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MEDICAL LIABILITY REFORM: STOPPING THE SKYROCKETING PRICE OF HEALTH CARE

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BEFORE THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

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THURSDAY, FEBRUARY 17, 2005

HOUSE OF REPRESENTATIVES
COMMITTEE ON SMALL BUSINESS
Washington, DC

The Committee met, pursuant to call, at 10:08 a.m. in Room 2360, Rayburn House Office Building, Hon. Donald A. Manzullo, presiding.

Present: Representatives Manzullo, Velazquez, Chabot, Lipinski, Graves, Akin, Christensen, Davis, Musgrave, Bordallo, Grijalva, Sanchez, Poe, Barrow, Sodrel, Fortenberry, Fitzpatrick, Westmoreland and Gohmert.

Chairman MANZULLO. Good morning. It is my pleasure to welcome you to today's Small Business Committee hearing on the critical issue of skyrocketing medical liability insurance, and its impact on health care and access to health care.

This is a hearing to highlight the problem that exists in health care. I am not that much interested in hearing about specific legislation, so I will counsel the witnesses to speak about your own personal experiences. This is an opportunity, a national opportunity to share your horror stories. Even though legislation is out there, I would much prefer to hear what has happened to you because it is very important that the American people understand, first of all, that there is a problem. There is no better way to demonstrate a problem than to have people who are in the medical profession themselves tell us what their firsthand stories are, or anecdotal stories of your colleagues that have been through something like that.

Congress needs to explore ways to slow down the rising health care costs, and the reasons that the costs of health care continues to see increases, is the spiraling cost of doctor's medical liability premiums and hospitals facing the same problem.

Litigation has escalated and awards have skyrocketed. Multi-million dollar court decision and jury awards have left doctors with medical liability premiums increases of 40 to 50 percent each year. Doctors in certain high-risk fields of medicine can expect to be sued at least once in their career.

Between 2000 and 2003, the number of medical liability claims has jumped 46 percent in Illinois, to more than 3,500 claims. The average indemnity per claim also has risen dramatically. In 1990, the average indemnity was about $310,000; in 2003, it was nearly

$600,000 according to the Illinois State Medical Insurance Exchange.

As a result, many doctors are retiring or leaving the practice of medicine. Emergency rooms in rural facilities have been particularly impacted. Many other doctors are moving to states that have taken action to cap jury awards which stabilizes medical malpractice costs.

In my home state of Illinois, it is common practice for doctors to move a few miles to Wisconsin and set up shop there. I know of one OB-GYN in Illinois who left her practice to go back to being a pharmacist where she could earn more money and not worry about medical malpractice and premiums. She explained that after paying malpractice insurance, she and another physician made $50,000, a third doctor made $60,000, a forth doctor made $70,000. Their office manager made more than all of them, $75,000. These were four ladies practicing in suburban Chicago, and as of three years ago her medical liability insurance was $425,000 for the four of them.

In my hometown of Rockford, we have lost several of our neurosurgeons to the Badger state. In southern Illinois, there are very few neurosurgeons, if any, left at all.

This not only affects the cost of medical care, it affects access to medical care. There are numerous stories about women having to drive an hour or more to see their doctor to deliver their baby. If you are in a car accident, there may not be a neurosurgeon available to save your life. If you live in a rural area, a clinic or hospital may have been closed.

Just in case you do not think this affects you and your pocketbook, doctors must practice defensive medicine by ordering extra tests to protect themselves against potential law suits. It is estimated that the federal government, through its funding of Medicare and Medicaid, paid an additional $28 billion to $48 billion per year for health care due to the cost of medical liability coverage in defensive medicine.

Thirty years ago California passed comprehensive medical liability reform. Who would ever think California would lead in the reform?

According to the Department of Health & Human Services, states that have limited non-economic damages have seen premium increases by less than 20 percent. States without limits on non-economic damages have seen premium increase on average of 45 percent.

There is quantifiable evidence that medical liability reform works. According to the AMA, there are 20 states that are in crisis. None of those crisis states have passed a medical liability reform. Well, actually Illinois did, but several years ago the Illinois Supreme Court held it was unconstitutional according to the Illinois Constitution.

The other problem we have had here, is that there has been an unnecessary war between physicians and attorneys, and that has got to come to an end. I practiced law for several years, and even though I did mostly defensive law, if your son gets hurt in a car accident, you want to get the best trial lawyer available. So the continuous pounding by some of the trial lawyers, I do not think

that gets anywhere. There has to be a way where everybody in this country comes to a consensus; that there is a problem, and something has to be done with regard to it.

Maryland just came up with a very interesting result. It imposed a two percent tax on HMOs with an indemnity fund that will help to stop the dramatic increases in medical liability premiums. The State of Wisconsin, met with Governor Doyle, also has an indemnity fund with a $500,000 cap.

I am open to plans that will help the medical profession, and at the same time maintain at least a basic form and fairness for the truly injured plaintiff that needs redressing in the courts. There is a way to do it, and that is one of the reasons that we have you here to tell your side of the story on it, and try to come up with some possible solutions.

I look forward to the testimony of the witnesses here this morning. We have a five-minute clock on there. When it goes red, it is time to sum it up, and I look forward to the opening statement of my ranking member, Congresswoman Velazquez.

[Chairman Manzullo's statement may be found in the appendix.]

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

Mr. Chairman, while I certainly recognize that it is your prerogative to delve into the issue you have a personal interest in, it is something we have witnessed for two Congresses now. My question is why—what are we doing here today?

We are supposed to be discussing the Committee's views on estimates for Fiscal Year 2006 budget request for the Small Business Administration, not holding a hearing on an issue that our Committee has no jurisdiction over.

We are supposed to be discussing why the administration wants to terminate programs like the MICRA, that for every dollar we invest, generates $2 in revenue, not of a hearing that was held two weeks ago in the Judiciary Committee, and then last week in Energy and Commerce.

We are supposed to look at how the agency's budget, which has been cut in half in just four years, is failing this nation. Mr. Chairman, these informational-like hearings are fine. We could just start calling them info hearings. I suggest that next week we have a hearing on how the budget will impact small business.

But this type of hearing should not come at the expense of our other duties, and that is what is happening today. It was an unacceptable deficiency that took place last Congress in this Committee, and was why Democrats raised this issue last week. We will continue to do so until the Committee starts to live up to its responsibility, all of its responsibility, not just a select few.

I am sorry to the witnesses that have to be here today to witness this exchange on how this Committee is not working properly. Your issues are very important, and I look forward to your testimony. Its just that we should not be holding this hearing today of all days.

We are facing a health crisis in this country. It is outstanding that in the United States, the country with the world's largest GNP, there are 44 million Americans who cannot afford health care. We should be outraged.

Nowhere is this health care gap more striking than in our nation's small businesses. More than 60 percent of the 33 million adults and 11 million children without health insurance are small businesses owners, employees, or family members. That fact is the real tragedy we must focus on is this issue, and address it.

Small businesses bear the brunt of the health insurance crisis because of lack of good choices for them and the high cost. An increasing health care cost is an important matter for small businesses. Unfortunately, in the past few years many have seen annual health insurance premium increases in double digits. One element of increasing costs is high medical practice premiums. That is the issue we will examine today.

In the last Congress, we addressed this medical malpractice twice, and last week the same bill was introduced again. The stories of staggering malpractice insurance rates are well known to us, but it is important we get to the heart of the matter and find out what is really driving those increases. That is the information we need to provide a real solution to the problem, and reduce costs for these doctors, and ultimately help small businesses.

After all, Congress has been asked to step in and change 150 years of case law that allow states to control the way victims of medical malpractice were made whole. Major changes to our legal system must at least be based on the best independent data. We have solutions based on emotion which will not solve anything.

Unfortunately, that is not an easy task. Each side has their compelling stories. While one side sees a courtroom crisis driving up premiums, driving out doctors and driving away small businesses, the other side sees an insurance industry jacking prices to make up for cyclical investment losses.

If malpractice premiums ultimately are not reduced, then the insurance industry's benefit from the protective barriers on recovery by patients or their families. In both cases, small businesses and their employees will get hurt.

While we hear from health professionals today, there is also compelling data that malpractice costs and jury awards are a small fraction of overall medical costs. We also have some practical experience on which to base our decision since caps and restriction are already in place in 25 states.

In some of those states, the same kinds of caps that we are being asked to consider have failed to hold down medical malpractice rates. Texas and Florida are two examples. Perhaps the correct answer lies somewhere in between.

In our zeal to help our nation's entrepreneurs we have seen several bills move through Congress that were represented as small business relief, but in reality provided the lion's share of the benefits to large corporations. I hope that today's hearing will be able to separate hard facts from perceptions and help us make choices that actually address the problem and reduce costs for small businesses.

Thank you, Mr. Chairman

[Ranking Member Velazquez's statement may be found in the appendix.]

Chairman MANZULLO. Thank you, Congresswoman Velazquez.

Our first witness is Dr. Don Palmisano from Metairie, Louisiana. My dad was born in Donaldsonville.

Dr. PALMISANO. Oh.

Chairman MANZULLO. Down there in swamp country.

Dr. PALMISANO. Yes, sir.

Chairman MANZULLO. And Dr. Palmisano, we look forward to your testimony.

STATEMENT OF DR. DONALD PALMISANO, AMERICAN MEDICAL ASSOCIATION

Dr. PALMISANO. Good morning. Thank you. I want to thank Chairman Manzullo and Ranking Member Velazquez for holding this hearing to focus on how our broken medical liability system affects patient access to quality health care.

My testimony is on behalf of the American Medical Association, which sets policy through a democratic process in its house of delegates composed of physicians representing every state, over 100 national medical specialty societies, federal service agencies as well as medical students.

The AMA's policy on how to fix the broken medical liability system is detailed in our written statement. My testimony today is not only from the perspective of a medical professional, but that of a small business. In fact, approximately 75 percent of practice-based physicians work in or own small practices of less than nine physicians.

Medical liability insurance premiums are part of our overhead expenses, and when expenses increase, physicians must either raise revenue by increasing fees or cut other expenses to sustain their practices. Increasing fees are becoming more challenging as Medicare, Medicaid and managed health care plans limit payments for services rendered to patients.

Alternatively, to trim expenses, physicians face the difficult choice of cutting staff, foregoing new medical equipment, or limiting certain aspects of their practice. The litigious climate in our country also is taking its toll, such as decreasing the availability of physicians who provide obstetrical care.

When I took part in a physician rally in Fort Lauderdale, Florida, with more than 500 physicians and patients demanding action on the liability crisis, I met a young obstetrician, Dr. Chandra Azman. She stood hand in hand with her pregnant patient and told the crowd that helping a woman deliver her baby is the most extraordinary experience a doctor can have, and I will not be doing that anymore.

Her liability premiums had tripled. She had no choice but to give up her part of the practice she treasured most. It is a loss beyond calculation for her and her patients.

Anytime vital health care services are limited, patients' access to care is jeopardized, especially emergency care. In 2003, 17-year-old John Lucas from Greenwood, Mississippi was in an auto accident.

John suffered a serious head injury, and was taken to Delta Regional Medical Center in Greenville, which has a Level II trauma center.

Tragically, that day Greenville's only remaining neurosurgeon was not available. John had to be air-lifted to University Medical Center in Jacksonville, but by the time he arrived it was too late. He never regained consciousness and died six weeks later.

For 25 years, Greenville had 24-hour neurosurgical coverage, but the medical liability crisis in Mississippi ended that. One of the two neurosurgeons in Greenville no longer practices neurosurgery because of the legal climate and costs of liability insurance.

John's father, himself a trauma surgeon, said his son picked the wrong day to have his accident. The bleed inside his head had doubled by the time he received care.

There is also the story of LeeAnn Dyce from Vicksburg, Mississippi, who testified before the House Judiciary Committee about a very personal, very tragic consequence of the liability crisis. Her husband Tony was in an auto accident and suffered a head injury that resulted in permanent brain damage because there no longer was a neurosurgeon at the hospital, as he had left the state because of the liability crisis.

These are just a few of the hundreds of stories I have heard as I have talked to physicians and patients across the country. They represent the symptoms that tell us our nation is facing a crisis because of a broken medical liability system. Escalating jury awards and the high cost of defending against lawsuits, even meritless claims, are the primary drivers of increasing medical liability insurance premiums.

This crisis exacts a steep cost in terms of access to care for patients, stress on physicians, and strain on the entire health care system.

Mr. Chairman, the AMA looks forward to working with Congress to pass common sense medical liability reforms this year so that patients can have greater access to medical care. The health of the nation depends on it.

Thank you.

[Dr. Palmisano's statement may be found in the appendix.]

Chairman MANZULLO. Doctor, your complete statement along with those of all the other witnesses will be made part of the record without objection.

I also noticed that you are attorney.

Dr. PALMISANO. Yes, sir.

Chairman MANZULLO. And a doctor.

Dr. PALMISANO. Yes, sir.

Chairman MANZULLO.

Our next witness is Dr. Tom Gleason with the Alliance of Specialty Medicine in Morton Grove, Illinois.

Dr. Gleason, we look forward to your testimony. You might want to pull the microphone up a little bit closer. Thank you.

TESTIMONY OF DR. THOMAS GLEASON, ALLIANCE OF SPECIALTY MEDICINE

Dr. GLEASON. Yes, sir. Thank you.

Chairman Manzullo, Ranking Member Velazquez, and members of the Committee, my name is Thomas F. Gleason, M.D.

Chairman MANZULLO. A little bit closer. We are having problems with the microphone.

Dr. GLEASON. Yes, sir. How is that? Is that better?

Chairman MANZULLO. Proceed, please.

Dr. GLEASON. Okay, thank you.

I am a practicing orthopedic surgeon in Illinois, and managing partner at the Illinois Bone and Joint Institute, a partnership of approximately 70 orthopedic surgeons. On behalf of the Alliance for Specialty Medicine, we appreciate the interest this Committee has taken over the past several years to assess the status and cost of health care in this country.

The Alliance believes that health care—the health care infrastructure of this country is in critical need of an overhaul, that we have lost sight of what is important for ensuring that our patients receive the very best care that they deserve. The escalating costs of medical liability insurance is threatening to change the structure of health care in this country, leaving lasting consequences both in terms of how health care will be delivered, and who will be available to deliver their care.

My partners and I see examples of this day after day in our practice. Americans in need of emergency services are most at risk of losing access to the necessary specialty care. As the risks and cost to care for these patients rise, so does the risk of losing orthopedic surgeons in our practice who currently cover two-thirds of the nights on call in one of the busiest trauma centers in Chicago. This is particularly alarming knowing that this trauma center is already inundated with transfers from more and more community hospitals in Illinois that no longer have physicians available for emergencies.

Pediatric coverage at emergency rooms continues to worsen. Children are being transferred without even being examined and even for basic orthopedic cases where some of these transfers have taken hours to process.

Recently, because no orthopedic surgeon was available, a 25-year-old male was recently transferred 80 miles from Rockford to Lutheran General Hospital, a Level I trauma center in Parkridge, after sustaining an unstable pelvic fracture. The patient was not volume resuscitated adequately in the initial hospital, and the transfer delayed emergency care by seven hours.

By the time he arrived he was grossly volume depleted. The fluid administration consisted of rapid volume replacement, including blood, leading to delusional coagulopathy and ARDS, or Adult Respiratory Distress Syndrome—known complications from volume replacement in massive quantities after blood loss. The patient died.

Timely care at the initial institution could have prevented this tragic outcome.

Public aid and HMO patients also lose a medical environment of diminishing resources and high operating expenses as a result of the increasing litigious environment. Average reimbursements are considerably lower for these patients. Physicians cannot afford to pay operating expenses serving these patients alone. A high number of these patients are pediatric orthopedic cases.

Since July 2002, our medical liability premiums have increased 250 percent to $5.6 million, an additional $4 million in premium costs. Current base premiums for a orthopedic surgeon in Cook County are now $212,000 a year for $2 million in coverage, which includes spine coverage.

We are concerned with the increasing number of physician retirements at early ages. The chief of orthopedics at one hospital I staff belongs to a small orthopedic practice that switched insurance companies in order to lower their premium rates. Because the insurance company required him to practice at least five more years in order to receive a discount and sizeable tail cost, he is retiring now, and I have had to assume his administrative duties, taking me further away from patient care while we are also now short one additional orthopedic surgeon.

More and more physicians are also restricting how they address non-emergency high-risk cases or eliminating these cases altogether from their practice. Our total joint positions have already set limits on patients they operate on and treat.

Due to the increased risk of infection and thrombosis, one of the most experienced and productive joint surgeons in Illinois, and arguably the country, has reservations about operating on individuals with a body mass index over 40; in other words, for example, a person who is five foot, 204 pounds, or six foot, 294 pounds.

We believe that is a result of the medical liability crisis patients face a patchwork of care across the states where access to specialists is decreasing, and assurances of timely emergency care is no longer possible.

As a nation, we have a duty and an obligation to my patients and to your constituents. We believe that Congress must act now or the landscape will be forever changed. The need for reform has now escalated to a national problem that requires a national solution.

Thank you for considering our comments and recommendations. The alliance looks forward to working with the members of this Committee and Congress to address this important health care policy issue.

[Dr. Gleason's statement may be found in the appendix.]

Chairman MANZULLO. Thank you, Doctor.

Our next witness is Dr. Chad Rubin with the American College of Surgeons, and Dr. Rubin comes from Columbia, South Carolina. We look forward to your testimony.

Dr. RUBIN. Originally from Illinois.

Chairman MANZULLO. Where in Illinois?

Dr. RUBIN. Carbondale.

Chairman MANZULLO. Wrong end of the state.

Dr. RUBIN. Yes.
[Laughter.]

Chairman MANZULLO. But Congressman Tim Johnson would not say that. Go ahead, please.

TESTIMONY OF DR. CHAD RUBIN, AMERICAN COLLEGE OF SURGEONS

Dr. RUBIN. Mr. Chairman, Representative Velazquez, and Members of the Committee. Thank you for allowing me to present my story.

I am a general surgeon in Columbia, South Carolina, and I am here representing myself and the 65,000 members in the American College of Surgeons.

In a growing number of states, surgeons are having a very difficult time trying to even find medical liability insurance, and the ones that they find are so expensive that some of them cannot afford it. We are experiencing double and sometimes triple digit increases per year in malpractice insurance.

In South Carolina, we have a Joint Underwriters Association. It is state-run, this is not for profit. It is state-run. Myself, I have seen an 816 percent increases in my malpractice premiums over the course of the last nine years. I have never been sued. Last year alone, 117 percent increase. The increases, along with my nine other partners, were in a single general surgery group. We are the largest private practice in town. Every year we are finding that we have to borrow the money to pay our malpractice premiums. We are a small business. That is exactly what we do. We have to borrow just to keep going.

Essentially, with the actual increases year after year after year, we are feeling the squeeze. Basically, Medicare sets the rates now. The insurance companies set the rates. Other small businesses can pass these expenses on to the consumer. We cannot. We just have to suck it up and try to figure out how we are going to pay for it every year.

In addition, because of the increasing premiums, three of my partners have stopped practicing vascular surgery, to try to reduce their costs. Two of my partners do beriatric surgery, or weight reduction surgery. We received day before a yesterday a notice from the Joint Underwriters Associations that their malpractice premiums are going to increase $26,000 alone this year because they do beriatric surgery. I suspect they are going to stop doing that.

This crisis is having a very detrimental effect through South Carolina. Last month one of the prominent OB-GYNs in town announced that he is going to stop delivering babies. There is only spotty neurosurgical coverage in Myrtle Beach. This is an issue that affects both people inside of South Carolina, and also the people that come and visit our state. If you have an accident in Myrtle

Beach, you better be lucky and be on one of those days when there is a neurosurgeon that is there.

My own personal story. This crisis has reached epidemic proportion in Illinois. My mom lives in Illinois. She has had two strokes. She has pulmonary fibrosis. She has round-the-clock care. She has round-the-clock oxygen. Her primary care doctor of several years left a couple of years ago, and she had to find another doctor. The only pulmonolist, lung specialist in southern Illinois left the state, and ironically, the only neurosurgeon that I know of in southern Illinois moved to Columbia, South Carolina, and there is no coverage.

Her physiatrist, who is a rehab specialist, who is trying to help rehabilitate her nonfunctioning arm, moved from Carbondale to St. Louis, and now she has to travel two and a half hours to go see him. This is all a direct effect of what the malpractice premiums have done. Physicians are leaving the state. There is ample evidence in my mind that the skyrocketing costs of liability is having an effect on health care, it is having an effect on the health care of my own mother.

I ask you to please consider some of the reforms that you mentioned, Mr. Chairman, particularly the MICRA-type caps. When I first got involved and really began having problems as far as in the increase in premiums, I had a conversation with my mom, and she said, I really do not think I support that because if people are injured, they deserve to be compensated. And I said, you do not understand. What we are talking about is non-economic. We are talking about pain and suffering. We are talking about punitive damages.

She was not convinced. Now she is. She is very much in support as is the rest of my family except for my sister who is an attorney, who works in Madison County.

Chairman MANZULLO. Worked in Madison County. That bills comes before the House today.

Dr. RUBIN. Very good. But I ask you to please consider this. This is a patient access issue. It is a small business issue. I am in a small business and I do not know how I am going to afford to keep paying these premiums.

I thank you very much for giving me this opportunity.

[Dr. Rubin's statement may be found in the appendix.]

Chairman MANZULLO. Thank you, Doctor.

Our next witness is Hilda Heady. She is with the National Rural Health Association out of Morgantown, West Virginia. She brings us a unique perspective in terms of her expertise, and we look forward to your testimony.

TESTIMONY OF MS. HILDA HEADY, NATIONAL RURAL HEALTH ASSOCIATION

Ms. HEADY. Thank you, Chairman Manzullo and Ranking Member Velazquez, Committee Members.

I really appreciate the opportunity to address you on behalf of the National Rural Health Association. I am currently the elected president.

The NRHA is a 7,000-member national nonprofit organization that provides leadership on rural health issues. Our mission is to try and improve the health and well being of rural Americans across the board and we do this through grass roots advocacy, communication, education, and research. I want to make three points with you today.

One, rising medical liability costs impact and hurt rural patients and rural health care providers. Two, medical liability rising costs also impact small businesses in rural communities; and three, we all need to do something about it because we all are responsible and we all have a part in the solution.

First, the quality of health care for rural patients is being put in jeopardy and I can use a personal story to demonstrate this. One of my colleagues, a fellow by the name of Dennis McCutcheon, who lives in a hill-top farm in a very, very rural area of West Virginia, with his wife Anne, have taken care of 15 elderly friends and family members in either their own person home or in Dennis and Anne's home.

Three years ago his mother fell, and they suspected a broken hip. By the time that the ambulance got to her the EMTs were on the radio, and they were told not to go to the hospital that they had planned to go to because all of the orthopedic surgeons that were in practice in that hospital had left. They had left the state and they were not there that day.

They were also told that the only remaining orthopedic surgeon in practice in this town of over 25,000 was at another hospital. So they took her to that particular hospital.

When they arrived there they discovered that the only surgeon that was there to help her was currently in surgery and there were 15 hospitalized patients waiting to see him, and they were all waiting for surgery. Most of them were elderly.

His mother finally went into surgery with a very tired surgeon after more than a 36-hour wait with a totally separated hip joint.

I am also privileged in my work to work with aspiring physicians, nurse practitioners, pharmacists, and so forth that we try to recruit in our state to go into rural communities.

Last year at the height of our malpractice crisis, which is the third one in my professional life, at least in West Virginia, I was counseling with a young man about going into rural practice, and he just looked at me and he said, "Hilda, I want to go into rural medicine, but I am afraid I can't make it because I am afraid I cannot afford it."

Physicians are seeking work at academic health centers and community health centers in our state just for—to just try and reduce the overhead that they see in their practices.

As I said, this is the third crisis that I have been through since I have been in health care in our state. I recruited the first OB-GYN ever to practice in a very rural county in north-central West Virginia. He was an exciting, bright, young physician just right out of residency. We recruited him out of Pennsylvania, which was a

coup, at least for us. He was in practice with us, and of course we gave him his package and offered him and paid his malpractice.

When he began working with us, his malpractice premium was $6,700. In three years, he had to close his practice and leave, and if he had remained there when his premium was next due, it was $65,000, and that was in three years.

Now, that was some years ago. Right now in our state if an OB-GYN could find a malpractice premium for $65,000, they would jump at the chance.

The second point I want to make is that rising costs of malpractice hurts small businesses. Certainly small businesses have to pay for and contribute to the health care of their employees. That is one of the places that they are first hurt. And while we continue with the debate, and point fingers at each other about the rising costs of liability and what causes it and what does not cause it, the patients and their providers are the ones that are hurt by our debate.

We also know that many in most of our rural communities across the country that the health care industry is either the first, second, or third largest employer in that community. Most rural providers are still small businesses such as mom and pop pharmacies, private doctors' offices, physicians' offices, private dentists' offices, and so on.

Rising medical liability costs severely impacts these small businesses so that when a doctor or dentists closes their practices the losses are not only to the health care and the access and the quality of health care in that community, it is also a loss of jobs.

In our own state in rural communities, for every one physician that we have in practice, we also have another 4.3 full-time jobs.

The third point is that we all are—

Chairman MANZULLO. You have got a red light.

Ms. HEADY. Oh, I am sorry.

Chairman MANZULLO. Can you summarize that in 30 second?

Ms. HEADY. I certainly will.

I would like to draw your attention to the recommendations in our program that we submitted to you from the National Rural Health Association, and for Congress to take up this issue. I hope that they bring everybody to table, lawyers, doctors, insurance industry, and consumers.

Thank you.

[Ms. Heady's statement may be found in the appendix.]

Chairman MANZULLO. Thank you very much.

Our next witness is Lawrence E. Smarr, I guess that is correct, S-M-A-R-R, President of the Physician Insurers Association of America out of Rockville, Maryland. And Mr. Smarr, we look forward—are you a physician?

Mr. SMARR. No, I am not.

Chairman MANZULLO. Okay, Mr. Smarr, we look forward to your testimony. Thank you.

TESTIMONY OF LAWRENCE E. SMARR, PHYSICIAN INSURERS ASSOCIATION OF AMERICA

Mr. SMARR. Chairman Manzullo, Ranking Member Velazquez, and Members of the Committee.

I am the president of the Physician Insurers Association of America, an association comprised of professional liability insurance companies owned and/or operated by physicians, dentists and other health care providers. Our 48 domestic insurance companies members insure over 300,000 doctors and 1,300 hospitals in the United States.

The PI members can be characterized as doctors insuring doctors, or hospitals insuring hospitals. We cover over 60 percent of America's private practicing physicians.

I will be referring to this set of charts which you should have before you.

Over the past five years, insurers have seen their financial performance deteriorate substantially due to rapidly rising claim costs. These costs translate into higher health care costs that must be borne by small businesses.

According to AM Best, the medical liability insurance line of business incurred $1.55 in losses and expenses for every dollar of premium it collected in the year 2001. This statistic rose to $1.55 and has gradually declined to an estimated $1.33 for 2004, and Best estimates this statistic will be $1.31 this year, in 2005.

The impact of insurer rate increases accounts for the gradual improvement. However, Best also calculates that the industry can only incur $1.14 in losses in order to break even, and so we are still in the hole in 2005.

The primary driver of this crisis, as conformed by both the GAO and the National Association of Insurance Commissioners, has been paid claim severity, or the average cost of a paid claim.

Your first exhibit shows the average dollar amounts paid to claimants on behalf of individual physicians since 1988. The mean payment amount has risen by 6.6 percent per year during this period as compared to 2.9 percent for the Consumer Price Index. The data for this exhibit comes from the PIAA data sharing project which is a patient safety database created in 1985 to identify common trends in malpractice claims, and to date over 199,000 claims and suits have been reported.

One very troubling aspect of the medical malpractice claims is the proportion of those filed which are without merit as show on the next exhibit. Almost 70 percent of all claims filed against individual practitioners reported in 2003 were dropped or dismissed by the court. 5.1 percent were won by the doctor at trial, and only eight-tenths of one percent were won by the plaintiff. The remainder, 24 percent, resulted in a settlement payment.

A review of the average claim payment values for 2003 is revealing. As show on the next exhibit, the mean indemnity payment amount on behalf of an in defendant was over $328,000, average verdicts cost $431,000, and settlements only $233,000.

Most medical malpractice cases have multiple defendants and thus these values are below those which may be reported on a case basis.

The next exhibit 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 a total number of payments.

And the next few charts show this difference between California and the rest of the country, and if you look at the top line on the right-hand side where it is heading, you can see that the gap has grown dramatically through 2003, and this proves that the California MICRA law works.

These savings are clearly demonstrated and the rates charged to California doctors, as show on the next exhibit, successful experience in California and other states, such as Colorado, make it clear that these tort reforms do work without lowering health care quality or limiting access to care.

For example, an OB-GYN in Los Angeles pay $66,000 compared to his or her Miami counterpart who pays $277,000.

Increasing medical malpractice claim costs on the rise for over three decades have finally reached the level where the rates that insurers must—

Chairman MANZULLO. You have got a red light there.

Mr. SMARR. I am going to conclude right now, sir.

