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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable SAXBY CHAMBLISS, a Senator from Georgia.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

God of grace and glory, we owe You far more than we can ever repay. Thank You for Your gift of abundant life and freedom from the chains of evil. Thank You also for the love of family, for the joy of health, and for the challenges that make us stronger.

Lord, deliver us from pride and ingratitude. Inspire our leaders with Your presence. May each Senator enable You to lay the foundation for every decision he or she makes. Protect these leaders as they come and go.

Continue to keep each of us from falling. Empower us to be faithful to our high calling to be Your sons and daughters. Bless our military and all who risk their lives for freedom. We pray this in Your gracious Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable SAXBY CHAMBLISS led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. STEVENS).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, February 24, 2004.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby

appoint the Honorable SAXBY CHAMBLISS, a Senator from the State of Georgia, to perform the duties of the Chair.

TED STEVENS,
President pro tempore.

Mr. CHAMBLISS thereupon assumed the Chair as Acting President pro tempore.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The Senator from Nevada.

SCHEDULE

Mr. ENSIGN. Mr. President, today the Senate resumes consideration of the motion to proceed to S. 2061, the OB/GYN medical malpractice bill. Senators who wish to speak on the bill are encouraged to come to the floor during today's session. The Senate will recess from 12:30 until 2:15 for the weekly party lunches.

At 5 p.m. the Senate will vote on the motion to invoke cloture on the motion to proceed to the bill. As a reminder, last night the majority leader filed cloture on the motion to proceed to S. 1805, the gun liability bill. The cloture vote on the motion to proceed to the gun liability bill will occur on Wednesday.

I ask unanimous consent that the time until 12:30 p.m. be equally divided between the two managers or their designees; provided further that the time from 2:15 until 4:50 p.m. be equally divided in the same manner; with the final 10 minutes prior to the 5 p.m. cloture vote equally divided between the two leaders or their designees, with the majority leader in control of the final 5 minutes.

Mr. REID. Mr. President, this is an equitable distribution of time and will save a lot of confusion. We therefore agree.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

HEALTHY MOTHERS AND HEALTHY BABIES ACCESS TO CARE ACT OF 2003—MOTION TO PROCEED

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of the motion to proceed to consideration of S. 2061.

Mr. ENSIGN. Mr. President, I wish to make a few opening comments on the medical liability bill. Last year we had a debate in the Senate on proceeding—not voting on but proceeding—to an overall medical liability reform bill. That vote was 49 to 48 in favor of going to the bill. Unfortunately, the rules of the Senate provide that one needs 60 votes. Otherwise, a filibuster, as it is commonly referred to, is continued. You cannot proceed to debating the legislation or to votes or amendments.

There are currently 19 States, according to the American Medical Association, that are in crisis. Nineteen States are experiencing some kind of crisis with their medical system because of problems with medical liability insurance. All but 5 States of the remaining are showing some problems, the type of problems that have led to those 19 States being in crisis.

We had the vote last year and couldn't get it done. Senator GREGG and I have introduced the bill before us today, the Healthy Mothers and Healthy Babies Access to Medical Care Act. This bill limits the scope of reform of the medical liability system to the practice of obstetrics and gynecology and the doctors involved in those practices.

Using my own State as an example, at the University of Nevada School of

• This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.



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Medicine there has been a dramatic decrease in the number of medical students deciding to go into obstetrics. This is happening at a time when Nevada is the fastest growing State in the country. Southern Nevada—Las Vegas, in particular—is by far the fastest growing metropolitan area in the Nation. Not only are we not adding the OB/GYNs we need, we are actually losing them.

The other side will argue that the General Accounting Office did a study and determined that doctors are not giving up their licenses. They said that doctors are not leaving their States.

The problem with what the General Accounting Office did is, they went to the State boards and only did a survey of licenses. I was a practicing veterinarian and still have a license in veterinary medicine. Once you have a license, you never give it up because you never want to take the exam again. So when the General Accounting Office asked the State board of medical examiners how many doctors have given up their licenses, and they found out nobody had given up their licenses, that should not surprise anybody because they are not going to give them up. That does not mean these doctors are not quitting practice in Nevada and other States—Pennsylvania, West Virginia, Washington State, Mississippi, and many others around the country. It means they haven't given up their licenses because they don't want to take the exam again. But they are limiting their practices. And many of them are leaving those States that are affected.

Several years ago, California gave us a good model. California is right next to my State of Nevada. California passed what is known as MICRA. It is a medical liability reform bill. Luckily, they passed it back then because the trial lawyers have become so powerful across the United States that you could never get the same piece of legislation passed in California. That would be a shame because it has worked so well. It is the model around which we built the legislation on the Senate floor today.

In California—Los Angeles, for example—OB/GYN medical liability insurance is somewhere a little over \$50,000 a year. In Las Vegas, where we don't have and haven't had this wonderful MICRA law on the books, premiums can run anywhere from \$110,000 up to \$200,000 a year. Not only that, they are telling the doctors in Las Vegas, you have to limit the number of deliveries you do, especially if you are practicing on high-risk deliveries.

If you are a woman who has a high-risk pregnancy, you want the best possible doctor you can get. Unfortunately, those doctors are having to limit their practice or retire or leave the State because they cannot afford medical liability coverage any longer.

This is a crisis—a crisis of access to health care for women who need the health care, women who are in search of gynecological services or women

who are about to deliver babies. The stories—there are many of them—are tragic in many circumstances.

This is, by the way, only one area of our health care system that is in crisis. Trauma is another place, and we are going to address that later this year—emergency rooms. As a matter of fact, the level I trauma center in Las Vegas closed a couple of years ago because the doctors could not afford to practice there because of the liability. There were so many lawsuits—not lawsuits that actually had merit to them; some of them did but most of them did not. Because of the potential liability, the doctors said we cannot afford to work here. So the level I trauma center that serves a four-State region had to close. That is the same level I trauma center, for those who followed the national news this last year, where Roy Horn of Siegfried and Roy was treated after the tiger had attacked him. It is an excellent level I trauma center. It saves many lives.

We had a press conference last year where a woman whose father was in Las Vegas and had an accident while the level I trauma center was closed. He had to be transferred to another hospital, and because of the delay in treating him, we could definitely argue that this man would be alive today if the trauma center had not closed. That trauma center was only closed for 1 week, and it was closed for that reason. The State of Nevada stepped up; our Governor stepped up and said we will cover that trauma center under the laws of the State of Nevada.

What are the laws of the State of Nevada? It has a \$50,000 cap of liability—total cap. Not \$50,000 for pain and suffering but a total cap of \$50,000. That is not even close to what this bill says. This bill has a \$250,000 cap on non-economic, nonmedical damages. You can still get all the economic damages you would have incurred; for instance, loss of income or other types of economic damages. You can get all of the medical coverage you would need. It is just that \$250,000 cap on pain and suffering awards. Those are the awards we have seen that are getting outrageous all across America.

That level I trauma center, luckily for Roy Horn, was open. Without the type of intense care you can receive in a trauma center, Roy Horn, I think it could be argued, would not be with us today.

Mr. President, even though we have limited this bill to the practice of obstetrics and gynecology, we do have a much bigger problem in this country, a problem that must be addressed. We are in a political season today. We know that. It is an election year for the President, the Senate, and the House, and there is a lot of politics going on. Some people say: You guys are just doing this with OB/GYNs to make a political issue out of it.

If people want to stand up and say that they don't want to fix the problem happening with access to care for

women and children, then I guess that is a political issue. I think it is a legitimate political issue. People need to know where Senators stand. They need to know where our Presidential candidates stand on issues of this importance. I believe that when they find out where candidates stand, whether they are incumbents or challengers, this issue will make a difference in their vote come November.

It is that important to our overall quality of life in America. I believe it is wrong that we have to have people moving, or not moving, from State to State because they cannot get access to quality care because the medical liability costs are too high—one reason versus another reason.

Some States have enacted good reform. Colorado and California are the best examples. My State enacted a bill, but, unfortunately, it will take several years before we know whether that bill will withstand challenge in the courts. Also, there were two huge loopholes in that bill that the trial lawyers were able to get in that you will be able to drive a truck through. That is why many in the medical community in Nevada are trying to close those loopholes.

We need enactment at the national level. Sixty percent of all medical bills are paid by the Federal Government between Medicare, Medicaid, and veterans. It is a national priority. We must get this medical liability crisis under control so that our trauma centers are not closing, so that women have access to their OBs, gynecologists, and nurse midwives, who are also covered under this bill. They sometimes get left out of the discussion, but they are a very important part of our health care delivery system in this country and delivering healthy babies.

The ACTING PRESIDENT pro tempore. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I thank the Senator from Nevada. I know of his personal interest in this issue. He has offered legislation before. Today we are considering S. 2061, which has been offered initially by Senator GREGG of New Hampshire and Senator ENSIGN.

It is important to note that this bill, which was brought directly to the floor, has not been the subject of any committee hearings. In fact, there has been no effort, to my knowledge, to sit down and find a bipartisan compromise or sponsorship for this legislation. This bill was presented to the Senate a few days before we went into recess, and now it is being called this day.

What is interesting, as well, is that there are announcements from the Republican leadership that we will quickly move after the vote on this bill to other issues, and they have been enunciated.

The point I want to make is this: I don't believe this is a constructive effort that leads us to a solution to a national problem. This, instead, is a bill

being called for one reason only: To get a rollcall. It is a bill being called today to put Senators on the spot. Vote yes; vote no. Why? Because, frankly, there are some on one side of the issue who want to demonstrate that they are concerned. So they are bringing a bill to the floor. They want a rollcall so they can say to those who are looking for some change and for some legislative progress: See, we moved quickly on this. We brought a bill to the floor and, darn it, it didn't pass. We will try to get to it later in the session.

From my point of view, that is not the way to approach this. We should have dealt with this in good faith and constructive, bipartisan effort to try to find a solution to a serious national problem. But that is not the case. Instead, we are having a head-on collision between the trial lawyers on one side and the doctors on the other side.

I come to this debate as someone who had a little bit of experience in this issue a long time ago. Before I was elected to Congress 21 years ago, I was a practicing lawyer. I used to defend doctors who were sued for medical malpractice. I did that for 5 or 6 years. I came to understand the nature of these lawsuits and how complicated and painful many of them are. Then I was on the other side of the table, representing patients who went into a doctor's office or a hospital and were injured and they sought compensation because of these injuries. So I have seen both sides of the issue. I come to this debate with the belief that we need to bring all of the parties together to find a solution. What we have with this bill, I am afraid, does not come close to addressing a serious national issue.

Mr. President, I see that the Democratic leader, Senator DASCHLE, has taken to the Senate floor. I planned on giving a rather lengthy speech. At this point, I would like to yield the floor to the Senator from South Dakota and then I can resume after he is finished.

The ACTING PRESIDENT pro tempore. The minority leader is recognized.

Mr. DASCHLE. Mr. President, I think the distinguished Senator from Illinois for his courtesy, and I appreciate very much the leadership he has provided. He has said on many occasions that it is imperative we address this issue in a meaningful, comprehensive way. Senators on both sides of the aisle recognize that this situation will not resolve itself; that it must be addressed. But like him, I share the concern that the bill before us just doesn't do that.

Last year, the Senate was asked to consider a bill that promised to reduce insurance premiums for doctors by restricting the legal rights of injured patients. That bill was rejected by a strong bipartisan margin in the Senate for one simple reason: It was a sham. It put the profits of insurers ahead of the rights of patients, while offering doctors no real relief whatsoever.

Today we are being asked to consider yet another bill that seeks to close the

doors of the courthouse to victims of malpractice, this time under the guise of expanding health care access for women and infants.

Once again, the Senate should reject this bill for what it is: a maneuver designed to protect nothing but the profits of insurance companies, HMOs, pharmaceutical companies, and medical device manufacturers.

Democrats and Republicans agree that skyrocketing malpractice insurance premiums are a serious challenge. Too many doctors, especially obstetricians and gynecologists, are being forced to pay exorbitant premiums because of the arbitrary actuarial formulas of insurance companies. This is a national problem, and it demands our attention. But like last year, this bill actually does nothing to help doctors. Despite the claims of the insurance companies, every piece of available evidence shows that capping damages has absolutely no impact on the cost of malpractice insurance.

According to the Medical Liability Monitor in a sampling representative of all States with caps on damages, malpractice insurance premiums for OB/GYNs actually increased by as much as 54 percent in 2003. In States without caps on damages, OB/GYN premiums increased no more than 14 percent in 2003. Many States without caps saw no increases whatsoever.

We have a situation, again documented by the Medical Liability Monitor, that States with caps saw increases of as much as 54 percent last year. States with no caps saw increases of no more than 14 percent last year.

A recent study by the Weiss rating organization found that caps on non-economic damages failed to result in lower premiums for doctors, despite the fact they did reduce the amount insurers had to pay out to victims. Insurers merely kept the savings for themselves and left doctors to fend for themselves.

In the months since we last discussed this issue, the GAO and the CBO both released reports demonstrating that the primary factor driving insurance premiums higher is not malpractice awards, but the insurance companies' desire to recover their investment losses. After trying to pass on the cost of their bad investments to doctors, they are now trying to do the same thing by limiting the rights of injured patients.

Even the insurance industry admits that caps will not protect doctors from higher insurance premiums. A press release published on March 13, 2002, by the American Insurance Association stated:

Insurers never promised that tort reform would achieve specific premium savings. . . .

Just last year, Bob White, president of the largest medical malpractice insurer in Florida, stated:

No responsible insurer can cut its rates after a [medical malpractice tort "reform"] bill passes.

Take it from the insurers themselves, no doctor should expect lower insur-

ance rates as a result of this bill, and no woman should expect greater access to health care for themselves or their babies.

What women should expect, on the other hand, is a two-tiered legal system that restricts their rights in the courthouse if they are hurt by the negligence of a doctor, HMO, drug company, or medical device manufacturer.

This bill is unjust. It restricts women's access to the legal system while preserving it actually for men.

Under this bill, if a man shows signs of lung cancer and his illness is misdiagnosed due to the negligence of his doctor, he can recover damages to compensate him fully for his injuries. But if a woman with cervical cancer suffers the same negligence, her damages will be arbitrarily capped. If a man is prescribed defective blood pressure medication by an internist, he can recover full damages. But if a woman is prescribed blood pressure medication during pregnancy that causes blood clots, her damages will be capped.

The real problem with this bill is not merely that it values the injuries of men and women differently, as troubling as that is, the real problem is that it presumes that politicians in Washington are better able to determine how to compensate injured patients.

Every year, tens of thousands of women and infants are injured at the hands of OB/GYNs.

Nine years ago, Colin Gourelly of Nebraska suffered complications at birth due to his doctor's negligence. Today, he has cerebral palsy and is confined to a wheelchair. In his short life, he has needed five surgeries to correct bone problems and sleeps in a cast every night to prevent further orthopedic problems.

Shannon Hughes from South Carolina was in the middle of a difficult labor. Despite repeated calls, the doctor wouldn't come until her 35th hour of labor. It turned out that the umbilical cord was wrapped around her baby's neck cutting off oxygen. Today, Shannon's son, Tyler, is severely brain damaged and bedridden. He requires constant medical care and is fed through a tube.

When Alexandra Katada was born in McKinney, TX, the doctor stretched her spine, destroying her nerves, leaving her partially paralyzed. The baby's elbow was pulled from its socket and broken. She died 8 months later from her spinal injuries.

Let us be clear: No amount of money can compensate a parent for their child's pain, but malpractice awards are not simply about money. They are about offering victims a sense of justice, a way to hold accountable those responsible for their injuries or the death of their loved ones.

Some have said that without limits, the legal system looks more like a lottery. But no jury award could ever make the parents of Colin Gourelly or Tyler Hughes or Alexandra Katada feel

that they were holding a winning ticket.

Malpractice awards are decided by juries and approved by judges. This is the same system on which we rely to decide life and death issues in capital cases. Why would we not trust our citizens to fairly evaluate how to deliver justice for the victims of medical malpractice?

Democrats are eager to work together with our colleagues to craft a real solution to the problem of rising malpractice premiums. But, once again, rather than working with us to craft a true compromise that would address the problems of increasing insurance premiums, the Republican leadership has decided to bring this bill to the floor with the same level of problems, the same concerns we had 7 months ago.

If our colleagues were serious about combating the rising cost of malpractice premiums, they would join us in supporting bipartisan legislation that includes both long-term and short-term solutions that directly address the rising premiums without harming injured Americans—solutions such as individual tax credits to offset costs when premiums rise sharply; reasonable limits to punitive damages; prohibitions against commercial insurers engaging in activities that violate Federal antitrust laws; sensible ways to reduce medical errors; and direct assistance to geographic areas that have a shortage of health care providers due to dramatic increases in malpractice premiums.

The Senate faced a similar situation discussing concerns about the rising terrorism insurance rates. Some thought then that the only solution was to undo the jury system. Instead, the Senate worked together and developed a bipartisan solution that fixed the problem and brought down insurance rates dramatically.

