ASSESSING THE NEED TO ENACT MEDICAL LIABILITY REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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ASSESSING THE NEED TO ENACT MEDICAL LIABILITY REFORM

THURSDAY, FEBRUARY 27, 2003

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

The subcommittee met, pursuant to notice, at 10:08 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Barton, Upton, Greenwood, Deal, Burr, Norwood, Shadegg, Pickering, Buyer, Pitts, Ferguson, Tauzin (ex officio), Brown, Waxman, Pallone, Eshoo, Stupak, Green, Strickland, Capps, DeGette, and Dingell (ex officio).

Staff present: Cheryl Jaeger, majority professional staff member; Nandan Kenkeremath, majority counsel; Patrick Morrisey, deputy staff director; Eugenia Edwards, legislative clerk; Steve Tilton, health policy coordinator; David Nelson, minority economist; Jonathan Cordone, minority counsel; Nicole Kenner, minority staff member; and Jeff Donofrio, minority staff intern.

Mr. BILIRAKIS. The subcommittee will come to order.

Without objection, the subcommittee will proceed pursuant to committee rule 4(e). No objection having been heard, so ordered.

The Chair recognizes himself for an opening statement.

First, I would like to thank our witnesses for appearing before this subcommittee today. Our committee certainly values your expertise, and we are grateful for your cooperation and attendance.

The Health Subcommittee held a hearing last year,

hearings over a period of time have been held on this subject, to learn more about a major crisis in our health care system, namely how spiralling professional liability insurance premiums are adversely affecting patient access to care.

I know that during our hearing, the last hearing, there were did diverging views about what was causing this spike in insurance premiums and what potential solutions might look like. However, there was no debate about the fact this crisis is beginning to have a devastating effect on patient access to health care; and I know that my constituents—and I would like to think all of our constituents—are demanding that Congress act in some way to control these run-away insurance premiums.

Fortunately, Congress does have a model to draw on. California's Medical Injury Compensation Reform Act, or MICRA, has helped shield our Nation's largest and most diverse State from the huge increases in insurance premiums that so many other States like

Florida are struggling with. In fact, according to data compiled by the National Association of Insurance Commissioners, California's medical malpractice insurance premiums have increased 167 percent from 1976 to 2000, while the rest of the country has experienced increases of 505 percent. California's experience suggests to me that meaningful tort reforms can have a very positive effect in terms of controlling increases in professional liability insurance premiums.

MICRA was the foundation of H.R. 4600, the Health Care Act which the House of Representatives passed during the last Congress. While I was disappointed in our inability to send a bill to the President for his signature, I am looking forward to the opportunity that we have before us during this Congress. The crisis has certainly not gone away and nor has our need to act.

While I believe that last year's Health Subcommittee hearing provided members—and we had much debate during our markup—with an excellent opportunity to learn more about this issue, I think we can all benefit from further discussion. I remain especially interested in learning more about how insurance premiums are determined. I know we have heard from many people on the other side and from witnesses that much of the problem has to do with the insurance industry and whatnot. Well, we need to know that. We need to learn more about it. So we also need to know about how meaningful tort reform is going to control increases and professional liability and insurance premiums.

Again, I would like to extend a warm welcome to all of our witnesses. I would like to take a minute to welcome back Mr. Hurley, Jim Hurley, Chairperson of the American Academy of Actuaries, Medical Malpractice Subcommittee. I thought your testimony, Mr. Hurley, at last year's hearing was invaluable; and I know that we all appreciate the independent, objective perspective your organization provides on how actuarial standards relate to how insurance companies develop premium levels.

While I am well aware of the range of opinions regarding this issue in the Health Subcommittee, I sincerely hope that members take advantage of the expertise. Frankly, I would love it if we could all focus on the one area that we keep hearing about and that is the effect that the insurance companies have on this particular problem. But I can't really shut off what one might choose to do with our time. But I do hope we will take advantage of the expertise we have before us to learn about the causes of this crisis and potential solutions.

I now yield to the ranking member, my friend from Ohio, for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman; and thank you for your cooperation in this issue and your willingness to work with both sides and come up with a real solution to medical malpractice.

I ask unanimous consent to enter into the record member statements, including Mr. Dingell's here if I could.

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding this hearing to assess the issue of medical liability. Although this hearing has been broadly cast to cover a wide range of inter-

ests that extend beyond doctors and patients, it is an appropriate opportunity to address the rising cost of malpractice insurance, which is a very real problem for doctors and patients alike.

These high insurance rates are leaving doctors with few options. Those who can afford to pay the increased cost of providing medical services, will. Those who cannot afford the increase are forced to assume significant personal liability, leave high-risk specialties, or leave the profession altogether. At best, health care will become more expensive for patients. At worst, in addition to higher prices, patients will be denied access to care, and lifesaving treatments will not be provided.

This is a serious problem that deserves deliberate consideration. Unfortunately, legislation pending before this committee, H.R. 5, focuses on drastic reforms of the judicial system that extend well beyond the issue of medical malpractice. While inefficiencies in our courts may be a contributing factor to this crisis, it is by no means the only cause—or even the single largest cause—of the current crisis.

As the subject of this hearing appropriately indicates, the protections of H.R. 5 extend well beyond the doctor-patient relationship. The provisions contained in this bill will shield HMOs, insurance companies, and drug and device manufacturers from liability. No evidence has been presented to the Committee demonstrating that these privileged industries need additional protections, yet H.R. 5 grants them a special status under the law that is unprecedented.

Moreover, these dramatic protections hurt the rights of injured patients in an equally unprecedented manner. There is a human cost to this legislation that we must not forget. We will hear from a courageous and impressive young woman today, Heather Lewinsky. She will explain how her life has been affected by the malpractice of a plastic surgeon. The pain, suffering, fear, and trauma that Heather has courageously confronted are real, and she should be compensated. And the loss of seventeen year old Jésica Santillán must be devastating to her family. If malpractice is to blame for young Jésica's passing, as it certainly appears, her family should be compensated for their loss. Neither Heather nor the Santillán family would qualify for significant economic damages. The harm caused to both is almost exclusively non-economic in nature, but it unquestionably is still great harm.

While claiming to provide unlimited economic damages, H.R. 5 would disproportionately hurt women, seniors, and low-income families by limiting non-economic damages to $250,000. Because a significant component of economic damages is an individual's income, such a system would disproportionately value the lives of those with high incomes over low-wage earners, stay-at-home moms, and senior citizens. For example, if the CEO's of the very drug companies and HMO's that this bill protects were injured, their economic damages would be worth millions upon millions of dollars. By comparison, if a stay-at-home mom were injured in an identical manner, she would have very limited economic damages awarded to her.

H.R. 5 also limits the amount of time in which an injured patient can seek just compensation to three years from the date an injury manifests itself. The concept of manifestation is not established in law nor is it clearly defined in the legislation. There are certainly circumstances when an injury could manifest itself without a patient knowing of its existence for three or more years. An illness such as HIV could manifest itself and not be discovered—nor expected to be discovered—by a patient for many years. This legislation would prevent that patient, and many others, from being compensated at all.

Unfortunately, my Majority colleagues are quite determined to move quickly and harshly. Their legislation reaches well beyond malpractice and offers no guarantees of assistance to providers and communities. Physicians and patients are asked to cross their fingers and hope that some of the benefits given to insurance companies and large corporations will trickle down to them. And women, seniors, and low-income families are left to pay the very real price of these benefits. It is wrong.

But the rising cost of malpractice insurance is a real problem—requiring careful, balanced, and targeted legislation. I am in the process of finalizing legislation that will provide direct, targeted assistance to physicians and communities to assist with the current crisis. It will also institute limited, common sense tort reforms to weed out frivolous lawsuits and provide stability in our courts while protecting the fundamental rights of patients. Lastly, the legislation I will propose would create an independent commission to examine every aspect of the current insurance crisis, propose additional solutions to address the current crisis, and make recommendations to avoid any future malpractice insurance crisis. I hope that at some point in the process a balanced approach such as this will prevail, but I'm not holding my breath.

Mr. BILIRAKIS. Without objection, the opening statements of all members will be made a part of the record.

Mr. BROWN. First of all, thank you to all the witnesses; special thanks to Heather Lewinski for her courage and for joining us. Thank you, Heather, and thank you all of you.

I would suggest that our efforts in this legislative process be guided by the following principle: A good medical malpractice reform bill should prevent outrageous increases in medical malpractice premiums and improve access to quality medical care.

This principle embodies two concepts: We should ensure that the bill will—not may but will—address premium spikes and improve access to care, and we should ensure that the bill does not reform away the medical malpractice liability system's role in promoting responsible quality medical care.

Let me briefly explore each of these ideas, Mr. Chairman.

The professed goal of medical malpractice caps is to introduce more predictability into the system. Uncertainty, our friends in the insurance industry say, is what really endangers patient's access to health care. This is an important point. Insurers make an actuarial calculation of the additional premiums needed to counter uncertain jury awards. They literally put a number on it. It follows, insurers tell us, that we can easily stem the medical malpractice premium crisis by capping jury awards. No more uncertainty means no more premium spikes.

The industry doesn't explain, though, how uncertainty, which has been a part of the system for years, can possibly explain the recent spike in premiums, but it would be a shame to let a silly little thing like logic ruin a good story.

The industry balks when anyone dares suggest that insurers demonstrate that they are, in fact, reducing premiums in response to the caps. The insurance industry and my friend Mr. Greenwood, who helped kill an amendment to last year's bill that would establish this requirement, claimed that it can't be done. Apparently, insurers can make an actuarial calculation and increase premiums to compensate for uncertainty, but they cannot make an actuarial calculation and decrease premiums, decrease premiums when that uncertainty is diminished.

I understand why insurers and the bill's sponsor would fend off attempts to require proof that this bill accomplishes its ostensible goal. After all, liability caps are reversible. But because liability caps raise serious equity issues, serious ethical issues, I would suggest that any measure that fails to ensure that insurance company savings from damage caps are passed on to doctors, that savings from caps are passed on to doctors in reduced premiums, they simply can't meet the first part of our test for malpractice legislation. It cannot ensure that our actions will improve access to care.

Let me suggest a way to reduce doctor premiums and increase access to quality medical care. It is pretty straightforward. All we need to do find out what the problem is and fix it.

Insurance companies won't provide the information we need to understand recent premium increases. They won't demonstrate how their bottom line has actually been affected by jury awards, by investment income or the lack thereof, by past rate-setting decisions and the like. When asked to provide this information, the industry says that is proprietary information. We can't give that to you.

So Congress—get this. Congress is expected to pass legislation that caps compensation to patients whose lives have been irreparably harmed by medical malpractice without any concrete evidence that the cause of the crisis stems from higher unpredictable jury awards because the insurance industry won't tell us. It is more important to protect proprietary accounting information for that industry than it is to protect patients who have been injured. Have our values drifted that far off course?

Mr. Chairman, this subcommittee doesn't have to legislate in the dark. We have the power to subpoena, to subpoena insurance company records and discover for ourselves what is actually going on here. I have offered this suggestion to the majority before but to no avail. It is not too late. We can dispense with the glossy arguments and competing statistics. We can get to the bottom of this problem. We can pass a bill that addresses it. But to do that we need to subpoena the records of medical malpractice insurers. It is irresponsible to move forward without doing that.

The second element of our guiding principle is equally straightforward. Our actions must not compromise the effectiveness of America's medical malpractice liability system. Doctors are as close to miracle workers as we have in our society, but, like the rest of us, they are not perfect and in a few cases there are a few bad guys. When doctors don't do their jobs, patients suffer. As Heather Lewinski's testimony today amply demonstrates, that suffering is personal, and it is lifelong.

Proponents of Mr. Greenwood's health bill say the bill is actually patient friendly. After all, it doesn't cap economic damages. But Heather was 8 years old when a doctor's negligence changed her life forever. She obviously had no job, she had no prospects for employment when she was 8 in the foreseeable future, and she was awarded as a result no economic damages.

Under the health bill, Mr. Greenwood's bill, the punitive cap is kept at the lower of $250,000 or double the economic damages.

One more moment, Mr. Chairman.

Mr. Chairman, two times zero is still zero. This bill would literally tell children like Heather that the value of punishing people who harm them is, in fact, zero.

The issue of medical malpractice is an important one, deserving a serious sincere effort by this committee. We can still develop legislation that improves both access to and quality of care. I hope that this subcommittee will do that.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Greenwood, for 3 minutes or would you defer?

Mr. GREENWOOD. I think I will take my 3 minutes, Mr. Chairman.

Mr. BILIRAKIS. I am not surprised.

Mr. GREENWOOD. It is my bill, after all.

What can we agree on? I don't think it is difficult for us to agree that we have a crisis with regard to the availability and the cost of medical liability insurance. I don't know anyone who disagrees with that.

In my State of Pennsylvania, the crisis is particularly acute. We have lost 900 doctors. The trauma center that would serve my family and the families of most of the people that I represent closed

its doors in December because it could—because of its incredibly exorbitant increase. I think the insurance rates went from $7 million a year to $21 million a year. They are only open now on the promise from Governor Rendell that he will do something before this, and I remain very skeptical that that will happen. So there is a crisis.

The question, of course, is how do we fix the crisis? Mr. Brown has agreed we ought to fix the crisis. Mr. Brown assigns blame to the insurance companies. I can assure you that if I thought that there was a fix there I would fix it. I have no particular reason, I don't know of anybody who has a particular reason to not go after the insurance companies if that is where the problem is.

But here is the problem with that argument: 60 percent of the doctors in this country get their medical liability insurance from physician-owned companies. Physician-owned companies have as their purpose trying to provide physicians with the lowest available priced policies.

Now, if these physician-owned companies are not able to underbid the private insurance companies that some are claiming are price gouging, then where is the logic? Where is the logic that says that the price spikes are caused not by the environment of the courtroom and the excessive noneconomic damages that are paid but somehow lies in the management practices of the insurance companies when, again, 60 percent of the doctors in this country get their malpractice, if they can, from physician-owned companies, and 30 percent in my State of Pennsylvania get their medical liability insurance from physician-owned companies?

The gentleman from Ohio suggested that, gee, all we need to do is get the insurers in here to open their books and get the information. My understanding is that the Democrats did not invite any insurance companies to come in and be questioned at this hearing. We have had actuaries testify at hearing after hearing as to the causes of the price spikes. I think their testimony has been very direct and supports the logic of the bill.

The bottom line is we need to get this crisis resolved. We need to find a bipartisan way to do it. We need to do it in the House and the Senate. I personally am open to whatever works, but it will be a failure of the Congress and a waste of our time if we pass legislation that becomes so watered down that we get 218 votes in the House and 51 votes in the Senate and 60 votes to break a filibuster and sign it into law and it doesn't solve the crisis. I think we ought to be focused on solving the crisis, solving it rationally and not being partisan about it.

Thank you, Mr. Chairman.

[The prepared statement of Hon. James C. Greenwood follows:]

PREPARED STATEMENT OF HO. JAMES C. GREENWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, I thank you for holding this hearing. Today, I look forward to hearing from our witnesses as we explore, examine and confront the medical liability insurance crisis.

The word "crisis" is often thrown around in Washington DC but let me tell you something that fits this term, under any definition: From December 21 until January 3 of this year, for thirteen days, the trauma center of Abington Hospital, in Abington, PA closed its doors because the doctors staffing this critical facility could not obtain the affordable medical liability insurance they needed to practice. For those

thirteen days, fundamental protections to the health and the lives of the families in this area ceased to exist. How have we come to this?

The purpose of this hearing is to help this committee—and the public—learn and understand the events and forces contributing to the growing inability of people across the country to find a doctor. What is more, we need to understand why americans in many states can no longer go about their daily lives knowing that if the worst happens—the doctor is in place and on call.

In the Philadelphia region we have a special obligation and a proud legacy to protect. Since 1751, when the founders of Pennsylvania Hospital, Benjamin Franklin and Dr. Thomas Bond, opened the doors to the nation's first hospital, we have been a leader in health care. Even today, almost one in seven doctors in the United States did some part of their medical training in Philadelphia, which is home to a host of excellent medical schools and institutions.

But the signs appear ominous and this legacy is threatened. Recently, Methodist Hospital in south Philadelphia, which has served that community for more than 100 years was forced to close its obstetrics practice. Why? And what hardships have been visited upon the expectant mothers who counted on those services?

This crisis affects more than just patients and doctors. In an Energy and Commerce Oversight and Investigation Subcommittee hearing I chaired on this crisis in my home district on February 10, 2003 we heard from two hopsitals and trauma centers operating in southeastern Pennsylvania, St. Mary Medical Center and Abington Hospital about the problems growing day-by-day to find and retain the physicians needed by these facilities to keep open their doors.

I am deeply saddened and angered that this crisis is having permanent and long-term effects: Weakening hospitals, debilitating medical schools, reducing the number of doctors who practice, and destabilizing health care institutions—all to the detriment of the people desperately in need of skilled medical treatment.

Again I ask: Why? that is the question we seek to answer here today.

Let me tell you what I know so far. The access to health care has been restricted because the individuals and institutions delivering that care cannot find the affordable insurance required to practice medicine. Insurance companies are raising their rates across the state and turning down doctors looking to find new policies.

What is happening to insurers? Insurance companies set their premiums based on their risk—the amount they estimate they will have to pay. You would naturally expect to pay more to insure a $50,000 home than a $500,000 home. What do you think an insurance company would say to someone who wanted to insure a house, but could not tell the value except that it could be worth either $10,000 or millions? Pennsylvania medical liability insurers face a similar quandary. They simply cannot make reasonable business decisions of their risk when they don't know with each passing year what juries will award.

In the past 3 years, according to a recent Wall Street Journal editorial, juries in Philadelphia have awarded more in medical damages than the entire State of California. In 2000, Pennsylvania had 19 awards individually exceeding $5 million.

In light of this, can we begin to understand why Pennsylvania insurers, facing the unpredictability of Pennsylvania court verdicts, continue to increase their rates? Can we then see why Pennsylvania's largest physician insurer this year raised its premiums an average of 54%? Does this help us start to recognize why 72% of Pennsylvania doctors, according to a 2001 survey, deferred the purchase of new equipment or the hiring of new staff because of malpractice costs? And now can we see why, since January 2001, more than 900 Pennsylvania physicians have closed their practice, moved out of state or refused to do high-risk procedures?

I asked "why" earlier. Let's trace the problem back to this fact: Insurers cannot properly, reasonably and competitively offer insurance to medical providers because of an unpredictable tort system prone to "jackpot" awards.

No one will argue that patients injured by the negligence of a medical provider do not deserve compensation—but we have lost all sense of proportion in the area of non-economic, intangible damages. How do we put a price tag on suffering, loss of enjoyment of life, or embarrassment? A jury of peers is the best and fairest system of justice we have. They make decisions of profound importance every day across the country based first on the rule of law but second on their sense of justice.

But we must ask: What informs, what creates this sense of justice and gives it proportion? How have we set benchmarks for putting a dollar value on another person's pain or embarassment? Are we guided by the amounts we see in sensational headlines or advertisements of lawyers trumpeting huge recoveries? Are we guided by the woman who won millions for spilled McDonald's coffee? Where ever we found that price tag we hang on another's suffering—it is clear that all sense of proportion seems to have be lost.

Reasonable caps on such subective damages, in my estimation, when teamed with a specific package of other reforms, will bring juries, verdicts and insurance rates back to earth.

I have recently introduced legislation in the House designed to address this root problem. However, I am ready to work with members on both sides of the aisle, in both chambers to achieve a solution that will be signed into law by the President.

Again, thank you to the two committees for holding this joint hearing.

Mr. BILIRAKIS. I thank the gentleman.

Ms. Eshoo for 3 minutes, unless she would prefer to defer.

Ms. ESHOO. Good morning, Mr. Chairman. Thank you for having this hearing.

For 2 years now we have been discussing and debating what to do with medical malpractice premiums. Clearly, there is a problem. What is not so clear is what our solution should be.

I am a Californian, and in my State we have a law that we have heard mentioned many, many times, MICRA. The bill was passed by a Democratic legislature, and it was signed by a Democratic Governor in 1975. It has been on the books ever since without a single change. While it may not be the sole reason why premiums in California have stayed reasonable and stable, I think that it has contributed.

Representative Greenwood has introduced a bill that he has described as a Federal version of MICRA. What I want to use my time for respectfully is to dispute that assertion. Because it is not the same. The bill places a $250,000 cap on noneconomic damages for suits against physicians, insurers, HMOs, nursing homes and drug and medical device manufacturers. MICRA limits that cap solely to physicians. H.R. 5 also places a cap on punitive damages. MICRA does not.

One of the reasons MICRA has worked is because it is proscribed in its scope. If we want to get to the heart of this problem, we should focus our efforts on those who really need the help. I am very concerned that extending these provisions to those outside of the physician community will have a deleterious effect on patient care and on our legal system. We can do tort reform and weed out frivolous lawsuits. We have done it before. I was a part of that.

Additionally, H.R. 5 doesn't set up any mechanism to review the insurance industry. They are clearly a part of this. It is not about assigning blame. You have to look at all the stakeholders. California's MICRA has never been updated for inflation since it became law.

I think there is a downside of it I think that is worth mentioning. $250,000 from 1975 is worth approximately $68,000 today. We should think about indexing for inflation if we are to do anything at the Federal level. Patients should be fairly compensated for any wrongs that are visited upon them because every life has worth, regardless of whether they have an income or not.

So I look forward to hearing our witnesses giving their testimony today on these issues and others, and I thank the chairman for holding this hearing.

Mr. BILIRAKIS. I thank the gentlelady.

The chairman of the full committee, Mr. Tauzin.

Chairman TAUZIN. Thank you, Mr. Chairman. Thanks for holding this hearing as we try to, as the gentlelady from California indicated, use the experience of States like California and my own in

Louisiana to try to help with the problem that has now become a huge national crisis.

I don't have to dwell on the problem. I think we all understand it. When trauma units close down and obstetric services are denied people and pregnant women can't find a doctor to help them deliver a child because the doctors have gone out of business in their community. The system is creating health care victims that have nothing to do with lawsuits and medical errors. It just has to do with people that can't get health care.

In Louisiana, we are seeing an extraordinary occurrence. Let me be honest with you. We in Louisiana passed medical liability reform. I voted against it when I was in the legislature. I am a convert to the principle. I watched it work. I watched it have the good effects in Louisiana that we saw in California. I watched in Louisiana incredibly as more and more physicians from the neighboring State of Mississippi are moving into our State because they can't anymore stand the pressure of lawsuits and insurance costs in the State of Mississippi.

I talked to Mr. Pickering about that. I go hunting in Mississippi a lot. I wouldn't ask everybody from Mississippi to move from Louisiana. Doctors, okay, but that is not a good way for them to make a choice. The fact of the matter is that when people who have dedicated their lives to serving the health care needs of their neighbors find they have to leave their home State, go live in another State because the liability system is driving them to a point where they no longer look at patients as people who need care but they look at them as potential plaintiffs——

I have a young member of the family who is a physician. He is a urologist in Thibodaux. He is my younger sister's husband. I watched him go to medical school, brilliant young man. I watched him go through his medical training. I watched him come back home to Thibodaux. He performed amazing surgery on my father. It made such a difference in his health. And I watched him perform those medical miracles on friends of mine throughout my community. He got roped into one of these suits not too long ago, and he defended it successfully. He was roped into a suit brought against the hospital he works in. It has changed him. I have seen what was such an incredible feeling he had about his work and his life and what he was doing to help people become a much more cautious and cynical sort of approach. He still loves his work and does great work, but he is a changed man, having gone through that experience.

I know that doctors who might help one another avoid medical error don't share information today because of fear of lawsuits. I know doctors prescribe a lot more medical tests and drugs and all sorts of things to people in my home community, even with our medical reform, because they are afraid if they don't do these things, even though they don't think they are necessary, somebody is going to call that malpractice and drag them through the courts.

Now, I am a lawyer. I am a recovering lawyer I keep telling people. I used to handle plaintiff cases when I was in practice, and I value a legal system that gives people a right of redress when they have been harmed. But the legal system needs always to be bal-

anced and sometimes rebalanced to make sure it doesn't do more harm than good.

While we need to preserve the right of people to recover when somebody wrongfully kills their child because of malpractice or wrongfully hurts someone's mouth because of bad dentistry, whatever, it may be we need to preserve those rights and make sure there is adequate and fair recovery. We also need to be concerned about the young men and women who dedicate their lives to taking care of parents and neighbors and their friends and who suddenly today look upon their patients with fear instead of the kind of loving attention that they came out of medical school determined to show whenever they entered a hospital or surgery room to do a medical procedure. I think it is time for to us balance this out on the Nation.

This medical liability reform bill patterned after what was done in California, my home State of Louisiana is I think the kind of medicine we need to make sure we aren't creating more victims unnecessarily in this system, to make sure that, in fact, people get rewarded properly when there has been an injury but we don't encourage lawsuits where 60 percent of them today are either dismissed or withdrawn and where 58 percent of the recovery goes to somebody other than the victim, the patient.

We need some work here. We need to balance this out a little better. We need to give the doctors and nurses and health care personnel in our country a little bit of credit. We need to understand they didn't dedicate their lives to service just to be in a lawsuit every other day.

I thank you, Mr. Chairman.

[The prepared statement of Hon. W.J. "Billy" Tauzin follows:]

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

Thank you, Mr. Bilirakis for holding this timely hearing.

Mr. Chairman, our legal justice system is out of balance. Excessive litigation is driving up health care costs, forcing doctors to leave their practices, causing hospitals to shut down and leaving America's patients in a state of "code red."

We have seen this issue all over the news in recent years. Last year, we heard about a Level 1 trauma center in Las Vegas closing, forcing severely injured patients to travel an additional 500 miles for equivalent care. In Mississippi, one-third of the neurosurgeons have left the state—an incredible number especially when you consider the substantial toll stroke has on the state. In West Virginia and Pennsylvania, obstetrics units have closed, leaving some pregnant women without direct access to a qualified physician to deliver their baby. The stories go on and on. Patients are being victimized by a lack of access to certain health care services across our country, partially because of a runaway tort system.

For those of us who have served in our state legislatures, this issue is not new. Louisiana once faced a similar patient access to care crisis. My state responded by enacting medical liability reform that has withstood constitutional challenges as well as attempts to dilute its effectiveness. Their guidelines for health care lawsuits ensure that injured patients receive greater compensation while at the same time deter frivolous lawsuits that extort health care professionals and drive doctors from the practice of medicine. While medical liability insurance rates have skyrocketed across the country, doctors are not leaving their practices in the state of Louisiana. In fact, over the past year, doctors in neighboring states have sought refuge in Louisiana. Of course, we love having more people come to our state, but I don't think this is the way we want to accomplish it.

I know those advocating for federal legislation modeled after California's Medical Injury Compensation Act feel quite the same way as the doctors in Louisiana do: medical liability reforms work and they really do have an impact on patient care. Without medical liability reform, fear of lawsuits deters doctors from sharing infor-

mation that is critical to learning how to prevent systematic mistakes, stymieing efforts to reduce medical errors and improve patient safety. Without medical liability reform, doctors will continue to engage in defensive medicine, performing tests and prescribing medicines that are not necessary to better the health of the patient, driving up health care costs for all Americans.

And the costs to the system are not insignificant. Some analysts estimate tort reforms could lead to reductions of well over $50 billion per year in health care expenditures, without serious adverse consequences for patients. Without medical liability reform, insurance rates will continue to force doctors out of practice, leaving some patients without access to health care. Because when doctors spend less time thinking of a patient as a "potential lawsuit" and more time treating the patient, the patient receives better care.

I have said it before, and I will say it again. When injured patients have to wait, on average, 5 years before a medical injury case is complete, our judicial system has failed. When injured patients lose 58 percent of their compensation to attorneys and the courts, our judicial system has failed. When 60 percent of malpractice claims against doctors are dropped or dismissed, but the fear of litigation still forces doctors with twenty-five years of experience to retire early, our judicial system has failed.

Members of this Committee have taken the lead in drafting legislation to help restore some degree of common sense to our tort system. We realize that our current system is too slow, too expensive, too inefficient and most importantly, fails to improve the health of our country. I applaud the Members of this Committee for the leadership and thoughtfulness they have shown in advancing legislation to address this critical issue.

Today, I look forward to the witness testimony. And I encourage all of my colleagues, on both sides of the aisle, to listen carefully to the information presented by the witnesses today. It will, no doubt, prove useful as we move forward H.R. 5, the HEALTH Act, through subcommittee and full committee mark-ups next week.

Mr. BILIRAKIS. Mr. Stupak.

Mr. STUPAK. I will waive, Mr. Chairman.

Mr. BILIRAKIS. All right. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

The highest maxim of the medical profession is "first do no harm." in other words, unless a patient will benefit from amputation, the doctor should not cutoff their leg. As legislators, I think we should also be served by following the same maxim. Unless the people will benefit from a reduction in their rights, we should not reduce their rights.

Now, we all know that doctors, particularly doctors in some practice groups and subspecialties, are suffering from high insurance rates. But what we have learned from hearings both last year and last month is that there are serious reasons to question claims that capping damages in medical malpractice lawsuits will actually reduce premiums for those doctors. If we pass reforms with caps, we will be denying victims their rights to sue and recover damages for medical malpractice while at the same time passing those caps do nothing to help doctors.

Mr. Chairman, we have several charts which all, for some reason, are labeled Exhibit 1 that I am going to ask to have entered into the record of this hearing which show that, in States like California, when you put caps on medical malpractice damages, it absolutely did not reduce premiums. So I would ask unanimous consent to put those charts in, and I will be showing those later.

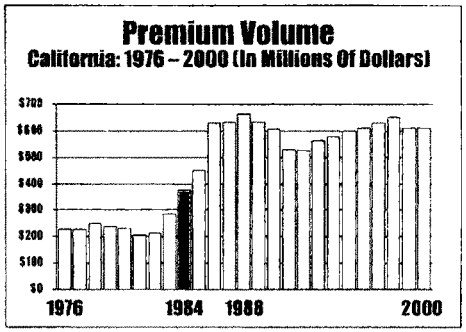
Mr. BILIRAKIS. Without objection.

[The information referred to follows:]

Exhibit 1

Medical Malpractice

What Did MICRA Do To California Premiums



- California Premiums Were Flat In the Late 1970s & Early 1980s Before MICRA Was Fully Implemented
- MICRA Declared Constitutional In 1984 And Premiums Rose 77% Until 1988
- In 1988 Proposition 103 Passed And Premiums Dropped 21% Over The Next Several Years
- Proposition 103 NOT MICRA Lowered Premiums

Source. Data from The National Association Of Insurance Commissioners. Report on Profitability (various years).

Exhibit 2a

Premiums And Damage Caps for Top 26 States

States In Blue Have Caps Affecting Noneconomic Damages

State	Premium	Status Of Cap
Florida	$94,107	$250,000/$350,000. Applies unless docotr refuses arbitration
Michigan	$62,389	$280,000
Nevada	$58,482	$350,000
Ohio	$51,969	the greater of 250000 or 3 times the plaintiff's economic loss
West Virginia	$50,311	$1M
Illionis	$50,285	None
Texas	$50,072	$500,000 in Wrongful Death cases only
Pennsylvania	$48,375	None
District of Columbia	$46,693	None
New York	$46,355	None
Connecticut	$44,332	None
Massachusetts	$41,389	$500,000
Kentuky	$40,117	None
Wyoming	$38,609	None
New Jersey	$37,339	Noneconomic Damage Abolished in Wrongful Death Cases
Louisiana	$35,352	$500,000 Overall Cap excluding future Medicals
Missouri	$34,438	$547,000
Arizona	$33,905	None
Utah	$33,345	$400,000
Rhode Island	$32,904	None
Califonia	$30,331	$505,000
North Carolina	$29,129	$500,000
Alaska	[illegible]	$500,000
Delaware	$28,664	None
Maryland	[illegible]	[illegible]

•Derived from data provided by Medical Liability Monitor (Oct 2002)

Exhibit 2b

Premiums And Damage Caps for Bottom 27 States

States In Blue Have Caps Affecting Noneconomic Damages

State	Premium	Status Of Cap
MEDIAN-Mississippi	$26,873	$500,000
New Mexico	$26,544	$600,000
Colorado	$26,070	$250,000 noneconomic; $1M overall
New Hampshire	$25,598	None
Hawaii	$25,280	$375,000
Montana	$24,934	$250,000
Tennessee	$24,504	None
Georgia	$24,300	None
Washington	$23,947	None
Oregon	$23,919	None
Alabama	$22,535	None
Kansas	$22,481	$250,000
Virginia	$21,701	$1.6M OverallCap (Economic + Noneconomic Damage)
Iowa	$20,969	None
South Carolina	$18,655	None
Vermont	$18,237	None
Maine	$18,119	$400,000 in Wrongful Death cases only
Arkansas	$16,981	None
Wisconsin	$15,924	$350,000
North Dakota	$15,790	$500,000
Idaho	$15,536	$400,000
Nebraska	$14,314	$1.25M Overall Cap (Economic + Noneconomic Damage)
Indiana	$13,281	$1.25M Overall Cap (Economic + Noneconomic Damage)
Minnesota	$12,801	None
South Dakota	$12,212	$500,000
Oklahoma	$11,118	None

•Derived from data provided by Medical Liability Monitor (Oct 2002)

Exhibit 3

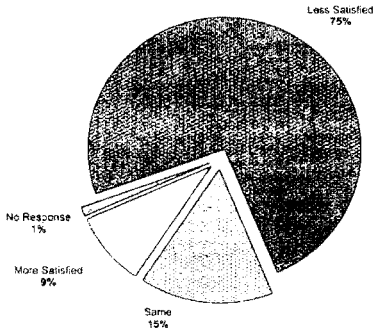
2001 PHYSICIAN SURVEY RESULTS

In February 2001, The California Medical Association (CMA), in partnership with its component medical societies, conducted a statewide survey of physicians. CMA presents the findings below.

QUESTION 1: In the last five years, has the practice of medicine been more or less satisfying to you? (2,260 physicians (98%) responded to this question)

More Satisfying	**198**	**9%**
Less Satisfying	**1,720**	**75%**
The Same	**342**	**15%**
No Response	**47**	**1%**

Q 1. Physician Satisfaction in the last five years



Source: California Medical Association

Exhibit 4

Question 3: If less satisfying, what are the sources of your dissatisfaction? (Please rank each option from 1 — 5; 1 = highest level of dissatisfaction) (1,975 physicians (86%) responded to this question.[9])

Highest level of dissatisfaction[10]

Low Reimbursement =	**55%**
Managed Care Hassles =	**53%**
High Practice Expense =	**43%**
Government Regulation =	**41%**

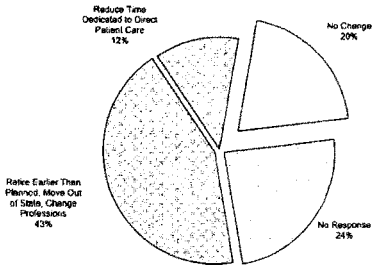
Source: California Medical Association

Exhibit 5

Question 4: Within the next 3 years do you plan to: (1,744 physicians (74%) responded to this question)[11]

Leave patient care in California: i.e., move out of state to a better medical economic/practice environment; retire earlier than planned; change professions (non-patient-care career)	989	43%
Reduce the amount of time spent in direct patient care	284	12%
No change	471	20%
No Response	563	24%

Q.4 Physicians Plans for the Next Five Years



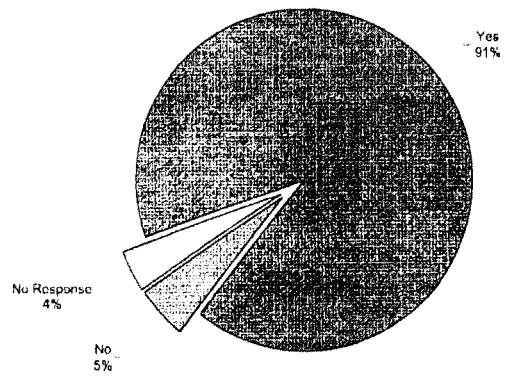
[11] Total does not equal 100% because of rounding to the nearest decimal point.

Source: California Medical Association

Exhibit 6

Question 10. Do the current California reimbursement levels and regulatory environment negatively impact the quality and availability of medical care? (2,225 physicians (96%) answered this question.)

Yes	**2,109**	**91%**
No	**116**	**5%**
No Response	**82**	**4%**



Source: California Medical Association

Ms. DEGETTE. It is also ridiculous to address medical malpractice reform when we don't look at the cost of insurance and other factors in pricing of malpractice premiums. Among the contributors of rising malpractice premium costs are issues totally related to victim's compensation, the cyclical nature of the insurance business cycle, management or mismangement of investments and reserves and even pressures health care financiers and the creation of restrictive delivery systems such as managed care have wrought. Managed care and the pressures that health care financiers place on providers share the blame in part because, as insurers and companies put pressure on physicians to reduce the amount of time they spend with patients as well as cut down on the number of referrals to specialists, mistakes are often made.

Focusing on damage caps as the height of malpractice reform ignores these and other issues acknowledged to be factors. I would like to say that many say, well, we are not capping noneconomic—we are not capping economic damages, we are only capping noneconomic damages. But in the case of Ms. Lewinski, in the case of stay-at-home moms, in the case of children, when you cap noneconomic damages to a proportion of economic damages you are leaving them with no compensation.

Now, in fact, I think this is your traditional congressional problem or solution in search of a problem. Because of all of the medical malpractice cases, 88 percent of patients did not sue when there was bona fide medical malpractice, 22 percent have sued, and the reason is because of patient-doctor relationships. So let's look at the real reasons this is going on.

Mr. Chairman, I do look forward to this hearing.

Mr. BILIRAKIS. I thank the gentlelady.

Mr. Upton.

Mr. UPTON. I have a statement for the record, and I defer.

Mr. BILIRAKIS. Let's see. Mr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman. I would like to make an opening statement, please.

I thank you very much and the authors of this bill for bringing this critical legislation to us this morning. I think all of you are to be commended for your efforts.

This bill is before us today because we have a crisis in this country. Call it professional liability insurance, call it medical malpractice insurance, whatever you call it, the premiums providers pay for insurance are skyrocketing. The impact of these skyrocketing premiums are affecting access people have to health care. I think probably all can agree with that.

Now I understand that the reasons for the recent premium increases are very complex. I happen to believe we should examine the insurers' antitrust exemption. I do believe we should look at ways to make sure that investment losses don't create premium crisis. However, there is one area we can immediately address that can change the insurance market. We can limit the damages available to an injured patient. That will bring a much-needed stability to insurers, to the providers of health care and, ultimately, to premiums.

Is a $250,000 limit on noneconomic damages the right amount? I am not sure it is. I can tell you I don't know what the right num-

ber is. I am certain, though, that there must be a number out there that we can agree upon that is reasonable and just.

We are not limiting recovery for economic damages in any way. We allow punitive damages to be as much as twice economic damages. But to say that there never can be any limit, any limit on noneconomic damages, no matter how high, is not a reasonable position to take today.

Mr. Chairman, this bill is about access, but it is also about defensive medicine and a lot of money that is being wasted in health care. If we don't address the issue of medical malpractice insurance, we run, in my opinion, the risk of jeopardizing the health of patients because they cannot get in to see a doctor when they need one. We can do without many lawyers, but since our health care facilities are stretched as thin as they are we really cannot afford to do without our physicians today.

It is of interest to me, I wonder, should we come to some reasonable limit, some reasonable number on noneconomic damages, might we have a lawyers' strike? Maybe that is not at all a bad idea. But a physicians' strike scares me to death.

I strongly encourage members to support this bill. It is like any other bill I ever voted for: I hate some of it, and I love some of it. Even my own bills I feel that same way about. But we are dealing with a crisis, and this is one of the ways we can help with the crisis, save money in health care by defensive medicine and make it reasonable so our physicians can protect themselves and their families and go about the business of treating patients.

Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Ms. Capps for 3 minutes.

Ms. CAPPS. I will submit a statement, and I will wait.

Mr. BILIRAKIS. So you will have 8 minutes.

Mr. Deal.

Mr. DEAL. I reserve my time, Mr. Chairman.

Mr. BILIRAKIS. You reserve your time. You also have 8 minutes.

