosby	Hockley	Stonewall
	Dallam	Hutchinson	Swisher
	Dawson	Roberts	Terry
	Deaf Smith	Kent	Wheeler
	Dickens	King	Yoakum
	Donley		
	Andrews	Kimble	Runnels
	Callahan	Loving	Schleicher
	Coke	Martin	Sterling
	Coleman	McCulloch	Sutton
E	Concho	Menard	Taylor
	Crane	Midland	Tom Green
	Ector	Mitchell	Upton
	Glasscock	Nolan	Ward
	Howard	Reagan	Winkler
	Irion		

Table A3 (continued)
MEDICAL MALPRACTICE REGION BOUNDARIES

Territory	Counties		
F	Atascosa	Comal	Lampasas
	Austin	Coryell	Lavaca
	Bandera	Falls	Lee
	Bastrop	Fayette	Llano
	Bell	Gillespie	Medina
	Blanco	Gonzales	Milam
	Brazos	Guadalupe	Robertson
	Burleson	Hays	San Saba
	Burnet	Karnes	Washington
	Caldwell	Kendall	Williamson
	Colorado	Kerr	Wilson
G	Archer	Grayson	Mills
	Baylor	Hamilton	Montague
	Bosque	Hardeman	Navarro
	Brown	Haskell	Palo Pinto
	Clay	Henderson	Parker
	Collin	Hill	Rockwall
	Comanche	Hood	Shackelford
	Cooke	Hunt	Somervell
	Denton	Jack	Stephens
	Eastland	Johnson	Throckmorton
	Ellis	Jones	Van Zandt
	Erath	Kaufman	Wichita
	Fannin	Knox	Wilbarger
	Foard	Limestone	Wise
	Freestone	McLennan	Young

Territory	Counties		
H	Anderson	Houston	Rusk
	Angelina	Jasper	Sabine
	Bowie	Lamar	San Augustine
	Camp	Leon	San Jacinto
	Cass	Madison	Shelby
	Cherokee	Marion	Smith
	Delta	Morris	Trinity
	Franklin	Nacogdoches	Tyler
	Gregg	Newton	Upshur
	Grimes	Panola	Walker
	Harrison	Polk	Waller
	Hopkins	Red River	Wood

Table A4
TDI PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE DATA CALL, August 15, 2001
PROJECTED UNLIMITED COST PER INSURED PHYSICIAN
EXCLUDING PHEN-FEN CLAIMS
Regional Data

Region *	1996	1997	1998	1999	2000	Total	Avg. Docs Per Year	Statewide Relativity	Trend
1 Total	$10,209.12	$18,128.73	$16,077.39	$16,019.86	$17,759.12	$15,627.02	2,743	0.942	10.3%
2A Total	$9,919.46	$8,058.36	$10,436.07	$10,846.33	$21,020.02	$11,818.84	2,018	0.712	19.7%
2B Total	$13,774.60	$20,066.30	$22,910.30	$10,741.18	$11,377.94	$15,765.64	923	0.950	-9.6%
3 Total	$7,905.38	$8,542.41	$15,792.32	$9,762.77	$31,184.65	$14,723.22	1,376	0.888	33.4%
4 Total	$10,944.03	$14,402.67	$15,009.07	$15,624.91	$17,006.28	$14,773.07	1,021	0.891	10.1%
5 Total	$11,608.56	$28,979.87	$26,553.78	$33,621.17	$59,217.61	$31,128.43	271	1.877	40.6%
6 Total	$5,591.10	$18,058.50	$16,362.12	$7,848.25	$8,476.73	$11,008.55	197	0.664	0.0%
7 Total	$6,396.92	$24,736.43	$18,424.65	$7,041.26	$17,727.39	$14,471.32	354	0.872	8.1%
8 Total	$18,170.39	$25,522.77	$21,793.95	$36,457.72	$14,282.03	$23,273.60	401	1.403	-1.2%
9 Total	$21,317.45	$28,241.76	$34,612.92	$34,711.15	$45,257.59	$32,865.46	454	1.981	18.7%
A Total	$8,313.12	$25,358.35	$30,623.02	$15,785.98	$70,719.64	$29,975.79	81	1.807	46.3%
B Total	$16,628.67	$14,987.12	$25,754.92	$12,155.65	$47,258.06	$22,949.44	603	1.383	20.7%
C Total	$13,479.65	$11,128.87	$17,645.25	$15,080.04	$21,601.87	$15,602.22	468	0.941	13.3%
D Total	$8,794.67	$11,909.51	$9,814.40	$14,475.71	$59,981.34	$20,109.59	142	1.212	49.7%
E Total	$13,717.80	$9,744.05	$10,514.07	$25,240.58	$5,622.33	$13,196.84	414	0.796	-8.0%
F Total	$7,854.47	$4,495.63	$10,077.97	$6,325.02	$19,108.44	$9,588.76	755	0.578	23.6%
G Total	$18,991.20	$17,269.29	$23,240.36	$15,557.39	$20,107.23	$19,026.11	1,286	1.147	0.1%
H Total	$15,291.26	$13,112.37	$20,622.65	$22,065.20	$33,856.95	$20,985.06	882	1.265	23.5%
Grand Total	$12,099.97	$14,671.13	$17,564.25	$15,458.03	$23,260.00	$16,588.41	14,388	1.000	14.6%

Notes:

- Regional data may be distorted by differing distributions of insured specialties by region. For example, Region X may have a larger proportion of high (low) risk specialties and therefore have a higher (lower) unlimited loss cost.
- Distortions may be cause by translating claims-made data into accident years.
- Some regions lack statistical credibility.

* See Medical Malpractice Region Boundaries in the Appendix on pages 33-34.

Table A5
TDI PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE SPECIAL DATA CALL, August 15, 2001
PROJECTED NUMBER OF REPORTED CLAIMS PER 100 INSURED PHYSICIANS [1]
EXCLUDING PHEN-FEN CLAIMS
Regional Data

Region *	1996	1997	1998	1999	2000	Total	Avg. Docs Per Year	Statewide Relativity	Trend
1 Total	18.87	24.89	23.37	23.19	22.85	22.60	2,743	0.954	3.2%
2A Total	13.69	11.80	15.00	16.48	12.96	13.92	2,018	0.588	2.3%
2B Total	18.11	22.77	28.24	23.94	13.58	21.18	923	0.894	-5.1%
3 Total	15.76	17.46	18.43	16.11	16.56	16.86	1,376	0.712	0.2%
4 Total	15.35	18.77	19.30	20.30	24.29	19.89	1,021	0.840	10.5%
5 Total	18.13	31.24	26.47	23.86	23.58	24.23	271	1.023	2.6%
6 Total	8.55	22.70	14.47	19.71	22.24	17.15	197	0.724	19.4%
7 Total	16.51	24.76	24.73	12.98	25.73	20.77	354	0.877	2.4%
8 Total	27.02	29.42	29.42	43.29	24.08	30.72	401	1.297	1.6%
9 Total	26.60	24.71	31.02	34.81	28.84	29.20	454	1.233	5.2%
A Total	14.42	24.82	32.75	33.87	79.27	37.00	81	1.562	45.1%
B Total	36.79	52.25	79.76	60.52	358.02	112.98	603	4.770	60.0%
C Total	17.90	18.35	19.22	28.56	19.09	20.57	468	0.868	5.9%
D Total	12.28	14.92	11.52	14.73	26.66	15.76	142	0.666	16.6%
E Total	16.04	11.93	12.90	15.91	5.47	12.66	414	0.535	-17.0%
F Total	11.67	11.97	14.70	19.46	16.41	14.86	755	0.627	12.4%
G Total	17.76	22.11	26.11	22.63	15.83	20.74	1,286	0.875	-2.0%
H Total	18.29	20.15	22.73	26.09	18.59	21.19	882	0.895	3.0%
Grand Total	17.75	21.14	23.82	23.54	32.30	23.69	14,388	1.000	13.9%

[1] More than 75% of reported physician and surgeon medical malpractice claims are closed without an indemnity payment.