We should pursue the same model for addressing this problem as well.

There is no question that malpractice rates are a serious problem. Doctors and patients deserve a real answer. This bill is not it. I urge my colleagues to reject cloture.

I yield the floor.

The PRESIDING OFFICER (Mr. SANTORUM). The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from South Dakota because I think he has raised an important issue of concern in this debate and that is one I have initiated in my opening remarks. We need to have a constructive bipartisan conversation about a serious national problem. Instead, this bill, S. 2061, was introduced just a few days ago without a committee hearing, reference to committee, without any attempt to find common ground and find a solution. In fact, it is being called today so there will be a vote on record and nothing else. It is anticipated the bill will not go forward.

I spoke to doctors in Illinois over the weekend, doctors who share my con-

cern about the medical malpractice premium situation in our State. I have told them what we are doing today is frankly a political exercise. It is an exercise to come up with a roll call vote so those on one side of the issue can go to their supporters and say, we have worked hard. We brought this bill to the floor, we have been stopped, and we cannot get back to it because we are so busy. Frankly, that is no solution. In State after State, including my State, there are areas where there are serious medical malpractice premium problems. They arise for a variety of reasons. Memorial Hospital in Belleville, IL, has lost numerous obstetricians and gynecologists in the last year due to rising malpractice premiums. Community leaders in that town, which I am familiar with—it is an area I grew up in—have come to me and said, this is a real source of concern. We are losing doctors. They are doctors who are leaving the practice to retire early, and I met one doctor in that circumstance. There are some who are moving to rural counties where the malpractice premiums are lower and they are further away, of course, from the people they originally served. Some are moving across the river to Missouri where they are finding malpractice premiums are a fraction of what they are in Illinois.

There is no doubt in my mind there is a serious problem that needs to be addressed. It is not just in the obstetrical/gynecological area. The OB/GYN issue is an important one, but there are other areas of need relative to trauma care, neurosurgery, and orthopedic surgery. The list is long and we need to address it in a serious and responsible way.

This bill, however, is being brought to us on a moment's notice. This bill is being brought to us in an effort to really check off the box that says, yes, we considered medical malpractice and now we are going to move on. That is unfair and it is unfortunate, and we can do better.

I will tell my colleagues a story about some of the situations I know of in my State. Eduardo Barriuso, who is a physician in the Humboldt Park area of Chicago, pays \$104,000 a year for malpractice insurance. He earns about \$175,000 because the patients he sees are poor patients, Medicaid and Medicare patients. Doctors who depend on Medicaid and Medicare are not wealthy individuals, but they perform a valuable function because if they are not there to serve the poorest of the poor, then who will?

This doctor says that faced with \$104,000 in annual premiums and a \$175,000 annual income, he cannot continue his practice, and he certainly cannot pass on the higher costs of medical malpractice insurance to his patients who are poor people.

Another Chicago area OB/GYN has announced he is going to study to obtain his pharmacist license. Right now he is paying \$115,000 a year for liability insurance.

Let's go to the root cause of the issue. Why are we even debating this issue of medical malpractice? There are several reasons. First, the men and women who are engaged in the medical profession are some of the most important people in our lives, some of the most important people in America. These are men and women who at great personal sacrifice go to medical school so that they are trained and skilled to be there when we need them, when our families need them. Time and again, my family and most who are following this debate have turned to a doctor in the hopes that he or she can cure an illness, provide some hope, give people some reason to believe they can overcome a disease, disability, or an injury.

Doctors are so critically important to all of us and yet when one takes a look at a doctor's practice, at a doctor's skills, there is a human side to the equation. They are human beings. They do make mistakes. Some are simple negligence. Some are far worse. When these mistakes occur, when a patient is in a hospital or a doctor's office and the wrong thing is done and that patient is injured, what should happen? In most walks of life in America, we are held accountable for our actions.

If I decide this evening to take my car and go out speeding on a highway, strike another car and injure someone, I will be held accountable. I was negligent. I did not reach the standard of safety that is expected of me as a driver and I must pay the price. That is true for businesspeople, for individuals, for virtually everyone in America. It is certainly true for medical professionals. When they make a mistake by negligence or intentional misconduct, they can and should be held accountable. I think that is part of our system of justice. Very few, if any, people argue that is not a reasonable thing to do.

How serious then are the number of medical errors and medical malpractice cases that occur across the United States? Well, the most far-reaching study of the extended cost of medical errors in hospitals and doctors' offices was published by the Journal of the American Medical Association last October. This is a dispassionate, objective analysis of the likelihood of medical errors and medical negligence in America. The authors of the study analyzed 7.4 million patient records from 994 hospitals in 28 States, representing some 20 percent of all the hospitals in America. This was an exhaustive study.

They concluded medical injuries in hospitals "pose a significant threat to patients and incur substantial costs to society," and "are a serious epidemic confronting our health care system."

A study in the Journal of the American Medical Association has told us as we go into this debate the first thing we can acknowledge is we have an epidemic of medical negligence in America. Now this was not the Journal of

the American Trial Lawyers. This was the Journal of the American Medical Association. They published a study that told us and warned us we have a serious problem in America.

The study found injuries in U.S. hospitals in the year 2000, for just one year, led to approximately 32,600 deaths, at least 2.4 million extra days of patient hospitalization, and additional costs of up to \$9.3 billion. These injuries did not include adverse drug reactions or malfunctioning medical devices.

Dr. Carolyn Clancy, Director of the Agency for Health Care Research and Quality, called medical errors "a national problem of epidemic proportions."

This was at a hearing before the Government Affairs Committee last June. She said Congress and the Bush administration need to make sure health care professionals work in systems that are designed to prevent mistakes and catch problems before patients are injured.

According to the Institute of Medicine, the medical errors epidemic has caused more American deaths per year than breast cancer, AIDS, and automobile accidents combined. It is the equivalent to a jumbo jetliner crashing every 24 hours for an entire year.

More than 70 studies of the past decade have documented serious quality problems in medical treatment, yet this bill before us today, S. 2061, does absolutely nothing to address this underlying problem of patient safety. How can we in good conscience talk about a medical malpractice problem and conclude the only place we need look is to the courtroom, to the patient once injured who goes to the courthouse seeking some compensation, some accountability for an injury that was absolutely no fault of their own? Yet the bill before us is absolutely silent when it comes to making doctors' offices, hospitals, and patient treatment safer.

This last Sunday in the New York Times, an interesting article on patient safety was published. I ask unanimous consent that the article be printed in the CONGRESSIONAL RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the New York Times, Feb. 22, 2004]
RUNNING A HOSPITAL LIKE A FACTORY, IN A
GOOD WAY

(By Andrea Gabor)

On the face of it, SSM St. Joseph Health Center, a small hospital in suburban St. Louis, does not seem very revolutionary in business terms. The hospital is a nonprofit institution run by the Franciscan Sisters of Mary. The chief executive, Alan Kevin Kast, is a former seminarian who begins his meetings with prayer and refers to his hospital as a ministry. A crucifix hangs in every room.

Yet St. Joseph is also guided by worldly objectives. The 364-bed hospital, part of SSM Health Care, which has 20 hospitals in four states and is led by Sister Mary Jean Ryan, is in the vanguard of health care change. By using the quality and productivity techniques that helped strengthen American in-

dustry in the 1980's, the hospital has improved patient care and reduced medication errors, waiting time in the emergency room and infection rates. It has even sharply reduced nursing turnover, which prevents many hospitals from delivering consistent care.

Other hospitals are also starting to use some of the techniques that have made industry more efficient in its quest to improve quality and save money. Every year, preventable medical errors cost \$9 billion, and tens of thousands of lives, according to a recent study by the Agency for Healthcare Research and Quality, part of the Department of Health and Human Services, and Johns Hopkins University.

Whether in industry or in health care, a quality strategy "gives a unified vocabulary for thinking about production as a system with a focus on customers," said Donald Berwick, founder of the Institute for Healthcare Improvement, an advocacy organization based in Boston.

Many hospitals are using a road map provided by General Electric, which has been selling its productivity-enhancing, cost-cutting elixir known as Six Sigma, along with medical imaging equipment, to hospitals around the country. Six Sigma is a statistical measure that can be applied to any industry and refers to a goal of reducing errors to 3.5 parts per million. Two years ago, for example, the North Shore-Long Island Jewish Health System contracted with GE Medical Systems and the Harvard School of Public Health to help start a leadership training center. Similarly, after close to a decade of cost-cutting, the Yale New Haven Hospital also recently signed up with GE.

New devotees of quality are beginning to measure and analyze everything from waste and waiting time to infection rates and the narrow avoidances of mistakes in treatment, as well as organizational barriers to improvement.

In a culture ruled by a fear of malpractice, the focus on quality involves a shift from secrecy to transparency—including reporting and dissecting mistakes.

That shift may be helped by a provision of the Medicare legislation passed in December that withholds a small part of Medicare payments if a hospital refuses to disclose quality data. "It's not a lot of money, but it's incredibly historic," said Robert Galvin, director for global health care of G.E. and a founder of the Leapfrog Group, an industry consortium aimed at improving health care. A few hospitals, including Dartmouth Hitchcock Medical Center in New Hampshire and the nine hospitals that form the Wisconsin Collaborative for Healthcare Quality, have begun to publish comparative quality data on their Web sites, including statistics like mortality rates.

At St. Joseph, where a quality strategy was first embraced in the late 1980's, measurement, standardization and analysis are obsessions.

"When I came here, everything was done differently," said Filippo Ferrigni, who has led the hospital's intensive care unit since 1987. "We didn't even measure blood pressure the same way in everyone. We decided we needed to have internal standards for measurement of at least blood pressure, pulmonary artery pressure, temperature, the fundamental building blocks of medicine."

The quality push at St. Joseph and the other hospitals in the group has led to systemwide benefits. In 1999, the company was in the red, but in 2002 it had net income of \$17 million, on revenue of \$1.8 billion. Amid nationwide nursing shortages, it lowered annual turnover to about 10 percent in 2002 from 15 percent in 2000. The national average turnover rate is more than 20 percent.

At St. Joseph, the zeal for quality improvement is helping the sickest patients. When Dr. Ferrigni read an article in a recent issue of *The New England Journal of Medicine* linking high glucose levels to an increased chance of infections, he knew that he had found his next big opportunity for improving patient care. Infections acquired in hospitals and intensive care units are common, according to a report released in December by the government's Agency for Healthcare Research and Quality; about two million patients are infected each year at a cost of more than \$4.5 billion.

The stress of illness results in higher glucose levels for most patients—not just those with diabetes. Dr. Ferrigni decided to see if lowering glucose levels in the intensive care unit by giving patients intravenous insulin would lower infection levels. Initially, the project ran into "tremendous resistance," he said. Doctors were concerned that giving patients insulin might result in brain injury and seizures. Dr. Ferrigni, however, persuaded his colleagues to allow him to gradually reduce blood sugars of patients in the intensive care unit. As blood sugars declined among the patients, overall mortality in the unit declined by 40 percent.

The results were so astonishing that the hospital decided to make the reduction of glucose levels for all patients, not just those in intensive care, a quality goal. Today, all patients are given glucose tests and, if necessary, get insulin. Hospitalwide, that change is credited with reducing deaths over all, not just from infections, by 28 percent from the average recorded from 1998 to 2001.

Because each serious infection costs about \$35,000, the savings are also huge. "This is the single most important leverage point for reducing mortality that's available to hospitals," Dr. Ferrigni said. "This is incredibly powerful stuff."

The effort, however, also demonstrated a major organizational challenge. "Doctors write the orders, but nurses have to make it work," Dr. Ferrigni said, explaining that the glucose initiative significantly increased nurses' workloads.

Blood sugar, once measured four times a day, now must be measured 12 times a day in intensive care. Once nurses saw the impact of the glucose testing, however, "they got all over it," Dr. Ferrigni said.

Some of the greatest quality challenges involve persuading employees in various departments to cooperate. Consider the effort, known as 30/30, to cut waiting time in emergency rooms. The goal is to evaluate patients with life-threatening illnesses or injuries in just 30 seconds and to reduce the time needed to admit patients to a hospital bed from the emergency room to 30 minutes.

Improvements in the emergency room involved a number of departments. When X-rays were needed, it often took an hour for an X-ray technician to get to the emergency room. To solve the problem, one X-ray technician was permanently transferred there. Or, in admitting psychiatric patients, the hospital had to wait for an evaluation by an outside psychological social worker before moving patients out of the emergency room, a process that averaged 90 minutes. To reduce the wait, the hospital hired a psychological social worker.

Within two years, SSM St. Joseph has met its objectives in the emergency room 94 percent of the time, up from about 65 percent when the project began. To help keep the organization from becoming complacent, patients receive a coupon for \$10 of groceries when SSM misses its 30/30 target. The hospital spent \$14,450 in 2003 on coupons.

The hospital now spends about \$200,000 more each year on increased emergency-room staffing. But a jump in admissions has

more than made up for that cost. In 2002, St. Joseph garnered about 68 percent of all new emergency room admissions in St. Charles County. After years without growth, the hospital also had a 7 percent increase in patient admissions in general in 2001, and the same increase in 2002.

Some major health care institutions, like Johns Hopkins and the Mayo Clinic, have been pursuing quality initiatives for years, but generally the mantra has been slower to penetrate big institutions.

Large teaching hospitals, which juggle teaching, research and patient care, have special challenges. Because of their residency programs, many of their doctors are temporary. At Yale-New Haven, one big question is whether a hospitalwide quality effort can succeed when only 10 percent of the hospital's 2,600 physicians are full-time. The rest are community physicians or professors at the School of Medicine.

The hospital began its Six Sigma effort in the intensive care unit, which had its own staff of nurses. The project involved reducing a relatively high rate of blood-stream infections that occur in patients who have catheters.

When management broached the subject with Heidi Frankel, director of surgical critical care at the hospital and a doctor at the Yale School of Medicine, she was skeptical. "This isn't an assembly line; it's an I.C.U.," Dr. Frankel recalled saying. "But it turned out to be a brilliant and inspired thing to use rigid corporate improvement techniques in a patient model because there are many things we do that are repetitive, and that we could standardize."

After winning over fellow doctors and residents, Dr. Frankel standardized the catheterization procedure and created a training video for the regular influx of new residents. During the last year, the surgical intensive care unit cut its catheter-related infection rates by about 75 percent. A rigorous quality strategy appeals to many hospitals not only because it controls costs, but also because it can improve care. But the process can take years to master. That is why, at St. Joseph, the true believers would also recommend a little prayer.

Mr. DURBIN. Let me just note a few things about it. It is entitled "Running a Hospital Like a Factory, in a Good Way."

The article tells a story of a hospital in suburban St. Louis, the SSM St. Joseph Health Center. It is a very complimentary article. The hospital is a nonprofit institution run by the Franciscan Sisters of Mary and the chief executive, a former seminarian, has really decided to make St. Joseph's Hospital different. They have decided they are going to go after quality control and the reduction of patient injuries and accidents at their hospital. They are using techniques that are used by private industry. I will quote from the article:

Other hospitals are also starting to use some of the techniques that have made the hospital industry more efficient in its quest to improve quality and save money. Every year, preventable medical errors cost \$9 billion, and tens of thousands of lives, according to a recent study by the Agency for Healthcare Research and Quality. . . .

So this hospital, St. Joseph's, in suburban St. Louis, decided to consult with General Electric, a major corporation, to find a way to make the services they offer to their patients better.

They are using a process called Six Sigma. It is a statistical measure and refers to the goal of reducing errors to 3.5 parts per million. What they found is this:

New devotees of quality are beginning to measure and analyze everything from waste and waiting time to infection rates and the narrow avoidances of mistakes in treatment, as well as organizational barriers to improvement.

The article says:

In a culture ruled by a fear of malpractice, the focus on quality involves a shift from secrecy to transparency—including reporting and dissecting mistakes.

Let me go on in the article. They noted here one specific example. The New England Journal of Medicine had linked high glucose levels to an increased chance of infection, so this hospital decided, particularly in the emergency room and for critical patients, to continue to monitor their glucose levels to avoid the incidence of infection. The blood sugars declined among patients when they started monitoring them and administering insulin to keep blood sugars down. Simply by using this quality approach to reduce the likelihood of infection, this hospital reduced the overall mortality in the intensive care unit by 40 percent. The results were so astonishing that the hospital—and I quote again:

. . . decided to make the reduction of glucose levels of all patients, not just those in intensive care, a quality goal. Today, all patients are given glucose tests and, if necessary, get insulin. Hospitalwide, that change is credited with reducing deaths overall, not just from infection, by 28 percent from the average recorded from 1998 to 2001. Blood sugar in this hospital, once measured four times a day, now is measured 12 times a day.