Let's see who is next here. Mr. Strickland.

Mr. STRICKLAND. I would defer at this time and keep my time for the questioning, sir.

Mr. BILIRAKIS. All right.

Mr. Shadegg.

Mr. SHADEGG. I reserve my time.

Mr. BILIRAKIS. Eight minutes.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I will give my statement.

Mr. Chairman, I appreciate you holding this hearing on assessing the need for enactment of medical liability reform. This is an important topic, and it is correct it is a nationwide concern.

Without question, medical malpractice premiums have been increasing for physicians throughout our country, particularly in my home State of Texas. I have heard from many of my physicians who are experiencing significant increases in the premiums. These doctors have been serving patients in my area for decades and are being forced to decide whether they should keep practicing, restrict their service or move to another area.

The situation is unacceptable, and something must be done. But I am very wary of the Federal Government wading into this area of tort reform, an area that has traditionally been under the jurisdiction of States. In my experience in 20 years as a State legislator it has been dealt with in the State of California and even in my own State of Texas now with the legislature in session. There will be an issue, there will be a legislation to address this, because these medical malpractice lawsuits are typically only filed in State courts. That is where the States should be dealing with it.

To nationalize this type of issue, one, I think is asking for trouble. Because once Congress passes legislation, unlike our States who can change things very—fairly quickly, we do not. Are we going to force these cases to Federal courts? Are we going to provide Federal rules that our States have to live by? Which, again, I have a lot of elected State judges in Texas who have concerns about that.

My colleagues on the other side of the aisle cite the success of MICRA, the California experience; and there is a legitimate question on whether MICRA has, in fact, been successful in reducing medical malpractice premiums. But, again, we are looking at a successful case, if it is in California, but it is California who dealt with their issue.

I hope that we would as Members of Congress respect that the States can deal with it, the States are going to address it, and the States have addressed it, those States who have been in session.

I do have some concern about H.R. 5. I think it absolutely goes very much further than any medical malpractice. In fact, I am somewhat offended that if we are going to pass a medical malpractice reform for our physicians that we are also including HMOs, pharmaceutical manufacturers and medical device manufacturers. I think it is a sad day that we send out a doctor who is serving our patients as a smoke screen to be able to protect industries that really can stand on their own. If they need to have medical malpractice liability relief, then let them come on their own and not use our everyday physicians as a screen.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Buyer.

Mr. BUYER. I reserve.

Mr. BILIRAKIS. Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

Several weeks ago in New Jersey thousands of physicians planned a work stop Statewide in response to skyrocketing insurance premiums. Although I sympathize with doctors, especially those in high-risk specialties such as obstetricians and other surgeons, I have to express that H.R. 5 is not the solution to the current medical malpractice crisis.

I have several concerns with this legislation. First of all, if we are here to address the issue of medical malpractice, I see no reason why the scope of H.R. 5 must include protections for a broad variety of medical participants including HMOs, nursing homes, nurses, doctors and drug and device manufacturers. This bill is not limited to medical malpractice, and I am astonished that provisions

in this bill protect manufacturers, distributors or suppliers of drugs or medical devices from punitive damages.

It seems to me that what we have here is a very political effort to not only mention medical malpractice but also try to deal with a lot of other types of tort reform or even product liability reform. I don't think that the public understands that no effort has really been made to reach out to the Democrats and do anything on a bipartisan basis and rather just ram something through that is going to go to the floor that probably has no chance of ever passing.

Additionally, I find the statute of limitations outlined in the bill to be unacceptable. In most States, the time allowed for statute of limitations does not usually begin until the harm or injury is discovered or reasonably should have been discovered. Moreover, for children, many State statute of limitations does not begin until the child turns 18. I am particularly concerned about this bill being detrimental to children. I have three children of my own. So it is very much of a concern to me.

Basically, what I think the authors are saying is that, if we have legislation that limits noneconomic damages to $250,000, then the problem of medical malpractice premiums is simply going to go away. I don't buy that. It is a one-size-fits-all approach. It doesn't look at the actual underlying issue of health care and medical malpractice.

I think we have a major problem with insurance premiums.We have bad accounting or bad business judgment on the part of the insurance industry that hasn't been taken into consideration here.

What we should do is provide some kind of Federal reinsurance program. I have proposed that with H.R. 485, the Federal Medical Malpractice Insurance Stabilization Act.

I just want to say one more thing. I really don't think that the opportunity has been given today in terms of who is testifying here to really even have the option of understanding what the problem is all about.

I read in the papers yesterday about the Santillan family and this person, 17-year-old woman, named Jessica Santillan who lost her life on Saturday. This is a perfect example of someone whose representative should have been here testifying today. I don't know exactly why there isn't anyone here. I know they have asked to be here to have the opportunity to present testimony about why this legislation would not allow for a satisfactory outcome in a case like that. I think between the witnesses and the way the majority is going about this it is really not giving us an opportunity to learn what the root cause of this problem is.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman, for holding this important hearing today. This is one issue on which we cannot afford to waste time. The situation in my State of Pennsylvania is dire. Pennsylvania hospitals and physicians face skyrocketing premiums, causing major insurers to drop coverage or raise premiums. It is ridiculous that in some cases the new premiums are more than the actual income a health care provider earns annually.

What this really means is that we have a serious problem—not just a serious problem, actually, it is a crisis—with access to care

in Pennsylvania. The continued deterioration of the medical liability market in Pennsylvania threatens the viability of hospitals, of health systems and physician practices.

Brandywine Hospital in my district was forced to close its trauma center in June of last year due to lack of trauma surgeons. And the CEO Allen Larson, who cited, quote, soaring medical malpractice premiums that are driving surgeons out of State or into retirement, close quote, said that he tried to recruit new trauma surgeons only to find that all Pennsylvania graduates of trauma surgery left the State to start practicing elsewhere. This means that severely injured patients must be transported to Philadelphia, almost an hour away, or other cities many miles away.

Chester County Hospital, another in my district, came very close to taking the drastic step of closing its maternity ward when insurance for obstetricians skyrocketed. The doctors reported that they would have to discontinue offering care at that hospital, and the hospital stepped in at the last minute with a temporary solution and actually put these independent physicians on their payroll in order to provide coverage for them through the hospital captive insurance company. Since Chester County Hospital does 2,100 or so deliveries a year, this load was too big for other providers in the area to pick up; and women would have to leave our county to have their babies.

Mr. Chairman, we will hear many arguments today from doctors and trial attorneys and insurance companies, but I hope we can see clearly through all of this to the bottom line: The current system is not working. Patients are being denied care because large numbers of physicians are leaving the State. And this is one case in which we need to have uniform minimum standards. Doctors should not have to choose where to live or work due to their malpractice insurance.

As you know, the Pennsylvania State legislature did pass legislation this year that included numerous tort reforms and some economic relief. However, the financial pressures created by the escalating medical liability crisis will not be resolved by these limited tort reforms. Passage of the health act is critical because it contains important reforms. Key among them is the establishment of a cap on noneconomic damages.

Let's be honest, at the end of the day, this legislation is not about doctors or insurance. It is about mothers having places to deliver their babies and accident victims having a nearby trauma center to go to.

I strongly support this legislation and look forward to hearing from our witnesses before us today. I yield back.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Ferguson.

Mr. FERGUSON. Thank you, Mr. Chairman. Appreciate you holding this hearing.

In New Jersey, where I am from, we are fortunate to have one of the greatest health care systems anywhere. We have top-notch hospitals. We have some the best doctors and nurses anywhere. We have some the best medical research anywhere in the world. Our medical professionals are devoted to their work and to the people that they serve. They serve on the front lines of our Nation's health

care system in a way that I think really exemplifies the best of the American spirit.

But in New Jersey today we face a perfect storm. The dramatic rise in lawsuits, coupled with the skyrocketing liability insurance costs for doctors and hospitals, they are jeopardizing patient care. If we don't take corrective action now, the situation is only going to become more severe. After all, without insurance, doctors can't practice. But high insurance costs are forcing many doctors in our State to abandon their practices. With too many frivolous lawsuits too many of our doctors are being forced to settle cases for large amounts of money, even when they haven't committed an error.

In New Jersey, in the year 2000, more than $190 million was paid out to cover jury awards, a figure that put our State in the top ten in the Nation. These lawsuits have caused doctors' liability insurance premiums to mushroom and increased the cost of health care for all of us. Because premiums and lawsuits are threatening doctors in an unpredictable and unlimited manner, many doctors in New Jersey can't afford to get affordable insurance coverage at all.

What is most disheartening is that litigation fears not only increase the cost of health care but also have discouraged doctors from helping individuals who are most in need and who can't afford their services. Many doctors can't volunteer their services for patients who can't pay, and the proportion of physicians who provide any charity care at all has declined nationwide. This deprives patients of long-term, trusted relationships and sometimes leaves them without a doctor altogether.

My family, as many others, has personally experienced the effect of this crisis in New Jersey firsthand. Three weeks ago, my wife and I were blessed with our third child. My wife's due date was the very week of the job action that Mr. Pallone had referenced before. Over the last few months, we have seen many physicians leaving their practice; and in my wife's doctors OB/GYN practice my wife's doctor's partner left the State recently because of her insurance premiums. My wife's doctor's premiums went up 40 percent just this year.

While our physician gave us every guarantee that she would be there for us when the day came, and she was, there are fathers and mothers and loved ones who I fear for. I fear that the bond between patients and their doctors will be broke and that these patients will not have access to the trusted professionals because of the frivolous lawsuits and the resulting insurance premiums which are forcing doctors to abandon their practices.

There is no reason it has to be like this. It is simply not right when those physicians who want to provide their services are discouraged from doing so because of the fear of litigation. Patients should have their day in court, and this legislation allows patients to have their day in court. But the legislation also protects patients by preserving and not breaking the bond of the doctor-patient relationship.

I want to thank Mr. Greenwood for introducing this important legislation. I look forward to hearing the testimony from the witnesses today. Thank you.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Let me take this opportunity to thank our witnesses here today. I am sorry we couldn't provide better weather for you, and hopefully you won't get stuck here.

Let me respond to something that was said earlier. I have worked very successfully with people on the other side of the aisle to produce health care legislation with those individuals who look for solutions, and I look across the aisle today with the same intent and with the previous history with them of one of accomplishment. I also make no bones about the fact that I choose not to work with those on the other side of the aisle or on my side of the aisle that choose to use this only for political purposes. Because we have reached the point in health care where we need answers, and we need answers now.

After working on health care for now 8 years, I am well aware of the complexity of the health care delivery system. Some people today are going to say that enacting Federal medical malpractice reform is not going to help our health care delivery system. Other people are going to say that this legislation will serve two important purposes: first, that it will decrease health care costs through reductions in the malpractice insurance premiums; and, second, it is a positive step toward reigning in a litigious society.

If it were up to me, the debate on this issue would be a looser pay system where we take a much bigger bite at getting at the frivolous lawsuits that I think have become prevalent in society. It is somewhat ironic to me that the same individuals that criticize us being here debating this and proposing this legislation today are in fact the ones that use the argument on other health care issues that it is doctors, it is hospitals, it is nurses, it is health professionals who we should empower to make more decisions.

It is not insurance companies and so on, but it is health care professionals that should be empowered to play a bigger role in the health care solution in this country. In fact, it is doctors and hospitals and nurses and health care professionals that have over and over and over again said to us that the first thing we need to do to try to curb the inflation cost in health care is reign in the lawsuits that are currently taking place. We are attacking exactly the place that health care professionals have said is the first place we need to go.

There is no question in my mind that this legislation will help our health care system. As long as medical malpractice premiums continue to increase, our overall health care costs will increase. I want patients to have the access to high-quality and reasonably priced health care and, yes, to have the right to pursue when harmed. I think we have protected that.

I urge my colleagues to support Representative Greenwood; and I yield back, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Pickering.

Mr. PICKERING. Mr. Chairman, thank you for this very important hearing.

As we look at Medicare, Medicaid, veterans' health care, prescription drugs, the delivery of health care, rural health care, health care in States like mine in Mississippi which over the past

few years has been in a State of crisis and we look at our responsibilities as a committee and as a Congress as to how do we have a comprehensive health care policy for our country that we have access to insurance for the individuals that are providers can practice without the fear of being bankrupted by an excessive jury verdict, what can we do to contain the cost, make health care available to all Americans and my State of all Mississippians?

This is a very important piece, a very important part, a very important component of a comprehensive health care policy.

Later this year, we will be working on Medicare reforms. We will be working on a prescription drug benefit. The Veterans Committee will be looking at what they have to do to get veterans' health care. If we look at all components, this issue about out-of-control lawsuits and the cost increase that is put into every system and every place and every community, because of it we have to act on this piece of it just as we have to act on all those other things.

I want to join with Congressman Burr. In my home State of Mississippi, a bipartisan compromise was reached this past year, legislation was passed, and we believe that it will make a significant difference in our State.

Now the caps in the State legislature and Mississippi that were passed were higher than the caps passed in this legislation, a $500,000 cap on noneconomic damages, and then over time it would increase with inflation, $750,000 cap by 2011, $1 million by 2017. It is a reasonable and a common-sense approach to solving the problem in Mississippi.

I hope the same type of common-sense approach, bipartisan approach can be found here in Congress. As we look at overall health care, we have to have this piece as part of our strategy and part of our policy to be able to make health care affordable and available and at a high quality to all Americans.

So, Mr. Chairman, I look forward to working with you on this and hope that we can find a way to find a common ground and consensus just as we did in Mississippi this past year.

Mr. BILIRAKIS. I thank the gentleman.

I believe that takes care of all the opening statements. As we said earlier, any written opening statements could be made a part of the record.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I commend you for holding today's hearing to assess the need to enact medical liability reform to address the growing malpractice insurance crisis affecting physicians, hospitals, and other health care providers in many states and address some of the factors fueling the double-digit increases in health care premiums with which large and small employers and individuals and families across the nation are grappling.

My state of Michigan has already put in place a number of the important reforms similar to the federal reforms we are contemplating. As a result, Michigan is not experiencing the malpractice insurance crisis that is gripping many other states. But we are certainly not immune from such experiences as sharp increases in premiums and insurers withdrawing from our market. Last year, for example, the emergency physician group serving one of the largest hospitals in my district almost lost its malpractice insurance. Had help not come at the very last minute, an entire community could have lost access to emergency care. Similarly, a large physician practice serving the poor and uninsured in Southwest Michigan could not afford to

renew its malpractice insurance policy because of a sharp increase in the premium. They were eventually able to find more affordable insurance, but only by increasing their exposure.

While I have thus been very supportive of federal medical liability reform, I hope that as this process moves along, we will be mindful one potential problem that a federal pre-emption of certain state laws could pose for physicians. Specifically, many Michigan physicians are concerned that by pre-empting our state joint-and-several liability provision and replacing it with a "fair share" provision, they may face higher malpractice liability insurance premiums and be forced to purchase considerably more coverage than they now typically carry. I hope that during the course of these hearings, we can explore these concerns.

Again, Mr. Chairman, thank you for your leadership on medical liability reform. I look forward to working with you again this year as we seek to address this issue that is critical to continued access to affordable, community-based care across Michigan and our nation.

PREPARED STATEMENT OF HON. STEVE BUYER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. Chairman. Thank you for bringing this measure, H.R. 5, before the Subcommittee. This is timely legislation to ensure that our constituents have access to health care.

H.R. 5 strikes an appropriate and reasonable balance between the need for patients who have been harmed to seek redress and the need of all patients to have access to health care services.

The State of Indiana has been at the forefront of ensuring an effective medical liability system. More than 20 years ago, the State of Indiana enacted reform to its medical liability system. This system has served the State and its citizens very well and has served as a model for other States, including the State of our fine full Committee Chairman.

Nothing in the legislation we are moving today would inhibit Indiana from keeping its current medical liability system. In Indiana, a medical review panel is convened to review the validity of the medical claims in the case. Indiana law places limits on the liability of health care providers. Recovery over this limit is provided by a compensation fund managed by the State. Total recovery is capped and attorneys' fees are capped. Injured patients receive compensation in a timely fashion.

It is my understanding that under the intent of H.R. 5, Indiana will be able to retain the core aspects of its medical liability system. These include, the medical review panel requirement, the total compensation cap, and the limits on providers' liability. It is also my understanding that, should this legislation be enacted, other States could follow Indiana's lead and adopt similar reform to their systems.

With these understandings, Mr. Chairman, I urge that the Subcommittee move this legislation forward.

PREPARED STATEMENT OF HON. ERNIE FLETCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. Chairman, thank you for conducting this hearing today. As a physician, I have always tried to do what is best for my patients. As a Member of Congress, I still try to do what is best for patients in Kentucky and across America.

I hear stories about women who have to drive 75 miles or more to have their babies delivered and end up delivering in their cars, because their doctor quit delivering babies or the nearby maternal wards have closed due to out of control medical liability premiums.

What is best for the patient? I believe that unlimited medical liability awards are bad for patients, because they cause malpractice insurance prices to climb, resulting in more expensive care, fewer doctors, and an access to care problem. Trial lawyers argue that limiting awards is bad for patients because it means that the most serious injuries aren't properly compensated. However, H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003, which I support, actually ensures fair compensation for everyone. We need to keep in mind that everyone is entitled to full compensation for their actual losses, medical bills and wages under H.R. 5. This is very fair.

Punitive damages under the HEALTH Act would be two times economic damages—which are not capped, or $250,000, whichever is greater. Punitive damages are meant to send a message, not to compensate the victims. Unfortunately, trial

lawyers have been winning outlandish punitive damage awards—mainly for themselves—at the expense of the patients, providers, and all Americans.

Its not unusual to hear stories of doctors moving from Kentucky to Indiana or from Nevada to California to take advantage of the lower cost of medical liability insurance. Passing H.R. 5, the HEALTH Act, which reasonably reforms our liability system, will enable insurers to hold premiums at a lower, more constant rate without arbitrarily setting price controls on premiums that further exacerbate the access to care problem we face.

We will hear today from some who do not support comprehensive liability reform, claiming that it is the stock market's fault that we are seeing malpractice liability premiums rising. Yet the stock market hit the insurers in Kentucky and Nevada as much as they did in California and Indiana. Furthermore, insurance rates did not jump in states like California in the past couple of years, as they did in Nevada, Pennsylvania, and West Virginia. Having a reasonable limit on pain and suffering, which is unquantifiable, and other reforms in H.R. 5 will help improve the current unhealthy cycle, which trial lawyers are currently perpetuating.

Lawsuits are a poor answer to medical events. They don't prevent injuries and they don't reduce medical errors. But they do create an atmosphere of fear, defensiveness, and distrust in the physician-patient relationship. As a physician, I took an oath "to do no harm." The only bill today that will help physicians to keep that oath is one that safeguards safe and timely access to care through reasonable, comprehensive and effective health care liability reform, and H.R. 5 does just that.

The rapid escalation in medical malpractice awards and the resulting rise in medical liability premiums are major problems that demand action now. It affects patients' access to quality care, especially women and patients in rural areas. It is clear that these excessive awards are driving the cost of health care up, which is a major concern for most Kentuckians and Americans. Legislation must be passed to control this critical problem both at the state and federal levels. I have strongly supported previous attempts to pass reform and will continue to support passage of significant medical liability reform.

Mr. BILIRAKIS. We will go right now to the panel. I want to welcome all of you.

Ms. Heather Lewinsky is, I know, from the Pittsburgh area or that is an address, the Buffalo. But we thank her for her courage in wanting to come here. There is nothing to be afraid of.

Mr. Jim Hurley is here on behalf of the American Academy of Actuaries; Mr. Heistand is CEO and General Counsel for Californians Allied for Patient Protection; Mr. Rosenfield is the President of the Foundation for Consumer and Taxpayer Rights; Ms. Rosenbaum is Hirsch Professor of Health Law and Policy at G W.; Mr. Lawrence C. Smarr is President of Physicians Insurance Association of America; and Dr. Donald J. Palmisano is President of the American Medical Association.

Again, welcome. I am going to set the clock to 5 minutes, and your written statement is already a part of the record so we would hope that you complement it more than anything else.

Ms. Lewinski, please proceed when you are ready.

STATEMENTS OF HEATHER LEWINSKI; JAMES HURLEY, ON BEHALF OF THE AMERICAN ACADEMY OF ACTUARIES; FRED J. HIESTAND, CEO AND GENERAL COUNSEL, CALIFORNIANS ALLIED FOR PATIENT PROTECTION; HARVEY ROSENFIELD, PRESIDENT, FOUNDATION FOR CONSUMER AND TAXPAYER RIGHTS; SARA ROSENBAUM, HIRSCH PROFESSOR OF HEALTH LAW AND POLICY, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES; LAWRENCE E. SMARR, PRESIDENT, PHYSICIANS INSURERS ASSOCIATION OF AMERICA; AND DONALD J. PALMISANO, PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Ms. LEWINSKI. My name is Heather Lewinski. I am a 17-year-old high school senior. I recently saw President Bush on television saying that Congress should pass a law saying that doctors or hospitals who injure people through their medical mistakes should never have to pay the patients more than $250,000 for their pain and suffering. I do not believe that doctors should be blamed for everything bad that happens to a patient, but if they make a mistake the patient's pain and suffering can be way more than $250,000. Unfortunately, I know this from personal experience.

When I was 8 years old, a doctor performed a surgery on my face that never should have been done. He told my parents that he had tried this surgery successfully on many other patients with my condition, but my parents and I later found out that that was not true. This doctor had never done the surgery before; and, in fact, we were told that no doctor in the whole United States had ever recommended this surgery for a condition like mine. I feel like the doctor was using me as a guinea pig.

The doctor told my parents that he would be able to take care of my problem with two easy surgeries a few months apart. He also told my parents that I would have no visible scars. I wish that doctor had just told the truth. I ended up with horrible scars all over my face, and I have gone through 14 major surgeries on my face to try to correct what he did. I have had so much pain over the past 10 years I can't even begin to tell you about all of it.

I never had any surgery before this doctor operated on me, so I never knew what to expect. After I went through the first surgery, I had so much pain like I had never felt before. Since then, it has never gotten better with any of my surgeries and in addition has instilled a horrible fear. Every time one of my surgeries is approaching I would get frightened and always thinking about the surgery and the pain I would be in. It would get so bad that I actually would have to sleep with my mother for many nights before the surgery. That went on with all of my operations, and it did not matter whether I was 9 or 13 or 14 years old. This makes me feel stupid. Here I am a teenager, but I end up sleeping with my mom because I am so afraid of surgery, the hospital and everything that goes with it.

After every surgery I had I would be forced to stay in the hospital for awhile. Then when I go home where I would be in bed or on the sofa for weeks. My mouth would be wired shut. My face would be swollen. My entire head would be wrapped in bandages. Sometimes the pain was so bad it would feel like my whole face

was going to explode. It was like someone had a hammer and kept hitting me.

I remember 1 day we were driving to the hospital for one of my surgeries, and it was around Christmas time. There was a song on the radio called, It's a Marshmallow World. I started to cry, and I said to myself, it really isn't a marshmallow world.

I will never forget the first time I looked at my face after surgery. The doctor told us that I wouldn't have any noticeable scars. I took the bandages off my face and looked in the mirror and just cried. I could not believe what he had done to my face. He tried to do another surgery to fix it, but that only made things worse. I not only had these thick red scars all over my face but now the corner of my mouth was all pulled down. I looked like I had a stroke.

After all of my surgeries, my face and my whole body would hurt so bad. I wanted to hide away because I did not want anyone to see me. My appearance was so gruesome that no one should have to see me.

From third grade through 8th grade, I missed so much school from all the surgeries that I had trouble keeping up. In third grade, I missed from March until the end of the year. In fourth grade, I missed from Thanksgiving break until the rest of the school year. In fifth, sixth, seventh, and eighth grades, I missed anywhere from 3 to 5 months of school each year. I had to have tutors and be home schooled all this time. I remember that even though I have always been a good student they had to label me "special ed" because I missed so much time. I hated that label.

I still cannot believe I have gone through 14 surgeries. You never get used to the pain, and the fear never goes away. But by far the worst the part about everything that has happened to me is the way my face looks and how people treat me. I wish people could see the inside of me and know the kind of person I really am, but all they see is those scars on my face, and they stare. From third grade until now, every time I walk into the halls or into class or in the cafeteria people are staring. The kids in school constantly tease me and called me names like Two Face, the character from the Batman movie. I hated to eat in the cafeteria because I could not close my mouth, and I would drool. Because of the corner of my mouth, the way my mouth looked, the kids would walk around school and pull down their lip and mock me like they had a stroke.

I hate to go out in public because adults stare, and some of them even come up to me and ask questions. I remember once being in an ice cream parlor with my family, and there was a lady with her son, and she just kept pointing to my face and then talking to her son. This sort of thing happens to me all the time.

I really like people, but I have only one close friend, my girlfriend Angela who I grew up with. It is so hard for me to meet new people and make friends because they just stare. And even a few other kids who are supposedly my friends at school will not walk with me in the halls, and it seems like they are always two to three steps behind me. I quit riding the bus from school a long time ago because it was torture. My mom has to take me to school and pick me up.

Sometimes I wish so hard that there was some magic that I could just make myself invisible to other people and still be able to enjoy them.

I am now a high school senior, and I have never had a boy ask me on a date. I will be 18 in a few months, and I have never kissed a boy. I remember one time sitting in the cafeteria a few years ago, and a boy came up to me and asked me if I was doing anything on Friday. I was so excited that I almost fell over, but then he went back to his table with his friends, and they started laughing and pointing at me, and I realized it was just a joke.

The only school dance I ever attended was in ninth grade. It was a Valentine's Day dance, and I wanted to go so bad, but no one asked me. I finally asked out a boy that lives next to me if he would go, and he was so nice that he could not say no. I was so excited, and my parents really bought me the works—a new dress, new shoes, makeup, hair. My dad told me I looked like a princess, and I just remember looking in the mirror and seeing my face and hoping that the boy would not be looking at my scars.

I have never really been involved in school activities because I just do not have that many friends. The one activity that I have that I really love is training and showing dogs. I have been doing that for a few years. Other people hire me to train and show their dog, and I also train and show my own dogs. I usually compete in dog shows on the weekends in New York and some other States. I have been really lucky and have been able to win several awards competing against adults at the dog shows. I think one of the reasons that I like dog training so much is that animals can't stare or laugh at you.

I will be graduating from high school on time in a few months, and I have already been accepted into college. Because of my fears of meeting new people. I chose a college that is close to my house so I do not have to stay in a dorm with other kids.

My biggest wish is that someday I will find a boy who will look at and see me for what is on the inside of my heart and my mind and not my appearance. I would love to get married and have a family some day, but if I am honest with myself I do not know that that will ever happen, so I have made other plans. I will finish college and become a kindergarten teacher. I have always loved babysitting kids and being around them. Little children do not stare so much, and they just accept you for what is inside. I will teach school and live in the country with lots of dogs, and I will be self-sufficient.

I know that the President is trying to make good decisions, but if he could see everything that I have gone through for the last 10 years and everything that I am going to go through for the rest of my life, I think he would realize that he is wrong about this law and that every patient is entitled to be judged as an individual based on what they have gone through.

I think that most doctors try to do the best they can for people. But sometimes they do things that should not be done. And when that happens, I think she should be responsible for all the harm they cause and not just part of it. I know that nothing could be done to change what has happened to me. But I hope that if we keep the laws strong, maybe a doctor will be more careful in the

future and no other little girl will have to go through what I have. Thank you.

[The prepared statement of Heather Lewinski follows:]

PREPARED STATEMENT OF HEATHER LEWINSKI

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see is those scars on my face, and they stare and glare at me. From third grade until now, every time I walk in the halls or into class or in the cafeteria, people are staring, and I hate it! The kids in school have constantly teased me and called me names like "Two Face," the character from the Batman movie. I hated to eat in the cafeteria because I could not close my mouth, and I would drool profusely. Because of the way the corner of my mouth looked, the kids would walk around school and pull down their lip and mock me like they had a stroke.

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The only school dance I ever attended was in 9th grade. It was the Valentine's Day dance, and I wanted to go so bad, but no one asked me. I finally asked our a boy that lives next to me if he would go with me, and he was so nice that he could not say no. I was so excited and my parents really bought me the works—a new dress, new shoes, make up, hair. My dad told me that I looked like a princess, and then I just remember looking in the mirror and seeing my face and hoping that the boy would not be looking at my scars.

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I know that nothing can be done to change what happened to me, but I hope that if we keep the laws strong maybe a doctor will be more careful in the future and no other little girl will have to go through what I have.

Thank you very much.

Mr. BILIRAKIS. Thank you, Heather, and you are going to be a tough act for anyone to follow.

But Mr. Hurley is next.

STATEMENT OF JAMES HURLEY

Mr. HURLEY. It is indeed a tough act to follow. Chairman Bilirakis, Ranking Member Brown and members of the subcommittee, thank you for inviting me to testify today on behalf of the American Academy of Actuaries. The Academy is the public policy and professionalism organization for actuaries practicing in all specialities within the United States. The Academy is nonpartisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy also develops and upholds actuarial standards of conduct qualification and practice. For those not familiar with actuaries, actuaries collect and evaluate loss and exposure data to advise about rates to be charged for prospective coverage and reserve liability to be carried related to coverage already provided.

The Academy appreciates this opportunity to comment on issues related to the availability and pricing of medical malpractice insurance. In the time available, I would like to highlight a few key points from my written statement. I will start by discussing recent experience in the medical malpractice line of business. During the 1990's, the medical malpractice line experienced favorable operating results. This was contributed to by favorable reserve development on prior coverage years and healthy investment returns. Insurers competed aggressively. Health care providers shared in the benefit of improved loss experience and higher levels of investment income through stable or decreasing charged premiums.

Recently, however, the cost of medical malpractice insurance has been rising. Rate increases have been precipitated in part by the growing size of claims, more frequent claims in some areas and higher defense costs. The decline in expected future bond yields exacerbates the need for rate increases. From a financial standpoint, medical malpractice results deteriorated for the 3 years ending 2001. 2002 data is not yet available, but is projected to reflect similar results.

Two indicators of financial results are the combined ratio and the operating ratio. We can obtain these indicators or reporting from AM Best Company, a company that offers comprehensive data to insurance professional and tracks these results. The combined ratio is an indication about how the company is doing in its insurance underwriting. For all companies reporting to AM Best, the combined ratio of 130 percent and 134 percent for 1999 and 2000 respectively, deteriorated to 153 percent for 2001. For underwriting this represents a loss of 53 cents on each dollar of premium written in 2001.

Preliminary projections for 2002 are for a combined ratio of just under 140 percent. A measure of the overall profitability of insurers is the operating ratio. The AM Best operating ratio adjusts the combined ratio for other expense and income items primarily investment income but it is before Federal income tax. The operating ratio for 1999/2000 was approximately 106 percent indicating a net loss of six cents on every dollar of premium. This deteriorated to 134 percent in 2001, indicating a loss of 34 cents on every dollar of premium. Given lower interest income, the 2002 operating ratio will probably not improve as much as the projected improvement in the combined ratio. At these levels, 2001 and 2002 results are

the worst they have been in 15 years or more, approximating levels of the 1980's.

This data is clear. Today the loss in operating environment has deteriorated. Benefits of favorable reserve development appear to be gone and the available investment income offset has declined. In fact, some see that the reserve liabilities may require increases to cover current ultimate loss obligations. As a result, rates for both insurers and reinsurers need to increase to properly align with current loss and investment income levels. Companies failing to do this jeopardize their surplus base and their financial health. My written statement summarizes the two key drivers of financial results and their effects on operating results and surplus for some 30 companies specializing in this coverage. These companies represent about one third of the companies reporting to AM Best. The results for these companies are more favorable than the overall industry, but reflect similar deterioration.

In chart B on page 6 of my testimony, the total after-tax operating income for these companies is shown. The favorable operating income of the earlier years in the 20 percent neighborhood declines to a slight profit in 2000 and to a 10 percent loss in 2001. Regarding the impact on surplus chart E on page 8 of my testimony demonstrates the change in surplus from year to year for these same companies. Surplus increased through 1999 but at a decreasing rate. Importantly however, surplus declined in 2000 and more significantly in 2001. This is important because surplus represents the capital base for these insurers. Its decline reduces capacity to write new or renewing business prospectively and lessens insurers ability to absorb any adverse development on business written in prior years.

This, coupled with voluntary and involuntary withdrawals, for example, Saint Paul, MIIX, reciprocal of America has contributed to availability problems in addition to affordability problems. Companies continuing to write medical malpractice insurance must interpret the current experience and determine what rates to charge for prospective coverage. In addition, tort reform is discussed as one means to address the current challenges. The Academy, which takes no position for or against tort reform, has previously reviewed and commented on this subject. These observations include, one, a package that performs is more likely than individual reforms to affect losses and premiums.

Two, key among reforms is a per medical injury non-economic cap at a relatively low level and mandatory collateral source rule.

Three, poorly crafted reforms can actually increases losses and therefore rates.

Four, we must have reasonable expectations. Reforms may not yield immediate rate reductions, particularly given the rate increases being implemented today, since the actual effect including judicial confirmation will not be immediately known. Such reforms do not affect the economic components of the claim costs, and thus severity will still likely drive the need for increases in the future, but perhaps at some lower level. Such reform should make the loss environment more predictable, encourage market participation and reduce concerns of insurers about large subjective non economic damage components to claims.

In closing, I should comment on some frequent misconceptions. One misconception is that companies are increasing rates to recoup stock market losses. This is not true. The rate making process is forward looking and does not reflect loadings for past pricing inadequacy or past investment losses. It reflects expectations of future loss costs and on the investment side primarily prospective interest yields. In general, when prospective bond yields decline, rates will increase, all else being equal. Additionally, rates and investments are subject to regulatory oversight in most States. A second misconception is that companies cause the current problems. Medical malpractice is difficult to price and underwrite successfully which is, in part, why companies specializing in the coverage dominate it. Companies made decisions in the mid to late 1990's expecting continuation of recent stable——

Mr. BILIRAKIS. Please finish up, would you, sir.

Mr. HURLEY. Yes, sir. Unfortunately, the environment changed and loss costs increased, favorable reserve development ceased and investment yields declined and reinsurance costs jumped. This caused rates that need to increase. The Academy and I appreciate the opportunity to provide an actuarial perspective to these important issues, and we will be glad to provide the subcommittee with any additional information that would be helpful in your deliberation.

Mr. BILIRAKIS. Thank you. Thank you, sir. I am sure we will give you an opportunity during the inquiry to finish up.

[The prepared statement of James Hurley follows:]

PREPARED STATEMENT OF JAMES HURLEY, CHAIRPERSON, MEDICAL MALPRACTICE SUBCOMMITTEE, AMERICAN ACADEMY OF ACTUARIES

INTRODUCTION

The American Academy of Actuaries appreciates the opportunity to provide comments on issues related to patient access to health care and, in particular, the availability and pricing of medical malpractice insurance. The Academy hopes these comments will be helpful as Congress considers related proposals.

This testimony discusses what has happened to medical malpractice financial results and its likely effect on rates, tort reform, and some discussion of frequent misconceptions.

MEDICAL MALPRACTICE—WHAT HAS HAPPENED?

The medical malpractice insurance marketplace is in serious turmoil after an extended period of reported of high profitability and competitiveness during the 1990s. This turmoil began with serious deterioration in financial results, continued with some consequences of these results and, at least at this point, gives rise to an uncertain future. Industry-wide financial results reflect a 2001 combined ratio (the measure of how much of a premium dollar is dedicated to paying insurance costs of the company in a calendar year) that reached 153 percent and an operating ratio (reducing the combined ratio for investment income) of about 135 percent; the worst results since separate tracking of this line of business began in 1976. Projections for 2002 are for a lower combined ratio of approximately 140 percent and probable lesser improvement in the operating ratio. This follows 1999 and 2000 operating ratios of 106 percent.

The consequences of these poor financial results are several. Insurers have voluntarily withdrawn from medical malpractice insurance (e.g., St. Paul, writer of approximately nine percent of total medical malpractice insurance premium in 2000) or have selectively withdrawn from certain marketplaces or segments of medical malpractice insurance. In addition, several insurers have entirely withdrawn due to poor financial results (e.g., Phico, MIIX, Frontier, Reciprocal of America, some of which are under regulatory supervision). Overall, premium capacity has been reduced by more than 15 percent. These withdrawals fall unevenly across the states

and generally affect those identified as jurisdictions with serious problems more severely than others.

Capacity to write business would have decreased even more if not for the fact that much medical malpractice coverage is written by companies specializing in this coverage, some of whom were formed for this specific purpose.

The future outlook is not positive, at least in the short term. Claim costs are increasing more rapidly now than they were previously. Further, the lower interest rate environment would require higher premium rates, even if losses were not increasing. The combined effect is that there are likely to be more poor financial results and additional rate increases.

Background

Today's premium increases are hard to understand without considering the experiences of the last decade. Rates during this time period often stayed the same or decreased relative to the beginning of the period due to several of the following factors:

- Favorable Reserve Development—Ultimate losses for coverage years in the late 1980s and early 1990s have developed more favorably than originally projected. Evidence of this emerged gradually over a period of years as claims settled. When loss reserves for prior years were reduced, income was contributed to the current calendar years, improving financial results (i.e., the combined and operating ratios). That was the pattern during the middle to late 1990s for 30 provider-owned medical malpractice insurers whose results are shown in Chart A. What is evident from that chart is that favorable reserve development (shown as a percentage of premium) was no longer a significant factor in 2001 for these insurers as the effect approached zero. In contrast to the experience of these provider-owned insurers, the prior-year reserves for the total medical malpractice line of business actually deteriorated in 2000 and in 2001.
- Low Level of Loss Trend—The annual change in the cost of claims (frequency and severity) through most of the 1990s was lower than expected by insurers, varying from state to state and by provider type. This coincided with historically low medical inflation and may have benefited from the effect of tort reforms of the 1980s. Rates established earlier anticipated higher loss trends and were able to cover these lower loss trends to a point. As a result, rate increases were uncommon and there were reductions in several states. This was justified in part because the rates established at the beginning of the last decade proved too high, inasmuch as carriers had assumed higher loss trends.

  Insurers responded to the emerging favorable loss trend in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others increased rates modestly and tried to refine pricing models to improve overall program equity. In general, however, premium adequacy declined in this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower, particularly in some jurisdictions.
- High Investment Yields—During the 1990s, investment returns produced a real spread between fixed income rates of return and economic inflation. Counter to what some may believe, medical malpractice investment results are based on a portfolio that is dominated by bonds with stock investments representing a minority of the portfolio. Although medical malpractice insurers had only a modest holding of stocks, capital gains on stocks also helped improve overall financial results. These gains improved both the investment income ratio and the operating ratio.
- Reinsurers Helped—Many medical malpractice insurers are not large enough to take on the risks inherent in this line of insurance on their own. The additional capacity provided by reinsurers allows for greater availability of medical malpractice. Similar to what was happening in the primary market, reinsurers reduced rates and covered more exposure, making the net results even better.
- Insurers Expanded Into New Markets—Given the financial results of the early-to-mid-1990s, some insurers expanded into new markets (often with limited information to develop rates). They also became more competitive in existing markets, offering more generous premium discounts. Both actions tended to push rates down.

What Has Changed?

Although these factors contributed to the profitability of medical malpractice insurance in the 1990s, they also paved the way for the changes that began at the end of the decade.

- Loss Trend Began to Worsen—Loss cost trends, particularly claim severity, started to increase toward the latter part of the 1990s. The number of large claims increased, but even losses adjusted to eliminate the distortions of very large claims began to deteriorate. This contributed to indicated rate increases in many states.
- Loss Reserves Became Suspect—As of year-end 2001, aggregate loss reserve levels for the industry are considered suspect. Reserve reductions seem to have run their course. As mentioned earlier, the total medical malpractice insurance industry increased reserves for prior coverage year losses in 2000 and 2001, although results vary on a company-by-company basis. Some observers suggest that aggregate reserves will require further increases, particularly if severity trends continue or intensify.
- Investment Results Have Worsened—Bond yields have declined and stock values are down from 1990s highs. The lower bond yields reduce the amount of expected investment earnings on a future policy that can be used to reduce prospective rates. A one percent drop in interest rates can be translated to a premium rate increase of two to four percent (assuming no changes in other rate components) due to the several year delay in paying losses on average. A 2.5 percent drop in interest rates, which has occurred since 2000, can translate into rate increases of between 5 percent and 10 percent. Note that this factor may discourage an insurer from maintaining market presence and also may discourage new entrants.
- The Reinsurance Market Has hardened—Reinsurers' experience deteriorated as their results were affected by increased claim severity and pricing changes earlier in the decade. Because reinsurers generally cover the higher layers of losses, their results are disproportionately influenced by increases in claim severity. This, coupled with the broadly tightened reinsurance market after Sept. 11, has caused reinsurers to raise rates substantially and tighten reinsurance terms for medical malpractice.