Chairman MANZULLO. All right, thank you.

Mr. SMARR. They have reached the point where doctors can no longer afford to pay these premiums, and as has been pointed out, they cannot pass them along, and so we urge you to pass effective health care liability reform in the House as you have done nine times in the past.

Thank you.

[Mr. Smarr's statement may be found in the appendix.]

Chairman MANZULLO. Thank you very much.

Our next and final witness is Joanne Doroshow, is that correct?

Ms. DOROSHOW. That is correct.

Chairman MANZULLO. Okay. Executive Director of the Center for Justice and Democracy from New York City, and we look forward to your testimony.

TESTIMONY OF JOANNE DOROSHOW, CENTER FOR JUSTICE AND DEMOCRACY

Ms. DOROSHOW. Thank you, Mr. Chairman, Representative Velazquez, and the members of the Committee.

Chairman MANZULLO. Go ahead.

Ms. DOROSHOW. Okay. Mr. Chairman, you asked us at the beginning of your statement to have us share our horror stories with the Committee today, and you should have been with us last week because we brought down to Washington 50 families, all of whom had suffered life-altering consequences of medical negligence, some unbelievably horrible stories.

A family from Louisiana brought their baby who had some trouble with their stomach. They took him in for an acid reflux test. The physician punctured his esophagus. He went into cardiac arrest, was brain damaged severely. Another woman who had unnecessarily both her breasts removed because the lab had mixed up her results, and they told her she had cancer when she did not. I mean, it was story after story like that, and I would hope at some point if this Committee is going to further explore this issue, that you make sure that you hear from these families because these are really the forgotten voices in this debate over medical malpractice and how to solve doctors' insurance premiums.

I know you do not want to get into specifics of legislation. I will only say that all of the solutions that so far have been proposed by Congress, the bills that have passed recently, all of them take away patients' rights, whether cases are frivolous or not, no matter how severe an injury is, no matter how meritorious a claim, and the insurance industry's major role in creating this crisis for doctors is completely ignored in all of these bills as is the role of the epidemic amount of medical malpractice that exists very sadly in this country today.

Now, the hearing is about costs, and just very briefly let me tell you about the costs of medical malpractice. The cost of premiums, the cost of claims are each below one percent of total health care costs in this country. The Congressional Budget Office has said the legislation that Congress is considering would reduce health care costs by about .4 to .5 percent. Defensive medicine costs, according to the Congressional Budget Office, are very, very small. But the cost of malpractice is huge, 17 to 29 billion dollars a year that injuries are causing victims of malpractice in this country according to the Institute of Medicine. If you are going to reduce costs, that is where you have to look.

Now, in terms of insurance rates for doctors, yes, there are many doctors that are being price-gouged by their insurance companies. There is no question. In fact, this is the third time in 30 years that we have seen this kind of crisis in this country. It happened in the mid-seventies, which is when California responded by passing their cap. It happened again in the mid-eighties, when a number of states succumbed to pressure by the insurance industry, and were told this is how you reduce rates, pass caps, and a number of them did.

Well, now we are in the third crisis, and you will find in states like Maryland and Missouri that have had a cap on damages since the mid-eighties, both of them are having severe increases in insurance rates.

The Missouri Department of Insurance put out two studies last year. Claims are down in Missouri. Medical malpractice payouts are down. They have a cap. But rates for doctors went up 121 percent.

Then you look at Illinois. Illinois, yes, rates are going up pretty dramatically there. Illinois happens to have the weakest insurance regulation of any state in the country, and today our organization in Illinois is having a new conference announcing a new patient safety network. Victims that have come forward to oppose the efforts by legislators in Springfield to try to cap damages there, and they have asked the insurance department to force the companies to open up their books, to release the actuarial tables that they are using to justify these astronomical rate hikes because so far these companies have refused to do so.

And like Illinois, and in many states, according to the National Center for State Courts, filings are down in malpractice cases, payouts have been stable for years, but now we see record-breaking profits by the insurance industry. Last year broke all records, and in Washington state the physicians' insurance, the mutual company that insures 70 percent of the doctors we are seeing now—they have now asked for a 7.7 percent decrease.

I see my time is up.

Chairman MANZULLO. You have got a red light there.

Ms. DOROSHOW. Just to sum up, you have got to look at the insurance industry's role in this, and you have got to look at patient safety measure. There are many, many, other ways of dealing with this problem, solving this problem for doctors, but do not do it on the backs of patients.

Thank you.

Chairman MANZULLO. Thank you very much.

I am going to hold the members to the five-minute clock too because of the numbers that are here. Being the Chairman, I will take the first five minutes of questions.

I would like to see a dialogue between—Ms. Doroshow, are you an attorney?

Ms. DOROSHOW. Yes, I am.

Chairman MANZULLO. Okay, between you and Mr. Smarr, and the rest of you. First of all, we recognize that there are horrible cases out there, where malpractice does exist, and tremendous losses have occurred. And as Ms. Velazquez mentioned in her opening statement, there has to be a balance somewhere in between.

Is there a myth that—my number one question—are insurance companies out of control? Are they making record profits? And if so, why are so many going out of business? Who wants to tackle that?

Ms. DOROSHOW. Well, they are. I mean, I will—

Chairman MANZULLO. Go ahead.

Ms. DOROSHOW. They are making record profits. They—

Chairman MANZULLO. Okay, get specific. Which ones?

Ms. DOROSHOW. Well, the property casualty industry has made $28 billion last year—

Chairman MANZULLO. Well, no, that is—

Ms. DOROSHOW. —the first nine months.

Now, medical malpractice—

Chairman MANZULLO. Medical malpractice?

Ms. DOROSHOW. Well, you look at, for example, the reference I just made to the company in Washington State. Record-breaking net income last year, which is why they have now asked for a 7.5—

Chairman MANZULLO. Is that profit or net income?

Ms. DOROSHOW. That is what it is.

Chairman MANZULLO. All right.

Ms. DOROSHOW. It is basically the same thing.

Chairman MANZULLO. Anybody want to—do you know the name of the company? Somebody want to tackle that?

Ms. DOROSHOW. Physicians Insurance.

Dr. RUBIN. Well, I guess the two arguments I would have. First of all, going back to South Carolina, the Joint Underwriters Association is state run. They are not for profit, and if this is so profitable for the insurance companies, why have they all left our state?

I only have two private carriers that I can turn to. St. Paul got out of the business completely. So if this is profitable, why are they getting out?

Chairman MANZULLO. Mr. Smarr, your association represents the insurance companies?

Mr. SMARR. Yes, we do.

Chairman MANZULLO. Go ahead.

Mr. SMARR. Well, as I testified, the combined ratio for the industry is about 1.33 for 2004, meaning we are incurring $1.33 in losses and expenses for every dollar of premium we collect; $1.14 is break even. The difference is investment income. That is how we can have a $1.14 and still break even.

The industry is losing money. My members, which are owned and operated by doctors, are losing money. They have lost money three years in a row. We are hoping that perhaps we will break even when the 2004 numbers are published, but it is just false to confuse this with the property and casualty industry.

Chairman MANZULLO. Switch the microphone over to Ms. Doroshow. Go ahead.

Ms. DOROSHOW. Okay. Now, when he is talking about incurred losses, let me tell you what that is. That is as a result of severely overstating reserves. That is what they do during the hard market when they are trying to raise the rates. That is not actual payouts. And what I would ask the Committee to do is ask Mr. Smarr for the actual cash flow from—

Chairman MANZULLO. You can ask him.

Ms. DOROSHOW. Well, I will ask him to release the actual cash flow, what you actually took in and paid out last year, because that is not what you use to base your combined ratio figures on.

And by the way, they are also making investment and come off their surplus, which is not included in those figures either.

Chairman MANZULLO. Mr. Smarr.

Mr. SMARR. I do not even know what you are talking about the surplus issue, but it is improper to compare what an insurer pays out this year with what it takes in this year. There is a 22-month lag between the time a claim happens and it is reported to the insurer. Just think of auto insurance. It is reported the same day. And then there is another 33-month lag between the time the insurer knows about it and the claim closes. So it is four and a half years of trend that must be calculated into premiums that insurers are collecting today.

The claims we are paying today are for premiums that were collected four and a half years ago, and it can take as long as 10 or 12 years to pay out that money.

Chairman MANZULLO. Ms. Doroshow?

Ms. DOROSHOW. Well, I think it is pretty well recognized that during these hard market periods the insurers will tend to overstate their reserves. They pad them. And that is what those loss figures are.

I would ask for that information for the last five years, what they paid in and what they paid out.

Chairman MANZULLO. All right, I will do this. You send me a letter, and you tell me what you want from the insurance companies, all right? And let me bounce that around, okay?

But let me go back here to Dr. Rubin. You come from the state where it is not for profit.

Dr. RUBIN. That is correct.

Chairman MANZULLO. Okay. And quickly, your experience again?

Dr. RUBIN. Again, I have seen an 816 percent increase in the last nine years, 117 percent last year. They are not making a profit there, and again, all the other private carriers are pulling out.

Chairman MANZULLO. A good point. Dr. Gleason quickly.

Dr. GLEASON. Yes. In Illinois, there is a Department of Insurance that requires yearly figures, also that requires audits every three years.

Furthermore, I have to ask myself if this is so profitable, why in Chicago and Illinois has the number of insurers gone from 17 in 2001 down to five this year? And of those five, one, Medical Protective, only take people with no previous lawsuits. AD Capital has been downgraded twice in the last 12 months. ISME, the largest insurance of 16,000 individuals, currently is taking on no new individuals other than those joining current practices. And finally, PIC Wisconsin has retreated to Wisconsin and Iowa, and are no longer writing in Cook County.

Chairman MANZULLO. Ms. Velazquez.

Ms. VELAZQUEZ. Well, I guess that if we hold another hearing, I will have also—I will ask the Chairman to bring another witness that might provide some more balance responses between the two sides that are here represented, and that would be Attorney General Eliot Spitzer from New York.

Dr. Palmisano, in your testimony you commend California for their law, the MICRA law which contains reforms similar to those you are asking Congress to support in federal law. California also has a rather extensive insurance reform law. We have heard that it was not until insurance reform was enacted in 1988 that premium stabilized.

You have been a malpractice insurance executive and advisor, have you not?

Dr. PALMISANO. Well, I was on the board of a company for eight years in the eighties, one of the mutual companies form by Louisiana State. I am on the board of the doctors company in California.

Ms. VELAZQUEZ. Okay.

Dr. PALMISANO. And I have a company called Intrepid Resources which is a risk-management company, that is correct. But I am here today on behalf of the—

Ms. VELAZQUEZ. No, it is okay. I just wanted for you to be on the record.

Dr. PALMISANO. Yes, and this testimony would be given by Dr. Nelson or anyone else. This is AMA testimony.

Ms. VELAZQUEZ. That is okay. Given the California experience you cite, do you see insurance reform as a necessary partner to the health field?

Dr. PALMISANO. Well, the example given about Proposition 103, we have a document from AMA on the AMA website called "Medical Liability Reform Now," which goes into that.

Whenever a law is passed in the state, to get the benefit of the reforms one has to make sure that it is constitutional. It is presumed to be constitution but if the insurers drop their rates immediately what happens is if it is declared unconstitutional, like Texas on two occasions, Oregon, then they have not collected enough money.

Ms. VELAZQUEZ. Sir, I do not have much time.

Dr. PALMISANO. We do not believe that—

Ms. VELAZQUEZ. My question to—

Dr. PALMISANO. —Proposition 103—

Ms. VELAZQUEZ. So you do not—

Dr. PALMISANO. No, we think the insurance—

Ms. VELAZQUEZ. —insurance malpractice should be part of any health reform bill?

Dr. PALMISANO. We think the insurance commissions have the authority now.

Ms. VELAZQUEZ. Okay, just say yes or no. Yes?

Dr. PALMISANO. Yes.

Ms. VELAZQUEZ. Ms. Joanne Doroshow.

Ms. DOROSHOW. Yes.

Ms. VELAZQUEZ. What is your comment on that?

Ms. DOROSHOW. Well, I think there is no question Proposition 103 is the reason rates have dropped in California. Proposition 103 came in 13 years after MICRA passed. As a result of Proposition 103, you also saw probably three of the most critical parts of it is there is an automatic hearing for any rate hike about 15 percent, and the public can intervene. And as a result of Proposition 103, in the last years three companies went in for rate hikes higher than that. There was a hearing. The consumers did intervene, and the insurance commission knocked those rate hikes down, saving doctors in California millions and millions of dollars. That is how it works.

Ms. VELAZQUEZ. Thank you.

Dr. Palmisano, I looked at your map of crisis states, and I must agree it is frightening to see all those states, including New York, as red states. I was interested to—

[Laughter.]

Ms. VELAZQUEZ. I was interested to see that New York was listed as a crisis state for medical malpractice. So I looked at your bullet points on the problems in New York.

Are you rating this on those four newspaper articles you cite?

Dr. PALMISANO. I am sorry, ma'am? Am I what?

Ms. VELAZQUEZ. The rating that you gave New York, is it based on the four newspaper articles that you cited?

Dr. PALMISANO. It is based on a number of things: loss of access of care. It is based on the number of insurers. It is based on the escalation in the rates. It is based on the number of suits that have high awards. It is based on a combination of factors that make it a crisis state.

Ms. VELAZQUEZ. Are you aware that the General Accounting Office noted that your survey on physicians cutting back services had a response rate of only 10 percent, and did not specify cutbacks in specific services?

Dr. PALMISANO. Well, we are aware that the surveys that are done have to ask additional questions. It is like the statement made in Illinois that there is the same number of doctors as last year. You have got find out if the doctor actually practices in the state. Sixty percent of the doctors have licenses in more than one state. You have to find out if an obstetricians still deliver babies.

Ms. VELAZQUEZ. Okay.

Dr. PALMISANO. Or if the neurosurgeon does head trauma.

Ms. VELAZQUEZ. Sure.

Dr. PALMISANO. Those are questions that need to be asked in addition.

Chairman MANZULLO. Joanne, what is your comments or reaction on the red states?

Ms. DOROSHOW. On the—

Ms. VELAZQUEZ. Crisis?

Ms. DOROSHOW. On the crisis in red?

Ms. VELAZQUEZ. Yes.

Ms. DOROSHOW. Well, I mean, I think that there is a crisis in red and blue states, depending on the insurance situation in the states. It certainly does not depend on whether there is a cap in the state because we know that there are many states with caps that have seen rates skyrocket.

The way to solve that—I mean, what we are seeing is a state like California that has more moderate rates is due to the insurance regulatory law in the state.

Ms. VELAZQUEZ. Okay, thank you.

Dr. Gleason, on page 13 of your testimony you report that applications to medical schools are down by 22 percent. Is it your contention that this is due to the medical liability crisis?

Dr. GLEASON. Yes, ma'am, that is part of it. That is down 22 percent since 1997.

Ms. VELAZQUEZ. Okay.

Dr. GLEASON. And in addition to that you can also look at, for example, pediatric orthopedic fellows.

Ms. VELAZQUEZ. Okay.

Dr. GLEASON. Currently there are only six whereas six years ago there were 50, and we go on with in terms of positions—

Ms. VELAZQUEZ. Okay.

Dr. GLEASON. —for residencies filled as far as neurosurgery, emergency room trauma, and OB-GYN as well.

Chairman MANZULLO. Ms. Musgrave. Go ahead.

Ms. VELAZQUEZ. It seems that the General Accounting Office does not agree with you. It says in their report that the U.S. physician population increased 26 percent which was twice the rate of total population growth between 1991 and 2001, and during this period the average number of physicians per 100,000 people were increased from 214 to 239.

Thank you, Mr. Chairman.

Chairman MANZULLO. Thank you. Ms. Musgrave.

Ms. MUSGRAVE. I have a question for Mr. Smarr, please. There is almost an innuendo that you are withholding information that distorts whether or not you are making a profit.

Could you respond to that, please?

Mr. SMARR. Well, the insurance industry, including medical malpractice insurance, is perhaps the most regulated industry of all. Each year and on a quarterly basis as well, insurers file very detailed financial statements with their state insurance departments, and all this data is then aggregated by the National Association of

Insurance Commissioners, and the books are essentially open, because the basic elements that one needs to know are in those documents, and as well, rate filings made with state insurance departments are public documents. All the actuarial support for those rate increases or decreases are available to the public.

Ms. MUSGRAVE. Thank you very much.

Could you go over the four-year period that you emphasized before? You know, there is a very simplistic way of looking at things, how much money was paid in premiums in a year, and what your claims were. But could you go over the lag time aspect of that again?

Mr. SMARR. Well, the key element is that when a year closes the insurer does not know how many claims it is going to have for that year and/or the value of those claims when they are ultimately paid. There is a distinction between claims made and the current coverage, which I will not get into but there is some difference there.

And so the insurer must estimate its future payments it is going to make as far as 10 years down the road, and so monies are set aside in what are called incurred but not reported losses, and it is indeed an estimate of what the ultimate liabilities are going to be.

In the latter part of the 1990s, it has been proven that these reserves were woefully inadequate, and that is why the industry has booked a loss for the past five years.

Ms. MUSGRAVE. Thank you very much.

Ms. Heady, much of my district is rural, and when you start talking about the difficulty that rural physicians face, it really strikes a cord with me.

Could you emphasize, please, the other things that affect attracting rural physicians, and then complicated by these incredible premium increases? What do you predict for rural America in regard to health care?

Ms. HEADY. I appreciate very much, Ms. Musgrave, the question. The other issues that impact the recruitment and retention of rural physicians, of course, in a business climate have to do with their ability to generate revenues to cover their salaries, the salaries of their employees, and so on and so forth.

The primary issue is the disparity in reimbursement for rural providers and rural physicians versus urban. We all, at least if we do not know, we should know that there is a myth operating in this country that it is cheaper to do business in rural America, certainly in health care, than it is in urban areas. And that is absolutely false.

The Medicare wage index system that they use to differentiate payments is also based on myth; that you can pay the people less to do the same kind of job in rural America than you can in urban America, and absolutely converse is true. In order for rural communities to attract specialists and highly qualified individuals in the health care industry, they many times have to pay more than their urban counterparts.

If you put the rising malpractice premiums for rural providers on top of that, then you have a tremendous falling house of cards. We do—we absolutely do know that the average incomes for physicians, nurse practitioners, PAs, so on and so forth in rural areas are much lower than they are for their urban counterparts, and that is primarily because of the differences, the disparities in reimbursements around for the same kind of service.

Other issues have to do with the strength of the economic community, the payer mix in that community, and in most of our rural areas we do have larger pockets of low-income individuals or individuals that are on third-party payment kinds of systems, where we see a lot of states actually supporting a lot of the health care industry in those rural areas, and I hope that answers your question.

Ms. MUSGRAVE. It did very well. Thank you.

Thank you, Mr. Chairman.

Chairman MANZULLO. Thank you. Congressman Barrow.

Mr. BARROW. Thank you, Mr. Chairman.

Well, I do not think there is any question that the practice of medicine is not what it used to be, and speaking for myself, I can say that the practice of law is not what it used to be either, but I would not trade places. There is no question there is a crisis in the health care community as a result of skyrocketing costs in medical malpractice insurance.

What I want to do is just focus for a couple of questions on the effectiveness of the prime suggested remedy for all of this. And that is caps on what folks can recover is sort of the cure for what ails us here.

There have been a least a couple of objections, I think, that are important to the notion that limiting the rights of recovery of those people who are truly deserving. Victims who have seriously been injured in excess of the amount of any arbitrary caps, are the only effective way to curb abuses on the part of other folks; that limiting the rights of the truly needy is the only way to deter bad behavior on the part of the truly greedy.

Now, one of the groups of objections to that has been that it is just unfair, that it is just unfair to take away rights of recovery from folks who are genuinely deserving of some means, some social engineering, we are trying to manipulate or manage the behavior of other folks.

So, Dr. Gleason, I want to ask you a question. What do you say to folks who argue that it is just plain unfair to place an arbitrary cap that limits the right of recovery of someone who is genuinely deserving of compensation in excess of the cap as sort of the way in which we—the price you have got to pay in order to be able to deter bad behavior on the part of other folks?

Do we just say that is just tough? That is the way the cookie crumbles?

Dr. GLEASON. Well, first of all, I think that you have to keep in mind that what is being proposed is not the right for recovery.

These injured individuals do get recovery in terms of all economic costs in terms of their rehabilitation, care, future earnings, past earnings, things of that nature.

Also, what we are proposing is that they get it in a more speedy fashion. In California, we know that they get it within three years, whereas in New York it takes six years.

Furthermore, we are asking that they get more of what they deserve by limiting attorney's fees, for example. So that is one part if.

Mr. BARROW. Your answer, assumes, Doctor, that there are no cases that a cap would adversely affect; that there are no cases in which folks can agree on different sides of the issue; that just and fair compensation is in excess of the cap.

When you answer back to me and say that ultimately the economic losses, you are kind of gliding over a lot of cases, but you are basically avoiding the issue that there are some folks who are not going to be allowed to recover what all agree they should recover in an ideal award in cases, in their case, as the things we have to do in order to be able to get at folks someplace else.

Dr. GLEASON. The bottom line here is how do we provide the best care to our patients.

Mr. BARROW. No, I am asking about the fairness issue. I am asking about the fairness issue right now. I understand the point you are making, and I want to focus on that.

Dr. GLEASON. Right.

Mr. BARROW. But right now, what do you say to folks who think this is just an unfair way to go about doing it?

Dr. GLEASON. It is a fair way to go about doing it. It is what is best for our country. It is what is best for delivering care. We know that in states with caps, for example, before there were any caps there was an even distribution of doctors throughout the country. Since the caps have been instituted, we look at states with caps and states without caps. Those with caps have 135 doctors per 100,000 patients. States without caps have 120 doctors.

And you might say 15 doctors, what is the difference? But you talk to the patients that are in my practice that are waiting two to three weeks to see me, and if we had an extra one or two doctors, that would make a big difference.

Mr. BARROW. Dr. Gleason, it still does not give me something I can tell the victim who deserves to be compensated in excess of the amount of the cap. Why it is they should accept that as the price they have to pay in order to achieve the kind of result you are talking about?

On the subject you raised though, on the subject of whether or not they work, I want to compare and contrast the experience that California had after Proposition 103 with the experience that California had after they adopted caps back in the seventies.

Ms. Doroshow, can you help us understand what role, if any, Proposition 103 had in the stabilization—we heard a lot of talk about the stabilization it achieved in California. Can you help us understand whether or not Proposition 103 had something to do with that, or whether or not that is attributable to the caps that were adopted a decade before?

Ms. DOROSHOW. Well, certainly the Insurance Commissioner of California would agree that it had an impact. They just—he just recently wrote a letter to the Energy and Commerce Committee for a hearing they had last week.

According to the data we have seen, rates went up about 450 percent during the 13 years that MICRA was in effect, the cap before Proposition 103 came into effect. And since then rates have been down about eight percent whereas they have gone up nationally about 25 percent.

I would also note that there is also, as I mentioned earlier, a very important provision of Proposition 103, so that if there is a rate request higher than 15 percent, there is an automatic hearing.

There had been medical malpractice insurers that have gone in for rate hikes in California in the last two years. No question about it. But as a result of Proposition 103, they have been knocked down, and that is a very practical impact without even looking at the years of data where you see that it has had an impact.

I should also say that the RAND Corporation did a study about what victims are most severely impacted by MICRA, and what they found was that it falls on patients and families who were severely injured or killed as a result of medical negligence, so we know that that is really the kind of families that are most hurt by that cap.

Mr. BARROW. Mr. Smarr, you pointed out that medical malpractice insurers are among the most heavily regulated businesses, but you can argue they are not the most effectively regulated at the state level.

Why should health care providers, doctors and hospitals in California have protections under Proposition 103 in California that folks back in Georgia do not have? Do you not all support Proposition 103-type reforms all across the country?

Mr. SMARR. The elements of Proposition 103, such as an elected insurance commissioner, the prior approval of rates exist, and hearings, exist in states throughout the country. My experience is in Pennsylvania where I was responsible for filing rates with the state insurance department and defending them, and I can assure you that our rate filings were intensely scrutinized, but the insurance commissioner approved the rates because the filings were just.

We do not think Proposition 103 has had any effect in California. Proposition 103 required the rollback of rates by 20 percent. In fact, what happened is medical malpractice insurers at the time when it became effective in 1992 paid back a 20 percent one-time—I will use the word rebate—to policyholders of an annual premium, and were allowed to do that as part of their normal dividend practice, and at that time they were paying dividends to policyholders in excess of 30 percent.

We have looked at figures for all these years. We have looked at the figures in California. Since it was enacted there have been three hearings. Now, it was enacted in 1988 or 1989. There have been three hearings, and it can be argued that those are politically motivated as well, and the reductions that the carriers were given by the department were minor in nature.

Chairman MANZULLO. Thank you. Congressman Westmoreland.

Mr. WESTMORELAND. Thank you, Mr. Chairman, and first of all, let me thank you for continuing to have these hearings because I know that the House has passed this legislation, medical reform, for the last three Congresses, but I am sure that the situation has changed every year, and I am sure it is getting worse rather than better. So I think it is important that we continue to have these hearings.

Can I call you Joanne, because I have heard the Chairman pronounce your last name, and the Ranking Member, and I am afraid I would give it a Georgia dialect so if I can call you Joanne.

Ms. DOROSHOW. Whatever you like is fine.

Mr. WESTMORELAND. You mentioned the terrible story about the baby that—the reflux and his esophagus was torn, and that is a terrible situation, but my children, I have three. My baby daughter is 28 now. We used to give our children Paraguart. I mean, we did not know if they had reflux or acid indigestion or whatever. In fact, it was not until one of my grandchildren was born that I even knew that babies had reflux.

And so is it not true that now medicine has come so far and doctors out of fear of not going through the whole diagnostic test cause patients to have more tests? Or identify more things that are wrong, and just under the law of averages the more treatment you get the more room there is for a mistake?

And in this particular case, were these mistakes or was it malpractice? Because there is a difference to me between the two.

Ms. DOROSHOW. Well, we did only invite families down who had either settled or somehow resolved their case, so there was medical negligence, or at least if not an admission of it, at least a settlement of some sort. I mean, that is the only basis that we had to go on. But we were not bringing down just anybody that had a medical error in a hospital. These are real, real cases of negligence.

And you know, there have been many agencies that have looked at this issue of defensive medicine, and really what has been happening, and all I can tell you is what other agencies have found. Basically what, for example, the Office of Technology Assessment found when they looked at this in 1995 was that less than eight percent of all diagnostic procedures are likely to be caused primarily by liability concerns, and that most physicians who order aggressive diagnostic procedures do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability.

The Congressional Budget Office and the National Bureau of Economic Research, which just recently put out a report, made similar findings. I am not a physician, but I can only report on what the agencies that I read have found.

Mr. WESTMORELAND. Well, you know, when I found out about this hearing, I called some of my doctors back home because, you know, I believe in doing to that end user kind of guy that these things effect, and the one thing—one of the comments that they all made was the fact that they now feel pressed into doing more diagnostic tests than what they have been in the past out of fear of a malpractice lawsuit.

Ms. DOROSHOW. Well, I do hear that anecdotally from physicians. That is not what the agencies have found. And you know, we meet many victims all the time who are dying as a result of the failure of a physician to do the proper diagnostic procedure.

My own father died of colon cancer after his family physician refused for a period of five years after he went in with the symptoms to do all basic testing necessary to save his life.

We run into families like this all the time. So I think that you could probably find many anecdotal stories on the other end of this as well.

Mr. WESTMORELAND. Yes, ma'am. You know, and we were talking about a fairness issue because with medical liability reform it always—you know, the lawyers always want to throw insurance companies in it, and the doctors want to blame somebody. It kind of comes down to doctors versus lawyers really and truly.

And being in the building business, I have had to deal with lawyers before, and of course, I deal with doctors, and you know, if I go to the doctor, I have to sign a paper that I understand everything that could go wrong. I mean, from getting a sore throat to dying. I mean if you are going to take a medicine or if you are going to have a procedure, whether you are having hang nail removed or whatever it is. I have never had an attorney—I have never had them disclose to me what could happen to me, I guess. There is just a certain verdict.

Chairman MANZULLO. Well, it is a good thing because at this point you are out of time.

Mr. WESTMORELAND. Okay. Well, let me close by saying this. I just think the reality of it is that doctors are called upon many times, many times woke up in the middle of the night to go, and as your neurosurgeon, you may get called to make a decision, a five-minute decision, somebody's life is in the balance. And I think we need doctors that are willing to do that, and that we need to help them and really gird them up.

Chairman MANZULLO. Okay, thank you very much.

Mr. WESTMORELAND. Thank you.

Chairman MANZULLO. Thank you. Dr. Christian-Christensen.

Ms. CHRISTENSEN. Thank you, Mr. Chairman.

As most of my colleagues know, and I guess the panelists also know, I am a physician, and I am still a member of some—of the professional organizations, so this issue is very important to me as is the issue of the skyrocketing costs of health care.

But to me, it is very important that we get it right, and that this issue does not become a political pawn; that the issue does not become a political pawn. We have to get it right.