Those who follow this debate and will read this article in the CONGRESSIONAL RECORD I think will understand the point I am trying to make. If we are going to reduce the likelihood of doctors being sued for malpractice, the first stop in that conversation should be the reduction of medical errors. If we do that, we are serving two goals: reducing doctors' exposure to malpractice and we are making certain that patients will go through their medical experience with a much better outcome.

You would think that would be the first title in this bill, "Reducing Medical Accidents, Reducing Medical Errors." This bill does not even address that. This bill says that after you are injured, after you have gone to court, after you have successfully been given a verdict, this bill is going to restrict and reduce the amount of money you can recover.

From an insurance company's point of view and the view of some doctors, that is good enough. But from the viewpoint of making American hospitals and medical practice safer, that is hardly the place to start. Frankly, this bill does not address the core issue.

Mr. CORNYN. Will the Senator yield for a question?

Mr. DURBIN. I am happy to yield for a question.

Mr. CORNYN. In my own State of Texas, that passed a constitutional amendment along with implementing legislation to reduce the cost of medical liability insurance, we have seen reductions offered by medical liability carriers of 12 percent in one case and projected to be as much as a 19 percent reduction in medical liability insurance costs.

While I certainly would agree with the Senator from Illinois that reduction of errors is an important goal, would he not find a reduction of medical liability insurance rates of 12 to 19 percent one way to reduce the cost of health insurance and health care generally, in a way that would benefit the public generally?

Mr. DURBIN. I thank the Senator from Texas. I am aware of his State's experience. I am not an expert on it, but I read a little bit about it.

I will say to him I will be citing some statistics in the course of my remarks that will show that the caps on recovery for victims of medical negligence have reduced premiums in some States but not in others. It is an unpredictable outcome, when you reduce the exposure of a doctor for his malpractice, as to whether or not the cost of medical malpractice premiums goes down.

I would further say to the Senator from Texas, if our goal is simply to reduce medical malpractice premiums, frankly, we could stop people from suing in court. We could basically say you can't go to a courthouse if you are a victim. Malpractice insurance would cease to exist in that case.

What we are trying to do here is find a balance, a balance that is just and fair and says if you are an innocent victim of medical negligence, you are entitled to a day in court and a reasonable recovery. That doesn't mean you can come in and expect punitive damages in every instance, or some enormous verdict in every instance, but we should be able to say that if you are a victim, you will be able to recover a reasonable amount for your injuries.

I say to the Senator from Texas, in this bill, this jury of the Senate has decided that we know the maximum amount any woman or baby should be entitled to recover in a medical malpractice action for noneconomic losses. We are saying here that, regardless of the facts, regardless of the culpability of the doctor, regardless of the circumstances, regardless of how serious the injury is, the maximum amount which the jury of the Senate will render in verdict for the victim is \$250,000 for pain, suffering, and disfigurement.

I say to my friend from Texas, there are some who say that is just the price you have to pay; if you want to keep malpractice premiums down, you are going to have to say in some circumstances there is going to be an outcome that makes us feel a little uncomfortable. I am going to give examples of specific cases where \$250,000 in

pain and suffering is not even close to compensating the family and the child who are the victims of malpractice in these OB/GYN circumstances.

Mr. CORNYN. Will the Senator yield for a further question?

Mr. DURBIN. I am happy to yield without yielding the floor.

Mr. CORNYN. The Senator from Illinois makes an important point, and that is there will invariably be one or two, perhaps, cases, or a handful of cases, or an example you can point to where a \$250,000 limit on noneconomic damages might seem to be too low. But would the Senator agree that what we are trying to do is use a rather indirect means to try to accomplish a greater good for the patients who are denied access to health care?

For example, in 154 of the 254 counties in my State, a woman cannot find a baby doctor to deliver her baby because of the cost of malpractice insurance. Many obstetricians simply decide to give up and retire or to move someplace else where malpractice liability rates are lower.

While the Senator no doubt can find an example where the amount is lower than a jury perhaps might award, why shouldn't we take a step in the direction of bringing some predictability and thus bringing some reasonableness in reducing the rates for liability insurance so people can have access to doctors where they live?

Mr. DURBIN. The Senator from Texas makes an excellent point. I think that is the reason, I would say to my colleague, why once this bill is defeated—and I hope it is defeated—once it is defeated, we really have a responsibility here.

We come from different sides of the political spectrum. We are about as far apart as they come in this Chamber in terms of our political philosophy, but I think we both can see there has been a problem. The medical malpractice premiums in parts of your State and parts of my State have reached record high levels. These premiums are forcing my good doctors in Illinois to retire, move away to another State or to an area that is friendlier when it comes to the cost of the premiums. There is a denial of coverage. There is a denial of services to a lot of poor people in Texas, Illinois, and a lot of other States.

Shouldn't we come together instead of a take it or leave it bill that has never been referred to the Senate Judiciary Committee, never been the subject of a hearing, does not address issues of medical safety and other issues we can agree should be part of this conversation? Shouldn't we at the end of this debate on this bill sit down and honestly try, on a bipartisan basis, to find common ground and compromise that would serve the goal the Senator is suggesting, the greater good, to make sure these good doctors across America will be there when we need them?

I thank the Senator from Texas.

Mr. CORNYN. If the Senator will yield for a final question.

Mr. DURBIN. I am happy to yield.

Mr. CORNYN. I appreciate the spirit in which the comments are offered by the Senator from Illinois, because this is a subject where we do need to have a rational debate. Unfortunately, because we cannot get 60 votes to allow the floor debate and actually vote, we are engaging in a hypothetical exercise.

Wouldn't the Senator from Illinois deem it important for this body to have a realistic, rational debate and ultimately vote to see what the will of this body and the people we represent is when it comes to trying to get some handle on reducing the costs of liability insurance so more mothers can have access to obstetricians and more people can have access to health insurance by reducing health insurance costs?

Mr. DURBIN. I agree with the Senator from Texas. I thank him for his comments which I believe are good-faith comments.

In my rank on this side, I do not set the calendar of how bills are determined; your leader, Senator FRIST, does that. I suggest the best place to start is not on the floor of the Senate but for a group, on a bipartisan basis, to try to come up with an honest answer to this issue and bring it to the floor and stand together to try to pass this bill in a responsible way. Simply bringing a bill, take it or leave it, a few days, no committee hearings, does not serve the needs we are addressing.

I see a few other colleagues on the floor so I will go through a few points quickly and return to the Senate later in the day if there is an opportunity.

This particular bill does not address the problems of malpractice premiums in an honest fashion. The problem with malpractice premiums is a cyclical insurance problem. We have had crises before with high premiums in the 1970s and 1980s. Many States passed changes in the law to address this, some in tort reform and some in insurance reform.

This bill does not even look at the insurance companies that are offering medical malpractice insurance. What it is basically saying is that we are not even going to ask the question as to whether these companies are overcharging doctors and hospitals. Instead, we are going to say that the only culprits, the only people who are at fault in this conversation, are the victims of medical malpractice. They are the ones who have to tighten their belt, take fewer dollars. We will not even consider in 2061 asking that the insurance companies be held accountable for their own conduct and ask whether they are gouging us when it comes to prices.

How can we have an honest discussion of the medical malpractice issue without addressing medical safety, without asking these important questions of the insurance company?

This bill does not address frivolous lawsuits. The proponents of tort reform claim frivolous lawsuits are at the root

of the problem. This bill does not do anything to cut down on the number of such suits but only punishes those who make it to court.

Keep this in mind: If a lawsuit is worth \$250,000 in noneconomic losses, which is the maximum under this bill, this is a lawsuit where the plaintiff clearly has a cause of action which a jury or judge has decided is a worthy cause of action worth compensation. These are not frivolous lawsuits that would have \$250,000 in noneconomic losses. Something happened. A patient went to a hospital or to a doctor and was injured wrongly.

This bill is saying we are not going to address frivolous lawsuits. We will basically say those who are entitled to recover are limited in the amount they can recover.

One of the worst parts of this bill, we will hear arguments in the Senate that we need OB/GYNs across America and without these doctors to deliver babies we will be at a disadvantage. Frankly, no one can argue with that. But when we read the bill, it is about more than doctors. This bill, like the last one we considered last year, has been expanded to provide protection against lawsuits filed against pharmaceutical companies and medical device companies.

We are finding, time and again in the Senate, whatever the issue, the Republican side of the aisle insists there be at least one provision in every bill that is going to benefit the drug companies of America. In this situation they are saying these drug companies should not be held accountable for the damages and injuries caused by their products involved in OB/GYN practice.

Why would we do this? Why would we decide we are going to exempt them from exposure, liability, and accountability for some of the drugs and devices that are being used across America that cause injury to innocent people? That is exactly what they do.

Let me give some examples of the types of litigation that would have been eliminated by this bill, had it been in law. The Dalkon Shield was an IUD on the market in the early 1970s and caused thousands of women to suffer miscarriages, loss of their female organs, and infertility. It took eight punitive damage awards to force the manager of the Dalkon Shield to finally recall the product. It was not a law passed by Congress. It was a lawsuit filed against the company because of their dangerous product; 400,000 claims were eventually filed against A.H. Robins, the manufacturer of Dalkon Shields. Evidence established that Robins, the device company, knew that its IUD was associated with high rates of pelvic disease and septic abortion and that this company had misled doctors about the device's safety and had dropped or concealed studies on the device.

Why in the world we would protect this brand of reckless, irresponsible corporate behavior with this bill? The honest answer is because politically

the pharmaceutical companies and the medical device companies have a death grip on this Congress. They get what they want. We saw that when we considered the prescription drug bill for seniors and we are seeing it again. There is not a bill that comes through here, not one that passes through the traffic in the Senate, where somebody is not looking for a way to increase the profits and reduce the liability of pharmaceutical companies. This is a further illustration of it.

There are other things I could point out, drugs or devices that have been used. Let me give one from the State of Georgia. A&A Medical, a Georgia-based manufacturer of OB/GYN devices such as forceps, failed to sterilize tens of thousands of devices from 1999 to 2002, posing life-threatening injuries to women. Former staff of this company told FDA investigators that sterile and nonsterile devices were routinely shipped in the same batches. A month after urging the company to voluntarily recall its products, the FDA seized and destroyed the company's inventory. The owners of A&A Medical left the country after the seizure.

These are the kinds of companies we are trying to protect with this bill? This is not a question about whether a doctor could deliver a baby in Texas, Connecticut, Ohio, or Alabama. It is a question about whether or not these companies will be held accountable for their wrongdoing.

There is an approach that can be used and should be used that can bring a positive outcome. Senator LINDSEY GRAHAM from the State of South Carolina and I have introduced bipartisan legislation. We have worked to try to include in this legislation the key elements that we think are necessary for medical malpractice reform. Let me tell you what they include.

First, dealing with medical safety, establish a voluntary system to share medical error information among providers and patient safety organizations. The information shared will be immune from legal discovery so there is some transparency in what occurs but no liability, so a greater likelihood they would exchange information.

Also, consistent with the Institute of Medicine, the bill creates a new center for quality improvement. We provide immediate relief for doctors and hospitals.

If there is one point I make, it is this: If Senators are hearing back home that medical malpractice premiums are too high and that you should vote for this bill, keep in mind what Senator ENSIGN of Nevada said in the debate we had a few months ago on a similar bill. Capping noneconomic losses will not reduce medical malpractice premiums for doctors for 4 to 6 to 8 years. Why? Because there is a long tail of liability. Doctors' acts today that constitute negligence can result in court suits tomorrow, next year, and for years to come when those injuries are finally discovered. If we

cap noneconomic losses today, there will not be a relief for doctors in their medical malpractice premiums for years to come.

Senator GRAHAM and I considered that and said we have to deal with this directly. And dealing with it directly means offering a tax credit, particularly to those doctors in specialties where the premiums have gone too high. Doctors today deduct the cost of medical malpractice premiums from their business expenses.

We would go further and offer to doctors and hospitals a tax credit when their premiums skyrocket. That is the only reasonable way to provide immediate relief. We have given tax breaks to a lot of wealthy people across America under this Bush administration. Why can't we, when it comes to the medical professionals, say they should have a tax credit so that skyrocketing premiums do not force them out of business into retirement or to move their practice?

In our legislation, we reduce frivolous lawsuits. We put in the Durbin-Graham bill penalties for attorneys who file frivolous lawsuits: The first time, damages; the second time, even more expense; and the third time we would subject them to losing their license to practice law for a frivolous lawsuit. There is no reason any doctor or any person, for that matter, should be subjected to a lawsuit which ties them up at great expense, costs their insurance company money, and raises their premiums when, in fact, that lawsuit is frivolous. There are few of these, but there should be none. We think there should be a penalty for those who take advantage.

We also stop any competitive activities by insurers under the McCarran-Ferguson Act, and we provide resources to help hard-hit areas of doctor shortages, particularly rural and inner-city areas, through the Department of Health and Human Services.

We also address the issue of reinsurance. This is a topic we never talk about. Most medical malpractice premiums are charged against the initial liability which is usually in the range of \$1 million, and then the umbrella policy which covers all the damages which might exceed \$1 million. Then companies are brought in, reinsurance companies, that sell the original insurance policy. These are the areas where we believe there is a need for reform.

Reinsurance costs are about 28 percent of medical malpractice premiums. Their prices swing widely. They are mainly international corporations subjected to little regulation. Frankly, since September 11, reinsurance costs have gone up dramatically across America.

As this chart illustrates, this is Hurricane Andrew; reinsurance costs spiked in America. Then they went back down again. This is 9/11. After 9/11, reinsurance costs have gone up. So why are these medical malpractice insurance companies charging higher

premiums? Part of it is the cost of reinsurance. Senator GRAHAM and I address this and believe that we should create a Federal fund which deals with reinsurance, where there would be contributions from doctors, hospitals, and health care professionals, and we can see some stability in the amount that is charged.

This situation we have before us is clear. Caps don't work. This chart shows the percentage increase in median premiums for medical malpractice from 1991 to 2002, the States without caps, no limitations on recoveries in verdicts, and the States with caps are shown in red. You can see that Arizona, New York, Georgia, and Washington, with no caps, had very modest increases in malpractice premiums.

Take a look at California, which has a \$250,000 cap, Kansas, Utah, and Louisiana. In this period of time, malpractice premiums went up dramatically in the States with the caps. There is little or no correlation between the caps and the fact that malpractice premiums are going up.

Look at these OB/GYN insurance premiums in damage cap States versus noncap States in 2003: In California, a State with caps, there was a 54-percent increase in OB/GYN premiums with caps in place at the State level; in Oregon, zero percent increase; against the State of Washington, California, 15 percent; State of Washington, zero percent; Colorado, 29 percent with caps, Georgia, only 10 percent without caps; New Mexico, 52 percent increase in OB/GYN medical malpractice premiums with caps, and in the State of Arizona, 14 percent. It is an illustration that you just can't rely on these caps to bring down malpractice premiums for many years, if at all, and in many cases not at all.

Look at the percentage increase in median premiums: States with caps, 48 percent between 1991 and 2002; States without caps, 36 percent.

This is an important issue that needs to be addressed. I see my colleagues waiting. I will yield the floor but return later in the debate.

I hope my colleagues will understand that we have a serious national problem that needs to be addressed, but we should not address it in a way that is partial, that does not do justice to the serious challenges we face. We need to reduce medical errors. We need to hold insurance companies accountable. We need to bring about tort reform which stops frivolous lawsuits. We need to move into the area of tax credits for doctors now—not 4, 6, and 8 years from now—so they can pay their malpractice premiums and do it in a fashion that is fair—fair to the people who have been injured and fair to the medical professionals who are so important to all of our communities.

I yield the floor.

The PRESIDING OFFICER (Mr. BROWNBACK). The Senator from Alabama.

Mr. SESSIONS. Mr. President, we are, indeed, losing physicians in the

practice of medicine throughout America. Senator DURBIN expressed concern in the conversations he has been having with doctors in his State, even though he opposes this bill. I traveled to Alabama this past week and visited five or six hospitals. I was at Fayette and Wedowee and Gadsden and Alexander City. As I traveled the State talking to doctors, to hospitals about their insurance premiums, it is a very real problem.

This is not a new issue. We have been talking about it for a number of years. The reform of litigation of malpractice cases in California is the model for this legislation. It has worked very well in California.

The people who are paying the premiums, people who are subjected to lawsuits, people who care about this every day, people who are giving up their practice every day as a result of abusive lawsuits, they support this legislation. Do they not know what this is all about? Do they not know what they are asking for? These are matters that are quite serious.

I believe capping noneconomic damages has a good effect. When you look at a doctor who delivers a baby, is that doctor a guarantor of a healthy baby? They can't do that. They cannot be the guarantor that every birth they preside over will result in a healthy baby. They are responsible if they are negligent and that negligence causes damage to a child. There is no doubt about that. So that is what we need to focus on.

The limit on damages does not limit damages for injuries in care for a child who lives many years with a great disability. They can recover unlimited amounts for that.