Notes:

- Regional data may be distorted by differing distributions of insured specialties by region. For example, Region X may have a larger proportion of high (low) risk specialties and therefore have higher (lower) claim frequencies.
- Distortions may be cause by translating claims-made data into accident years.
- Some regions lack statistical credibility.
- Projected values for the year 2000 are subject to a good deal of uncertainty.

* See Medical Malpractice Region Boundaries in the Appendix on pages 33-34.

Table A6
TDI PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE DATA CALL, August 15, 2001
PROJECTED UNLIMITED COST PER REPORTED CLAIM [1]
EXCLUDING PHEN-FEN CLAIMS
Regional Data

Region *	1996	1997	1998	1999	2000	Total	Avg. Docs Per Year	Statewide Relativity	Trend
1 Total	$54,098	$72,848	$68,786	$69,073	$77,732	$69,155	2,743	0.987	6.9%
2A Total	$72,477	$68,288	$69,594	$65,811	$162,198	$84,925	2,018	1.213	17.0%
2B Total	$76,048	$88,139	$81,134	$44,859	$83,799	$74,422	923	1.063	-4.7%
3 Total	$50,151	$48,925	$85,685	$60,605	$188,362	$87,317	1,376	1.247	33.1%
4 Total	$71,311	$76,736	$77,752	$76,956	$70,018	$74,271	1,021	1.061	-0.3%
5 Total	$64,032	$92,756	$100,307	$140,911	$251,156	$128,473	271	1.834	37.0%
6 Total	$65,418	$79,556	$113,090	$39,820	$38,123	$64,181	197	0.916	-16.2%
7 Total	$38,751	$99,916	$74,506	$54,263	$68,896	$69,690	354	0.995	5.6%
8 Total	$67,255	$86,764	$74,085	$84,209	$59,313	$75,749	401	1.082	-2.8%
9 Total	$80,147	$114,282	$111,592	$99,702	$156,923	$112,560	454	1.607	12.8%
A Total	$57,668	$102,171	$93,512	$46,611	$89,217	$81,008	81	1.157	0.9%
B Total	$45,202	$28,682	$32,290	$20,086	$13,200	$20,314	603	0.290	-24.6%
C Total	$75,290	$60,642	$91,817	$52,799	$113,148	$75,856	468	1.083	7.0%
D Total	$71,643	$79,826	$85,230	$98,244	$225,026	$127,563	142	1.821	28.4%
E Total	$85,506	$81,700	$81,497	$158,695	$102,795	$104,229	414	1.488	10.9%
F Total	$67,319	$37,565	$68,574	$32,505	$116,450	$64,543	755	0.922	10.0%
G Total	$106,941	$78,114	$89,014	$68,739	$127,024	$91,753	1,286	1.310	2.2%
H Total	$83,614	$65,087	$90,721	$84,559	$182,076	$99,020	882	1.414	19.9%
Grand Total	$68,176	$69,395	$73,723	$65,664	$72,010	$70,034	14,388	1.000	0.5%

[1]More than 75% of reported physician and surgeon medical malpractice claims are closed without an indemnity payment.

Notes:

- Regional data may be distorted by differing distributions of insured specialties by region. For example, Region X may have a larger proportion of high (low) risk specialties and therefore have higher (lower) claim severities.
- Projected values for the year 2000 are subject to a good deal of uncertainty.
- Some regions lack statistical credibility.

* See Medical Malpractice Region Boundaries in the Appendix on pages 33-34.

Table A7
Medical Malpractice Insurance
Calendar Years 1991 - 2000
UNDERWRITING PROFIT AS A PERCENT OF DIRECT PREMIUMS EARNED

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	Ten Year Average
Texas	-80.3	-47.7	-62.7	-47.9	-47.3	-43.1	-26.7	-59.9	-84.4	-65.6	-56.5
Maryland	12.1	-1.7	-7.1	-33.8	-22.3	-18.7	-56.6	-94.3	-51.1	-64.7	-33.8
Florida	4.5	-14.3	-3.5	-25.9	-35.8	-15.9	-54.1	-44.8	-46.6	-94.4	-33.1
Illinois	-60.0	-59.8	-51.2	-30.0	-24.8	7.8	-7.1	-37.6	-2.4	-43.2	-30.8
Tennessee	7.6	-1.8	3.4	-7.8	-3.5	-15.9	-47.4	-7.8	-67.6	-149.0	-29.0
Pennsylvania	-83.6	41.2	0.4	33.9	-22.4	-35.0	-26.0	-33.9	-81.2	-63.1	-27.2
North Carolina	-19.8	-7.2	-10.2	-20.5	-12.9	-3.6	-38.8	-30.3	-52.7	-42.6	-23.9
Ohio	-9.3	3.6	-8.9	17.8	-15.8	-17.7	-30.2	-57.2	-50.2	-67.9	-23.6
New Jersey	-66.8	-66.6	-30.9	-23.8	-30.2	-45.2	0.5	1.0	29.5	20.6	-21.2
Arizona	-10.9	-6.4	-6.2	5.2	-0.8	-38.8	-29.7	-64.3	-22.3	-27.8	-20.2
New York	-45.8	-104.2	-35.3	-10.8	14.7	12.7	32.1	-32.7	-35.0	13.7	-19.1
Massachusetts	-45.5	35.1	28.1	57.7	5.8	-4.6	-40.1	-30.9	-51.5	-123.6	-17.0
Georgia	7.8	20.5	23.7	4.2	9.0	6.9	-19.7	-23.0	-43.4	-64.2	-7.8
Virginia	5.0	0.5	-1.9	18.2	3.4	8.6	-18.3	-31.3	-29.2	-15.3	-6.0
California	49.8	-15.0	-8.4	2.0	-4.0	-7.4	2.9	4.7	-3.8	4.4	2.5
Michigan	-23.7	-0.4	1.4	-2	28.5	20.4	23.4	9	-0.2	24.8	8.1

Source: NAIC Profitability Report

Table A8
Medical Malpractice Insurance
Calendar Years 1991 - 2000
PERCENTAGE RETURN ON NET WORTH