The bottom line is that these changes require insurers to increase rates if they are to preserve their financial health and honor future claim payments.

The Results

To obtain a better understanding of the effect of these changing conditions, we focus on the results of 30 specialty insurers that are primarily physician owned or operated and that write primarily medical malpractice business. Their results reflect the dynamics of the medical malpractice line. This sample represents about one-third of the insured exposures in the United States.

These insurers, achieving more favorable financial results than that of the total industry, showed a slight operating profit (four percent of premiums) in 2000. This deteriorated to a 10-percent operating loss in 2001 (see Chart B).

There are two key drivers of these financial results:

- Insurance Underwriting—For these companies, a simplified combined ratio was calculated by dividing calendar year loss and loss adjustment and underwriting expenses by premium. The combined ratios were 124 percent and 138 percent in 2000 and 2001, respectively. That means in 2001, these insurers incurred $1.38 in losses and expenses for each $1.00 of premium. The preceding five years were fairly stable, from 110 percent to 115 percent. Deterioration of the loss and loss adjustment expense ratio drove these results; the underwriting expense ratio remained relatively constant (see Chart C).
- Investment Income—Pre-tax investment income (including realized capital gains and losses) derives from policyholder-supplied funds invested until losses are paid as well as from the company capital ("surplus"). The ability of investment income to offset some of the underwriting loss is measured as a percentage of earned premiums. This statistic declined during the measurement period from the mid-40 percent to the mid-30 percent level and, in 2001, to 31 percent (see Chart D).

This offset will continue to decline because (i) most insurer-invested assets are bonds, many of which were purchased before recent lower yields, and interest earnings do not yet fully reflect these lower yields; and (ii) the premium base is growing due to increased rates and growth in exposure. Invested assets are not increasing as rapidly as premium and, therefore, investment income as a percentage of premium will decline.

The effect of these results on surplus is reflected in Chart E, which shows the percent change in surplus from one year to the next. Surplus defines an insurer's capacity to write business prospectively and to absorb potential adverse loss development on business written in prior years (see Chart E).

Tort Reform

Some states enacted tort reform legislation after previous crises as a compromise between affordable health care and an individual's right to seek recompense. The best known is the Medical Injury Compensation Reform Act or MICRA, California's tort reform package. Since MICRA's implementation in 1975, California has experienced a more stable marketplace and lower premium increases than have most other states.

Tort reform has been proposed as a solution to higher loss costs and surging rates. Many are suggesting reforms modeled after California's MICRA, although some have cautioned against modifying the MICRA package. The Academy, which takes no position for or against tort reforms, has previously reviewed and commented on this subject. Based on research underlying the issue, we observe the following:

- A coordinated package of tort reforms is more likely than individual reforms to achieve savings in malpractice losses and insurance premiums.
- Key among the reforms in the package are a cap on non-economic awards (on a per-event basis and at some level low enough to have an effect; such as MICRA's $250,000) and a mandatory collateral source offset rule.
- Such reforms may not assure immediate rate reductions, particularly given the size of some increases being implemented currently, as the actual effect, including whether or not the reforms are confirmed by the courts, will not be immediately known.
- These reforms are unlikely to eliminate claim severity (or frequency) changes but they may mitigate them. The economic portion of claims is not affected if a non-economic cap is enacted. Thus rate increases still will be needed.
- These reforms should reduce insurer concerns regarding dollar awards containing large, subjective non-economic damage components and make the loss environment more predictable.
- Poorly crafted tort reforms could actually increase losses and, therefore, rates.

FREQUENT MISCONCEPTIONS

In closing, it might be helpful to address some frequent misconceptions about the insurance industry and medical malpractice insurance coverage.

Misconception 1: "Insurers are increasing rates because of investment losses, particularly their losses in the stock market."

As we have pointed out, investment income plays an important role in the overall financial results of insurers, particularly for insurers of medical professional liability, because of the long delay between payment of premium and payment of losses. The vast majority of invested assets are fixed-income instruments. Generally, these are purchased in maturities that are reasonably consistent with the anticipated future payment of claims. Losses from this portion of the invested asset base have been minimal, although the rate of return available has declined.

Stocks are a much smaller portion of the portfolio for this Group, representing about 15 percent of invested assets. After favorable performance up through the latter 1990s, there has been a decline in the last few years, contributing to less favorable investment results and overall operating results. Investment returns are still positive, but the rates of return have been adversely affected by stock declines and more so by lower fixed income investment yields.

In establishing rates, insurers do not recoup investment losses. Rather, the general practice is to choose an expected prospective investment yield and calculate a discount factor based on historical payout patterns. In many cases, the insurer expects to have an underwriting loss that will be offset by investment income. Since interest yields drive this process, when interest yields decrease, rates must increase.

Misconception 2: "Companies operated irresponsibly and caused the current problems."

Financial results for medical liability insurers have deteriorated. Some portion of these adverse results might be attributed to inadequate knowledge about rates in newly entered markets and to being very competitive in offering premium discounts on existing business. However, decisions related to these actions were based on expectations that recent loss and investment markets would follow the same relatively stable patterns reflected in the mid-1990s. As noted earlier, these results also benefited from favorable reserve development from prior coverage years. Unfortunately, the environment changed on several fronts (loss cost levels increased, in several states significantly; the favorable reserve development ceased; investment yields declined; and reinsurance costs jumped.

While one can debate whether companies were prudent in their actions, today's rate increases reflect a reconciliation of rates and current loss levels, given available interest yields. There is no added cost for past mispricing. Thus, although there was some delay in reconciling rates and loss levels, the current problem reflects current data.

Misconception 3: "Companies are reporting losses to justify increasing rates."

This is a false observation. Companies are reporting losses primarily because claim experience is worse than anticipated when prices were set. Several companies have suffered serious adverse consequences given these financial results, including liquidation or near liquidation. Phico, MIIX, Frontier and, most recently, the Reciprocal of America, are all companies forced out of the business and in run-off due to underwriting losses. Further, the St. Paul Cos., formerly the largest writer of medical malpractice insurance, is now in the process of withdrawing from this market. One reason for this decision is an expressed belief that the losses are too unpredictable to continue to write the business.

The Academy appreciates the opportunity to provide an actuarial perspective on these important issues and would be glad to provide the subcommittee with any additional information that might be helpful.

CHART A: LOSS RESERVE DEVELOPMENT AS PERCENTAGE OF PREMIUM

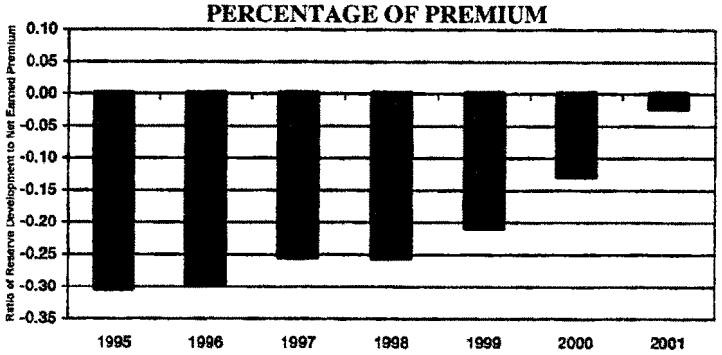


CHART B: CALENDAR YEAR OPERATING RESULTS TURN NEGATIVE

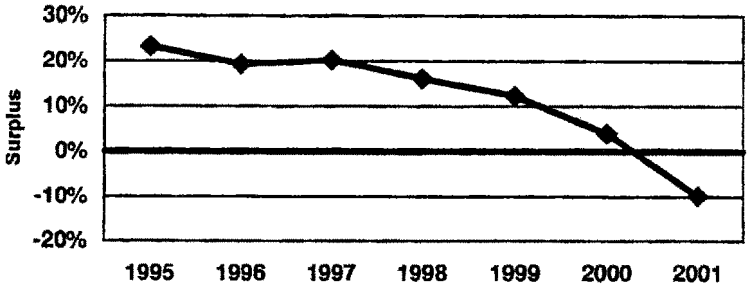


CHART C: COMBINED RATIO

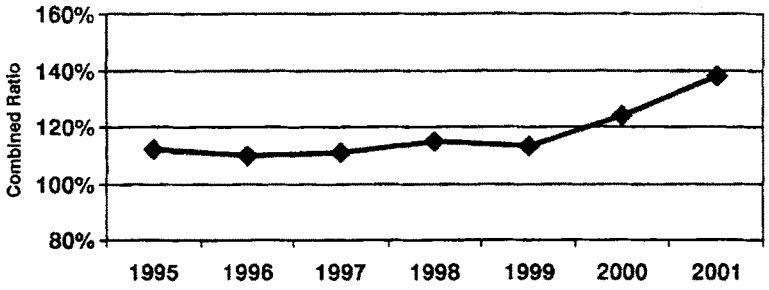


CHART D: INVESTMENT INCOME AS A PERCENTAGE OF PREMIUM DECLINES

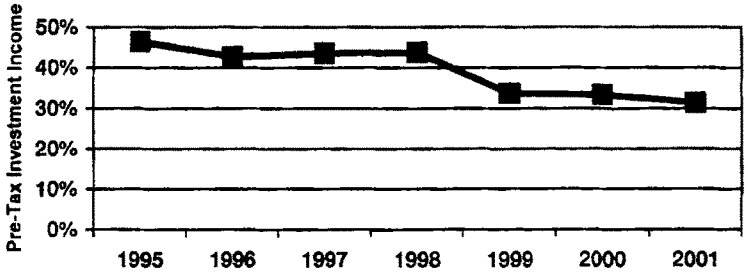
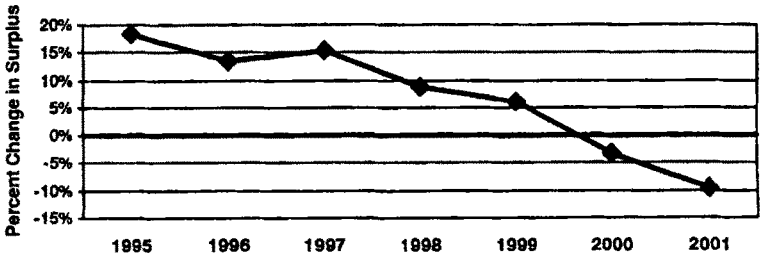


CHART E: SURPLUS CHANGE TURNS NEGATIVE



Mr. BILIRAKIS. Let's see. Mr. Hiestand. Is that correct?
Mr. HIESTAND. Hiestand.
Mr. BILIRAKIS. Thank you.

STATEMENT OF FRED J. HIESTAND

Mr. HIESTAND. There was once a Member of Congress, actually there were two by that name. But I don't know whether we are related. Anyway I appreciated hearing the opening remarks of everyone, and sort of feel from listening to that, that I am not sure how much we have to teach you. You seem to be well versed on it. But it does sound to me simply like deja vu all over again, as Yogi Berra would say. Because when I first had my baptism over this issue, it was back in California in 1974 through 1976 when Henry Waxman, who was then the chairman of the Assembly Health Committee, asked if I would be the consultant on medical malpractice because a number of health care providers, professional associations, had said to him at the time as the chairman of the Health Committee, that this was a burgeoning problem.

They had experienced just a couple of years previously, some very large increases in their malpractice rates, and they wanted him to look into it and see what could be done. I think Mr. Waxman asked me to get involved because we worked together, and I knew nothing about the subject, meaning I didn't have a bias one way or the other, though I suppose since my background was as a poverty and public interest lawyer up until then, I had a bias, it was sort of plaintiff-oriented. The notion that we would all had been taught in law school was the purpose of the tort system was to restore people to whole and restoring people to whole meant every kind of damage that could be brought to bear on the subject in the way of compensation.

But I did what you are all familiar with doing when I became the consultant of this committee, and that is, go around and interview all the experts on the subject, the self-identified and other recognized experts, and then we set up hearings and we held a number of hearings and produced a committee report that made recommendations that are now mirrored in H.R. 5 the heart of it I would say, the recommendations on collateral source, you know, other sources of income that injured people are entitled to receive for the injuries they are suing on, besides just the damages from the defendant, periodic payments for future injuries that people are going to get, or future damages that they would get; sliding contingency fee scale so that the more seriously injured patients got a larger share of the income than the attorney and so forth.

Now, one of the recommendations that fell on the cutting room floor and turns out to be the heart of MICRA was the limit on noneconomic damages. That was felt when the preliminary report came out in June 1974 predicting that there was going to be a crisis, but, of course, we predicted what everybody told us with the exception of the organized plaintiffs bar that there was a crisis and that was going to hit some time soon. You predict those things and you never know whether you are going to be accurate or not. We, unfortunately, were more accurate than we wanted to be because December of that year, California physicians, hospitals and oth-

ers were hit with 400 percent increases in their malpractice insurance premiums.

And Mr. Waxman left and came back to Congress. I was still sort of stuck there as consultant to the Select Committee, which Howard Berman had taken over at the time. And we had been discussing what we were going to do with that committee in his office when the calls came in from the reporters about the increase in the malpractice rate.

So the crisis hit California, but at least we had some recommendations about what to do about it that had been based on a 2-year study and a lot of hearings. And Governor Brown called a special session and asked if I would be his advisor on malpractice, and that is when he really put his finger on what I think is one of the early seminal views about why you probably need to limit non-economic damages when you have this kind of a crisis. He asked me if anything had been left on the cutting room floor, Governor Brown did in the way of recommendations, and I said yeah, the limit on non-economic damages. He asked why. I said it was felt to be maybe too draconian, too controversial, so we just left it out.

And he said, well, what is controversial about it and I said limiting people for non economic damages just didn't strike people right. And his remark to me was, have you read Roger Traynor's dissenting opinion in the case of Seffert versus L.A. Transit Authority? And to those of you not familiar with Roger Traynor, he was the chief justice for the California Supreme Court for a number of years, one of the most respected liberal jurists and the father of modern products liability law, a big believer in loss spreading. Roger Traynor's dissenting opinion in that case, which was, in 1962, over an award of about $54,000 said, you know, you can't continue to pay people for non-economic damages if you really want to compensate them for their true losses.

But that is not for the courts to decide, he said. It is for the legislature. So Governor Brown suggested that we do limit non-economic damages, and when the democratically controlled legislature faced with that crisis, they came up with a limit of $250,000, which seems, according to the Office of Congressional Office of Technology Assessment, the Rand Corporation and the Health and Human Services Agency, has been the single most important factor responsible for keeping malpractice premiums from skyrocketing out of hand in California.

So we like what you are doing in H.R. 5. We think things have been stable in California for more than a quarter of a century now as a result of MICRA. We wish we never had to face the crisis, but it turns out we came up with a solution that seems to work. And we hope it would work for everybody else. Thank you.

[The prepared statement of Fred J. Hiestand follows:]

PREPARED STATEMENT OF FRED J. HIESTAND, CEO AND GENERAL COUNSEL, CALIFORNIANS ALLIED FOR PATIENT PROTECTION

Mr. Chairman and Members of the Committee: Thank you for the invitation to share with you the background of how California learned to control what was once its own runaway medical liability insurance crisis.

From 1974-76, I was immersed in an emergency over the cost and availability of medical liability insurance for California doctors and hospitals—first as the consult-

ant to the Legislative Committee that studied its causes and predicted its occurrence, and then as advisor to the Governor and the Legislature who had to come to grips with it through the enactment of legal reforms. Now and for the past four years I have served as CEO and General Counsel to CAPP, a broad based organization of health care providers, professional medical associations, medical liability carriers and community clinics dedicated to preserving and protecting those very legal reforms that took effect in 1976 and tamed our state's medical liability crisis. This almost thirty year journey of biography as history underscores that what we learn from the past may help us to avoid repeating its unfortunate excesses. It also counsels CAPP and our allies to support federal efforts to bring uniformity and certainty to the malpractice crises now afflicting numerous states through legislation modeled on California's experience, such as HR 5. Here, in a "nutshell" is that history.

THE CALIFORNIA EXPERIENCE, OR DEJA VU ALL OVER AGAIN

In late 1974 California physicians and hospitals were shocked by announcements from the major insurance companies writing medical liability coverage for them that their premiums needed to be raised 400%. This calamity was predicted by the Assembly Select Committee on Medical Malpractice in a report issued earlier that summer by its chairman, Assemblyman Henry A. Waxman, which warned that:

> [M]edical malpractice group insurance rates for doctors have increased more than four hundred percent (400%) in just two brief years between 1968 and 1970; [moreover,] [t]he medical malpractice insurance market is a highly unstable one and, if rates continue to escalate as they have in the past few years, malpractice insurance carriers may be priced outside the market.

(Preliminary Report, Assembly Select Committee on Medical Malpractice, June 1974, Pp. 3-4.)

Waxman's warning was prescient, though it did not anticipate the suddenness or severity of California's medical malpractice insurance crisis. Alarmed hospitals and physicians responded to it by restricting medical care to emergencies. Access to needed health care was jeopardized for Californians in the same way it is today threatened for citizens in Florida, New York, Nevada, Kentucky, Ohio, Pennsylvania, West Virginia and other states undergoing their own medical malpractice insurance crises. Within a few months newly elected Governor Jerry Brown called an extraordinary session of the Legislature in which he proclaimed:

> The cost of medical malpractice insurance has risen to levels which many physicians and surgeons find intolerable. The inability of doctors to obtain such insurance at reasonable rates is endangering the health of the people of this State, and threatens the closing of many hospitals. The longer term consequences of such closings could seriously limit the health care provided to hundreds of thousands of our citizens.

(Proclamation of Governor Edmund G. Brown, Jr. to Leg. (May 16, 1975) Stats. 1975 (Second Ex. Sess. 1975-1976) p. 3947.)

Not everyone agreed at the time that there was a real crisis in California. Personal injury attorneys charged, as they do today about the catastrophes sweeping other states, that California's malpractice insurance emergency was "contrived," a result of bad stock market losses by insurers. To separate fact from fantasy California's Joint Legislative Audit Committee ordered the Auditor General to undertake a study to determine the reasons for the crisis. In December 1975 that study, contracted by the Auditor General to Booz-Allen Consulting Actuaries, reported that "premiums paid by California doctors for medical malpractice insurance have increased significantly over the past fifteen years, but have not kept pace with increasing claim costs; [and] the average premium in 1976 is expected to be about five times higher than the 1974 average." (California Medical Malpractice Insurance Study, Report by Booz, Allen & Hamilton, Inc. for the Office of the Auditor General, State of California, Dec. 5, 1975, Pp. 1-2.).

By the time the Auditor General reported that California's malpractice insurance crisis was indeed "real," the Legislature enacted the Medical Injury Compensation Reform Act of 1975 ("MICRA"). MICRA's purpose is stated in its preamble:

> The Legislature finds and declares that there is a major health care crisis in the State of California attributable to skyrocketing malpractice premium costs and resulting in a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of this state. The Legislature, acting within the scope of its police powers, finds the statutory remedy herein provided is intended to provide an adequate and reasonable remedy within the limits of

what the foregoing public health and safety considerations permit now and into the foreseeable future.

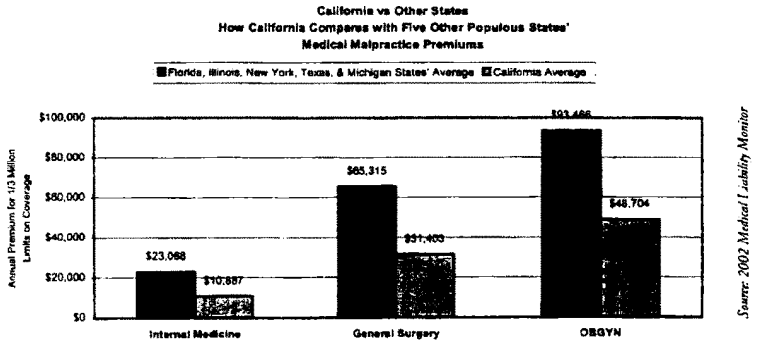
(Stats. 1975, Second Ex. Sess. 1975-1976, ch. 2, § 12.5, p. 4007.)

THE "KEY LEGAL REFORMS" FOR TAMING RUNAWAY MALPRACTICE LITIGATION AND LIABILITY PREMIUMS

The "statutory remedy" that tamed runaway malpractice premium costs was comprehensive and dealt with major changes in the regulation of the medical profession, insurance and legal reforms. Most of these reforms were recommended by the Assembly Select Committee on Medical Malpractice that Henry Waxman chaired in 1974 and Governor Jerry Brown urged be adopted in his proclamation calling the Legislature into a special session to solve the crisis. MICRA's legal reforms curbed unfair practices and inefficiencies in our system for resolving medical malpractice disputes. It put a ceiling of $250,000 on exploitive non-economic "pain and suffering" damages, and assured full compensation for economic losses: wages, medical bills, rehabilitation and custodial care for as long as necessary.

MICRA also permits arbitration of medical liability disputes, lets the jury know of other payments a plaintiff is receiving for the same injuries sued on, marshals and preserves resources for ongoing care of the plaintiff by allowing periodic payment of future damages, and assures that the most severely injured plaintiffs get a proper share of any recovery by requiring that attorneys' contingency fees be paid on a sliding scale—the larger the recovery the smaller the lawyer's percentage.

MICRA achieved for California stable and, in comparison to the rest of the country, reasonably affordable malpractice insurance premiums charges. States without MICRA reforms are now experiencing their own version of California's mid-1970s medical liability crisis. Since 1975, *California's premiums have risen 168 percent, while the average U.S. premium has increased 420 percent.* Today, as the chart below shows, the average annual liability premium for an Ob/gyn doctor in California is $48,700, half the average doctors pay in the rest of the country.



THE IMPORTANCE OF THE $250,000 CEILING ON NON-ECONOMIC DAMAGE

A seminal opinion upholding the validity of MICRA against constitutional attack affirmed that "the goal of [the $250,000 limit on recoverable non-economic damage] [is] to ensure the availability of health care and the enforceability of judgments against health care providers by making medical malpractice insurance affordable. The amount of non-economic damages is still limited to $250,000 for each injured plaintiff and thus will not result in "the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble..." (*Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 163.)

Courts have consistently and repeatedly made clear the purpose of MICRA and its non-economic damage provision:

> The legislative history of MICRA does not suggest that the Legislature intended to hold down the overall costs of medical care but instead demonstrates... that the Legislature *hoped to reduce the cost of medical malpractice insurance, so that doctors would obtain insurance for all medical procedures and would resume full practice; indeed, in this respect [available] statistics suggest that MICRA was in fact successful.* The statistical information before the Legislature

> indicated, however, that insurance costs amounted to only a small percentage of overall medical costs (see, e.g., Assem. Select Com. on Medical Malpractice Preliminary Rep. (June 1974) p. 49), and thus in an era of substantial inflation—as experienced in the late 1970's—even the total elimination of mal- practice insurance premiums could not reasonably have been expected to reduce the overall cost of medical care.

(American Bank & Trust Co. v. Community Hosp. of Los Gatos (1985) 36 Cal. 3d 359, 373; italics added.)

Restricting recovery for non-economic loss is neither a novel nor radical notion. Former Chief Justice Roger Traynor, the father of modern products liability law and advocate for "spreading the loss" of injury compensation through insurance, long ago recognized the need to cabin these subjective and highly elastic damages. In *Seffert v. L.A. Transit Authority* (1961) 56 Cal.2d 498, Traynor dissented from approval of a non-economic damage award of $134,000 in a negligence action to a woman whose foot was injured while boarding a city bus and whose economic losses were about $54,000.

> There has been forceful criticism of the rationale for awarding damages for pain and suffering in negligence cases. Such damages originated under primitive law as a means of punishing wrongdoers and assuaging the feelings of those who had been wronged. They become increasingly anomalous as emphasis shifts in a mechanized society from ad hoc punishment to orderly distribution of losses through insurance and the price of goods or of transportation. . . . [¶] [A]ny change in this regard must await reexamination of the problem by the Legislature.

When the Legislature followed Justice Traynor's suggestion and reexamined the problem of non-economic damage awards in the context of the malpractice insurance crisis of 1975, it decided to cap them at $250,000. The considered judgment of the Legislature and the Governor was that limiting recovery for non-economic damages to that amount would dampen the skyrocketing cost of medical malpractice insurance. This policy decision has withstood numerous legal challenges because it is right.

> The continuing availability of adequate medical care depends directly on the availability of adequate insurance coverage, which in turn operates as a function of costs associated with medical malpractice litigation. Accordingly, MICRA includes a variety of provisions, all of which are calculated to reduce the cost of insurance by limiting the amount and timing of recovery in cases of professional negligence. [¶] MICRA thus reflects a strong public policy to contain the costs of malpractice insurance by controlling or redistributing liability for damages, thereby maximizing the availability of medical services to meet the state's health care needs. With specific reference to [the ceiling on non-economic damage], this court has also observed that "[o]ne of the problems identified in the legislative hearings was the unpredictability of the size of large non-economic dam- age awards, resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag . . . different juries place on such losses. The Legislature . . . reasonably . . . determined that an across-the-board limit would provide a more stable base on which to calculate insurance rates."

(*Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, 112, citing and quoting from *Fein v. Permanente Medical Group, supra,* 38 Cal.3d at 163.)

MICRA's non-economic damage cap and those from nineteen other states echoing it have arrested spiraling malpractice insurance premium charges. As one scholarly study[1] states:

> The weight of empirical evidence suggests that . . . some of the legal reforms had the intended effect of stabilizing liability insurance markets and reducing the overall level of medical malpractice payments. The largest reductions in payments and premiums were attributable to a few provisions, *notably caps on awards* and modifications of the collateral source rule . . .

Other studies about the benefits of the damage cap on malpractice insurance rates reached the same conclusion. A 1995 study by the American Academy of Actuaries found, for example, that in California (since MICRA was enacted) medical mal-

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[1] Bovbjerg & Sloan, *No-Fault for Medical Injury: Theory and Evidence* (1998) 67 U. Cin. L. Rev. 53, 62 (italics added). For empirical evidence on the impact of tort reforms, see Danzon, *The Frequency and Severity of Medical Malpractice Claims* (1984) 27 J.L. & Econ. 115; Hamilton, Rabinowitz, & Alschuler, Inc., Claim Evaluation Project (1987); Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence* (1986) 49 Law & Contemp. Probs. 57; Sloan et al., *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis* (1989) 14 J. Health Pol. Pol'y & L. 663.

practice costs have fallen substantially from about 28 percent of the national total in 1975 to about 10 percent in 1994—while California's share of physicians held steady at 15 percent.[2] Paralleling this decrease, the state's portion of national malpractice premium costs was sliced in half. In New York, however, where a damage cap was never enacted despite the adoption of other piecemeal reform measures over the years, there were no observable improvements in the state's relative costs. New York's physician population hovered between 12 and 14 percent of the national total, but its malpractice losses zigzagged from just above 16 percent of the national cost in 1975 to 22 percent in 1979, to about 15 percent in 1985, and back to above 22 percent in 1993.[3] Ohio experienced a gradual decline—about one percent from 4 to 3 percent—in costs following tort reforms enacted in 1975.[4] This package included a cap on damages that was challenged in court in 1982, resulting in sharp increases that peaked in 1985 (at 6 percent) when the cap was overturned. Ohio's loss payments remained fairly constant until this year, when premium charges spiraled over the top for doctors in high risk specialties.[5]

In 1995, the congressional Office of Technology Assessment also confirmed that "caps on damage awards were the *only* type of State tort reform that consistently showed significant results in reducing the malpractice cost indicators."[6] This same conclusion was recently reached by the federal Department of Health and Human Services (HHS), which reported that "a major contributing factor to the most enormous increases in liability premiums has been the rapidly growing awards for non-economic damages in states that have not reformed their litigation system to put reasonable standards on these awards."[7] The HHS report emphasizes that the medical malpractice insurance crises now engulfing twelve states "is less acute in states that have reformed their litigation systems. States with limits of $250,000 or $350,000 on non-economic damages have average combined highest premium increases of 12-15%, compared to 44% in states without caps on non-economic damages."[8]

The HHS study credits MICRA, especially its ceiling on recoverable non-economic loss, for holding down medical malpractice insurance rate increases and keeping open access to health care:

> California has more than 25 years of experience with this reform. It has been a success. Doctors are not leaving California. Insurance premiums have risen much more slowly than in the rest of the country without any effect on the quality of care received by residents of California. Insurance premiums in California have risen by 167% over this period while those in the rest of the country have increased 505%. This has saved California residents billions of dollars in health care costs and saved federal taxpayers billions of dollars in the Medicare and Medicaid programs.[9]

MICRA's substantial public benefits through reduced malpractice premium costs have not come at the expense of plaintiffs' ability to be fairly compensated for their losses. "Leading malpractice carriers report that between 1984 and 1997 payments to [medical] malpractice plaintiffs . . . increased 139 percent while inflation grew less than half that amount (54.5%) and health care costs rose less than 120 percent."[10]

> A plaintiff in a $400,000 medical malpractice case in 1984, where half the award was for non-economic damage, today would receive $1.195 million, or $442,500 more than what the injury is worth measured by the rise in the cost of living. This result is likely due to plaintiffs' attorneys creatively exploiting

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[2] *Actuaries Use States' Experiences To Argue For Comprehensive Malpractice Reforms,* 22 Health Legislation & Regulation 47 (Nov. 27, 1996)(Faulkner & Gray, Inc.).

[3] *Id.*

[4] *Id.*

[5] "A study released this week by *Medical Liability Monitor* . . . found that four insurers are charging Cleveland-area obstetricians from $74,581 to $152,496 this year for malpractice coverage . . . A bill pending with the Ohio legislature would place a $300,000 cap on non-economic awards for pain and suffering in medical malpractice . . . Nineteen states already have limits, ranging from $200,000 to $1 million . . . [T]he average premium for obstetricians nationwide was $56,546. In states with tort reform, that figure ranges from $17,786 to $55,084." (Powell, *Docs Preach at Practices—Physicians Say Limiting Malpractice Awards will Lower Insurance Costs,* Akron Beacon Journal, Oct. 10, 2002, p. 1.)

[6] U.S. Congress, Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs,* OTA-BP-H-119, p. 64 (Washington, D.C.: U.S. Gov't. Printing Office, Oct. 1995).

[7] *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System* 12 (Health and Human Services: July 24, 2002).

[8] *Id.* at p. 14.

[9] *Id.* at p. 17.

[10] Hiestand, *MICRA Management,* Los Angeles Daily J., March 4, 1999, p. 6.

what they get (unlimited economic loss) to offset the MICRA limit [on non-economic loss].[11]

Numerous scholarly studies show that the $250,000 ceiling on non-economic damages is a major factor accounting for the principal difference between California's stability and the chaos of other states in professional liability coverage costs. Despite these savings, the average malpractice settlement and award in California, adjusted for post-MICRA inflation, is greater today than it was before MICRA. Without MICRA, pay outs by California carriers on behalf of health care providers sued for professional liability would mirror the claims experience of other states and send corresponding coverage costs through the roof.

California's medical malpractice disputes are settled 23 percent faster than in the rest of the country. The cost of settlements is 53 percent lower than the national average. The Congressional Budget Office stated that medical malpractice reform like California's will result in savings of $1.5 billion over ten years. The congressional study does not include the hidden costs of defensive medicine. A Stanford University study shows that California's medical liability reforms would save the national health care system $50 billion a year in defensive medicine costs. Reducing health care costs safeguards access to medical care for those who lack basic health coverage.

MICRA is a proven success. Medical liability no longer deprives our citizens of access to health care. Congress and other states now look to the California experience as they try to fashion solutions to the growing emergency with medical liability insurance. MICRA continues to prove that providing fair and equitable compensation for those negligently injured can be achieved in ways that preserve an orderly insurance marketplace and maintain access to quality health care. It is a success for Californians, and if enacted by Congress will benefit patients and taxpayers nationally.

Mr. BILIRAKIS. Thank you very much Mr. Hiestand.

Mr. Rosenfield.

STATEMENT OF HARVEY ROSENFIELD

Mr. ROSENFIELD. Thank you, Mr. Chairman. Good morning, members of the committee. My name is Harvey Rosenfield. I am the president of the, Foundation for Taxpayer and Consumer Rights, which is a Los Angeles-based consumer and citizen advocacy organization. Mr. Chairman, what brought us to the table at this hearing today, would be an effort to stop the epidemic of medical malpractice, which claimed the lives of between 100- and 150,000 Americans every year in hospitals alone.

Instead, we are worrying about how much doctors have to pay for medical malpractice coverage, though for most of them, it is between 1 and 5 percent of their annual revenues, and it is tax deductible. And all the premiums for medical malpractice and all the payments by insurance companies for claims amount to an infinitesimal fraction of our national health care expenditures.

Nevertheless, because of the doctors on strike and some doctors experiencing tremendous rate increases, we are here today to talk about whether MICRA will lower insurance premium. And on that, California can give some guidance because there is a law in California that lowered insurance premiums for doctors and that refunded $135 million in premiums to physicians. I was the author of that law. It was not MICRA. It was proposition 103.

If I could have Exhibit 1, please, on the presentation. If you look at the chart that is contained in the second page of our testimony, you will see the following: In 1975 the legislature passed MICRA in the midst of a crisis, panicked, doctors striking, special session of the legislature. Rates after MICRA passed, between then and 1988 with a brief dip after the insurance crisis of the 1970's ended

[11] *Id.*

and the insurance industries performance in the economy improved, premiums for physicians rose between 1975, and 1988, under MICRA, 450 percent.

Physicians point out that MICRA, the cap in MICRA was not upheld until February 1985. Between 1985 and 1988, which was the second insurance crisis in the last three decades when the insurance companies ran into trouble with their investments and interest rates dropped, between those years, after the MICRA cap was upheld as constitutional, premiums went up 47 percent alone in those 3 years. During the 13 years of MICRA, insurance companies, medical malpractice insurers operating in California, paid out only 31 cents in claims for every dollar they took in.

In 1988, the voters got fed up with the absence of lower insurance premiums, despite repeated so-called tort reform in California, and so they put proposition 103 on the ballot. Proposition 103 mandated a rate freeze, a 20 percent rollback, stringent regulation of the profits expenses, and most importantly for our debate today, projections of future losses. It repealed the industry's antitrust exemption, created an elected insurance commissioner, and gave the public the right to challenge unjustified rate changes.

Insurance companies spent $80 million to try to defeat prop 103 at the ballot box, which gives you some idea of the amount of fear that is reflected in the fact that to this day, and before this committee, you are going to be told that it didn't work, even though the results are in disputable. Proposition 103's $1.2 billion in rate refund checks included $135 million from medical malpractice insurers to physicians.

And don't you believe that when they tell you today that oh, these insurance companies were going to roll back their rates anyhow, because they fought prop 103 bitterly in the courts. They spent tens of millions of dollars on attorneys' fees to try to stop that initiative, and only when they lost everything did they finally understand as an industry that they had to role back $1.2 billion in premiums. After proposition 103 passed in the 13 years that we have data for, premiums went down 20 percent in the first 3 years, and then between then, 1988 and 2001, premiums in California for medical malpractice went down an average of 2 percent.

Tort reform has never lowered insurance premiums anywhere in the country at any time, any kind of tort reform. The insurance industry itself has admitted that in Florida and other States. Why does 103 work? 103 works because the crisis concerns the investment and interest rate and investment income of the insurance companies and the fear of regulation and the actual regulation of prop 103 lowered insurance premiums. Mr. Chairman, I have 1 minute to talk about MICRA if I may, please. If you will indulge that.

Mr. BILIRAKIS. Go ahead, sir.

Mr. ROSENFIELD. Here is what MICRA has done in California. For those of you who really want to understand what it has done, it has prevented innocent victims of medical malpractice from getting lawyers because the combination of the caps on the damages, the sliding scale caps on the attorney's fees, and the requirement that taxpayer programs pay for the victims before the doctor or the negligent hospital or the insurance company pay, has made it fi-

nancially economically impossible for attorneys to take all but the most serious cases involving all but the most wealthy people. Health care, which HMO based financial driven health care, in which bean counters make decisions about how the quality of medicine is delivered, combined with the MICRA caps, have been a disaster for this State.

I want to conclude with this, Mr. Chairman. For 200 years, American juries have been deciding how to allocate personal responsibility in our country. I want to say that the principle that should guide this committee as the Congresswoman suggested at the beginning, should be the principle that ought to be followed by the American Medical Association and the minority of American doctors who are following the AMA in this campaign against the rights of patients. First do no harm. With all due respect to members of this committee, I ask you, why you should substitute your judgment for juries. I ask you to search your hearts and explain to us, tell us who are you to tell Heather Lewinski how much her pain and suffering is worth? Thank you very much, Mr. Chairman.

[The prepared statement of Harvey Rosenfield follows:]

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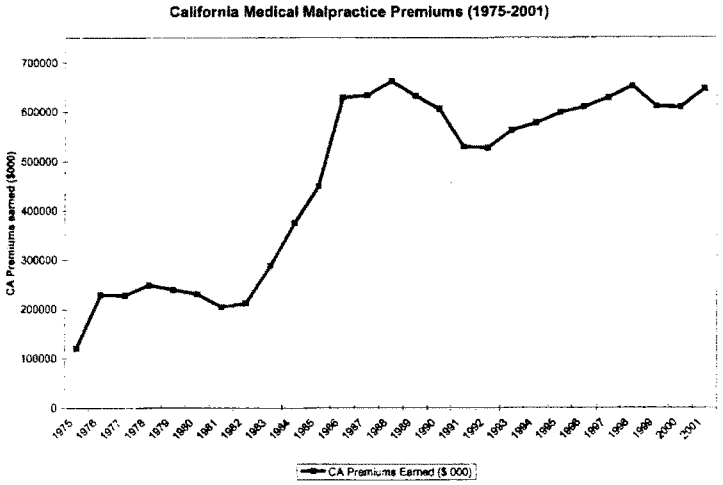
Testimony of Harvey Rosenfield
The Foundation for Taxpayer and Consumer Rights[1]
Before the House Energy and Commerce Committee
Subcommittee on Health
February 27, 2003
Washington, D.C.

"Assessing the Need to Enact Medical Liability Reform"

Girl in Transplant Mix-Up Dies After Two Weeks

[1] The Foundation for Taxpayer and Consumer Rights is a California-based non-profit, non-partisan citizen education and advocacy organization. FTCR's main issues are insurance, health care, and energy deregulation. I am the author of California Proposition 103, and President of the organization. Web: www.consumerwatchdog.org.



SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001, Direct Premium Earned 1975, A.M. Best, special data request

13 Years Of MICRA: 450% INCREASE In Medical Malpractice Premiums

13 Years Of Prop 103: 2% DECREASE In Medical Malpractice Premiums

Mr. Chairman and Members of the Committee:

There is a law in California that has lowered insurance premiums for doctors, hospitals and other health care providers. It is unique in the United States, and it is a model for the rest of the country.

It is not the infamous malpractice caps law known as MICRA, however.

In 1988, California voters, facing skyrocketing insurance premiums and angry at the failure of tort reform to deliver its promised savings, went to the ballot box and passed the nation's most stringent reform of the insurance industry's rates and practices – applicable to all lines of property-casualty insurance, including auto, homeowners, commercial and medical-malpractice.

Proposition 103:

- **Mandated an immediate rollback of rates of at least 20%** – rate relief to offset excessive rate increases by establishing a baseline for measuring appropriate rates. Prop. 103 required a roll back of at least 20% for all property and casualty insurance companies, *including* medical malpractice insurers.

- **Froze rates for one year**. Ultimately, because of the delay caused by insurance company legal challenges to Proposition 103, rates remained frozen for four years pursuant to decisions by the state's insurance commissioner.