Under California law, these are some of the verdicts that have been rendered to compensate families for children who were born with serious disabilities: In December, an \$84 million verdict was rendered because of a 5-year-old with cerebral palsy after a mishandled birth; \$25 million in San Diego County because a boy had severe brain damage; \$27 million in San Bernardino for a woman who was a quadriplegic because of failure to diagnose a spinal injury; \$21 million in Los Angeles for a newborn girl with cerebral palsy and mental retardation as a result of a birth-related injury. They go on.

These are real recoveries to compensate people for economic losses they will have in the future and to allow them every possibility to see that the child or the person who is injured can be taken care of with the best conditions we can make. We are concerned about the explosion of punitive damages. Some people say the person who did wrong ought to be punished.

As a matter that we need to think about, the system is out of whack. The person who commits malpractice is not the one who is punished. The person who commits malpractice—for the most part, hopefully, certainly, all of

them doctors—has insurance. They don't pay the verdict. The insurance company pays the verdict. How do they get the \$21 million or whatever they have to pay out in the verdict? How do they get that money to compensate the victims? They raise the rates on everybody; the innocent and those who commit errors. It is driving up the cost to practice.

I have a wonderful friend, an OB/GYN, in my hometown of Mobile. We go to church together. He was telling me about a doctor that just gave up his practice. He handled 60 or 80 births a year. His insurance was \$60,000 a year. That is almost \$1,000 per birth. This week, I was in a hospital in Alabama. They told me 3 years ago they gave up deliveries—there were 200 deliveries a year in this small town, and the hospital had less than 50 beds—because they could not afford the insurance. The hospital quit doing it. The physician in the community also quit delivering. This is a fact, a reality, and it is driving good physicians out of health care.

No group of doctors in America has the hammer falling harder on them than the doctors who deliver our babies. They are getting hit with extraordinary increases. They are getting sued to an extraordinary degree. We need to do something about it. We have bills here, and whatever the bill is, they say "we need to do something, but this isn't the way to do it; but we want to do something about it. We have bills here, and whatever the bill is, they say "we need to do something, but this isn't the way to do it; but we want to do something about it. They say "there are problems, I will admit, Senator, but this isn't the right bill." They say "you have not done this or that," and on and on. The result of that is we never pass anything. I believe it is time to do something about this issue. We can do something about this.

When you look at the cost of delivering babies in America today, the liability cost is a very significant portion of it. Not only that, doctors—particularly those who have been practicing for a number of years—do not like the agony of going through a lawsuit. There is the combination of premiums and the threat of being dragged through court for long periods of time, and that is not good. That is why they are quitting.

I was at one of the hospitals in Gadsden this week. One of the nurse supervisors came up to me after I had been asked in the meeting whether we were going to do anything about the liability problem. She said she and the hospital had been in litigation. She had been away from the hospital for 10 days during the trial of this case. They were not negligent and they won the lawsuit, but millions of dollars were spent on that litigation. This is happening all over America. Most of the cases are defendants' verdicts, but many cases are coming in with extraordinarily high verdicts. The BMW case out of Alabama, decided by the Supreme Court, raised real questions about how do you decide what punitive damages ought to be. Does the jury just feel bad

this day or look at the victim and feel sympathetic, or are they more sympathetic to one person than another? They come up with \$50 million for one person, and maybe in a similar situation they would come up with \$500,000. These are aberrational verdicts in the country.

We are saying that there should be a limit for compensating noneconomic damages. It is modeled on a successful program in California. I believe we are facing a national crisis in health care. It is a crisis that ought to be confronted. It is not going to go away. A big part of it is litigation. If you don't believe it, ask any doctor or hospital you know. They sue everybody, including the nurses, doctors, the aides, the hospital, the manufacturer of the hospital bed, or whatever, that might be possibly construed as being connected. All of that adds up to a tremendous burden, a tremendous cost on our health care system.

The truth is health care costs are continuing to go up. One of the factors is litigation costs, which are going up even faster than other costs. We need to contain that and bring some rationality into it. I am willing to listen to other ideas. I am not sure California is perfect, but I will say it is working there. I believe it will work for our country. I thank our majority leader, Dr. BILL FRIST, for bringing this up. It is time to debate this. We need to pass something soon to protect the availability of health care. We need to make sure hospitals and doctors are not quitting delivering babies. That hurts us in America and hurts health care in America.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, I have been listening to the arguments posed by our colleague from Illinois, Senator DURBIN, and our colleague from Alabama, Senator SESSIONS. I find myself sort of agreeing with both of these individuals. Clearly, this is an area that cries out for some solution. We have been back at this issue over and over again. Like my colleague from Alabama, and I suspect my colleague from Illinois as well, I was home in Connecticut over the past week and I have received letters from radiologists, and I have talked to OB/GYNs and others. My State ranks third in the country in the rate of premiums for OB/GYNs, which I will address in a minute. This is an area that clearly needs to be addressed. So I appreciate the comments of my colleague from Alabama, that is, to see if we cannot find solutions to this.

As the Senator may recall, I have not been shy when it comes to tort reform issues, having authored the securities litigation reform bill, uniform standards legislation; and I have dealt with the issue of terrorism insurance, and Y2K legislation with BOB BENNETT. I am someone who wishes we were debating class action reform now. There, we

have an agreement. It is not going to satisfy everybody, but I have agreed with BILL FRIST and others. Senators SCHUMER and LANDRIEU and I have worked across party lines to come up with a compromise solution on class action reform. That is a bill I believe we could actually adopt.

Here we are going to spend 2 days debating a cloture motion we both recognize is probably going to fail this evening. But we have a class action reform bill we can get done. I regret I am not arguing on behalf of that proposal, rather than standing here and reluctantly disagreeing with this particular bill; although I am agreeing with my colleague from Alabama that we cannot allow year after year to go by without addressing this issue. I regret we didn't make the effort here we did on class action. On class action, once the cloture motion was defeated on the motion to proceed, people reached out and said let's see where we can find common ground on this. I think we have done that. Only time will tell if the compromise will work. That is how you have to function in this body, when you have 100 Members representing different constituencies and ideas and proposals, where there is a commonality and purpose to try to arrive at an answer to a staggering problem. One of the problems—not all, but one of the problems—is associated with health care. I will go into that in a minute. It seems to me we should pause and reach out and see if we cannot find that common answer. It may not satisfy everybody, but certainly it will come up with some intelligent responses to this problem.

So I say to my constituency in Connecticut, and elsewhere, I am listening to you and I hear you. I know we have to answer this. The question is, is this particular proposal the answer to the problem we face, with the rising increase in malpractice premiums. What actually could be done that may address the issue?

As my colleagues know, this legislation is similar to the one the Senate rejected last year. It would place, as we all know, a \$250,000 cap on noneconomic damages that can be awarded to a plaintiff in a medical malpractice case. The bill we are considering today has been narrowed, but in narrowing it, its defects have not been remedied. Like S. 11, the previous bill, this bill would apply to claims brought by health care professionals, health care organizations, such as HMOs, insurance companies, as well as product liability claims brought against medical device and drug manufacturers, by and on behalf of pregnant women and children. However, it would only apply to claims relating to obstetrics and gynecological services. We are dealing with a reduced universe of people in this area, much narrower from the proposal of last year.

Once again, this legislation would cap noneconomic damages at \$250,000. It would put the same cap on punitive

damages while imposing a stiffer evidentiary standard. It would also reduce economic damages a victim could collect by subtracting benefits paid by health insurance, life insurance, disability insurance, and Social Security benefits. In short, it would make it much harder for the victims of medical malpractice in this narrow area to receive fair and just compensation, in my view.

This legislation would not affect all victims of malpractice. We pointed out the bill we are dealing with seeks to limit the legal rights of a specific segment of our society, women and newborns.

It is important to remember that this bill is going to affect those who have actually been injured by malpractice. We are not debating whether there has been a judgment. There has been a decision that malpractice has occurred. A jury has already, in these cases, decided the victims are eligible to collect noneconomic damages. Furthermore, it will hurt the most seriously injured, those who might receive a noneconomic damage award of more than \$250,000 were it not for the arbitrary cap.

We are essentially telling women and infants that the injuries and suffering they experience are not worth as much as injuries and suffering of others.

The assumption is if we just do this in this one area, we are then going to be able to bring down the costs of these premiums. In fact, I suggest that if the empirical evidence made that case, I would be very tempted to support this bill. I say that to my colleagues who are the authors of this legislation. But, in fact, the data and information, unfortunately, does not substantiate the claim that by establishing a cap, you will achieve the desired results of lesser premiums on malpractice insurance.

The argument used by supporters of this bill is OB/GYNs are particularly hit by rising medical premiums. I want to make it clear that I am not insensitive to that claim. As I said earlier, I have heard from many in my own State. In Connecticut, we face the third highest premiums in the country for OB/GYNs. My doctors pay an average of \$102,000 every year in medical liability premiums. I have heard from them on numerous occasions about the difficulties they face in the current environment. The vast majority are good doctors who are working to provide the best possible care they can for their patients. They are doctors on whom families in Connecticut and newborns can rely. It is the same across the country. I know, having had a newborn in my own household, a child born to my wife Jackie and me a little over 2 years ago, the tremendous care and attention we received from our OB/GYN in Virginia, where Grace was born.

The question is not whether these people are paying higher premiums. The question is, Is the solution being proposed by this legislation actually going to address this problem? Again,

if I thought it would do that, I would be very tempted to support this legislation, as someone who has offered legislation dealing with frivolous lawsuits and other claims. I am not adverse to tort reform. In fact, I am disappointed. We are discussing tort reform in this instance, and we are also going to be talking about the tort liability of gun manufacturers. It is going to be interesting to hear people on that issue.

We had language included in the Energy bill to deal with MTBE. Senator SCHUMER of New York eloquently made the case, asking why we should be eliminating the liability of a product that was causing such damage. I am frustrated to know that we are protecting people from liability because of the political pressures that occur.

I am prepared to support intelligent tort reform, but this problem, as serious as it is, is not addressed by this solution. Will this legislation do anything to reduce premiums? Let me tell you why I don't think it does.

If we are limiting the ability of women and young children to hold accountable doctors, nurses, insurance companies, and others for harm resulting from a mistake, we certainly must make sure we are doing so for a very good reason.

The answer to the question posed above is a resounding no, in my view. The suggestive link between jury awards and rising premiums has not been established at all. In fact, to the contrary. Nor is there a link between insurance premiums and access to health care. In fact, the evidence suggests quite the opposite.

The two pillars upon which this bill is based are deeply flawed, in my view. First, some would suggest jury awards have exploded in both numbers and dollar amounts. That is something we will hear over and over, that victims are winning more and more so-called jackpot malpractice cases. But the facts are quite different.

The amount defendants and insurers are paying for medical malpractice claims, including jury awards and settlements, has increased in a manner that is consistent with and even lags behind medical inflation. Over the 10-year period from 1992 to 2001, the mean payout in medical malpractice cases rose by 6.2 percent per year, while medical inflation was rising at 6.7 percent annually over the same period of time. In other words, malpractice awards are rising exactly in the manner we would expect. They are tracking health care costs.

Of course, a rise in premiums might also be explained by an increase in the number of malpractice claims. That is also an argument we are hearing. Again, this is not the case. Between 1995 and 2000, the number of claims filed actually decreased by 4 percent, and the number of medical malpractice payouts decreased by 8.2 percent between 2001 and 2002. So we are not seeing these numbers go up financially, nor are the actual numbers of malpractice cases increasing. Both are the

two pillars upon which this bill is based. It is the reason people are saying we need to have the cap on these noneconomic awards.

The case made by supporters of this legislation is further damaged, in my view, when we compare States that currently have caps on noneconomic damages with States that have no such caps. As I mentioned previously, my home State of Connecticut has the third highest average premium for OB/GYNs. Connecticut has no cap. However, seven of the 10 States with the highest premiums do have caps. Last year, premiums actually increased by 17.1 percent for OB/GYNs in States with caps compared to a 16.6 percent increase in States without caps.

In the year 2003, the average premium for an OB/GYN in States with caps was \$63,000. The average premium in States without caps was \$59,000. So if anything, the evidence suggests caps on patient damages actually correspond to higher insurance premiums for doctors.

I said that rather quickly. Let me run by it again and make the case. The argument, again, is if you don't have caps, then these premiums go up. But if you look at places that have caps, seven of the 10 States with the highest premiums for OB/GYNs do have caps—seven of the 10. Last year, premiums actually increased by 17.1 percent in States with caps—an increase of 17.1 percent—compared to 16.6 percent in States without caps.

Again, if anything, the evidence suggests caps on patient damages actually correspond to higher insurance premiums for doctors.

The ineffectiveness of caps is illustrated by the experience in the State of California. Ironically, supporters of caps point to California as the model for limiting noneconomic damages. The State does, in fact, have a \$250,000 cap and premiums have remained stable relative to the rest of the country. However, California adopted the cap in 1975, and over the next 13 years in California, with a cap of \$250,000, premiums increased by 450 percent. This is comparable to a nationwide trend during that same period.

Then in 1988, California did something else. It passed comprehensive insurance reform. Only at that point did insurance premiums stabilize, decreasing 2 percent between 1988 and 2001. So for 13 years, when they had caps on the awards, they actually had premiums go up 450 percent, tracking the national average. In 1988, they put a cap on insurance premiums. Then they began to see the decline.

California is very worthwhile to look at, but we have to look at it in its totality. Don't disregard what happened in 1988. If we only look at 1975 to 1988, for that 13 years, there is nothing to brag about at all. The numbers went up as much as they did all across the country. It is only from 1988 up to now that we begin to see the real changes as a result of the insurance reforms in that State.

So California is a good example, but look to all of California. I could continue to quote numbers to underscore my point, but I do not want to bore my colleagues with recitations of data. I think it is important because without knowing what the facts are and understanding the argument, we cannot understand how best to deal with a very legitimate problem of trying to get these premium costs down. Does this solution meet that problem? One has to look at the data and the facts, and the facts are not holding this point up very well, in my view.

The point is very simple: The number of medical malpractice claims is not rising. The amount awarded to victims is consistent with inflation. The story in States with caps is similar to that without caps. Based on this evidence, we are being asked to limit the rights of pregnant mothers and infants. I do not think we ought to do that. The facts fail utterly to dictate such a conclusion.

If neither the number nor the amount of malpractice awards can explain rising premiums, then what is the explanation? Something is going on that is causing these premiums to continue to skyrocket as they are in my State and others across the country. According to several analyses that have been done, the increase in premiums does in fact correlate with the stock market and interest rates.

One recent study showed that premiums very closely tracked the insurers' economic cycle. During good economic times, insurers slash premiums in order to attract as much business as possible. Insurance companies receive their money from two sources. They get it from premium payments as well as investments. So when there is a good, healthy market going on, then they will reduce premiums because the cycles in the market are allowing them to sustain their economic growth. When there is a downturn in the economy and the stock market is not doing as well, the insurance industry is faced with only one other solution and that is to raise the premiums in order to keep the cashflow coming in.

So it is not complicated. As someone who comes from a State with a lot of insurance companies, I know that is how this is done. There is not some great magical secret out there. This is exactly how it occurs. So, obviously, during good economic times, insurers will cut the premiums in order to attract as much business as possible, which makes sense. This is because every new policy brings in additional float, money to invest in a booming market so they bring in the dollars. However, when the market turns and investment returns are weak, as has happened in the last few years, insurers raise their rates or, in some cases, leave the market altogether. When this happens, the result is often a crisis in the availability and affordability of insurance, and that is exactly what we are seeing today.

I will take a moment to address one other claim made by the supporters of this bill, and that is that rising premiums have reduced access to care for women and infants. Again, this is a very significant claim and needs to be addressed. Once again, I do not think the facts support that argument.

Between 1999 and the year 2002, the number of OB/GYNs across the country actually increased by 1,700 people. Only 6 States out of 50 saw a decrease in the number of OB/GYNs. That is not good news for those six States, but the argument that across the country this is occurring is not borne out by the facts. Actually, there were 1,700 new OB/GYNs in 44 States, so the number is stable or increasing, and in 6 States the number is going down. We ought to be conscious of that because that could be a trend that needs to be addressed.

Again, I underscore what I said at the outset. This is a serious problem but a serious problem demands a serious solution. Unfortunately, this bill is not that answer.

As an interesting note, by the way, where we are losing OB/GYNs, half of those six States have caps on the amount that can be collected in noneconomic terms. So we are talking about a bill that places caps on noneconomic awards, and in six States the number of OB/GYNs is declining, and yet three out of the six States have actual caps. One has to ask oneself: If this is failing in half of the States in terms of attracting or keeping OB/GYNs, is this bill or this idea the right solution to this problem? I think the conclusion is no, it is not, unfortunately, if those are the facts.

A GAO report from August of last year identified access to care as a problem—and I am quoting—"in scattered, often rural areas where providers identified other long-standing factors that also affect the availability of services."