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	Ten Year Average
Texas	-9.4	5.6	-2.9	-4.4	-4.0	1.5	6.7	-1.7	-8.2	-3.3	-2.0
Florida	19.7	14.7	15.4	-0.7	-4.7	7.7	-5.1	-0.5	-2.8	-14.0	3.0
North Carolina	7.8	17.3	11.9	4.2	8.4	11.8	1.2	4	-4.1	0.4	6.3
Maryland	23.0	19.8	14.2	2.3	7.1	8.5	1.2	-7.4	0.3	-3.1	6.6
Ohio	13.4	21.9	12.4	19.7	6.6	6.8	4.7	-4.3	-2.3	-4.6	7.4
Illinois	3.1	5.5	3.6	5.4	7.6	18.2	12.9	5.7	11.3	3.1	7.6
Tennessee	22.2	22.1	19.7	11.7	13.8	9.8	1.5	11.5	-4.3	-23.4	8.5
Arizona	14.6	19.2	14.5	13.8	12.4	2.7	4.7	-1.4	4.3	5.2	9.0
New Jersey	-2	1.8	9.6	8.2	7.3	4.9	14.7	14.3	17	18.4	9.4
Pennsylvania	-7.5	44.7	20.3	30.1	10.5	7.2	8.4	4.9	-6.9	-2.6	10.9
Virginia	18.9	19.0	14.2	18.1	12.9	14.7	6.3	3.4	2.5	7.7	11.8
Georgia	19.0	25.8	23.2	12.9	14.6	13.9	6.9	6.7	-0.6	-3.2	11.9
New York	13.3	4.0	13.8	14.4	19.9	18.8	20.7	9.7	7.4	17.1	13.9
Massachusetts	0.5	34.5	28.3	34.1	16.7	14.0	7.0	9.3	4.7	-3.7	14.5
California	37.7	15.9	15.1	15.0	13.0	11.6	13.8	13.8	8.8	13.7	15.8
Michigan	12.0	22.1	18.9	13.8	23.5	20.4	19.5	15.4	10.9	19.3	17.6

Source: NAIC Profitability Report

Table A9
COMPANIES WRITING PHYSICIANS AND SURGEONS
MEDICAL PROFESSIONAL LIABILITY INSURANCE
Based on Data Reported as of 3/31/02

INSURANCE COMPANY NAME	STATUS IN TEXAS	FORMS AND RATES REGULATION	NO. OF INSURED
Texas Medical Liability Trust (TMLT)	Authorized pursuant to 21.49-4	Forms and rates are not subject to TDI regulation, however, the Trust is required to submit forms and rates for informational purposes	9,964
The Medical Protective Company	Admitted	Forms are prior approval and rates are file and use – Art. 5.13-2 and 5.15-1, Texas Insurance Code	5,235
The Doctors Company, An Interinsurance Exchange	Admitted	Forms are prior approval and rates are file and use – Art. 5.13-2 and 5.15-1, Texas Insurance Code	1,456
Texas Medical Liability Insurance Underwriting Association (JUA)	Authorized pursuant to 21.49-3	Forms are prior approval and rates are file and use – Art. 5.13-2 and 5.15-1, Texas Insurance Code	510*
American Physicians Insurance Exchange (APIE)	Admitted	Forms are prior approval and rates are file and use – Art. 5.13-2 and 5.15-1, Texas Insurance Code	278
Evanston Insurance Company	Surplus Lines	Forms and rates unregulated	115
Texas Hospital Insurance Exchange (THIE)**	Admitted	Forms are prior approval and rates are file and use – Art. 5.13-2 and 5.15-1, Texas Insurance Code	19
CNA**	Admitted	Forms are prior approval and rates are file and use – Art. 5.13-2 and 5.15-1, Texas Insurance Code	17
Essex Insurance Company	Surplus Lines	Forms and rates unregulated	3
American International Group***	Admitted	Forms are prior approval and rates are file and use – Art. 5.13-2 and 5.15-1, Texas Insurance Code	
American International Group***	Surplus Lines	Forms and rates unregulated	
		TOTAL	17,597

Table A9 (continued)
COMPANIES WRITING PHYSICIANS AND SURGEONS

INSURANCE COMPANY'S WRITING THROUGH PURCHASING GROUPS	STATUS IN TEXAS	FORMS AND RATES REGULATION	NO. OF INSURED
Preferred Professional Insurance Company**	Admitted	Writes through Purchasing Group – forms and rates not required to be filed for approval	269
The Medical Assurance Company, Inc.	Admitted	Writes through Purchasing Group – forms and rates not required to be filed for approval	264
Steadfast Insurance Company	Surplus Lines	Writes through Purchasing Group – forms and rates not required to be filed for approval	257
Truck Insurance Exchange	Admitted	Writes through Purchasing Group – forms and rates not required to be filed for approval	87
Health Care Indemnity**	Admitted	Writes through Purchasing Group – forms and rates not required to be filed for approval	69
Texas Medical Insurance Company**	Admitted	Writes through Purchasing Group – forms and rates not required to be filed for approval	43
NCMIC Insurance Company**	Admitted	Writes through Purchasing Group – forms and rates not required to be filed for approval	10
Zurich American Insurance Company	Admitted	Writes through Purchasing Group – forms and rates not required to be filed for approval	7
American Zurich Insurance Company	Admitted	Writes through Purchasing Group – forms and rates not required to be filed for approval	6
		TOTAL	1,012

Table A9 (continued)
COMPANIES WRITING PHYSICIANS AND SURGEONS

RISK RETENTION GROUPS	STATUS IN TEXAS	FORMS AND RATES REGULATION	NO. OF INSURED
Ophthalmic Mutual Ins Co.**	Registered	Risk Retention Group - Forms and rates not required to be filed	231
OMS National Insurance Company**	Registered	Risk Retention Group - Forms and rates not required to be filed	226
National Guardian Risk Retention Group	Registered	Risk Retention Group - Forms and rates not required to be filed	185
Preferred Physicians Medical, Inc.**	Registered	Risk Retention Group - Forms and rates not required to be filed	45
		TOTAL	687

*Updated JUA info – see Table A10

**Company only writes certain segments of the market

***Incomplete Data Submitted

Table A10
TEXAS MEDICAL LIABILITY INSURANCE UNDERWRITING ASSOCIATION (JUA)

Policy Information as of 7/31/02
• 1,032 Physicians and other Non-Institutional risks (approximately 1,000 physicians)
• 13 Hospitals
• 24 Nursing Homes (12 for-profit and 12 not-for-profit)
1,069 total policies

Table A11
SUMMARY OF INVESTMENT INCOME FROM 1989 - 2000
Medical Malpractice Predominating Companies

Year	Total Invested Assets (000)[1]	Gross Investment Income (000)[2]	Investment Expenses (000)	Net Investment Income (000)[2]	Realized Capital Gains (000)	Unrealized Capital Gains (000)	Net Investment Income Yield	Realized Capital Gains Yield	Unrealized Capital Gains Yield	Total Yield
1989	$12,873,166	$1,046,450	$36,920	$1,009,530	$77,371	$23,801	7.8%	0.6%	0.2%	8.6%
1990	$14,457,169	$1,155,491	$40,765	$1,114,726	($3,270)	($32,552)	7.7%	0.0%	-0.2%	7.5%
1991	$16,081,076	$1,214,828	$44,904	$1,169,924	$152,890	$75,523	7.3%	1.0%	0.5%	8.7%
1992	$17,418,375	$1,220,473	$51,805	$1,168,668	$374,629	$28,519	6.7%	2.2%	0.2%	9.0%
1993	$19,651,822	$1,256,155	$76,032	$1,180,123	$482,407	$450	6.0%	2.5%	0.0%	8.5%
1994	$20,668,173	$1,268,458	$53,045	$1,215,413	($22,176)	($65,727)	5.9%	-0.1%	-0.3%	5.5%
1995	$23,125,183	$1,435,007	$53,926	$1,381,081	$275,979	$193,941	6.0%	1.2%	0.8%	8.0%
1996	$23,944,659	$1,442,560	$77,298	$1,365,262	$274,658	$89,567	5.7%	1.1%	0.4%	7.2%
1997	$24,277,779	$1,429,102	$81,880	$1,347,222	$409,279	$218,041	5.5%	1.7%	0.9%	8.1%
1998	$24,588,665	$1,387,926	$85,457	$1,302,469	$547,200	$33,246	5.3%	2.2%	0.1%	7.7%
1999	$24,522,751	$1,329,357	$85,158	$1,244,199	$289,536	$79,883	5.1%	1.2%	0.3%	6.6%
2000	$23,273,762	$1,295,291	$66,456	$1,228,835	$380,462	($441,648)	5.3%	1.6%	-1.9%	5.0%
						1998-ending Average Yield[3]	5.5%	1.2%	0.3%	7.0%
						1999-ending Average Yield[3]	5.3%	1.3%	0.3%	6.9%
						2000-ending Average Yield[3]	5.2%	1.5%	0.1%	6.8%

[1] Average of invested assets at beginning and end of the year. Also includes investments in affiliates and home office real estate.
[2] Includes interest, dividends and real estate income. Includes income from affiliates and home office real estate.
[3] A 3-year average of investment income, and 10-year averages of realized and unrealized capital gains is used.