- **Created a stringent disclosure and "prior approval" system of insurance regulation**, which requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Proposition 103 gives the California Insurance Commissioner the authority to place limits on an insurance company's profits, expenses and projections of future losses (a critical area of abuse).

- Authorized consumers to **challenge insurance companies'** rates or practices in court or before the Department of Insurance.

- **Repealed anti-competitive laws** in order to stimulate competition and establish a free market for insurance. Proposition 103 repealed the industry's exemption from state antitrust laws, and prohibited anti-competitive insurance industry "rating organizations" from sharing price and marketing data among companies, and from projecting "advisory," or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents/brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. And it authorizes individuals, clubs and other associations to unite to negotiate lower cost group insurance policies.

- **Promoted full democratic accountability** to the public in the implementation of the initiative by making the Insurance Commissioner an elected position.

A copy of the text and a detailed description of Proposition 103 and its provisions can be found in our testimony before the Oversight and Investigation Subcommittee on February 10, 2003 and we ask that it be made a part of the record of this hearing.

Insurers spent $80 million in their unsuccessful effort to defeat Proposition 103, including the cost of sponsoring three competing ballot measures that would have enacted "tort reform." Having seen how "tort reform" laws passed at the behest of the insurance industry in 1975 and 1986 had had no effect on premiums, the voters rejected the industry's 1988 measures by enormous margins.

Proposition 103 worked. Insurance companies refunded over $1.2 billion to policyholders, including doctors. In the closely studied area of auto insurance, California was the only state in the nation in which auto insurance premiums actually dropped between 1989 and 2000 – by a startling 25%, while rising 26% on average throughout the rest of the nation, according to NAIC data.[2] A 2001 study by the Consumer Federation of America concluded that the prior approval provision of Proposition 103 blocked over $23 billion in rate increases for auto insurance alone through 2000.

What Proposition 103 has done for doctors has not received as much attention.[3] But the results are indisputable, particularly when compared to MICRA.

I. Medical Malpractice Insurance Premiums in California Rose 450% During the Thirteen Years after the Passage of MICRA

MICRA was enacted in 1975 at the height of the so-called insurance crisis of the 1970s, when the national economy was weak and insurers investment returns were low. Insurance companies increased malpractice premiums at an unprecedented rate. In fact, years later, doctors successfully sued Travelers Insurance for overcharging doctors by increasing prices by

[2] National Association of Insurance Commissioner, "State Average Expenditures & Premiums for Personal Automotive Insurance in 2000," (July 2002).
[3] California auto insurers also prospered during the same period. A calculation of annual return on net worth from 1990 to 1999 reveals that these insurers received a 16.0 percent return compared to only 10.9 percent received by auto insurers nationally. Dr. Robert Hunter, Director of Insurance,"Why Not The Best? The Most Effective Auto Insurance Regulation In The Nation," Consumer Federation of America. June 2001

327% in 1976, as is discussed below.[4] At the time, however, striking doctors joined with insurance companies – as they have today – to promote changes in the tort laws as a solution to soaring malpractice premiums. However, after a modest decline in California and US premiums reflecting improved insurance company investment returns, by 1982 malpractice premiums were rising higher than ever.

During the insurance crisis of the mid-1980s, insurers once again blamed their conduct on extraordinary increases in lawsuits and claims. During that same period, despite MICRA, California malpractice premiums increased by an average of more than 20% annually. By 1988, thirteen years after the passage of MICRA, California medical malpractice premiums had reached an all-time high – 450% higher than in 1975, when MICRA was enacted.

Insurance companies and the medical lobby argue that premiums continued to increase after MICRA's passage because of court challenges to the law. However, the California Supreme Court upheld MICRA's periodic payments rule in July of 1984, the collateral source offset in November 1984 and the damage cap in February of 1985. Despite that ruling, malpractice premiums in California increased more dramatically in 1986 than any year after the passage of MICRA. Between 1985, when the cap was upheld, and 1988, malpractice premiums soared 47%, to the highest levels in California history.

Figure 1. Premium Increases During the 1980s Insurance Crisis

Year	California Premiums Earned	Percentage Change
1983	$287,256,000	36.37%
1984	$374,661,000	30.43%
1985	$449,727,000	20.04%
1986	$629,448,000	39.96%
SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001		

II. Proposition 103 Reduced Medical Malpractice Insurance Premiums

A. Proposition 103 Imposed A Moratorium on Rate Increases in California

Proposition 103 required that all insurance rates were to be frozen for one year at the rolled-back rate level (at least 20% lower than rates in effect one year before election day, November 8, 1988). After the passage of the initiative, the insurance commissioner declared a

[4] "Doctors Will Get Refunds on Insurance," by S.J. Diamond and Harry Nelson, *Los Angeles Times*, February 6, 1981.

moratorium was declared on all rate increases by medical malpractice insurance companies, as well as other insurers, pending resolution of the insurers' legal challenges to Proposition 103 and the promulgation of regulations governing the rollback process.

The initiative itself, including the rollback requirement, was upheld by a unanimous California Supreme Court in May, 1989. The insurance commissioner at the time continued the freeze while developing rollback regulations. Litigation delays blocked the rollback regulations, and when California's first elected insurance commissioner took office, he announced final rollback regulations and re-authorized the rate freeze pending payment of the rollbacks by each insurer. Largely because of lawsuits brought by the insurers against the rollback regulations, the rate freeze remained in effect for many insurers through 1994.

B. Premiums Dropped by 20% After Proposition 103

Unlike MICRA, Proposition 103 explicitly required a rate rollback of up to 20%. The relevant portion of California Insurance Code Section 1861.01 reads:

> For any coverage for a policy . . . of insurance subject to this chapter . . . every insurer shall reduce its charges to levels which are at least 20% less than the charges for the same coverage which were in effect on November 8, 1987.

Medical malpractice rates in California began to fall immediately after the passage of Proposition 103, and, within three years of the passage of insurance reform, total medical malpractice premiums had dropped by 20.2% from the 1988 high.

Figure 2. Premiums dropped after Prop. 103

Year	Cal. MedMal Premiums (total)	% change	Cumulative % Change
1988	$663,155,000	--	--
1989	$633,424,000	-4.5%	-4.5%
1990	$605,762,000	-4.4%	-8.7%
1991	$529,056,000	-12.7%	**-20.2%**

SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001

After adjusting for inflation (using the Consumer Price Index - All Urban Consumers), the premium drop is actually 30.7%.

C. Proposition 103 Required Medical Malpractice Insurers to Refund $135 Million to Doctors

Lobbyists for the insurance industry have told lawmakers in some states that Proposition 103's rollback did not apply to medical malpractice insurers, or that no malpractice insurers paid the rollbacks required by Proposition 103. For example, Mr. Lawrence Smarr, representing the Physician Insurers Association of America, in written testimony provided to the Subcommittee on Oversight and Investigations, stated that: "medical liability insurers were not the intended target of Prop. 103, but were covered by the resulting regulations." Further, Mr. Smarr says "no monies were returned to policyholders as a result of Prop. 103."[5]

These statements are false. Medical malpractice insurers were among the first insurance companies in California to comply with Proposition 103's mandatory rate rollback. Three of the state's largest malpractice insurers – Norcal Mutual, SCPIE and The Doctors Company – refunded $69.1 million to doctors by 1992. By 1995, insurers providing medical malpractice coverage issued more than $135 million in refunds to policyholders.[6] According to a California Department of Insurance news release of February 18, 1992:

> The Doctors' Company follows two other medical malpractice insurance groups and the Automobile Club of Southern California in agreeing to voluntarily comply with the rollback provisions of Proposition 103. The agreement calls for the return of $18.5 million to the company's 9,500 California physician members, a 19.24% rebate...
>
> The company joins two other medical malpractice insurers, Norcal Mutual and the Southern California Physicians Insurance Exchange (SCPIE) that have already agreed to pay Proposition 103 rebates to their policyholders. Norcal Mutual agreed to pay 9,000 policyholders $19.9 million, while SCPIE's agreement calls for $30.7 million to be paid to its 13,800 members.

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[5] Testimony of Lawrence E. Smarr, President, Physician Insurers Association of America, Before the United States House of Representatives Committee on Energy and Commerce Subcommittee on Oversight and Investigations, regarding: The Medical Liability Insurance Crisis: A Review of the Situation in Pennsylvania. February 10, 2003, p. 28.

[6] In a related disinformation effort, Mr. Smarr and representatives of some of the other insurers that were forced to make the refunds now claim that these insurers were only paying "dividends" that they would have paid anyhow. These assertions are contradicted by the legal settlement orders signed by the insurers themselves, in which it is expressly stated that the refunds were made pursuant to the Prop. 103 rollback requirement; that the refunds were made for the year in which the rollbacks were required, 1988-1989, and included interest until the date the orders were signed – several years later; and finally that the insurers were ordered to report the refunds as rollbacks required by 103, and to treat them – for accounting purposes only -- on their books as a "return of premium" or "dividends."

A copy of news releases by the California Department of Insurance announcing the malpractice rollback settlements and articles about the malpractice rollbacks can be found in our testimony before the Oversight and Investigation Subcommittee on February 10, 2003 and we ask that it be made a part of the record of this hearing.

Figure 3. Proposition 103 Mandated Refunds Paid by Major Medical Malpractice Insurers

Malpractice Insurer	Total Refund**	Date Paid
Norcal Mutual Insurance Co.	$19,875,172	10/6/91
SCPIE	$30,730,384	10/15/91
Doctors Insurance Co.	$18,519,217	2/20/92
Medical Insurance Exchange of CA Gp.	$4,725,452	10/8/93
St. Paul Cos.*	$10,000,000	6/28/94
Dentists Insurance Co.	$1,886,342	5/26/95
Zurich-American Insurance Gp.*	$13,495,977	10/25/95
Farmers Insurance Gp.*	$35,978,041	12/14/95
Total Paid by Major Malpractice Insurers	**$135,210,585**	

Source: California Department of Insurance
*Insurer carried several property-casualty lines, which were subject to Prop 103 Rollback. Refund amount was paid to policyholders in all lines, including physicians. Other insurers carried medical malpractice exclusively at the time of the rollback.
**Refund amount includes interest.

It should be noted that under Proposition 103, each insurer was given the opportunity to demonstrate, in an administrative hearing, that its rates were not excessive and hence it could not afford to pay the 20% rollback. That the voters could order insurance companies to pay a rate rollback -- and that an examination of these medical malpractice insurers' books evidenced so much waste, inefficiency and profiteering that they were ordered to make massive refunds – is apparently such a frightening precedent to the insurers and the medical lobby that they are desperate to deny that the refunds ever took place.

D. Strict Regulation of Rate Increases Followed Rate Freeze, Rollbacks

Upon payment of the rate rollback refunds, insurers were then subject to Proposition 103's "prior approval" regulatory system, which requires medical malpractice insurers to justify rate increases or decreases to the Department of Insurance, and the commissioner may, at any time, invalidate an insurers' rate if it is too high *or too low*.

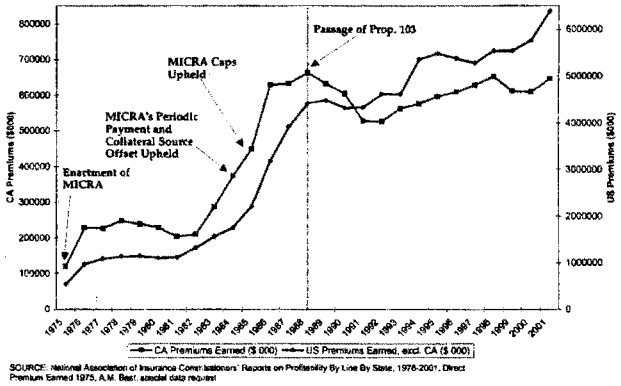
III. Comparing MICRA v. Proposition 103

The following charts and tables graphically illustrate that Proposition 103, not MICRA, reduced malpractice premiums in California.

California doctors' premiums generally tracked premiums countrywide between 1975 and 1988, following the recognized boom-bust "insurance cycle" that has coincided with each insurance "crisis" in this country, including the present one.[7]

But malpractice premiums fell sharply in California immediately after passage of Proposition 103, as Figure 4 illustrates by comparing premium growth in California and nationwide. Moreover, they continued to drop in ensuing years, bucking the national trends, and then stabilized while national rates continued to fluctuate.

Figure 4. Medical Malpractice Premiums: CA v. US (1975-2001)



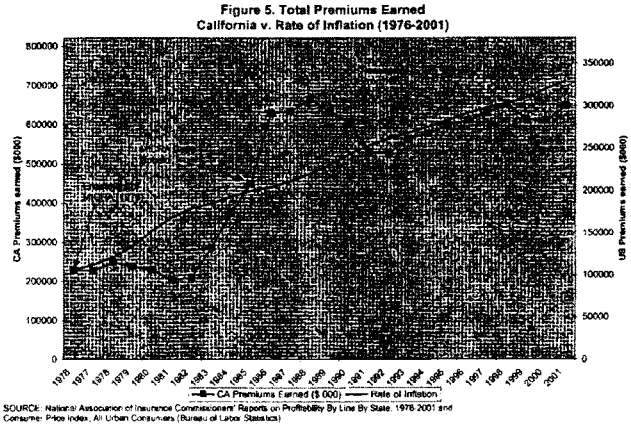
SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001. Direct Premium Earned 1975, A.M. Best, special data request

In the first thirteen years after the enactment of MICRA, California doctors' premiums rose by 450%, much faster, overall, than the national rate of inflation. After California voters enacted

[7] "Medical Malpractice Insurance: Stable Losses/Unstable Rates," Americans for Insurance Reform, October 10, 2002.

insurance reform Proposition 103 in 1988, medical malpractice rates first fell dramatically and then generally followed the rate of inflation or declined further.

Figure 5. Total Premiums Earned
California v. Rate of Inflation (1976-2001)



SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001 and Consumer Price Index, All Urban Consumers (Bureau of Labor Statistics)

The data also show that Proposition 103's "prior approval" system, under which the commissioner may, at any time, invalidate an insurers' rate if it is too high *or too low*, has ameliorated some of the premium instability induced by the "insurance cycle." The price chaos of the 1970s and 1980s was replaced with a steady reduction of rates and then continued relative price stability for California doctors in the 1990s, through the current "insurance crisis."

Figure 6. Annual Change in California Medical Malpractice Premiums

MICRA years	Premium Chaos	Proposition 103	Price Stability
1975-1976	+89.35%	1988-1989	- 4.48%
1976-1977	-0.60%	1989-1990	- 4.37%
1977-1978	+9.53%	1990-1991	-12.66%
1978-1979	-3.94%	1991-1992	- 0.48%
1979-1980	-3.64%	1992-1993	+6.93%
1980-1981	-11.47%	1993-1994	+2.45%
1981-1982	+3.35%	1994-1995	+3.62%
1982-1983	+36.37%	1995-1996	+2.07%
1983-1984	+30.43%	1996-1997	+3.09%
1984-1985	+20.04%	1997-1998	+3.78%
1985-1986	+39.96%	1998-1999	- 6.25%
1986-1987	+0.71%	1999-2000	- 0.34%
1987-1988	+4.61%	2000-2001	+6.15%

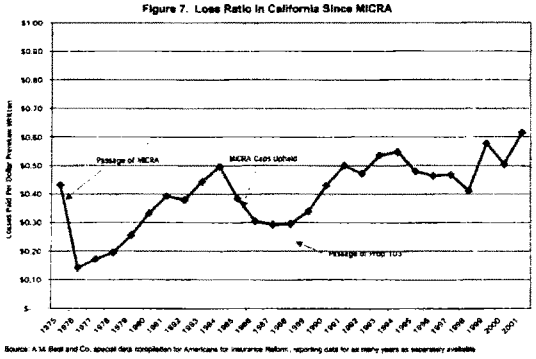
SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001

MICRA Resulted in Less for Injured Patients, More for Insurance Companies and Insurance Defense Lawyers

As a result of the severe malpractice caps in MICRA, insurance companies in California have consistently retained more of the premium dollar and paid a lower percentage of each premium dollar to victims than the national average. As would be expected under the onerous provisions of MICRA, the losses paid by insurers dropped in California immediately after the passage of MICRA, and for the next three years malpractice insurers paid less than twenty cents toward victims' compensation for every dollar worth of premium paid to insurers by doctors.

In fact, between the enactment of MICRA in 1975 and the 1988 passage of Proposition 103, which disallowed excessive rates (and thereby forced loss ratios towards more appropriate levels), California insurers never paid out in claims more than half of premiums written. Between 1976 and 1988, the average percentage of each premium dollar paid out in the form of compensation to malpractice victims – expressed as a "loss ratio" – was 31.4%. The balance – sixty-eight cents of every premium dollar – paid for other insurer costs, primarily profits, insurance company lawyers and overhead. That is, more than sixty-eight cents of every premium dollar paid by doctors was used for purposes other than compensating victims. Insurers had promised doctors lower premiums, but instead of reducing premiums commensurate with the lower claims payouts associated with malpractice caps, insurers simply captured higher profits in California.

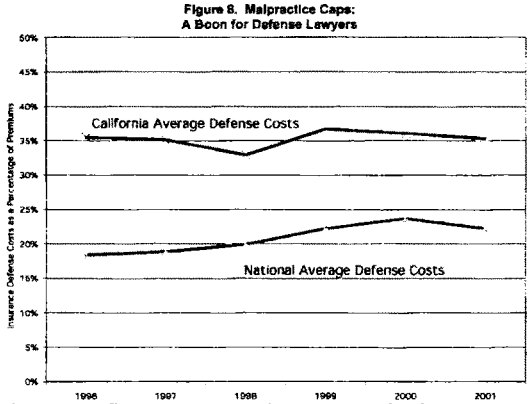
Figure 7. Loss Ratio in California Since MICRA



While the malpractice loss ratio has improved in California under Proposition 103, it continues to oscillate around 50%, indicating that an astonishing fifty cents of every malpractice premium dollar that physicians pay remains with insurers. What are insurers doing with this money?

The NAIC data expose another product of MICRA: medical malpractice insurers in California are spending far more money fighting the claims of injured patients than the national average. That is, California malpractice insurers spend a disproportionate amount of a premium dollar on direct defense costs, which includes insurance company lawyers, expert witnesses and other claim adjustment expenses. Between 1996 and 2001, California medical malpractice insurers spent an average of 35% of premiums on defense costs compared to the 21% national average, excluding California.

Figure 8. Malpractice Caps: A Boon for Defense Lawyers



Source: Special data collection for FTCR. National Association of Insurance Commissioners, by permission. The NAIC does not endorse any analyses or conclusion based upon the use of its data.

Indeed, NAIC data show that California medical malpractice insurers incurred more costs fighting claims than actually paying claims in 1992 and 1993, and in 1994 and 1995, defense costs continued to be exceptionally high as compared to the losses incurred in California.

Figure 9. Malpractice Defense Expenditures (1992-1995)

Year	Total California Losses Incurred/ (As Percentage of Premium Earned)	California Defense Costs Incurred/ (As Percentage of Premium Earned)	Countrywide Losses Incurred/ (As Percentage of Premium Earned)	Countrywide Defense Costs Incurred/ (As Percentage of Premium Earned)
1992	**$209,545,400 (39.8%)**	***$216,389,850 (41.1%)***	$3,571,184,500 (69.5%)	$1,644,286,400 (32.0%)
1993	**$214,504,520 (38.1%)**	***$226,327,600 (40.2%)***	$3,342,439,500 (64.6%)	$1,554,157,200 (27.9%)
1994	$216,289,120 (37.5%)	$203,600,160 (35.3%)	$3,514,615,500 (59.3%)	$1,554,157,200 (26.2%)
1995	$248,028,900 (41.5%)	$226,513,140 (37.9%)	$3,571,184,500 (59.3%)	$1,830,272,300 (30.1%)

SOURCE: National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001

The insurance industry and doctors argue for limits on victims' attorneys' fees under the guise of returning more money to the victims of malpractice. However, in some years, insurers have spent a greater proportion of doctors' premiums on their own lawyers and defense costs in California, with liability limits in place, than on compensating patients, contradicting a

premise of "liability reform." In other states, victims receive more of the premium dollar, while the insurers' own legal expenses are less.

What explains this behavior? Because the rigid caps make it more difficult for victims to obtain representation and prosecute a case, and because such caps limit companies' exposure, insurers have an incentive to withhold claims payments as a negotiating tactic, forcing plaintiffs and their attorneys to spend inordinate resources to recover losses. This "scorched earth" litigation conduct discourages cases and forces patients to accept lower recoveries.

Additionally, insurance companies owned by physicians have an incentive to fight harder to protect physicians' from having to admit liability even if liability is clear.

Although, under the strictures of MICRA, insurers will continue to pay limited claim settlements in California, sustained and increasingly rigorous regulation will continue to improve insurers' loss ratio over time, as noted below.

IV. Tort Restrictions Enacted During the Previous Crisis Did Not Lower Premiums

There should be little surprise concerning California's experience with MICRA results. After the fusillade of restrictions on the rights of malpractice victims in the 1980s took effect, insurance companies did not cut their malpractice premiums accordingly, as numerous studies have since verified.

Legislation enacted in Florida in the spring of 1986 at the behest of a coalition of insurance companies, medical lobbies and corporations contained dramatic restrictions on victims' rights. But it also required insurers to reduce their insurance rates concomitantly, unless they could demonstrate to state insurance regulators that the limitations on consumers' rights would not reduce their costs. Six months after the law was enacted, two of the nation's largest insurance companies told the Florida Insurance Department that limiting compensation to injury victims would not reduce insurance rates. St. Paul Fire and Marine Insurance Company, then the nation's largest medical malpractice insurer, and Aetna Casualty & Surety Co., provided an extensive "actuarial analysis" of five specific limitations on victim's rights that the insurance industry had promised would reduce premiums. Overall, the Aetna report

concluded that one provision of the law would reduce rates by a maximum of 4/10 of 1 percent, while all the other tort restrictions would have "no impact" on rates.[8] In fact, Aetna asked for a 17 percent rate *increase* based on its analysis of the impact of the law. The St. Paul study concluded that the restrictions "will produce little or no savings to the tort system as it pertains to medical malpractice." [9] St. Paul stated:

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

In April, 1987, the insurance industry's rate-making agency, the Insurance Services Office (ISO), released the results of a study intended to respond to repeated demands from policymakers and legislators across the country that the industry provide empirical data to support its claims that changes in the tort law system would alleviate the nation's insurance crisis. The study examined the responses of 1262 insurance adjusters from nine property-casualty insurance companies and two independent adjusting firms located in 24 states. The adjusters were asked to determine the impact of actual restrictions in the tort laws of 15 of the states on six hypothetical injury cases. In addition, they were asked to judge the impact of similar proposals that did not become law in the remaining nine states. Much to the chagrin of the insurance industry, the study failed to support years of insurance industry propaganda. Instead, it disclaimed any impact upon rates. One insurance industry official was quoted as saying, "Some state legislators are going to be shaking their heads after hearing us tell them for months how important tort reform is, and now we come out with a study that says the legislation they passed was meaningless." [10]

The Florida filings and excerpts from the ISO study can be found in our testimony before the Oversight and Investigation Subcommittee on February 10, 2003 and we ask that it be made a part of the record of this hearing.

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[8] Letter from Thomas L. Rudd, Superintendent of Insurance Department Affairs, Commercial Lines, Aetna Casualty and Surety Company, to Florida Insurance Commissioner Bill Gunter and Charlie Gray, Chief of Bureau of Policy and Contract Review for the Florida Department of Insurance, August 8, 1986, enclosing "Bodily Injury Claim Cost Impact of Florida Tort Law," Aetna Casualty and Surety Company.

[9] Addendum of St. Paul Fire and Marine Insurance Company," undated 1986 filing before the Office of the Insurance Commissioner of Florida.

[10] Robert Finlayson, "Insurers Fear Reform Foes to Capitalize on ISO Study," *Business Insurance*, May 18, 1987, p. 2.

Indeed, in the midst of the "crisis," the federal government's watchdog agency, the U.S. General Accounting Office, published a study of six states that had enacted many different forms of tort law restrictions during the "crisis" of the mid-1970s, including caps on compensation. The GAO report showed that the price of medical malpractice liability insurance in California had increased dramatically since the passage of MICRA. In fact, "premiums for physicians increased from 16 to 337 percent in southern California ... between 1980 and 1986."[11] The GAO study concluded:

> While it is not possible to assess the extent to which the act [MICRA] has had an impact on the state's malpractice situation, our analysis of key indicators indicated that the problem is continuing to worsen in California. [12]

According to the GAO, four states (Arkansas, Florida, New York and North Carolina) reported that the restrictions had had "little effect" on insurance premiums. [13] So-called "tort reform" does not lower insurance premiums.[14]

When MICRA failed to deliver the promised premium reductions in California in the late 1970s, physicians participating in the Southern California Physicians Council (SOCAP) sought recourse by filing a lawsuit (on a contingency fee basis) against their malpractice carrier, Travelers Insurance Co., for what the physicians described as a "rip-off." Travelers ultimately agreed to pay over $50 million, including refunding excessive projections of future losses -- roughly 18% of each physician's premiums for 1976-1978. As the President of the Los Angeles County Medical Association put it: "This proves that we were right during the crisis; premium increases of 486% or even 327% were unjustified."[15]

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[11] U.S. General Accounting Office, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms* (Washington, D.C.: U.S. Government Printing Office, 1986), p. 25.
[12] *Ibid.*, p. 26
[13] *Ibid.*, pp. 2-3.
[14] In 1999, FTCR studied auto insurance premium changes since 1989 among states that did not allow third party accident victims to sue insurers for bad faith, which insurers argue is key to lower auto insurance rates. Twenty-four of the 26 states with restrictions on such lawsuits faced 25% rate increases or more over the 7 year period studied. States with restrictions averaged larger rate increases than states with no legal restrictions on bad faith suits. Not only is California, which passed Proposition 103 in 1988, the only state, with tort limits that saw a reduction in that period, it is the only state to have had reduced premiums in the nation as a whole between 1989 and 1996.
[15] Edward Zalta, "Finally, Travelers Refunds SOCAP Policyholders More than $18 Million in Premium Overpayments," LACMA Physician, February 23, 1981, pp.26-29. Article attached.

IV. Proposition 103 Reduces Insurance Rates Because the "Crisis" Is the Creation of the Insurance Industry, Not Litigation

The present insurance "crisis" – apparent in homeowners, auto, commercial liability as well as medical and other malpractice lines – constitutes the apogee of a financial cycle to which the insurance industry is subject:

> Insurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely underprice their policies and insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market. But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market usually degenerating into a "liability insurance crisis." A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. Again, in 2002, the country is experiencing a "hard market," this time impacting property as well as liability coverages with some lines of insurance seeing rates going up 100% or more.[16]

Fitch, a Wall Street rating firm, recently began a discussion of the current "crisis" by harkening back to the last one:

> We need to look back at the hard market of the mid-1980s.... The last major hard market turn was in the mid- 1980s, and was inspired greatly by a sharp drop in interest rates. In years prior to the mid-1980s, cashflow underwriting was prevalent in which a significant amount of naive capital was attracted to the property/casualty industry on the lure of making strong investment returns on the premium "float" between the time premiums were collected and claims were paid. Naturally, much of the naive capacity was directed at long-tail casualty and liability lines at both the primary and reinsurance levels in order to maximize the float. In the early 1980s, nominal interest rates were running in the mid-teens. When interest rates dropped off and significant reserve deficiencies were simultaneously detected, many insurers suffered large losses to both earnings and capital. The result was a sharp turn in the market, especially in long-tail lines, and the emergence a socalled "liability insurance crisis." The liability insurance crisis included a sharp drop in availability of coverages, and huge price increases (in many cases several-fold).[17]

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[16] "Medical Malpractice Insurance: Stable Losses/Unstable Rates," Americans for Insurance Reform, October 10, 2002.

[17] Fitch Ratings, Inc., Insurance Special Report Review & Outlook: 2001/2002: U.S. Property/Casualty Insurance, January 17, 2002, p. 19-20.

Indeed, by early 2002, insurers had already begun licking their chops as they looked forward to an infusion of profits from the latest "crisis." In its "Groundhog Forecast 2002," the Insurance Information Institute projected a 14.7% increase in premiums, the industry's "fastest pace since 1986" – the last crisis.[18] The Auto Insurance Report proclaimed, "The Stars Are Lining Up for Solid Profits in '02-'03."[19] "How Much longer to P-C Nirvana?" asked the National Underwriter, saying, "Like kids on a long car trip headed for summer vacation, many insurance company employees and the agents that represent them have found themselves wondering just how much longer this trip to property-casualty nirvana can last."[20] Said an industry executive: "This manic behavior leads our customers to believe we don't know what we're doing, and I think they have a point. This is a generation of insurance professionals who need to learn how to be successful with something other than low premiums."[21]

A California-based "bed pan mutual" put it this way:

> THERE THEY GO... AGAIN! In a predicted cyclical panic, many commercial medical liability insurers around the country are again multiplying premium rates, refusing to insure some specialties, leaving doctors and hospitals without insurance, or going broke, just as such companies did in 1975. These events are the big news for 2001, and they demonstrate again how doctors benefit by owning their own properly motivated and operated malpractice insurance companies...WE PREPARED FOR THIS.[22]

While careful to make the obligatory propaganda bow to MICRA, the Medical Insurance Exchange of California's explanation for its "preparations" makes clear that the current "crisis" is the result of economic forces and other insurance companies' financial mishaps:

> MIEC has always known the liability insurance panic would happen again. It is happening now but it will affect MIEC policyholders only moderately, because of MICRA in California, and because MIEC has long been prepared for this cycle with Board and management policies and motivations that have been rare among most of our competitors. MIEC policyholders will be especially well-protected in all the states in which we insure:
>
> * We have set our loss reserves conservatively, charged realistic premiums, and we operate the company economically. When our costs to defend doctors and to pay claims are less than expected, we return the money to our doctor-owners, and to no one else.

[18] www.iii.org/media/industry/financials/groundhog2002/ visited 11/21/02.
[19] Auto Insurance Report, May 13, 2002, p. 1.
[20] National Underwriter, July 22, 2001, p. 26.
[21] "Liability Insurers Urged to Take Long View for Industry's Financial Health," Orlando Business Journal, November 26, 2002 at http://orlando.bizjournals.com/orlando/stories/2002/11/25/daily25.html?t=printable.
[22] Medical Insurance Exchange of California, Annual Report, http://www.miec.com/annual_report.html, visited February 24, 2003.

* We have not been and are not interested in competing for "market share." We decline to cut premiums or offer low bids to achieve speedy growth. We do not make unjustifiable "sales volume" discounts, because we consider them unfair to those who do not try to negotiate discounts. We do not want to be "the biggest," or nationwide, or to engage in costly competition for a dangerous "market share."
* We have carefully accumulated reserves, staff, and resources to defend our doctors properly.
* We have carefully selected and priced our risks. We have sought to insure solo practice, small partnerships and small groups. Because managed care generates a special risk, we have not actively sought such risks, and are not renewing those we have.
* We use MIEC funds only for worthy projects or activities that have direct relevance to lowering the risks and costs of professional liability. We believe that our insured doctors prefer to select their own charitable contributions, but we contribute to legislative and judicial activities that defend MICRA and other reforms and the judicial process.
* We have no sales or marketing staff, and engage only legal, actuarial, tax and investment consultants. We seek to insure doctors who believe our promise that we will not charge them more—or less—than is necessary to protect them properly. This subtle underwriting selection enhances quality and quantity of our "market share."
* We ask and receive sponsorship and cooperation from medical societies that wisely identify stability, security, economy, comfort and sophisticated service for their members in this most stressful aspect of their profession.[23]

The country is presently suffering through the trough of the third insurance cycle in as many decades. No sudden increase in claims or awards is responsible for the crisis. Thus, so-called "tort reforms" are irrelevant. Proposition 103 has controlled premiums and stabilized the insurance marketplace in California because:

• Its controls on insurers' rate of return, expenses and loss reserves – coupled with the possibility of a challenge to rates by the insurance commissioner or the public – restrain insurers from the imprudent gyrations that characterize the highs and lows of the insurance cycle.

• Regulation has ended the cost-plus pass-through mentality pervasive in the insurance industry. In a poorly-regulated environment, the more insurers charge, the more they can invest. There is no incentive to control expenses, especially since the insurers' exemption from the antitrust laws enables them to circulate expense data. Under Proposition 103, insurers have tightened their belts as predicted: cutting agent commissions, reducing expenses, fighting fraud, and promoting loss prevention.[24]

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[23] Id.

[24] Two years after Proposition 103 passed, the Los Angeles District Attorney noted that, "until coming under pressure to lower rates under Proposition 103, [insurance] carriers simply settled claims and passed the cost to consumers in the form of higher premiums. 'That has begun to change,' he said. 'Insurance companies are getting serious about fraud.'" Lois Timnick, *51 to Face Charges in Auto Insurance Fraud Roundup*, L.A. TIMES, Oct. 18, 1990,

Indeed, the insurance industry's fear of provoking more Proposition 103-style reforms may have protected the nation from a modest "crisis" in the early 1990s. As the U.S. economy entered a recession—accompanied by a drop in investment income to which the industry would normally respond with premium increases—industry officials warned each other to avoid the destabilizing premium gyrations of the mid-1980s. As one insurance executive explained, "The last soft market was driven purely by the need for cash to invest. . . . We all know we can't do the dumb things we did last time. . . . We will not see a repeat of 1985-86."[25] Another executive has observed: "I don't think you'll see a 1985-1986 repeat. There are too many regulatory restraints put in place to preclude it. A lot of regulations addressed our own stupidity. We made the bed and now we have to lie in it."[26] And a senior official with the Insurance Services Office, an industry trade group, warned:

> As an industry, nothing will disrupt our relations with customers faster—not to mention regulators and public-policy makers—than an abrupt recovery from our current underwriting down cycle. . . . Remember the fallout from the last recovery: California's Proposition 103 and other price-suppression laws, threats to the industry on the antitrust front, and virulent consumer hostility.[27]

Of particular importance to the current "crisis" is regulatory oversight of insurers' loss projection practices and reserving policies. These accounting practices are responsible for statements such as "malpractice insurers will pay out approximately $1.40 for every premium dollar collected in 2001 and 2002."[28] Weiss ratings reported insurer malpractice claims up 106.8% between 2000 and 2001, an extraordinary leap in the amount insurers say they will have to pay out within one year.[29] While booked as losses for tax and regulatory purposes,

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at B4. Heightened scrutiny of claims by insurers is at least partly responsible for the 48% reduction between 1989 and 1994 in lawsuits for personal injury auto accidents filed in California Superior Courts. *See* JUDICIAL COUNCIL OF CAL., 1996 ANNUAL REPORT 109.

[25] Mark A. Hofmann & Christine Woolsey, *Marketplace Not What It Used To Be: Insurers*, BUS. INS., July 13, 1992, at 55.

[26] *Id.*, at 1, 14.

[27] *Not Like 1985's: ISO Official Predicts Next Upturn in Cycle to be Gradual*, INS. WK., Oct. 19, 1992, at 15, 15.

[28] STATEMENT OF THE PHYSICIAN INSURERS ASSOCIATION OF AMERICA Presented by Richard E. Anderson, M.D., Chairman The Doctors' Company Before the Subcommittee on Health Committee on Energy and Commerce U.S. House of Representatives Regarding: "Harming Patient Access to Care: Implications of Excessive Litigation" Wednesday July 17, 2002, p. 9.

[29] Insurers also projected a nonsensical 76% increase in auto accident payouts during this period. "Property and Casualty Insurers Suffer $9 Billion Loss in 2001; Terrorist Attacks and Corporate Bankruptcies Contribute to Record Claims of $381 Billion," Weiss Ratings, July 8, 2002, p. 1. http://weissratings.com/News/Ins_General/20020708pc.htm.

these phantom losses never fully materialize, and the money held in reserve for them is later quietly moved into profits, or used to subsidize premium reductions during the trough of the insurance cycle. Here is how Dr. Robert Hunter, a former insurance commissioner described it:

> "Paid losses" are a far more accurate reflection of actual insurer payouts than what insurance companies call "incurred losses." Incurred losses are not actual payouts. They include payouts but also reserves for possible future claims – *e.g.*, insurers' estimates of claims that they do not even know about yet. While incurred losses do exhibit more of a cyclical pattern, observers know that this is because in hard markets, as we are currently experiencing, insurers will increase reserves as a way to justify price increases. In fact, the current insurance "crisis" rests significantly on a jump in loss reserves in 2001.
>
> Historically, reserves have been later "released" to profits during the "softer" market years. For example, according to a June 24, 2002, *Wall Street Journal* front page investigative article, St. Paul, which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the1980s, so it "released" $1.1 billion in reserves, which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states. Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.[30]

In California, insurance companies are now requesting substantial malpractice rate increases, requiring heightened regulatory scrutiny. Under Proposition 103, our organization challenged a recent 15.6% rate increase proposed by the state's second largest medical malpractice insurer, SCPIE Indemnity. Our actuary has calculated that SCPIE should *lower* physicians' rates by more than six percent rather than raise rates as the company proposed.

IV. The Medical Lobby and MICRA

It is clear that MICRA did not lower insurance premiums in California, and that the principle beneficiaries of MICRA have been insurance companies and negligent doctors.

But what of the medical lobby – the American Medical Association and its counterparts in states across the nation, whose member doctors can be found in recent weeks angrily on strike,

[30] "Medical Malpractice Insurance: Stable Losses/Unstable Rates," Americans for Insurance Reform, October 10, 2002.

refusing to see patients and threatening to "leave the state" unless MICRA legislation is enacted?

The physicians promoting MICRA complain that they cannot afford the increasing cost of malpractice coverage. This is hard to fathom, since, according to *Medical Economics* magazine, medical malpractice insurance premiums account for between 1.2% of a doctor's gross receipts and 5.5% of receipts, depending upon the specialty. General surgeons, for example, have a relatively high average malpractice premium of $21,641 annually, but that is only a small fraction of a surgeon's $497,633 average collections for 2001. That same surgeon has, on average, a net income of more than $257,000 per year, *after* accounting for expenses, such as rent, staff salaries and medical malpractice insurance. In other words, that doctor will make more in a year than many brutally injured patients will have access to for a lifetime of suffering under the proposed non-economic caps.[31]

Pediatricians spend a mere 1.4% of their office's gross receipts on malpractice insurance – about $6,628 per year according to the most recent data presented in the *Medical Economics* surveys. Even obstetricians, who pay some of the highest premiums, only spend about 5.5% of their annual receipts on insurance. They still, on average, earn $231,000 per year after expenses. Other than baseball players, not too many workers would strike if their annual take-home pay approached a quarter of a million dollars.

The highly visible threat that physicians will close their practices and move elsewhere absent passage of MICRA legislation has proved a potent political tool. Apart from the practical difficulties of such a move, their remains the question of where they might go.

For, in California, where MICRA was pioneered nearly thirty years ago, physicians are apparently just as unhappy and are just as intent upon closing up shop and/or leaving the state, according to a remarkable study done by the California Medical Association (CMA) in 2001 – before the current crisis.

In an extensive survey of its own physician members, in February, 2001, "And Then There Were None: The Coming Physician Supply Problem," the CMA found that:

[31] "More Hours, More Patients, No Raise?" Medical Economics, November 22, 2002; "Expense Survey: What it costs to practice today," Medical Economics, December 9, 2002.