The question was asked: Why is this happening? The General Accounting Office comes back and said there are a lot of other factors that are causing a decline in the number of OB/GYNs. In addition, the GAO found—and I am quoting them again—"that many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis."

Unfortunately, this bill is a misguided attempt to solve a health care problem with a tort reform solution. I am disappointed that we are not using this time today to discuss the real issues. One issue I wish we were discussing is class action reform because I think we have come up with an answer that a majority of us could support. Regrettably, we are not spending two days debating that issue. We are debating a bill that is not going to go anywhere because the solution that is being called for does not do the job.

So instead of taking the few valuable days we have in this Chamber to deal with some issues before we adjourn for elections and conventions, we are not debating class action reform, we are

debating a bill that is going nowhere. That does not make any sense to me at all in terms of this agenda. So this is a waste of our time.

Let me get into other areas of health care because there are health care problems that need addressing. I am disappointed, though, that we are not going to debate class action reform but instead these tort reform issues. We do have problems with access to care in our country. We do have a patient safety problem in our country. We do have a health care quality issue in this Nation of ours. We do have a problem with rising health care costs in the Nation. This bill does not answer any of those problems.

Why are we not discussing real solutions to the issue of access to health care, to patient safety, to health care quality in this country, and to the problem of rising health care costs? The American people have a right to expect from this body better answers than the ones we are giving them on this bill dealing with the issue of rising premium costs.

Supporters of this bill are right about one thing: Far too many in this country have little or no access to health care. The latest Census Bureau figures released in September are alarming, to say the least. Forty-four million of our fellow countrymen, more than one out of every seven people in our great Nation, were without health care in the year 2002. This figure represents a 10 percent increase in the number of uninsured since the year 2000.

Numerous studies have shown that being uninsured has a drastic impact on the amount and quality of care individuals receive. Put very simply, the uninsured receive less care, lower quality care, and are at a greater risk of dying. The Institute of Medicine has estimated that every year 18,000 of our fellow citizens die prematurely in this country as a result of the effects of being uninsured.

Our country has a growing health care underclass. The Bush administration's response to this crisis has been woefully inadequate. Tax credits and health savings accounts will do little or nothing to help the vast majority of the 44 million people who are uninsured, such as low-income working families. By the way, the majority of the uninsured work every day on one, two, three, and four jobs. These are not people sitting around doing nothing. They are working. And we have nothing to say to them.

We are debating an issue of tort reform when we ought to be dealing with how to provide some health care coverage for these people and explain why 18,000 lives a year are being lost prematurely because of the lack of health insurance. We should be talking about creative ideas to offer meaningful assistance to the uninsured. There are a variety of ideas out there that are worth discussing.

We also have a health care quality and patient safety problem in the coun-

try. Again, according to the Institute of Medicine, as many as 98,000 Americans are killed every year as a result of medical errors. A study conducted by the Rand Corporation and published in the *New England Journal of Medicine* last year came to a similar conclusion. Individuals received the recommended treatment for their condition in only 55 percent of the cases, according to that study. In other words, nearly half the time patients did not receive the appropriate care. Why are we not debating that and discussing that issue today?

There are a variety of proposals to address this real threat to the American public. I am currently working with our colleagues on both sides of the aisle on issues that would have some real impact on the quality of care in our country. One meaningful step we can take almost immediately is to encourage the use of information technology in the health care setting.

The Senator from New York, Mrs. CLINTON, is deeply interested in this subject matter, as are several other colleagues. Improving quality is the best tool we have to address rising health care costs. Supporters of this legislation we are debating today would have you believe medical liability costs are the main driver of rising health care costs. But that is simply not the case. The Congressional Budget Office has estimated that malpractice costs represent, at most, only 2 percent of the overall health care costs in our country.

We ought to address this issue, but let's talk about it in the context in which it is really a problem. Furthermore, while health care costs more than doubled between the years 1987 and 2001, the total amount spent on medical liability premiums rose by only 52 percent over that same period. The real drivers of health care costs are prescription drugs and hospital spending. We should be using the time to pursue proposals to address these issues, including expanding the use of inexpensive generic prescription drugs, better chronic disease management and preventive medicine, and improving health care quality and efficiency.

Let me finish by saying, as ranking member of the Subcommittee on Children and Families, improving the health of women and children has been a priority of mine and many others who serve on that committee, including the Presiding Officer. If my colleagues are genuinely interested in healthier mothers and healthier babies, I can suggest any number of pieces of legislation that are pending here that would represent real steps towards achieving that goal. I am the coauthor of two bills, the Newborn Screening Save Lives Act and the Prematurity Research Expansion and Education for Mothers who Deliver Infants Early Act, the PREEMIE legislation, that I believe would go a long way towards improving the health and well-being of newborns. During the 107th Congress,

Senator HARKIN introduced the Safe Motherhood Act a comprehensive bill to ensure safe pregnancy for all women. Senator BINGAMAN introduced legislation to expand health care coverage for pregnant women under Medicaid and the State Children's Health Insurance Program.

There are a variety of such bills out there, offered on a bipartisan basis. The Senator from Ohio, Mr. DEWINE, and I have worked very hard on a number of these bills. I am not going to suggest they solve all the problems, but they are designed to deal with some of the very issues pregnant women and infants face every day. The idea that you are going to put a cap on noneconomic recoveries here and that is somehow going to address these other issues is ludicrous on its face. We ought to be spending the valuable time of this institution in debating and discussing and getting some of this legislation passed that could make a difference to these people.

I am not shy when it comes to tort reform. I have spent a good deal of time in my Senate career authoring bills dealing with tort reform. This is not one of them. This is not tort reform. This is not addressing the issue that people face every day and doctors face with rising premiums. There is a way of addressing that problem. When we get around to doing it and working on it, then we can take some pride in passing something that does something meaningful in this area. This bill doesn't do it.

I hope cloture will be denied. I yield the floor.

The PRESIDING OFFICER (Mr. ENZI). The Senator from Ohio.

Mr. VOINOVICH. Mr. President, I rise today in strong support of S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act, and I strongly encourage my colleagues to vote for cloture on the motion to proceed on this very important legislation.

I would like to point out in the beginning of my remarks, in response to some of the statements that have been made on the floor this morning, that there has to be a reason the American College for Obstetrics and Gynecology, the American Medical Association, and just about every medical group in the United States of America is supportive of this legislation. We would not be talking about it unless they really believed the passage of this legislation would have a dramatic impact on the liability costs that OB/GYNs are experiencing, causing so many of them to leave their practices.

This is a personal issue for me. Last summer when my daughter-in-law was expecting her fourth child, she learned that after the delivery, her doctor would no longer deliver babies. At the time, her doctor was in a four-physician group, all of them obstetricians. They never had any lawsuits against them. Yet their insurance premiums had skyrocketed from \$81,000 to over \$381,000 in just 3 years. That is \$75,000

per person over a period of 3 years. How could physicians be expected to afford rate hikes such as these?

We need to be doing something about it. This legislation is going to help. This legislation is so important because the effects of the medical liability crisis can be felt acutely by the obstetrics/gynecology community. Data from the American Medical Association indicates that 19 States currently face a medical liability crisis and 25 States show problem signs. Women of childbearing age have been impacted the most because 1 out of 11 obstetricians nationwide has stopped delivering babies and, instead, has scaled back their practice to gynecology only or just gotten out of the practice. In addition, one in six has begun to refuse high-risk cases.

How does this affect a patient's access to care? As premiums increase, women's access to general health care, including regular screenings for reproductive cancers, high blood pressure, cholesterol, diabetes, and other serious health risks, will decrease. It leads to more uninsured women because of health care costs that have gone up as a result of the fact that malpractice costs have gone up so astronomically in the last couple of years.

In 2002, 11.7 million women of childbearing age were uninsured. Without medical liability reform, a greater number of women ages 19 to 44 will move into the ranks of the uninsured. With fewer health care providers offering full services, the workload has increased significantly for those who still do. Wait times increase, putting women at risk. A physician facing higher premiums is likely to practice defensively, ordering more tests than medically necessary, seeking more opinions, and giving more referrals.

Women receive less prenatal care in our current environment. Improved access to prenatal care has resulted in record low infant mortality rates, an advance now threatened as OB/GYNs drop obstetrics. As some of you may have read, for the first time since 1958, the U.S. infant mortality rate is up. According to preliminary data released this month by statisticians from the CDC, the Nation's infant mortality rate in 2002 was 7 per 1,000 births. That is up from 6.8 in 2001. Some experts are attributing this to poor access to prenatal care, that that is the cause of this problem. Women have less preventive care. Women's general health care is routinely provided by community clinics and OB/GYNs. Women receive fewer screenings for reproductive cancers, high blood pressure and cholesterol, diabetes, and other serious health risks as OB/GYNs and community clinics reduce care.

The ramifications of this medical liability crisis on women's health care are shocking, and we feel this crisis very strongly in Ohio. The Medical Liability Monitor ranked Ohio among the top five States for premium increases in 2002. The OHIC Insurance Company,

among the largest medical liability insurers in the State, has reported that average premiums for Ohio doctors have doubled over the last 3 years.

I would like to point out that the argument that the insurance industry is ripping off doctors and raising rates to make up for investment losses, as some contended here on the floor of the Senate this morning, is preposterous.

I invite those Members who believe this to read an article from Brown Brothers Harriman Insurance Asset Management Group.

I ask unanimous consent that the article be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From BBH & Co. Insurance Asset Management, Jan. 21, 2003]

DID INVESTMENTS AFFECT MEDICAL MALPRACTICE PREMIUMS?

(By Raghu Ramachandran)

It's deja vu all over again in the medical malpractice arena.

Last July, the only trauma center in Las Vegas was forced to close. At the beginning of this year, doctors in Pennsylvania threatened to go on strike but relented when the incoming governor promised to support legislative reforms to limit jury awards in malpractice suits. Also in January, doctors in Weirton, West Virginia went on strike, forcing patients to travel up to 40 miles to find medical care. Doctors in neighboring areas of West Virginia considered joining the strike, threatening a near complete shutdown of the medical delivery system in the region. Doctors and hospitals around the country are suspending their practices and closing their doors because they can no longer afford the huge and increasing cost of medical malpractice insurance. The situation is increasingly reminiscent of the malpractice crisis of the 1970's. What is causing this controversy and what can be done about it?

According to Americans for Insurance Reform (AIR), "insurance companies raise rates when they are seeking ways to make up for declining interest rates and market-based investment losses." Mainstream media, such as The New York Times, have picked up this argument: "The steep drop in bond yields and the stock market has also fueled the crisis." These arguments are both misleading and inaccurate. The root causes of the problem are quite different from what is often suggested by the media, and their resolution is far less simplistic than the pundits imply.

In this paper, we will analyze several variables to demonstrate that asset allocation and investment returns have had little, if any, correlation to the development of the current malpractice problem. The crisis is rather the result of a generally unconstrained increase in losses and, over several years, inadequate premium income to cover those losses.

Given that conclusion, we will then examine several possible solutions and attempt to gauge the magnitude of changes necessary to resolve this problem.

AIR uses the following graph to demonstrate that losses have tracked inflation and that premiums vary because of the economy. The graph attempts to compare two key trends underlying the medical malpractice controversy: premiums per doctor (DPW/MD) and paid losses per doctor (DLP/MD). Both of these variables are expressed in constant medical dollars.¹

¹Graphs not reproducible in the Record.

LOSS INFLATION

AIR claims this shows "that since 1975, medical malpractice paid claims per doctor have tracked medical inflation very closely." In fact, the graph and the underlying data suggest exactly the opposite. First, they make an erroneous comparison. Since AIR uses real (or constant) medical dollars, they have already factored out the effect of medical inflation. So, any increase is a "real" increase in excess of medical inflation. One cannot compare real increases to inflation.

Second, the data show loss costs have increased significantly faster than inflation. Using data from the AIR report, we plotted medical inflation (CPI-U), premiums, and losses to show how each has grown since 1975.

One sees that the losses per doctor have grown at a much higher rate than either medical inflation or premiums per doctor. In order for losses in 2001 to have equaled the build up created by inflation in medical care during the period 1975-2001, companies would have to reduce the amount of paid losses by approximately 60%. Therefore, losses, not inflation, are the problem.

ECONOMIC EFFECT

The other claim made by AIR is that "insurance premiums (in constant dollars) increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the gains or losses experienced by the insurance industry's market investments and their perception of how much they can earn on the investment 'float.'" Unfortunately, they make this claim without any supporting analysis. Using the premium data from AIR, we found no correlation between premiums and the economy.

The standard measure of the effect one variable has on another is the coefficient of determination (r²); this value shows how consistently two variables move in the same direction. The coefficient of determination has values between 0 and 1. A value of 1 means that if the first variable moves up the second will move up at the same time; a value of zero means that there is no similarity in the movement of the two variables. The correlation coefficient has to be greater than 0.75 for us to claim the observed effect between the two variables is significant.

As a measure of the economy, we used the year-over-year change in GDP; as a measure of investment yield, we used the yield on a 5-year Treasury note. In our analysis, neither the direct premiums written nor the direct premiums per doctor showed any significant correlation to either the investment yield or GDP variable. The table lists the coefficients of determination generated by the regression analysis between the economy, investment yield, and medical malpractice premiums.

	GDP	Yield
DPW	0.0001	0.1255
DPW/MD	0.0104	0.0318

Several other analyses also failed to show a correlation between premiums and the economy. To test if the premium increases are related to the economy or bond market, we analyzed the correlation of the change in premiums to GDP and investment yield. To test whether premiums go up when the investment yield goes down, we analyzed the correlation between premiums and the change in yield as well as the correlation between the change in premiums and the change in yield.

One could reasonably claim that the premiums (or increases in premiums) are dependent not upon the company's performance this year but upon the company's performance in the previous year. To test this hypothesis, we regressed both premiums and

change in premiums to both the economy and investment yield in the previous year. For thoroughness, we also analyzed the correlation between both premiums and change in premiums with the change in yields in the prior year.

We also considered alternate measures for GDP and yield. We used industrial production as an alternate measure of the economy and the 10-year Treasury note as an alternate measure of yield. We also analyzed the effect the slope of the yield curve and the change in slope had on premiums. We performed all of the analyses above on these new variables.

In 64 different regressions between the economy, yield, and premiums, the highest coefficient of determination was 0.1505. Therefore, we can state with a fair degree of certainty that investment yield and the performance of the economy and interest rates do not influence medical malpractice premiums.

STOCK MARKET EFFECT

But what about the stock market? How did the drop in the equity markets affect insurance company performance? Are companies raising premiums because they lost money on Enron or WorldCom?

Obviously, the market decline affects insurance companies like every other investor, but the magnitude of the losses gets lost in the media hype. We analyzed the equity exposure in two stages. Stage one: Did medical malpractice companies have an unusually large amount of equities in their portfolio? Stage Two: Given their level of equity exposure, did they invest prudently in the market or did they gamble by investing in technology or telecom stocks?

Using NAIC filings, we can determine the amount of assets invested in equities.

Over the last five years, the amount medical malpractice companies have invested in equities has remained fairly constant. In 2001, the equity allocation was 9.03%. We can also compare how the medical malpractice sector compares to other P&C sectors.

This graph shows that medical malpractice companies have less invested in equities than other sectors of the industry.

Even if the equity allocation is not large relative to the industry or other insurance sectors, is 10% the correct amount for medical malpractice insurers to invest in equities? Insurance companies invest their assets as a fiduciary of the policyholders. As such, they must invest according to a "prudent investor" standard. This requires the company not only to consider the risk in an individual security, but also the risk to the portfolio as a whole. Prudent investors know that diversifying across asset classes can enhance return and reduce volatility. A simple analysis shows a conservative investor will have at least 10% invested in equities. Thus, a prudent insurance company should have some allocation to equities.

If the degree of equity exposure was not unusual, was the investing? Again using NAIC filing data, we can analyze the distribution of equity investments for medical malpractice companies and compare it to S&P performance.

(In percentage)

Sector	Medical malpractice companies	S&P sector return
Energy	5.6	-11.0
Materials	1.9	-5.4
Industrials	11.9	-26.2
Consumer Discretionary	15.9	-23.7
Consumer Staples	7.3	-4.3
Healthcare	14.1	-18.8
Financials	17.8	-14.5
Technology	17.9	-37.4
Telecom	6.3	-34.0
Utilities	1.4	-29.5

(In percentage)

Sector	Medical malpractice companies	S&P sector return
	100.0%
Total Return	-22.4%	
S&P Return	-22.2%	

We see that medical malpractice companies had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy.

As medical malpractice companies did not have an unusual amount invested in equities and since they invested these monies in a reasonable market-like fashion, we conclude that the decline in equity valuations is not the cause of rising medical malpractice premiums.

WHERE DO WE GO FROM HERE?

In order for any form of insurance coverage to be viable, the insurance company must receive more in premium dollars and investment income than they pay in losses and expenses. A simple measure of this is the ratio of paid losses to premiums. Over the last 27 years, and especially over the last 16, the paid loss ratio in medical malpractice coverage has steadily increased. Without some form of relief, this is not a good sign.