So no one would disagree that we have to reduce the rising costs of health care, but I think I would be negligent up here, especially because there are people on the Committee that do not know the full picture of health care, if I did not point out that malpractice premiums is only one cause. Health care disparities, lack of insurance for the 45 million people in this country, the costs of medication, our failure to use an ounce of prevention are all contributing factors to the skyrocketing price of health care, and we need to address all of them.

That being said, clearly we need a remedy to the problem of malpractice costs. They are placing a heavy burden on doctors. Regardless of what other conflicting information we have on many, many of the issues, it is placing a heavy burden on doctors, and I know—physicians that I know that some are moving from one jurisdiction to another, or are—if not closing their offices at some of the younger ages, some are retiring early just because they just cannot bear that burden anymore.

So I think it is very important, Mr. Chairman, that we have—that all of the issues are put on the table, and that we work towards developing a solution that is based on what works best and not what is political.

So I am willing to work with you and others to examine every approach clearly, and also to look at what other factors are involved. Certainly caps are not the only cause, and I guess that would lead me to my first question on the caps.

I, like my colleague Mr. Barrow here, very, very troubled about the cap issue because that is where all of the focus is being placed, and I personally feel it is a political issue more than a real issue. But the caps on the economic damages, even the cost of the lost wages, and the future earnings, because how do you determine what a person's future earnings might be at any given point in their life?

And to me, we are limiting—putting limits on where people's lives are at any given particular time. I am working on an issue at home with someone who today is a billionaire, but probably 15 years ago they were a teacher, and so how do you decide where you cap? and I guess I would like to—I am not going to ask that as a question, but I just want to say the caps are very, very troubling, and they are very troubling particularly to to minority populations because we generally are seen as persons that do not have the ability to rise above a certain point at any given time in our life, and I do not want the people that I represent to be kept where they are at any given time because of caps if they are damaged by negligence.

I want to ask, I guess I would start by asking this because I know time is going to be limited, Dr. Palmisano, Rubin and Gleason, what do you think should be done on the side of the insurance and the role that insurance plays on this? Because I note that the Weiss ratings say that despite caps on economic damages enacted in 19 states, most insurers continue to increase premiums. Caps did not reduce awards; that the median annual premium actually increased more in states with caps; and doctors in states with caps with caps actually suffered a significantly larger increase in insurance costs than doctors in states without caps.

So why are we focusing on caps and not taking a more comprehensive approach, and what do you recommend we do about the insurance side of this issue?

Dr. PALMISANO. Thank you, Doctor. The American Medical Association took all of the arguments against the recommendations that were being debated in Congress, and we tried to do scientific research, and we put that in a document, "Medical Liability Performed Now." It is available on the AMA website. We can make copies available to everyone on the Committee certainly.

When people say caps do not work, we have read those reports, and when you look at them scientifically, they are comparing apples to oranges. Missouri is constantly brought up as a state with caps. It is a cap per doctor per claimant. You could have multiple caps in a given case.

The California cap is a fixed cap, 250,000 on the non-economic, so you cannot have multiple caps in a case. California is not the only state, and they do not have Proposition 103 in effect. Louisiana, Indiana, New Mexico, Colorado, and Wisconsin, those are states that are stable that have caps that affect the non-economic damages among other things.

West Virginia had a cap of a million dollars for many years. It was ineffective. It is one of the crisis states. You have states with caps that have exceptions. The state with an exception, there is always a way to get through to the exception. Massachusetts is the state I was trying to think of. They had a cap for many years, but they have exceptions to the cap.

So we have to compare apples to apples. Caps do work, and in the bottom line the equation has to be that what is best for all of the citizens of America. It is—when you say why did this patient not get all of their non-economic damages, which is subjectively determined by a jury, you cannot quantify it objectively, but what about Dr. Lucas's son who dies, who could have been saved? What about LeeAnn Dyce's husband who could have been spared brain damage? What about the people who do not have a doctor, who have to try to make it to the next town, and the nurse who is pregnant who passes her own hospital up, delivers in a corner on the side of the road in America in 2002?

That is your responsibility to balance, and so our responsibility is to try to bring you as much information—

Chairman MANZULLO. My responsibility is to say we are out of time on this particular—

Ms. CHRISTENSEN. Already?

Chairman MANZULLO. Congressman Sodrel.

Mr. SODREL. Thank you, Mr. Chairman.

Just for the record, I am not an attorney nor a doctor. And in fact, I have seldom used the health care system, but I have paid for hundreds of working class folks, their health care premiums which have gone up double digit every year.

I would just like to ask—is it Doroshow? Is that the way you pronounce it?

Ms. DOROSHOW. That is correct, yes.

Mr. SODREL. Ms. Doroshow. Is it your testimony that there is nothing wrong with the current system?

Ms. DOROSHOW. No.

Mr. SODREL. I mean, that it works the way it should work and produces the desired result?

Ms. DOROSHOW. I think there is a very serious problem with regard to the insurance industry, their responsibility and their role in creating this crisis for doctors. I think the causes lie with them. I think the solutions lie with them. I also believe that there is a serious problem with the amount of malpractice in this country, and that—you know, the day the President went to Madison County in early January, the very day he went there to give a speech advocating capping damages, the White House released a report which it had commissioned done by the University of Iowa, and the Urban Institute, which found that there was a small number of doctors responsible for most malpractice, and if state disciplinary boards did a better job of simply weeding those doctors out of the system, both incidents of malpractice and lawsuits would be reduced.

Now, you do not hear the President talking very often about that study, and you do not hear either the insurance industry or the medical societies talking about it either, but it is something that the consumer goods have been pushing, particularly Public Citizen and their health research group have been pushing for it for years. This would save this country billions in terms of, you know, lost wages and health care costs and so forth due to medical injuries.

There are many other ways of addressing this issue of medical errors that either Congress or the states could look at. In terms of what Congress could do with regard to the insurance industry, there is not that much because the federal government is not allowed to regulate it, but they could repair the antitrust exemption under the McCarron-Ferguson Act, which basically allows insurance to price fix during these hard market periods when there is a lack of competition in the market.

I would hope that the Congress would take a look at that again because those proposals have been around for awhile.

Mr. SODREL. So your testimony is there is something wrong but it is not—it does not lie with the medical—or lie with the legal system, it lies with the medical system, and the insurers of the medical system?

Ms. DOROSHOW. Right.

Mr. SODREL. Mr. Rubin, would you like to follow up on that?

Dr. RUBIN. I would very much, because in support of the medical system.

Mr. SODREL. Dr. Rubin, excuse me.

Dr. RUBIN. That is okay. I am on the medical executive Committee at the teaching hospital. We actually have dealt over the last couple of years with two issues trying to remove physicians who the physicians themselves feel may not be up to standard. Both have filed lawsuits and have prevented us from taking them off the staff. So I do not think that argument files.

Mr. SODREL. So I guess the bottom question here is how we prevent all the best and brightest from aspiring to be attorneys in the United States.

Dr. RUBIN. That is right. Well, just keep doing what we are doing and none of them will become doctors.

Mr. SODREL. Thank you, Mr. Chairman.

Chairman MANZULLO. Thank you. Congress Lipinski from the great state of Illinois.

Mr. LIPINSKI. Thank you, Mr. Chairman. I have to—following on Mr. Sodrel, I have to start off by saying I am not an attorney. I nearly escaped that about 17 years ago. I am a doctor, but not the kind that you want to go to with medical problems, not a medical doctor.

A couple of questions. I made these—many of the question I had have been asked already. I have a couple of things. One quick question: Ms. Doroshow, do you believe that states—you seem to be suggesting perhaps that states are not regulating the insurance companies as they could be or as they should be?

We see with Eliot Spitzer in New York, the latest thing on the—with the health insurance brokers. You know, I have had people who are in the health insurance industry saying, well, yes, we have known this has been going on, and I sort of wonder, well, why did it take so long?

Do you think that states should be doing more and they are not? Do you think—or do you think that more states need to have, you know, different laws?

Ms. DOROSHOW. Well, states do not do a very good job of regulating rates, that is for sure. Sometimes the laws do not even allow

them to, like in Illinois, where the insurance department is prohibited from even denying an excessive rate if they see it. But most states do not have prior approval. Basically the insurers file the rate, and they use it. It is called file and use.

In addition, I think state insurance departments tend to be pretty understaffed and underfunded, and they are hit with lots of actuarial data, and lots of information from rate filings from their insurers, and they cannot always do a proper examination of what the insurers are filing.

So we have also advocated at the state level more funding for state insurance departments so that they can do a better job. But even—

Mr. LIPINSKI. It can have a significant impact on this crisis or do you think that is just a small part?

Ms. DOROSHOW. No. I mean, if the regulation—laws were stronger, it could have a significant impact. What we have advocated is, what you need to do, is there are sharp ups and downs in this insurance cycle. We are in the third one in 30 years of a very, you know sharp up. What you need to do is kind of modulate that cycle, get better control so there aren't those sharp ups and downs, and that is what a stronger insurance department could do with better regulatory laws.

Mr. LIPINSKI. We have heard from—and I also have to say I am new here. I have not been dealing with this issue as many of my colleagues have. I have been dealing with it for a few years. Are these insurance companies, are they really hurt?

I mean, I have heard you say—suggest that they are not, but it seems from what other witnesses have said that they are, the insurance companies themselves are hurting now.

Ms. DOROSHOW. Well, if you read the trade journals where they actually report on the successes and the profits of the insurance industry, you will find them quoting, you know, their results as outstanding, and record breaking, and the best they have ever seen. So I think you have got to look beyond—

Mr. LIPINSKI. Okay, I will have to look at that myself and see some more on that.

On more question, I will pick out Dr. Palmisano, but anyone else who wants to address this, I have heard that the estimates, the medical malpractice, about how much they add on to the cost of health care is under one percent. It is pretty small. Do you believe that? Do you agree that that is the case, that it is not a problem that is affecting the cost of health insurance? It is just affecting the doctors, where the doctors are?

Dr. PALMISANO. Well, we believe that is not a correct way to frame the question. What they say is it is one percent to two percent of the total health care costs, so why should we worry about it?

Well, you should worry about it because it is 100 percent for the neurosurgeon who no longer practices in a community. It is 100 percent for the patient who needs a neurosurgeon.

Mr. LIPINSKI. You think it really is a doctor—the problem is for a doctor, what you have all been addressing here. I was just wondering about if anyone thinks that it is also a bigger problem in terms of health care, of the cost itself. I understand what you are saying about the doctors. Does anyone—Ms. Heady?

Ms. HEADY. Well, it is 100 percent of the cost if the doctor closes their practice, and I think that the more vulnerable parts of our population, the low income, minorities and rural areas see this significantly impacting the quality of their health care services.

Mr. LIPINSKI. Thank you.

Chairman MANZULLO. Okay. Congressman Fitzpatrick.

Mr. FITZPATRICK. Thank you, Mr. Chairman.

Chairman MANZULLO. No, I am sorry. Congressman Gohmert. He was here before you. Go ahead.

Mr. GOHMERT. Thank you, Mr. Chairman, and I appreciate everyone's time here today. I am an attorney, and I have a lot of doctor friends, and was a judge for a decade, been on chief justice to finish a term as appellate judge as well, and I have wrestled with these issues. I appreciated, Mr. Barrow, your insightful comments and questions, and acknowledge there is a problem, and also Dr. Christensen acknowledging that there is a problem. We have got to deal with it.

I noticed, Mr. Smarr, in your Exhibit 9 you pointed out a glaring problem that I am not sure the caps address, and that is this problem of 75 percent of doctors coming out without any kind of finding of fault. And as a judge, I saw it over and over again. The plaintiffs' attorneys, you know, sue everybody that touches a file, and as one doctor said after a year, she got dismissed right before trial, "That is it?" She stood in my court saying, "That is it? What about my year of pain and suffering? What about my lost wages? What about my costs? What about my insurance going up? I knew I had no fault but this has just ripped me up."

And she had good questions all. I am sure you would acknowledge that, right, Ms. Doroshow. I mean, that is a problem, right?

Ms. DOROSHOW. Well, I think it is true that most plaintiffs are not successful in their medical malpractice cases. I would not say that is because they are without merit. I would say that these cases are extremely difficult to prove, and expensive to fund, and they do not always—they are not always able to do that. These are usually not smoking gun cases. It takes a lot of investigative work, and a lot of expense to do that.

On the other hand, if the cases are being dismissed, and verdicts are not happening, then where is the crisis?

Mr. GOHMERT. Well, we see the crisis by the health care insurance cost, and when you see 75 percent of all doctors have no finding of fault, then there is a problem, and that would appear to be one area that needs to be addressed.

Mr. Smarr indicates that that clearly shows personal injury attorneys trying these woefully deficient and recognized meritorious actions. What I repeatedly heard is they are practicing defensive law by suing everybody so that they do not get beyond the statute of limitations and find everybody turn and point to one person that they did not include.

So I see that as a problem, whether you will acknowledge it or not, and I hear that from plaintiffs. But what I am wondering about is how we deal with that issue, and I like a carrot as well as a stick, and I am wondering if you have incentive—a disincentive to sue people without—who may not have any fault, so that the physicians could be awarded attorney's fees if they are dismissed without some finding of fault or agreement between the parties.

Or on the other hand, if they are into the lawsuit and a party after limitations identifies somebody outside the lawsuit as having responsibility, then extend limitations for 30 days to allow him to bring that party in so that we do not keep bringing in 70 percent of doctors who are ultimately dropped or dismissed without a finding of fault. That is one thought I have, and if I have got time, I will ask for comments.

But another thought I also had is beyond the cap issue, allowing the loser pay system to level the playing field, and one other issue would be, in Texas, as I understand, neurosurgeons have started trying to police doctors for hire and examining the testimony of everybody in depositions or at trials who has their board certification, to see if it meets the standards of that certification so that, you know, doctors are more careful about hiring themselves out.

People talk about frivolous lawsuits, but most lawsuits do have some doctor somewhere who has been paid to say this doctor screwed up, and here is an affidavit supporting that. Then they get into the suit, find out more information, and then 70 percent of them get dropped. So that seems like that may be a potential area to help police things as well.

So anyway, I am interested in your comments in my remaining time.

Chairman MANZULLO. Well, we have got seven seconds here.

Mr. GOHMERT. Did not know how much yellow meant.

Chairman MANZULLO. Yes, let me go onto Congressman Bordallo. We may have time for a second round here.

Ms. BORDALLO. Thank you very much, Mr. Chairman, and ladies and gentlemen. I want to thank the health care professionals nationwide for the hard work and commitment to the communities in which we live, and we definitely, as evidenced here by all of the witnesses and my colleagues, we definitely have a crisis.

I come from the territory of Guam, and we have a reasonably effective system of preventing frivolous lawsuits. Petitioner cases must be heard by an arbiter, and may only be appealed in court. But despite these controls, malpractice insurance continues to go out of control. I just wanted to make that comment.

Another comment is in June 2003, Families USA report the average compensation of CEOs in the health insurance industry's 11 leading companies was $15.1 million without even including stock options. So this does not sound like an industry that is struggling to make ends meet. I just want to make that comment.

Now, my question, and I think this is to you, Mr. Smarr. I believe that market solutions are the most efficient way to solve many problems, but I also understand that they require effective regulations, and I have also heard today that medical malpractice is driving insurers out of the market.

Could it be that the lack of competition among insurers is in fact the causes of higher premiums?

Mr. SMARR. We actually saw intense competition in the marketplace in the early 1990s, when this line of business was profitable, and in fact rates were going down. I know I was making rate filings that were going down at that time. But when the market hardened, when the cost of claims rose so high, and when investment income, which we use to offset claims, declined, we knew the bond rates were at an all-time low, companies not only got the marketplace, they went broke. There are a number of them across the nation who no longer exist. Or like St. Paul, a very large insurance company, who made a strategic decision to drop out of this line of business worldwide because it was not the most efficient way to use its capital.

It is a question now of rates not yet being adequate, not that the companies are making money, because they are not. And so I cannot see how the fewer number of carriers in the marketplace can contribute to higher prices because of lack of competition.

Ms. BORDALLO. Would anyone else like to comment? Yes.

Ms. DOROSHOW. Yes. I mean, it is very true there is a lot of competition when there is a soft market, and it falls away when we are in a hard market period. I do want to address this St. Paul issue and some of these companies that pulled out.

In June 2002, the Wall Street Journal had a front-page article about St. Paul and what had happened to that company, why it was pulling out, and it was due to basically mismanaged reserves by this company. Other companies had followed along and they should not have been in medical malpractice in the first place, and they pulled out when the market turned hard.

St. Paul is a company that has long mismanaged its finances and reserves. In fact, in the late nineties, the Attorney General, then Insurance Commissioner of Minnesota, went on Night Line. There was an entire show devoted to this, St. Paul and Mike Hatch. Mike Hatch had done a whole study about St. Paul, and was a closed-claim study, and basically found that St. Paul had grossly misled the public as to the situation with its own claims and so forth.

Night Line had its own actuaries and investigators double check his work. They went on, they supported it with a whole show devoted to that. I think it was 1988-1989, something like that, but this is a company that has had a lot of problems, and it is not because of lawsuits going up.

Ms. BORDALLO. Thank you for that information. Thank you, Mr. Chairman.

Chairman MANZULLO. Mr. Fortenberry, you had just remarked, and Mr. Fitzpatrick, you can be right after him.

Mr. FORTENBERRY. Thank you, Mr. Chairman. I apologize for leaving the room, so if this ground was already covered, please accept my apologies.

Chairman MANZULLO. In fact, we are going to stick around here for a second round because—if it is okay with the witnesses. Does anybody have to catch an airplane?

Dr. PALMISANO. At four.

Chairman MANZULLO. Four. We will not be that long.
Mr. Fortenberry.

Mr. FORTENBERRY. I will try to hold the remarks to allow you to catch your plane.

Dr. PALMISANO. Thank you.

Mr. FORTENBERRY. Dr. Palmisano, I noticed in your testimony a statistic that I am familiar with, which is that the government spends—the government's own health care obligations are impacted by this very question, and I think it is a very important to point this out, particularly in these very difficult fiscal times that we are living with.

According to the Health and Human Services, I believe, and unfortunately I have already sent your testimony off with my staff to be filed because I thought it was important, the cost of medical liability is between 70 billion and 125 billion or so—

Dr. PALMISANO. One hundred and twenty-six billion, yes.

Mr. FORTENBERRY. —every year? The cost savings in the framework in which we are discussing of excessive medical liability, in some way trimming excessive medical liability, and that is the key adjective here, excessive, would be about $50 billion to the government's program.

You might want to elaborate a little bit on that if you can. I know you are lifting those statistics from Health and Human Services, but I think it is an important component of this discussion, and let me leave you with a final comment as well.

I think there are outstanding points being made throughout this discussion. I think what the key is here is balance, and some of

these reforms, I think, are getting at allowing the health care industry to continue to deliver basic health care services in a reasonable fashion, allowing those who are injured from negligence to have redress in the court system, but in a way that does not undermine the very ability of the health care industry to deliver its services in the first place.

And so I think fundamentally that is what we are wrestling here with, if you want to comment on the savings potentially to the government, that would be helpful.

Dr. PALMISANO. Yes, sir. That is on the written testimony handed in on page 11. Seventy billion to 126 billion determined by the U.S. Department of Health & Human Services attributed to the cost of defensive medicine. And if you had reasonable limits on non-economic damages, it would reduce the amount of taxpayers' money the federal government spends by up to 50.6 billion per year.

And as you talk to physicians around the country, there is no question that they do test because someone says, you know, if you do not have this, you better document it, because if you do not have this, someone was knocked unconscious, that is one indication to get perhaps a CT scan.

On the other hand, if someone was hit on the head and they were not unconscious and they have no neurological loss, and someone says but if they bleed later on, and someone will say that you should have gotten this test, and they said, well, we better get the test to so we can document it if litigation comes.

If I might just add one thing about—I am a surgeon. I have been practicing for about 40 years. One of the things I do is make the diagnosis of appendicitis. I get informed consent, and I recommend an operation. If I had, and I get instant peer review, the pathologist looks at the specimen and he says, she says appendicitis, no appendicitis, normal appendix, if I had a 70 percent normal return rate, they would not let me operate at my hospital, and that is one of the problems with this system.

There are so many that you brought up, Judge, there are so many cases being filed. The Institute of Medicine report, they said these are not bad doctors. These are bad systems that we need to fix. And you all passed a good bill last year, and the Senate passed a good bill, and it did not get out of conference Committee, the Patients Safety and Quality Improvement Act of last year.

And it is the aviation safety reporting system applied to medicine. You can voluntarily report, experts review it, give you feedback on changing the system, and you disseminate in a unidentified fashion. That works for commercial aviation, it will work for medicine.

So we think patient safety is very critical in this too, but something has to be done. You mentioned early about the responsibility. This country is built on a free enterprise system. Small businesses make up a big part of the free enterprise system. And there is accountability in business. If you don't meet your expenses, you go out of business.

And so we need to have some accountability for attorneys who file suits that do not have any merit, and if you want to have a loser pays, AMA has a policy on that. We will be glad to give it

to you. It is on the AMA website in policy finder. If you lose in a case, and it is shown that there was—you have to pay the other side's defense costs on an hourly basis, approved by the judge, both plaintiff and defense. So that is one thing we have looked at over the years. We have that in our policy.

So a lot of things can be done, but just to say, you know, we have got to stop malpractice. The Troy Brennan that you all have heard in the past in Congress had Harvard show that there is no correlation between the monies paid by these insurance companies and negligence. The only correlation is with disability. So we have a very expensive system that does not accurately measure negligence, and you have people who get 33.3 to 50 percent, including the money that the patient, the injured patient needs for the rest of their life for medical treatment, and that is the big incentive for these cases.

Chairman MANZULLO. Congressman Fitzpatrick.

Mr. FITZPATRICK. Thank you, Mr. Chairman. Just following up on that, I would like to hear Ms. Doroshow's response to—I guess it is an AMA officially adopted policy of a loser pay system?

Dr. PALMISANO. Yes, sir, and the only thing I did not mention is that if the patient or the client is not able to pay, then the attorney is responsible.

Ms. DOROSHOW. Well, look, loser pays for someone who is injured, in need of medical care, unable to work is a horrible system. It will have a devastating chilling effect on the pursuit of any legitimate claim because of the prospect that that person is going to have to pay the insurance companies' defense fees if they were to lose the case, and given statistics, you know, it is very difficult to win these cases, it would have a horrible chilling effect on the pursuit of legitimate malpractice cases.

And you know, there are only one in eight people who are victims of medical malpractice that sue in this country. That is it. There is an awful lot of malpractice going on that no one is being accountable for already, so that is about the last direction you want to go.

Mr. FITZPATRICK. How about with respect to frivolous cases that are filed? I think we—you know, just as there are legitimate cases that are filed, there are frivolous cases that are filed. With respect to the frivolous cases.

Ms. DOROSHOW. No question that attorneys who file frivolous cases should be sanctioned, and there is Rule 11, there are other rules already on the books that do that. I have no problem with that.

Mr. FITZPATRICK. There are many states that do not have Rule 11 type sanctions, and it reason it becomes a crisis in some states—

Chairman MANZULLO. Could you talk into the microphones, Congressman? Thank you.

Mr. FITZPATRICK. I am sorry, Mr. Chairman.

Chairman MANZULLO. That is okay. Go ahead.

Mr. FITZPATRICK. And the reason it becomes a crisis in some states, some states have not been able to deal with it. I come from the Commonwealth of Pennsylvania. I came after your testimony, I apologize, due to a conflict, but I have your testimony here, and I am going to read it on the way back to my district today not only because of your expertise. I have seen your resumes and I appreciate your time here today, but this is a serious issue for my district, my state, and I believe for the nation.

But when I came into the room I was listening to the Ranking Member, I think, make an inference that this is a crisis only in red states. As I said, I come from the Commonwealth of Pennsylvania.

Ms. VELAZQUEZ. I did not say that. I am here.

Mr. FITZPATRICK. Okay.

Ms. VELAZQUEZ. I was referring to his map.

Mr. FITZPATRICK. Sorry. I apologize and stand correct. I come from the Commonwealth of Pennsylvania, southeastern Pennsylvania, Box County specifically. There are seven community hospitals in Box County, and I sit on the board of directors of one of those hospitals, and the directors of all the hospitals have watched in Pennsylvania as doctor after doctor have left the practice, and we ask them why all the time, and it is always the same reason. They cannot afford to practice in the Commonwealth of Pennsylvania anymore.

The highest risk specialty, I am sure is not just Pennsylvania, it is delivering babies, OB-GYN. I have a wife, three daughters, five sisters and a mother. Specifically, and anybody that might want to care to address this, I mean I see this as—if it is a crisis, it is a crisis first on the delivery of women's health care, and if you addressed that, again I apologize, but if anybody just cares to address how this issue is affecting specifically the delivery of health care to women.

Dr. PALMISANO. If I might briefly. It is a very serious problem for women, and obstetrics. They pay, and you know, it is over $260,000 in south Florida, and patients are having trouble finding obstetricians, and people who have complications, they are having problems finding someone to deal with those complications, so it is a serious problem.

In your state of Pennsylvania, of those states that are painted red on our map that we declare the crisis states, Pennsylvania is probably in the worst shape of all the states. In Pennsylvania, no one will sell you insurance. The law requires you to carry a million dollars of insurance. Nobody will sell you the insurance above

$500,000, so the state, in your state, has to do what is called the M-Care Fund, and the state passes it, and then in 2003-2004, the state with their own actuaries, they raised the rates 30 percent.

Ms. DOROSHOW. But the solutions to this problem, again, they lie with the insurance industry. We do not dispute at all that doctors and some specialists are being price gouged, absolutely true. Capping damages is not going to do anything to help those doctors.

There are specific reforms that our organization and other consumer groups have laid out over the years, not just regulation of rates, but collapsing categories, experience rating, other kinds of reforms that could really help those physicians. Having been born and raised in Philly, I am very sympathetic with the situation in Pennsylvania myself.

But again, you cannot solve this problem on the backs of patients. It is not the legal system that is responsible here. It is the insurance industry's own business and accounting practices.

Chairman MANZULLO. I think Hilda had a response, Congressman.

Ms. HEADY. Yes. Mr. Fitzpatrick, I appreciate your question. I do have very personal experience in the area of women's health, and the impact that this has had particularly in rural areas. Primarily because—you know, this particular malpractice crisis right now hit subspecialties. Before that, it was in primary care. And this is the third series of crises that we have had without fixing the problem.

We do see those practitioners who are primary care practioners who have experience and training that goes on for fellowship in OB-GYN. That is the first provider that stops that kind of service in rural areas. And when we are lucky enough to have OB-GYNs in rural areas, then they just simply cannot afford to do that.

Now, I might make a lot of enemies or a lot of friends with this next comment, but I am tired of the finger pointing, and it is not just an issue of doctors and lawyers or lawyers and doctors and the insurance companies and so forth. There are four segments of our society that have both responsibility and I believe that there is a solution in there. It is the legal profession. It is the medical profession. It is the insurance industry, but it is also consumers.

And one of the things that we have done in our society over the last 50 years is we have abdicated a lot of our own personal responsibility into a field of medical science looking for solutions to problems that we ourselves need to take care of. And as long as we may lose our doctor in our rural area, but if we smoke when we are pregnant, you know, and we know that we should not, then that is shame on us.

And I do agree with Dr. Christensen's observation that the cost of health care—I mean, this is just one little piece of it, but until we get at this table, all four of those groups of society, we are not going to find a solution, and we are going to continue to point fingers at each other, and while we do that we have got people, real consumers out there that are the ones that are hurting. Thank you.

Chairman MANZULLO. Mr. Smarr, go ahead.

Mr. SMARR. Thank you.

Chairman MANZULLO. We are still on your time. I extended it, Congressman Fitzpatrick, because we are at the end of the questioning. Then we will have a second round.

But go ahead and answer the question.

Mr. SMARR. I would like to respond regarding the insurance industry in Pennsylvania. The major carriers, the Pennsylvania Medical Society Liability Insurance Company I helped found that company in 1977, and at the time I worked for the medical society, and we thought, well, the commercial carriers are gouging us. They are ripping us off. A company called Argonott came in with a 200 percent rate increase, and we had a hearing. And the result was the doctors of Pennsylvania raised $9 million in capital to found that company, which is the leading writer in the state today, and we now know the truth.

We know that the claims are real, that the costs are high, and the medical society has the data. It has the experience to know that the issue is the rising cost of tort claims, and this happened all across the country where doctors raised their own capital because they did not believe the commercial insurance industry, and the truth is there, the data is available to the public, and we know that contrary to what Joanne said, if you look at page 5 of my written testimony, you will see a chart that talks about the profitability of the lines of insurance in the United States, and you will see medical malpractice being the least profitable line of insurance. It has been this way many years running. And while the P&C industry maybe profitable as a whole, that now is not.

Thank you, Mr. Chairman, Mr. Fitzpatrick.

Chairman MANZULLO. Okay, let us take a second round. I am going to do something unusual, Donna, I am going to trade time with you. You are a physician, and I want you to go ahead. You are recognized for five minutes, and then I will take your time when your time will normally be up.