Source: Bests Aggregates and Averages 1990 - 2001 Editions

PIAA

Average and Median Claim Payments
PIAA Data Sharing Project

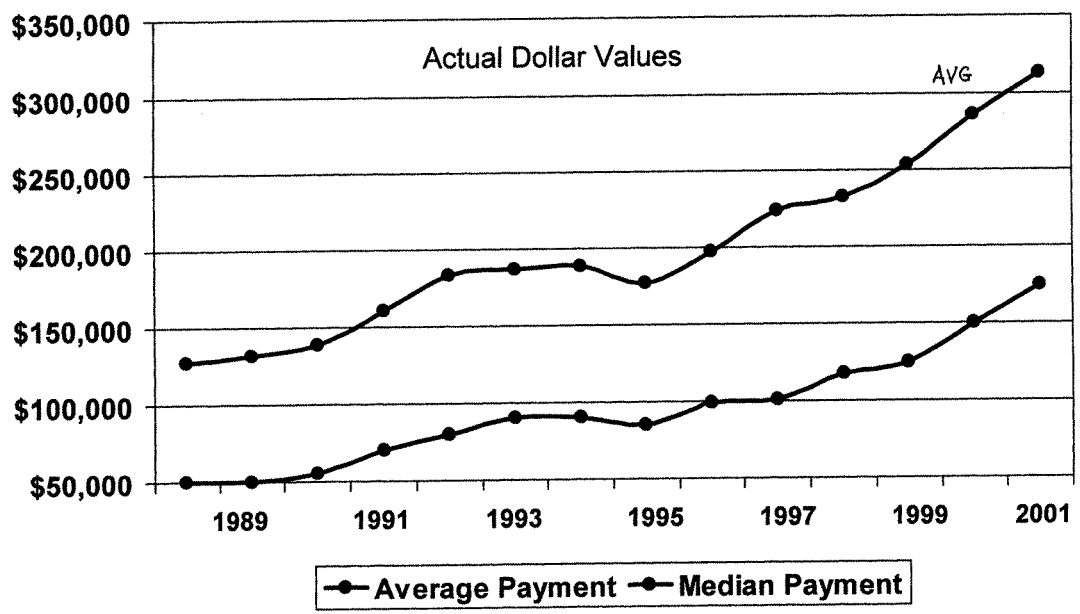


EXHIBIT B

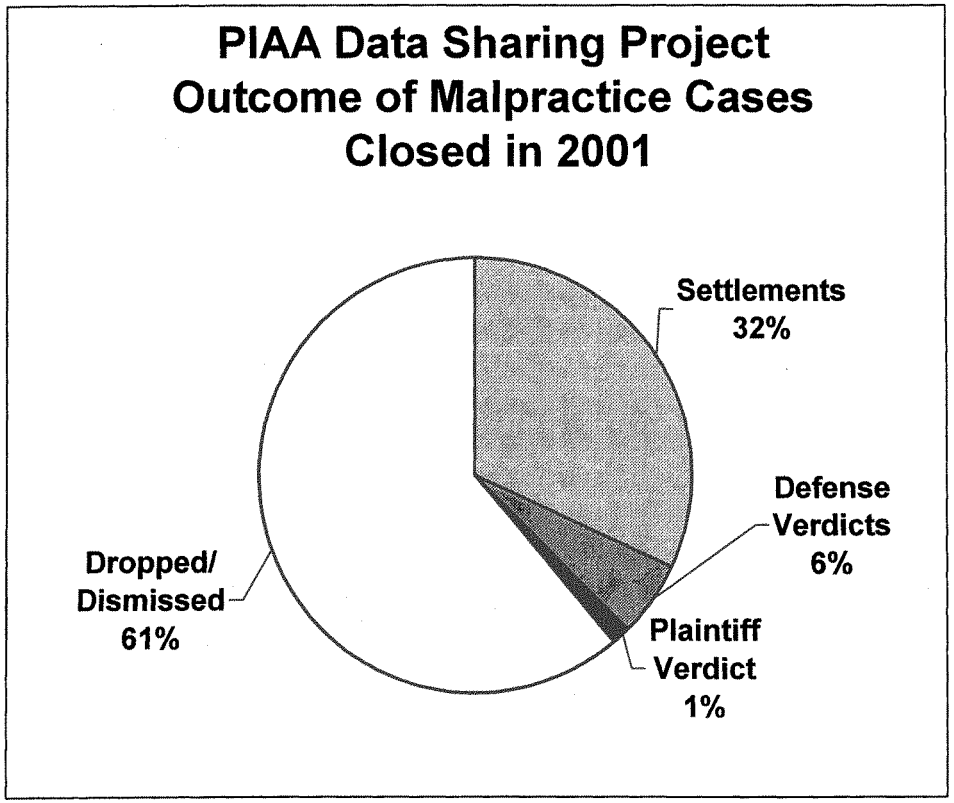

PIAA Data Sharing Project
Outcome of Malpractice Cases
Closed in 2001
Settlements
32%
Defense
Verdicts
6%
Plaintiff
Verdict
1%
Dropped/
Dismissed
61%

EXHIBIT C

PAYMENT VALUES – 2001

As of 09/04/02

Mean Indemnity Payment	**$310,215**
Mean Settlement	**$ 299,003**
Mean Verdict	**$ 496,726**

EXHIBIT D

PAYMENT VALUES – 2001

As of 09/04/02

Mean Indemnity Payment	$310,215
Mean Expense Payment	$ 28,801
Defense Verdict	$ 85,718
Plaintiff Verdict	$ 91,423
Settled	$ 39,891
Dropped/Dismissed	$ 16,743