Although the paid loss ratio is a good starting point, that metric excludes other expenses such as incurred losses, loss adjustment expenses, general operating expenses, etc. as well as income from investments. A.M. Best provides the combined loss ratio (paid loss + change in reserves + expenses) for the medical malpractice industry. By subtracting the paid loss ratio, from the AIR report, from the combined ratio, we can get an estimate of the other expenses for an insurance company. The average expense ratio for medical malpractice companies was 43% when investment income is included and 74% when investment income is excluded.

Over the last 27 years, the average paid loss ratio was 47% and the minimum paid loss ratio was 16%. In 2001, the industry paid loss ratio was nearly 75%. In other words, for every dollar that comes in the door, 75 cents is paid out. When combined with the expense ratios cited earlier, it is clear that it has been extremely difficult—if not impossible—for insurance companies to earn a profit writing medical malpractice insurance. Further, at this rate of expenditure, after the company pays its losses and expenses, there is very little "float" on which they can earn investment income.

Medical malpractice paid loss ratio 1975-2001

	In percent
Average loss ratio	46.8
Minimum loss ratio	15.9
2001 loss ratio	74.4

To increase profitability, companies must effect one of three changes: reduce their losses, increase their premiums, or increase their investment income. As the industry, in aggregate, cannot control return on investments, they have only two choices. Using the methodology above, we can estimate the magnitude of the change required to restore profitability to the industry.

If losses are held constant—i.e., no change in loss and expense trends, then we are left with increasing premiums to restore the industry to profitability. For premiums to have kept up with medical inflation for the period 1975 to 2001, they would have to increase by 41%. For premiums to have kept up with the increases in paid losses since 1975, they would have to increase by 325%. For the industry's average loss ratio to drop back to its 27-year average, premiums would need to rise by 59%. For the loss ratio to drop to its

nadir during that period, premiums would have to increase by 368%.

Dollars % Increase

2001 DPW/MD	\$9,719	
Premium required for:		
Average Loss Ratio	15,448	59
Minimum Loss Ratio	45,478	368

Clearly, increases of this magnitude are intolerable, for both the industry and state regulators. In this regard, St. Paul's experience is noteworthy. Prior to its withdrawal from the market, the company was granted 31% less in rate increases than indicated. It is little wonder that they responded as they did!

ST. PAUL RATE FILINGS

(In percentage)

State	Date	Indicated increase	Increase filed	Difference
1	1/1/2001	76.10	25.00	40.90
2	3/7/2001	-34.30	-43.00	15.30
3	1/1/2001	54.50	35.00	14.40
4	6/1/2000	39.20	5.00	32.60
5	11/1/1999	28.70	5.00	22.60
6	1/1/2001	55.20	10.00	41.10
7	2/1/2001	18.90	-21.00	50.50
8	1/1/2001	90.80	35.00	41.30
9	1/1/1999	18.50	5.00	12.90
10	1/1/2002	73.00	35.00	28.10
11	1/1/2001	26.80	12.50	12.70
12	1/1/2002	70.20	45.00	17.40
13	1/1/2002	67.30	40.00	19.50
14	1/1/2001	49.30	10.00	35.70
15	10/1/1999	88.10	5.00	79.10
16	1/1/2002	71.00	10.00	55.50
17	1/1/2002	82.60	45.00	25.90
18	7/1/2000	12.50	0.00	12.50
19	7/15/2000	57.00	7.50	46.00
20	7/1/2000	17.10	5.00	11.50
21	1/1/2000	40.90	5.00	34.20
22	7/1/2000	58.90	8.50	46.50
23	1/1/2001	50.70	15.00	31.00
Average		48.40	13.00	31.60
Average excluding #2		52.20	15.60	32.40

St. Paul had the luxury of falling back on other lines of business. Unfortunately, many special medical malpractice companies, such as state PIAA companies, do not have other lines of business to fall back on.

RATING AGENCY RESPONSE

The reaction of rating agencies to these trends is another important ingredient in the medical malpractice landscape. Principal concerns of the agencies are "solvency" and the "leverage" built into the premium and surplus structure of the industry. While agencies usually express the benchmarks for the measurements (ratios) in ranges, trends are also important. Either level or trend can result in a downgrade in a company's rating, a serious event in the corporate life of an insurer.

In 2001, medical malpractice companies had an average premium-to-surplus ratio of 0.72. As premiums are increased, this ratio will rise. If premiums rise too quickly, we would observe a spike in this ratio as it takes time for the increased premiums to show up in surplus. Unless rating agencies account for this, a company could find they cannot raise their rates by the required amount for fear of impairing their rating. In fact, several companies have been downgraded recently, with premium leverage given as the primary reason. (The situation is exacerbated by the fact that with the industry suffering from reduced capacity as a result of the St. Paul type experiences, companies are adding to their number of insureds. This puts further strain on their leverage ratios.) Fortunately, the rating agencies seem to be aware of the problem.

TAMING LOSSES

If companies cannot increase their premiums, then they must be able to control the burgeoning increase in losses. Our analysis suggests that the level of losses would

have to decrease by 37% to achieve the average loss ratio and by 79% to obtain the minimum loss ratio observed over the past 27 years. Such reductions would require significant change in the tort environment.

	Dollars	% decrease
2001 DLP/MD	\$7,232	
Losses required for:		
Average Loss Ratio	4,549	-37
Minimum Loss Ratio	1,545	-79

The paid loss number cited above includes both jury awards and settlements. Large jury awards have the pernicious effect of enticing more lawsuits, most of which are settled out of court but with an expense to the company. Prudent reforms, such as MICRA, reduce not only the jury awards but also reduce the amount of lawsuits filed.

SUMMARY

The magnitude of these changes suggests that the eventual solution to the current malpractice problem will be a blend of premium increases and tort reform. Since the financial shortfall compounds itself over time, it is imperative that the solution set be developed as quickly as possible. Without significant relief in fairly short order, the country may find itself facing an accelerating loss of available medical care.

Mr. VOINOVICH. The subject of the article is "Did Investments Affect Medical Malpractice Premiums?" It concluded:

... asset allocation and investment returns have had little, if any, correlation to the development of the current malpractice problem.

The article goes on to say:

The crisis is rather the result of a generally unconstrained increase in losses and, over several years, inadequate premium income to cover those losses.

The article also goes on to say:

We see that medical malpractice companies had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy. As medical malpractice companies did not have an unusual amount invested in equities and since they invested these moneys in a reasonable market-like fashion, we conclude the decline in equity valuations is not the cause of rising medical malpractice premiums.

Finally, I will finish up with a summary:

The magnitude of these changes suggests that the eventual solution to the current malpractice problem will be a blend of premium increases and tort reform. Since the financial shortfall compounds itself over time, it is imperative that the solution set be developed as quickly as possible. Without significant relief in fairly short order, the country may find itself facing an accelerating loss of available medical care.

And I contend that acceleration is well underway not only in OB/GYN but in other aspects of the medical profession.

According to a November 2000 study of the American College of Obstetricians and Gynecologists, 59 percent of responding Ohio OB/GYNs have been forced to make changes to their practice such as quitting obstetrics, retiring, relocating, decreasing gynecological surgical procedures, no longer performing gynecologic surgery, decreasing the number of deliveries, and/or decreasing the amount of high-risk obstetric care because of unaffordable

and unavailable medical liability insurance. Of the respondents, 86 percent no longer practice obstetrics, which forces a potential of some 14,000 pregnant Ohio women to find new OB/GYNs to provide their obstetric care.

This is not the statistics. I have received dozens of testimonials from doctors saying they are quitting their practice because of the rising cost of medical liability insurance. A friend of mine shared with me a letter from an OB/GYN in Dublin, OH, who decided to retire from his practice.

He wrote the following to his patients:

On June 17, 2003, I received my professional liability insurance rate quote for the upcoming year, and it is 64% higher than last year's rate. I have seen my premiums almost triple during the past two years, despite never having had a single penny paid out on my behalf in twenty-seven years as a physician. Even worse, during this time the insurance company has reduced the amount of coverage that I can purchase from \$5 million to only \$1 million, while jury verdicts have skyrocketed, often exceeding \$3-4 million. If I were to purchase this policy, I would be putting all of my family's personal assets at risk every time that I delivered a baby or performed surgery. I refuse to do that.

I have therefore decided to retire from private practice on July 31, 2003, the final day of my current liability insurance policy. This is not a decision that I take lightly, but unfortunately it has become necessary. For many of you, I have been part of your life for years. I have delivered your babies, and helped you through some of life's most difficult challenges. It has truly been an honor.

I received another letter from Dr. Ben Alvarez. He worked for Beachwood OB/GYN. He sent a letter informing his patients he was relocating to Minnesota this March. He says, in part:

The decision to leave Ohio is the direct result of the medical malpractice crisis: with a clean record, my annual premium will reach well over \$100,000 this July. I cannot, and will not, in good conscience play the insurance company's game—it's just that simple. What's not simple is saying good-bye to a town and people that have given me so much. Ob/Gyn is so different from other medical specialties due to the emotional and personal relationships that exist between us. I have been blessed to have experienced with so many of you the joy of a new baby's arrival; prayed about the outcome of surgery; and also shared the painful moments.

I ask unanimous consent to have the complete letter printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

BEACHWOOD OB/GYN, INC.,
Lyndhurst, OH, January 4, 2004.

MY DEAREST PATIENTS: It is with a heavy heart that I inform you that I shall be relocating to Minnesota in March. The decision to leave Ohio is the direct result of the medical malpractice crisis: with a clean record, my annual premium will reach well over \$100,000 this July. I cannot and will not, in good conscience play the insurance company's game—it's just that simple.

What is not simple is saying good-bye, to a town and people that have given me so much. Ob/Gyn is so different from the other medical specialties due to the emotional and personal relationships that exist between us. I have been blessed to have experi-

enced with so many of you the joy of a new baby's arrival; prayed about the outcome of a surgery, and also, shared the painful moments. Indeed, it is I who thank God for having met you, for, because of you, I have become a better, more complete, human being.

Do not despair over the continuity of your care. My colleagues in the practice will keep the ball rolling. From a practical standpoint, I would encourage you to set up follow-up appointments with any one of the doctors. Drs. Varyani and Goldshmidt have schedules that allow for more flexibility, but Drs. Bellin, Evans, Klein and Vexler are also available to continue your care. They are all excellent doctors and have my complete confidence.

Farewell, my friends, and the best to you and your families.

With sincere affection and melancholy.

BEN ALVAREZ,

MD.

Mr. VOINOVICH. After speaking at a physicians' rally in Ohio, I received a letter from a young doctor, Geoff Cly. Dr. Cly received a notice from the insurance carrier that the premiums would increase by 20 percent, \$30,000, this plus the \$20,000 increase from the year before, forcing him to make a difficult decision of uprooting his family and practice to go to another State. Doctor Cly was unable to make the insurance premiums and still take care of his student loan obligations and his family. He moved to Fort Wayne, IN. He said to me: Senator, I am going to Indiana. My liability insurance will be less there. But the practice has gotten so much different than what I anticipated it to be that I am seriously thinking, after I pay off my college loans, I am going to get out of medicine.

It is a tragedy what is happening today in my State and other States throughout this country. For those of my colleagues who think medical liability reform is a State issue, I ask them to read this letter and see how the medical liability crisis transcended State lines, particularly my friends from the neighboring State of West Virginia. Our Ohio physicians who practice along the border are feeling the effects of their proximity to West Virginia and its favorable plaintiffs' verdicts. They are feeling these effects in their increasing insurance premiums.

It is amazing the number of counties along the West Virginia border and eastern Ohio where they have no more OB/GYNs. They just left. These counties go bare, with no OB/GYN to provide services to protect women.

I could go on and give more and more examples of Ohio physicians who had to leave the practice of medicine. Dr. Komorowski of Bellevue stopped delivering babies after 20 years when he found out the day after Christmas last year that his liability insurance was tripling to more than—listen to this—\$180,000. Dr. Komorowski, the only obstetrician in Bellevue, figured it would cost him nearly 11 months of his salary to pay the premium increase in addition to taxes and other expenses.

It is out of control. We need to do something now, not just for Ohio but

for the rest of the country as well. Obstetrics/gynecology is among the top three specialties in the cost of professional liability insurance premiums. Nationally, insurance premiums for OB/GYNs have increased dramatically. The median premium increased 167 percent between 1982 and 1998. The median rate rose 7 percent in 2000, 12½ in 2001, 15.3 in 2002, with increases as high as 69 percent according to a survey by the Medical Liability Monitor, a newsletter covering the liability insurance industry.

According to the Physicians Insurance Association of America, OB/GYNs were first among 28 specialty groups in the number of claims filed against them in 2000. OB/GYNs were the highest of all the specialty groups in the average cost of defending against a claim in 2000 at a cost of almost \$35,000. In the 1990s they were first, along with family physicians, general practitioners, in the percentage of claims against them closed with a payment of 36 percent. They were second after neurologists in the average claim payment made during that same period.

Although the number of claims filed against all physicians climbed in recent decades, the phenomena do not reflect an increased rate of medical negligence. In fact, OB/GYNs win most of the claims filed against them. In 1999, an American College of Obstetricians and Gynecologists survey of its membership found that over one-half, 54 percent of claims against OB/GYNs were dropped by plaintiff attorneys, dismissed or settled without payment; 54 percent of the cases that did proceed. OB/GYNs won 7 of 10 times. Enormous resources are spent to deal with these claims, only 10 percent of which are found to have merit.

The cost to defend these claims can be staggering and often mean that physicians invest less in new technologies that help patients. In 2000, the average cost to defend a claim against the OB/GYN was the highest of all physicians.

According to the American College of Obstetricians and Gynecologists, the typical OB/GYN is 47 years old, has been in practice for 15 years and can expect to be sued 2.53 times over his or her career. Over one-quarter of the residents have been sued for care provided during their residency. And that is another problem we are seeing in this country: Many residencies are going unfulfilled because of the medical malpractice lawsuit abuse growth in this country. Medical school enrollments have been impacted by what young people are seeing happening in the medical profession in this country.

In 1999, 76 percent of the American College of Obstetricians and Gynecologists fellows reported they had been sued at least once so far in their career. The average claim takes over 4 years to resolve. I know from anyone who has been the subject of a lawsuit that 4 years is 4 years of stress as they worry about what is going to happen as a result of the outcome of that litigation.

The legislation we are debating today gets us on our way to turning these statistics and stories around. It provides a commonsense approach to our litigation problems that will help keep consumers from bearing the cost of costly and unnecessary litigation while making sure that those with legitimate grievances have recourse through the courts.

Throughout my career in public service, health care has been one of my top legislative priorities. We all want access to quality, affordable health care. We do have a problem in this country in terms of access to quality health care. In my State, I have conducted eight listening sessions. The result from all those sessions, regardless of who was there, is that the system is broken, and we need to plow new ground.

When the quality is not there, when people die or are truly sick due to negligence or other medical error, they should be compensated. We want that. But when healthy plaintiffs file meaningless lawsuits to shake the money tree to get as much as they can get, there is a snowball effect and all of us pay the price.

The last time I spoke on this subject, I had the front and back cover of the white pages and the yellow pages of the Cleveland phonebook. The front cover and back cover of both of them were advertisements for personal injury lawyers giving specific examples of encouraging people to file suits based on the information they had in their advertisement.

For the system to work, we must strike a delicate balance between the rights of aggrieved parties to bring lawsuits and the rights of society to be protected against frivolous lawsuits and outrageous judgments that are disproportionate to compensating the injured and made at the expense of society as a whole.

I have been concerned about this issue since my days as Governor of Ohio. In 1996, I essentially had to pull teeth in the Ohio Legislature to pass a tort reform bill. I signed it into law in October of 1996. Three years later, the supreme court ruled it unconstitutional. If that law had withstood supreme court scrutiny—and it should have; we now have what I call a balanced supreme court in Ohio—Ohioans would not be facing the medical access problems they face today: Doctors leaving their practice, patients unable to receive the care they need, and the cost of health insurance going through the roof.

During my time in the Senate, I have continued my work to alleviate the medical liability crisis. To this end, I have worked with the American Tort Reform Association to produce a study in August of 2002 that captured the impact of this crisis on Ohio's economy in order to share these findings with my constituents and colleagues. Guess what we found. What we have in this country today, in my opinion, not only

in this area but in a lot of areas, is a litigation tornado that is ripping through the economy. We found in Ohio that the litigation crisis costs every Ohioan \$636 per year and every Ohio family of four \$2,544. These are alarming figures, and the numbers are from 2 years ago. Which family do you know that can pay \$2,500 for the lawsuit abuse of a few individuals?

Next to the economy and jobs, the most important issue facing our country today is health care. In fact, it is a major part of what is wrong with the economy. We have too many uninsured, and those who have insurance face soaring premiums every year, making it less likely they can continue to pay them. In addition, employers are facing spiraling costs and in some cases don't even provide insurance.