Ms. CHRISTENSEN. I appreciate that, Mr. Chairman.

I was reading some testimony from another hearing back in last year where a survey from Medical Economics was quoted, and I was quite surprised at where they found the malpractice premiums accounting for between 1.3 percent and 5.5 percent of doctors' gross receipts.

I wanted to ask, well, maybe I will ask Dr. Gleason since Dr. Palmisano had a chance to answer my last question. That seemed very low to me.

Dr. GLEASON. That is low. Currently, in Cook County the premiums for 2 million - 4 million coverage are $212,000 per year. That constitutes approximately 15 percent at least of our receipts and over 10 percent of my overhead.

Ms. CHRISTENSEN. But what do you—I think Ms. Doroshow talked about some of the ways that the cost of insurance could be

addressed, for instance, compressing rating categories. What would the physician groups think about that?

Apparently the malpractice insurance charges specialties paying the highest premiums, between 800 percent and 1300 percent of what they charge specialties, paying the lowest premiums, and that they charge doctors with incidents no more than 200 or 300 percent of what they charge doctors with clean records.

Would the physician groups that you represent support that?

Dr. GLEASON. I am sorry. Could you say that again? I got a little bit lost.

Ms. CHRISTENSEN. Compressing rating categories so that it would reduce the differential in rates between the categories, possibly combine certain categories so that the costs would be spread out instead of concentrating a lot of the costs on one group of physicians versus the other.

Dr. GLEASON. Well, I think that costs are spread out because we are in different categories in terms of severity. But the fact remains that in Illinois, if I go to Iowa, if I go to Wisconsin, if I go over to Indiana, that my rates will—and incidently, these are three states with caps—that my rates will be anywhere from one-quarter to one-sixth of what they are in those states.

The fact remains that 160 physicians from down in Madison, St. Clair County have left in the last year; that the transfers, for example, out of state to St. Louis University have increased—doubled over the last two years almost to three a day, and to Berns Hospital having increased 400 percent.

Ms. CHRISTENSEN. I just thought it was rather low and I just wanted to get some feedback on whether you know that was a figure that most people agreed to.

I agree that, you know, people are leaving, people are moving, and that it has impacted health in some areas.

Dr. Palmisano, I know and I guess to some extent I practiced some defensive medicine in my time, but I am interested in the portion of your testimony where you talk about efforts to improve patient safety and quality being stifled because of lawsuit fears.

Can you explain that or give us an example?

Dr. PALMISANO. Yes, Doctor. The American Medical Association believes that efforts in patient safety are stifled; that people are afraid to come forward when they almost make a mistake because they are afraid that someone will think, well, we need to use punitive measures here.

The Aviation Safety Reporting System is the model that we recommend, and you all passed it with only six dissenting votes, and the Senate passed it last year with unanimous consent. We think it is a good model. It has worked well for commercial aviation.

It would encourage people if they make a mistake to call up, report that, and learn how to fix the system. Most of these are system problems. The nurse trying to resuscitate a patient told by the doctor to give a medication to get rid of excess fluid. She draws up

the medication, gives it to the patient, the patient gets worse, the patient dies. She calls a code. They try to resuscitate the patient to no avail, and they find when they have looked at the broken medication vials, they say why is that concentrated potassium chloride there? The reason story, real person in a movie called "Beyond Blame, Nine Minutes," a very powerful movie. And she says, oh, my goodness, I must have killed the patient by giving the wrong medication.

A good nurse, outstanding record, and she get punished for that because of this bad system, and it is a tragedy for the patient, and the system fix is not to have concentrated potassium chloride at the nursing station. You keep those types of medications for the pharmacist to mix in the pharmacy.

Ms. CHRISTENSEN. Are not hospitals still responsible for dealing with some of those through their case—through a process of rounds and case studies?

Dr. PALMISANO. Well, they are, but more and more it is becoming difficult to discuss this for fear of someone being dragged into a lawsuit, and it is just like defensive medicine, a study that was done that showed 79 percent of physicians practice defense medicine. Fear of being sued causes 79 percent of physicians to order more tests because of concerns about potential medical liability lawsuits. That was the study done by Common Good.

So yes, there are safety systems set up in hospitals, and we encourage that. The AMA encourages that, the JCHO, the AMA with the National Patient Safety Foundation in 1996. We have given over $7.3 million to it. We have encouraged the trial board to match our donations. To date, they have not. But we think organizations like that, they have only one mission, to measurably improve patient safety, get human factors experts, nurses, physicians, attorneys, everybody together to try to figure out how to make the system safer, and one of the problems is this fear of reporting an error that one made.

We believe everyone has an ethical obligation. If you make an error and hurt the patient, you have to tell the patient about that, and do the best, and that is what patients want. They want to be told when an error was made, but they also want to know what happened, what are you going to do prevent this from happening to someone else, and ideally they would like to have someone say they are sorry.

Ms. CHRISTENSEN. Is that clock set at five minutes? But that is okay.

Chairman MANZULLO. I have got to go to another meeting. I am going to ask Congressman Sodrel to conclude the hearing. I want to thank all of you for some really excellent testimony, and I have got an idea about the next hearing. I think we should bring in the insurance companies. I want to see them go head to head, Joanne, you are coming.

This has got to be resolved because, Hilda, you are right. Everybody is pointing their fingers, and you have got two groups of peo-

ple being heard here. You have got innocent plaintiffs that are entitled to reasonable access to the court and to a fair verdict. Then you have got physicians who unquestionably are leaving the practice because they cannot afford to pay the high cost of medical malpractice insurance. Those are two extremely serious questions. I believe that they are not mutually compatible; that you can resolve both of those things. That is, I think, the direction we are going to go.

I want to know if someone is making $15 million a year and he says his insurance company is in crisis, let him testify as to why it is in crisis, and why he is making that kind of money. I think these are fair questions because the entire insurance industry is on the line here.

But I have to leave and thank you very much. Congressman, if you could come, and then recognize Congresswoman Velazquez.

Ms. VELAZQUEZ. I do not have any more.

Chairman MANZULLO. You have no more questions then?

Ms. VELAZQUEZ. Well, then come have a seat. Then you are up next on the round of questions. Thank you.

[Pause.]

Ms. VELAZQUEZ. Yes, I changed my mind, Mr. Doroshow. I just would like to give you, Ms. Doroshow, an opportunity to react to any of the comments that have been made if you feel that you needed to respond and you did not have the time.

Ms. DOROSHOW. I just would love to talk about a recent survey which was just reported a couple of weeks ago that we saw in Reuters, and let me just quote it.

"Eighty percent of U.S. doctors and half of nurses surveyed said they had seen colleagues make mistakes but only 10 percent ever spoke up. Fifty percent of nurses said that they have colleagues who appear incompetent, and 84 percent of physicians and 62 percent of nurses and other clinical care workers have seen co-workers taking shortcuts that could be dangerous to patients. Doctors and nurses do not talk about these problems because "People fear confrontation, lag time, or feel it is not their job."

Nowhere in here do you see any mention of fear of lawsuits. I think there are problems in terms of errors being reported. I think we would agree that there is a tremendous amount that could be done in this area, but imagining that it is fear of liability that is the principal or even the only reason for this is just simply wrong.

Ms. VELAZQUEZ. Thank you.

Mr. SODREL. [Presiding] I was next up before I took the chair, and I guess I would first like to say, Dr. Rubin, I am in the transportation business, and I have replaced employees that I thought were guilty of malpractice or about to commit malpractice, and found myself sued for replacing them. So it is like you are sued if you do, and you are sued if you do not.

But when I look at the chart back here on the principal lines of business on insurance companies, and I think it was brought up earlier by Mr. Smarr that the medical malpractice line of insurance has been subsidized basically by commercial auto, personal auto, fire or inland marine, and other insurance lines. I do not think that is the best thing for us to be doing in the insurance business, you know, as—they have a saying in the country, turn on its own bottom.

But I would like to ask Dr. Gleason. You say you have a practice of several physicians. Do you self-insure? Do you self-insure any part of that?

Dr. GLEASON. No, we do not. We did take some time a couple of years ago to explore the captive option, and we sent our figures off to the actuarials, and at the time and even today we still find it more economical, if you call it economical, to stay with Illinois State Medical Insurance Society.

Mr. SODREL. So business did not look quite as lucrative whenever you went in. I mean, we keep hearing that the insurance companies are making profits, but then we have one person here that is involved in the malpractice insurance business where it is not making money, and you have investigated taking on some of your own liability, and that did not look to be very lucrative.

Dr. GLEASON. Yes, sir, that is correct, and that at both a 70 percent competency level as well as a 90 percent competency level.

I would just like to raise another point, and that regards Proposition 103. It is my impression, and correct me if I am wrong, but when MICRA was enacted in 1975, it took another 11 years to ratify that, and beginning at that time the costs of premiums and the costs of health care reimbursements to injured people began to come down, and by the time that Proposition 103 was enacted and ratified two years later, the awards and costs had already diminished 71 percent by that time, and then subsequently continued to fall. That is just something that I felt in terms of my preparation was notable to me.

Furthermore, we also have states like Oregon, a model that we can look to in terms of what has happened over that 11 years that caps were in effect there, and then were judged to be unconstitutional, and see the rise in premiums and cases, and then also we have Texas, of course, which shows some promising signs.

Mr. SODREL. Thank you, Doctor. Did you have any further questions? No.

Well, seeing none, in the absence of objections, we stand—I would like to thank all the witnesses for being here, and appreciate you spending the extra time to answer the extra questions, and we stand adjourned.

[Whereupon, at 12:16 p.m., the Committee was adjourned.]

House Small Business Committee
"Medical Liability Reform: Stopping the
Skyrocketing Price of Health Care"
February 17, 2005
10:00 am

Opening Statement
Chairman Donald A. Manzullo

Good morning. It is my pleasure to welcome everyone to today's Small Business Committee hearing on the critical issue of skyrocketing medical malpractice insurance and its affect on health care and access to health care.

I applaud the President's leadership on this issue. He supports reforms in our medical liability law that would: improve the ability of patients to collect compensation for their economic losses in a timely manner; ensure that recoveries of non-economic damages would not exceed $250,000; and limit punitive damages to $250,000.

Year after year, small businesses rank health care as the number one issue that affects their business. The ability to offer health care to employees is a competitiveness issue for many small businesses as they seek to attract and retain the best employees to their business.

Congress needs to explore ways to slow down the rising health care costs. One of the reasons that the cost of health care continue to see double-digit increases is the spiraling cost of doctors medical malpractice premiums.

Litigation has escalated and awards have skyrocketed. Multi-million dollar court decisions and jury awards have left doctors with medical liability premiums increase 40 to 50 percent per year. Doctors in certain fields of high-risk fields of medicine can expect to be sued at least once in their career.

Between 2000 and 2003, the number of medical liability claims has jumped 46 percent in Illinois to more than 3,500 claims. The average indemnity per claim also has risen dramatically. In 1990, the average indemnity was about $310,000. In 2003, it was nearly $600,000, according to the Illinois State Medical Insurance Exchange.

As a result, doctors are retiring or leaving the practice of medicine. Emergency rooms and rural facilities have closed. Many other doctors are moving to states that have taken action to cap jury awards, which stabilizes malpractice costs. In my home state of Illinois, it is common practice for doctors to move to a few miles to Wisconsin and set up shop.

I know of one OB-GYN in Illinois who left her practice to go back to being a pharmacist where she could earn more money and not worry about malpractice premiums. She explained that after paying malpractice insurance, she and another physician made $50,000. A third doctor made $60,000 and the fourth doctor made $70,000. Their office manager made more than all of them: $75,000.

In my hometown of Rockford, we have lost several of our neurosurgeons to the Badger State. In southern Illinois, there are almost no neurosurgeons left at all.

This not only affects the cost of medical care; it affects access to medical care. There are numerous stories about women having to drive for an hour or more to see their doctor to deliver their baby.

If you are in a car accident, there may not be a neurosurgeon available to save your life. If you live in a rural area, a clinic or hospital may have closed. The United States has the best medical system in the world, only you may not be able to access it.

Just in case you think this doesn't affect you or your pocketbook, doctors must practice defensive medicine by ordering extra tests to protect themselves against potential lawsuits. It is estimated that the federal government, through its funding of Medicare and Medicaid, pay an additional $28 billon to $48 billion per year for health care due to the costs of medical liability coverage and defensive medicine. That is your tax dollars.

Thirty years ago, California passed comprehensive medical liability reform. According to the Department of Health and Human Services, states that have limited non-economic damages have seen premium increases by less then 20 percent. States without limits on non-economic damages have seen premiums increase on average of 45 percent.

This is quantifiable evidence that medical liability reform works. According to the AMA, there are 20 states that in crisis. None of those crisis states have passed medical liability reform.

It is clear that the Congress must pass Medical Liability Reform. The House passed this legislation last Congress and we are set to take up this legislation again. Hopefully the Senate will join with us to reform the medical liability system and save our health care.

I look forward to the testimony of all the witnesses here this morning and I turn to my colleague, the Ranking Member for her opening statement.

Small Business Hearing – Opening Statement
Medical Liability Reform
February 17,2005

An estimated 60% of the 41 million uninsured Americans live in families with people employed by small businesses.

Small business owners have to find their insurance on an individual basis, making it difficult and expensive to find affordable health care.

Costs of liability insurance drives up the price of health care as they are passed both to small business employers and employees in the form of higher premiums.

In 2002, monthly premiums for employer-sponsored health insurance increased by 12.7% - the largest increase in 12 years.

Letting small businesses control and save their health care dollars as they see fit allows people to make the right decisions about their health coverage.

Health Savings Accounts, tax free accounts for medical expenses, do just that, but are not

available in all states, such as New York. This needs to be changed.

Additionally business owners cannot afford health coverage for their employees because they are unable to achieve the economies of scale and purchasing power of larger corporations.

The administrative costs incurred by small businesses are higher than those of larger businesses; 25-27 percent verses 5-11 percent for larger businesses.

Small Businesses need AHPs to level the playing field and give them the same advantages as larger employers have under ERISA.

These associations could allow as many as 8.5 million uninsured access to private sector health insurance.

Medical liability and its soaring costs have reached epidemic proportions for our nation's doctors and specialists.

From 1998 to 2002 the average payment for a malpractice claims has risen by an annual growth

rate of nearly 8% which is more than twice the rate of general inflation.

The increasing liability premiums forced 16% of obstetricians in New York to quit practicing obstetrics.

The only hospital in a county I represent does not have 24/7 neurosurgical coverage.

From 2000 to 2002, 4,000 physicians choose to stop practicing or left the state altogether.

Each year, about 15 malpractice claims are filed for every 100 physicians. About 30 of these claims result in an insurance payment.

In New York alone, medical insurance payouts on behalf of physicians were $495.7 million in 1993 and climbed to $705.7 million by 2003.

Committee on Small Business
Hearing on Medical Liability Reform
Statement of Ranking Member Nydia Velazquez
February 17, 2005

Mr. Chairman, today, we are facing a health care crisis. It is astounding that in the U.S. - the country with the world's largest GNP– there are 44 million Americans who cannot afford health care. We should be outraged.

Nowhere is this health care gap more striking than in our nation's small businesses. More than 60 percent of the 33 million adults and 11 million children without health insurance are small businesses owners, employees or family members. That fact is the real tragedy we must focus on and address.

Small businesses bear the brunt of the health insurance crisis because of lack of good choices for them and the high cost. Any increase in healthcare cost is an important matter for small businesses. Unfortunately in the past few years, many have seen annual health insurance premium increases in double digits.

One element of increasing costs is high medical malpractice premiums. That is the issue we will examine today. In the last Congress, we addressed this medical malpractice twice and last week the same bill was introduced again. The stories of staggering malpractice insurance rates are well known to us.

But it is important we get to the heart of the matter and find out what is really driving those increases. That is the information we need to provide a real solution to the problem and reduce costs for these doctors and, ultimately, help small businesses.

After all, Congress is being asked to step in and change 150 years of case law that allowed states to control the way victims of medical malpractice were made whole. Major changes to our legal system must at least be based on the best independent data we have. Solutions based on emotion won't solve anthing.

Unfortunately, that is not an easy task. Each side has their compelling stories and horrendous anecdotes. While one side sees a courtroom crisis driving up premiums, driving out doctors, and driving away small businesses, the other side sees an insurance industry jacking prices to make up for cyclical investment losses. If malpractice premiums ultimately aren't reduced, then the insurance industries benefit from the protective barriers on recovery by patients or their families. In both cases, small businesses and their employees still get hurt.

While we will hear from health professionals today, there is also compelling data that malpractice costs and jury awards are a small fraction of overall medical costs. We also have some practical experience on which to base our decision since caps and restrictions are already in place in 25 states. In some of those states, the same kinds of caps we are being asked to consider have failed to hold down medical malpractice rates. (Texas and Florida for example.)

Perhaps the correct answer lies somewhere in between.

In our zeal to help our nation's entrepreneurs, we have seen several bills move through Congress that were represented as small business relief but in reality provided the lion's share of the benefits to large corporations. I hope that today's hearing will be able to separate hard facts from perceptions and help us make choices that actually address the problem and reduce costs for small businesses.

American Medical Association
Physicians dedicated to the health of America

1101 Vermont Avenue, NW
Washington, DC 20005

Statement

of the

American Medical Association

to the

Committee on Small Business
U.S. House of Representatives

RE: Medical Liability Reform: Stopping the Skyrocketing Price of Health Care

Presented by: Donald J. Palmisano, MD, JD

February 17, 2005

Division of Legislative Counsel
202 789-7426

Statement

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RE: Medical Liability Reform: Stopping the Skyrocketing Price of Health Care

Presented by: Donald J. Palmisano, MD, JD

February 17, 2005

On behalf of the physician and medical student members of the American Medical Association (AMA), I want to thank Chairman Don Manzullo (R-IL), Ranking Member Nydia M. Velázquez (D-NY), and Members of the Small Business Committee for holding this hearing to examine ways to stop the rampant increases in medical liability insurance premiums and protect patient access to quality health care.

I am Donald Palmisano, MD, JD, Immediate Past-President of the AMA and a general and vascular surgeon from New Orleans, LA. The policy of the AMA is decided through its democratic policy-making process in the AMA House of Delegates, which meets twice a year. Our House is comprised of physician delegates representing every state, over 100 national medical specialty societies, federal service agencies (including the Surgeon General of the United States), and six sections representing hospital and clinic staffs (medical students, resident physicians, young physicians, medical schools, organized medical staffs, and international medical graduates). AMA policy dictates support for national medical liability reform. In particular, the AMA supports federal legislation based on California's medical liability reforms known as MICRA.

Not only are physicians medical professionals, their practices typically operate as small businesses. AMA data show that approximately three-fourths of practice-based physicians work in or own small practices (businesses). Among practice-based physicians, roughly 33 percent are in solo-practice, 26 percent are in practices with between 2 and 4 physicians, and 16 percent are in practices with 5 to 9 physicians.[1] In addition, self-employed physicians employ an average of 4.1 non-physicians.[2]

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[1] Department of Economic and Statistical Research, American Medical Association, The Practice Arrangements of Patient Care Physicians (2001), available at http://www.ama-assn.org/ama1/pub/upload/mm/363/pmr-022004.pdf.
[2] American Medical Association, Physician Socioeconomic Statistics (2003 edition).

As with any small business, physician practices generally do not have the economic and other resources necessary to absorb or shift the cost of rapidly increasing insurance premiums, let alone the high costs imposed by unfunded government mandates resulting from paperwork and other regulatory requirements. When overhead expenses increase, physicians must either increase fees or cut other expenses just to sustain their practices. For physicians, raising fees is becoming more difficult as Medicare, Medicaid, and managed health care plans arbitrarily limit payments for services rendered to patients. Alternatively, if physicians are forced to trim expenses, they are generally limited in their options and must make difficult choices, such as cutting staff, limiting staff benefits (e.g., health insurance), or forgoing the hiring of additional staff or the purchasing of advanced medical equipment. In some cases, physicians must limit certain aspects of their practice in order to find or afford medical liability insurance. For example, numerous family physicians are no longer delivering babies because it is cost prohibitive to insure that component of their practice. Anytime vital health care services are limited, patients' access to care is jeopardized.

THE CRISIS

What defines a crisis? In medicine, a crisis is defined as a sudden intensification of symptoms in the course of a disease. For the past several years, we have seen numerous symptoms that tell us our nation is facing a crisis because of a broken medical liability system. The symptoms are unmistakable: patients having to leave their state to receive urgent surgical care; pregnant women who cannot find an obstetrician to monitor their pregnancy and deliver their babies; community health centers reducing their services or closing their doors because of liability insurance concerns and the increasing fear of litigation; efforts to improve patient safety and quality being stifled because of lawsuit fears, just to name a few.

Escalating jury awards and settlements, and the high cost of defending against lawsuits, even those without merit, are driving medical liability insurance premiums to unprecedented levels.[3] As insurance becomes unaffordable or unavailable, physicians are being forced to relocate, close their practices, or drop vital services—all of which seriously impede patient access to care. Emergency departments are losing staff and scaling back certain services, such as trauma units, while 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. Many young physicians and medical students are opting out of high-risk specialties even before their careers begin, while other physicians are choosing to retire from practice altogether.

In the course of the past year there were several significant developments relating to the medical liability crisis. For example, going into 2004 the AMA had identified 19 states in crisis.[4] In June 2004, however, the AMA announced that Massachusetts had become the 20th

[3] A compendium of data supporting medical liability reform and debunking arguments against reform is available on the AMA Web site at http://www.ama-assn.org/go/mlrnow.
[4] Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, and Wyoming (see attached map).

state in a full-blown medical liability crisis due to its deteriorating medical liability climate and the growing threat of patients losing access to care. Data from the Massachusetts Medical Society show how patients' access to care may be in jeopardy as increased medical liability costs force physicians to restrict the services they provide, especially high-risk specialists in neurosurgery, orthopedic surgery, obstetrics, and general surgery. The situation outside of Boston is particularly worrisome, as the most recent data show there are only 23 neurosurgeons based outside of Metro Boston to serve 39 hospitals and the time to recruit a neurosurgeon has increased from 23 months in 2002 to 30 months in 2004.

There was also significant activity at the state level with legislatures passing medical liability reform bills in Iowa, Mississippi, Missouri, Oklahoma, and Wyoming.[5] In Iowa and Missouri, however, the efforts of the legislatures proved to be in vain as the governors of those states vetoed their respective legislature's liability reform measures. Also in 2004, the citizens in four states (Florida, Nevada, Oregon, and Wyoming) voted on ballot measures related to medical liability reform. While the efforts in these states (and the states with existing liability reforms) are indicative of the severity of the problems in the medical liability system and the desire to find effective solutions, the goal of stabilizing medical liability insurance premiums may prove elusive in the short term as legal challenges continue to work their way through the respective state court systems. These are a few reasons (more of which are discussed below) why the AMA believes it will take a federal approach to resolve the 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 of our country—and in several cases entire states—into risky areas to be sick, because it is so risky to practice medicine. A 2003 report by the Blue Cross/Blue Shield Association showed that 56 percent of Blue Cross/Blue Shield plans in crisis states report that physicians are leaving their practice, retiring, or no longer performing some high-risk procedures.[6] According to the American College of Obstetricians and Gynecologists, rising liability insurance costs combined with the increased fear of being sued have driven one in seven of America's ob-gyns from the practice of delivering babies.[7] Our future physicians are concerned as well, with 48 percent of America's medical students indicating that the liability situation is a factor in their choice of specialty, affecting patients' future access to critical services.[8] Moreover, 82 percent of Americans believe that physicians are being forced to leave their practices because excessive litigation puts the cost of liability insurance out of reach.[9]

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[5] In addition, in 2003 seven states passed laws to avert falling further into crisis (Arizona, Florida, Idaho, Mississippi, Ohio, Texas, and West Virginia).
[6] Blue Cross Blue Shield Association, The Malpractice Insurance Crisis: The Impact on Healthcare Cost and Access (2003).
[7] American College of Obstetricians and Gynecologists, Medical Liability Survey, July 19, 2004.
[8] Division of Marketing Research & Analysis Survey, American Medical Association (2003).
[9] Wirthlin Worldwide for the Health Coalition on Liability and Access (2004).

Throughout 2004, the medical liability crisis only got worse. Access to health care is now seriously threatened in 20 states, up from 12 states in 2002.[10] In many other states a crisis is looming—a crisis that not only threatens access to quality medical care, but also stifles medical and scientific innovation, inhibits efforts to improve patient safety, discourages new treatments and procedures, heaps billions of dollars in additional costs upon a health care system already strained to the breaking point, and places lives at risk. Virtually every day for the past four years 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. Below is just a sample of recent media reports that illustrate the problem faced by patients and physicians. Additional stories can be found on the AMA Web site at http://www.ama-assn.org/go/crisismap.

FLORIDA

- In Florida, emergency neurosurgery patients are increasingly being transported from Palm Beach County to hospitals in Broward and Miami-Dade counties, and sometimes as far as Tampa and Gainesville. In March, one of those patients, Mildred McRoy, died six days after being transferred to a hospital in Broward County because no neurosurgeon was available to treat her in Palm Beach County. (*Palm Beach Post*, March 9, 2004)

- Lee Memorial Health System officials announced they were giving the state a required six-month notice to close the trauma center after two neurosurgeons quit, leaving only two to handle 24-hour on-call duty. The center treats more than 1,000 trauma-alert patients a year. Recruitment efforts to bring neurosurgeons to Lee County have been disappointing. "The fact is, three trauma centers in Florida have notified the state that they can't hang on much longer," according to Lee Memorial's government consultant. (*The News-Press*, December 14, 2003)

- At least seven Florida hospitals have closed their obstetrics units due to insurance concerns, and four other hospitals have reduced or limited obstetrics services. In addition, ten hospitals have eliminated, reduced or limited neurological services. (Florida Hospital Association, January 2, 2003)

GEORGIA

- Georgia's ongoing crisis has negatively affected patient access for children, women and families throughout the state. Only seven pediatric neurosurgeons are left in the state. Women in Statesboro often wait between 6 - 9 months for routine mammogram since fewer radiologists are willing to read mammograms. Nine Macon obstetricians have stopped delivering babies or will soon do so. Two of three obstetricians in Eastman have left the state, leaving the remaining obstetrician to deliver nearly 200 babies without backup coverage. (Medical Association of Georgia)

[10] See attached map of medical liability crisis states.