EXHIBIT E

PIAA Data Sharing Project

% of Paid Claims by Payment Threshold

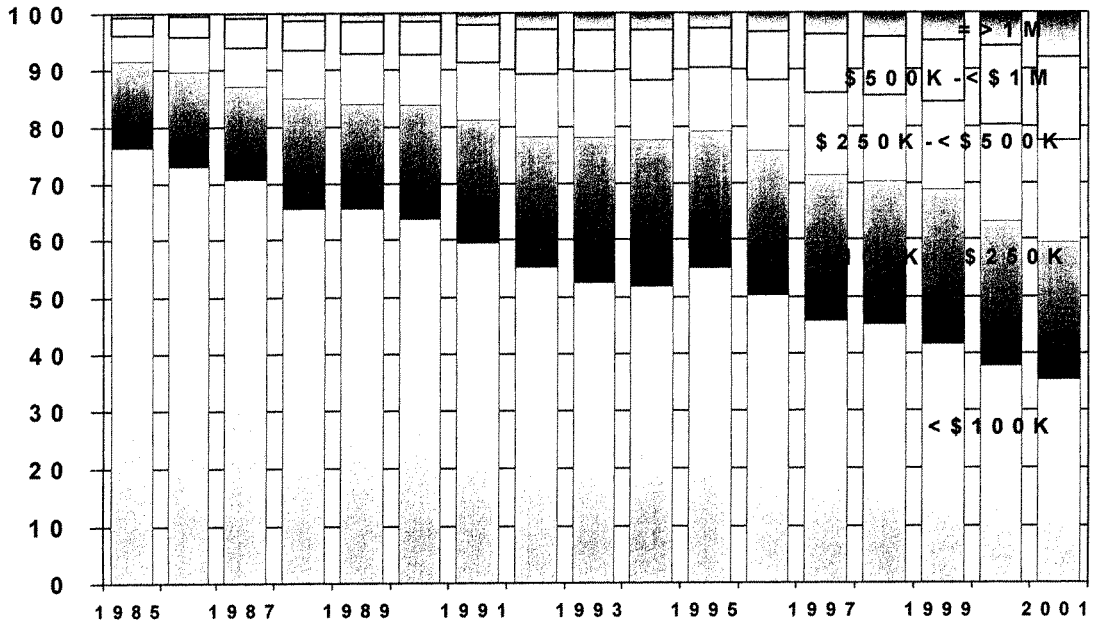


EXHIBIT F

PIAA Data Sharing Project

Claim Payments =>$1 Million

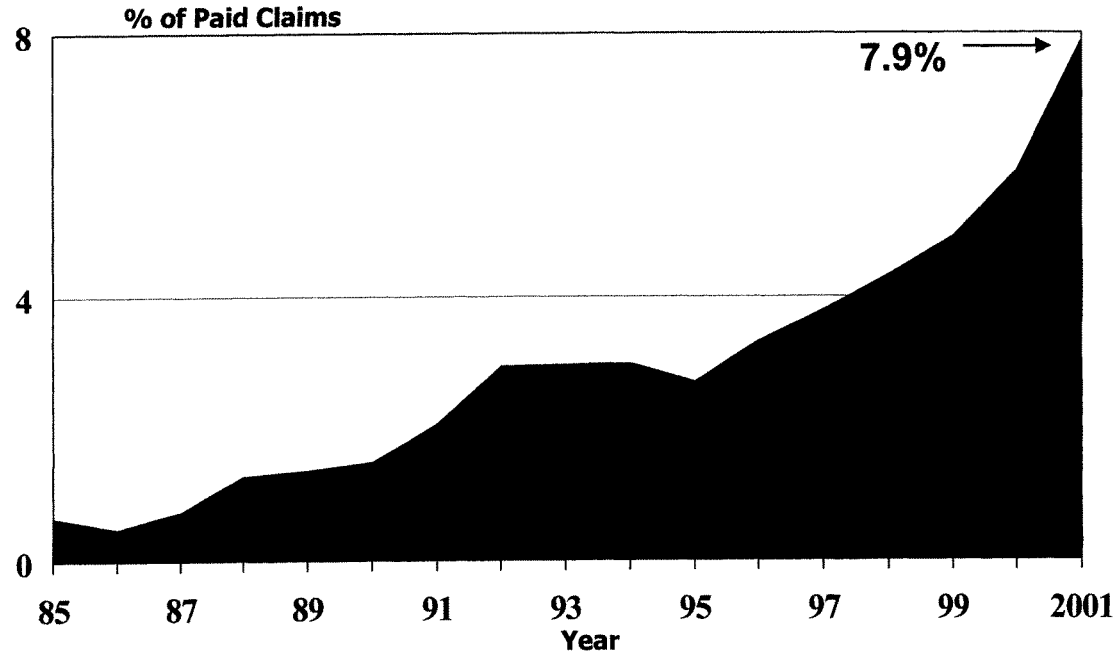
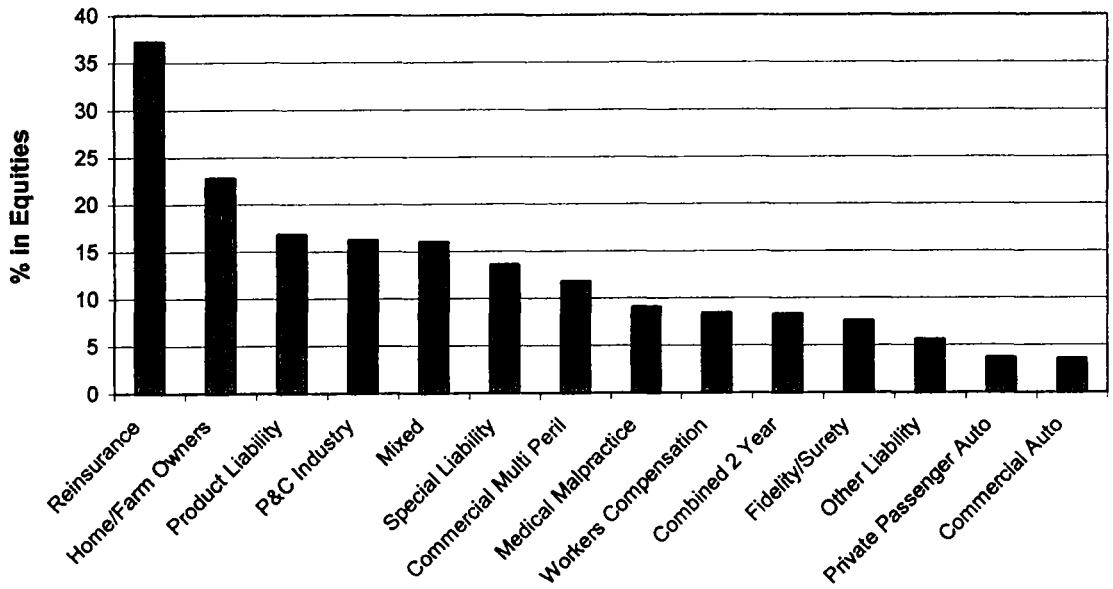


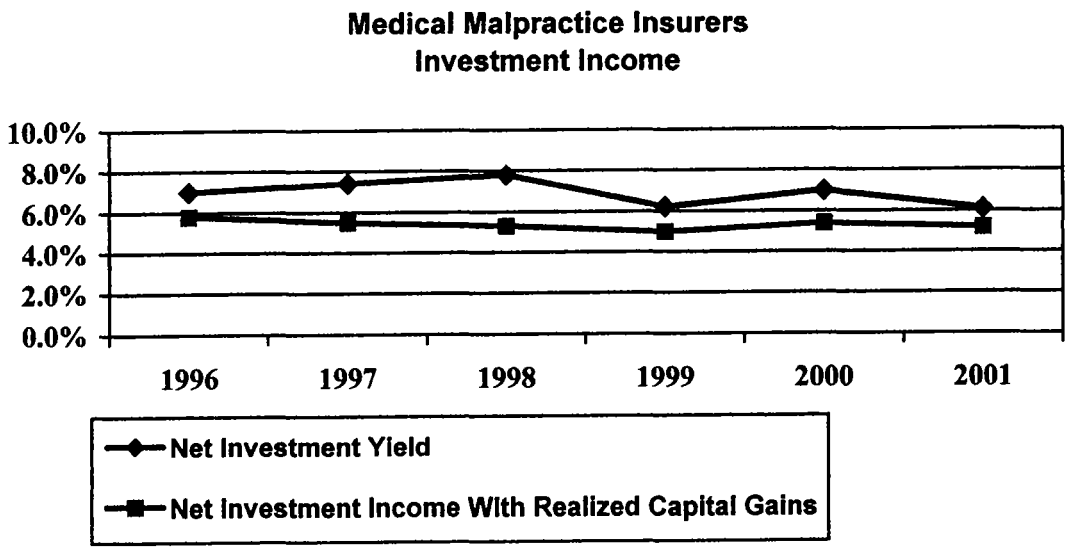
EXHIBIT G

P&C Equity Allocation 2001



Source: Brown Brothers Harriman & Co., Insurance Industry Asset Allocation Study using NAIC data