- 43% of surveyed physicians plan to leave medical practice in the next 3 years. Another 12% will reduce their time spent in patient care.
- Seventy-five percent of physicians have become less satisfied with medical practice in the past five years.
- More than 1/4 of physicians would no longer choose medicine as a career if starting over today, and more than 1/3 of those who would still choose medicine would not choose to practice in California.
- Low reimbursement, managed care hassles and government regulation are the greatest sources of dissatisfaction.
- The time physicians spend in patient care has declined by 7% in the last 5 years; 44% of physicians spend less time with patients than 5 years ago.
- 58% of physicians have experienced difficulty attracting other physicians to join a practice.
- More than 25% of physicians had difficulty in recruiting doctors in Los Angeles, Orange, Riverside, San Diego, Ventura, Marin, Del Norte, San Luis Obispo, Tehama and Shasta-Trinity counties.
- Primary care, neurology, orthopedic surgery and neurosurgery lead in specialty shortages.
- 2/3 of physicians are not advising their children to practice medicine. (p.ii)

The CMA says:

> Indicators of significant physician dissatisfaction with medical practice and physician flight from California are dramatic. There appear to be widespread problems recruiting new physicians. Low reimbursement and managed care hassles are taking their toll. Only a third of physicians would still choose to practice in California if they had to do it over today. (p.iii).
>
> Hundreds of physicians throughout the state report their plans to quit practice in California. (p.ii).
>
> **These findings foretell a dark and startling picture concerning physician supply in California. They predict a future with many fewer physicians.** Negative career, professional and economic pressures in the California health care system are having the ultimate impact causing physicians to leave medicine and creating barriers for others to practice in the state. (p.18).
>
> Physicians in California overwhelmingly report dissatisfaction with the current practice of medicine, and a majority say they will express this dramatically in the next three years by quitting practice or otherwise cutting hours spent treating patients. The result will be fewer physicians, longer waits for care, less preventive medicine and higher costs to the health care system. Of the 55% of physicians who will reduce time spent treating patients: 78% will change professions, leave the state or retire early... Only a third of physicians (35%) would still choose to practice in California. (p.18).

The CMA study is a decisive refutation of the rosy picture painted by the AMA – and the CMA – of California under MICRA. Indeed, far from heaven on earth for physicians, California is apparently one of the less lucrative states in which to practice medicine in the nation. *Medical Economics* reports that doctors in the West, many of whom are in California,

earn the lowest annual salary in almost every specialty and overall, with an average of $212,810.[32]

Placed in the current context, the CMA study raises the question of whether the dissatisfactions driving doctors to promote MICRA are based on financial considerations that have nothing to do with the legal system.

Moreover, the California Medical Association has recently alerted its members that "CMA is getting an increasing number of calls from physicians who have been notified of large increases in professional liability insurance premiums and from others who have been dropped by their carriers. In some cases, the physicians say they have had no settlements or suits filed against them."[33]

Contrary to the claims made by proponents of MICRA, restricting malpractice payouts would do nothing to benefit the economy. MICRA has been portrayed by physicians and, most recently, President Bush, as a way to lower health care costs for the nation. This is incorrect. Medical malpractice premiums are 0.55% of the national health care expenditures, an all time low.[34] Malpractice payments to victims by insurers averaged $3 billion per year between 1991 and 1999 – roughly 0.3% of national health care expenditures, according to industry data. By contrast, the total cost of malpractice deaths and injuries to the national economy has been estimated at ten times the amount of payouts.[35] Capping physicians' annual salaries at $250,000 would probably have more of an impact upon national health care expenditures – organized medicine has not yet proposed such caps on themselves – but it would still be of negligible impact.

Trading on their credibility – already diminished in recent years as profit-driven HMO medicine has wreaked havoc upon patients – the physicians promoting MICRA insist that it has provided other benefits to Californians, and thus deserves to be considered as a model for legislation in other states and for legislation which would federalize the malpractice tort system by imposing MICRA nationally. However, there is no independent evidence that

[32] "More Hours, More Patients, No Raise?" Medical Economics, November 22, 2002
[33] http://www.calphys.org/html/bb093.asp.
[34] Letter to President Bush, Consumer Federation of America, July 30, 2002.
[35] Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).

MICRA has been of value to anyone other than the insurance companies – and perhaps the fraction of physicians, estimated at 5%, who commit 54% of the malpractice in the U.S.[36]

Ignored by the supporters of MICRA is the impact it has had upon patients.

V. MICRA: The Impact on Patients

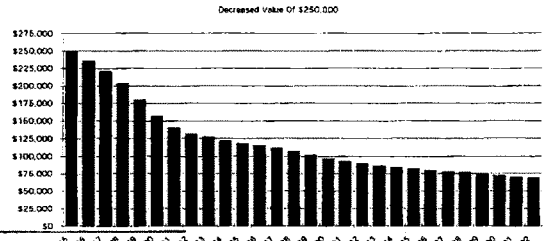
In recent years, Californians have been confronted with MICRA's devastating human impact and its failure to achieve its financial goals. The California legislature has tried twice in the last four years to remove MICRA's limits. Unfortunately, the legislative grip of the insurance industry has proven too strong.

MICRA's main provisions:

- Place a $250,000 cap on the amount of compensation paid to malpractice victims for their "non-economic" injuries.
- Permit those found liable for malpractice to pay the compensation they owe victims on an installment plan basis.
- Establish a sliding scale for attorneys fees, which discourages lawyers from accepting serious or complicated malpractice cases.
- Eliminate the "collateral source rule" that forces those found liable for malpractice to pay all the expenses incurred by the victim.

A. Capping Medical Malpractice Victims' Compensation Causes Innocent Patients More Pain And Suffering

The MICRA cap has no flexibility, with respect to egregiousness of the negligence or to account for inflation. As a result of the latter rigidity, the real value of the caps has declined



[36] "Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors' Lobby," Congress Watch, January 2003, p. 21

substantially over time. In order to provide the same level of compensation in today's dollars, the cap would have to be approximately $800,000. Put another way, the $250,000 MICRA cap has decreased in value since 1975, when compared to the Consumer Price Index, to approximately $70,000. Though health care costs – hospital charges, medical fees, *etc.* – have risen dramatically since 1975, compensation for non-economic damages has been frozen by the statute.

Non-economic injuries include pain, physical and emotional distress and other intangible "human damages." Such damages compensate for severe pain; the loss of a loved one; loss of the enjoyment of life that an injury has caused, including sterility, loss of sexual organs, blindness or hearing loss, physical impairment, and disfigurement.

Applying a one-size-fits-all limit to non-economic damages objectifies and erases the person, considering them as a fixed "thing" for the purposes of law, so that there is no recognition of the uniqueness of their suffering. There is no quicker way to strip an individual of their humanity than to fail to recognize their suffering.

Caps on "non-economic" compensation devalue the lives and health of low-income patients. Caps on pain and suffering discriminate against the suffering of low-income people whose "economic" basis – wages – are limited. A strictly "economic" evaluation based on wages devalues what victims will create or produce in the future, their quality of life, as well as an injury's impact on their ability to nurture others. For instance, a laborer may lose his arms due to the exact same act of medical negligence as a corporate CEO, but the CEO would be able to collect millions and the laborer would be closely limited to the $250,000 cap. A housewife similarly would be limited to the cap no matter the physical or emotional depths of her injury. Caps assign greater value to the limbs and lives of some people than the limbs and lives of others.

Caps make taxpayers foot the bill for dangerous doctors' mistakes. Malpractice victims receive full compensation only for medical bills and lost wages. But those who are not wage earners – such as seniors, women, children and the poor – have no other resource from which to pay for unforeseen medical expenses and basic needs. A cap forces malpractice victims to seek public assistance from state or federal programs funded by taxpayers

In many cases, California 's cap system has limited the liability for egregious systemic error to an acceptable cost of doing business, permitting systemic medical negligence to continue undeterred. There is no incentive to address systemic problems. Deterrence to wrongdoing is especially important at HMOs. Arbitrarily applying one-size-fits-all caps to systemic wrongdoing lets HMOs know there is a financial limit to how much they will pay no matter how egregious and irresponsible their conduct. This is carte blanche in many cases to throw caution to the wind.

Ironically, proponents of MICRA claim it limits "defensive medicine" procedures. The Congressional Office of Technology Assessment reported in July 1994 that "defensive medicine," procedures purported to be driven by physicians' fears of lawsuits, account for only 8% of medical procedures and may in fact constitute merely preventative, high quality health care. As the OTA stated, fear of lawsuits can often simply make those with the least incentive to be cautious more cautious with their patient. This is precisely the incentive HMOs and their doctors and hospitals now need.

B. Periodic Payments Reward Convicted Wrong-Doers At The Expense Of Malpractice Victims They Injure

MICRA permits defendants found liable for malpractice to pay jury awards on a periodic, rather than a lump sum, basis, if the award equals or exceeds $50,000 and the defendant requests it. Jury-designated malpractice awards can be restricted by the judge as to the dollar amount paid each period and the schedule of payments. The periodic payment arrangement, once approved by a judge, cannot typically be modified -- unless the victim dies earlier than expected, in which case the defendants, rather than the family of the deceased, retain the balance of what they owe.

This provision of MICRA allows the negligent provider or its insurance carrier to control, invest and earn interest upon the victim's compensation year after year. No adjustment is made in the payments to reflect unexpected trends in the inflation rate or changes in the cost of medical care.

If the defendant enters bankruptcy or simply ceases to pay, the victims are forced to return to court and engage in another lengthy legal proceeding. Another problem is that an inflexible payment schedule leaves the victim without sufficient resources in the event that unanticipated medical or other expenses arise. This is most likely to occur in the years immediately following the injury, when the periodic payments are unlikely to cover the aggregate costs.

Periodic payments allow insurers to invest and earn interest on the money owed injured victims. Periodic payment schedules permit convicted perpetrators or their insurers to control the money owed victims and profit from its use year after year. If the insurance company happens to fall into bankruptcy due to bad investments, the victim is denied the agreed upon compensation.

If a patient dies, all payments stop and the victim's family receives nothing. Wrong-doers are rewarded for causing the most severe, life threatening injuries. If a patient dies, periodic payments immediately cease and the guilty physician is allowed to keep the remainder of their money. Awards do not revert to the next of kin.

Periodic payments reduce the already limited compensation received by victims, as the value of the verdict diminishes over time due to inflation. No adjustment is ever made in the payments to reflect the inflation rate or changes in the costs for medical care -- which have risen sharply and well above the inflation rate for many years.

Periodic payments puts the burden on the victim to meet their basic needs. The periodic payment arrangement, once approved, is extraordinarily difficult to modify. If costs of the victim's medical care increases beyond their means, or a special expensive medical technology is made available which the victims requires, the injured patient must retain a lawyer to have the schedule modified - and may very well not succeed.

Closed-door settlements that result from the periodic payment provision let dangerous doctors off cheap and shield their name from public record. In California, the periodic payment provision results in the settling of cases through closed door agreements – even after a verdict for the victim. Because periodic payments reduce the value of awards over time due to inflationary factors, plaintiffs are encouraged to enter a settlement for a greatly reduced amount. Not only insurers of convicted doctors pay significantly lowered penalties for wrong-

doing in California, but the state Medical Board – as a result of a lawsuit by the California Medical Association – reports no information about negligent doctors who have settled cases to the public, denying consumers vital information to deter future incidents of medical malpractice.

C. Capping Plaintiff Attorney Contingency Fees, But Not Defense Attorney Fees, Denies Victims' Representation

MICRA sets a sliding contingency fee schedule for plaintiffs' attorneys representing victims of medical malpractice. The MICRA fees are limited to 40% of the first $50,000 recovered; 33 1/3% of the next $50,000; 25% of the following $100,000, and 15% of any amount exceeding $200,000. MICRA does not limit the fees of the defendant's lawyers.

Only the most seriously injured victims with clear-cut cases to prove and substantial economic damages can ever find legal representation. In states with caps on attorney contingency fees for medical malpractice cases (and particularly in states such as California where a victim's pain and suffering compensation is also capped), victims of medical malpractice simply cannot find legal representation. It is not cost effective for attorneys to take the vast majority of cases. Says the President of Safe Medicine For Consumers, a California-based medical malpractice survivors group, "The vast majority of individuals who contact us are women, parents of children or senior citizens. 90% of these individuals are unable to pursue meritorious medical malpractice cases because they can not find legal representation on a contingency basis and their savings have been wiped out."

Limiting plaintiff attorney contingency fees, but not defense attorney fees creates an uneven playing field for victims. Defendants can typically afford very high priced attorneys who fly special expert witnesses in from around the country. A contingency fee practice demands that a plaintiff's attorney must front the cost of expert witnesses to refute the testimony of experts flown in by the defendant. With caps on fees, such costs become prohibitive for the victim's legal counsel.

Undermining the contingency fee mechanism contributes to a deteriorating quality of health care and passes costs onto taxpayers. Left without legal representation in California, victims go uncompensated, and dangerous doctors go undeterred. Taxpayers pay the cost of low-

income victims' medical care and basic needs through public assistance programs if the physicians responsible for the injuries are not held accountable.

Undermining the viability of contingency fee mechanism discriminates against low-income patients who are most of risk of medical malpractice. A contingency fee system is a poor patient's only hope of affording an attorney to challenge a negligent physician. Undermining such a system through caps on fees, that reduce incentives for attorneys to take malpractice cases, gives dangerous doctors, hospitals and HMOs a license to be negligent in poor neighborhoods.

D. Imposing A Collateral Source Offset Forces Taxpayers And Policy Holders To Pay For Wrongdoers Errors

The collateral source rule prohibits defendants charged with negligence from informing the jury that the plaintiff has other sources of compensation, such as health insurance or government benefits, including social security and disability. The purpose of this long-established doctrine is to ensure that the jury holds the defendant responsible for the full cost of the harm the defendant caused by requiring the defendant to pay all the victim's expenses -- even if a collateral source has already paid them.

Application of another legal doctrine, known as subrogation, ensures that the collateral source rule does not result in "double recoveries" for injured victims. Under subrogation rights -- which are applicable to virtually all health insurance policies, government programs, and workers' compensation systems -- the third-party payor of a health or job loss benefit has the legal right to take funds from a malpractice award to reimburse itself for payments it has already made to the malpractice victim. The collateral source rule, in conjunction with subrogation rights, ensures that wrongdoers pay for the full amount of the harm they cause, and that victims do not receive double payments for their injuries.

For example, an injured individual's health care coverage usually pays the victim's medical bills. Under the traditional collateral source rule, if the victim sues the wrongdoer for compensation, including payment of medical bills, the defendant cannot tell the jury that the bills have already been paid by another source. However, once the jury makes an award to the victim, including damages for medical care, the health insurer can exercise its subrogation

rights, and recover from the defendant (or the victim, if the award has been paid) the amount of money already paid for the victim's medical bills.

MICRA repealed these rules in California. Consequently, in a trial, defendants may introduce evidence of insurance or other compensation obtained by the plaintiff. The jury is further permitted to reduce its award against the defendant by the amount of alternative compensation the victim received or is entitled to. As with the cap on non-economic damages, abolition of the collateral source rule reduces the amount of money the wrongdoer must pay. In effect, responsibility for the harm is transferred to the victim, who purchased the insurance coverage, to the victim's insurer, and/or to taxpayers. Moreover, once the defendant tells the jury about payments made by collateral sources, MICRA prohibits the collateral source from using the subrogation process to obtain reimbursement from the wrongdoer.

Collateral source offsets will shift billions of dollars per year in malpractice injury costs caused by the negligent onto taxpayers and the health insurance system. The cost of injuries incurred as a result of medical malpractice total $60 billion each year, according to the Harvard School of Public Health. Instead of wrong-doers bearing the full cost of these injuries, tax-payer funded programs, such as social security, and policy-holder funded health plans, will be forced to pick up the tab.

A collateral offset forces poor patients onto welfare, while wrong-doers' fortunes will be protected. Low income victims "entitled" to public assistance payments from taxpayer-funded supplemental social security, social security disability and aid to families with dependent children become government assistance recipients while the insurers earn interest at the victim's expense.

D. Protecting HMO's Will Only Increase the Problem of Medical Malpractice

In addition to its severe restrictions on injured patients, HR 5 will ensure that healthcare liability claims against HMOs are subject to the MICRA caps. Arbitrarily applying one-size-fits-all caps to systemic wrongdoing lets HMOs know there is a financial limit to how much they will pay no matter how egregious and irresponsible their conduct. The proposed cap will limit HMO's liability for egregious systemic error to an acceptable cost of doing business, permitting systemic medical negligence to continue undeterred. Deterrence to wrongdoing is

especially important at HMOs, but this bill will drastically reduce the liability of negligent, cost-cutting HMOs when these companies' decisions harm patients.

VI. CONCLUSION

Malpractice litigation is not responsible for the present "crisis," and malpractice caps did not solve the California crisis of the 1970's.

The real crisis today is not the price of malpractice insurance, but the epidemic of medical mistakes and negligence, so the best way to reduce malpractice claims is to reduce the amount of medical malpractice in our country. The solution is not limiting the rights of victims of malpractice to have their day in court.

In order to address both the drastic increases in malpractice premiums and the crisis of medical malpractice itself, there must be an increase regulation of the insurance industry's prices and underwriting practices, following the model of California's Proposition 103.

The following bullets set forth a comprehensive malpractice insurance reform proposal:

1. **Premium Reduction**
   - Require medical malpractice insurers to provide an automatic 20% discount to good doctors
   - Differentiate poor doctors from the rest of the pool by charging rates based on "experience rating," a physician's history of malpractice claims
   - Require insurance companies to spread risk more equitably by placing physicians in a reduced number of underwriting categories
   - Prohibit insurers from arbitrarily canceling or refusing to renew policies
   - Mandate a 20% rate rollback and rate freeze

2. **Insurer Accountability**
   - Require state departments of insurance to approve all malpractice rate increases before the rates can go into effect
   - Oblige state insurance departments to set upper and lower limits on permissible rates and to limit expenses, loss projections and profits
   - Demand that insurance companies open their financial books for public scrutiny

- Fund state insurance departments more thoroughly
- Make the insurance commissioner of each state an elected official, responsible to the public

3. **Create New Mechanisms for Insuring Doctors**
   - Allow state to enter into multi-state agreements that create regional medical malpractice pools, thereby spreading risk more effectively in states with few doctors.
   - Create a national not-for-profit insurance company that insures every doctor in the nation. This could also be done at the state level.

4. **End Insurance Industry Collusion**
   - Revoke insurance companies' federal exemption from anti-trust laws so they must compete

5. **Make Malpractice Data Public**
   - Make malpractice data obtained by the National Practitioner Data Bank (NPDB) public. The NPDB which tracks doctor disciplinary actions, hospital revocation of physicians' privileges and malpractice claims paid by insurers throughout the country.
   - Require insurance companies to provide all claims and settlement information involving malpractice claims to state licensing boards. Require all boards to make that information public
   - Toughen Government Monitoring and Discipline of Physicians. Boards should be controlled by non-physician majorities, provided adequate resources, and given more disciplinary authority. All formal disciplinary actions and complaints should be made available as public records.

These reforms do not blame the victims of malpractice but instead address the insurance cycle that has led to repeated "crises" over the past thirty years. Only with strong regulation of the medical malpractice insurance industry can we protect the public from having to solve another "crisis" every ten years.

Mr. BILIRAKIS. Thank you very much, sir.
Ms. Rosenbaum.

STATEMENT OF SARA ROSENBAUM

Ms. ROSENBAUM. Good morning Mr. Chairman, members of the subcommittee. I am a law professor at the George Washington University Medical Center, and I am particularly cognizant of the problems that malpractice insurance premium cost increases are causing for my colleagues. And I have great hope that this committee and Congress ultimately can find a legislative approach to this problem that will give them some relief. My background as a law professor has me regularly read statutes and my conclusion about the legislation that is before you today is that this bill, read in its most common sense fashion, goes far, far beyond the problem that, it is my understanding, you are here to address.

There are two problems or two issues that this bill really deals with, and it has two pieces of operating legislative proposals in them. One is provisions designed to regulate the procedures that are used in the health care lawsuit, as the bill defines them. The other is a preemption of certain kinds of claims against health care providers and manufacturers in health care lawsuits. It is the preemption part of this bill that I want to focus on.

In the legislation, the term health care lawsuit is defined as any health care liability claim concerning the provision of health care, goods and services, regardless of the theory of liability on which the claim is based. A liability claim is a demand by any person, whether or not against a health care provider, which is based on the provision of use of or payment for health care services.

Because of the choices made in drafting this bill, the concept of who are plaintiffs, who are defendants and what is a claim covered by the preemption provisions of the bill are enormous. Plaintiffs, because the word any is used in describing any person, could be State attorneys general, could be an assistant United States attorney, it could be government officials acting under the color of law, pursuing civil or criminal charges that result in monetary award or monetary damages, civil money penalties, anything that results in the payment of money.

It is really not clear where the limits end on who is a plaintiff. And in addition, the—because the bill reaches both actions and claims, the use of the word "action" is quite distinct from the use of the word "claim." an action is a common term of art in drafting used to describe enforcement actions as well as individual civil actions. Defendants, of course, are limitless in this bill because of the use of the term "manufacturer," provider of health care goods and services. The kinds of claims that would fall within the ambit of this bill, even though the procedural provisions might not apply, but the claims that would be preempted go far, far beyond common law or statutory claims arising under State law that involve professional negligent on the part of physicians.

Claims that sound in fraud, claims that sound in unfair practices, violations of civil rights laws, violations of labor laws, potentially violations of criminal laws, violations of consumer protection statutes, violation of antitrust laws, violations of environmental laws. All of these claims, potentially, are swept into the preemption

provisions of the statute. And the preemption provisions reach Federal laws as well, because the bill is quite clear in which laws are saved. But interestingly, it saves defenses, but it doesn't save claims. So Federal fraud claims, Federal antitrust claims, Federal civil rights claims, criminal claims, environmental law claims, labor claims. I could not find the end point of the claims in this bill.

My testimony provides you with examples actually drawn mostly from either cases that have been litigated in court or that are pending at this point involving the kinds of claims resulting in large financial recoveries that might or might not be a preempted claim under this bill. The examples range from hundreds of millions of dollars in restitution as a result of RICO violations by large health care corporations to toxic waste dumping, by manufacturers of medical care goods and devices, to, obviously, billions of dollars in claims brought by people injured when they use a pharmaceutical drug or device as directed.

All of this seems to fall within the ambit of this bill, and I think that, in that sense, the bill goes well beyond what you need to do in order to provide reliever to physicians. Thank you.

[The prepared statement of Sara Rosenbaum follows:]

PREPARED STATEMENT OF SARA ROSENBAUM, HAROLD AND JANE HIRSH PROFESSOR, HEALTH LAW AND POLICY, INTERIM CHAIR, DEPARTMENT OF HEALTH POLICY, THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

Mr. Chairman and Distinguished Members of this Subcommittee: I am a professor of health law and policy at the George Washington University, specializing in health services law. I am the co-author of one of the nation's leading health law textbooks and have regularly appeared as a Congressional witness over the past 25 years.

Thank you for inviting me to present testimony on H.R. 5, The Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2003. My testimony will focus on the scope of the legislation's proposed shield against non-economic damages with respect to the plaintiffs whose claims would be affected, the corporate defendants that would benefit from the shield, and the types of injuries that would be shielded.

H.R. 5 is drafted broadly and is ambiguous in its use of terms and definitions. However, reading the bill in a common sense fashion, I have concluded that this measure is so vast in scope that it reaches every conceivable health care claim against every health care corporation or manufacturer of health care products, regardless of whether the violation of law in question bears any relationship to what would reasonably be considered the types of injury commonly associated with the concept of medical liability. In this sense the measure extends far beyond its popular billing as one related to the crisis facing physicians and other medical professionals in individual practice.

KEY ELEMENTS OF H.R. 5

H.R. 5 would establish federal standards for causes of action that fall within a new federal definition of "health care lawsuit." The term "health care lawsuit" is defined as

> "any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, or market, promoter or seller of a medical product, regardless of the theory of liability on which the claim is based * * *" § 9(7)

A health care liability claim means

> A demand by any person, whether or not pursuant to ADR against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer or promoter or seller of a medical product * * * which are based on the provision of, use of, payment for (or the failure to provide, use or pay for)

health care services or medical products, regardless of the theory of liability on which the claim is based * * * § 9(9)

The term "health care goods or services" means

Any goods or services provided by a health care organization, provider or by any individual working under the supervision of a health care provider that relates to the diagnosis, prevention or treatment of any human disease or impairment or the assessment of the health of human beings." § 9(12)

The term "medical product" encompasses both drugs and devices as defined under the federal Food, Drug and Cosmetic Act. § 9(14). Because it would be the Sense of Congress that a "health insurer should be liable for harm caused when it makes a decision as to what care is medically necessary and appropriate," § 13, I interpret this provision to extend a shield to managed care organizations for both acts of medical negligence and negligent medical decision-making in the context of coverage of coverage determinations.

THE SCOPE OF THE SHIELD AGAINST DAMAGES IN H.R. 5

The popular understanding of this legislation, as reflected in press coverage, is that it is intended to shield individual clinical practitioners against punishing liability judgments. However, the bill's actual reach is breathtaking.

Plaintiffs

Because the definitions reach actions by "any" person, I interpret this to cover individual, private legal claimants as well as State Attorneys General and the U.S. Attorney General representing the public interest under public laws that permit financial recoveries of any kind (money damages, civil money penalties, fines, and other financial penalties).

I have reached this conclusion based on the fact that the bill specifically reaches both "action" and "claim," and that a customary use of the term "action" is to describe governmental enforcement actions that may carry criminal, injunctive or monetary penalties. The bill appears to contain no provision that exempts enforcement actions brought by federal or state public officials.

Defendants

The sweep of the above-cited definitions mean that any corporate defendant engaged in the "health care" business would be covered by the shield, regardless of the size of the corporation or the nature of the offense. The only exception to the shield would be if an individual plaintiff could prove either a deliberate failure on the defendant's part to avoid unnecessary injury or a malicious intent to injure, which is defined as "intentionally causing or attempting to cause physical injury other than providing health care goods or services." § 9(13).

Claims

The measure appears to encompass within the scope of the claims to which the shield applies every conceivable health care liability claim under law, not simply claims involving professional medical negligence of a clinical nature. Thus, criminal laws, laws to prevent anticompetitive conduct, civil rights law, worker protection law, and environmental laws all appear to fall within the ambit of the protection. Every conceivable claim appears to be affected regardless of underlying theory (defenses would be preserved). Examples of State law claims theories are:

- common law or statutory medical negligence claims (either individual or against medical care corporations under vicarious or direct theories)
- common law and statutory law theories of product liability such as breach of express or implied warranty, failure to warn, general corporate negligence, defective design, defective manufacturing
- fraud and deceit
- unfair trade practices
- civil rights laws
- labor law (including worker protection statutes)
- criminal law
- consumer protection
- antitrust law
- environmental laws

Examples of Federal law claims apparently covered by the Act are:

- fraud and abuse (e.g., RICO, False Claims Act)
- antitrust (Sherman Act, Clayton Act, other laws)
- civil rights laws
- criminal statutes

- federal food and drug laws including standards for the production and sale of prescription and over-the-counter drugs and devices and dietary supplements
- federal environmental health laws
- federal labor laws
- federal contract enforcement laws that provide for liquidated damages
- restitution to the extent that restitution is not understood to be part of economic damages

The only federal law that appears to be saved is the federal Vaccine Injury program. Otherwise, only federal defenses are preserved. H.R. 5, § 10.

EXAMPLES OF CLAIMS AFFECTED BY THE LEGISLATION

The following examples are meant to be illustrative of the types of claims that are filed (or could be filed) against providers of health care goods and services or manufacturers, suppliers, or promoters of medical products:

- A nationwide, publicly traded managed care corporation, with full access to the medical records of an exceedingly high risk pregnant woman, denies round-the clock inpatient preterm management care and orders part day home care instead. An hour after the nurse leaves for the day, the woman goes into preterm labor and loses her baby before they can be transported to the hospital. The corporation rebuffed both the overwhelming evidence in her case (including a similar previous labor) as well as all appeals by her physician.
- A renowned organ transplant medical center fails to institute the most basic "redundancy" safeguards within its organ transplant surgery program, such as deliberate and repetitive matching of donor and recipient blood types. As a result, the wrong organs are transplanted and the patient dies.
- A national health care corporation is sued by the United States Attorney for knowingly and deliberately overcharging ERISA subscribers hundreds of millions of dollars in premiums by deliberately concealing the actual cost of goods and services covered, even while promising to pay 80% of subscribers' claims. In some cases, subscribers actually paid nearly 80% of the claim as a result of fraud. The federal government seeks billions of dollars in restitution.
- A restraint of trade action is brought by generic drug manufacturers against large pharmaceutical companies for price-fixing, with the potential for recovery of treble damages under U.S. antitrust law.
- A False Claims Act case is instituted against a large for profit hospital chain for deliberately overcharging the federal government by manufacturing unnecessary surgeries through its cardiac care centers.
- A national nursing home chain is accused by HHS and the U.S. Attorney of deliberately incentivizing its members to engage in a series of unsafe practices, ranging from over-medication to the unlawful use of restraints. The same chain is accused by the Department of Labor of numerous violations of federal occupational safety violations.
- A manufacturer of medical devices develops a form of contraceptive that when used as directed causes death and injury including rare and oftentimes fatal septic abortions.
- A pharmaceutical company manufacturers a drug which, when used as directed, causes a rare form of malignant vaginal cancer.
- A device manufacturer develops a heart valve that when inserted as directed, actually results in valve failures caused by fractures at the point at which struts were welded to the valve rings.
- A large manufacturer of health care goods and services fails to exercise reasonable care when getting rid of toxic manufacturing materials and succeeds in poisoning the water supply of a community.
- A pharmaceutical manufacturer produces an appetite suppressant that when taken as directed causes heart valve abnormalities, disability and death.

Virtually none of these claims relates to specific acts of professional negligence by individual clinicians while furnishing health care to patients. They all involve acts by in many cases enormous corporations, and range from violations of health laws to violations of every conceivable form of state or federal law that relates to health care services or the manufacturing of health care products.

I am happy to answer questions.

Mr. BILIRAKIS. Thank you, Ms. Rosenbaum.

Mr. Smarr.

STATEMENT OF LAWRENCE E. SMARR

Mr. SMARR. Chairman Bilirakis, Congressman Brown and committee members, I am Larry Smarr, and I am the president of the Physician Insurers Association of America. The PIAA is an association comprised of professional liability insurance companies that are owned and/or operated by doctors, dentists hospitals and other health care providers. Our 43 member companies really can be characterized as health care professionals caring for the professional liability risk of their colleagues, doctors insuring doctors, hospitals insuring hospitals. We believe that our member companies insure over 60 percent of the private practicing physicians in the United States.

Over the past 3 years, medical liability insurers have seen their financial performance deteriorate substantially due to the rapidly rising costs of medical liability claims. The primary driver of the deterioration has been paid claims severity or the average cost of a paid claim. This has been confirmed by the president of the National Association of Insurance Commissioners in its February 7 letter to Senator Gregg, which is attached to my written testimony.

Exhibit A before you shows the average dollar amounts paid in indemnity to plaintiffs on behalf of the individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9 percent over the past 10 years, as compared to 2.6 percent for the consumer price index. The data for this exhibit comes from the PIAA data-sharing project, which is a medical cause of loss data base created in 1985 for the purpose of identifying common trends among malpractice claims, which are used for patient safety purposes by the PIAA member companies.

Right now there are over 180,000 claims and suits in this data base. One very troubling aspect is the proportion of those claims and suits filed, which are ultimately determined to be without merit. As shown on Exhibit B, 61 percent of all claims closed in 2001 were dropped or dismissed by the Court. An additional 5.7 percent were won by the doctor at trial. Only 33.2 percent of all claims closed were found to be meritorious, with most of these being made through settlement.

When claims are concluded at verdict, the defendant prevailed an astonishing 80 percent the time. As shown in Exhibit C, the mean settlement amount on behalf of an individual defendant was just over $299,000. Most medical malpractice cases have multiple defendants, and thus these values are below those which may be reported on a case basis. The mean verdict amount last year was almost $497,000.

Exhibit D shows the mean expense payment for claims by category or disposition, as can be seen the cost of taking a claim for each doctor named in a case, all the way through trial, is fast approaching $100,000. And we win 80 percent of these. Exhibit E shows the distribution of claim payments at various payment thresholds. It can be readily seen that the number of larger payments represented by the upper bars on this chart are growing as a percentage of the total number of payments. This is especially true for payments at or exceeding $1 million, which comprised almost 8 percent of all claims paid on behalf of the individual practitioners in 2001 as shown in exhibit F.

This percentage has doubled in the past 4 years. Insurers rely on investment income to offset premium needs. Medical malpractice insurers are primarily invested in high grade bonds and have not lost large sums in the stock market. Brown Brothers Harriman, a leading investment and asset management firm in a recent investment research report states that over the last 5 years, the amount medical malpractice companies have invested in equities has remained fairly constant.

In 2001, the equity allocation was 9.03 percent. As Exhibit G shows, medical liability insurance companies invested significantly less in equities than did all property casualty insurers with med mal being the short black bar on that exhibit. While insurer interest income has declined due to falling market interest rates, when interest rates declined, bond values increase. This has had a beneficial effect in keeping total investment income level when measured as a percentage of total invested assets. This is shown on Exhibit H. Thus the assertion that insurers have been forced to raise their rates because of bad investments is simply not true. The answer to the current problem, the PIAA firmly believes is the adoption of effective Federal health care liability reform similar to the California MICRA reforms enacted in 1975.

The keystone of the MICRA reforms is the $250,000 cap on noneconomic damages. These reforms are similar to the provisions of H.R. 5 passed by—which is before you now. Last year's bill, H.R. 4600, was scored by the CBO as providing over $14 billion in savings to the Federal Government, and an additional $7 billion to the States. Using annual data published by the National Association of Insurance Commissioners, Exhibit I documents the savings California practitioners and health care consumers have enjoyed since the enactment of MICRA over 25 years ago.

As shown, total malpractice premiums reported to the NRC since 1976 have grown in California by 167 percent, compared to 505 percent in the rest of the Nation. These savings are clearly demonstrated in the rates charged to California doctors as shown on Exhibit J. Successful experience in California and other States, such as Wisconsin, make it clear that MICRA style tort reforms do work without lowering health care quality or limiting access to care. Now we have heard about prop 103. Prop 103 actually had no effect on California medical liability or premiums.

In an effort to derail desperately needed tort reforms, the Association of Trial Lawyers of America and related individuals and groups have stated that the beneficial effects shown on Exhibits I and J are due to prop 103. This is just not true. Medical liability insurers were not the intended target of prop 103, but were nonetheless subject to it. However, given the high level of dividends being paid by medical malpractice insurers at the time, they were not required by the insurance commissioner to roll back rates. While malpractice insurers did make one-time refunds equal to 20 percent of 1 year's premium, which, in these amounts, were improved in normal dividends they were paying during that period of time.

Prop 103 did not result in the lowering of insurance rates and did not result in the return of additional moneys that would have ordinarily been paid through the normal insurance dividend proc-

ess. The PIAA strongly urges members of the committee to support and pass legislation, which will assure full payment of a truly injured payment's economic losses as well as up to $250,000 in noneconomic damages, thereby assuring fair compensation for patients, and also assuring Americans that they will be able to receive necessary health care services. Thank you.

[The prepared statement of Lawrence Smarr follows:]

PREPARED STATEMENT OF LAWRENCE E. SMARR, PRESIDENT, PHYSICIAN INSURERS ASSOCIATION OF AMERICA

INTRODUCTION

Chairman Bilirakis, Congressman Brown and Committee Members, I am Lawrence E. Smarr, President of the Physician Insurers Association of America (PIAA). Thank you for allowing me the opportunity to appear before you today and speak about the need for the enactment of H.R.5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003.

As we all know, professional liability insurance premiums for doctors and hospitals are rapidly rising in many states to levels where they cannot afford to pay them. These increased premiums are caused by the ever-increasing size of medical liability insurance payments and awards. The unavoidable consequence is that physicians are moving away from crisis states, reducing the scope of their practices, or leaving the practice of medicine altogether. Likewise, hospitals are being forced to close facilities and curtail high-risk services because they can no longer afford to insure them.

DOCTORS INSURING DOCTORS

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

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

When the PIAA and many of its member companies were formed in the 1970's, we faced a professional liability market not unlike that which we are experiencing today. At that time, insurers, all of which were general commercial carriers, were experiencing rapidly increasing losses, which caused them to consider their continuance in the market. Many of the major carriers did indeed exit the market, leaving a void that was filled by state and county medical and hospital associations across the country forming their own carriers. Again we see the commercial carriers, such as St. Paul, exiting the market. But, this time, the provider owned carriers are in place and are indeed providing access to insurance and stability to the market.

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

My goal here today is to discuss what the PIAA sees as the underlying causes of the current medical liability crisis. I want to stress that I believe that this situation should be characterized as a medical liability crisis, and not a medical liability insurance crisis. The PIAA companies covering the majority of the market are in sound financial condition. The crisis we face today is a crisis of affordability and

availability of insurance for health care providers, and more importantly, the resulting growing crisis of access to the health care system for patients across the country.

INSURANCE INDUSTRY UNDERWRITING PERFORMANCE

Medical liability insurance is called a long-tail line of insurance. That is because it takes on average two years from the time a medical liability incident occurs until a resulting claim is reported to the insurer, and another two and one-half years until the average claim is closed. This provides great uncertainty in the rate making process, as insurers are forced to estimate the cost of claims which may ultimately be paid as much as 10 years after the insurance policy is issued. By comparison, claims in short-tail lines of insurance, such as auto insurance, are paid days or weeks after an incident.

Over the past three years medical liability insurers have seen their financial performance deteriorate substantially due to the rapidly rising cost of medical liability claims. According to A.M. Best (Best), the leading insurance industry rating agency, the medical liability insurance industry incurred $1.53 in losses and expenses for every dollar of premium they collected in 2001. While data for 2002 will not be available until the middle of this year, Best has forecast that the industry will incur $1.41 in losses and expenses in 2002, and $1.34 in 2003. The impact of insurer rate increases accounts for the improvement in this statistic. However, Best also calculates that the industry can only incur $1.14½ in losses and expenses in order to operate on a break-even basis. This implies that future rate increases can be expected as the carriers move toward profitable operations.

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

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

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

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

THE ROLE OF INVESTMENT INCOME

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

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

As shown on Exhibit 5, stocks have averaged only about 11% of cash and invested assets, thus precluding major losses due to swings in the stock market. Unlike stocks, high grade bonds are carried at amortized value on insurer's financial statements, with changes in market value having no effect on asset valuation unless the underlying securities must be sold.

The experience of the PIAA carriers is confirmed on an industry-wide basis through data obtained from the NAIC by Brown Brothers Harriman, a leading investment and asset management firm. Brown Brothers reports that "Over the last five years, the amount medical malpractice companies has invested in equities has remained fairly constant. In 2001, the equity allocation was 9.03%." As Exhibit 6 shows, medical liability insurers invested significantly less in equities than did all property casualty insurers.

Brown Brothers states that the equity investments of medical liability companies "...had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy.

The Brown Brothers report further states:

> Since medical malpractice companies did not have an unusual amount invested in equities and what they did was invested in a reasonable market-like fashion, we conclude that the decline in equity valuations is not the cause of rising medical malpractice premiums.[1]

While insurer interest income has declined due to falling market interest rates, when interest rates decline, bond values increase. This has had a beneficial effect in keeping total investment income level when measured as a percentage of total invested assets. This is shown in Exhibit 7 below. Thus, the assertion that insurers have been forced to raise their rates because of bad investments is simply not true.

THE INSURANCE CYCLE

Opponents of effective tort reform claim that insurance premiums in constant dollars increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the industry's investment performance. The researchers at Brown Brothers also tested this theory, and found no correlation between changes in generally accepted economic parameters (Gross Domestic Product (GDP) and 5-year treasury bond rates) with direct medical liability premiums written. In fact, Brown Brothers conducted 64 different regression analyses between the economy, investment yield, and premiums, and found no meaningful relationship. The report produced by Brown Brothers states:

> Therefore, we can state with a fair degree of certainty that investment yield and the performance of the economy and interest rates do not influence medical malpractice premiums.[2]

INSURER SOLVENCY

A key measure of financial health is the ratio of insurance loss and loss adjustment expense (amounts spent to handle claims) reserve to surplus. This ratio has deteriorated (risen) for the PIAA carriers since 1999 to a point where it is approximately two times the level of surplus, as shown on Exhibit 8 below.

The relationship between reserves (amounts set aside to pay claims) and surplus is important, as it is a measure of the insurer's ability to contribute additional amounts to pay claims in the event that original estimates prove to be deficient. *At the current approximately two-to-one ratio, these carriers in aggregate are still in sound financial shape.* However, any further deterioration in surplus due to underwriting losses will cause a deterioration in this important benchmark ratio indicating an impairment in financial condition. Under current market conditions, characterized by increasing losses and declining investment interest income, the only way to increase surplus is through rate increases.