- The Athens Women's clinic, which has offered obstetrics services for 35 years, announced May 21 that the state's medical liability crisis was forcing it to no longer deliver babies. It will continue to offer gynecological services. (*Athens Banner-Herald*, May 21, 2004)

- More than two dozen medical liability insurers have left Georgia, according to MAG Mutual, one of the state's remaining carriers. Since 1995, MAG Mutual's average payout in jury awards and settlements has increased from $215,000 a case to $465,300. Last year, it paid claims in 20 cases of more than $1 million. (*Atlanta Journal-Constitution*, February 8, 2004)

ILLINOIS

- Because of the state's legal climate, Illinois physicians pay some of the highest medical liability insurance premiums in the nation. Ob-gyn premiums have risen from $103,000 in 2002 to $148,000 in 2004; and general surgeons' premiums have risen from $68,000 in 2002 to $103,000 in 2004. Neurosurgeons typically pay more than $200,000. (Illinois State Medical Insurance Exchange, February, 2005)

- The frequency and severity of claims is skyrocketing in Illinois. Between 2000 and 2003, the number of medical liability claims has jumped 46 percent in Illinois to more than 3,500 claims. The average indemnity per claim also has risen dramatically. In 1990, the average indemnity was about $310,000. In 2003, it was nearly $600,000. (Illinois State Medical Insurance Exchange, February 2005)

- Patients in Illinois are losing access to neurosurgical care. The Memorial Hospital of Carbondale's administrator, George Maroney, explained that southern Illinois lost the only two neurosurgeons south of Springfield in 2004 because of rapidly increasing medical liability insurance premiums. Because of Illinois' well-earned reputation for litigiousness, Maroney still has not been able to replace them. (*The Southern*, January 5, 2005)

- In February 2003, two Joliet neurosurgeons stopped practicing brain surgery, leaving the city's only two hospitals without full-time coverage for head trauma cases. Joliet's two hospitals, Silver Cross Hospital and Provena St. Joseph Medical Center, acknowledge they will be unable to handle all emergency head trauma cases. They say they may have to stabilize and transport serious cases 45 minutes to the nearest trauma center. (*Chicago Tribune*, February 16, 2003)

- Heidi Ruppenthal and her son Alex know first hand the importance of having neurosurgical care available locally. Alex, who incurred a brain injury while playing ball at school, is alive today only because he had access to a neurosurgeon near home. Lisa Kasten was not as lucky. Her father, who lived in Belleville, suffered a serious head injury, but with little neurosurgical care available locally, had to be transferred to Missouri where he later died. (Illinois State Medical Society, February 1, 2005)

- When three obstetrician-gynecologists on staff at Advocate Lutheran General Hospital in Park Ridge learned their 2004 liability insurance premiums would climb from $345,000 to $510,470, they decided to take their practice to Kenosha, Wisconsin, where during their first year their combined insurance will cost $50,018. "This state is like the Titanic," said one of the doctors. "A year ago, we saw the iceberg. Now we've already hit." (*Chicago Tribune*, March 12, 2004)

MASSACHUSETTS

- Cape Cod lost its only board-certified neurosurgeon when Robert Leaver, MD, retired early rather than face insurance premiums that reached $115,000. Dr. Leaver, who said he would have to perform about 100 operations just to pay his insurance bill, had no intention of retiring. (*Cape Cod Times*, October 6, 2003)

- Large jury awards and settlements continue to occur in Massachusetts, putting further pressure on the liability system. In 2003, there were jury awards of $3.18 million and $1.8 million. Settlements were reported for $3.75 million and $3.25 million, eight settlements between $2 million and $3 million, and eight settlements between $1 million and $2 million. (*Mass. Lawyers Weekly*, January 19, 2004)

MISSISSIPPI

- Days before Mississippi's new reforms went into effect (January 1, 2003), several counties saw a rush of lawsuit filings. Hinds County saw a 200-300 case increase; Holmes County had at least 30 additional lawsuits filed; Rankin County's increase went from less than 300 to nearly 400. (Associated Press, December 30, 2002)

- Only two neurosurgeons remain in practice in the Gulf Coast-area of Mississippi, and general surgeons are in short supply because of the state's medical liability crisis. "Everybody is reduced to the same low level of trauma care that we had 20 years ago," said Steve Delahousey, vice president of operations at American Medical Response ambulance service. (*Biloxi Sun Herald*, January 29, 2003)

- Rural obstetric care is in serious jeopardy. Cleveland has lost three of six Ob-gyns, Greenwood has lost two of four, and Yazoo City, with 14,550 residents, has no one practicing obstetrics. (Associated Press, November 19, 2003)

- Dr. Ron Graham, an orthopedic surgeon in Gulfport, received a retroactive premium increase in May of $36,000, then another increase in September. He said he's already been informed that when renewal time comes next year, it will double. That means in 10 years he's seen a 400 percent increase, he said. He may be forced to close his practice and put his four employees out of work. (*Biloxi Sun Herald*, November 7, 2003)

- Although there are several companies licensed to write medical liability insurance policies, state insurance commissioner George Dale said few new policies are actually

being written. "A lot of the companies still perceive that Mississippi is not a good place to do business," he said. (Associated Press, April 28, 2004)

MISSOURI

- St. Anthony's Health Center in Alton will lay off 50 to 75 employees in coming months. William E. Kessler, president and CEO of St. Anthony's, blamed the layoffs on declining revenue associated with increased medical liability insurance premiums and the resulting exodus of doctors from the community. (*St. Louis Post-Dispatch*, June 26, 2004)

- Dr. Al Elbendary, a gynecological oncologist, left a group practice and eliminated a rural outreach clinic because of rising professional liability premiums. "Women with gynecologic cancers in Ste. Genevieve, Carbondale and Chester now have to drive over a hundred miles to see a gynecologic oncologist and receive the care they deserve," said Elbendary. (*St. Louis Post-Dispatch*, October 31, 2002)

- After obstetrician Jamie Ulbrich's liability insurance carrier stopped doing business in Missouri, the best coverage he and three colleagues at their Marshall clinic could find would have cost them double what they paid in 2003. The four doctors decided they couldn't each afford the $50,000 liability insurance premium, so they decided to stop providing obstetric service and instead work solely as family physicians in 2004. (Associated Press, January 3, 2004)

NEVADA

- "I left Nevada because the litigation climate had driven medical liability premiums to astronomical heights," obstetrician-gynecologist Shelby Wilbourn, MD, testified before a Congressional subcommittee. Dr. Wilbourn, whose premiums increased to $108,000, moved to Maine this year and still receives calls from some of the 8,000 patients he saw during his 12 years in Nevada. "Liability isn't about fault or bad practice-it's about hitting a jackpot. Even the best obstetrician-gynecologists have been sued, many more than once." (Associated Press, February 12, 2003)

- Mary Rasar's father died in Las Vegas after the only Level 1 trauma center was forced to [temporarily] close due to skyrocketing medical liability costs. Jim Lawson was injured July 4 in a traffic accident and rather than being rushed to the Level 1 trauma center at nearby University Medical Center, which had been forced to close, Lawson was taken to a hospital that did not have the resources necessary to save his life. He died while physicians tried to stabilize him for airlift to Salt Lake City. (PR Newswire, April 21, 2003)

- The ongoing crisis has caused one of the few remaining liability insurers, American Physicians Assurance, to pull out of Nevada, a move that will leave about 125 doctors looking for new coverage to continue their practices. Dr. Fred Redfern, president of the Nevada Orthopedic Society, said the withdrawal of another insurance carrier

should alarm Nevadans. He said APA is his third insurance carrier to decide to leave Nevada because of the high cost of fighting medical liability claims. "This is not a good place to practice medicine. That's the message doctors are getting," he said. (*Las Vegas Review-Journal*, January 29, 2004)

NEW JERSEY

- A New Jersey Hospital Association survey shows that 100% of New Jersey hospitals saw an increase in liability insurance premiums in 2002, with the average hospital experiencing a 50% increase. Liability insurance has increased 203% from 1999. (New Jersey Hospital Association, January 29, 2003)

- An eight-physician ophthalmology practice, which treats premature babies born with retinopathy-a condition that can lead to blindness-will no longer offer the procedure due to the high-risk and liability exposure. (Medical Society of New Jersey)

- Dr. Stephen Smith says that part of the reason costs are going up is the doctors are now forced to practice defensive medicine. "What bothers me so much is that element of -- of fear and doubt that is created by this system we're in. What we're doing now is we practice [defensive] medicine. His father, also a physician, is worried that the legal climate could cause a future shortage of high-risk specialists: "the best students are not going into high-risk fields, they're not going into OB, they're not going to neurosurgery." (*60 Minutes*, March 9, 2003)

NEW YORK

- Of the 13 largest medical negligence lawsuits in the United States in 2002, seven were in New York state, according to the National Law Journal, including a $94 million verdict from a Brooklyn jury. (*Albany Business Review*, March 21, 2003)

- Awards greater than $1 million are three times more frequent in New York than in California, a state that has had reforms since 1975, according to the Insurance Information Institute. (*Poughkeepsie Journal*, April 1, 2003)

- Many young doctors won't specialize in obstetrics. They fear the threat of lawsuits and wince at liability insurance costs, which can be as much as $200,000 per year. Last summer, Manhattan's Elizabeth Seton Childbearing Center, which practiced natural childbirth, had to close when its medical liability insurance premiums rocketed to $2 million. (*New York Daily News*, February 12, 2004)

- Dr. John Cafaro, 45, an obstetrician-gynecologist in Garden City, said some doctors are paying $130,000 for only $1 million worth of protection. "But we are getting sued for $85 and $90 million at a time," he said. "You do the math. Every time I walk into an operating room I put my family's life savings on the line." (*New York Times*, May 25, 2003)

NORTH CAROLINA

- Hospitals in North Carolina have had insurance premiums go up 400 percent to 500 percent in the past three years, the North Carolina Medical Society says. Small, rural hospitals were hit hardest. (*Winston-Salem Journal*, March 9, 2004)

- "If we remain in North Carolina we will likely be forced to make the decision to limit procedures which carry high risks (but also are often life-saving)," said K. Stuart Lee, M.D. of Eastern Neurosurgical and Spine Associates Inc. Dr. Lee's practice saw their medical liability premiums increase 116 percent last year. (*The News and Observer*, January 26, 2003)

OHIO

- From 2001-02, Ohio physicians faced medical liability insurance increases ranging from 28 to 60 percent. Ohio ranked among the top five states for premium increases in 2002. General surgeons pay as much as $74,554, and obstetrician-gynecologists pay as much as $152,496. Comparatively, Indiana general surgeons pay between $14,000-$30,000; and obstetrician-gynecologists pay between $20,000-$40,000. (*Medical Liability Monitor,* October 2002)

- Dr. William Hurd, chairman of the department of obstetrics and gynecology at the Wright State University School of Medicine, said the liability crisis already is driving young doctors out of the Dayton area. "In the last two years, not a single one of our (obstetrical-gynecological) residents has set up a practice in Dayton, or even Ohio," Hurd said. (*Dayton Daily News*, August 28, 2002)

- "My wife and I are both physicians and just arrived in Wausau [Wisconsin] in March. We fled the crisis in Ohio after spending our whole careers in that state," said Christopher J. Magiera, a gastroenterologist. Magiera and his wife, Pamela G. Galloway, a general surgeon, gave up their 15-year-old practice when their medical liability premiums were projected to reach $100,000 apiece. In Wisconsin, they pay a fraction of that. (*Journal Sentinel*, April 20, 2003)

- Dr. Rebecca Glaser, a popular breast cancer specialist, will retire from surgery on April 1 because of high liability insurance premiums. "I think it's horrifying when we lose a physician who has literally a one-of-a-kind practice," said Donna Buchheit, one of Glaser's breast cancer patients. She continues, "It is literally a life and death issue. The legislature needs to understand that. It is not melodramatic to say that there will be women who die this year because of this. I certainly hope I won't become one of them." (*Dayton Daily News*, February 28, 2004)

PENNSYLVANIA

- In 2000, Philadelphia accounted for 82 percent of the $415 million in medical liability awards in Pennsylvania, and 14 of the 19 awards that exceeded $5 million, according

to the Pennsylvania Trial Lawyers Association. (*The Wall Street Journal*, January 28, 2003)

- More than two out of three medical residents in six medical specialties chose to leave Pennsylvania after completing their training, according to the Philadelphia Daily News, which examined data from the city's major teaching hospitals between 1998-2002. "The resident brain drain is greatest among doctors going into high-risk specialties: ob-gyns, orthopedic surgeons and neurosurgeons. These doctors, not surprisingly, are most likely to be sued for malpractice, and pay some of the highest malpractice insurance premiums." (*Philadelphia Daily News*, May 28, 2003)

- A good example of Pennsylvania's lawsuit culture came in early 2004 when juries returned $15 million and $20 million verdicts on the same day. (Associated Press February 4, 2004)

- According to Grand View Hospital President Stuart Fine, the medical liability crisis is a main reason why patient access problems are occurring throughout the state and "has caused experienced doctors to leave the area, especially neurosurgeons, orthopedic and general surgeons, obstetricians and cardiologists. Few young doctors are coming in to take their place, and the result is a shortage of doctors." (*Morning Call* (Allentown, PA), January 23, 2004)

TEXAS

- David Gray is an emergency medical physician who has been thinking about moving to Colorado for several years to avoid lawsuits in Corpus Christi. His group of 16 emergency room doctors were sued six times in the last 30 days, as lawyers rushed to the courthouse to file cases before [recent] lawsuit caps went into effect. (*Corpus Christi Caller-Times*, September 16, 2003)

- A pregnant woman showed up in Dr. Lloyd Van Winkle's Castroville office in South Texas, less than 10 minutes from delivery. Her family doctor in Uvalde had recently stopped delivering babies, citing medical liability concerns, and the woman was trying to drive 80 miles to her San Antonio doctor and hospital. (*Fort Worth Star-Telegram*, January 26, 2003)

WYOMING

- The loss of even one physician can have dire consequences for Wyoming patients, yet the liability crisis has forced the loss of obstetricians in Wheatland, Cheyenne and Newcastle. Surgeons have disappeared from Casper and Gillette, and more may leave Jackson. And all remaining Fremont County anesthesiologists have left their practice. (Wyoming Medical Society)

- Emergency and trauma care also is in jeopardy in Jackson Hole and Gillette. Without trauma services in the popular ski town, patients' lives will be compromised by the long distance to the next open trauma center. Such travel can take several hours in

good weather. (*Jackson Hole News&Guide*, June 11, 2003 and *Buffalo Bulletin*, May 15, 2003)

FEDERAL SOLUTION

The medical liability crisis is a growing national problem that requires a national solution. If the crisis was just a matter of physicians obtaining or affording medical liability insurance in one state, we might agree that a national approach would not necessarily be required. However, the problem goes far beyond physicians and other health care professionals and institutions. The medical liability crisis has become a serious problem for patients and their ability to access health care services that would otherwise be available to them, including services provided to Medicare and Medicaid patients.

Also, the premise that it is within the ability of every state to enact legislation to effectively resolve their respective medical liability crisis has been shattered by the fact that many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reforms. For example, in 1995 the Illinois legislature enacted meaningful medical liability reforms that showed signs of improving the litigation climate in Illinois. In 1997, however, these reforms were struck down by the Illinois Supreme Court. Taking into consideration that studies show the litigation system to be an ineffective, and often unfair, mechanism for resolving medical liability claims, we believe that the time is ripe for a uniform, federal approach to resolving the liability crisis.

Moreover, there is a direct and compelling federal interest in reforming our outmoded medical liability system. According to estimates by the U.S. Department of Health and Human Services (HHS), altogether medical liability adds $70 billion to $126 billion to the cost of health care each year. These are the costs attributed to defensive medicine, which could be significantly reduced by effective medical liability reforms. These costs mean higher health insurance premiums and higher medical costs for all Americans, and especially for the federal government given that one-third of the total health care spending in our country is paid by the Medicare and Medicaid Programs. Further, HHS estimates that excessive medical liability adds $47.5 billion annually to what the federal government pays for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for federal employees, and other government programs. Recent data from the agency shows that reasonable limits on non-economic damages would reduce the amount of taxpayers' money the federal government spends by up to $50.6 billion per year.

A 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 for patients and their families as 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. It is also an extremely inefficient mechanism for compensating claimants where court costs and attorney fees often consume a substantial amount of any compensation awarded to injured patients.

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 support legislation that is based on the successful California law known as MICRA (Medical Injury Compensation Reform Act of 1975). In the 108th Congress, the House of Representatives passed two bills (H.R. 5 and H.R. 4280) that include language similar to MICRA. The major provisions in these bills 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 these bills;
- 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 have been proven to have stabilized 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, 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. Data from the National Association of Insurance Commissioners (NAIC) shows that total liability premiums in California increased only 245 percent between 1976 and 2002, compared to 750 percent for the rest of the U.S.

Studies and expert opinions confirm that MICRA reforms lower costs and improve access. In a study on the effect of reforms, Stanford University researchers Kessler and McClellan concluded that direct reforms, including caps on non-economic damages, reduced the likelihood that a physician will be sued by 2.1 percent. Within three years after enactment of a direct reform, premiums in direct reform states declined by 8.4 percent.[11] Another study by Stephen Zuckerman *et al.* looked at several types of reforms and concluded that capping medical liability awards reduced premiums for general surgeons by 13% in the year following enactment of that reform and by 34% over the long term. Premiums for general practitioners and obstetrician-gynecologists were impacted similarly.[12]

When liability insurance premiums are lower, more physicians are able to remain in practice, and the access to quality care is improved. A July 3, 2003, study from the Agency for Healthcare Research and Quality (AHRQ) looked at the distribution of physicians across states with and without caps on non-economic damages since 1970.[13] After adjusting for multiple factors, AHRQ found that by 2000, states with damage caps averaged 12 percent more physicians per capita than states without damage caps.

In a study released in May 2003, the Joint Economic Committee of the U.S. Congress stated: "Some of the key reforms proposed at the federal level, including the cap on pain and suffering damages, have proven successful at producing savings when implemented."[14] The study points to California, praising MICRA as "perhaps the most successful example of reform at the state level," and noting its slower rate of growth in medical liability premiums.[15]

Furthermore, there is strong public support for continued efforts to fix our broken medical liability system. A January 2005 survey by Public Opinion Strategies/Frederick Polls (for the AMA) shows that 73 percent of voters support a national law to limit the amount a jury can award in damages to compensate for pain and suffering in a medical liability lawsuit. These findings are consistent with the results of a Gallup poll released on February 4, 2003, which show that 72 percent of those polled favor a limit on the amount patients can be awarded for pain and suffering.

CONCLUSION

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 embodied in H.R. 5 and H.R. 4280 (108th Congress) have brought stability in those states that have enacted similar reforms.

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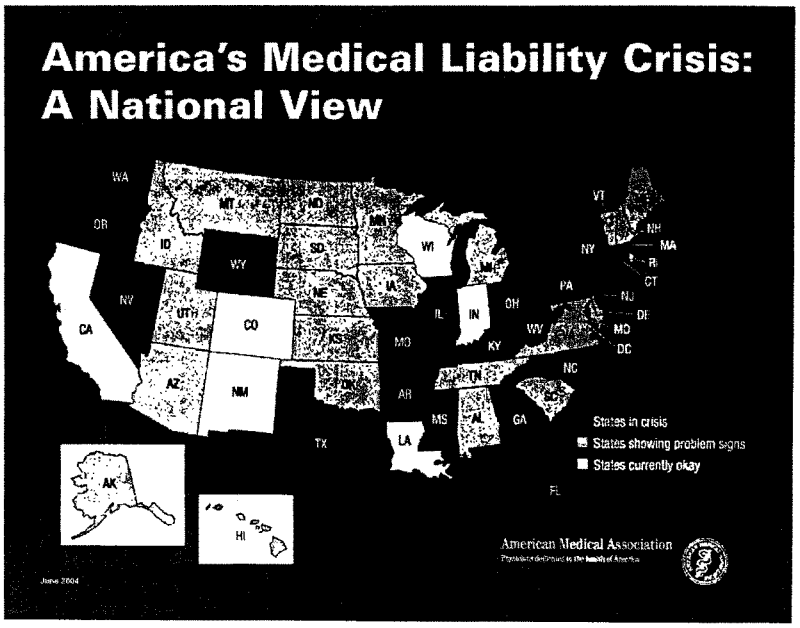
[11] Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS., 81-106 (1997).
[12] Stephen Zuckerman, Randall R. Bovbjerg & Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167-182 (1990).
[13] FRED HELLINGER & WILLIAM ENCINOSA, U.S. DEP'T OF HEALTH AND HUMAN SERVS., THE IMPACT OF STATE LAWS LIMITING MALPRACTICE AWARDS ON THE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS (2003).
[14] JOINT ECON. COMM., 108TH CONG., LIABILITY FOR MED. MALPRACTICE: ISSUES & EVIDENCE 19 (2003).
[15] *Id.*

The AMA believes the time for action is past due. Physicians across the country are making decisions now about the future of their practice, and patients are increasingly recognizing that the current litigation system jeopardizes access to quality health care services. The AMA has nearly 100,000 physicians who are actively participating in a grassroots network to call attention to the problem and effectuate change. Patients are involved, too. Our AMA Patients' Action Network currently has over 350,000 patients advocating for effective reforms by way of well over a million communications to their respective Members of Congress. By the second quarter of this year, we estimate that there will be 600,000 patients involved in the effort, and we are on track to exceed that goal.

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 highlighted in this statement answer these issues head on and would strengthen our health care system.

In his annual State of the Union Address, President Bush said that solving the medical liability crisis continues to be one of the nation's top priorities. The President called on Congress to pass medical liability reform that "will reduce health-care costs and make sure patients have the doctors and care they need." As we have done in the past, the AMA will work with the President and Congress to pass common sense medical liability reform legislation this year so that patients have greater access to health care and physicians can practice medicine more effectively.


America's Medical Liability Crisis:
A National View
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States in crisis
States showing problem signs
States currently okay
American Medical Association
June 2004

A Coalition of 13 Medical Societies Representing 200,000 Specialty Physicians in the United States

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Statement

of the

Alliance of Specialty Medicine

Presented by

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Before the

House Committee on Small Business

On the Subject of

"Medical Liability Reform: Stopping the Skyrocketing Price of Health Care"

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"Medical Liability Reform:

Stopping the Skyrocketing Price of Health Care"

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WITHOUT REFORM THE STATE OF AMERICA'S HEALTH NOW AND IN THE FUTURE IS AT RISK

Chairman Manzullo, Ranking Member Velázquez, and members of the Committee, my name is Thomas F. Gleason, MD. I am a practicing orthopaedic surgeon in Illinois, managing partner for the Bone and Joint Institute, Ltd, a partnership of approximately 70 orthopaedic surgeons, and a board certified member of the American Association of Orthopaedic Surgeons. On behalf of the Alliance of Specialty Medicine, a coalition of 13 medical societies representing 200,000 specialty physicians in the United States, I would like to thank you for holding this hearing to seek input from physicians and others regarding the impact the current litigation system is having on medical practices and our ability to continue to provide timely, high quality healthcare to our patients.

Mr. Chairman, we appreciate the interest this Committee has taken under your leadership, over the past several years, to assess the status and cost of health care in this country. Already four years ago this Committee held a hearing seeking input from physicians and other providers on the cost to medical practices as a result of record keeping and reporting requirements imposed by the U.S. Department of Health and Human Services. We believed then as we do now that the health care infrastructure of this country is in critical need of an overhaul, that we have lost sight of what is important for ensuring that our patients receive the very best care that they deserve. Now, the escalating costs of medical liability insurance is fast outpacing other regulatory requirements imposed on practices, threatening to change the structure of health care in this country, leaving lasting consequences on the U.S. healthcare system, both in terms of how health care will be delivered and who will be available to deliver that care. Physicians should be focused on directing resources to attending to our patients, rather than practicing defensive medicine under an increasingly litigious environment, and ironically, being forced to also focus more on the business of practicing medicine.

I am sorry to inform you today, that not only has the crisis not subsided, indeed, it has worsened. According to the American Medical Association, there are now twenty states in "full-blown"

crisis and twenty-four states and the District of Columbia are showing warning signs of a potential crisis Only six states -- California, Colorado, Indiana, Louisiana, New Mexico, and Wisconsin – are considered safe, and the common denominator is that they have all implemented effective medical liability reform.

Regarding the current status of this ongoing crisis, the media now report on a daily basis that as medical liability insurance becomes unaffordable or unavailable, more and more doctors, especially specialists, are no longer performing high-risk procedures, or they are being forced to move their practices to states with stable medical liability systems, or they are simply retiring from medical practice – leaving gaping holes in the healthcare safety net.

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 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 cardiothoracic 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 for millions, a nearby emergency department that is open to avoid unnecessary delays in getting treatment when time is of the essence.

The Alliance is encouraged that the Committee is assessing the impact of the medical liability crisis from a small business perspective. I would like to share with you some of the tangible, quantifiable costs of medical liability to a small business practice such as the Illinois Bone and Joint Institute, Ltd., a partnership with approximately 70 orthopaedic surgeons. The Illinois Bone and Joint Institute, Ltd. is a member of a larger entity, the Midwest Orthopaedic Network, L.L.C., a group of approximately 125 orthopaedic surgeons. The majority of our physicians practice in Cook County, and we represent approximately 20% of the orthopaedic surgeons practicing in Illinois.

From July 2002 to now, our medical liability premiums have increased 250% from $1.6 million to $5.6 million, an additional $4 million in premium costs. These premiums are after discounts (47.5% in 7/01-7/02 reduced to 40% in 7/04-7/05) from base rates. Discounts are determined based on past history of claims. We have had a good loss ratio. Our loss ratio as a group for the seven years preceding July 2002 was 91%. In five years, Cook County and the Illinois market has gone from 17 to 5 carriers---ISMIE (Illinois State Medical Insurance Exchange) Mutual, Medical Protective, AP Capital, PIC Wisconsin and ProAssurance. At least one carrier that we know of, PIC Wisconsin, has stopped writing new policies in Cook County and is focusing instead on Wisconsin and Iowa. ISMIE Mutual is currently experiencing a moratorium, only offering policies to new doctors and doctors joining existing groups with ISMIE Mutual coverage. All carriers have done away with discounts in an effort to build up their reserves.

Current base premiums for orthopaedic surgeons in Cook County are $128,000 or $153,000 (with spine coverage) for $1mil/3mil coverage and $177,000 or $212,000 (with spine coverage) for $2mil/4mil coverage. These premium costs have risen to such a degree that the Midwest Orthopaedic Network, through which our insurance is purchased, has instituted a surcharge program. This requires any physician who is named in three lawsuits in three years, regardless of how meritorious, or any physician who is involved in any action requiring an indemnity payout of $750,000

in any one year, to pay a surcharge to the group equal to 50% of his or her premium in year one, 25% in year two, and 12.5% in year three. Our colleagues in other Illinois counties, especially St.Clair and Madison Counties to the south of us, are experiencing even higher increases.

According to the Cook County Jury Verdict Reporter, the number of claims reported by ISMIE Mutual increased 46% between 2000 and 2003. In Cook County, from 1998 through 2003, the average total jury verdict went up 314%, and the average jury award for non-economic damages increased 247%. The average jury verdict in Cook County jumped from $1.07 million in 1998 to $4.45 million in 2003. By 2003, non-economic damages totaled 70 percent of the total monetary value awarded by the jury. Eighty percent of the claims filed against ISMIE Mutual policyholders result in no payment to the plaintiff. In the last five years, ISMIE Mutual has paid $150 million in defense costs for these non-meritorious claims.

An average of 7 medical liability suits are filed each year against orthopaedic surgeons in our practice. Currently, our practice has 49 open files where the average life of a suit is 7 years. This requires time away from practice for trials, preparation, depositions, etc. where other physicians are required to take on the care of additional patients. We have estimated that, as a direct consequence of the increasingly litigious environment, the maintenance associated with managing the patient's medical record has reduced by almost half the number of patients that a physician is able to see in any given day---from 10 patients per hour to 5-6 for a team of physicians and other health care staff.

We are concerned with an increasing number of physician retirements at earlier ages. The escalating costs and changing policies associated with tail premiums required by retiring physicians are creating incentives for early retirements. The chief of orthopaedics at one hospital I staff belongs to a small orthopaedic practice that switched insurance companies in order to lower their premium rates. Because the insurance company required him to practice at least five more years in order to

receive a discount on a sizeable tail cost, he is retiring now. I have assumed his administrative duties taking me further away from patient care, while we are also now short one additional orthopaedic surgeon for the department.

Public aid and HMO patients stand to lose the most in a medical environment of diminishing resources and high operating expenses as a result of the increasingly litigious environment. Average reimbursements are considerably lower for these patients---approximately $34 for public aid and $57 for HMO for office visits for orthopaedic surgeons in the Illinois Bone and Joint Institute. Physicians cannot afford to pay operating expenses serving these patients alone. This creates an access problem for these patients who need to be seen by a physician. A high number of these patients are pediatric orthopaedic cases. There are several physicians in our practice who are currently practicing at a deficit. Some of these physicians are incurring net losses close to $200,000. As our overhead costs continue to rise as a result of increasing premiums, we will not be able to sustain these loses.

Emergency room and high risk patients are also at risk of losing access to necessary specialty care in a litigious environment. Emergency trauma is currently responsible for over half of the income to the traumatologists in the Illinois Bone and Joint Institute. As the risk and costs to care for these patients rise, so does the risk of losing these physicians who currently cover two-thirds of the nights on call at one of the busiest trauma centers in Chicago. This is particularly alarming knowing that this trauma center is already inundated with transfers from more and more community hospitals in Illinois that no longer have physicians available for emergencies.

At another suburban Chicago hospital, three out of seven orthopaedic groups have already diminished or eliminated on-call services, and neurosurgeons have stopped taking call altogether, changing this hospital's status from a Level I to a Level II trauma center. Pediatric coverage at emergency rooms continues to worsen. Children are being transferred without even being examined,

and even for basic orthopaedic cases including femur fractures and supracondylar fractures, where some of these transfers have taken hours to process.

Because no orthopaedic surgeon was available, a 25 year old male was recently transferred from the Rockford area to Lutheran General Hospital, a Level I trauma center in Park Ridge, after sustaining an unstable pelvic ring. The patient was not volume resuscitated appropriately in the initial hospital and the transfer delayed emergent care by 7 hours. By the time he arrived he was grossly volume depleted. The fluid administration consisted of rapid volume replacement, including blood, leading to a dilutional coagulopathy and ARDS---known complications from rapid volume replacement in massive quantities after blood loss. The patient died. Timely and appropriate care at the initial institution, including gradual volume replacement, could have prevented this tragic outcome.

Neurosurgeons at Lutheran General Hospital have been blind-sided by a proliferation of inappropriate transfers of head-injured patients to their facility because smaller, community hospitals have lost their neurosurgeons. Patients are being air-lifted to Lutheran from hundreds of miles away and after hours.

More and more physicians are also restricting how they address non-emergency high risk cases, or eliminating these cases altogether from their practice. Our total joint physicians have already set limits on patients they operate on and treat. Due to increased risk of infection and deep venous thrombosis, one of the most experienced and productive total joint surgeons in Illinois, and arguably the country, has reservations about operating on individuals with a BMI over 40 (ie. 5', 204 lbs., 6'6", 294 lbs).

THE MEDICAL LIABILITY CRISIS: PATIENT ACCESS TO MEDICAL CARE IS IN JEOPARDY

As the Committee considers the current state of this national healthcare problem, I'd like to draw your attention to more evidence that demonstrates just how serious this crisis has become.