EXHIBIT H

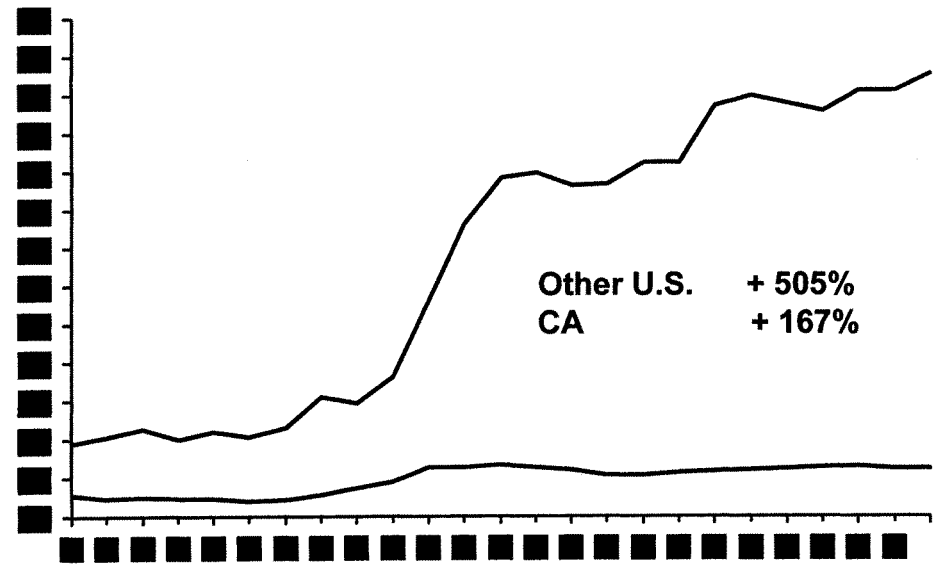


Source: A.M. Best Aggregates & Averages, 1997 through 2002 Editions,
(Predominantly Medical Malpractice Insurers).

EXHIBIT I

Savings from MICRA Reforms

California vs. U.S. Premiums 1976 - 2000



$ Billions

Source: NAIC Profitability By Line By State

EXHIBIT J

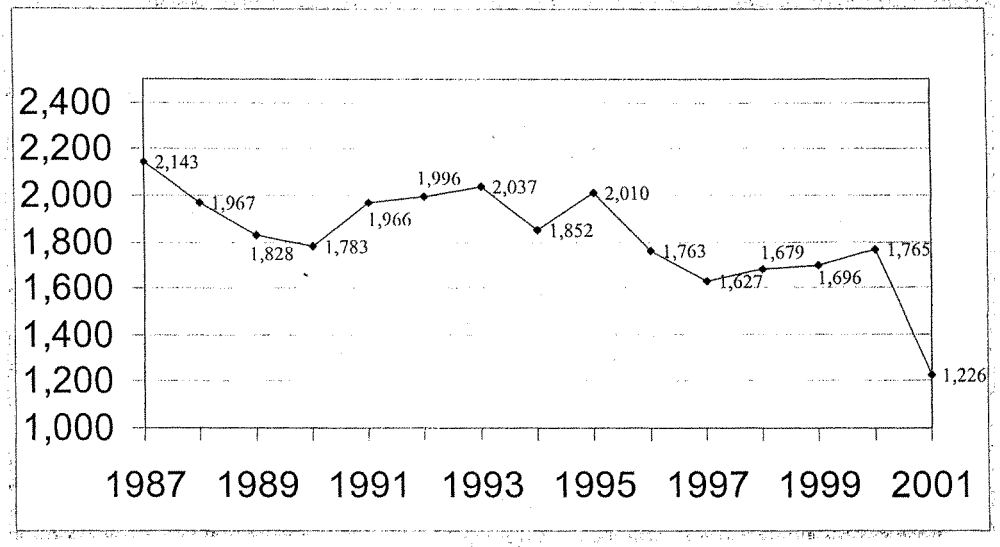
2002 Rates- $1mil/3mil Coverage
(as reported by Medical Liability Monitor)

	LA[1]	Denver[2]	Chicago[3]	Phila[4]	Miami[5]
IM	11,164	9,845	26,404	18,429	56,153
GS	36,740	34,644	68,080	82,157	174,268
OB/ Gyn	54,563	30,905	102,640	100,045	201,376

1 The Doctors Company
2 COPIC Insurance Company
3 ISMIE Mutual Insurance Company
4 Pennsylvania Medical Society Liability Insurance Company
5 First Professional Insurance Company