Net premiums written as compared to surplus is another key ratio considered by regulators and insurance rating agencies, such as A.M. Best. This statistic for the companies in the PIAA survey has also been deteriorating (rising) since 1999, showing a 50% increase in the two years ending in 2001. The premium-to-surplus ratio is a measure of the insurer's ability to write new business. In general, a ratio of one-to-one is considered to be the threshold beyond which an insurer has over-extended its capital available to support its underwritings.

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[1] Did Investments Affect Medical Malpractice Premiums? Raghu Ramachandran, Brown Brothers Harriman, January 2003.

[2] Did Investments Affect Medical Malpractice Premiums? Raghu Ramachandran, Brown Brothers Harriman, January 2003.

As can be seen on Exhibit 9, this statistic has also deteriorated, and the carriers in aggregate are approaching one-to-one. As the carriers individually approach this benchmark, they will begin to decline new risks, causing further availability problems for insureds. Rate increases the carriers are taking also have an impact on this important ratio as well as new business written.

THE CAUSE OF THE CRISIS

The effects described in the previous pages were caused by the convergence of six driving factors making for *the perfect storm,* as follows:

- Dramatic long term paid claim severity rise
- Paid claim frequency returning and holding at high levels
- Declining market interest rates
- Exhausted reserve redundancies
- Rates becoming too low
- Greater proportion of large losses

The primary driver of the deterioration in the medical liability insurance industry performance has been paid claim severity, or the average cost of a paid claim, and their associated expenses. The National Association of Insurance Commissioners (NAIC) confirmed this in a February 7, 2003 letter to Senator Judd Gregg, which states in part: "The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices." (letter attached)

Exhibit 10 shows the average dollar amount paid in indemnity to plaintiffs on behalf of individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9% during this period, as compared to 2.6% for the Consumer Price Index (CPIu). The data for Exhibit 10, as well as that for slides which follow, comes from the PIAA Data Sharing Project. This is a medical cause-of-loss database, which was created in 1985 for the purpose of identifying common trends among malpractice claims. PIAA member companies use the database for risk management and patient safety purposes. To date, over 180,000 claims and suits have been reported to the database.

Allocated loss adjustment expenses (ALAE) for claims reported to the Data Sharing Project have also risen at alarming rates. ALAE are the amounts insurers pay to handle individual claims, and represent payments principally to defense attorneys, and to a lesser extent, expert witnesses. Average amounts paid for three categories of claims are shown below. As can be seen, the average amount spent for all claims in 2001 has risen to just under $30,000.

One very troubling aspect of medical malpractice claims is the proportion of those filed which are ultimately determined to be without merit. Exhibit 12 shows the distribution of claims closed in 2001 as reported to the PIAA Data Sharing Project. Sixty-one percent of all claims filed against individual practitioners were dropped or dismissed by the court. An additional 5.7% were won by the doctor at trial. Only 33.2% of all claims closed were found to be meritorious, with most of these being paid through settlement. Of all claims closed, more than two-thirds had no indemnity payment to the plaintiff. When the claim was concluded at verdict, the defendant prevailed an astonishing 80% of the time. This data clearly shows that those attorneys trying these cases are woefully deficient in recognizing meritorious actions to be pursued to conclusion.

Analyses performed by the PIAA have shown that of all premium and investment income available to pay claims, only 50% ever gets into the hands of truly injured patients, with the remainder being principally paid to attorneys, both plaintiff and defense. Something is truly wrong with any system that consumes 50% of its resources to deliver the remainder to a small segment of those seeking remuneration.

A review of the average claim payment values for the latest year reported to the PIAA Data Sharing Project (2001) is revealing. As shown on Exhibit 13, the mean settlement amount on behalf of an individual defendant was just over $299,000. Most medical malpractice cases have multiple defendants, and thus, these values are below those, which may be reported on a per case basis. The mean verdict amount last year was almost $497,000 per defendant.

Exhibit 14 shows the mean expense payment for claims by category of disposition. As can be seen, the cost of taking a claim for each doctor named in a case all the way through trial is fast approaching $100,000. Exhibit 15 shows the distribution of claims payments at various payment thresholds. It can be readily seen that the number of larger payments are growing as a percentage of the total number of payments.

This is especially true for payments at or exceeding $1 million, which comprised almost eight percent of all claims paid on behalf of individual practitioners in 2001

(Exhibit 16). This percentage has doubled in the past four years, and clearly demonstrates why insurers are facing dramatic increases in the amounts they have to pay for reinsurance. While medical liability insurers are reinsured by many of the same companies having high losses from the World Trade Center disaster, their medical liability experience was rapidly deteriorating prior to September 11, 2001.

In addition to rising claim severity, like all other investors, medical liability insurers have faced declining market interest rates. Eighty percent of PIAA insurers' investments are placed in high-grade bonds. Exhibit 17 shows the long-term decline in high-grade bond earnings. As can be seen, this is not a recent phenomenon, but a long term trend.

Critics of the medical liability insurance industry say that insurers' reliance on investment income to offset premiums has caused turmoil in the marketplace, implying that the use of investment income is a bad thing. Nothing could be further from the truth. If insurers did not ever use investment income to offset premium needs, then rates would always be 30—40% higher than otherwise necessary. The role market interest rates play in determining pricing in medical liability insurance (and other lines as well) is a fact of life which we cannot control.

THE ANSWER

Medical liability insurers and their insureds have faced dramatic long-term rises in paid claim severity, which is now at historically high levels. Paid claim frequency (the number of paid claims) is currently remaining relative constant, but has risen significantly in some states. While interest rates will certainly rise and fall in future years, nothing has been done over the past three decades to stem the ever-rising values of medical malpractice claim payments or reduce the number of meritless claims clogging up our legal system at great expense—except in those few states that have effective tort reforms. In many states not having tort reforms, costs have truly become excessive, and insurers are forced to set rates at levels beyond the abilities of doctors and hospitals to pay. States having tort reforms, such as California, provide a compelling example that demonstrates how such reforms can lower medical liability costs and still provide adequate indemnification for patients harmed as a result of the delivery of health care.

The following reforms are those which the PIAA advocates be adopted at the federal level, which we also feel should be the standard for any state reforms enacted. They are based on the reforms found in the Medical Injury Compensation Reform Act (MICRA) which became effective in California in 1976 and which have been successful in compensating California patients and ensuring access to the health care system since their enactment.

The keystone of the MICRA reforms is the $250,000 cap on non-economic damages (pain and suffering) on a per-incident basis. Under MICRA, injured patients receive full compensation for all quantifiable damages, such as lost income, medical expenses, long-term care, etc. In addition, injured patients can get as much as one-quarter million dollars for pain and suffering. Advising juries of economic damages that have already been paid by other sources serves to reduce double payment for damages. An important component of MICRA is a reasonable limitation on plaintiff attorney contingency fees, which can be 40% or more of the total amount of the award. Under MICRA, a trial lawyer must be satisfied with only a $220,000 contingency fee for a $1 million award.

A Gallup poll published on February 5, 2003 by the National Journal indicates that 57% of adult Americans feel there are too many lawsuits against doctors, and 74% feel that we are facing a major crisis regarding medical liability in health care today. Seventy-two percent of respondents favored a limit on the amount that patients can be awarded for their emotional pain and suffering. Only the trial lawyers and their front groups disagree, seeing their potential for remuneration being reduced. Especially displeasing to them is MICRA's contingency fee limitation, which puts more money in the hands of the injured patient (at no cost reduction to the insurer).

The U.S. House of Representatives adopted legislation containing tort reforms similar to MICRA, including a $250,000 cap on non-economic damages, for the seventh time in September of last year. HR 4600, known as the HEALTH Act, was introduced and adopted on a bi-partisan basis. The Congressional Budget Office (CBO) conducted an extensive review of the provisions of HR 4600, and reported to Congress that if the reforms were enacted, "...premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

The CBO found that HR 4600 reforms would result in savings of $14.1 billion to the federal government through Medicare and other health care programs for the

period 2004—2012. An additional $7 billion of savings would be enjoyed by the states through their health care programs. The CBO's analysis did not consider the effects that federal tort reform would have on reducing the incidence of defensive medicine, but did acknowledge that savings were likely to result.

The US Department of Health and Human Services published a report on July 24, 2002, which evaluated the effects of tort reforms in those states that have enacted them. As stated in Exhibit 20, HHS found that practitioners in states with effective caps on non-economic damages were currently experiencing premium increases in the 12—15% range, as compared to average 44% increases in other states.

Annual data published by the National Association of Insurance Commissioners (NAIC) also documents the savings California practitioners and health care consumers have enjoyed since the enactment of MICRA over 25 years ago. As shown in Exhibit 21, total medical liability premiums reported to the NAIC since 1976 have grown in California by 167%, while premiums for the rest of the nation have grown by 505%. These savings can only be attributed to MICRA.

These savings are clearly demonstrated in the rates charged to California doctors as shown in Exhibit 22. Successful experience in California and other states makes it clear that MICRA style tort reforms do work without lowering health care quality or limiting access to care.

PROP 103 HAD NO EFFECT ON CALIFORNIA MEDICAL LIABILITY PREMIUMS

In an effort to derail desperately needed tort reforms as described above, the Association of Trial Lawyers of America and related individuals and groups have stated that the beneficial effects of MICRA as shown on Exhibit 21 are due to Proposition 103, a ballot initiative passed in 1988 aimed primarily at controlling auto insurance costs. The ballot initiative passed by a 51% majority vote, with voters in only 7 of California's 58 counties approving the measure. The major changes made by Prop 103 include:

- Making the insurance commissioner of California an elected, rather than appointed, official;
- Giving the insurance commissioner authority to approve rate changes before they can take effect;
- Requiring insurers to reduce rates by 20 percent from their levels on November 8, 1987;
- Requiring auto insurance companies to offer a 20 percent "good driver discount."
- Requiring auto insurance rates to be determined primarily by four factors;
- Allowing for payment of "intervenor fees" to outside groups that intervene in hearings conducted by the Department of Insurance [3].

Medical liability insurers were not the intended target of Prop 103, but were covered by the resulting regulations. However, Prop 103 did not have any substantive effect on reducing medical liability insurance rates. Prop 103 did have the effect of freezing most insurance rates in California until as late as 1994.[4] This all came at a time when medical liability insurers across the nation were seeing their rates level off or even decline.

Prop 103 added a provision to the California Insurance Code at Section 1861.01, which required insurers to roll back their rates to 20 percent lower than those in effect on November 8, 1987. However, this is not what happened to medical malpractice insurers.

One major California insurer, the NORCAL Mutual Insurance Company reached the very first consent agreement of any insurer with the California Department of Insurance in November of 1991. To satisfy the requirements of Prop 103, NORCAL was specifically permitted to declare a one-time 20% return of premium for policyholders insured between November 8, 1988 and November 8, 1989 as a dividend by March 31, 1992. NORCAL was not required to roll back its rates as a result of Prop 103. As NORCAL was already paying dividends exceeding 20% per year during the period in question, no additional monies were returned to policyholders as a result of Prop 103. The experience of other California physician owned companies, such as The Doctors' Company and the Medical Insurance Exchange of California, was similar to that of NORCAL. Even if California medical liability insurers had been re-

[3] Ironically, the Proposition 103 Enforcement Project headed by Harvey Rosenfeld, a self-proclaimed consumer advocate who led the fight for the adoption of Prop 103, has received almost $1.5 million in intervenor fees through 1997. In total, "consumer organizations" and individuals have received over $7.1 million in intervenor fees and administrative costs through 1997. Source: Personal Insurance Federation of America,

[4] Background on Insurance Reform—A Detailed Analysis of California Proposition 103,.

quired to reduce rates by 20%, this in no way could explain the wide gap in experience shown on Exhibit 21.

CONCLUSION

Increasing medical malpractice claim costs, on the rise for over three decades, have finally reached the level where the rates that insurers must charge can no longer be afforded by doctors and hospitals. These same doctors and hospitals cannot simply raise their fees, which are limited by government or managed care companies. Many doctors will face little choice other than to move to less litigious states or leave the practice of medicine altogether.

Legislators are now challenged with finding a solution to the medical liability insurance affordability and availability dilemma—a problem long in coming that has truly reached the crisis stage. The increased costs being experienced by insurers (largely owned/operated by health care providers) are real and documented. It is time for Congress to put an end to the wastefulness and inequities of our tort legal system, where only 50% of the monies available to pay claims are paid to indemnify the only 30% of claims filed with merit and the expenses of the remainder. The system works fine for the legal profession, which is why trial lawyers and others fight so hard to maintain the status quo.

The PIAA strongly urges members of the House to pass effective federal health care liability reform, thereby stopping the exodus of health care professionals and institutions which can no longer afford to fund an inequitable and inefficient tort system which benefits neither injured plaintiffs or the health care community.

EXHIBIT 1

FINANCIAL RATIOS TO NET PREMIUMS EARNED

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

Source: Tillinghast Survey of PIAA Companies NAIC Filings

EXHIBIT 2

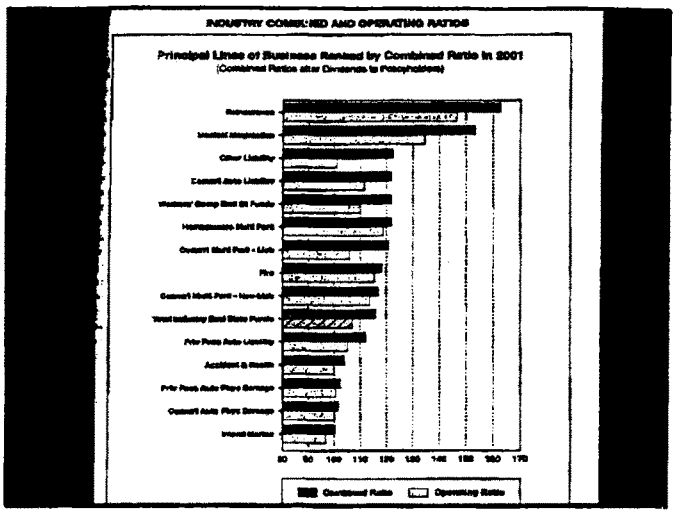


EXHIBIT 3

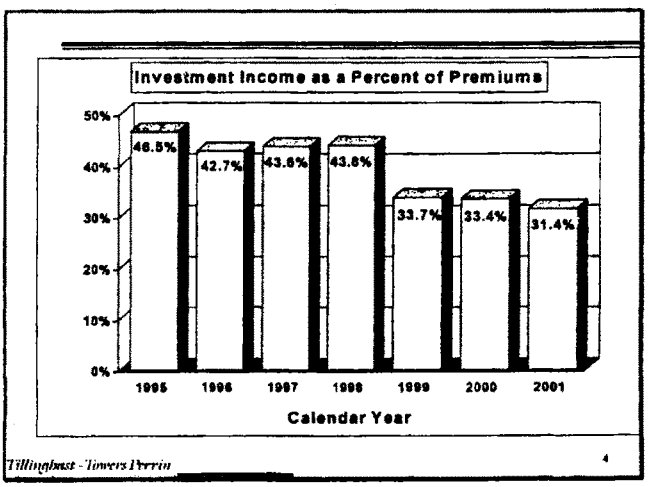


EXHIBIT 4

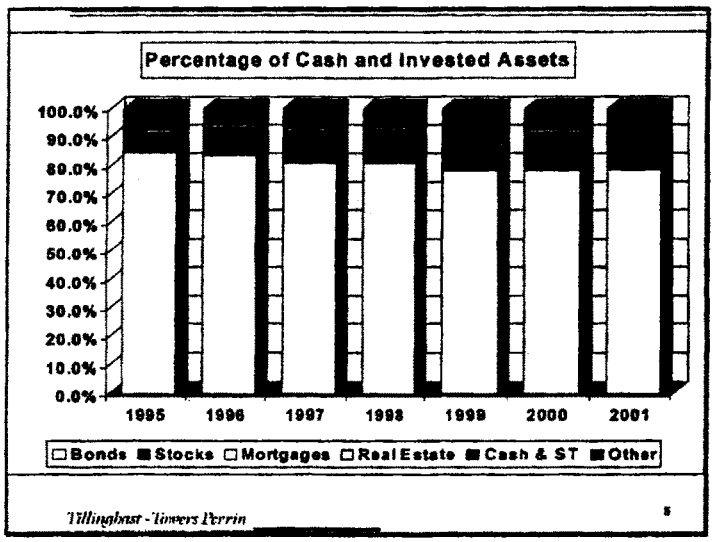


EXHIBIT 5

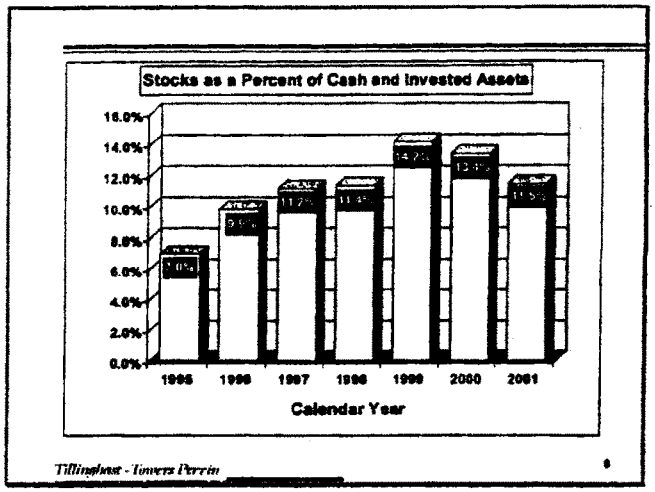
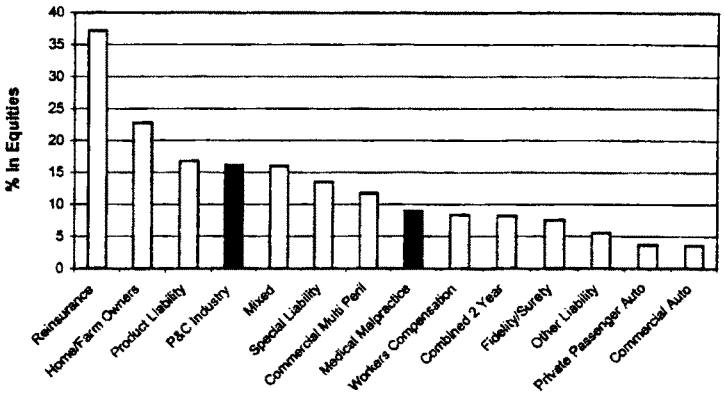


EXHIBIT 6

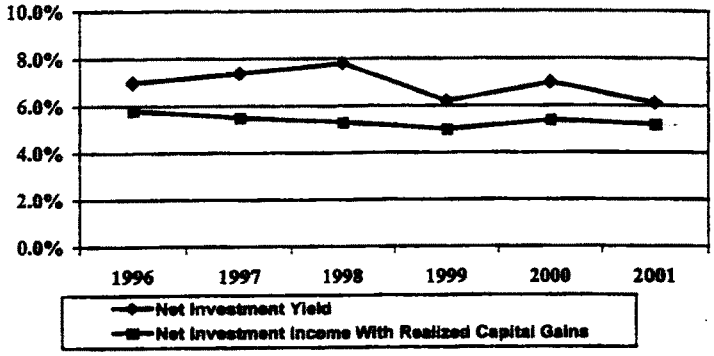
P&C Equity Allocation 2001



Source: Brown Brothers Harriman & Co., Insurance Industry Asset Allocation Study using NAIC data

EXHIBIT 7

Medical Malpractice Insurers Investment Income



Source: A.M. Best Aggregates & Averages, 1[illegible] through 2002 Editions,
(Predominantly Medical Malpractice Insurers).

EXHIBIT 8

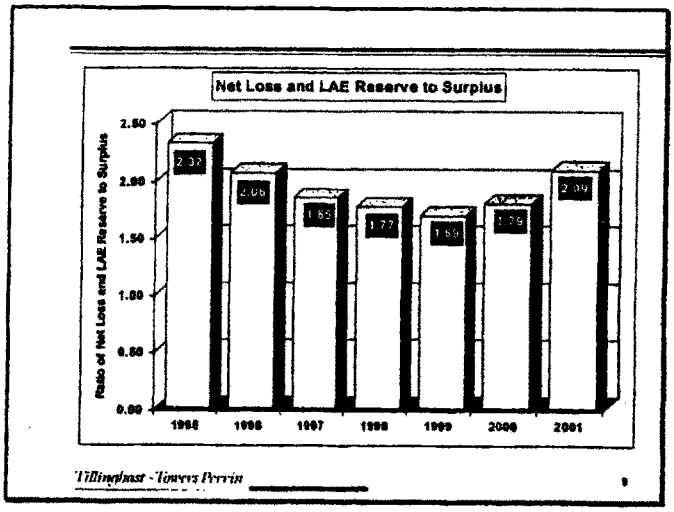


EXHIBIT 9

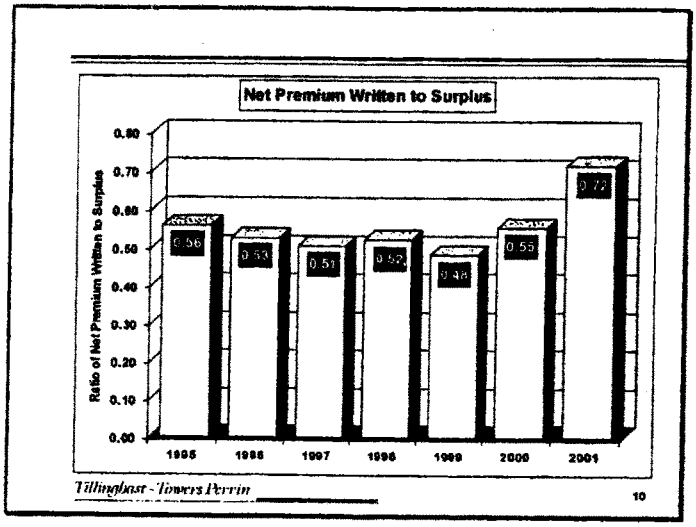


EXHIBIT 10

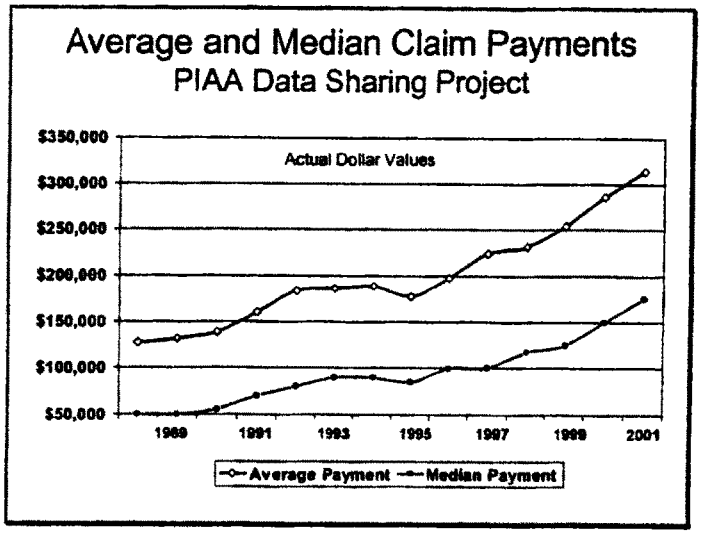


EXHIBIT 11

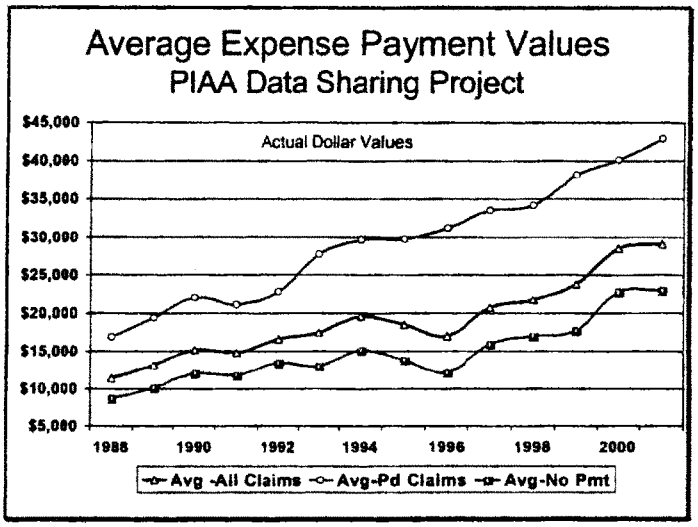


EXHIBIT 12

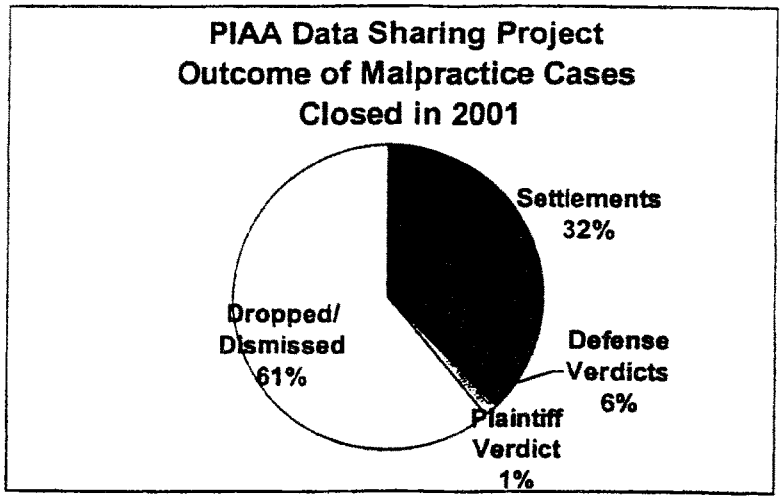


EXHIBIT 13

PAYMENT VALUES – 2001

As of 09/04/02

Mean Indemnity Payment	**$310,215**
Mean Settlement	**$ 299,003**
Mean Verdict	**$ 496,726**

EXHIBIT 14

PAYMENT VALUES – 2001

As of 09/04/02

Mean Indemnity Payment	**$310,215**
Mean Expense Payment	**$ 28,801**
Won at Trial	**$ 85,718**
Lost at Trial	**$ 91,423**
Settled	**$ 39,891**
Dropped/Dismissed	**$ 16,743**

EXHIBIT 15

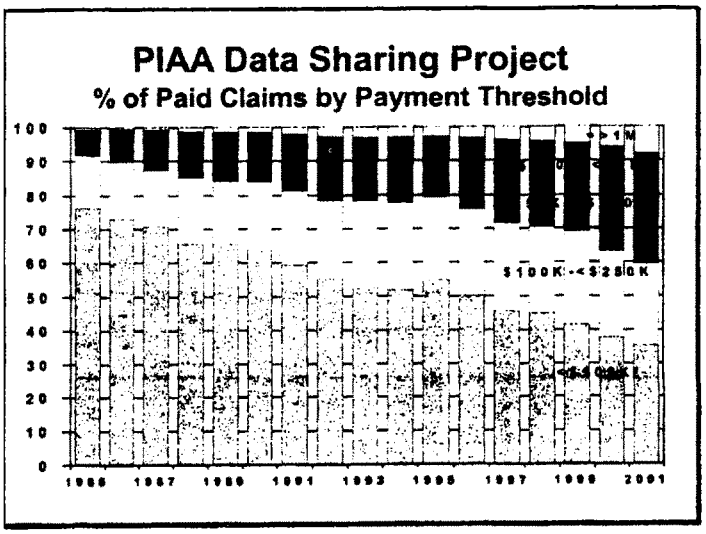


EXHIBIT 16

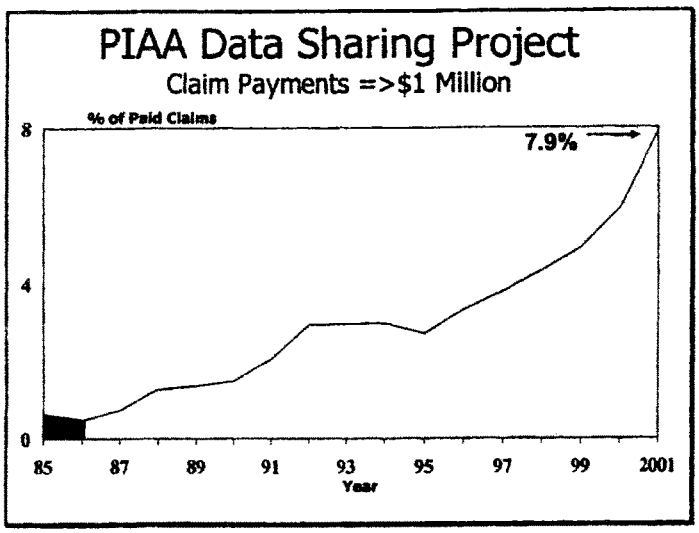


EXHIBIT 17

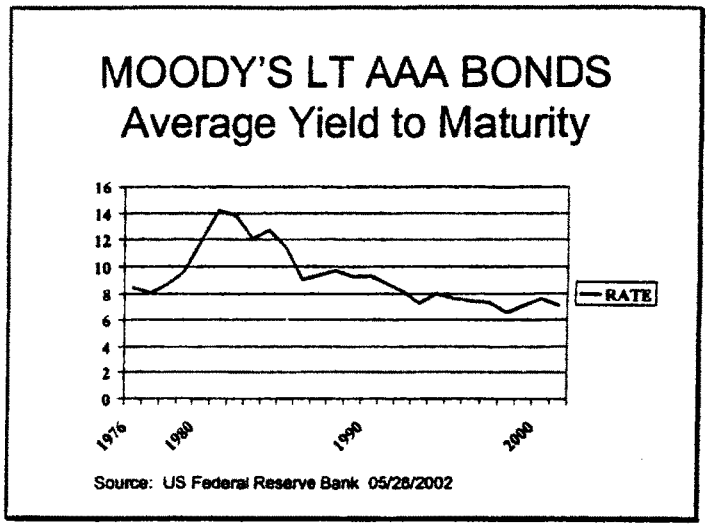


EXHIBIT 18

Health Care Liability Reform

- $250,000 cap on non-economic damages
- Collateral source offsets
- Periodic payment of future damages
- 1/3 year statute of limitations/repose
- Joint and several liability
- Contingency fee limits

EXHIBIT 19

CBO Scoring of HR 4600

September 24, 2002

$14.1 Billion Savings 2004 – 2012

$7 Billion Savings to the States 2004 - 2012

"...premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

EXHIBIT 20

USDHHS

Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System
July 24, 2002

"States with limits of $250,000 or $350,000 on non-economic damages have average combined highest premium increases of 12 – 15%, compared to 44% in states without caps..."

EXHIBIT 21

Savings from MICRA Reforms
California vs. U.S. Premiums 1976 - 2000

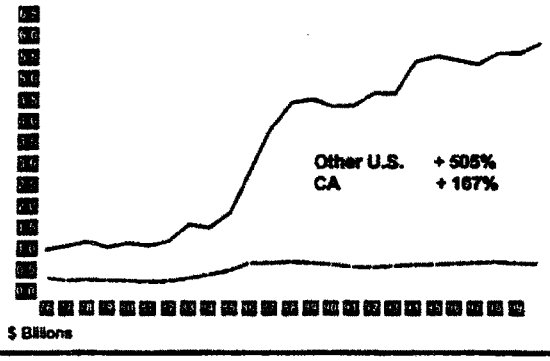


EXHIBIT 22

2002 Rates- $1mil/3mil Coverage
(as reported by Medical Liability Monitor)

	LA[1]	Mil-waukee[2]	Chicago[3]	Phila[4]	Miami[5]
IM	11,164	5,148	26,404	18,429	56,153
GS	36,740	18,020	68,080	82,157	174,268
OB/ Gyn	54,563	27,802	102,640	100,045	201,376

1 The Doctors Company
2 PIC Wisconsin
3 ISMIE Mutual Insurance Company
4 Pennsylvania Medical Society Liability Insurance Company
5 First Professional Insurance Company

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
February 7, 2003

Honorable JUDD GREGG
Chairman, Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20610-6300

DEAR CHAIRMAN GREGG: On behalf of the National Association of Insurance Commissioners (NAIC), I am pleased to respond to your letter of January 31, 2003 requesting information on medical malpractice insurance. Many states are experiencing escalating premium costs for this critical insurance coverage for doctors, while also encountering problems of availability and insufficient capacity to support a healthy competitive market.

State insurance commissioners share the concerns you and other Members of Congress are raising about improving the availability and affordability of medical malpractice insurance. We are vested with the responsibility of protecting the rights of consumers and assuring that insurers remain financially solvent and able to meet their claims obligations. While the recent trends in some states over limited availability and escalating premiums make oversight critical, we would caution that any reforms be considered carefully, especially in recognition of reforms already enacted in several states.

In September 2002, we established a Market Conditions Working Group to look at these issues more closely and based upon that review make recommendations to regulators. The working group has scheduled a public hearing on Saturday, March 8, 2003. We are hopeful this hearing and other efforts will help guide state and federal policymakers as they work to explore potential solutions. We will look forward to sharing with you the results of this hearing.

Our responses to the questions in your letter are as follows:

(1) Are medical malpractice insurance rates subject to state law prohibitions on excessive, inadequate, or unfairly discriminatory rates?

Almost all states have rating laws for property and casualty insurance, including medical malpractice. These rating laws require that insurance rates not be excessive, inadequate, or unfairly discriminatory.

(2) If a state determines that a rate is excessive, inadequate, or unfairly discriminatory, does the insurance regulator have the authority to reject or modify such a rate?

If a state receives a filing from an insurer that contains a rate that is believed to be out of compliance with the statutory rating standards, there are remedies available to address the problem. The most common regulatory approach available to insurance regulators is the ability to order a hearing on the non-complying rate. In states with prior approval laws, the commissioner generally has

authority to disapprove the non-complying rate, however the insurer is generally provided an opportunity for a hearing if it disagrees with the commissioner's decision. Only in rare instances does an insurance commissioner have authority to unilaterally modify a filed rate. Because of extremely high loss ratios in many states, regulator concerns have been with rate inadequacy, and not excessiveness or unfair discrimination.

(3) If states do have this authority, can you provide any examples where a state insurance regulator has rejected or modified an excessive or unfairly discriminatory medical malpractice insurance rate?

We are not aware of any recent state actions in this regard. State insurance regulators generally do have the authority to prevent anti-trust activities by insurers. These state laws are based on the NAIC model rating laws, which contain the following provisions.

"No insurer or advisory organization shall attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market or engage in a boycott, on a concerted basis, of an insurance market."

"No insurer shall agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to facilitate the reporting of statistics to advisory organizations, statistical agents or the commissioner. The fact that two or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, prospective loss cost, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists."

"No insurer or advisory organization shall make any arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of unreasonably restraining trade or lessening competition in the business of insurance."

States generally have adopted the NAIC model law provisions or equivalent provisions, thus comparable authority currently exists. Again, due to extremely high loss ratios, the concern has been with rate inadequacy.

(4) The Leahy legislation presumes that medical malpractice insurance carriers are engaging in "price fixing, bid rigging, and market allocation." Does the NAIC, or any of your members have evidence that medical malpractice insurance carriers are engaging in these types of criminal behaviors? If so, could you detail that information for us?

No. To date, insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation. The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices. A July 2002 report prepared by the Department of Health and Human Services also cites the impact of litigation and defense costs on this line of insurance.

(5) Notwithstanding the McCarran-Ferguson exemption from federal anti-trust laws, do state insurance regulators and attorneys general have the authority to prevent "price fixing, bid rigging or market allocations" under current state law? If so, could you explain the deficiencies in those laws and provide us with proposed remedies?

As noted in the previous question, states have strong laws that prohibit price-fixing and anti-competitive practices by insurers. The sharing of loss data among insurers is permitted, however, because it is necessary to encourage competition by giving potential new entrants to the marketplace and smaller insurers enough underwriting and rate-setting information to enter and remain viable in the medical malpractice marketplace. Again, the evident points to high loss ratios, not price-fixing, as the primary driver of escalating premiums.

(6) What percentage of the medical malpractice insurance market is composed of non-profit physician-owned mutuals? What incentive or incentives, if any, do you think these types of medical malpractice carriers face that would cause them to engage in "price fixing, bid rigging or market allocations?"

Non-profit physician-owned mutual insurers have developed in response to market availability concerns. Since the owners of these mutuals are also the customers, it would appear on the surface that market allocation might be occurring. Careful inspection will show that a mutual insurer is concerned with its policyholders' interests. Since each policyholder is also an owner of the com-

pany and the company is a non-profit entity, the goal of the mutual insurer is to deliver medical malpractice insurance to its policyholder/owners as inexpensively as possible. To do otherwise would contradict the goals of the mutual and jeopardize its non-profit status

(7) Finally, if the Leahy legislation were to be enacted, would it lower the underlying medical malpractice claims costs and stabilize medical liability insurance premiums? If yes, in what way would it do so?

No, we do not believe enactment of the Leahy legislation as originally drafted would change the underlying costs of malpractice claims or premiums. We now understand this language is being modified. The reason insurers are not writing, or are pulling back from medical malpractice insurance, is because there are many other lines of insurance that offer more opportunities for profit at a lower risk. The uncertainties and historical return in this line of business lead many commercial insurers to commit capital in other lines of commercial insurance. It is our experience this market will remain volatile in some states until such time as claims costs stabilize.

Finally, while we are seeing difficult market conditions in some states, it is by no means widespread in all states. Like all insurance markets, medical malpractice insurance markets vary from state to state. However, the cost drivers in all states are closely linked to claims losses.

I hope this information is helpful, and we look forward to being of assistance as your Committee continues its review of these issues. The NAIC and its members stand ready to provide whatever data and resources we have available to help Congress and the states improve the market for medical malpractice insurance.