❒ **Doctors are No Longer Performing Complex and High-Risk Medical Procedures**

America's women are at particular risk of losing access to vital healthcare services. The August 2003 General Accounting Office report entitled, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care," confirmed that rising medical liability insurance premiums have contributed to reduced access to obstetrical services, particularly in rural locations. According to a 2004 professional liability survey conducted by the American College of Obstetricians and Gynecologists, ob-gyns have made a number of practice changes as a result of the medical liability crisis:

- One in seven has stopped practicing obstetrics because of the risk of liability claims;
- Because of the risk of liability claims or suit, 22 percent decreased the amount of high-risk obstetric care; 14.8 percent stopped offering or performing VBACs; 9.2 percent decreased the number of deliveries; 12.3 percent decreased gynecologic surgical procedures performed; and 5.6 percent no longer perform major gynecologic surgery;
- Because of liability insurance costs and availability, 25.2 percent decreased the amount of high-risk obstetric care; 12.2 percent decreased the number of deliveries; 14.8 percent decreased gynecologic surgical procedures performed; and 5.4 percent no longer perform major gynecologic surgery

Patients in need of care from surgical specialists like orthopaedic surgeons and neurosurgeons are affected by the crisis, as these physicians are also restricting their practices. According to the American Association of Orthopaedic Surgeons, rising liability premiums have

caused 55 percent of orthopaedic surgeons to avoid at least some procedures due to liability concerns; 39 percent now avoid performing spine surgery; and 6 percent have eliminated all surgery.

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons report similarly alarming findings. Based on a 2004 national survey of U.S. neurosurgeons, the AANS and CNS found that over one-half of survey respondents have limited services because of rising medical liability insurance premiums and/or increased risk of suit. Of those limiting services, 70 percent refer complex cases to other neurosurgeons; 71 percent no longer perform aneurysm surgery; 23 percent no longer treat brain tumors: 75 percent no longer operate on children; and 34 percent no longer perform complex spine procedures. These patients are typically sent to academic medical centers or large tertiary care hospitals for treatment, often requiring patients to travel great distances to receive neurosurgical care.

Even specialists who are not usually considered "high-risk" cite medical liability pressures as the reason why they are restricting services. For example, according to the American Urological Association, over 41 percent began referring complex cases in the past two years and one in four no longer perform such procedures as cystectomy (which is complete bladder removal, usually for cancer patients).

The elderly may also be particularly affected, as decreases in reimbursements for complex medical procedures have declined to the point where Medicare no longer even covers the cost of medical liability insurance. Specialists with a high volume of Medicare patients, such as cardiologists and cardio-thoracic surgeons, and their patients who need high-tech, lifesaving heart therapy, will likewise feel the effects of the crisis.

❒ **Patient Access to Emergency and Trauma Care is at Risk**

While the medical liability crisis affects patients who need many types of medical care, access to timely and efficient emergency and trauma care services is in particular jeopardy. When patients rush to the ER, they assume the hospital will be open and doctors will be there to treat them. However, because of the medical liability crisis, this is no longer always the case. The liability crisis is now severely straining our nation's already stressed emergency medical system, as patients who have no access to doctors inevitably end up on the emergency department's doorsteps, further exacerbating the hospital emergency department overcrowding problem.

In addition, to secure affordable medical liability insurance or to minimize their risk of lawsuits, many physicians, including neurosurgeons, orthopaedic surgeons, cardiothoracic surgeons, and obstetricians and cardiologists, are no longer serving "on-call" to hospital emergency departments. For example, according to a 2004 hospital emergency department survey conducted by The Schumacher Group, three of four emergency departments diverted ambulances in the last 12 months in part because no specialists were available. Of these, one third diverted patients six or more times a month and an additional 28 percent diverted patients three to five times a month. More than one-fourth of hospitals reported losses in specialty coverage related to a fear of lawsuits.

The above referenced August 2003 GAO report confirmed that rising medical liability premiums have contributed to reduced access to emergency surgery services, particularly in rural locations, because certain high risk specialists like neurosurgeons and orthopaedic surgeons are no longer serving on-call to hospital emergency departments. Over one-third of surveyed neurosurgeons have reported that they have altered their emergency and/or trauma call coverage because of liability concerns. Neurosurgeons across the country are now limiting the types of emergency cases that they treat, they are limiting the hours that they serve on-call, or they have stopped providing emergency

call altogether. Twenty-one percent of orthopaedic surgeons have likewise eliminated emergency department call.

- **Doctors are Moving to States with a More Favorable Medical Liability Climate**

Every state that is experiencing a medical liability crisis reports that doctors are leaving in droves in search of another location in which to practice where the medical litigation climate is more favorable. The list of states experiencing the exodus of doctors continues to grow, and as with other elements of this crisis, specialists are most likely to "hit the road" in search of a safe haven state. Pennsylvania has been especially hard hit, and some counties no longer have any practicing orthopaedic surgeons and 12 maternity wards closed in Philadelphia alone. Moreover, 80 percent of Pennsylvania medical students are leaving the state, instead of staying to practice in this highly litigious area of the country. Neurosurgery's survey data show that nearly 19 percent of practicing neurosurgeons either plan to, or are considering, moving their practice to another state where the medical liability costs are relatively stable. Prior to the recent enactment of medical liability reform, Mississippi had lost 35 percent of its neurosurgeons in a two year period. Last year, 21 out of 79 neurosurgeons surveyed in Missouri stated that they were considering leaving the state, and today, there are no longer any neurosurgeons in Southern Illinois.

- **Doctors, Trauma Centers and Other Medical Providers are Closing their Doors**

An even more troubling aspect of the current crisis is the fact that many physicians are simply finding it impossible to stay in practice at all, and once gone, they are not easily replaced. In extreme cases, emergency departments and trauma centers have been forced to shut down completely because the physicians have been unable to secure medical liability insurance at any price. The GAO confirmed that the medical liability crisis caused trauma centers to close in Florida, Mississippi, Nevada, Pennsylvania and West Virginia. The same has been true in other states, including Arizona, Maryland, Ohio and Texas. These closures are coming during a time when the number of visits to the

nation's emergency departments climbed over 20 percent from 89.8 million in 1992 to 107.5 million in 2001.

Within the past several years, nearly 700 mammography facilities have closed nationwide. The continued and steady closing of mammography facilities throughout the country has led to increased waiting times for women seeking both screening mammograms and diagnostic mammograms. The longer waiting times are now on the brink of affecting clinical outcomes for those women who must wait for a possible diagnosis of breast cancer.

Individual physicians are also retiring. In the case of neurosurgery, in 2001 alone, 327 board certified neurosurgeons retired, representing an alarming 10 percent of the neurosurgical workforce in the United States. In addition, another 33 percent of neurosurgeons report that they are planning to retire early. Five percent of orthopaedic surgeons have retired earlier than they otherwise would have.

Current and future shortages of high-risk specialty physicians will increase the magnitude of the problem. According to the American Hospital Association's March 2003 Liability Insurance Survey, over one-half of hospitals across the country reported difficulty in recruiting physicians because of the medical liability crisis. A recent study of third and fourth-year medical students found that nearly one-half said the current crisis was a significant factor in their specialty choice, with many future doctors no longer choosing high-risk specialties such as ob-gyn. In the 2004 National Resident Matching Program, the number of ob-gyn training slots filled by U.S. medical school seniors declined for the third year in a row to 65.1 percent – a decrease of 20 percent over the past decade. The number of U.S. medical students entering neurosurgery and emergency medicine residencies declined to 86 percent and 77.5 percent, respectively. Finally, applications to medical schools have dropped 22 percent since 1997. With an increasingly aging population, the country can ill-afford to

lose good doctors prematurely and to have a healthcare litigation system that deters our best and brightest from choosing medicine as a career.

CAUSE OF THE CRISIS: THE CURRENT MEDICAL LITIGATION SYSTEM IS BROKEN

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. 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 closed claims data from the Physicians Insurance Association of America (PIAA), the median jury award nearly doubled from 1997 to 2003, increasing from $157,000 to $300,000. The average award increased from $347,134 in 1997 to $430,727 in 2002. Data collected by Jury Verdict Research (JVR), which reports statistics for a smaller number of cases that reach the trial stage, reflects these same trends. According to JVR, the median medical liability jury award doubled from $500,000 in 1995 to over $1 million in 2002 and the average jury award has soared to an astonishing $6.2 million, up from $1.8 million in 1996. Finally, the number of mega-verdicts is also on the rise. In 1997, only two medical liability verdicts topped $20 million. In 2001 and 2002, however, seven of the top 20 awards were related to medical liability, including a $95.2 million birth injury judgment in New York. The combined total of these seven awards was nearly $3 billion.

Overall medical liability tort costs are rapidly increasing, and far outpace the growth in medical costs generally. For example, according to the Insurance Information Institute, from 1975 through

2000, medical liability costs have grown a whopping 1,642 percent as compared to a 449 percent increase for general medical costs.

❒ **Increased Awards and Settlements Mean Insurers are Paying Out More than they are Collecting, Necessitating Steep Premium Increases**

A June 2003 General Accounting Office (GAO) report, entitled "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," confirms what we already know: increased losses on claims are the *primary* contributor to higher medical liability insurance premium rates.

Indeed, according to the Insurance Information Institute, which analyzed data from A.M. Best (an independent insurance rating agency that analyzes insurance companies' overall financial strength and creditworthiness), the cumulative underwriting loss for the medical liability insurance sector from 1990 to 2001 was nearly $10 billion. This dramatic rise in medical liability awards and settlements has meant that professional liability insurers have been paying out more than they have been collecting in premiums. In 2002, medical liability insurance companies were paying out $1.65 in claims for every medical liability premium dollar collected. In 2003, according to the National Underwriter Data Services, insurers were paying approximately $1.38 for every premium dollar collected. While the ratio of payouts to premium dollars collected has become more aligned, insurance companies are still finding it necessary to raise physicians' premiums to keep pace with anticipated claims. Obviously, this situation is not sustainable, and this trend is therefore forcing insurance companies, which must set their rates based on anticipated future losses, to steeply increase doctors' medical liability premiums to ensure adequate reserves to pay future judgments.

As a result, over the past several years, physicians across the country have faced double, and sometimes triple, digit rate increases. Alliance members, including high-risk specialists like neurosurgeons, orthopaedic surgeons, obstetricians, cardiothoracic surgeons and emergency physicians, have been disproportionately affected by these premium increases. For example:

- According to one national survey of neurosurgeons, between 2000 and 2004 the national average premium increase was 84 percent, from $44,367 to $81,749. The median rate for neurosurgeons in Illinois is now $200,000 and in some states, neurosurgeons' premiums have reached nearly $400,000 per year.
- Rates for ob-gyns continue to be among the highest. According to the *Medical Liability Monitor's* 2004 rate survey, in 2004, obstetricians paid $277,241 in Florida, up from $249,169 in 2003. Illinois ob-gyns received a 66.9 percent increase in 2004, paying $230,428 as compared with $138,031 in 2003. And in Pennsylvania, premiums for ob-gyns increased 34.4 percent in 2004 to $172,178 from $128,114 in 2003.
- Utah orthopaedic surgeons saw medical liability rate increases of 60 percent from 2002 to 2003 and in Texas they have risen by more than 50 percent. In Pennsylvania, a survey conducted in June 2002 revealed rate increases as high as 59 percent. In other areas of the country, orthopaedic surgeons are finding that their premiums have risen by over 100 percent, even if they have never had a claim filed against them.
- Over the past several years, over 95 percent of emergency medicine physicians have experienced medical liability premium increases, with approximately 69 percent facing increases between 60 to 500 percent. This is attributed to the fact that emergency medicine physicians are almost always named in any litigation that arises from a patient encounter that begins in the emergency department. Since most hospital admissions now come through the emergency department, these doctors are experiencing steep premium rises even though the lawsuits against them may have no merit and result in either dismissal or a defendant's verdict.

- Even those specialists who are not in high-risk categories are affected by this upward trend in premium costs. For example, 80 percent of recently surveyed dermatologists reported that their premiums increased over the past years and those dermatologists who were insured by a state plan were paying nearly double what their colleagues were paying in the private market.

❒ **Medical Liability Insurance is Unavailable**

Not only are medical liability insurance premiums rising at astronomical rates, but many doctors have found it increasingly difficult to obtain medical liability insurance at any price. Citing the increases in liability losses, several companies, including, St. Paul, MIXX, PHICO, Frontier Insurance Group and others, have either recently stopped selling medical liability insurance or have gone out of business, leaving thousands of doctors scrambling to find replacement coverage. Of the companies that have remained in the market, many are no longer renewing insurance coverage for existing policyholders and/or they are not issuing new insurance policies to new customers. This is particularly true in states that have no effective medical liability reform laws in place.

The June 2003 GAO report confirmed that the declining profitability of the medical liability insurance market has caused many insurers to either stop selling medical liability policies altogether or reduce the number of policies they sell, putting even greater pressure on the remaining insurance companies to raise their premiums to cover expected losses. Alliance members have witnessed the impact of this problem first hand. For example:

- In 2002, nearly 40 percent of orthopaedic surgeons in Pennsylvania were not able to renew their medical liability coverage with the same carrier and 31 percent did not find new coverage.
- In 2002, 15 percent of dermatologists experienced difficulties securing their liability insurance. In some cases, dermatologists in solo practice who have never even been sued were forced to turn to the state for coverage because the remaining insurers in their area made a blanket decision to no longer insure solo practice physicians, regardless of specialty.

- A recent study found that in recent years, approximately 33 percent of surveyed neurosurgeons have switched insurance companies, and of these, 41 percent did so because their insurance company failed or withdrew from the market. In addition, neurosurgeons in Florida have been unable to obtain medical liability insurance at any cost, forcing them to "go bare" or self-insure. Across the nation, even those neurosurgeons who only have one claim against them (regardless of the outcome of the case) are finding it difficult to find insurance coverage.
- Three of four insurance carriers with the largest market share in Missouri recently stopped writing policies in that state. This means that physicians can often obtain a quote from only one company. For example, one group of 12 cardiologists could get only one quote with an 80 percent increase for 2003.

SCOPE OF THE CRISIS: A NATIONAL PROBLEM THAT REQUIRES A FEDERAL SOLUTION

Those who oppose federal legislation to fix this crisis cite various reasons in support of their contention that this is not a national problem that merits a federal solution. In particular, they note that the regulation of insurance and healthcare is generally left to the states and therefore this is a matter that the states should attend to. The Alliance respectfully disagrees with these objections. Today, healthcare delivery has no borders and it should be equal from state to state. We currently have a patchwork of liability reforms, and because of this uneven system, access to healthcare varies according to the liability climate of each state. Every patient, every citizen, in every state deserves equal protection under the law, both in compensation for negligent injury, and in timely access to healthcare, particularly emergency and specialty care. The undisputed truth is that one way or another, this problem now touches nearly every American and a federal solution is therefore a national imperative.

❒ **Nearly All States are Facing a Medical Liability Crisis**

According to the American Medical Association, there are now twenty states in "full-blown" crisis: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, Nevada, West Virginia, and Wyoming. Twenty-four states and the District of Columbia are showing warning signs of a potential crisis. For high-risk specialists like neurosurgeons, the situation is even more widespread than the AMA reports, as the American Association of Neurological Surgeons and Congress of Neurological Surgeons have identified at least 22 states that are currently facing a medical liability crisis, with another 16 facing a potential crisis.

❒ **Every American Pays the Costs of the Current Medical Litigation System**

According to the U.S. Department of Health and Human Services (HHS), in its 2003 report entitled, "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care," the current medical litigation system imposes enormous direct (e.g., premiums, legal fees, expenses and payouts) and indirect costs (e.g., defensive medicine) on the health care system. In 2004, for example, 55 percent of surveyed neurosurgeons reported that they are practicing defensive medicine and have altered their treatment protocols because of liability concerns, including ordering more diagnostic or other tests. 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 $70-120 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. Citing the findings of the Department of Health and Human Services and the Congressional Budget Office's (CBO) cost estimate of HR 5, the HEALTH Act, the Congressional Joint Economic Committee concludes that federal medical liability reform legislation that includes a cap on non-economic damages would generate significant fiscal savings for the Federal Government. The combined annual budget savings attributed to decreased direct and indirect costs would total approximately $12.1 billion to $19.5 billion. Over a ten-year period (2004-2013), if medical liability reform legislation passed, a total of between $67 billion and $106 billion in savings would accrue to the federal government.

- **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 Florida and Ohio, have enacted medical liability reform laws, only to have their state Supreme Courts strike them down as unconstitutional. Other states, like Arizona, Kentucky, and Pennsylvania have explicit constitutional prohibitions on damage limits. Still others, like Montana, have not had their laws tested and reviewed by their highest court. In addition, new laws passed by Mississippi and West Virginia may also face court challenge, and it will be years before it is determined whether these laws pass state constitutional muster. As a consequence, despite the increasing medical liability crisis in many of these states, they are essentially powerless to act to effectively solve the problem.

SOLUTION TO THE CRISIS: MEDICAL LIABILITY REFORM LEGISLATION PATTERNED AFTER CALIFORNIA'S MICRA

The cornerstone of any legislation should include the principles that injured patients deserve their day in court and that they are entitled to receive full, just and fair compensation. Congress should therefore adopt medical liability reforms that have a proven track record and will help strike the necessary balance between compensating injured patients and ensuring access to healthcare for all Americans. 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 Alliance believes that any federal reform must contain the key elements of MICRA, which 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 (without exceptions or an inflationary adjuster) on non-economic damages, such as pain and suffering;
- Resolving claims quickly by establishing a reasonable statute of limitations for filing a lawsuit;
- Ensuring appropriate payments are there when patient need them by allowing for periodic payments of damages rather than lump sum awards;
- Maximizing the amount of the award that goes to injured patients by placing reasonable limits on attorneys' fees;
- Focusing liability on those at fault, not on "deep pockets," by eliminating joint and several liability; and
- Preventing double recovery of damages through collateral source reform

Congress may want to consider additional reforms (which were not included in last-year's House-passed version of the HEALTH Act) that would:

- Ensure that juries are advised by actual experts by establishing expert witness standards; and
- Unclog the courts and reduce the societal costs of lawsuits by limiting frivolous lawsuits

In addition, Congress should ensure that federal medical liability reform does not preempt *effective* state reforms.

As the subcommittee moves forward with its deliberations on this legislation, the Alliance urges you to keep in mind the following points about the effectiveness of MICRA:

- **MICRA Fully Compensates Injured Patients Quickly**

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, in December 2002, a 5 year-old Alameda County boy with cerebral palsy and quadriplegia because of delayed treatment of jaundice after birth was awarded $84,250,000; a 3 year-old Contra Costa County girl with cerebral palsy as a result of birth injury was awarded $59,317,500 in October 2002; a 30 year-old homemaker from Los Angeles with brain damage because of lack of oxygen during recovery from surgery, was awarded $12,558,852 in July 2002; and in November 2000, a 25 year-old San Bernardino County woman with quadriplegia because of failure to diagnose a spinal injury was awarded $27,573,922.

Medical liability claims are also paid most quickly in California versus all other states. According to the National Practitioner Data Bank's 2003 Annual Report, in 2003, the mean delay between an incident that led to a payment and the payment itself was 4.59 years. In California, it was 2.98 years. The slowest state to close claims was Massachusetts, which was 6.19 years.

❒ **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 somehow 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. According to data from the National Association of Insurance Commissioners, from 1976 to 2002, liability premiums for California physicians rose only 245 percent as compared with 750 percent of physicians in the rest of the United States. Data from a survey of neurosurgeons validates these trends, and both actual premiums and the rate of increase for neurosurgeons in California, as compared to neurosurgeons who practice in states where there are no reforms in place, are significantly lower.

State	2000 Median	2004 Median	Percentage Increase
California	**$45,598**	**$59,583**	**31%**
Ohio	$43,001	$136,416	217%
Illinois	$70,000	$200,000	186%
Washington	$35,816	$88,400	147%
Missouri	$40,500	$98,000	142%

❒ **Federal Government and Other Experts Agree that MICRA Works**

U.S. Government experts and others 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 U.S. Department of Health and Human

Services, Congressional Budget Office and Joint Economic Committee issued reports evaluating the HEALTH Act, came to the same conclusion, and the GAO, in its August 2003 report, found that "premium growth was lower in states with non-economic damage caps than in states with limited reforms." In addition to these government experts, others have studied the effectiveness of MICRA. A 2004 study by the RAND Corporation, entitled "Capping Non-Economic Awards in Medical Malpractice Trials" concluded that MICRA's contingency fee reform and limit on noneconomic damages has decreased insurer payouts and redistributed more money from personal injury attorneys to injured patients. Finally, according to Kenneth Thorpe, in a study published in the January 2004 edition of *Health Affairs*, insurance premiums are 17 percent lower in states with caps on noneconomic damages and they are one-quarter lower in states with both caps on noneconomic damages and discretionary collateral offsets.

- **States with Damage Caps Have More Doctors Available to Treat Patients**

Opponents of medical liability reform cite various statistics to claim that tort reforms, especially caps on damages, have had no affect on stemming the tide of this crisis. In addition, in its August 2003 Report, the GAO asserts that its analysis of medical licensure data proves that not only are physicians not moving or retiring as a result of increased medical liability premiums, but in the crisis states it reviewed there actually was an increase in the number of licensed physicians. The Alliance takes issue with these claims for several reasons:

- Medical licensure data is in no way indicative of the number of physicians who are actually practicing medicine in a particular state. Rather, it merely means that a certain number of physicians hold a license to practice medicine. Physicians tend to hold multiple state licenses and typically retain their licenses when they relocate or retire from active practice. Thus, taken

alone, medical licensure data provides no useful information to prove or disprove the affects of the medical liability crisis on physician supply.

- According to a July 2003 study conducted by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, entitled "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians," states that have enacted laws capping damage payments in medical liability cases have more physicians per capita than those who have no cap or very high damage caps. The study found that in 1970, before any states had a law capping damage payments, in all states there were virtually identical levels of physicians per 100,000 citizens. Thirty years later in 2000, however, states that had adopted a cap averaged 135 physicians per 100,000 citizens, while states without caps averaged 120.

- The May 2003 Joint Economic Committee study concluded that "the number of doctors at the state level is sensitive to the malpractice insurance costs: higher premiums reduce the number of practicing physicians."

The clear and simple truth is that MICRA and other similar laws work. 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.

❒ **Americans Overwhelmingly Support a MICRA-Style Solution**

Americans are becoming acutely aware of the impact this crisis is having on the nation's healthcare system and the care they receive. Studies show that they overwhelmingly favor passage

of federal legislation to reform the current medical liability system and create a system that balances the rights of patients to obtain appropriate compensation for injuries caused by medical negligence with the rights of all citizens to have access to medical care. A March 2004 poll conducted by Wirthlin Worldwide for the Health Coalition on Liability and Access found that:

- 82 percent of the Americans surveyed believe that doctors are being forced to leave their practices because excessive litigation has put the cost of medical liability insurance out of reach.
- By a huge margin, 72 percent of those surveyed said that health care expenses for all people are being driven up by the rising cost of medical liability lawsuits.
- The high number of medical liability lawsuits is unjustified, according to 55 percent of the survey respondents. Only 16 percent say that the number of lawsuits against health care providers is lower than justified.
- Three-quarters of Americans want Congress to pass reforms to fix the medical liability crisis. 72 percent favor a law that guarantees full payment for lost wages and medical expenses but limits non-economic damages; 73 percent want to limit the amount of money personal injury trial lawyers can get from the excessive litigation settlements their clients receive.

A January 2005 poll conducted by Public Opinion Strategies for the American College of Emergency Physicians reached similar conclusions, confirming that three out of four (75 percent) of Americans recognize the current system interferes with physicians' ability to provide quality care; 85 percent of Americans believe the current legal system – with no consequences for pursuing frivolous lawsuits and publicity about large monetary awards – is responsible for rising medical insurance costs; and 73 percent favor liability reform that includes placing limits on non-economic (pain an suffering) damages.

WITHOUT REFORM THE STATE OF AMERICA'S HEALTH NOW AND IN THE FUTURE IS AT RISK

Clearly the health of our nation's citizens is at considerable risk. Because of the medical liability crisis, more and more people are finding it difficult to get the specialized medical attention they need, when they need it. This is causing a national health care emergency. Thus:

- When patients can't find a specialist close to home, they must sometimes travel great distances, often going out of state, to get their medical care.
- When fewer specialists are available, hospital emergency departments and trauma centers must shut their doors, and patients with emergency medical conditions lose critical life-saving time searching for an available emergency room.
- When specialists stop performing high-risk medical services, patients are often referred to academic medical centers, and these medical facilities are already overburdened and are ill equipped to handle the increase in patient volume.
- When specialists retire at an early age, the looming shortage of doctors is accelerated, which, if left unchecked will place additional burdens on the health care system as the population ages and requires more medical care from an increasingly shrinking pool of practicing doctors. Once gone, these doctors are hard to replace, and those states currently facing a medical liability crisis are having a difficult time recruiting new physicians to their communities adding to the shortage of doctors in many parts of the country.
- 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 healthcare systems in the world.

We have reached a very important juncture in the evolution of the U.S. healthcare system. At a time when lifesaving scientific advances are being made in nearly every area of healthcare, patients

across the country are facing a situation in which access to health care is in imperiled. 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 Alliance is hopeful that the Congress's continued efforts to highlight and debate this crisis will lead to the passage of 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.