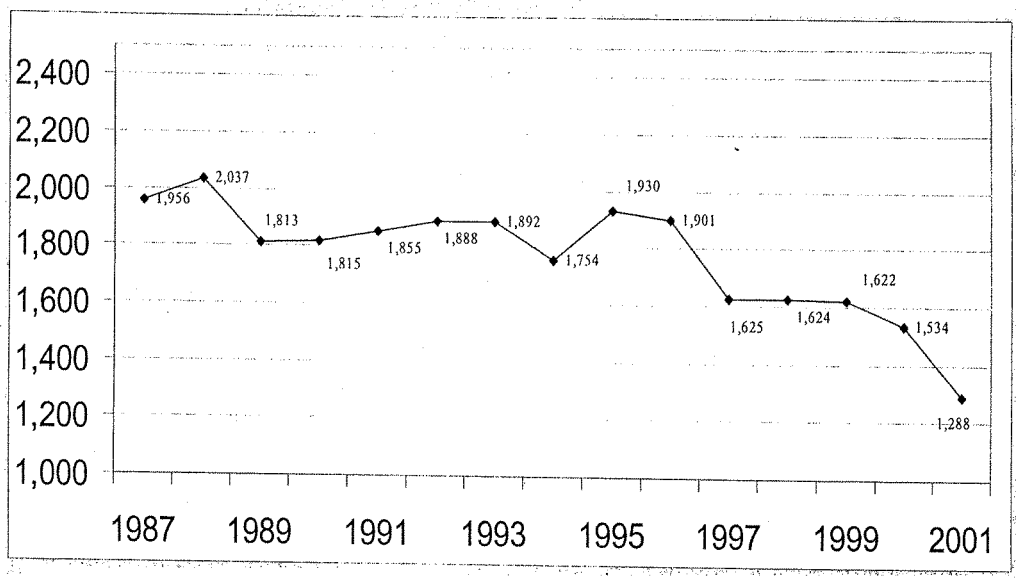
Angoff

MISSOURI MEDICAL MALPRACTICE REPORTED CLAIMS, 1987 - 2001



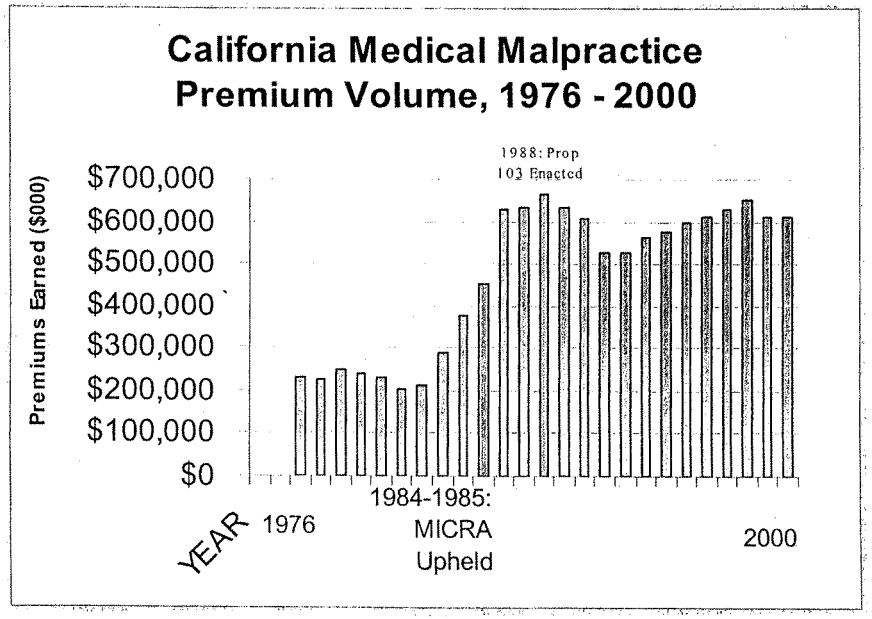
Source: 2001 Missouri Medical Malpractice Insurance Report

MISSOURI MEDICAL MALPRACTICE CLOSED CLAIMS, 1987 - 2001



Source: 2001 Missouri Medical Malpractice Insurance Report

CALIFORNIA MEDICAL MALPRACTICE PREMIUM VOLUME 1976 - 2000



Source: NAIC, Profitability By Line By State, 1977-2001

CALIFORNIA MEDICAL MALPRACTICE PREMIUM VOLUME
1976 - 2000

YEAR	PREMIUMS EARNED $000
1976	228,451
1977	227,077
1978	248,724
1979	238,932
1980	230,230
1981	203,825
1982	210,652
1983	287,256
* 1984	374,661
**1985	449,727
1986	629,448
1987	633,903
***1988	663,155
1989	633,424
1990	605,762
1991	529,056
1992	526,496
1993	563,004
1994	576,771
1995	597,660
1996	610,003
1997	628,858
1998	652,601
1999	611,785
2000	609,712

* MICRA's collateral source and periodic payment provisions upheld by California Supreme Court
** MICRA's cap on damages and limits on plaintiff's attorney's fees upheld by California Supreme Court
*** Prop 103 enacted
Source: NAIC, Profitability By Line By State, 1977-2001

MEDICAL MALPRACTICE v. ALL P/C LINES
1991 - 2000

	Loss Ratio	Return on Net Worth
Medical Malpractice	60.1	12.1
All Lines	66.9	8.3

Source: NAIC, Profitability By Line By State, 2001

Exh. 5

FCC-86-2172

Commercial Insurance Division
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123

August 8, 1986

RECEIVED
AUG 11
FORMS AND CONTRACTS

Honorable Bill Gunter
INSURANCE COMMISSIONER
Florida Department of Insurance
Tallahassee, FL 32301

ATTN: Mr. Charlie Gray, Chief
Bureau of Policy and Contract Review

Dear Mr. Gray:

RATE REVISION
CONTRACTORS LIABILITY POLICY PROGRAM
THE AETNA CASUALTY AND SURETY COMPANY
THE STANDARD FIRE INSURANCE COMPANY
THE AUTOMOBILE INSURANCE COMPANY OF HARTFORD, CONNECTICUT

In accordance with your Insurance Laws, our Companies file a revised liability rate level which results in an overall selected premium increase of 17.2% with an annual premium effect of $622,250.

Our Companies' decision to revise rates results only after a thorough and comprehensive analysis. We evaluated our experience, market conditions, tort reform, and other relevant factors as they affect the establishment of adequate rate levels. The enclosed exhibits prepared by actuarial unit are submitted in support of our rate filing decision, and demonstrate that the resultant rates are neither excessive, inadequate, nor unfairly discriminatory.

We propose to implement this filing with respect to all policies written on or after January 1, 1987. So as to not delay the filing of our rate level decision, revised rate pages will be forwarded under separate cover when available.

A stamped, self-addressed envelope is enclosed for your convenience in responding.

Sincerely,

Thomas L. Rudd

Thomas L. Rudd, Superintendent
Insurance Department Affairs - Commercial Lines

BODILY INJURY CLAIM COST IMPACT OF FLORIDA TORT LAW CHANGE

Summary

The following table summarizes the expected impact of the new Florida law on bodily injury claims costs (including Allocated Loss Adjustment Expenses). The impacts shown were developed from data gathered via a special claim study conducted by the AEtna. The claim study and the analysis are detailed in the succeeding sections of this memorandum.

Impact of Tort Law Changes

Impact of Tort Law Changes

Tort Law Change	Line of Business: Products Bodily Injury	Line of Business: All Other General Liability
Collateral Source Offset	0	(0.4%)
Joint & Several	0	0
Limitation of Noneconomic Damages to $450,000	0	0
Punitive Damages	0	0
Future Economic Damages over $250,000 Paid at Present Value	0	0

All Other General Liability includes the bodily injury liability portion of package policies, SMP Section II, and monoline General Liability policies. The analysis as shown is based solely on AEtna data and, therefore, is applicable only to AEtna's book of business.

Claim Study

The attached special claim analysis form, designed to gather data on the impact of the tort reforms, was completed by experienced Branch Office claim personnel. Claims eligible for analysis were selected according to the following criteria:

1. Commercial Casualty claims (excluding National Accounts business) for policy years 1981 through 1985
   a. reported prior to January 1, 1986
   b. open as of May, 1986
   c. closed during the last six months

2. All claims in category (1) with indemnity payments or reserves over $25,000 were analyzed (total of 55 claims).

3. Fifty closed claims with indemnity of less that $25,000 were randomly selected.

The completed forms were reviewed for internal consistency prior to coding and analysis.

Collateral Source Analysis

Exhibits I and II detail the analysis of the revision in the collateral source rules. Exhibit I is for claims over $25,000 indemnity. Exhibit II is for claims under $25,000 indemnity.

Exhibit I shows that since the right of subrogation exists for many collateral sources available to the plaintiff, the economic losses incurred are not expected to be substantially reduced due to the law change. Furthermore, current AEtna claim settlement practices recognize, in part, the existence of collateral sources as part of the negotiating process used in arriving at a mutually satisfactory damage value with the plaintiff.

Exhibit II shows that for claims under $25,000, no additional savings are expected due to the change in Florida law.

Joint and Several Analysis

Exhibit III details the analysis of joint and several additional payments made by AEtna. Total joint and several payments were 4.5% of indemnity payments over $25,000. A review of each claim generating additional payments due to joint and several liability indicated no reduction in those payment due to the interaction of economic damages sustained by the plaintiff, the percentage of liability assigned to AEtna's insured, and the policy limits purchased.

Analysis of Limitation of Noneconomic Damages to $450,000

Nine claims had the potential for coming under the new limitation for noneconomic losses. The nine cases were identified on the basis of full liability value--not our insured's share of the liability. Data in the above format allowed for a review of whether total claim value could be reduced and whether such a reduction would impact on AEtna's incurred claim cost.

The review of the actual data submitted on these cases indicated no reduction of cost. This result is due to the impact of degree of disability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff; all seemed to reduce the expected noneconomic component of damages to less than $450,000.