Sincerely,

MIKE PICKENS
Commissioner of Insurance, Arkansas, President, NAIC

EXHIBIT A

Average and Median Claim Payments
PIAA Data Sharing Project

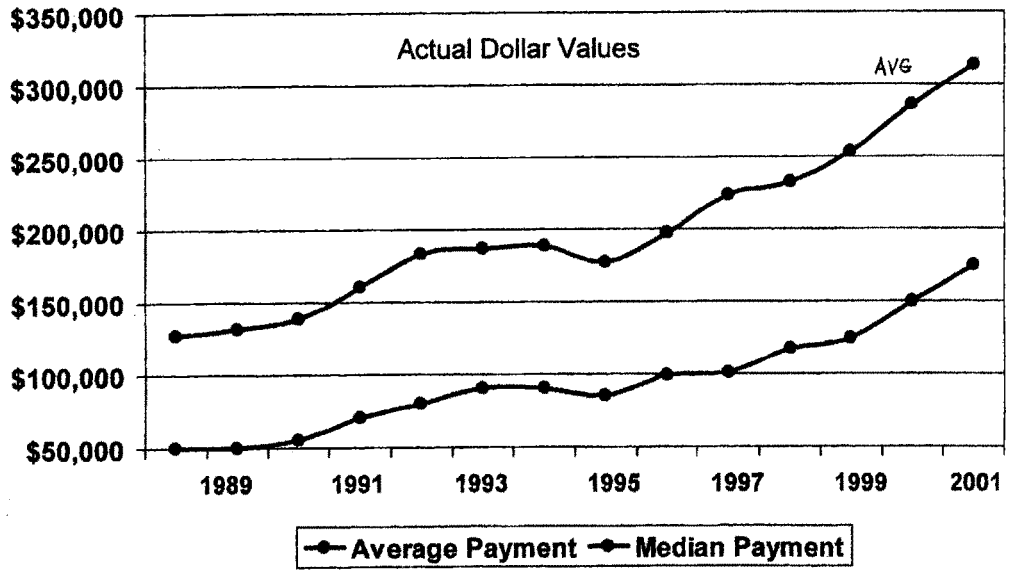


EXHIBIT B

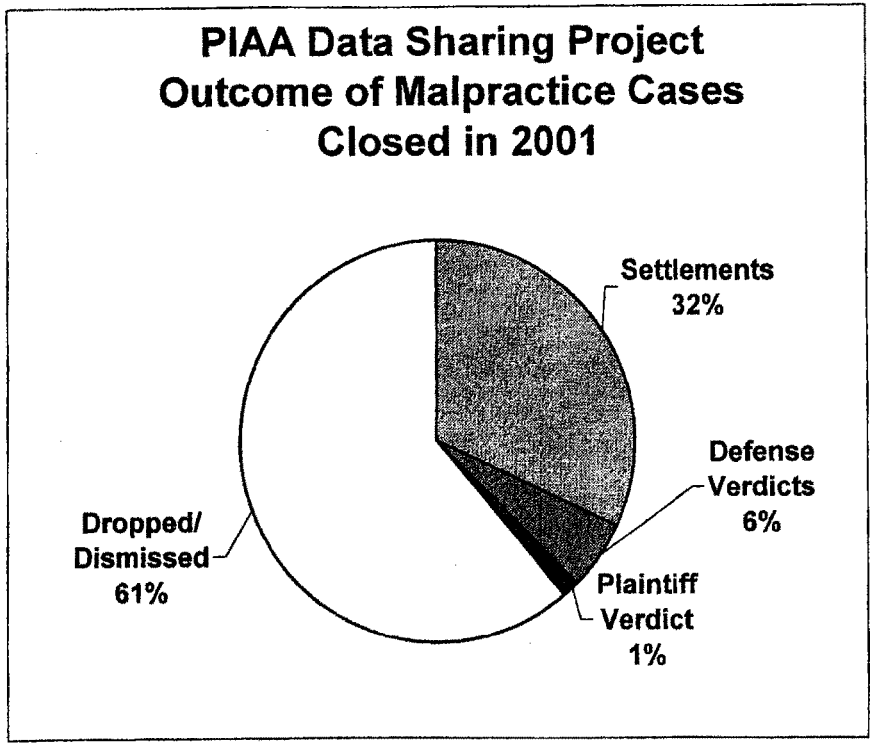

PIAA Data Sharing Project
Outcome of Malpractice Cases
Closed in 2001
Settlements
32%
Defense
Verdicts
6%
Plaintiff
Verdict
1%
Dropped/
Dismissed
61%

EXHIBIT C

PAYMENT VALUES – 2001

As of 09/04/02

Mean Indemnity Payment	**$310,215**
Mean Settlement	**$ 299,003**
Mean Verdict	**$ 496,726**

EXHIBIT D

PAYMENT VALUES – 2001

As of 09/04/02

Mean Indemnity Payment	$310,215
Mean Expense Payment	$ 28,801
Defense Verdict	$ 85,718
Plaintiff Verdict	$ 91,423
Settled	$ 39,891
Dropped/Dismissed	$ 16,743

EXHIBIT E

PIAA Data Sharing Project

% of Paid Claims by Payment Threshold

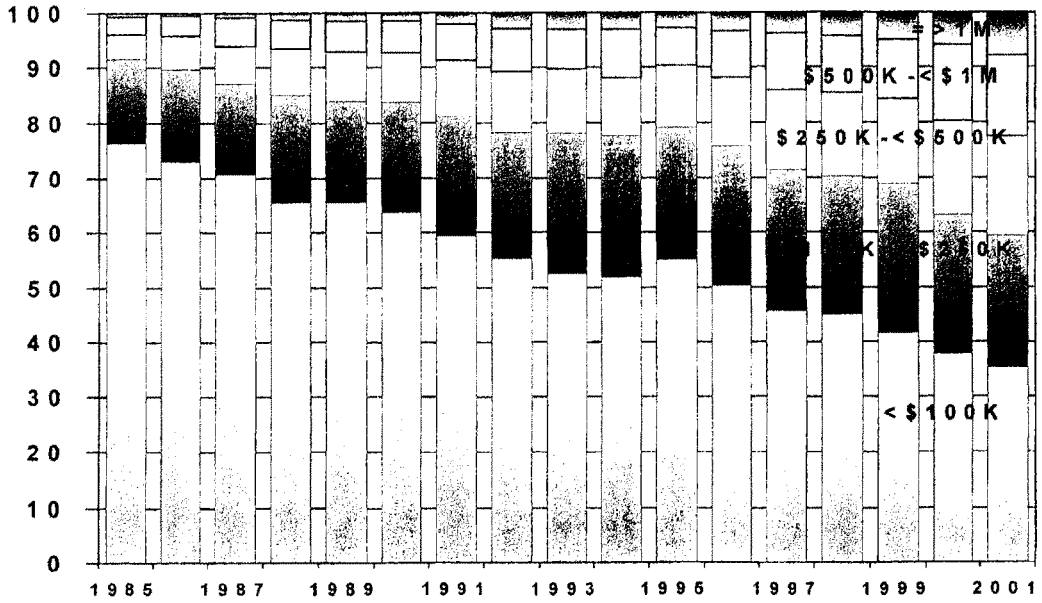


EXHIBIT F

PIAA Data Sharing Project

Claim Payments =>$1 Million

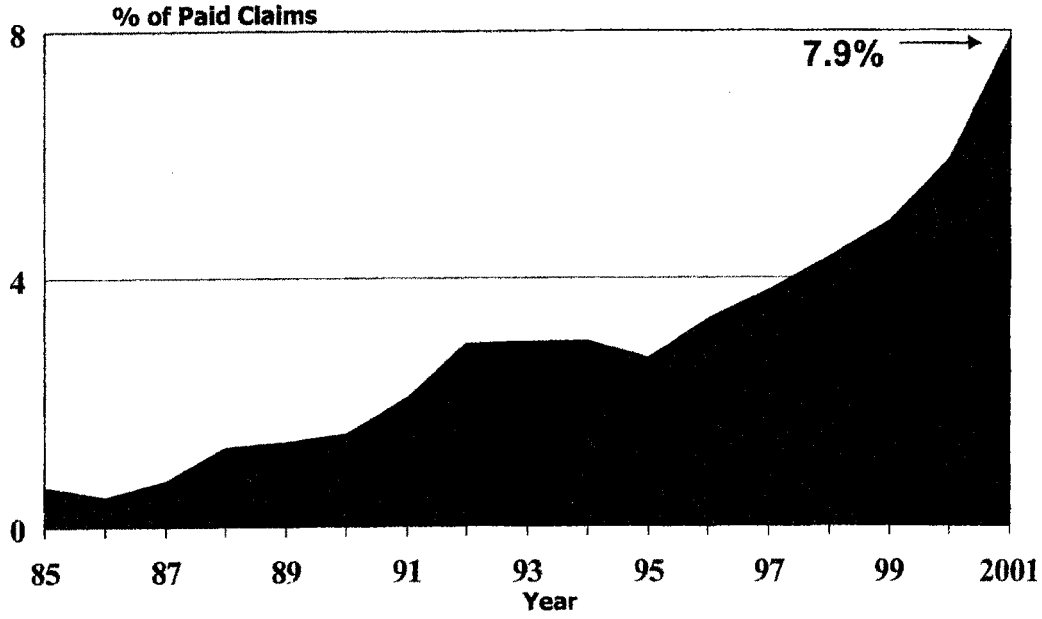
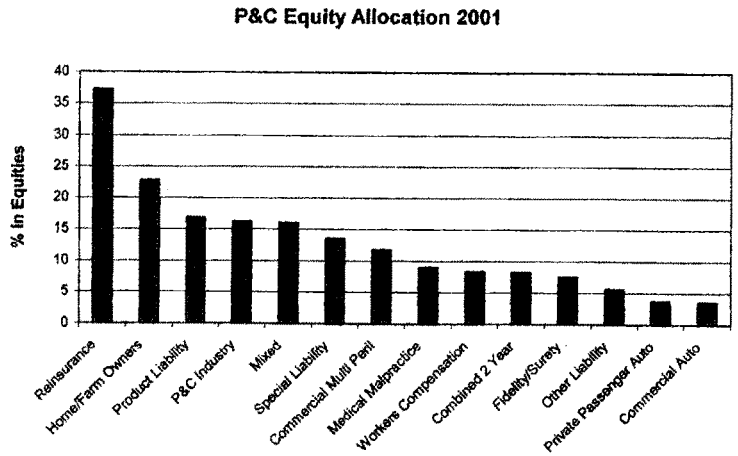
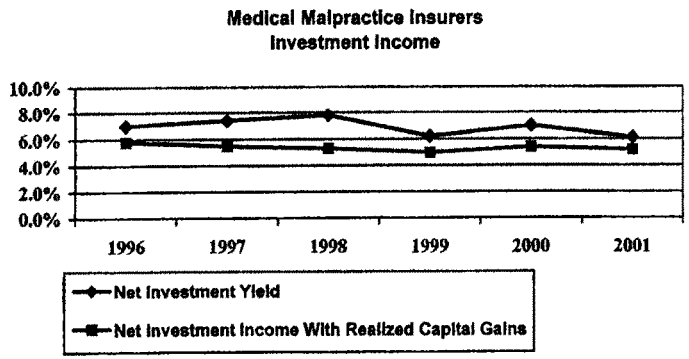


EXHIBIT C



Source: Brown Brothers Harriman & Co., Insurance Industry Asset Allocation Study using NAIC data

EXHIBIT H

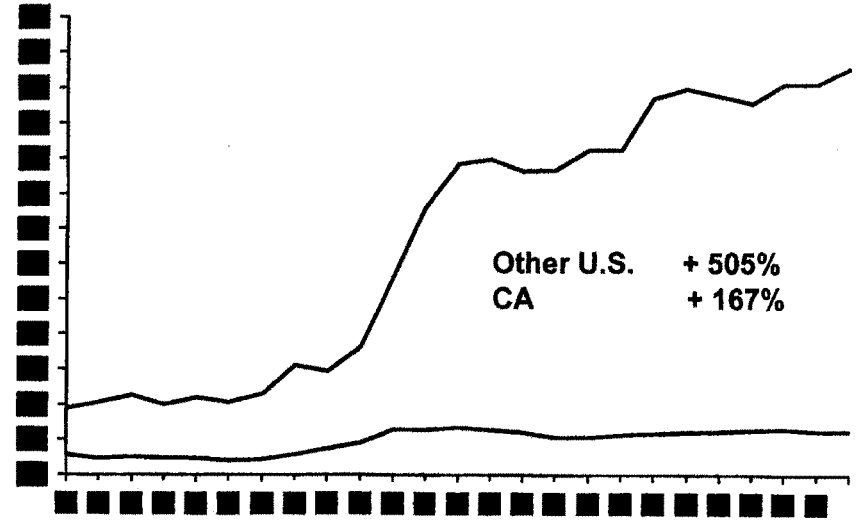


Source: A.M. Best Aggregates & Averages, 1997 through 2002 Editions.
(Predominantly Medical Malpractice Insurers).

EXHIBIT I

Savings from MICRA Reforms

California vs. U.S. Premiums 1976 - 2000



Source: NAIC Profitability By Line By State

EXHIBIT J

2002 Rates- $1mil/3mil Coverage

(as reported by Medical Liability Monitor)

	Los Angeles[1]	Milwaukee[2]	Chicago[3]	Phila[4]	Miami[5]
IM	$11,164	$5,148	$26,404	$18,429	$56,153
GS	36,740	18,020	68,080	82,157	174,268
OB/ GYN	54,563	27,802	102,640	100,045	201,376

1 The Doctors Company
2 PIC Wisconsin
3 ISMIE Mutual Insurance Company
4 Pennsylvania Medical Society Liability Insurance Company
5 First Professional Insurance Company

Mr. BILIRAKIS. Thank you, Mr. Smarr.
Dr. Palmisano.

STATEMENT OF DONALD J. PALMISANO

Mr. PALMISANO. Good morning. I am Donald Palmisano, president-elect of the American Medical Association and a surgeon in New Orleans. The policy of the American Medical Association is decided through a Democratic policymaking process involving physician delegates representing every State, nearly 100 national specialty medical societies, Federal service agencies and other group sections. AMA policy dictates support for national medical liability reform. My testimony represents this policy. Thank you, Mr. Chair, for inviting the AMA to participate in today's hearing. I want to express our gratitude to you, Representatives Greenwood, Cox and Tauzin, and other cosponsors of H.R. 5 for your efforts to bring reasonable reforms to our broken medical liability system.

Mr. Chair, you know that our health care system is facing a crisis when patients have to leave their State to receive urgent surgical care or when pregnant women cannot find an OB-GYN physician to monitor their pregnancy and deliver their baby, or when community health center have to reduce their services or close their doors because of liability insurance concerns. You know that our health care system is facing a crisis when physicians and other health care professionals believe they work in a culture of fear rather than a culture of safety, or when efforts to improve patient safety and quality are stifled because of lawsuit fears.

Escalating jury awards and the high cost of defending against lawsuits, even meritless claims, are causing medical liability insurance premiums to soar. Over the past 2 years, many physicians have been hit with medical liability premium increases of 25 to 400 percent as reports show the average jury award reaching $3.5 million.

As medical liability insurance becomes unaffordable or unavailable, physicians are forced to close their practices or drop vital services seriously affecting patient access to care. Twelve states are currently in a crisis, and we are concerned that more States will be in a full-blown crisis in the near future. Several recent government and private sector reports confirm that the cause of the liability crisis is the unrestrained escalation of jury awards. Opponents claim that the soaring medical liability insurance premiums are the result of declining investments in the insurance industry, and that liability reforms do not stabilize the insurance markets. These claims are misleading based on flawed analysis and contrary to the facts.

AM Best recently reported that medical liability insurers have approximately 80 percent of their investments in the bond market, and investment yields have been stable and positive since 1997. Other credible sources, including Brown Brothers Harriman's recent study, conclude that "investment did not precipitate the current crisis."

In Florida, a nonpartisan taskforce recently found the recommendation that the greatest long-term impact on health care provider liability insurance rates, and thus eliminate the crisis of availability and affordability of health care in Florida, is a

$250,000 cap on non-economic damages. This limit on non-economic damages has worked in California, and it can work nationwide. The National Association of Insurance Commissioners, NAIC, studied 24 years of premiums in California. They found that premiums across the Nation increased three times faster than premiums in California.

In addition, studies show that the tort system is an extremely inefficient mechanisms for compensating patients, returning less than 50 cents on the dollar already to claimants, and less than 22 cents for actual economic losses.

Mr. Chair, as you have recognized, the time for action is past due. We must act now to fix our broken medical liability system. That is why the AMA is here supporting H.R. 5, and that is why we join with numerous members of a broad based coalition known as the Health Coalition on Liability and access to urge this Congress to promptly reform the medical liability system. We must bring common sense back to our courtrooms so that patients have access to their physicians, whether in emergency rooms, delivery rooms or operating rooms. In effect, we need to have balance. We need to make sure that all of the patients in America have access to care. Thank you.

[The prepared statement of Donald J. Palmisano follows:]

PREPARED STATEMENT OF DONALD J. PALMISANO, ON BEHALF OF AMERICAN MEDICAL ASSOCIATION

On behalf of the physician members of the American Medical Association (AMA), I appreciate the opportunity to testify before you today regarding an issue that is seriously threatening the availability of and access to quality health care for patients. I would especially like to express our gratitude to you, Mr. Chair, and Representatives Jim Greenwood (R-PA), Chris Cox (R-CA), Billy Tauzin (R-LA), and other cosponsors of H.R. 5 for providing a much needed focus for action at the national level.

I am Donald Palmisano, MD, JD, President-elect of the AMA and a general and vascular surgeon from New Orleans, LA. The policy of the AMA is decided through its democratic policy-making process in the AMA House of Delegates, which meets twice a year. Our House is comprised of physician delegates representing every state, nearly 100 national medical specialty societies, federal service agencies (including the Surgeon General of the United States), and six sections representing hospital and clinic staffs, resident physicians, medical students, young physicians, medical schools, and international medical graduates. AMA policy dictates support for national medical liability reform. In particular, the AMA supports H.R. 5, the HEALTH Act.

Mr. Chair, you know that our health care system is facing a crisis when patients have to leave their state to receive urgent surgical care. You know that our health care system is facing a crisis when pregnant women cannot find an OB/GYN to monitor their pregnancy and deliver their baby. You know that our health care system is facing a crisis when community health centers have to reduce their services or close their doors because of liability insurance concerns. You know that our health care system is facing a crisis when dedicated professionals, who have trained for years, want to give up the work of a lifetime and retire. You know that our health care system is facing a crisis when physicians and other health care professionals believe they work in a culture of fear, rather than a culture of safety. You know that our health care system is facing a crisis when efforts to improve patient safety and quality are stifled because of lawsuit fears. An unrestrained medical liability system is driving our health care system into crisis.

As you have recognized, the time for action is past due. Physicians across the country are making decisions now, and more and more patients are wondering, "Will their doctor be there?" We must act now to fix our broken medical liability system. That is why we are here supporting H.R. 5, and that is why we join with numerous other members of a broad-based coalition known as the Health Coalition for Liability and Access to urge this Congress to promptly reform the medical liability system.

ACCESS TO CARE IS AT RISK

The crisis facing our nation's medical liability system has not waned—in fact, it is getting worse. Escalating jury awards and the high cost of defending against lawsuits, even frivolous ones, have caused medical liability insurance premiums to reach unprecedented levels. As a result, a growing number of physicians can no longer find or afford liability insurance. Over the past two years, many physicians have been hit with medical liability premium increases of 25 to 400 percent. Some hospitals have seen premiums increase 140 percent in the same time period.

The most troubling aspect of this crisis is its impact on patients. As insurance becomes unaffordable or unavailable, physicians are being forced to close their practices or drop vital services—all of which seriously impede patient access to care. Emergency departments are losing staff and scaling back certain services such as trauma units. Many obstetrician-gynecologists and family physicians have stopped delivering babies, and some advanced and high-risk procedures (such as neurosurgery) are being postponed because physicians can no longer afford or even find the liability insurance they need to practice. According to the American Hospital Association's 2002 TrendWatch 1, more than 26% of health care institutions have reacted to the liability crisis by cutting back on services, or even eliminating some units.

A 2002 survey conducted by Wirthlin Worldwide shows that 78 percent of Americans say they are concerned about access to care being affected because doctors are leaving their practices due to rising liability costs.

Virtually every day for the past year there has been at least one major media story on the plight of American patients and physicians as the liability crisis reaches across the country. Access to health care is now seriously threatened in states such as Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. On top of this, we expect at least five more states to be in a full blown crisis in the near future, with a crisis looming in at least 26 other states. A sample of media reports in the appendices to this testimony illustrates the problems faced by patients and physicians in some of these states—problems many other states will face if effective tort reforms are not enacted.

We must bring common sense back to our courtrooms so that patients have access to their emergency rooms, delivery rooms, operating rooms, and physicians' offices.

THE LITIGATION SYSTEM IS CAUSING THE CRISIS

The primary cause of the growing liability crisis is the unrestrained escalation in jury awards that are a part of a legal system that in many states is simply out of control. While there have been several articles published since the mid-1990s indicating that increases in jury awards lead to higher liability premiums, in the last year a growing number of government and private sector reports show that increasing medical liability premiums are being driven primarily by increases in lawsuit awards and litigation expenses.

In his State of the Union Address last month, President Bush stressed that we all are threatened by a legal system that is out of control. The President stated that "Because of excessive litigation, everybody pays more for health care and many parts of America are losing fine doctors." The President's remarks are substantiated in several recent government and private sector reports—reports making clear that the medical liability litigation system in the United States has evolved into a "lawsuit lottery," where a few patients and their lawyers receive astronomical awards and the rest of society pays the price as access to health care professionals and services are reduced.

Recent Federal Government Reports

In a July 2002 report released by the U.S. Department of Health and Human Services (HHS), the federal government concluded that the excesses of the litigation system are threatening patients' access to health care. This federal government report states that insurance premiums are largely determined by the litigation system, and that the litigation system is inherently costly, unpredictable, and slow to resolve claims. **Just to defend a claim now costs on average over $24,000. Further, the fact that about 70 percent of claims end with no payment to the patient indicates the degree to which substantial economic resources are being squandered on fruitless legal wrangling—resources that could be used to reduce health costs so that more Americans could find health insurance.**

Even when there is a large award in favor of an injured patient, a large percentage of the award never reaches the patient. Attorney contingent fees, added with court costs, expert witness costs, and other "overhead" costs, can consume 40-50 percent of the compensation meant to help the patient.

On September 25, 2002, HHS issued an update on the medical liability crisis. This update reported on the results of a survey conducted by Medical Liability Monitor (MLM), an independent reporting service that tracks medical professional liability trends and issues. According to MLM, the survey determined that the crisis identified in HHS's July report had become worse. The federal government reported that:

> The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage. Premiums are spiking across all specialties in 2002. When viewed alongside previous double-digit increases in 2000 and 2001, **the new information further demonstrates that the litigation system is threatening health care quality for all Americans as well as raising the costs of health care for all Americans.** (emphasis added)

This federal government update further highlights that liability insurance rates are escalating faster in states that have not established reasonable limits on unquantifiable and arbitrary non-economic damages. The government's report states that:

> . . . 2001 premium increases in states without litigation reform ranged from 30%-75%. In 2002, the situation has deteriorated. **States without reasonable limits on non-economic damages have experienced the largest increases by far, with increases of between 36%-113% in 2002.** States with reasonable limits on non-economic damages have not experienced the same rate spiking. (emphasis added)

HHS also compared the range of physician liability insurance premiums for certain specialties in California, which has established reasonable limits on awards for non-economic damages, to the premiums in states that have not enacted similar limits. The results reveal how excessive awards for non-economic damages affect premiums. For example, in 2002, OB/GYNs in California paid up to $72,000 in medical liability premiums. In Florida, which does not limit non-economic damage awards, OB/GYNs paid up to $211,000 for liability coverage.

Further, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress), which included a limitation on non-economic damages, asserts that:

> CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 4600 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law.

In Florida, as indicated in the example given above, medical liability premiums are among the highest in the nation. The situation in Florida has become so dire that Governor Bush created a special Task Force to examine the availability and affordability of liability insurance. This Task Force held ten hearings over a five month period and received extensive testimony and information from numerous, diverse sources.

Among the many findings in its report released on January 29, 2003, **the Governor's Task Force found that the level of liability claims paid was the main cause of the increases in medical liability insurance rates.** The Task Force ultimately concluded that "the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages."

Recent Private Sector Reports

Evidence that the litigation system is broken, and that the medical liability crisis is growing, is further established in a study released by Tillinghast-Towers Perrin on February 11, 2003. Tillinghast reported that "The cost of the U.S. tort system grew by 14.3% in 2001, the highest single-year percentage increase since 1986," which is "equivalent to a 5% tax on wages." This is the only study that tracks the cost of the U.S. tort system from 1950 to 2001 and compares the growth of tort costs with increases in various U.S. economic indicators. Some of the key findings of this study are stunning:

- The U.S. tort system is a highly inefficient method of compensating injured parties, returning less than 50 cents on the dollar to people it is designed to help and returning only 22 cents to compensate for actual economic loss.

- As of 2001, U.S. tort costs accounted for slightly more than 2% of GDP, signaling an increase after a 13-year decline in the ratio of tort costs to GDP.
- While the cost of the U.S. tort system has increased one hundred fold over the last fifty years, GDP has grown by a factor of only 34.
- **Medical malpractice costs have risen an average of 11.6% a year since 1975 in contrast to an average annual increase of 9.4% for overall tort costs, outpacing increases in overall U.S. tort costs.**

The study also adds that "These trends continued in 2002, with no sign of abatement in the near future." In a press release accompanying this study, a Tillinghast principal stated that, "Absent sweeping tort reform measures, we expect most of these trends to continue in 2003 and beyond."

In a 2001 report by Jury Verdict Research, data show that in just a one year period (between 1999 and 2000) the median jury award increased 43 percent. Further, median jury awards for medical liability claims grew at 7 times the rate of inflation, while settlement payouts grew at nearly 3 times the rate of inflation. Even more telling, however, is that *the proportion of jury awards topping $1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top $1 million, and the average jury award has increased to about $3.5 million.*

These are just a few examples of growing evidence that reveal that out-of-control jury awards are inexorably linked to the severe increases in medical liability insurance premiums. It is clear that corrective action through federal legislation is urgently needed.

Blaming Insurance Industry Investments Is A Red Herring

Organizations opposing H.R. 5 have claimed that soaring medical liability insurance premiums are the result of declining investments in the insurance industry, and that liability reforms do not stabilize the insurance market. The reports discussed above, as well as several other authoritative and credible studies, reveal such claims to be misleading, based on flawed analysis, and contrary to the facts.

Last month, Brown Brothers Harriman & Co. (BBH) released a report ("Did Investments Affect Medical Malpractice Premiums?") that analyzed the impact of insurers' asset allocation and investment income on the premiums they charge. **BBH concluded that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of the U.S. economy, or interest rates, on the other hand.**

In addition, on February 4, 2003, BBH released an addendum to this study that analyzed National Association of Insurance Commissioners (NAIC) data to determine whether investment gains by medical liability insurance companies declined in the recent bear market. BBH asked the question: "Did medical malpractice companies raise premiums because they had come to expect a certain percentage gain that was not achieved due to market conditions?" BBH determined that the decline in equities (which are a small percentage of insurance company investments) was more than offset by the capital gains by bonds (which make up a substantial part of insurance company investments) due to a decline in interest rates. **BBH concluded that "investments did not precipitate the current crisis."**

BBH's findings are corroborated by other recent reports. On September 25, 2002, HHS released an update on the medical liability crisis addressing claims that the crisis is caused by the management practices of the insurance industry. HHS concluded that such claims are not supported by facts, stating **"Comparisons of states with and without meaningful medical liability reforms provide clear evidence that the broken medical litigation system is responsible."**

In addition, a summary of medical liability insurer annual statement data in A.M. Best's Aggregates & Averages, Property-Casualty, 2002 edition shows that the investment yields of medical malpractice insurers have been stable and positive since 1997. A.M. Best reports that medical liability insurers have approximately 80% of their investments in the bond market. Also, **recent NAIC data show that physicians' medical liability insurance premiums between 1976-2000 have risen 167% in California (which established effective liability reforms in 1975) compared to 505% in the rest of the United States.**

The report on which H.R. 5 opponents base most of their speculations, produced under the direction of J. Robert Hunter for the Americans for Insurance Reform (AIR), is flawed in a number of ways. The AIR/Hunter study purports that there is no current explosion in medical liability insurance payouts, and that the explosion in medical liability insurance premiums is due to the insurance underwriting cycle. While *medical liability insurance premiums, medical liability award payouts,* and *tort law factors* differ across states, the premium and payout data presented in

AIR's report are at the national level. One cannot use national data to draw valid conclusions about how state-specific changes in premiums may be related to state-specific changes in payouts. **Conclusions about what has or has not caused recent premium escalation without accounting for the state-level factors listed above are unsupportable.**

In addition to claiming that the current medical liability crisis is an insurance issue, there have been attempts to argue that medical liability insurance premium rates in California have remained stable because of Proposition 103, not because of the successful medical liability reforms (known as MICRA—discussed later) that have been in place in California since 1975. Such claims are misguided. Proposition 103, also known as the Insurance Rate Reduction and Reform Act, applies to all lines of insurance, not just medical liability insurance. It was passed as an initiative by the voters in 1988 (thirteen years after MICRA), yet did not take effect until 1989. This is when the state's high court struck down its rate rollback provisions while maintaining the remainder of the law.

Proposition 103 implemented a basic standard that "no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter." However, Proposition 103 provides that "every insurer which desires to change any rate shall file a complete rate application with the commissioner." Proposition 103 also requires that the Department of Insurance grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance.

According to Californians Allied for Patient Protection, "Insurers have regularly applied for and obtained significant rate increases in all lines of insurance, except medical liability where MICRA has kept the rates from rising astronomically. Between September and the end of October, 2002, for instance, the Insurance Department approved more than 75 applications for double-digit increases in insurance rates." **None of these approved increases included medical liability insurance.** This illustrates that Proposition 103 is not responsible for keeping medical liability premiums down. Rather, as we discuss later, it is MICRA that has been the force behind California's success.

Such misdirected claims as discussed above are a disservice to patients who are losing access to health care services, and an affront to the physicians and other health care professionals who dedicate their lives to healing and caring for the sick and working to find ways to improve the quality of care. America's medical liability crisis is too serious and the consequences of inaction too grave for the public and Congress to use anything but the facts to make decisions about reform. In short, these claims are counterproductive to the debate on resolving the medical liability crisis.

FEDERAL SOLUTION

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

Also, the premise that it is within the ability of every state to enact legislation to effectively resolve their respective medical liability crisis has been shattered by the fact that many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reforms. Taking into consideration that studies show the litigation system to be an ineffective, and often unfair, mechanism for resolving medical liability claims, we believe that the time is ripe for a uniform, federal approach to resolving the liability crisis.

Moreover, there is a direct and compelling federal interest in reforming our outmoded medical liability system. According to estimates by HHS, altogether medical liability adds $60 billion to $108 billion to the cost of health care each year. This means higher health insurance premiums and higher medical costs for all Americans, and especially for the federal government given that one-third of the total health care spending in our country is paid by the Medicare and Medicaid Programs. Further, HHS estimates that excessive medical liability adds $47 billion annually to what the federal government pays for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for federal employees, and other government programs.

THE LIABILITY CRISIS AND PATIENT SAFETY

The AMA's policy is to be part of the solution to improving patient safety and quality. The AMA believes that one preventable error is one error too many. In fact, the AMA helped launch the National Patient Safety Foundation (NPSF) in 1996 to address patient safety issues, well before publication of the IOM report. The NPSF's approach is to create a culture of cooperative learning and mutual improvement, as opposed to a culture of shame and blame.

Quality of care improves when there is greater access to physicians and health care services. A culture of safety requires a legal environment that encourages professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients. An over-litigious system is anathema to building a strong and effective national patient safety program.

Under our current liability system, the reality of being sued is daunting to just about everyone in the medical community. A 2002 Harris Interactive study (*The Fear of Litigation Study—The Impact on Medicine*) illustrates just how detrimental the litigious nature of our society is to physicians and other health care professionals. This study reveals the extent to which the fear of litigation affects the practice of medicine and the delivery of health care—"From the increased ordering of tests, medications, referrals, and procedures to increased paperwork and reluctance to offer off-duty medical assistance, the impact of the fear of litigation is far-reaching and profound."

The study shows, among other things, that more than three-fourths (76%) of physicians believe that concern about medical liability litigation has negatively affected their ability to provide quality care in recent years, and nearly all physicians and hospital administrators feel that unnecessary or excessive care is provided because of litigation fears. It also shows that an overwhelming majority of physicians (83%) and hospital administrators (72%) do not trust the current system of justice to achieve a reasonable result to a lawsuit.

The Harris study found that a majority (59%) of physicians believe ("a lot") that the fear of liability discourages open discussion and thinking about ways to reduce health care errors. The AMA has long believed that health professionals and organizations should be encouraged to report and evaluate health care errors and to share their experiences with others in order to prevent similar occurrences. However, this "culture of fear" caused by our over-litigious society suppresses such information.

The AMA strongly supports the principle underlying the 1999 Institute of Medicine (IOM) report entitled, *To Err is Human: Building a Safer Health System,* that the health care system needs to transform the existing culture of blame and punishment, which suppresses information about errors, into a "culture of safety" that focuses on openness and information-sharing to improve health care and prevent adverse outcomes. The AMA also supports the IOM's focus on the need for a system-wide approach to eliminating adverse outcomes and improving safety and quality, instead of focusing on individual components of the health system in an isolated or punitive way.

Toward this end, the AMA supports H.R. 663, the "Patient Safety and Quality Improvement Act," which was favorably reported by the House Energy & Commerce Committee on February 12, 2003. H.R. 663 would provide a framework to create a "culture of safety" by establishing a confidential, non-punitive, and evidence-based system for reporting health care errors. There is a very broad and strong consensus of agreement on this legislative approach within the health care community. By implementing this approach, errors can be identified and analyzed to improve patient safety by preventing future errors.

In addition to patient safety and quality improvement, the fear of litigation stifles the advancement of new medical treatments and medications, encourages physicians to practice defensive medicine, overwhelms the health care system with paperwork—leaving less time for patient care, and discourages qualified candidates from pursuing a career in medicine or from moving to a state with a bad liability climate.

THE PRACTICAL SOLUTION

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as devastating or worse to patients and their families than injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation.

This compensation should include, first and foremost, full payment of all out of pocket "economic" losses. The AMA also believes that patients should receive rea-

sonable compensation for intangible "non-economic" losses such as pain and suffering and, where appropriate, the right to pursue punitive damages.

Unfortunately, our medical liability litigation system is neither fair nor cost effective in making a patient whole. Transformed by high-stakes financial incentives, it has become an increasingly irrational "lottery" driven by open-ended non-economic damage awards. As mentioned above, studies show that our tort system, in general, is an extremely inefficient mechanism for compensating claimants—returning less than 45 cents on the dollar to claimants and only 20 cents of tort cost dollars to compensate for actual economic losses.

To ensure that all patients who have been injured through negligence are fairly compensated, the AMA believes that Congress must pass fair and reasonable reforms to our medical liability litigation system that have proven effective. Toward this end, **we strongly urge Congress to pass the "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act,"** a *bipartisan* bill that would bring balance to our medical liability litigation system.

The major provisions of the HEALTH Act would benefit patients by:

- Awarding injured patients *unlimited* economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);
- Awarding injured patients non-economic damages up to $250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in this bill;
- Awarding injured patients punitive damages up to $250,000 or up to two times economic damages, whichever is *greater*;
- Establishing a "fair share" rule that allocates damage awards fairly and in proportion to a party's degree of fault; and
- Establishing a sliding-scale for attorneys' contingent fees, therefore maximizing the recovery for patients.

These reforms are not part of some untested theory—they work. The major provisions of the HEALTH Act are based on the successful California law known as MICRA (Medical Injury Compensation Reform Act of 1975). MICRA reforms have been proven to stabilize the medical liability insurance market in California—increasing patient access to care and saving more than $1 billion per year in liability premiums—and have reduced the time it takes to settle a claim by 33 percent. MICRA is also saving California from the current medical liability insurance crisis brewing in many states that do not have similar reforms. In fact, according to MLM, as discussed above, the gap between medical liability insurance rates in California and those in the largest states that do not limit non-economic awards is substantial and growing.

MICRA-type reforms are effective, especially at controlling non-economic damages. Several economic studies substantiate this point. One study looked at several types of reforms and concluded that capping non-economic damages reduced premiums for general surgeons by 13% in the year following enactment, and by 34% over the long term. Similar results were shown for premiums paid by general practitioners and OB/GYNs. It was also shown that caps on non-economic damages decrease claims severity (i.e., amount of the claim) (Zuckerman et al. 1990).

Another study published in the *Journal of Health Politics, Policy and Law* concluded that caps on non-economic damages reduced insurer payouts by 31%. Caps on total damages reduced payouts by 38% (Sloan, et al. 1989). Another study concluded that states adopting direct reforms experienced reductions in hospital expenditures of 5% to 9% within three to five years. If these figures are extrapolated to all medical spending, a $50 billion reduction in national health spending could be achieved through such reforms (Kessler and McClellan, Quarterly Journal of Economics, 1997).

Further, as discussed above, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress) asserts caps on non-economic damages have been *extremely effective in reducing the severity of claims and medical liability premiums.* Conversely, a 1996 American Academy of Actuaries study shows that *medical liability costs rose sharply* in Ohio after the Ohio Supreme Court overturned a liability reform law in the 1990s that set limits on non-economic damages. (Ohio recently enacted a new liability reform law.)

Furthermore, a Gallup poll released on February 5, 2003, show that 72% of those polled favor a limit on the amount patients can be awarded for pain and suffering. This Gallup poll is consistent with a 2002 survey conducted by Wirthlin Worldwide showing that three-quarters of Americans understand the detrimental effect that excess litigation has on our health care system. The Wirthlin survey shows that the vast majority of Americans agree we need common sense medical liability reform.

In addition to the 78 percent discussed above who said that they are concerned about access to care, the survey found that:

- 71 percent of Americans agree that a main reason health care costs are rising is because of medical liability lawsuits.
- 73 percent support reasonable limits on awards for "pain and suffering" in medical liability lawsuits.
- More than 76 percent favor a law limiting the percentage of contingent fees paid by the patient.

CONCLUSION

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an erosion in access to care because their physicians can no longer find or afford liability insurance. The reasonable reforms of the HEALTH Act have brought stability in those states that have enacted similar reforms.

By enacting meaningful medical liability reforms, Congress has the opportunity to increase access to medical services, eliminate much of the need for medical treatment motivated primarily as a precaution against lawsuits, improve the patient-physician relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emotional, of health care liability litigation. The modest proposals in the HEALTH Act answer these issues head on and would strengthen our health care system.

The AMA appreciates the opportunity to testify on the adverse effect that our current medical liability litigation system imposes on patient access to health care and urges Congress to pass H.R. 5, the HEALTH Act.

Mr. BILIRAKIS. Thank you very much, sir.

A number of the members up here have 8 minutes for their inquiries, and we will remind you of that. I will just go ahead and start the questioning.

Mr. Rosenfield, and not that this question is not maybe appropriate to all of the others too, but I—late in the fall, I was invited to attend a large gathering, I will call it a seminar, if you will, because that is really what it turned out to be. Of an awful lot of medical providers in my part of Florida where they had, and my part of Florida is the Tampa Bay area, where they had, I guess, he is an attorney from Miami, come up and others, to advise doctors on how to go bare, b-a-r-e, I guess, that bare, advise them how to get rid of their assets and protect their assets and whatnot, and just go bare, without any insurance at all.

Now, it has been stated by at least one or two of you, didn't have to be stated, that we are taking away, in effect, constitutional rights of some of the—a patient, of Ms. Lewinski, and others, to be able to get a proper remedy, et cetera. But I would ask you, if a doctor has gone bare, and more and more are going that way, now you are talking about, I mean, if you are talking about a proper remedy, we are talking about no assets. And is that not more injurious to the patient than, let's say, a cap would be where there is insurance there, there is coverage and there is insurance, and certainly, the economic damages would be covered, would be picked up?

Mr. ROSENFIELD. Mr. Chairman, that is seriously injurious. But the premise of your question is that it is an inescapable reality. I think the experience in California under proposition 103 with stringent regulation is that you can force insurance companies to reduce their rates. And I think the message you are hearing from the—and we heard in Langhorne in the subcommittee hearing was that before the Congress, the 108th Congress moves to limit how much

victims of medical malpractice can receive, we ought to, it ought to investigate what is really going on with the insurance industry.

Because of the vast and overwhelming majority of evidence, even from the insurance industry, and I have included some of it in my written testimony, and I have an exhibit, with your permission, I would like to make part of the record. Even the insurance industry itself acknowledges that there is a cycle that occurs. And we have had three of them in the last 30 years, when we run into trouble in the market, when insurance companies' interest rates are lower and their investment income is reduced and the stock market goes bad, which this is a double whammy for them this time around.

When all of those things happen, the insurance companies run into trouble. The investigation should be into whether there is away to lower insurance premiums. And if the private insurance companies do not wish to sell insurance to doctors, the Congress could do many things to make it more—I am sorry.

Mr. BILIRAKIS. Well, forgive me. But I didn't want you to take up my entire 5 minutes.

Mr. ROSENFIELD. I am sorry.

Mr. BILIRAKIS. You pretty well, I guess, answered my question.

Mr. Hurley, do you agree with the gentleman?

Mr. HURLEY. Agree in the sense that it is caused by investment losses and things like that?

Mr. BILIRAKIS. Well, certainly he made that comment here toward the end.

Mr. HURLEY. No, I do not agree that this investment losses cause companies to increase rates. As I mentioned in my testimony, rates are developed in a forward looking fashion. They do not depend on or look back at and recoup past investment loses. They do not recoup past inadequate rates. They are made based on projections of expected losses and expected future rates of return, not past rates of return or losses.

Mr. BILIRAKIS. Well, you seem to be awfully positive. Mr. Rosenfield seems to be awfully positive, and yet you disagree and we are supposed to leaf through all that and come up with what—Mr. Smarr. Comment? You are certainly, you certainly disagreed on proposition 103 and its effect.