The Many Faces of the Medical Liability Crisis

Arizona

- **Ob-gyn:** Deborah Wilson made the tough decision to stop delivering babies in June 2003. "It was a really tough decision. I just knew I couldn't do it anymore once I realized the risks. You've just got a target on your back." Dr. Wilson delivered approximately 50 babies a month for over 17 years. One of the many patients forced to find a new obstetrician was Patty Jasinski, who was seven months pregnant with her second set of twins at the time. Dr. Wilson was Jasinski's obstetrician for nearly two decades, helping her through five miscarriages, an ectopic pregnancy and the birth of her first set of twins. (*East Valley Tribune*, April 2004)

- **Neurosurgeon**: Timothy Putty, MD writes: "A 60ish year old man presented to St. Joseph's Emergency Dept. with a cerebral hemorrhage. The ED physician tried to find a neurosurgeon to care for this patient. None of the neurosurgeons that go to that particular hospital was available or on call. The ED physician tried to transfer to another hospital in Tucson, but none had neurosurgical coverage that evening, and the University Hospital was full (on diversion). This patient was subsequently flown out of the city, to San Diego, and I believe ultimately died" (American Association of Neurological Surgeons/Congress of Neurological Surgeons 2004)

Florida

- **Neurosurgeon:** Mildred McRoy suffered a hemorrhagic stroke in February and was rushed to JFK Medical Center in Atlantis, Florida for treatment. However, JFK stopped providing around-the-clock neurosurgical coverage in July because of the medical liability crisis. In fact, there wasn't a single neurosurgeon on call in all of Palm Beach County. Ms. McRoy was transported 40-miles away to North Broward Medical Center more than eight hours later. She was operated on by neurosurgeon Gary Gieseke, but died after being in a coma for several days. Almost all of the neurosurgeons at the hospital are "bare" and are not willing to take on the risk of emergency procedures without insurance. The hospital has begun paying for on-call services in an effort to provide the necessary 24/7 coverage. (*Palm Beach Post*, March 6 and 18, 2004)

- **Orthopaedic surgeon:** Diana Carr, MD writes: "In my community only two orthopaedists (including myself) of the five will see children. My practice is limited to pediatric upper extremity. The other pediatric orthopaedic surgeon is on call in rotation with the three others who do no pediatrics. The 75-percent of the time he is not on call, children have to go to Tampa, Orlando or St. Petersburg where pediatric orthopaedists are available. This is a two-hour ride each way for the initial appointment and all follow-ups." (American Association of Orthopaedic Surgeons)

- **Ob-gyn:** Manatee Obstetrics & Gynecology physicians will end obstetrical services at the practice September 2004 due to rising medical liability costs, leaving hundreds of expectant mothers to find a new baby doctor this fall. State Rep. Bill Galvano, R-Bradenton, is an immediate victim of this escalating crisis. His pregnant wife, Julie, was scheduled to deliver their third child at Manatee in October. (Bradenton Herald, April 15, 2004

Georgia

- **Ob-gyn:** In 2003 there were three obstetricians in Eastman, Georgia. Today there is one. One moved out-of-state and the other 42-year old doctor quit obstetrics. (Medical Association of Georgia, 2004); Dr. Patricia Ritchie Haynes recently quit her 23-year ob-gyn practice at Piedmont Hospital after learning her malpractice premium was going to rise by 50 percent in one year. (*Atlanta Journal-Constitution*, Feb. 8, 2004); The Athens Women's clinic, which has offered obstetrics services for 35 years, announced May 21 that the state's medical liability crisis was forcing it to no longer deliver babies. It will continue to offer gynecological services. (*Athens Banner-Herald*, May 21, 2004)

- **Emergency Physicians:** "At my hospital in Atlanta, GA, the surgeons (including orthopedists) decided that due to... skyrocketing premiums, they would work less call, leaving us for several months with every third day with surgeons and orthopaedics on call. My hospital is the designated site for Hartsfield Airport, the busiest airport in the nation. Multiple patients have had to be transferred and a colleague had a stabbing that had a significant delay in care due to lack of coverage." (American College of Emergency Physicians, 2005)

- **Neurosurgeon:** Last year there were four neurosurgeons in Albany, Georgia and the local hospital had neurosurgical trauma coverage 24 hours a day, seven days a week. Today there are two and the hospital only has a neurosurgeon on-call 50 percent of the time. If area residents suffer a head or spinal injury, stroke or other neurosurgical emergency on the "wrong day" they must be air-lifted to Macon or Columbus, if a neurosurgeon is available there. (Medical Association of Georgia, 2004)

Hawaii

- **Neurosurgeon:** Premiums for neurosurgeon Dilworth Rogers of Kahului have risen from $30,000 a year in 2000 to over $79,000 in 2004. As a result, Dr. Rogers no longer treats pediatric patients or patients with aneurysms or complex brain or spine problems. These patients must be sent to a facility more than 30 miles away. Unless something changes in the next year, Dr. Rogers will be forced to close his practice and move to another state with tort reforms and a more stable professional liability environment. (American Association of Neurological Surgeons/Congress of Neurological Surgeons, 2004)

- **Neurosurgeon:** Michon Morita is Hawaii's only pediatric neurosurgeon. Because of the medical liability crisis, he has been forced to limit the types and amount of cases he treats. "If I can't see these patients, they have to go to the mainland," he said. (American Association of Neurological Surgeons/Congress of Neurological Surgeons, 2004)

Illinois

- **Neurosurgeon:** In February 2004, 85-year-old retired machinist Fred Andricks tripped and hit his head. Because of the medical liability crisis there are no neurosurgeons left in Belleville. After a delay, Mr. Andricks was transferred to a St. Louis, MO medical center where he received treatment. Unfortunately he died the next day from swelling of the brain. After learning of her father's fate, Lisa Kasten said "All the talk was that this was going to happen and that someone would not get care when they needed it. I just never realize it would be my dad." (American Association of Neurological Surgeons/Congress of Neurological Surgeons 2004)

- **Emergency Physician:** In August 2004, a cable snapped when Richard Rhodes was unloading his stock car into a garage, injuring his hand. He was rushed to the Alton Memorial Hospital emergency room with his thumb and little finger missing. There were no doctors at the hospital available to reattach his fingers. The emergency room physician called more than six hospitals in an effort to transfer Mr. Rhodes, but no other hospitals or accepting transfers for this type of injury. After several hours, Mr. Rhodes was airlifted to a hospital in Springfield and his fingers were reattached. Unfortunately because of the delay, the reattachment did not take and his thumb had to be amputated two weeks later. Mr. Rhodes blames the loss of his thumb on the medical liability crisis in Illinois. Mr. Rhodes said, "The doctor did everything he could to find someone to help. I kept saying that I had insurance. But what's a sense of having insurance if you can't find anyone to work on you?" (*The Telegraph*, August 2004)

- **Urologist:** Roger Rives MD and David Didomenico are the only two urologists and Sarah Bush Lincoln Health Center in Mattoon. In an effort to reduce their professional liability risks, they have stopped performing more risky, highly invasive procedures, including prostate and bladder surgery. They have tried to recruit a third urologist for more than 18 months, but have been unsuccessful. (*The Journal Gazette and Times-Courier*, August 2004)

- **Orthopaedic Surgeon:** "A five-year-old child was struck by an auto in Naperville and sustained a fracture of the femur and a small skull fracture with minimal underlying brain contusion. Such injuries would typical be treated by urgent casting by an orthopaedic surgeon and then a neurosurgeon would follow along to make sure the patient's brain injury remained stable. In this case, the neurosurgeon on call will not see any patient under 18. A pediatric orthopaedic surgeon was in attendance, waiting to treat the femur fracture, but without a neurosurgeon to follow the patient, transfer to Loyola had to be arranged. At Loyola, no pediatric orthopaedic surgeon was available, so the adult orthopaedic trauma surgeon had the child's leg placed in traction, inserting a pin just above the knee in order to hang the weights which pulled on the leg. The plan was to keep the child in traction for a few weeks, and then place the child in the cast. The family, after 2 days at Loyola, desired transfer of care back to their home town. The child was taken out of traction, placed in an ambulance, and transferred back to Edward Hospital in Naperville. He was eventually casted and sent home. The liability crisis has created a situation where this patient had to endure two useless ambulance rides with a broken femur, several extra days of hospitalization, and insertion and removal of a traction pin. This waste of resources and interference with medical care is repeated endlessly across the nation." (American Association of Orthopaedic Surgeons)

- **Ob-gyn:** Kim Dahlem, a mother of one, wants to have another baby next year, but she has a problem: She must find a doctor who will deliver it. The obstetrician-gynecologist who delivered her daughter in February 2003 recently decided, after 30 years in practice, to stop delivering babies because he could not afford the high cost of medical malpractice insurance. Dahlem, 32, does not live in Joliet or southern Illinois, areas reported to have lost many obstetricians because of the skyrocketing cost of professional liability insurance. She lives in northwest suburban Cary, and her gynecologist, Dr. Donald DeDonato, practices in Arlington Heights. "It's heartbreaking," Dahlem said of losing the physician who helped her through a difficult first pregnancy. "He was a blessing. . . . I was comfortable with him. It's hard having that ripped from you." (*Chicago Tribune*, September 22, 2004)

Iowa

- **Neurosurgeon:** Vincent Traynelis, MD writes, "At the University of Iowa we are seeing a marked increase in complex spine cases, cranial cases and pediatric cases because local, private practice neurosurgeons are no longer treating these patients out of liability concerns. Transfers to the University costs time and lives." (American Association of Neurological Surgeons/Congress of Neurological Surgeons, 2004)

- **Ob-gyn:** Dr. Dan Bohle delivered his final baby last year. After more than 19 years as an obstetrician, the Dubuque physician left the specialty to concentrate on gynecology because of medical malpractice insurance premiums that rank second-highest in all of American medicine. The premium problem is compounded by a lengthy statute of limitations for suits. "A lot of times there is a two-year statute of limitations," Bohle said, "but for OB it can be 18 years plus two years." (*Telegraph Herald*, July 14, 2003)

Maine

- **Neurosurgeon:** Waterville Neurosurgeon Eric Omsberg's premiums have increased from $46,000 for $2 million/$5 million coverage in 2000 to $300,000 for $1 million/$3 million coverage in 2004. The 552 percent increase has caused Dr. Omsberg to drop trauma and emergency call at some local hospitals in an effort to reduce his liability exposure. Dr. Omsberg writes "I am stuck. I am in my mid-40s with three grade school children and do not want to move right now. The liability crisis is devastating to this community!" (American Association of Neurological Surgeons/Congress of Neurological Surgeons, 2004)

Maryland

- **Surgeon:** Dr. Gina Sager, a 43-year-old general surgeon who was named one of the city's best breast surgeons in 2000 by Baltimore Magazine, was forced to give up her profession last year because of "malpractice liability concerns." Her malpractice insurance rates jumped from $21,000 to $59,000 in one year--including a $25,000 deductible--as a result of three meritless malpractice cases that were filed in tandem against her in 1997. "Besides the unexplainable emotional cost, it became very evident last year that if I didn't make some pretty dramatic changes, I would be unable to pay any bills," said Sager. "I apparently have the dubious distinction of being the youngest physician in Maryland to retire. (*Washington Times*, Sept. 1, 2003)

- **Orthopaedic Surgeon:** David B. Carmack, MD states, "I practice at the Maryland state trauma referral center (R Adams Cowley Shock Trauma) and am seeing a dramatic increase in trauma referrals for isolated orthopaedic trauma. Routine trauma will be turned away from the community and local hospitals and sent to the state trauma center, because of decreased numbers of community orthopaedic surgeons willing to take on a trauma patient. This overwhelms us at the state trauma center and limits access for our critically injured patients who indeed need to be here for life and limb threatening injuries." (American Association of Orthopaedic Surgeons, 2005)

- **Ob-gyn:** After 28 years of delivering babies, Pikesville physician Robert L. Brenner had a sentimental ambition: He wanted to deliver the babies of the babies he had ushered into the world. But that dream evaporated recently, three weeks before the first of the next generation was due, because Dr. Brenner couldn't afford malpractice insurance. Last month he scaled back his practice to gynecology alone in order to save $42,000 a year on malpractice coverage. Insuring combined obstetric and gynecologic services was consuming nearly 50 cents of every dollar he

and a partner are paid at $1,600 per delivery -- and a hefty premium increase is coming next year. He'd already laid off half his staff, shrunk his office space and brought his wife in to help. There was no place else left to cut. (*The Baltimore Sun*, 08/17/03)

Michigan

- **Orthopaedic surgeon:** Daniel Garcia, MD writes, "I am an orthopaedic surgeon in my 18th year of private practice, and the major insurer in my state of Michigan gave us very short notice almost one year ago that they were not going to renew coverage for our group. My malpractice premium increased 100% last April 2003 and I am now paying $124,000 for 200/600,000 coverage. I simply cannot continue to practice in this state for long. I have given up doing two or three specific types of orthopaedic procedures because of malpractice concerns or issues, and have turned a few patients away from surgery simply because of their demeanor or the impression they left me with at the time of their pre-op visit." (American Association of Orthopaedic Surgeons, 2005)

- Neurosurgeon: **Ann Arbor neurosurgeon Geoffrey Thomas stopped providing trauma and emergency call in 2004, dropping his premiums from $45,947 to $19,469. (American Association of Neurological Surgeons/Congress of Neurological Surgeons, 2004)**

Missouri

- **Orthopaedic Surgeon:** Poplar Bluff internist Donald Piland said, "Last year a patient of mine fell on the ice during the winter and suffered a compound fracture of the lower leg. Subsequently, she lost her leg due to a lack of orthopaedic coverage in our community. We had recently lost three orthopaedic surgeons in a span of one year, partly because they couldn't afford malpractice insurance premiums in the state of Missouri." (*Daily American Republic*, March 17, 2004)

- **Neurosurgeon:** Robert Grubb in St. Louis, Missouri wrote "I recently received a patient in a transfer from a small town in northeast Arkansas with a severe cervical spinal injury following a motor vehicle accident. The primary care physician said he called 17 different hospitals closer than St. Louis over a 24-hour period and could not find anyone to take the patient because no one had an available neurosurgeon. The patient was finally transferred to Barnes Jewish Hospital in St. Louis after more than 24-hours, way beyond the optimal time for treating such a devastating injury." (American Association of Neurological Surgeons/Congress of Neurological Surgeons, 2004)

Nebraska

- **Ob-gyn:** Dr. Steven Senseney said the money he takes in from delivering 15 to 20 babies a year does not cover the cost of the insurance he needs for obstetrics. If he quits, his colleagues would have a 24-hour burden of delivering the area's babies. Or it would force pregnant women to leave town, perhaps staying at hotels in larger cities for weeks before their due dates. (Doctors for Medical Liability Reform at www.protectpatientsnow.org)

New Hampshire

- **Ob-gyn:** Dr. Patricia Miller of Derry, NH, a town of 38,000, stopped delivering babies as of December 2003 because of increased medical liability insurance premiums. Dr. Miller, a solo practitioner for 15 years, delivered 8-10 babies a month, about 100 per year.

- **Ob-gyn:** Dr. Krishna Das closed her obstetrics practice because of skyrocketing medical liability costs and moved to North Carolina, leaving many women in Northern New Hampshire without obstetrical coverage. (New Hampshire Medical Society, April 2003).

New York

- **Neurosurgeon:** White Plains neurosurgeon Ed Kornel, president of the New York State Neurosurgical Society, and his partners stopped providing trauma and emergency coverage at South Sound Hospital last year in an effort to reduce their liability expose. The group will likely drop United Hospital and Phelps Hospital this year unless some relief is provided. Putnam Hospital in the area already does not have 24/7 neurosurgical coverage. (American Association of Neurological Surgeons/Congress of Neurological Surgeons)

- **Ob-gyn:** Jennifer Blovsky of Farmingdale has supported malpractice reform ever since the doctor who delivered her three children, Dr. Juliana Opatich of Bethpage, quit delivering babies last year because of the high cost of insurance. Last year when Mrs. Blovsky discovered that she was pregnant Dr. Opatich informed her that she could not deliver her fourth baby. Mrs. Blovsky said, "That was tough. Now when people ask me to recommend someone, I always say, 'Well I knew a wonderful person but she was driven out of business because of malpractice insurance.'" (*Newsday*, 01/26/03)

- **Orthopaedic surgeon:** John Olsewski, MD writes, that "Since 1994, I have provided the majority of the adult reconstructive spine care in the northern portion of the Bronx and the southern portion of Westchester County. In the past three years, I have seen my liability insurance premiums rise 25-percent. I have been forced to alter significantly my practice profile, referring out cases of a higher risk nature, which I would not have hesitated in the past to care for myself. In addition, the Level I Trauma Center in the Bronx, Jacobi Medical Center, will lose the emergency spine coverage of three of the four orthopaedic spine surgeons presently providing care, myself and two other colleagues, solely because of the increased liability risk of the clinical setting." (American Association of Orthopaedic Surgeons)

- **Gynecologic Oncology:** Five Long Island gynecologic-oncologists quit the practice altogether because of skyrocketing and unaffordable medical liability insurance premiums. That leaves only one gynecologic-oncologist within 110 miles to provide needed care. The only other option for patients is to travel a great distance or take a ferry to Connecticut. (American College of Obstetricians and Gynecologists, 2003)

- **Emergency physician:** A New York ER physician says, "I came from Canada, where I did my medical school and residency and have worked. I plan to move back there chiefly because the medical liability climate is better there. I enjoy being a doctor in Canada more than in the U.S. right now." (American College of Emergency Physicians, 2005)

Ohio

- **Ob-gyn:** Over the course of her pregnancy, Sharon Minson of northeast Ohio had four different ob-gyns because rising professional liability insurance rates kept forcing her doctors to stop delivering babies. "When you're pregnant, it should be a happy time," she said. "I just wanted continuity of care. You can't switch around like that." In the past two years, 46 of 72 ob-gyns have left Summit County in the past two years and more than 190 doctors have left Summit, Medina and Portage counties in that time frame. (*Akron Beacon-Journal*, October 21, 2004)

- **Gastroenterologist:** In July Cleveland gastroenterologist Gary Gottlieb of Mayfield Heights announced he was leaving Ohio after receiving a professional liability premium bill for $85,000, more than five times the amount he paid in 2002. Dr. Gottlieb will move to Arizona. In Arizona Dr. Gottlieb will pay between $5,000 and $12,000 for insurance. Dr. Gottlieb's partners have been unable to replace them. All of the gastroenterology fellows at The Cleveland Clinic have decided to leave Ohio to pursuit their careers elsewhere because of the high malpractice rates in Northeast Ohio (*Cleveland Jewish News*, July 2004)

- **Neurosurgeon:** Thomas Hawk of Columbus has stopped providing trauma and emergency call in an effort to reduce his liability premiums. He also writes, "I see lots of patients each week from West Virginia who cannot find neurosurgical care and are coming all the way to Columbus, Ohio to get care." (American Association of Neurological Surgeons/Congress of Neurological Surgeons)

Pennsylvania

- **Orthopaedic surgeon:** Shawn Hennigan, MD, recently moved from Pennsylvania to Wisconsin solely because of the medical liability crisis in Pennsylvania. (American Association of Orthopaedic Surgeons, 2004); David Yanoff, who has offices in Lehighton, Palmerton and Tamaqua, Pennsylvania, is closing up his practice and moving to Idaho because of skyrocketing professional liability premiums. Yanoff founded Mahoning Valley Orthopedics 16 years ago. (*The Morning Call*, February 21, 2004)

- **Neurosurgery**: In 2004, a 17-year old boy suffering a head injury in a car accident in Chester County, Pennsylvania died after no neurosurgeon could be found to treat his injury. The boy was originally taken to Brandywine Hospital, which lost all of its neurosurgeons because of the medical liability crisis. Hours later, he was transferred to Crozier-Chester Medical Center in Delaware County, but his brain had already begun to swell and nothing could be done. (The Morning Call, November 28 2004)

- **Neurosurgeon:** Recently, in Pottstown a 20 year old fell down a flight of stairs. He sustained significant head trauma. Several years ago he would have been taken to Pottstown Memorial Hospital where two full time neurosurgeons were on staff. At this time, though, since no local neurosurgeons were available, he had to go to Lehigh Valley Hospital. Because of inclement weather it was not possible to fly him by helicopter. He was, therefore, placed in an ambulance and arrived at Lehigh approximately an hour later. Within ten to fifteen minutes of arriving at Lehigh Valley he was in the OR but died there of a massive bleed. I do not know if it would have made a difference if this patient had been treated sooner but I surely know he had no chance with the situation as it now exists. (pamedicalcrisis.com, *Volume II, Issue No 5*)

Texas

- **Ob-gyn:** Ken First, MD, and orthopaedic surgeon writes, "My wife was an ob-gyn for 15 years. She had one legal case that was dropped in her entire career. She delivered a great many babies. Several years ago, my wife gave up obstetrics because the malpractice premiums were so high. She then practiced just gynecology surgery and primary care. The insurance rates were still high, and she was forced to retire leaving a ton of women without their doctor. She gave up her medical career to sell Mary Kay cosmetics. She works fewer hours and is already making a solid income without the liability." (American Association of Orthopaedic Surgeons, 2004)

- **Emergency physician:** An emergency physician who was chairman of the hospital's Emergency Department for over 10 years, quit medicine less than a year ago because of the exorbitant liability premium rates in Texas. Another left the **ER** because of the medical liability situation, noting that "I feel like I've wasted a residency and a lot of my life." (American College of Emergency Physicians, 2005)

- **Ob-gyn:** Two Dallas doctors, with over 40 years combined experience, quit obstetrics in 2004 due to high medical liability insurance premiums, leaving only 9 ob-gyns in the area. (Fellow communication to the American College of Obstetricians and Gynecologists, 2004).

- **Neurosurgeon:** Houston neurosurgeon Bruce Ehni writes "We are the recipient of much more serious and risky cases that would have otherwise been cared for locally. Here at our hospital in Houston we are receiving hemorrhages, traumas and other dire emergencies from as far away as El Paso and Brownsville – sometimes up to 600 miles or more! Some of these cases include: a patient with head trauma and a blown pupil flown in from Harlington (400 miles away); an aneurysmal hemorrhage with intracranial hemorrhage flown in from Laredo (300 miles away); and a brain tumor causing abrupt paralysis flown in from San Antonio (200 miles away). All of these communities have neurosurgeons. The "bad" cases end up in Houston despite the presence of neurosurgeons locally because everyone is trying to avoid being sued. It is bad for patients and bad for us. We are being dumped on endlessly." (American Association of Neurological Surgeons/Congress of Neurological Surgeons, 2004)

Statement
of the
American College of Surgeons

Presented by

Chad Rubin, MD, FACS

before the
Committee on Small Business
United States House of Representatives

RE: **Medical Liability Reform: Stopping the Skyrocketing Costs of Health Care**

February 17, 2005

Mr. Chairman, Representative Velazquez, and Members of the Committee, my name is Chad Rubin, MD, FACS and I am a general surgeon from Columbia, South Carolina. I am here representing the American College of Surgeons and its more than 65,000 Fellows.

In a growing number of states, surgeons are having difficulty obtaining medical liability insurance and, for those who are able to find coverage, the cost is often prohibitively high. Surgeons in some areas are experiencing double- and even triple- digit premium increases every year. At the same time, reimbursements from Medicare and other insurers are declining, providing no way to offset the continuing escalation in premium costs. We've seen particularly difficult situations develop in Illinois, West Virginia, Pennsylvania, New York, Ohio, Missouri, New York, and Georgia, and in many other states across the country.

Allow me to tell you about my experience in South Carolina. I am in a single specialty group practice of nine surgeons in Columbia. We are the major non-university group in town and cover all the hospitals in the city except the VA. Even though I've never been sued, my liability insurance premiums have increased by 816 percent in the last nine years—and by 117 percent last year alone. These increases, along with those my partners have experienced in their premiums, have forced us to borrow money each year in order to pay these costs. It is appropriate that I present this to the Committee on Small Business,

since most physician practices are, in fact, small businesses and we are feeling the "squeeze."

In addition to the economic impact that premium increases have had on our practice finances, they have also affected our ability to care for patients. For example, three of my partners have stopped performing vascular surgery because of the increased liability costs. Two of my partners who perform gastric bypass operations are currently evaluating whether or not they will be able to continue performing this procedure because of liability costs.

The crisis is having a detrimental effect on many South Carolina physicians and their patients. In the last month, an obstetrician-gynecologist in Columbia stopped delivering babies, and many counties in South Carolina have no OB coverage at all. In addition, Myrtle Beach now has only occasional neurosurgical coverage. Imagine being on vacation in Myrtle Beach and getting involved in a bad car crash or water sport accident and not having a neurosurgeon available at the closest hospital. The liability crisis is having a very real impact on the health and safety of South Carolina's citizens, as well as on our visitors from other states across the country.

Unfortunately, this crisis has recently had a profound impact on my own family. My mother lives in Carbondale, IL. As you know very well Mr. Chairman, the medical liability crisis is having a particularly dramatic affect in Illinois. My

mother is 74 years old. She has had two disabling strokes and has pulmonary fibrosis requiring around-the-clock care and home oxygen. Her primary doctor and her pulmonologist both left the state because their liability costs made practice there unsustainable. Now, southern Illinois has no pulmonologists. My mother's rehabilitation doctor moved to Saint Louis, and she now must travel to Missouri to see him.

Mr. Chairman and members of the Committee, this hearing is titled "Medical Liability Reform and the Skyrocketing Price of Health Care." There is ample evidence of the financial cost that the liability is having on our health care system, but the challenge many patients now face is receiving needed health care services.

Large premium increases and the declining number of liability insurance carriers are forcing many surgeons to make difficult decisions about limiting the scope of their practice, moving to other states, or retiring early. As a result, we see a growing access problem emerging throughout the country, with some frustrated surgeons leaving practice before turning 60. Considering the fact that surgeons do not complete their training until reaching their early- to mid-30s, such early retirements result in far too few years of service to patients and communities.

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February 17, 2005

For many years, the College has advocated the federal adoption of health care liability reforms like those enacted in California under the Medical Injury Compensation Reform Act (MICRA) of 1975. For over 25 years, MICRA has demonstrated that medical liability costs can be stabilized while patients' rights are protected.

Every year, the House of Representatives has considered and passed strong medical liability reform legislation that follows the MICRA blueprint. One of the most essential elements of these bills has been a limit on non-economic damages to control the continually escalating severity of claims.

A cap on non-economic damages does not prohibit an aggrieved individual from receiving compensation. Economic losses such as lost wages, medical expenses, and rehabilitation costs are fully covered. A reasonable $250,000 cap on non-economic damages would bring more economic stability to the medical liability system and still compensate individuals for pain and suffering.

In addition to the cap on non-economic damages, the following provisions are included in strong medical liability reform bills:

- collateral source payment offsets that prevent duplicate payments for the same expense.

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- periodic payment of future damage awards over $50,000.
- encouraging speedy resolution of claims
- fair share rule
- limits on plaintiff attorney contingency fees
- application of punitive damages only when there is clear and convincing evidence that the defendant intended to injure the claimant.

The College hopes that the House and the Senate will pass strong medical liability reform soon. The crisis confronting us continues to grow, and the impact is most severe on our sickest and most vulnerable patients.

I appreciate this opportunity to testify before the committee and I would be happy to take any questions.

The American College of Surgeons is a voluntary, educational and scientific organization of 62,000 Fellows devoted to the ethical and competent practice of surgery and to enhancing the quality of care provided to surgical patients. Founded in 1913, the College was established to improve the care of surgical patients and the safety of the operating room environment. For over 90 years, the College has provided educational programs for its Fellows and for other surgeons in this country and throughout the world. In addition, the College establishes standards for the practice of surgical, trauma, and cancer care, as well as guidelines for office-based surgery facilities. It also provides information on surgical issues to the general public.

American College of Surgeons
Division of Advocacy and Health Policy
1640 Wisconsin Avenue, NW
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American College of Surgeons
February 17, 2005

NATIONAL RURAL HEALTH ASSOCIATION

Testimony Before the
House Small Business Committee
February 17, 2005

Presented by:

NRHA President Hilda R. Heady, MSW
Executive Director, West Virginia Rural Health
Education Partnerships,
Associate Vice-President for Rural Health
West Virginia University
Morgantown, West Virginia

Chairman Manzullo, Ranking Member Velasquez, Members of the Committee, thank you for the opportunity to testify before you today. I am Hilda Heady, President of the National Rural Health Association.

The NRHA is a 7000 member national nonprofit organization that provides leadership on rural health issues. The association's mission is to improve the health and well-being of rural Americans and to provide leadership on rural health issues through grassroots advocacy, communications, education and research. The membership of the NRHA is a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health. Individual members come from all parts of the rural health landscape. We are community leaders, hospital and rural health clinic administrators, physicians, nurses, dentists, health planners, researchers and educators. Organizational and supporting members include hospitals, community and migrant health centers, state rural health offices and university programs.

Large jury awards, large settlements, and other financial losses to medical insurance companies are triggering rapid increases in the costs of liability insurance premiums. More than half of all jury awards are more than $1 million, and the average has increased to $3.5 million. As insurance becomes unaffordable or unavailable for rural providers, doctors are being forced to leave their practices and drop vital services. In rural and underserved communities, where access to quality care is already limited, rising liability costs are creating a crisis situation. Among the hardest hit states are Texas, Florida, West Virginia, Mississippi, Pennsylvania, Washington, Georgia, New Jersey, New York, Ohio, Oregon and Nevada.

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 only gynecology. This situation is seriously threatening women's access to care. Not only are seasoned physicians quitting OB practice, but obstetrics is having a very difficult time recruiting new doctors. Many rural communities no longer offer OB services.

Across the nation, health care providers are facing staggering increases in medical liability insurance premiums – if they can find coverage at all. Health care providers across the board and around the country are facing double-digit hikes in malpractice premiums. In 2001, physicians in eight states saw two or more medical liability insurers raise rates by 30% or more and a dozen states saw rate increases of 25% or more. A doctor in rural Mississippi can expect to pay $70,000 in malpractice premiums while the average yearly physician salary is only $72,000.

In my home state of West Virginia, we are seeing a trend of physicians closing their private practice to merge with a Community Health Center (CHC), where they would receive malpractice coverage under the Federal Tort Claims Act (FTCA) as an employee of a CHC. This arrangement allows the physician to continue practicing in his or her home area with a guaranteed salary, albeit typically lower than can be achieved through a private practice. However, the physician must sacrifice his or her independence and become subject to certain standards of productivity, health center collection policies, quality assurance and supervision by the health center's medical director. This may be acceptable for some physicians, but does not

work for all. In addition, these mergers are only made possible through the President's and Congress' initiative to expand CHCs and the additional funds that go along with it. As we all know, this funding stream is not guaranteed or unlimited. If it runs dry, the ability of physicians to make this transition will be severely limited. While CHCs are essential safety net providers that guarantee health access in underserved areas, they should not be seen as a replacement for private physician practices.

At our university school of medicine, our dean receives 3 to 4 calls per week from physicians in private practice, many in rural communities, seeking information about joining our faculty to enable them to reduce their malpractice insurance premiums. In Wheeling, West Virginia last year we lost all of our neurosurgeons and orthopedists due to malpractice insurance rates. Also last year, the trauma center at our largest tertiary health care facility was closed temporarily due to the loss of physicians. These sub-specialty physician losses clearly impact rural communities and patients as these are the areas that take care of the rural patient with seriously complicated and traumatic injuries and illnesses. Our rural primary care physicians must depend on these physicians for referral and when these are lost, the patients must be transported greater distances for care which put them at further risk. The premium for the state insurance plan for our faculty group practice plan was $3.6 million dollars last year and is $5.2 million this year. Our physicians are frustrated when they think of what could be done with the savings on such premiums. We need to recruit Pediatric Neurologists and Cystic Fibrosis specialists who treat very sick children whose families have low incomes.

This is the third malpractice crisis in my state during my career. During our second crisis, I was the CEO of a small rural hospital and had recently opened the state's first in-hospital birth center. I successfully recruited the county's first OB/GYN, only to have the practice close shop after three years and move just over the border into Pennsylvania for cheaper malpractice premiums. Currently, in my role in rural health professions education, we have had many medical students and residents report that they want to go into rural practice, yet they fear they cannot afford to do so due to the rate of malpractice coverage.

The negative effects of the medical liability crisis on rural patients are best demonstrated through a story told to me by a leader from one of our very rural communities. His mother had fallen eight or nine months earlier and spent about a week at home. The pain had worsened so he took her to Raleigh General Hospital in Beckley, West Virginia, where X-rays showed that her hip was fractured but had not separated. A very fine orthopedist did a good job of getting her back on her feet in a short while. Before the end of that year other problems forced them to place her in a nursing home in Fayetteville, West Virginia. On a Sunday morning in December, the home called to inform them that she had fallen and they believed she had broken a hip.