Analysis of Punitive Damages

Only two cases were found where punitive damages had an impact on the claim settlement value. The total impact was estimated at less than $15,000 or less than 0.1% of total indemnity payments. Consequently, it appears that there will be no impact on AEtna's claim values due to changes in the allocation of the punitive damages awarded.

Analysis of Installment Payment of Future Economic Damages Over $250,000

Ten claims had the potential for coming under this section of the law. The review of individual cases indicated no net savings to AEtna for the following reasons:

1. interaction of policy limits, past economic losses, and future economic losses

2. settlement value of the case

3. apparent implicit recognition of the periodic nature of future damages

Overall Summary

The expected net reduction in claim costs is based on an analysis of AEtna claims. As such, the analysis is applicable only to AEtna's book of business.

Due to the level of detail of the historical claim data, informed claim judgement was required in some instances to ascertain some of the detail required for the analysis. The judgement, if any, was exercised by experienced claim adjustors and is implicit in the analysis.

The analysis shown represents the best estimate of future cost reductions if the law as currently structured remains in effect. However, the sunset provision of the law takes effect in four years. Furthermore, the law applies only to cases filed under the law, and the Florida statute of limitations is four years. Consequently, it is possible that any plaintiff who might be severely impacted by the provisions of the law would delay filing until after the law expires. If this situation arises, then the expected reductions will be lower than those indicated in this memorandum.

SAVINGS FROM TORT REFORM ACCORDING TO ST. PAUL:

"The conclusion of the study is that the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice."

Exh. 6

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM

In 1986, Florida passed a number of changes to the tort system. We have reviewed the tort changes and their potential effect on our medical professional liability experience. Our review is based on a study of over 300 Florida closed claims. The total effect of the bill based on this evaluation was very small.

Evaluation:

Of the 313 closed claims that were studied, only four claims would have been effected by the law for a total effect of about 1% savings. (Exhibit A) Furthermore, all of these savings would have been eliminated if the courts had assigned only 10% more of the blame on our insureds than our claim department had estimated. It's highly likely that there would have been no savings on these claims had the bill been in effect. (Exhibit B)

Our study covered all of our Florida physicians, surgeons and hospital claims that closed in 1983 and 1984. Economic loss was determined based on the plaintiff's medical loss, weekly wage, and time lost from work. These losses were reduced for the time value of money.

We added the noneconomic loss cap to the total economic losses. The cap is $450,000 times the portion of negligence assigned to our insured. We compared this maximum award under the new law to the amount that the St. Paul actually paid on behalf of our insured.

The conclusion of the study is that the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice.

Comments on other provisions of the bill:

a. Collateral source offset

The medical malpractice provisions prior to this act provided for subrogation against collateral providers. The effect of this subrogation would be similar to the effect of the collateral source rule. Therefore, the net effect of eliminating the subrogation and allowing collateral sources is negligible.

b. Itemization of Damages

Damages were itemized in our evaluation of this tort reform and no savings were shown. They are probably already implicitly itemized by either juries or our claim department when settling claims. We expect no savings from this provision.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM
(Continued)

c. Frivolous Suit Protection

This provision can either work for or against us depending on who wins the case. No savings are expected from it.

d. Additur/Remittitur

This provision can also work for or against us. No savings are expected.

e. Punitive Damages

The legislation reduces the monetary incentive for punitive damage cases, but not total award amounts. Since these cases often have a retaliatory incentive, no savings are expected.

f. Timing of Effects

The tort changes made in Florida apply to losses occurring on or after July 1, 1986. On a claims-made policy, they will effect only the portion of our expected losses with accident date after July 1, 1986. This will impact the equivalent of our first year losses.

g. Conclusion

The tort law changes effective July 1, 1986 in Florida will, hopefully, have a positive impact on loss costs for occurrences after that date. However, to forecast the effect is highly speculative. Our evaluation of prior losses showed little or no savings under key provisions of the law and our analysis of other provisions show no expected savings. Our best estimate is no effect from the tort changes.

It can be hoped that the adoption of these tort changes will have an intangible effect on society, and further work to mitigate future loss trends. However, the trends in medical malpractice have been very high. The effect of the reform needs to be very strong to stem such trends.

Medical Professional Liability
State of Florida

Exhibit A

FLORIDA STATE TORT REFORM EVALUATION

EFFECT OF NONECONOMIC DAMAGES CAP, APPORTIONMENT OF LIABILITY, AND MANDATORY STRUCTURED SETTLEMENTS

FLORIDA PHYSICIANS' AND SURGEONS' DATA

LOSS SEVERITY	1984 INCURRED LOSS & LAE	PROJECTED PERCENTAGE SAVINGS	PROJECTED LOSS DOLLAR SAVINGS
EMOTIONAL	$759,962	0.0%	$0
TEMPORARY	$5,867,384	0.0%	$0
PERMANENT PARTIAL	$12,424,121	0.0%	$0
PERMANENT TOTAL	$8,347,000	0.0%	$0
DEATH	$9,337,688	4.5%	$420,196
TOTAL	$36,736,155	1.1%	$420,196

COUNTRYWIDE PHYSICIANS' AND SURGEONS' DATA

LOSS SEVERITY	1985 INCURRED LOSS & LAE	PROJECTED PERCENTAGE SAVINGS	PROJECTED LOSS DOLLAR SAVINGS
EMOTIONAL	$8,217,941	0.0%	$0
TEMPORARY	$81,459,529	0.0%	$0
PERMANENT PARTIAL	$110,004,377	0.0%	$0
PERMANENT TOTAL	$80,695,313	0.0%	$0
DEATH	$99,481,842	4.5%	$4,476,683
TOTAL	$379,859,002	1.2%	$4,476,683

Medical Professional Liability
State of Florida

Exhibit B

FLORIDA CLOSED CLAIM STUDY

CLAIMS PRODUCING SAVINGS UNDER JULY 1,1986 LEGISLATION

LOSS SEVERITY	ECONOMIC LOSS	INSURED NEGLIGENCE	INDEMNITY PAYMENT	NONECONOMIC CAP	PROJECTED SAVINGS
TEMPORARY	$0	0%	$66	$0	$66
TEMPORARY	$0	0%	$194	$0	$194
DEATH	$10,000	3%	$38,375	$11,250	$17,725
DEATH	$5,000	25%	$350,000	$112,500	$232,500

CLAIMS PRODUCING SAVINGS UNDER JULY 1,1986 LEGISLATION
ASSUMING 10% GREATER LIABILITY ASSIGNED TO INSURED

LOSS SEVERITY	ECONOMIC LOSS	INSURED NEGLIGENCE	INDEMNITY PAYMENT	NONECONOMIC CAP	PROJECTED SAVINGS
TEMPORARY	$0	10%	$66	$45,000	$0
TEMPORARY	$0	10%	$194	$45,000	$0
DEATH	$10,000	13%	$38,375	$56,250	$0
DEATH	$5,000	35%	$350,000	$450,000*	$0

* INSURED LIABILITY EXCEEDS CLAIMANT LIABILITY

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company

SAVINGS FROM TORT REFORM ACCORDING TO AETNA:

"IMPACT OF TORT LAW CHANGES

Tort Law Change	Line of Business: Products Bodily Injury	Line of Business: All Other General Liability
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Joint & Several	0	0
Limitation of Noneconomic Damages to $450,000	0	0
Punitive Damages	0	0
Future Economic Damages over $250,000 Paid at Present Value	0	0"

[Whereupon, at 5:48 p.m., the committee was adjourned.]

○