I have talked to one employer after another. They say: I want to provide health insurance for my workers, but I cannot afford to do it at \$10,000 for a family of four. I am asking my employees to pay more of the premiums. In many instances my employees cannot afford to pay the premiums so they are going without health insurance.

We have a real problem. Medical malpractice lawsuit abuse reform is having a dramatic impact on the cost of health insurance, in spite of what some of my colleagues have said. Providing the sort of commonsense approach found in the Healthy Mothers and Healthy Babies Access to Care Act is a win-win situation. The bill will help decrease the rising cost of health care. It will give patients access to care and it will curtail the rising cost of medical liability insurance for those physicians who provide prenatal delivery and postpartum care to mothers and babies.

Patients will not have to give away large portions of their judgments to their attorneys. Truly injured parties can recover 100 percent of their economic damages. Punitive damages are reserved for those cases where they are truly justified. Doctors and hospitals will not be held liable for harms they did not cause and physicians can focus on what they do best—practicing medicine and providing health care.

I urge my colleagues to vote for cloture so we can debate this issue and have an up-or-down vote on this legislation impacting on our most important patients: Pregnant women and their newborn babies.

There was some mention made of the General Accounting Office study of the medical liability crisis and access to care. I ask unanimous consent to have printed in the RECORD the response of the American Medical Association to that General Accounting Office report. It is very important.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MEDICAL LIABILITY CRISIS AND ACCESS TO CARE—AMA'S RESPONSE TO THE GENERAL ACCOUNTING OFFICE, SEPTEMBER 2003

The U.S. General Accounting Office (GAO) recently released two reports related to

America's medical liability crisis. [U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (June, 2003); and *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (August, 2003)]. The first report (June 2003) confirms that, since 1999, medical liability premiums skyrocketed in some states and specialties—and increasing settlements and jury awards ("paid claims") are the primary drivers for these increases. The second report (August 2003) confirms that America's medical liability crisis is causing access to health care problems in high-risk medical specialties and in select locations throughout America.

The GAO reports also confirm what the American Medical Association (AMA) has long held to be true—tort reform works. Medical liability premiums in states with strong caps on non-economic damages grew at a slower rate than states without caps on non-economic damages.

We appreciate the GAO's efforts and recognize that it is difficult to quantify the medical liability crisis. Among its findings, the GAO confirmed that:

Increased losses on claims are the primary contributor to higher medical liability premium rates (GAO 03-702, p. 15);

Premiums were higher (GAO 03-702, p. 14) and grew more quickly (GAO 03-836, p. 30) in states without non-economic damage caps than in states with non-economic damage caps;

Physician responses to medical liability pressures in the five crisis states have reduced access to services affecting emergency surgery and newborn deliveries (GAO 03-836, p. 5);

Similar examples of access reductions attributed to medical liability pressures were not identified in the four non-crisis states without reported problems (GAO 03-836, p. 5);

Insurers are not charging/profitting from excessively high premium rates (GAO 03-702, p. 32); and

None of the insurance companies studied experienced a net investment loss (GAO 03-702, p. 25).

However, the GAO's August report fails to accurately reflect the severity of the current crisis. Numerous changes to the GAO methodology would strengthen the basic findings of this report. Among the data sources, measures, or analytical methods that could be improved:

Examine all crisis states. To date, the AMA, in conjunction with its federation of state medical associations, has identified 19 states in a medical liability crisis. The GAO investigated access problems in only five of those states. In each of those states it found examples of reduced access to care. The GAO would have found similar access problems if it had examined the other 14 crisis states. In fact, the GAO did not identify any access problems in the four non-crisis states it examined. Therefore, the GAO's conclusion that access problems are not widespread is not substantiated.

Recognize increased impact on rural areas. Health care access problems do not have to affect every part of a state to create crisis conditions. Health care by its nature is local, where a loss of just one or a few physicians or other health care providers in a community can have a traumatic impact on the availability of health care services in that community. Many rural areas suffered from physician shortages prior to the recent escalation in liability premiums. It is precisely in those areas where access is already threatened that one would first notice the impact of physician's relocation or curtailment of certain services.

Appropriately measure physician mobility. Physician counts were based on state licen-

sure data, which do not accurately reflect the number of physicians practicing in a given location. Actual physician practice location information must be used instead.

Relying on the total number of licensed physicians is a state to track physician mobility is inappropriate. According to James Thompson, MD, President and CEO of the Federation of State Medical Boards of the U.S. (FSMB) in September 2003: "The number of licensed physicians in a state is not an accurate measure of whether patients have adequate access to health care. Physicians may reduce their practice, stop treating high-risk patients, or stop practicing altogether and still maintain their license. Also, the number of licensed physicians is not an accurate indicator of the distribution of those physicians in underserved areas. Licensed physicians may work in administrative, academic or other settings where they may not have a clinical practice. Also, many retired physicians maintain a license. Information in the Federation of State Medical Boards' database shows that approximately 60% of physicians are licensed in more than one state which indicates that they are licensed in states where they do not maintain a full-time or part-time practice."

Accurately count physicians by specialties and local markets. The GAO's method of measuring physician supply and potential access to care is not appropriate. Physician/population ratios that aggregate physicians across local markets and specialties obscure the significant market-specific or specialty-specific changes in the supply of physicians and availability of critically important medical services. Similarly, the number of high-risk sub-specialists that depart from any locality would likely account for only a small percentage of physicians in the state.

Use multi-payor data to accurately measure access to health care services that Medicare data alone do not capture. Utilization statistics based exclusively on data from a single payor (Medicare) exclude data for obstetric and emergency care, and fail to capture the impairment of access among other vulnerable populations, such as Medicaid patients. Medicare data are inadequate to identify changes in obstetric services because a vast majority of Medicare eligible beneficiaries are beyond reproductive age. Limitations in the data also preclude an assessment of changes in emergency room services. Therefore, the report significantly understates the impact of rising liability insurance premiums because it does not examine two clinical areas in which impairment of patient access has been the most severe—obstetric and emergency room services.

The AMA will continue to advocate on behalf of patients and physicians for national reforms similar to those already passed by the U.S. House of Representatives. America's patients are the ones who will suffer if Congress does not act soon. This is a crisis. It is not waning, and without real reforms more patients will be unable to find a doctor to deliver a baby, perform life-saving trauma surgery, or provide other critical care to high-risk patients who need it most.

Mr. VOINOVICH. I will summarize quickly some of the conclusions. It says: The GAO August report fails to accurately reflect the severity of the current crisis. Numerous changes in the GAO methodology would strengthen the basic findings. Among the data sources, measures, analytical methods that could be improved: Examine all crisis States. To date, the AMA, in conjunction with its federation of State medical associations, has identified 19 States that have a medical liability crisis.

They also suggest recognizing the increased impact on rural areas, which GAO did not do; approximately measure physician mobility. Physician accounts were based on State licensure data which do not accurately reflect the number of physicians practicing in a given location. Actual physician practice location information must be used instead.

They should accurately count physicians by specialties and local markets and use multi-payor data to accurately measure access to health care services that Medicare data alone do not capture.

I can tell you I have not completely read the GAO report, but I have read portions of it. Its connection to reality in my State is not there. I have talked to David Walker about it. I have talked to the people who did the report and encouraged them to look at some of the suggestions the AMA made and perhaps do another study that would accurately reflect what is really going on today in this country in terms of medical malpractice increases and what it is doing to access to health care.

I would like to end my remarks with the words of Dr. Evangeline Andarsio. Dr. Andarsio is an OB/GYN from Dayton, OH. I met Dr. Andarsio at a physicians rally in Ohio. I will never forget that day. It was October of 2002. It was very cold. I was freezing. In fact, when I got up, my teeth were chattering. But prior to my getting up, Dr. Andarsio started to speak. I thought to myself, this doctor is just going to go on and on and on. And I was cold. But as she started, as I listened intently to what she was saying, I was moved by her remarks. This was truly a dedicated physician who loved her patients, loved what she was doing, and who was unable to practice medicine the way she wanted to because of this malpractice lawsuit abuse problem she is confronted with in our State.

I would like to close with a quote from her speech:

Help us to maintain an ability to have a practice that offers patients excellent access to care—to continue one of the most important relationships in our lives—the doctor-patient relationship—thus maintaining individualized and compassionate care.

That is what much of this debate is about. It is about physicians being able to practice medicine and do it in a way they did back when my wife Janet and I were having our four children. There is a special relationship between an OB/GYN and a family. It breaks my heart to see so many of them leaving the practice of medicine because of these malpractice costs with which they are confronted.

We do have a crisis. This Senate is going to have to face up to it. I am hoping that we will have 60 votes today on cloture on the motion to proceed. I think we need to debate this issue. This issue has to be debated and the American people who are not aware of the crisis need to be made aware of it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. GREGG. Mr. President, what is the present situation relative to time?

The PRESIDING OFFICER. The Senator's side has 37 minutes and the other side has 12 and a half minutes.

Mr. GREGG. The Senator from Florida wanted 20 minutes. I ask unanimous consent that he be allowed to proceed after I speak for 20 minutes, but to the extent his time exceeds 12 minutes, it be debited against the time of the Democratic membership after we come back from the policy lunches.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. GREGG. Mr. President, I congratulate the Senator from Ohio for an excellent statement outlining the gravity of the problem we face, which is that women in this country are losing access to OB/GYN doctors, especially if they want to have babies. As a result, we are putting a lot of pressure on a lot of people—women, specifically, in their birthing years—and making it difficult, especially in rural areas, to get the type of health care we want them to get.

We are a society that is built around the concept of babies and children, and that is one of the more exciting things that happens in everybody's lifetime. Yet we are a society making it extraordinarily difficult now for doctors who practice the delivery of children and babies to practice their trade.

As I have said before, lawyers don't deliver children. Doctors deliver children. Unfortunately, the doctors are being driven out of the business by attorneys, and the cost of their malpractice premiums are going up radically. As a result, many doctors in my State are not delivering children anymore. I went through the specifics of that yesterday. I want to read a compelling letter I received from Debbie Risteen. She lives in Derry, NH. She has six children.

She wrote:

I regret I could not be here with you in person today to tell you my story myself, as it would have been quite an honor for me. Let me tell you a little about myself. I am a mother of 6 whose ages range from 12 to 8 months. I love children and I homeschool. One of my favorite things of our married life has been being pregnant and delivering our babies. What an incredible time all 6 have been!

I would like to describe to you a word picture for a moment. . . . It was a very difficult decision for me to decline coming to speak to you all today. One that took a lot thought. I need to weigh the cost at such a short notice. As much as I wanted to be here today, my family needed me more. If anything happened especially with the baby . . . I would be so far away to be able to meet the need and it would take me awhile to get to NH. In this picture, I now want you to see the importance of a pregnant woman needing the care of her OB. Someone she can depend on, trust in the decisions that lie ahead and most of all close in case of an emergency just like my family is depending on me.

You see, my heart was broken this Christmas when I learned of our dear friend, Dr. Pat Miller, would not be doing what was closest to her heart . . . delivering babies. I could not believe it, you are so wonderful at this, people need you, I would tell her.

12½ years ago we made one of the biggest decisions of our lives . . . to begin a family. When we got the exciting news, we were busy looking for the best care, a doctor who was up on the latest, one who could handle complications, a hospital close by, and the list went on. We learned of a new OB in the area . . . Pat Miller. We heard she was all the things we were looking for and more. We were thrilled to be in the care of someone as wonderful as her. Through all of our visits we became very close friends and I knew she truly cared about me, the child, and my husband. Being our first and not knowing what to expect, I knew she was right there if anything was to happen and I trusted her wisdom to do what was best for the both of us. As a matter of fact, 3 of our children were born on her day off and she spent the day at the hospital in case we needed her for any emergencies. It was a tremendous comfort not only to me through these 9 months, but also for my husband to know we were in the best care and it was close. We knew that no matter what lied ahead she was there and would make the best choices. As our family began to grow it was a huge help to have her close by, especially when bringing 1 then 2 and so on with me. I have been so fortunate through 6 pregnancies to not have any complications, but as we all know, there are no guarantees to this. Other women are not as fortunate as me, but I would love for them to be able to have the same comfort and trust that I have experienced with our OB. I love our children dearly, and I love babies, and my hearts desire in sharing my story with you, is for legislators to hear 1st hand the importance of people, like Pat Miller, to be able to continue what she loves and does best. To be able to provide an environment in which OB's can continue to deliver babies. To allow other mothers the same opportunity of trust and friendship that we still have today with our OB. Please listen to my heart . . . we need people like Pat Miller back in OB where she does what she knows best. Thank you for listening.

Sincerely,

DEBBIE RISTEEN.

That is a pretty compelling letter. It is anecdotal, but it is an anecdote happening across this country. Stories are being retold. Women are losing their OBs because these physicians are getting out of the practice of delivering babies because of the cost of their malpractice insurance. This bill will help alleviate that problem, and it is absolutely critical to give women this access and to not do things extremely discriminatory against women, and especially women who wish to become pregnant and have children.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. McCONNELL. Mr. President, I rise today in support of S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act, the principal sponsors of which were Senator GREGG and Senator ENSIGN.

Much of America cannot access basic medical services because lawsuits are driving insurance premiums through the roof and driving doctors literally out of business. Seven months ago a

majority of Senators voted to try to do something about this problem. Unfortunately, not a single Democratic Senator supported our effort and therefore we could not overcome a filibuster and were prevented from even considering S. 11, the Patients First Act of 2003.

In the last 7 months, the crisis has gotten no better. That is the bad news. The good news is our resolve has not waned so again we are before the American people waiting and willing to roll up our sleeves to fix this problem if our friends on the other side of the aisle will let us have a chance.

Like the bill we offered last July, the reforms we are now proposing are tried and true. They are based on California's MICRA legislation, which for a quarter of a century has stabilized insurance premiums and helped ensure access to health care for those in the Golden State. The Healthy Mothers and Healthy Babies Access to Care Act would allow plaintiffs to recover unlimited economic damages, up to a quarter million dollars in noneconomic damages, and punitive damages up to the greater of a quarter million or twice economic damages.

While the reforms in S. 2061 are similar to those in MICRA and S. 11, the scope of S. 2061 is much more narrow. The bill we are asking the Senate to begin considering today pertains only to obstetrics and gynecological services. If our friends across the aisle will not help us protect all medical professionals with MICRA-type reforms, then perhaps they will let us take this important step toward reform by protecting at least one specialty.

OB/GYNs provide some of the most critical medical services in our country. Unfortunately, OB/GYNs also suffer from some of the highest premiums. As a result, women and children across our country are placed in danger as they struggle to find, oftentimes unsuccessfully, basic obstetric care. This is a nationwide problem. Data from the American College of Obstetricians and Gynecologists illustrates the legal and financial jeopardy faced by OB/GYNs across our country today.

Obstetrics and gynecology are among the top three specialties with the highest professional liability insurance premiums. OB/GYNs were No. 1 among 28 specialty groups in the number of claims filed against them. OB/GYNs were also the highest of all specialty groups in the average cost of defending against a claim. OB/GYNs are also facing enormous increases in the average payout of claims brought against them.

For example, back in 1996, the average award against an OB/GYN was \$254,495. Between 1996 and 1998, the average award went up to about \$350,000—from \$250,000 up to \$350,000 in 2 years. By 2000, the average award against an OB/GYN had increased to about \$400,000. That is an increase of almost 40 percent in 4 short years.

This phenomenon is even more striking when one looks at cases involving alleged brain injuries to newborns.

Such cases account for 30 percent of all claims against OB/GYNs but research shows physician error is responsible for fewer than 4 percent of neurologically impaired infants. Despite the rarity of physician error in these cases, the average award in these few cases where obstetricians are at fault has dramatically increased in just a few years. In 1996, the average award in these type cases was about \$460,000. Two years later, the average award had doubled to \$935,000.

Today, the median award in child-birth cases has risen to over \$2 million. This is the highest category of award for all types of medical liability cases. American women should not be misled by these statistics. They should not worry that despite annual advances in medical technology and training there is somehow an increasingly poor level of obstetric care in this country.

No, these troubling statistics do not mean America's medical schools have lowered their standards and a rash of incompetent obstetricians has begun to practice medicine. In fact, according to the Society of Obstetricians and Gynecologists, over 80 percent of all cases that went to verdict against an OB/GYN resulted in judgments for the physician. In other words, on average eight out of 10 cases that went to trial against OB/GYNs were not meritorious.

It is the dramatic increase in awards noted above and the specter of such awards in settlement negotiations that is driving malpractice premiums through the roof, not a lowering of medical standards for practice.

Looking at my own State, the immediate result of skyrocketing liability premiums is the doctors pack up and move to a State such as California with liability reform or they just simply close their doors altogether. When this happens, the ultimate victims, of course, are the patients, the mothers and their children.