When the EMTs arrived to care for her and called Raleigh General they were informed that all five of the orthopedic surgeons at the hospital had left the area and the only one still in practice was at Appalachian Regional Hospital, so they took her there. The surgeon had been in the operating room since 7:00 a.m. and had several others ahead of her waiting to be seen. He operated until early afternoon and then made his round of room visits and office work and returned to the operating room. On Monday, he had the same kind of schedule and finally got to my colleague's mother at 10:30 that night. He was so tired he could hardly stand up when he came to tell them that all went well. He then left to go for some food, a shower, a bit of sleep

and had to be back in the OR at 7 am for another hip surgery. One of the surgeons who left the other hospital in 2002 was paying $94,000.00 for his malpractice insurance in Beckley, West Virginia. He moved to Blacksburg, Virginia where his insurance was only $25,000.00 that year. No one could expect him to stay.

In the chairman's home state, Provena St. Mary's Hospital in Kankakee, Illinois, lost two of its orthopedic surgeons in 2004 because the medical malpractice premiums became a disincentive for them to continue to practice in Illinois. In both cases, the surgeons moved across the border to Indiana where there are caps on medical malpractice for non-economic damages and the physicians did not have high premiums. One of the surgeons was chief of staff elect and the other was a hand surgeon. The community has not replaced the loss of these two orthopedic surgeons.

Likewise, in central Illinois, a Critical Access Hospital with minimal claims experience saw its malpractice premiums increase by 49% in 2004. Its only two family physicians providing OB services discontinued their practices in part due to the large increase in malpractice premiums. As a result, as of this month, the Critical Access Hospital has shut down its OB services.

To date some state approaches have been successful, others have not. When one state experiences a rise in malpractice premiums and awards, physicians move into a neighboring state only to have the crisis follow them a few months or years later. If the federal government is to take a serious approach to help with this issue, I urge Congress and the President, to not riffle through a band-aid box for the solution.

There are four segments of our society invested in this problem and each has a piece of the solution. The medical community needs to address improved methods of communication with patients and quality control. The legal community needs to find better ways to control unwarranted legal action. The insurance community needs to take responsibility for change within the system and take some leadership in pulling all the parties together, and finally, we as consumers of health care and patients need to take greater responsibility in our own health outcomes and stop blaming others for the fallibility of Mother Nature. In many ways we have relinquished much of our own personal responsibility through our dependence on medical science to repair the damages of poor life style choices. Any debate on this issue at the national level needs to engage all these segments of our society to address long lasting reform.

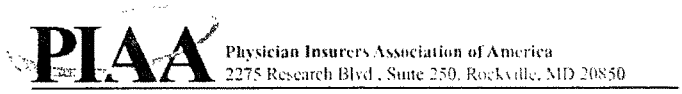
In this regard, the NRHA has outlined the following principles for professional liability reform efforts:

Policy recommendations:

- National adoption of proven minimum standards to make the medical liability system equitable, predictable, and timely.
- Secure the ability of injured patients to obtain timely, unlimited compensation for their "economic losses," including the loss of ability to provide unpaid services like care for children or parents.
- Ensure that recoveries for non-economic damages do not exceed a reasonable amount.
- Reserve punitive damages for cases where they are justified, and limit punitive damages to reasonable amounts.

- Provide for payments of judgments over time rather than in a single lump sum, to ensure that appropriate payments are there when patients need them and that defendants pay judgments in proportion to their fault.
- Ensure that old cases cannot be brought to trial years after an event discovery.
- Require that juries be informed if a plaintiff has other sources of reimbursement for an injury.
- Encourage the collection of patient safety and quality measurements to facilitate benchmarking and meaningful peer review.
- Provide legal safe guards to limit discoverability of internal and external data collection.
- Reforms to the medical liability system should result in lower, affordable premiums for patients.

Once again, I thank you for the opportunity to testify on this important issue. Please do not hesitate to call upon the NRHA in the future if we may be of any assistance.



STATEMENT

OF THE

PHYSICIAN INSURERS ASSOCIATION OF AMERICA

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

Before the

Committee on Small Business
United States House of Representatives

Regarding:

"Medical Liability Reform: Stopping the Skyrocketing Price of Healthcare"

February 17, 2005

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INTRODUCTION

Chairman Manzullo, Representative Velazquez and members of the Committee, 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 regarding the medical liability crisis as it affects patients and health care providers across the nation.

As we all know, medical liability insurance premiums have risen rapidly in many states, and continue to rise, to levels where doctors and hospitals 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, hospitals and other health care providers. Collectively, our 48 domestic insurance company members insure over 300,000 doctors and 1,300 hospitals and our nine international members insure almost 400,000 health care providers in other countries around the world. We believe that the physician owned/operated insurance company members of the PIAA insure over 60% of America's doctors. PIAA members can also be characterized as health care professionals protecting the professional liability risks of their colleagues - doctors insuring doctors, hospitals insuring hospitals. Unlike the multi-line commercial carriers, medical liability insurance is all that the PIAA companies do, and they are here in the market to stay.

The PIAA was formed almost 30 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. More than 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. And to the point of this committee, all of the PIAA companies are small businesses.

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. This void 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 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 the underlying causes of the current medical liability crisis and effective reforms to combat the 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 many 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.

Around the turn of the century medical liability insurers saw their financial performance deteriorate substantially due to the rapidly rising cost of medical liability claims. 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. According to A.M. Best (Best), the leading insurance industry rating agency, the medical liability insurance industry had a combined ratio of 155 in 2001 (in other words the industry incurred $1.55 in losses and expenses for every dollar of premium they collected in 2001). As insurers increased their rates, this statistic has improved since 2001. While data for 2004 will not be available until the middle of this year, Best has forecast that the industry will incur $1.33 in losses and expenses for every premium dollar earned in 2004, and $1.31 in 2005. However, Best also calculates that the industry can only incur $1.14 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 must 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 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 details the operating experience of 32 of the physician owned/operated insurance companies. A comparison of the combined ratios for physician owned/operated carriers versus the entire medical malpractice insurance industry is found in EXHIBIT 1, below. While the PIAA companies experienced the same financial deterioration trend as described in A.M. Best's industry analysis, their combined ratio figures were consistently better than the total medical malpractice insurance industry. For calendar year 2003, the combined ratio (including policyholder dividends paid) was 122, meaning that total liabilities were 22% more than the premiums collected. Even when considering investment income, net income for the year was a negative 2 percent. This follows two previous years with net income losses of 7 and 11 percent respectively in 2001 and 2002. This experience demonstrates that carriers' need to raise rates to attain a break-even status. Data for 2004 will not be available until early March of this year.

EXHIBIT 1

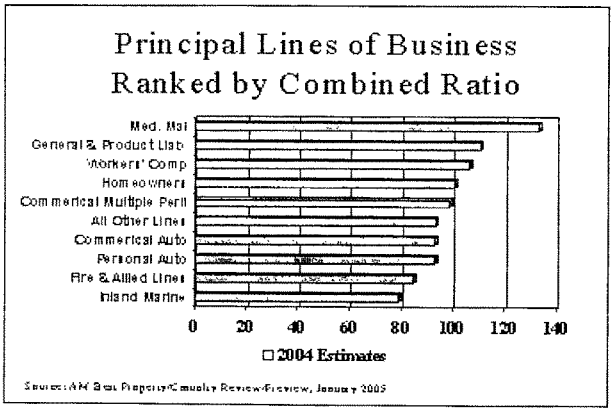
Comparison of Combined Loss Ratios

	Med. Malpractice Insurance Industry	PIAA Companies (excluding MLMIC)
2000	134	125
2001	155	137
2002	141	131
2003	138	122
2004 est.	133	N/A
2005 est.	131	N/A

Break even loss ration = 114 per A.M. Best

To compare this line of insurance (medical liability insurance) with other lines of property casualty insurance, EXHIBIT 2 looks at data also taken from A.M. Best. This shows that medical malpractice is the least profitable property and casualty line of insurance in 2004. Review of prior year combined ratios reveals the same fact for the years 2000, 2001, 2002, 2003.

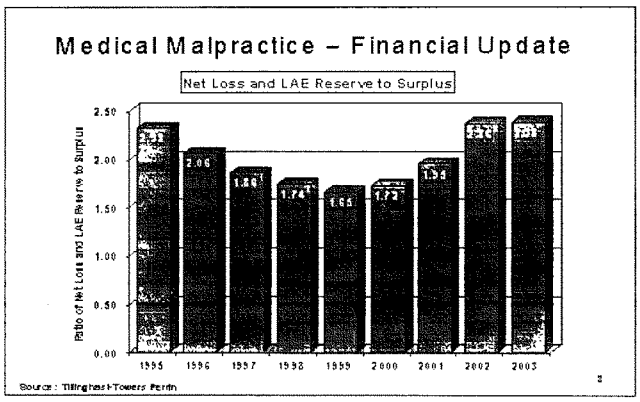
EXHIBIT 2



INSURER SOLVENCY

A key measure of financial health is the ratio of insurance loss and loss adjustment expense (amounts spent to handle claims) reserves to surplus. This ratio has deteriorated (risen) for the PIAA carriers since 1999 to a point where it substantially exceeds two times the level of surplus, as shown on EXHIBIT 3 below.

EXHIBIT 3

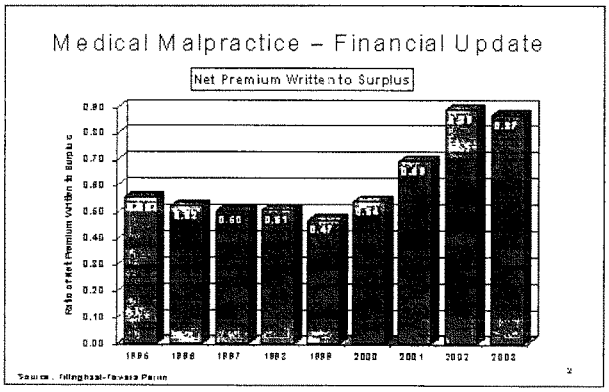


The relationship between reserves (amounts set aside to pay claims) and surplus is important, as it is a measure of the insurer's ability to contribute additional amounts to pay claims in the event that original estimates prove to be deficient. <u>At the current approximately 2.4 to 1 ratio, these carriers in aggregate are still in sound financial shape</u>. 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.

Net premiums written as compared to surplus is another key ratio considered by regulators and insurance rating agencies, such as A.M. Best. 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 4, this statistic has also deteriorated since 1999, 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 and new business written also have an impact on this important ratio.

EXHIBIT 4



THE CAUSE OF THE CRISIS

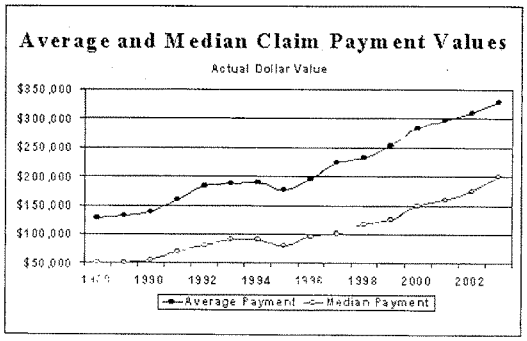
The market scenario described in the previous pages was caused by the convergence of several driving factors. I will discuss the five most prominent factors.

- Dramatic long term paid claim severity rise
- Long term rise in Loss Adjustment Expenses
- Greater proportion of large losses
- Declining market interest rates
- Paid claim frequency returning and holding at high levels

The data for EXHIBITS 5 - 11 come 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. These trends are used for risk management purposes by the PIAA member companies. To date, over 199,000 claims and suits have been reported to the database.

The primary driver of the deterioration in the medical liability insurance industry performance, as confirmed by both the Government Accountability Office and the National Association of Insurance Commissioners, has been paid claim severity, or the average cost of a paid claim. EXHIBIT 5 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 6.6% during this period, as compared to 2.9% for the Consumer Price Index (CPIu).

EXHIBIT 5



A review of the average claim payment values for the latest year reported to the PIAA Data Sharing Project is revealing. As shown on EXHIBIT 6, the mean settlement amount on behalf of an individual defendant in 2003 was just over $322,500. The mean verdict amount in 2003 was over $430,600 per defendant. Most medical malpractice cases have multiple defendants, and thus, these values are below those which may be reported on a per case basis.

EXHIBIT 6

PAYMENT VALUES – 2003

Mean Indemnity Payment	$328,757
Mean Settlement	$ 322,544
Mean Verdict	$ 430,601

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 in EXHIBIT 7, the average amount spent for all claims in 2003 has risen to just under $30,000.

EXHIBIT 7

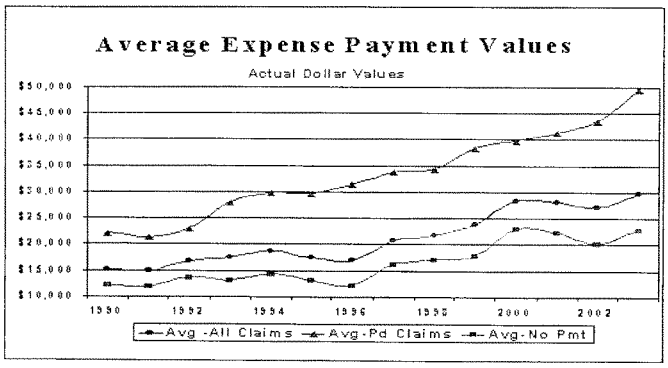


EXHIBIT 8 shows the average expense payment for claims by category of disposition. As can be seen, the cost of taking a claim for each doctor named in a case all the way through trial is fast approaching $100,000.

EXHIBIT 8

PAYMENT VALUES – 2003

As of May 2004

Mean Indemnity Payment	$328,757
Mean Expense Payment	$ 29,683
Won at Trial	$ 87,720
Lost at Trial	$123,543
Settled	$ 45,716
Dropped/Dismissed	$ 17,408

One very troubling aspect of medical malpractice claims is the proportion of those filed which are ultimately determined to be without merit. EXHIBIT 9 shows the distribution of claims closed in 2003 as reported to the PIAA Data Sharing Project. Fully 69.7% of all claims filed against individual practitioners were dropped or dismissed by the court. An additional 5.1% were won by the doctor at trial. Only 25.2% 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 86% of the time. This data clearly shows that personal injury 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 9

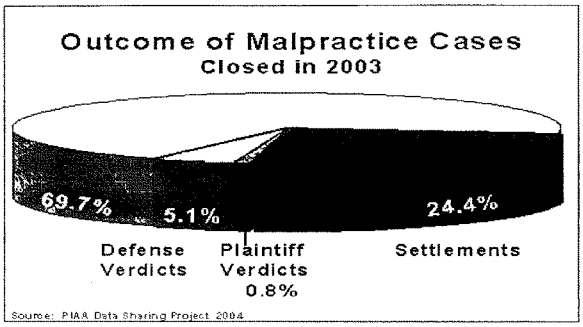
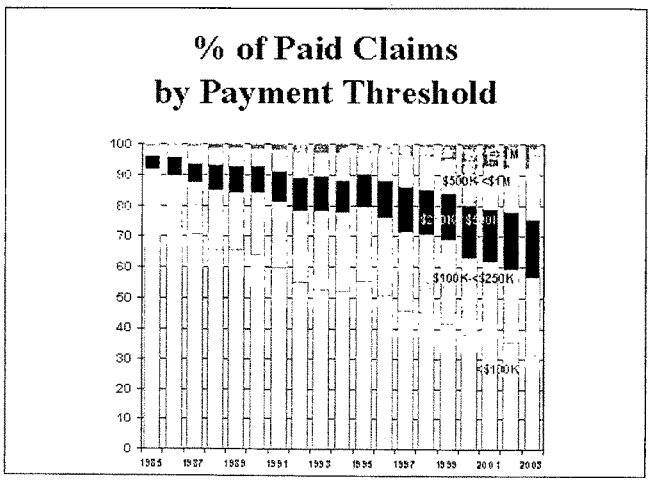


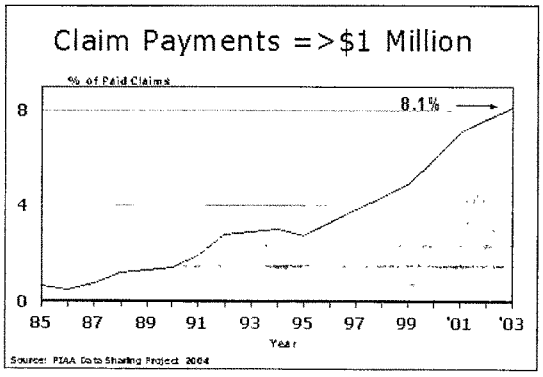
EXHIBIT 10 shows the distribution of claims payments at various payment thresholds. It can be readily seen that larger payments are growing as a percentage of the total number of payments.

EXHIBIT 10



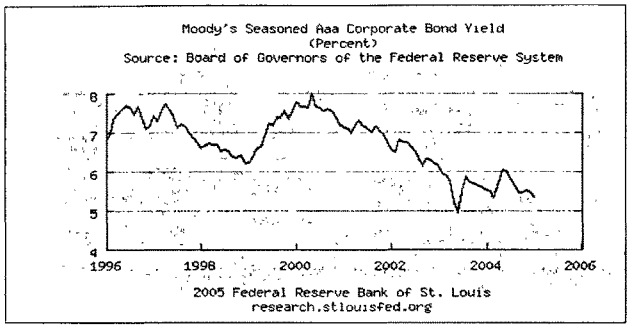
This is especially true for payments at or exceeding $1 million, which comprised almost eight percent of all claims paid on behalf of individual practitioners in 2003 (EXHIBIT 11). This percentage has almost doubled since 1998, and clearly demonstrates why insurers are facing dramatic increases in the 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 11



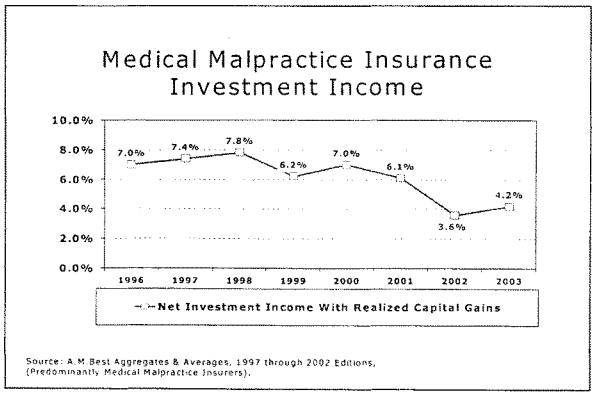
In addition to rising claim severity, like all other investors, medical liability insurers have faced declining market interest rates. Investment income plays a major role for medical liability insurers. Because medical liability is a "long tail" line of insurance, insurers are able to invest the premiums they collect for substantial periods of time, and use the resulting investment income to offset premium needs. PIAA Companies invest approximately 80% of their funds in high-grade bonds. EXHIBIT 12 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.

EXHIBIT 12



While insurer interest income has declined due to falling market interest rates, when interest rates decline, bond values increase and the net investment income of insurers has remained positive in all years. This is shown in EXHIBIT 13 below.

EXHIBIT 13



Source: A.M. Best Aggregates & Averages, 1997 through 2004 Editions
(Predominantly Medical Malpractice Insurers)

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 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]]

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 relatively constant, but has risen significantly in some states. While interest rates will certainly rise and fall in future years, there is no way to control this. There are ways 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. In many states that do not have 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 with effective tort reforms, however, 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.

Advocates of many kinds of systemic reforms in the United States have long promoted the idea of allowing states to serve as the social laboraties of the nation – experimenting with concepts that may be tested locally and spread nationally if and when they are proven successful. This is what led to the unprecedented reform of our welfare system in 1996. Wisconsin and other states took bold steps to fix a broken system, and the Congress spread those initiatives throughout the country once they had

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[1[1]] Did Investments Affect Medical Malpractice Premiums? Raghu Ramachandran, Brown Brothers Harriman, January, 2003.

proven successful. The PIAA believes the same course should be followed with regard to medical liability reform. We advocate the adoption, at the federal level, of 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. These reforms are listed in EXHIBIT 14:

EXHIBIT 14

Health Care Liability Reform

- **$250,000 cap on non-economic damages**
- **Collateral source rule reform**
- **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, and even the value of otherwise uncompensated services provided by the injured party (such as child care in the case of a stay-at-home mother). On top of this, MICRA provides for injured patients to get as much as $250,000 to compensate them for pain and suffering.

The second most important provision is collateral source rule reform. The PIAA does not advocate mandating the offset of collateral source benefits (those paid by health insurers, disability insurers, etc.) after a jury verdict has been reached. Instead, we support the MICRA standard of advising a jury during the trial that the plaintiff's health care costs, lost wages, etc., were already paid (usually years before) by these

other sources. The decision is then left in the hands of the jury as to whether or not those amounts should be factored into a total damage award. California's example has proven this to be effective in two ways. First, by informing a jury that such costs incurred by the plaintiff have already been compensated, the jury is more likely to rule on the facts of the case rather than make a decision solely based on sympathy for the plaintiff. This is a standard for which we should strive in all judicial matters. Second,

because non-economic damages are frequently awarded as a multiple of economic damages, the jury must know, before reaching a damage award, what the plaintiff's actual economic damages are. Offsetting collateral source benefits after the fact would still lead to non-economic damage awards that are artificially high. Furthermore, MICRA's prohibition on subrogation by collateral sources is vital, otherwise an injured party faces the risk of having to pay back funds to these sources despite the fact the jury already deducted those amounts from its final award.

These aforementioned provisions, a cap on non-economic damages and collateral source reform, are the keys to any effective medical liability reform. Both the American Academy of Actuaries and the Congressional Budget Office have identified these provisions as the elements of MICRA that, above all others, will reduce medical liability costs.

Other provisions of MICRA, however, should not be ignored. The reasonable limitation of plaintiff attorney contingency fees, which currently can be 40% or more of the total amount of the award, is an important element in protecting the needs of injured patients. Under MICRA, a personal injury lawyer must be satisfied with taking only a $220,000 contingency fee out of a client's medical liability award, thus leaving the injured patient with $780,000 in true compensation. While this provision does nothing to reduce the costs of medical liability to insurers, we feel it is critical to ensure that those who have suffered harm actually receive the funds that are intended to compensate them for the loss they have suffered.

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 personal injury lawyers and their front groups disagree, seeing their potential for massive remuneration being reduced.

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 ninth time in May of last year. HR 4280, previously passed in the 108th Congress as HR 5, was introduced and adopted on a bi-partisan basis. The Congressional Budget Office (CBO) conducted an extensive review of the provisions of HR 5, 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 5 reforms would result in savings of $18.1 billion to the federal government through Medicare and other health care programs for the period 2004 – 2013. An additional $8.5 billion of savings would be enjoyed by the states through their health care programs. The CBO's analysis did not include savings from the effects federal tort reform would have on reducing the incidence of defensive medicine.

EXHIBIT 15

Congressional Budget Office Scoring of HR 5

March 10, 2003

$18.1 Billion Savings 2004 – 2013

$8.5 Billion Savings to the States 2004 - 2013

"...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 16, 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 16

USDHHS

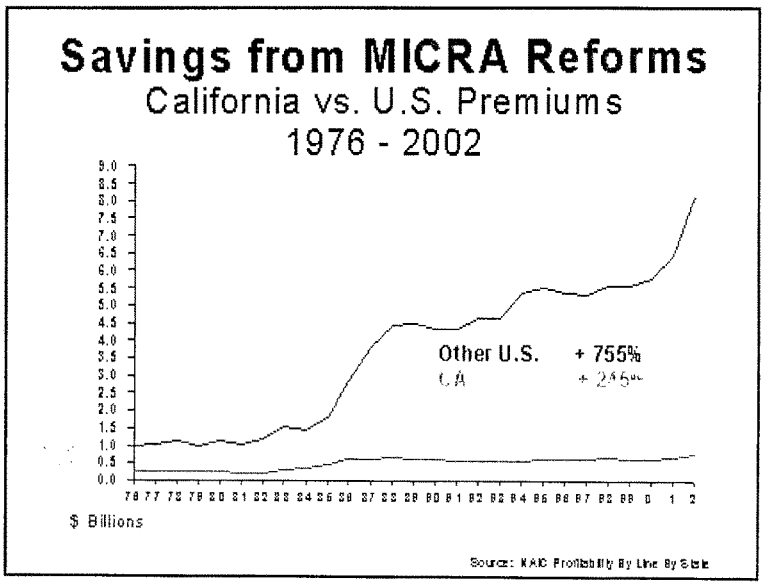
Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System
July 24, 2002

"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 17, total medical liability premiums reported to the NAIC since 1976 have grown in California by 245%, while premiums for the rest of the nation have grown by 755%. These savings can only be attributed to MICRA.

EXHIBIT 17



These savings are clearly demonstrated in the rates charged to California doctors as shown in EXHIBIT 18. 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 18

California Premiums Low w/Tort Reform:
Data Source: Medical Liability Monitor
2004 Premium Survey Data for Selected Specialties
$1 million/3 million limits

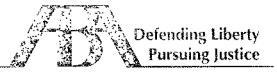
Specialty	Los Angeles[1]	Denver[2]	Chicago[3]	Miami[4]
Internal Medicine	$13,808	$12,711	$38,424	$69,310
General Surgery	40,436	43,529	102,700	277,241
OB/GYN	66,100	39,973	147,540	277,241

1 SCPIE Indemnity Co.
2 COPIC Insurance Co.
3 Illinois State Medical Ins. Services, Inc.
4 First Professionals Insurance Company

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 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 which 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 30% of claims filed have merit and where only 50% of the monies available to pay claims actually reach an injured party. The system works fine for the legal profession, which is why plaintiff injury lawyers and others fight so hard to maintain the status quo.



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February 23, 2005

The Honorable Donald A. Manzullo
Chairman
Committee on Small Business
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

I am writing to you on behalf of the American Bar Association regarding the February 17, 2005 Committee's hearings on medical liability and the skyrocketing cost of health care to present ABA views on the subject and on federal proposals to pre-empt the state laws on medical liability.

The ABA, which has over 400,000 members throughout the country has long opposed legislation that would pre-empt the state tort laws and impose federal medical professional laws on the states.

It has been suggested by some that enactment of such legislation would help the uninsured. This is simply not the case. Limiting compensation to those who have been injured by medical malpractice will not help the uninsured gain access to health insurance. While limiting medical malpractice awards would have a major impact on those patients most severely injured by malpractice, it would have only a minor impact on national health care costs. According to the Congressional Budget Office, malpractice costs make up less than 2 percent of overall health care spending. The CBO also reports that even if malpractice costs were reduced by 25 to 30 percent, it would only lower health care costs by 0.4 to 0.5 percent and would likely have a comparably small effect on insurance premiums.

The ABA is especially concerned about proposals that would place a cap on pain and suffering awards in states that have no such cap for patients who have proved in their state courts that they were harmed by malpractice or a defective medical product. Those affected by caps on damages are the patients who have been most severely injured by the negligence of others. No one has stated that their pain and suffering injuries are not real or severe. These patients should not be told that, due to an arbitrary limit, they will be deprived of the compensation they need to carry on. Yet legislation to cap pain and suffering awards, if enacted, would result in the most

seriously injured persons who are most in need of recompense receiving less than adequate compensation.

The rallying cry of proponents of this type of legislation has been that doctors have experienced significant increases in their insurance premiums. Insurance premiums in a number of areas are up significantly. Pre-empting the state tort laws and limiting the rights of patients to be compensated for malpractice and harm caused by defective medical products will not solve this problem. Caps on non-economic damages have failed to prevent sharp increases in medical malpractice insurance premiums, according to a white paper comparing states with caps to states without caps that was released June 2, 2003, by Weiss Ratings, Inc., an independent provider of ratings and analyses of financial services companies, mutual funds and stocks.

For over 200 years, the authority to promulgate medical liability laws has rested with the states. This system, which allows each state autonomy to regulate the resolution of medical liability actions within its borders, is a hallmark of our American justice system. Because of the role they have played, the states are the repositories of experience and expertise in these matters. Thus, the ABA urges your subcommittee not to approve legislation that would pre-empt the states' medical liability laws.

In addition to the policy reasons why this long- and effectively-functioning liability system should not be altered by the U.S. Congress, it should be noted that the constitutionality of the amendment will surely be challenged based on constitutional separation-of-powers grounds. The Supreme Court, in the decisions of *Pegram et al. v. Herdrich,* 120 S.Ct. 2143 (2000), and *Rush Prudential HMO, Inc. v. Moran,* 122 S.Ct. 2151 (2002), continued to recognize that it is appropriate for the states to handle health accountability matters because health care is an area traditionally left to the states to regulate. In addition, a number of states have constitutions that prohibit caps on damage awards in personal injury cases.

Currently, states have the opportunity to enact and amend their tort laws, and the system functions well. Congress should not substitute its judgement for the systems which have thoughtfully evolved in each state over time. To do so would limit the ability of a patient who has been injured by medical malpractice or by defective medical products to receive the compensation he or she deserves.

The ABA is concerned about those in America who are without health insurance. Since 1972, the ABA has been on record supporting access to quality health care for every American regardless of the person's income. In February, 1994, the ABA's House of Delegates reaffirmed its support of legislation calling for universal coverage for all through a common public or public/private mechanism though which all contribute. But federal legislation to pre-empt state liability laws would not help the situation.

We request that you include this letter in the record of your February 17 hearings. Thank you.

Sincerely,

Robert D. Evans

Robert D. Evans

Cc: Members of the Small Business Committee

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