Let's take a look at the Commonwealth of Kentucky. Kentucky does not have a medical liability reform system. Not surprisingly, liability insurance rates for OBs in my State increased 64 percent in one year from 2002 to 2003. Also not surprisingly in the last 3 years, Kentucky has lost one-fourth of its obstetricians.

Moreover, Kentucky has lost nearly half its potential obstetric services during this time when one factors in those who have limited their practices.

As this chart I have shows, roughly 60 percent of the counties in the Commonwealth of Kentucky have no obstetrician at all—none. These are counties in red on this map. It is a majority of the counties in my State that have no obstetricians at all.

Other counties, such as Perry County, down in southeast Kentucky, down this way, technically have a practicing OB/GYN, but that one doctor has stopped delivering babies within the last year, so if you are in Perry County, that doesn't do you much good. Still other counties, such as Greenup,

Lawrence, and Johnson Counties, in northeast Kentucky, have just one OB/GYN in each county, so if you are a woman in those counties you better hope there is not another woman having a baby when you are, or the doctor isn't out of town or busy with another patient. If that happens, you are going to have to drive through the hills on the backroads of eastern Kentucky to try to find a doctor to deliver your baby. All told, 82 of Kentucky's 120 counties have no OBs, or just have one OB.

According to Dr. Doug Milligan of Lexington, who specializes in caring for women with high-risk pregnancies, 11 OBs in eastern Kentucky have recently quit delivering babies or left the State, forcing women to drive for hours.

According to Dr. Milligan, apart from problems with delivering babies, some women are developing complications because they are not getting prenatal care.

So what should we conclude from all of this? The situation I have just described is not, unfortunately, unique to Kentucky. As you will hear from my colleagues, States across the country are in similar straits. So I commend Senator GREGG and Senator ENSIGN for trying to address this important problem.

As I have said earlier, their legislation is modeled on reforms that have stood the test of time in California, and it has been endorsed by the American Medical Association, the American College of Obstetricians and Gynecologists, and a host of other medical organizations.

I hope a dozen brave souls on the other side of the aisle will give the Senate a chance to consider this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I understand there was an agreement for the allocation of time evenly divided between the two parties this morning, and that there has also been an agreement to divide the time during the afternoon.

I have talked with our leadership. They have indicated I could use 10 minutes of our time this afternoon, for the Democratic side, and use it at this time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KENNEDY. What adjustment has to be made in the afternoon will be made.

Mr. President, I intend to speak to the issue before us, medical malpractice, in a moment. I will yield myself 6 minutes now and then I will speak on the medical malpractice in just a moment.

THE FEDERAL MARRIAGE AMENDMENT

Earlier today the President announced his endorsement of the Federal marriage amendment. By endorsing this shameful effort to write discrimination back into the Constitu-

tion, President Bush has betrayed his campaign promise to be "a uniter, not a divider."

The Constitution is the foundation of our democracy and it reflects the enduring principles of our country. We have amended the Constitution only 17 times in the two centuries since the adoption of the Bill of Rights. Aside from the amendment on prohibition, which was quickly recognized as a mistake and repealed 13 years later, the Constitution has often been amended to expand and protect people's rights, never to take away or restrict their rights.

By endorsing this shameful proposal, President Bush will go down in history as the first President to try to write bias back into the Constitution.

Advocates of the Federal marriage amendment claim it will not prevent States from granting some legal benefits to same-sex couples, but that is not what the proposed amendment says. By forbidding same-sex couples from receiving "the legal incidents of marriage," the amendment would prohibit State courts from enforcing many existing State and local laws, including laws that deal with civil unions and domestic partnerships and other laws that have nothing to do with such relationships.

Just as it is wrong for a State's criminal laws to discriminate against gays and lesbians, it is wrong for a State's civil laws to discriminate against gays and lesbians by denying them the many benefits and protections provided for married couples.

The proposed amendment would prohibit States from deciding these important issues for themselves. This Nation has made too much progress in the ongoing battle for civil rights to take such an unjustified step backwards now.

We all know what this is about. It is not about how to protect the sanctity of marriage, or how to deal with activist judges. It is about politics, an attempt to drive a wedge between one group of citizens and the rest of the country, solely for partisan advantage. We have rejected that tactic before and I hope we will do so again.

The timing of today's statement is also a sign of the desperation of the President's campaign for reelection. When the war in Iraq, jobs and the economy, health care, education, and many other issues are going badly for the President and his reelection campaign is in dire straits, the President appeals to prejudice in a desperate tactic to salvage his campaign.

I am optimistic the Congress will refuse to pass this shameful amendment. Many of us on both sides of the aisle have worked together to expand and defend the civil rights of gays and lesbians. Together, on a bipartisan basis, we have fought for a comprehensive Federal prohibition on job discrimination on the basis of sexual orientation. We have fought together to expand the existing Federal hate

crimes law to include hate crimes based upon this flagrant form of bigotry.

I hope we can all agree that Congress has more pressing challenges to consider than a divisive, discriminatory constitutional amendment that responds to a nonexistent problem. Let's focus on the real issues of war and peace, jobs and the economy, and the many other priorities that demand our attention so urgently in these troubled times.

Mr. President, as to the issue that we will be voting on this afternoon, on the medical malpractice legislation, I spoke on this issue yesterday but there are a few additional points that I wish to make today.

How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 6 minutes remaining.

MEDICAL MALPRACTICE LEGISLATION

Mr. KENNEDY. Mr. President, today's vote of S. 2061 is a test of the Senate's character. In the past, this body has had the courage to reject the simplistic and ineffective responses proposed by those who contend that the only way to help doctors is to further hurt seriously injured patients. Unfortunately, as we saw in the Patients' Bill of Rights debate, the Bush administration and congressional Republicans are again advocating a policy which will benefit neither doctors nor patients, only insurance companies. Caps on compensatory damages and other extreme "tort reforms" are not only unfair to the victims of malpractice, they do not result in a reduction of malpractice insurance premiums.

Once more, we must stand resolute.

We must not sacrifice the fundamental legal rights of seriously injured patients on the altar of insurance company profits. We must not surrender our most vulnerable citizens—seriously injured women and newborn babies—to the avarice of these companies.

This bill contains most of the same arbitrary and unreasonable provisions which were decisively rejected by a bipartisan majority of the Senate last year. The only difference is that last year's bill took basic rights away from all patients, while this bill takes those rights away only from women and newborn babies who are the victims of negligent obstetric and gynecological care. That change does not make the legislation more acceptable. On the contrary, it adds a new element of unfairness.

This legislation would deprive seriously injured patients of the right to recover fair compensation for their injuries by placing arbitrary caps on compensation for non-economic loss in all obstetrical and gynecological cases. These caps only serve to hurt those patients who have suffered the most severe, life-altering injuries and who have proven their cases in court.

They are the children who suffered serious brain injuries at birth and will never be able to lead normal lives. They are the women who last organs,

reproductive capacity, and in some cases even years of life. These are life-altering conditions. It would be terribly wrong to take their rights away. The Republicans talk about deterring frivolous cases, but caps by their nature apply only to the most serious cases which have been proven in court. These badly injured patients are the last ones we should be depriving of fair compensation.

A person with a severe injury is not made whole merely by receiving reimbursement for medical bills and lost wages. Noneconomic damages compensate victims for the very real, though not easily quantifiable, loss in quality of life that results from a serious, permanent injury. It is absurd to suggest that \$250,000 is fair compensation for a child who is severely brain injured at birth and, as a result, can never participate in the normal activities of day-to-day living; or for a woman who lost her reproductive capacity because of an OB/GYN's malpractice.

This is not a better bill because it applies only to patients injured by obstetrical and gynecological malpractice. That just makes it even more arbitrary.

The entire premise of this bill is both false and offensive. Our Republican colleagues claim that women and their babies must sacrifice their fundamental legal rights in order to preserve access to OB/GYN care. The very idea is outrageous.

For those locales—mostly in sparsely populated areas—where the availability of specialists is a problem, there are far less drastic ways to solve it. It is based on the false premise that the availability of OB/GYN physicians depends on the enactment of draconian tort reforms. If that were accurate, States that have already enacted damage caps would have a higher number of OB/GYNs providing care. However, there is in fact no correlation. States without caps actually have 28.4 OB/GYNs per 100,000 women, while States with caps have 25.2 OB/GYNs per 100,000 women.

And that is only one of many fallacies in this bill. If the issue is truly access to obstetric and gynecological care, why has this bill been written to shield from accountability HMOs that deny needed medical care to a woman suffering serious complications with her pregnancy, a pharmaceutical company that fails to warn of dangerous side effects caused by its new fertility drug, and a manufacturer that markets a contraceptive device which can seriously injure the user? Who are the authors of this legislation really trying to protect?

In reality, this legislation is designed to shield the entire health care industry from basic accountability for the care it provides to women and their infant children. It is a stalking horse for broader legislation which would shield them from accountability in all health care decisions involving all patients.

While those across the aisle like to talk about doctors, the real beneficiaries will be insurance companies and large health care corporations. This legislation would enrich them at the expense of the most seriously injured patients; women and children whose entire lives have been devastated by medical neglect and corporate abuse.

When will the Republican party start worrying about injured patients and stop trying to shield big business from the consequences of its wrongdoing?

If we were to arbitrarily restrict the rights of seriously injured patients as the sponsors of this legislation propose, what benefits would result? Certainly less accountability for health care providers will never improve the quality of health care. It will not even result in less costly care. The cost of medical malpractice premiums constitutes less than two-thirds of 1 percent—0.66 percent—of the Nation's health care expenditures each year. Malpractice premiums are not the cause of the high rate of medical inflation.

In this era of managed care and cost controls, it is ludicrous to suggest that the major problem facing American health care is "defensive medicine." The problem is not "too much health care," it is "too little" quality health care.

A CBO report released in January of this year rejected claims being made about the high cost of "defensive medicine". Their analysis "found no evidence that restrictions or tort liability reduce medical spending." There was "no statistically significant difference in per capita health care spending between States with and without limits on malpractice torts."

The White House and other supporters of caps have argued that restricting an injured patient's right to recover fair compensation will reduce malpractice premiums. But, there is scant evidence to support their claim. In fact, there is substantial evidence to refute it. In the past year, there have been dramatic increases in the cost of medical malpractice insurance in States that already have damage caps and other restrictive tort reforms on the statute books, as well as the States that do not. No substantial increase in the number or size of malpractice judgments has suddenly occurred which would justify the enormous increase in premiums which many doctors are being forced to pay.

The reason for sky-high premiums cannot be found in the courtroom.

Caps are not only unfair to patients, they are also an ineffective way to control medical malpractice premiums. Comprehensive national studies show that medical malpractice premiums are not significantly lower on average in States that have enacted damage caps and other restrictions on patient rights than in States without these restrictions. Insurance companies are merely pocketing the dollars which patients no longer receive when "tort reform" is enacted.

Focusing on premiums paid by OB/GYN physicians, the evidence is the same. Data from the Medical Liability Monitor shows that the average liability premium for OB/GYNs in 2003 was actually slightly higher in States with caps of damages—\$63,278—than in States without caps—\$59,224. It also showed that the rate of increase last year was higher in States with caps—17.1 percent—than it was in States without caps—16.6 percent.

This evidence clearly demonstrates that capping malpractice damages does not benefit the doctors it purports to help. Their rates remain virtually the same. It only helps the insurance companies earn even bigger profits. As *Business Week Magazine* concluded after reviewing the data, “the statistical case for caps is flimsy.” That was in the March 3, 2003 issue.

If a Federal cap on non-economic compensatory damages were to pass, it would sacrifice fair compensation for injured patients in a vain attempt to reduce medical malpractice premiums. Doctors will not get the relief they are seeking. Only the insurance companies, which created the recent market instability, will benefit.

Insurance industry practices are responsible for the sudden dramatic premium increases which have occurred in some States in the past 2 years. The explanation for these premium spikes can be found not in legislative halls or in courtrooms, but in the boardrooms of the insurance companies themselves.

Insurers make much of their money from investment income. Interest earned on premium dollars is particularly important in medical malpractice insurance because there is a much longer period of time between receipt of the premium and payment of the claim than in most lines of casualty insurance. The industry creates a “malpractice crisis” whenever its investments do poorly. The combination of a sharp decline in the equity markets and record low interest rates in recent years is the reason for the sharp increase in medical malpractice insurance premiums. What we are witnessing is not new. The industry has engaged in this pattern of behavior repeatedly over the last 30 years.

Last year, Weiss Ratings, Inc., a nationally recognized financial analyst conducted an in-depth examination of the impact of capping damages in medical malpractice cases. Their conclusions sharply contradict the assumptions on which this legislation is based. Weiss found that capping damages does reduce the amount of money that malpractice insurance companies pay out to injured patients. However, those savings are not passed on to doctors in lower premiums.

Between 1991 and 2002, the Weiss analysis shows that premiums rose by substantially more in the States with damage caps than in the States without caps. The 12-year increase in the annual malpractice premium was 48.2 percent in the States that had caps,

and only 35.9 percent in the States that had no caps. In the words of the report:

On average, doctors in States with caps actually suffered a significantly larger increase than doctors in States without caps. . . . In short, the results clearly invalidate the expectations of cap proponents.

Doctors, especially those in high-risk specialties, whose malpractice premiums have increased dramatically over the past few years, do deserve premium relief. That relief will only come as the result of tougher regulation of the insurance industry. When insurance companies lose money on their investments, they should not be able to recover those losses from the doctors they insure. Unfortunately, that is what is happening now.

Doctors and patients are both victims of the insurance industry. Excess profits from the boom years should be used to keep premiums stable when investment earnings drop. However, the insurance industry will never do that voluntarily. Only by recognizing the real problem can we begin to structure an effective solution that will bring an end to unreasonably high medical malpractice premiums.

There are specific changes in the law which should be made to address the abusive manner in which medical malpractice insurers operate. The first and most important would be to subject the insurance industry to the Nation’s anti-trust laws. It is the only major industry in America where corporations are free to conspire to fix prices, withhold and restrict coverage, and engage in a myriad of other anticompetitive actions. A medical malpractice “crisis” does not just happen. It is the result of insurance industry schemes to raise premiums and to increase profits by forcing anti-patient changes in the tort law. I have introduced with Senator LEAHY, legislation which will at long last require the insurance industry to abide by the same rules of fair competition as other businesses. Secondly, we need stronger insurance regulations which will require malpractice insurers to set aside a portion of the windfall profits they earn from their investment of premium dollars in the boom years to cover part of the cost of paying claims in lean years. This would smooth out the extremes in the insurance cycle which have been so brutal for doctors. Thirdly, to address the immediate crisis that some doctors in high risk specialties are currently facing, we should provide temporary premium relief. This is particularly important for doctors who are providing care to underserved populations in rural and inner city areas.

Unlike the harsh and ineffective proposals in S. 2061, these are real solutions which will help physicians without further harming seriously injured patients. Unfortunately, the Republican leadership continues to protect their allies in the insurance industry and refuses to consider real solutions to the malpractice premium crisis.

This legislation—S. 2061—is not a serious attempt to address a significant

problem being faced by physicians in some States. It is the product of a party caucus rather than the bipartisan deliberations of a Senate committee. It was designed to score political points, not to achieve the bipartisan consensus which is needed to enact major legislation. For that reason, it does not deserve to be taken seriously by the Senate.

I withhold whatever time I have and suggest the absence of a quorum.

THE PRESIDING OFFICER. Will the Senator withhold on suggesting the absence of a quorum?

Mr. KENNEDY. I withhold suggesting the absence of the quorum.

RECESS

THE PRESIDING OFFICER. Under the previous order, the hour of 12:30 having arrived, the Senate will stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:30 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH).

HEALTHY MOTHERS AND HEALTHY BABIES ACCESS TO CARE ACT OF 2003—MOTION TO PROCEED—Continued

THE PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, what is the state of business?

THE PRESIDING OFFICER. The time until 4:50 is evenly divided.

Mr. HATCH. Thank you, Mr. President.

I rise to speak in support of S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act.

This bill addresses the medical liability and litigation crisis in our country, a crisis that is preventing patients from receiving high quality health care—or, in some cases, any care at all because doctors are being driven out of practice. This crisis is limiting or denying access to vital medical care and needlessly increasing the cost of care for every American.

As you will recall, we have previously tried to remedy this crisis in access to care. Most recently, we debated S. 11 which failed to receive the 60 votes necessary to invoke cloture last July. You have to have a supermajority now on these types of issues because of the opponents of this bill—and some others.

The time to act is now. The health care crisis is jeopardizing access to health care for many Americans. The medical liability crisis is also inhibiting efforts to improve patient safety and is stifling medical innovation. Excessive litigation is adding billions of dollars in increased costs and reduced access to high quality health care.

Defensive medicine is way out of whack. We are spending billions of dollars on unnecessary defensive medicine because doctors are terrified they are going to be sued in these frivolous lawsuits—called medical liability suits—by personal injury lawyers.