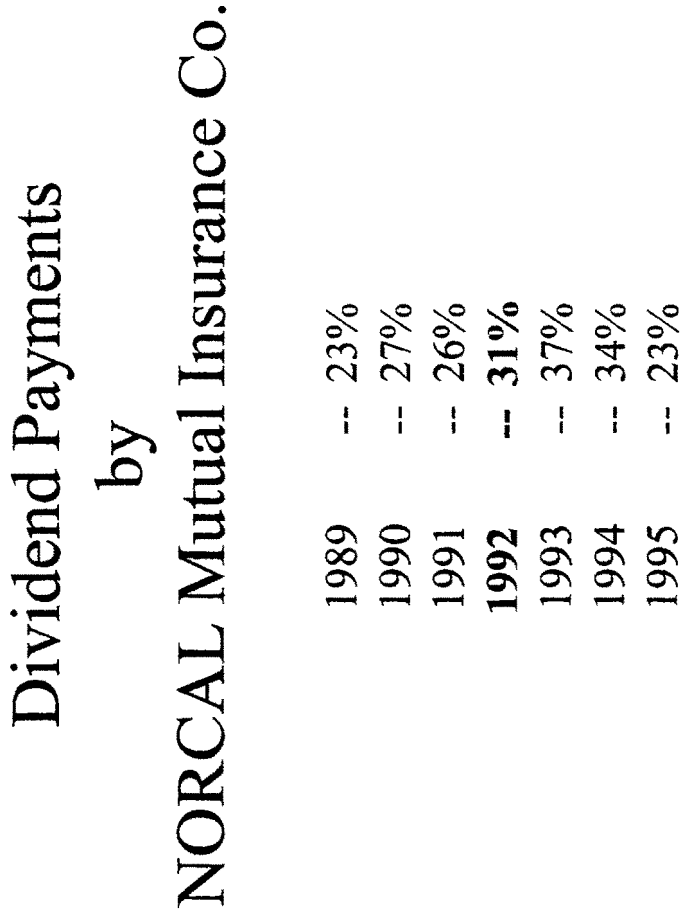
Mr. SMARR. I indeed do disagree with that. Medical malpractice insurers were not the intended target of proposition 103. It was an automobile insurance initiative. Nevertheless, prop 103 did cover them. Prop 103 was passed in, I guess, 1988 and the insurance industry was very opposed to prop 103. In fact, insurance companies were still negotiating with the commissioner into the mid 1990's as to how they were going to fulfill the requirements of prop 103. The very first insurance company that did come to an accord with the insurance commissioner was the Norcal Mutual Insurance Company, one of my physician-owned malpractice insurance companies. And Norcal, in its agreements with prop 103—now prop 103 required the rollback of rates to 20 percent below those in effect in some date in November 1987. It did not require the refund of any money if you read prop 103.

But Norcal reached an agreement with the insurance commissioner that it would refund 20 percent of premium for 1 year to its doctors and that would be the entire commitment they had under

prop 103. And this was a sizable amount of money. And I have the consent order signed by Norcal and two other of my member companies here, which I would like to have entered into the record where they did.

Mr. BILIRAKIS. Without objection.

[The information referred to follows:]



Mr. SMARR. Norcal, at the time, showing the exhibit before you now, was paying dividends in each of the years during the prop 103 issue in excess of 20 percent. And so Norcal was able to fulfill its obligation to refund 20 percent through the normal dividend process. And that is also stipulated in paragraph 4 of Norcal's consent order. And thus, Norcal did not pay out any more money than it otherwise would have paid because of prop 103, and it clearly did not roll back its rates. And I have talked to my other California member companies, and I have been told the same story.

Mr. BILIRAKIS. Thank you, sir. My time is expired.

Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman. Well, just following up, it is correct, isn't it, Mr. Smarr, that the vast majority of States require physicians to have malpractice insurance so the vast majority of physicians would not be able to go bare, correct?

Mr. SMARR. I believe that is true.

Ms. DEGETTE. Thank you.

Ms. Lewinski, I want to thank you for coming today. We all sit around and talk about actuarial issues and this and that. But we really heard the human face, and I know your mom tells you this because I am a mom, too. But let me tell you and you might listen to it from me, you will find a boyfriend because you are so pure of heart and so articulate and someone's going to love you very much. So I just want to tell you that. And I know we all appreciate you being here. I just want to ask you two questions. First of all, when you—when you had this terrible injury by your doctor, you were 8 years old, right.

Ms. LEWINSKI. Right.

Ms. DEGETTE. And so the jury did not give you any award of economic damages, correct?

Ms. LEWINSKI. That is correct.

Ms. DEGETTE. Mr. Chairman, I would just like the record to reflect that if this legislation passed, Ms. Lewinski, despite everything that happened to her, would be entitled to an award of zero. Now, I have a couple of more questions.

Mr. Hurley, I listened very carefully to your testimony today and the upshot is, for a variety of reasons, you have no idea, really, how passage of this bill would affect malpractice insurance rates for doctors, do you?

Mr. HURLEY. I have not made any projection about what the impact of that bill would be no.

Ms. DEGETTE. Right. So you don't really know what, if any, effect this bill would have on these doctors'insurance rates, right?

Mr. HURLEY. I have not projected to answer your question, I have not made a projection on what the effect would be in terms of the impact on rate level. I think it is safe to say that over the long term, a bill of this nature would, in fact, stabilize price increases because it will stabilize increases and losses over the long term.

Ms. DEGETTE. Thank you.

Now, Mr. Smarr, I also want to ask you, you don't really have any idea, if premiums will go down, if Congress passes this law either, do you?

Mr. SMARR. I do believe that if Congress passes this law, and it stands constitutional muster, that rates will be reduced.

Ms. DEGETTE. Do you have data to support that contention, sir?

Mr. SMARR. The data that I have is that produced by the Congressional Budget Office and by the GAO, which looked at this issue.

Ms. DEGETTE. Okay.

Mr. SMARR. Pardon me. I misspoke. It is the Department of Health and Human Services, not the GAO.

Ms. DEGETTE. Okay. Mr. Smarr and Mr. Rosenfield, I would like to have you take a look at Exhibit 2-A. I am sorry. Yeah. 2-A and 2-B, it is this chart right here. It should be on the back screen, if we could have someone put it up. It is labeled "premiums and damage caps for top 26 States." 2-B is for bottom 27 States. I don't know if you have that in front of you or not. There it is, behind you. Now, take a look at the top five States in terms of premium, Florida, Michigan, Nevada, Ohio, West Virginia. Do you see that?

Mr. SMARR. Yes.

Ms. DEGETTE. Now, in all of those states they have caps, correct, Mr. Smarr? Yes or no?

Mr. SMARR. No, I don't agree with that.

Ms. DEGETTE. You don't agree that they have caps? Mr. Rosenfield, do you believe they have caps in those five States, Mr. Rosenfield.

Mr. ROSENFIELD. Yes, I do believe that. I will double-check, but I believe it.

Ms. DEGETTE. Okay. Now, if you take a look, but yet, what I am looking at, those are the five States that have the highest premiums in the country, but they also have caps, correct, Mr. Rosenfield?

Mr. ROSENFIELD. You know, I can't—this is not our chart. I have been to those States. They have caps. I can't tell you what the amounts are.

Ms. DEGETTE. What the premium is?

Mr. ROSENFIELD. Yeah. I can't tell you.

Ms. DEGETTE. Okay. Take a look at now Exhibit 2-B, if you will. Take a look at the bottom, at least the bottom State, Oklahoma, they have the lowest premiums and they also have no cap; is that correct, Mr. Rosenfield?

Mr. ROSENFIELD. That is what that chart says.

Ms. DEGETTE. Do you know if that's true or not?

Mr. ROSENFIELD. It is not my chart. No, sorry.

Ms. DEGETTE. Mr. Smarr, do you know if that is true?

Mr. SMARR. I have no idea.

Ms. DEGETTE. Do you have any reason to disagree with that?

Mr. SMARR. I can't comment on the chart because I don't know where the data comes from.

Ms. DEGETTE. The data comes from Medical Liability Monitor. Are you familiar with that publication?

Mr. SMARR. I am very aware of that publication.

Ms. DEGETTE. Is that a legitimate publication?

Mr. SMARR. Yes, it is.

Ms. DEGETTE. Would you have any reason to disagree with this data?

Mr. SMARR. I might, because I don't know how the data was extracted from the publication.

Ms. DEGETTE. Okay. So you think that in Oklahoma they might have a cap. Do you disagree with these charts which indicate that the States with the highest premiums also have caps and the States with the lowest premiums either have very high caps or no caps whatsoever?

Mr. SMARR. Congresswoman DeGette, I can't agree with anything on that chart because I do not know how it was derived.

Ms. DEGETTE. Do you agree with the concept?

Mr. SMARR. The concept?

Ms. DEGETTE. Yeah.

Mr. SMARR. Yeah.

Ms. DEGETTE. Thank you.

Mr. BILIRAKIS. Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. It is difficult for us to reach a consensus on how to solve the problem since we can't, haven't reached anything like a consensus on what causes the problem. And the opponents of this legislation seem convinced that the cause of the problem has to do with either bad investments by insurance companies, or price gouging. That seems to be the mantra that is repeated over and over again.

Mr. Hurley, I know you have been asked this before, but looking at the chart there, we see a number of States, California, Colorado, New Mexico, Indiana, Wisconsin and Louisiana, that don't seem to be in crisis right now. Mr. Rosenfield believes that he is the hero in California, that the reason they don't have a problem is because of his efforts. That is disputed by others. But Mr. Rosenfield didn't pass propositions in those other States, so do you have any—can you offer us any wisdom or why there would be such variation among the States, even though you have said that you do not believe that investments, bad investments are the causal factors of these malpractice increases? Can you give us some wisdom as to why there is a variation in States?

Mr. HURLEY. Congressman, I will try. I think that to reiterate, it is not investments that is driving the prices. The prices are driven by losses. The losses are driven by the frequency and severity of claims in each jurisdiction and each jurisdiction has its own set of rules as to what happens in that jurisdiction in terms of filing a claim many so it is the frequency and severity of claims, that is affected by the rules that operate in each of those several States. And just to touch on the issue of prop 103, any form of regulation that is in place is not going to stop a company from going broke. If the losses are bad, companies will seek increased rates. If a regulation stops them from getting those increased rates commensurate with the losses they will go broke. The fact of the matter is that the losses didn't increase enough to cause companies to file rates in California that require them to get higher rates and therefore——

Mr. GREENWOOD. Okay. Let me stop you in the interest of time. So what we know is all of the—the stock market applied to all of those 50 States, even if it were, even if you tried to make the arguments that this is all about stupid investments, or not even stupid investments, but loss in the stock market, you would have the dif-

ficulty, I think, you would have a difficult time, I think, explaining why some States are insurance companies that provide insurance, liability insurance in the white States there, somehow had a different investment history than the States, than the companies providing insurance in the red States. That is nonsensical.

But you are saying it doesn't have anything to do with investments. It has everything to do with losses, and losses are a function of State law and an important function of State law is caps. And it so happens that the one thing that those white States all have in common is they all have caps.

Now, let me turn to Mr. Smarr. Mr. Smarr, I said in my opening statement that I had a hard time believing that this was, I would be delighted to solve this problem if we could figure, if we could lay the blame at the fault of the insurers and do something to fix that. That would be great with me. I just want to make health care available in my State. But you represent the physician-owned insurance companies, and would it be fair to say that the physician-owned insurance companies fundamentally exist for the purpose of trying to provide physicians with the lowest possible and most affordable medical liability premiums?

Mr. SMARR. Yes, sir, it would. The companies were formed back in the late 1970's, specifically for that purpose to provide a market for doctors and hospitals and dentists and to be able to ascertain the two true crosses of medical liability insurance, because nobody believed the commercial carriers at that time that things were as bad as they were.

Mr. GREENWOOD. Right. So you had to get away from those big bad private insurers which might have been price gouging, and let the physicians go about it themselves. Have you been able to significantly offer rates to your physicians, these companies that you represent, at a different, a significantly different rate than the private sector has.

Mr. SMARR. No.

Mr. GREENWOOD. Why is that?

Mr. SMARR. Because the costs were real.

Mr. GREENWOOD. The costs were real. So it is not that, even with all of their alleged price gouging and overpricing and all of their stupid investments and all of the rest, you are out there trying to find—to make investments that make sense. And I think it is only 15 percent of all insurance companies, I think, have—medical liability insurance companies invest in the stocks, isn't that what you said, Mr. Hurley?

Mr. HURLEY. It is approximately.

Mr. GREENWOOD. It is only 15 percent in stocks to begin with. Okay. But you are out there, your companies, who provide insurance for 60 percent of the doctors in the country; is that right?

Mr. SMARR. That's what we estimate yes?

Mr. GREENWOOD. So you are out there trying your level best to be as conservative with your investments, to be as conservative with your premiums, and you are still not able to significantly, if at all, offer a product at a lower price than any of the private sector; correct?

Mr. SMARR. Essentially correct, yes.

Mr. GREENWOOD. Okay. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Brown, 5 minutes.

Mr. BROWN. Thank you Mr. Chairman. I have a couple of quick questions.

Dr. Palmisano, you are a physician. Do you believe a $250,000 cap for all victims of malpractice is sufficient, no matter how severe the injury?

Mr. PALMISANO. The American Medical Association's policy is the MICRA legislation. That has been the policy for a number of years. And this past year, the American Medical Association voted to make medical liability reform its No. 1 legislative——

Mr. BROWN. Is that a yes?

Mr. PALMISANO. [continuing] priority.

Mr. BROWN. Could you give me a yes or no on that?

Mr. PALMISANO. Well, we believe you have to have a balance.

Mr. BROWN. Would you give me a yes or no? Do you think 250,000—I mean, you have got a policy. I don't want it explained. If you——

Mr. PALMISANO. I just want you to understand, it is the American Medical Associations policy. I am not giving my personal opinion here.

Mr. BROWN. Well, the American Medical Association thinks $250,000, regardless of the severity of the damage, is sufficient.

Mr. PALMISANO. For noneconomic damages, in order to balance and be sure we have access to care for all of the patients.

Mr. BROWN. No, I don't need the editorial comment. I only have 5 minutes.

Mr. PALMISANO. I am giving you the background.

Mr. BROWN. I appreciate that. Thank you, Dr. Palmisano. Mr. Smarr—I apologize for cutting you off like that. I just have several things I want answered. Studies show that only one in seven victims of malpractice ever file a claim. Is that too many? One out of seven?

Mr. SMARR. Is that too many?

Mr. BROWN. Yeah.

Mr. SMARR. No.

Mr. BROWN. Okay. What percentage of victims—what percentage of victims are entitled to compensation? If only one out of seven files.

Mr. SMARR. Well, I personally believe that any victim is entitled to be made whole.

Mr. BROWN. Made whole. Do you think a $250,000 cap is adequate always in every case?

Mr. SMARR. I believe that a $250,000 cap is an equitable standard, yes, I do.

Mr. BROWN. In every case?

Mr. SMARR. Yes.

Mr. BROWN. Okay. That's interesting. Okay. My friend, Ms. Rosenbaum, my friend Mr. Greenwood, mentioned in his opening statement there is no reason to subpoena insurance industry records, because he said because 60 percent of medical malpractice insurance is provided by physician-owned companies. The goal of a subpoena is, however, to gather information so we can justify the kind of sweeping change that this legislation offers.

Would you tell us what information we should want, we should need from insurance companies, the information that we can't, we seem to not be able to get, short of a subpoena? And the majority party won't allow a subpoena for whatever reason. They don't want us to know more about the inside workings of the insurance industry. Should we have to—what should we want, data on investment practices? Payroll of the executives? Amount in the reserves pay out on claims? What kind of information should we want?

Ms. ROSENBAUM. I think what you need to focus on, particularly are any internal studies that breakdown the relative magnitude of the various components of payouts. For example, there are studies that suggest that by far, in many cases, the highest part of the payout is the economic damage, that, in fact, non-economic damages are relatively modest. And that is because of the length of life of certain injured persons, the complexity of the treatment.

So I would want to know a great deal about exactly what a claim breaks down into. I would also want to know, I think, the extent to which there are internal memos and studies that identify the losses that a company experiences that are attributable to a shortfall in the premium-paid increases to the payout, versus the kinds of underlying shortfalls that simply come because of the way in which revenues are managed. This is true for any complex corporations; it is true for my own university, where our dilemma right now is not the tuition payments are too low, it is that the return on our endowment is too low.

And that drives tuition payments. And I assume that it is the same kind of complicated issue for any corporation—public, private, nonprofit, for profit. So it is that—it is the underlying cause of the escalation that you would have to get at.

Mr. BROWN. Thank you for that.

Mr. Rosenfield, you seemed, when Mr. Smarr was talking about Prop 103—not to try to read into your facial expression, but you seemed not to agree with that. But could you—we don't have a lot of time, but talk about briefly why you think 103 brought down rates and why MICRA didn't seem to? Briefly.

Mr. ROSENFIELD. Well, it is not my thinking. That exhibit 1 shows that premiums soared 571 percent until Prop 103 passed, and then they went down 20 percent. It is that insurance industry data. And the reason why is because—nothing inherent in tort reform—it does stop insurance companies from boosting premiums. There is no requirement that they not. And so when Proposition 103's regulatory structure took effect, it forced the insurance companies to reduce premiums for a one-time rollback and refund.

But then if you look at the other charts in the testimony, you will see that unlike the other States, where these wild gyrations—that is caused by the insurance industry cycle; that is actually documented by the medical insurer itself in my exhibit here, unlike other States because Prop 103 does not allow unjustified decreases, ill-advised decreases. So in California, 103 has eliminated the instability of the insurance cycle. That is a value too.

Mr. BILIRAKIS. Mr. Deal for 8 minutes.

Mr. DEAL. Thank you, Mr. Chairman.

I think all of you have provided very valuable insight. I want to question some of your statements and see if I can make some sense

out of it even further. Obviously one of our purposes here is to do something that is going to be effective, and one of the things that I think would be effective is to determine if several things will happen with H.R. 5 passing.

One would be, are we going to see a decrease in malpractice premiums?

Now, I think from hearing the testimony and reading the material here, I don't see that happening. Mr. Smarr, I am looking at your testimony on page 14, and you list the causes of the crisis, and it appears that only the latter one maybe is directly related to what we are doing here and that is a greater proportion of large losses. And you say the primary driver of the deterioration in the medical liability insurance industry performance has been paid-claim severity.

You go on to point out in your letter to Senator Gregg that the preliminary evidence points to a rising loss cost and defense cost associated with litigation as the principal drivers of medical malpractice prices.

So, are we going to see a decrease in medical malpractice cost if H.R. 5 passes?

Mr. SMARR. Yes, sir, I believe we will. And I believe that the experience in States that have effective tort reforms speaks to this.

The Congressional Budget Office, in scoring H.R. 4600, stated that if that bill, which is essentially identical to H.R. 5, were to become law, medical malpractice rates would be—I believe it is 25 to 30 percent lower than they would otherwise be had the legislation not been adopted.

Mr. DEAL. That seems to fly in the face of the testimony that Mr. Rosenfield had submitted as to what happened in the State of Florida, which immediately after their legislation was put in place, two of the larger ones immediately asked for rate increases and indicated that their reforms had no relationship to the cost of malpractice coverage.

How do you distinguish that?

Mr. SMARR. If you are referring to the cap on noneconomic damages that is in place in Florida, I can't remember if it is a $250-cap or a $500,000 cap, that cap only applies in cases where the issue is settled through arbitration; and that rarely happens because both sides have to agree to arbitration. So the cap in effect is not in effect.

Mr. DEAL. Okay. We have some very qualified people on this panel. I am going to ask you about the portions of this bill that, in my opinion, should relate to overall cost and their relation to the marketplace. I am going to ask if any of you have any studies to indicate if any of these have individually been scored as having an effect on premiums or availability, the cap on noneconomic damages.

Does anybody have any statistics to show what effect, if any, that has on rates or availability of coverage? What about statute of limitations?

Excuse me. Go ahead.

Mr. SMARR. Yes, sir. The Congressional Budget Office did indeed score that.

Mr. DEAL. Did they score that element alone as having a cost factor associated with it?

Mr. SMARR. I believe that is cited as being the primary driver, yes, sir, but I would have to go read the scoring analysis.

Mr. DEAL. So by capping the pain and suffering area, that has an effect on the ratio, on the availability and the cost of liability insurance?

Mr. SMARR. Yes, sir.

Mr. DEAL. Statute of limitations change? Anybody have anything associated with that? The apportionment of damages, anybody have any information indicating that makes a difference?

Mr. HURLEY. May I add something? I think there have been studies done of these things. I have not personally done those studies, but I think a couple of references have been made to studies that did look into some of these elements. They would have been done, for example, by the Office of Technology Assessment back in the earlier part of the decade, in those types of timeframes.

There have been other academic studies done by RAND and others that looked at some of those. Those might be helpful to access.

Mr. DEAL. Would that be true of the apportionment of damages provision, the collateral source rule, the periodic payments?

Mr. HURLEY. I think most of those elements have been addressed.

Mr. DEAL. If any of you have that material, I think it would be helpful if you could get that to us at a later time.

Let me tell you about one of the things that concerns me. And, Mr. Smarr, I have taken your statistics on chart 14, and I think all of us are concerned that we deal with this issue fairly.

Based on your mean indemnity payment of $310,215, if I calculated out using the limit on collateral fees for the plaintiff's attorney, let's assume you won that case at your average $310,000. As I calculate it out, he will be paid $78,198 out of that award.

Now, if I look at what you are paying your attorneys to defend that case, they lost the case, they are paid $91,423. In other words, the winning plaintiff's lawyer gets only 85 percent of the amount that the losing defense attorney gets. And if you have to reduce what the winning plaintiff's attorney gets from the award being received by the injured plaintiff, you reduce that award down to the point that your losing attorney is going to be paid 40 percent of the amount that the winning plaintiff, the individual injured party, is actually receiving.

Now, how do we reconcile that?

Mr. SMARR. Congressman Deal I didn't follow the first part of your calculation when you came up with the $78,000.

Mr. DEAL. Well, I have taken the contingent fee schedule on your average award of 310,000-plus. A winning attorney who gets that award is going to receive a little over $78,000; your losing attorney, by your statistics, is going to be paid in excess of $91,000.

What I am saying is—well, my bottom line, I guess, is, would you favor a situation in which the loser pay prevails? Or would you consider it fair that if we are going to disclose collateral sources, where some of these expenses may have been paid, the jury be told that the plaintiff's attorney is going to get a certain percentage of the award or anything along those lines?

You know, I think there is a basic element of feeling that the person who is the injured party here and their attorney are having to take the risk in filing the suit. I know you win most of the cases, I know you do; but if we are going to reveal collateral source, shouldn't the jury also know in this average award that 25 percent of it is going to go to the plaintiff's attorney and that they are not allowed to award the winning party that 25 percent? Is that fair?

Mr. SMARR. Award the winning party 25 percent?

Mr. DEAL. Yes. Yes. They are not allowed to consider an award for the plaintiff's attorney who wins the case, are they?

Mr. SMARR. Well, the plaintiff's attorney who wins the case gets the contingency fee, which is far in excess of 25 percent, as I understand it.

Mr. DEAL. Not according to what the law calls for that we are looking at. But he has to take that out of his plaintiff's award.

Mr. SMARR. That is true. That is the way the system works.

Mr. DEAL. Well, would you be amenable to the jury knowing that?

Mr. SMARR. My organization does not have a policy on that, and——

Mr. DEAL. Because your defendant's attorney is going to get paid anyway, aren't they, whether they win or lose?

Mr. SMARR. That is true.

Mr. DEAL. In fact, according to your chart, get paid a little more to lose than they do to win.

Can you give us an idea what the average per hour rate is that your companies are having to pay for defense attorneys?

Mr. SMARR. These costs are not, by the way, just attorneys' fees. About 75 percent of the costs are attorney fees, but they are also expert witnesses and court costs that are included.

Mr. DEAL. Expert witness fees are usually other doctors that are being paid to come testify.

Mr. SMARR. Usually other doctors; that is right.

Mr. DEAL. Can you give us an idea what the average per hour rate is being paid for the defense of these cases?

Mr. SMARR. I do not know an average because we have not computed one, but lawyers usually make $150, $200 an hour, $250 an hour.

Mr. DEAL. In this area, they get paid substantially more as a general rule, wouldn't you think?

Mr. SMARR. In malpractice work, my own personal experience in trying to control these costs is that the companies do a pretty good job of riding herd on the defense attorneys and keeping their fees down. The attorneys do a good bit of business with the malpractice companies, so they have some leverage over the defense attorneys so the fees are not as high as if you went downtown and hired a——

Mr. DEAL. Less you misunderstand my position, I do support the legislation. I just think there are some hard questions that we have to answer, and I think if you can help us answer those, we need to answer those.

Mr. BILIRAKIS. The gentleman's time has expired. I apologize, Mr. Smarr.

Mr. Waxman for 5 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

I believe medical malpractice is a serious problem, but I am amazed when my Republican colleagues want to take issues like health care for these seniors and the poor in our society and shift all that over to the State or important national environmental standards and say, we will let the States deal with it. Suddenly they don't think the States are capable of dealing with the medical malpractice issue even though it is the States that license the doctors and health care professionals, the States that regulate the insurance ndustry, and the States that discipline medical professionals if they don't do their job adequately.

I was involved with—as Mr. Hiestand pointed out in his testimony, the California proposal prior to when it was adopted when I was in the State legislature. But California adopted a proposal that I didn't fully agree with because I don't like the idea of arbitrary limits on recoveries for pain and suffering. But California did what it did; other States can do what they think is appropriate.

I think we ought to let the States operate in this area and not have the Federal Government take it over. I don't think Washington knows the best for everybody in the country, and I think States ought to deal with this matter. But the whole purpose of medical malpractice lawsuits is twofold: one, to make the injured person as a result of medical malpractice whole, to compensate them for their loss; and second, to deter doctors and other medical professionals from committing medical malpractice.

If you are going to make someone whole who has been injured, you ought not to put a limit, an arbitrary limit, on what they can recover. Heather Lewinski is here and testified from her own experience. To just say there ought to be an arbitrary limit of $250,000 for all the pain and suffering you have gone through—in how many operations was it, 13——

Ms. LEWINSKI. 14.

Mr. WAXMAN. [continuing] 14 separate operations from a doctor that didn't know what he was doing, committed clear malpractice; and to say that you were going to be compensated by an arbitrary amount for the rest of your life, how does that make you feel? Would you feel that you were compensated fully if you were given that limit?

Ms. LEWINSKI. Absolutely not.

Mr. WAXMAN. I think it is so unfair not to look at each individual case and then decide what is the right compensation for that individual.

Now, California has a law that appears to be successful; at least some people think it is very successful. But California does a lot of things that MICRA doesn't do. As I understand it, California regulates insurance a lot more than if this bill were adopted at the Federal level.

Is that right, Mr. Rosenfield?

Mr. ROSENFIELD. Yes, sir.

Mr. WAXMAN. So I don't know if the Republicans are going to say we ought to regulate insurance at the Federal level. I doubt it. They have been pretty accommodating to the insurance industry as long as I have been in the Congress of the United States.

So it is troubling to me to hear this notion that Washington knows best, one size fits all, that we can take away from the States the responsibility to figure out what is best for their own people, and then put some limit that is arbitrary on what somebody could recover when they are injured.

Now, whatever the figure someone had about the number of people that are injured from medical malpractice that never get any recovery, never even get into court—do you know that figure, Mr. Rosenfield?

Mr. ROSENFIELD. I think it is only one out of every eight injured victims actually filing a lawsuit.

Mr. WAXMAN. Why is that?

Mr. ROSENFIELD. Maybe the nature and extent of the injury, maybe that they are not sufficiently represented. In California, it is certainly because MICRA alters the cost-benefit ratio to make it impossible for an attorney to take all but the most egregious cases involving all but the most wealthy people.

Mr. WAXMAN. Well, the idea of a limit on pain and suffering was to—somebody said, to balance it out. But the real purpose then is not only not to compensate the person adequately, but to keep them from being able to get a lawyer?

Mr. ROSENFIELD. The undeniable impact of California of MICRA—and this has been and acknowledged by the insurance industry's top defense counsel who spoke before Congress on this point—is that it has deterred legitimate cases from getting into the courthouse.

Mr. WAXMAN. Let me ask another Californian, Mr. Hiestand.

Do you believe that the limit on pain and suffering of 250,000, which has not been adjusted for inflation, keeps some people from ever getting a lawyer to represent them?

Mr. HIESTAND. Well, the statistics don't show that. The frequency, that is, the number of claims that have been failed for medical malpractice, given the growth of physicians and the growth of the population, has not changed in California both before MICRA and after MICRA. So the number of lawsuits with those adjustments would indicate that there has not been an inability for people to get doctors.

And the Federal experience——

Mr. WAXMAN. Get lawyers.

Mr. HIESTAND. The Federal experience——

Mr. WAXMAN. Do you believe that there are a lot of people who are not compensated, who are victims of medical malpractice because the system does not lend itself to hearing their problems?

Mr. HIESTAND. Well, people, as Mr. Rosenfield mentioned——

Mr. WAXMAN. Yes or no?

Mr. HIESTAND. Yes or no.

Yes. People with small injuries can't get lawyers in all kinds of contexts. And that happens in medical malpractice.

Mr. WAXMAN. I thank you all. My time has expired.

Mr. BILIRAKIS. Mr. Norwood for 5 minutes.

Mr. NORWOOD. Yes, sir. Thank you, Mr. Chairman.

Ms. Rosenbaum, I want to—I know that you have taken time to try to go through some of the definitions, which is a very hard thing to do. Not being a lawyer, it is very difficult for me to under-

stand when words don't mean anything; one person thinks a word means this and another person thinks a word means that, so sometimes it is not clear what actually the definitions are. And I think most of us appreciate your insight on this very difficult part of trying to understand H.R. 5.

You made a comment that I found interesting when you said that perhaps we have the focus on the wrong thing. And I don't want to go here particularly, but you said that maybe we ought to be really looking at economic damages rather than noneconomic damages; and I find that very interesting and would appreciate it if you would respond to the committee on that and give us your thoughts about that.

I don't want to go there because we don't have but 5 minutes, but I have been suspecting that was maybe part of the problem too.

Could you just simply answer for me, do you support any changes to the existing medical liability system?

Ms. ROSENBAUM. What I support is some intervention that would stabilize, control and not allow these rapid price swings in malpractice——

Mr. NORWOOD. Would you be good enough to respond to the committee your thoughts on what changes would be appropriate, in writing, so that we could have time to look at that?

I have some thoughts about H.R. 5 that I believe I am right on, and I want to go through some of those, if I may, with you. Get this chart put up, please. I would like to go through some of those and see if you disagree with me.

I don't believe H.R. 5 prevents an injured patient from recovering so-called "pain and suffering" or noneconomic damages. I don't believe this bill prevents that, do you?

Ms. ROSENBAUM. Well, there is a limit on noneconomic damages.

Mr. NORWOOD. I understand there is a limit, but there is not a prevention of recovery of whatever that limit is.

Ms. ROSENBAUM. My understanding is, it is a cap.

Mr. NORWOOD. I believe H.R. 5 simply establishes a minimum Federal standard of $250,000 for noneconomic damages in States that have not already set a specific monetary amount on the size of noneconomic damage awards.

Do you agree with that?

Ms. ROSENBAUM. I do not. I think the preemption language only withholds preemption in those States whose limits are stricter.

Mr. NORWOOD. There are other attorneys who don't agree, obviously, the people—the lawyers who wrote up the bill; and somehow or another we have to figure that out. Perhaps—could you give us some information on that?

It is my understanding that the $250,000 for noneconomic damages in States that already have set an amount—if the State of Georgia sets an amount of 350,000, that is the amount that is going to be in the State of Georgia, according to the results of this bill. And I believe that—help me if you don't. I believe H.R. 5 does not change existing straight caps on noneconomic damages, even though some of those may be higher than 350,000—and obviously they are, according to that chart behind us.

And you don't believe that to be true in this bill?

Ms. ROSENBAUM. Looking at section 11(b) of the bill, I do not.

Mr. NORWOOD. I am informed by another lawyer that the 11(c) part of the bill does allow for that. So again it is one of those areas where we have a very friendly disagreement.

I guess I believe the 11(c) part does. I believe H.R. 5 does not prevent a State from keeping or enacting an entirely different standard to guide the award of compensatory and/or punitive damages.

Do you think H.R. 5 doesn't do that?

Ms. ROSENBAUM. I am sorry. Would you repeat the question?

Mr. NORWOOD. H.R. 5 doesn't prevent a State from keeping or enacting a different standard to guide the award for compensatory and punitive damages. In other words, other States can have higher damages if those other States pass that in their State.

Ms. ROSENBAUM. I would have to look at 11(b) and (c) and respond to you in writing. And it would be of great help to me if this part of the record could be sent to me so that I will have your full question.

Mr. NORWOOD. I am trying to make sure what I believe about H.R. 5, that I am going to vote for, is in fact so and I believe it. But I don't mind giving you the opportunity to make me look another way.

Last, let me point out this chart behind us that was put up—Mr. Smarr and others, I think you were pretty wise not to pay attention to that because you look at the top five who have high caps, also high premiums, and one would think it would be implied that all those caps didn't work.

But I think we all ought to note that Nevada and Ohio and West Virginia—in fact, West Virginia just had a special session of their legislature and just put those caps in place. So to say those caps equate to those premiums is very misleading.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Dingell for 5 minutes.

Mr. DINGELL. Mr. Chairman, thank you. I would like to defer to Mrs. Capps, if I could.

Mr. BILIRAKIS. Well, Mr. Stupak would be first.

Mr. Stupak for 8 minutes.

Mr. STUPAK. Thank you, Mr. Chairman.

And thank you, Mr. Dingell.

Mr. Rosenfield, you indicated in your testimony that insurance companies are exempt from antitrust.

Should Congress repeal that and why?

Mr. ROSENFIELD. Well, the voters repealed it in California because it is anticompetitive. And one of the problems with the industry has been that it circulates among insurers' data concerning losses, expenses, projections of future losses whether they materialize or not; and the circulation of this information is, by definition, anticompetitive since it allows all the other insurers to base their rates upon the same data.

Mr. STUPAK. So we heard testimony of a 400 percent increase, like that in California. If you are not subject to antitrust laws, you can set it wherever you want; isn't that correct?

Mr. ROSENFIELD. That is correct. And it is very easy, because they circulate this insurance among themselves as insurers and ev-

erybody is aware of it, everybody knows what all their competitors are doing.

Mr. STUPAK. So if we are really concerned about lowering rates for malpractice, should we not take away that exemption for insurance companies and make a more competitive market to help drive down the cost of insurance?

Mr. ROSENFIELD. That is what we did in California, and the impact not only on medical malpractice, but on auto insurance premiums was profound.

Mr. STUPAK. Well, we had that amendment, and actually it failed. So hopefully it will be part of this bill if it moves forward in this committee and onto the House floor.

Mr. Smarr, in your testimony, I was intrigued with your exhibit number 22 where you had the 2000 rates for L.A., Milwaukee, Chicago, Philadelphia, Miami. I come from Michigan, and we mirror Illinois quite a bit. Looking at it, Illinois doesn't have any caps, and Michigan does. In fact, our caps go back to, I believe, 1982. They were then increased again in—not increased, but more limitations were put on plaintiffs in 1994.

And in your chart here on exhibit number 22 you have for IM, which is internal medicine, $26,000 paid in Chicago; GS, general surgery, $68,000—these are in premiums—and then OB/GYN, $102,000. And you have got, "as reported by the Medical Liability Monitor."

Well, you know, I have got the Medical Liability Monitor here in front of me, a copy of it, and it is October of 2002, the same time; and when you take a look at internal medicine, it is $19,000, this for State of Illinois—Michigan, it is $26,000, again we have the caps.

On general surgery, it is only $51,000, not the $68,000 you report; Michigan it is $71,000—again, Illinois no caps, Michigan has caps.

And your OB/GYN for Illinois—again, no caps—at $79,000; Michigan, with the caps it has $88,000.

Every one of your figures is one-third higher than what is reported. And we are both citing the same Medical Liability Monitor, which you said was credible, and you even cite it in your report. How do we get a third higher for these folks in your figures when I have the other figures from the magazine that are a third less?

Mr. SMARR. Well, Congressman, I am reading from the source document of the ISMIE mutual insurance company, which is the largest writer in the State; it is a company that is formed and operated by the State medical association.

Mr. STUPAK. So you are saying, you took only one medical malpractice provider and used their statistics, which were probably the highest in Illinois. You didn't take the average of all the underwriters in Illinois to get the average that an Illinois physician would pay?

Mr. SMARR. I took the leading writer in the State that had the largest market share.

Mr. STUPAK. And also the highest?

Mr. SMARR. No, I did not do it with that in mind.

Mr. STUPAK. Answer me this question. We will disagree on the premiums.

Why would Illinois—why would Michigan be higher, $88,000 to $79,000 for OB/GYN, 71 to 51 for general surgery, 26 to 19 for internal medicine—why would Michigan be higher, and we have all these caps? We have had them in place for over 20 years. Why would it be higher than Illinois that have no caps if caps are the panacea to our problem here.

Mr. SMARR. First of all, ProAssurance has higher rates in Illinois than does ISMIE. Michigan, I am told, has what is called a frequency problem in that the doctors in Michigan actually buy lower limits of insurance than in other places in the United States, and they get sued more often.

Mr. STUPAK. Wait a minute. They have got lower rates? But according to your monitor, Medical Liability Monitor, which you agree on, Michigan's premiums are actually higher than Illinois. You would think Illinois, then, would have these problems. We don't have any caps there in Illinois.

Mr. SMARR. Again, it is related to the tort environment and the area of Michigan.

Mr. STUPAK. Well, the tort environment, Illinois would be much more generous to a plaintiff because they have no caps; and Michigan has caps, so they would be less generous to a plaintiff, correct?

Mr. SMARR. Michigan's caps simply aren't working.

Mr. STUPAK. How can they not work? If our cap is $280,000 in Michigan for noneconomic damages, how does an jury award more than $280,000 and the judge not roll it back if that is the State law?

Mr. SMARR. I believe the caps are higher for serious injuries.

Mr. STUPAK. Oh, really?

Mr. SMARR. There are exceptions to the Michigan cap, yes, sir, there are.

Mr. STUPAK. The highest you can get in Michigan, like the loss of a child, is $500,000. So how is that so much higher? I mean, in Illinois it is unlimited.

Mr. SMARR. Again, on a per doctor basis, if you will, there are more lawsuits. There is a frequency problem in the State of Michigan which is also driving rates in that State.

Mr. STUPAK. Do we have bad defense attorneys there or what?

Mr. SMARR. I don't know.

Mr. STUPAK. Let me ask you this one.

You know, you talk about your median. I want to go to your chart again; I think it is number 13 were you had almost like a half million dollars. You had, chart 13, median verdict is $496,726. And in the National Practitioner Data Bank—are you familiar with that?

Mr. SMARR. I am.

Mr. STUPAK. Is that a credible organization?

Mr. SMARR. Yes, sir, it is.

Mr. STUPAK. They have got—I have got to read right here from the National Practitioner Data Bank—the median medical malpractice payout for 2000 is $125,000 not $496,000.

How do you reconcile that? It is four times, your numbers are four times higher.

Mr. SMARR. I can reconcile that, Congressman.

First of all, you are comparing a median with a mean. Second, you are comparing an average payment value for all payments with an average payment value for a verdict.

Mr. STUPAK. You agree with me, these numbers just don't jibe?

Mr. SMARR. They are apples and oranges.

Mr. STUPAK. Apples and oranges. Okay.

How about this one. You run an insurance company. Some professors at Duke University, for Indiana, State of Indiana, looked at the medical liability issue there. And we always hear this thing that insurers constantly must settle frivolous lawsuits in order to make them go away.

Do you settle frivolous lawsuits to make them go away, your company?

Mr. SMARR. I don't work for a company. I work for a trade association.

Mr. STUPAK. Your association that provides the insurance——

Mr. SMARR. The physician-owned companies are much more reticent to make what is called an economic settlement. And that is where it is cheaper to pay a small amount in indemnity than incur large amounts in defending a claim. It is part of the fabric of why the company has reformed.

There are some cases where it is—where it is done, such as there are changes in the records and things like that.

Mr. STUPAK. Let me read this statement, professors from Duke Law School, who did this for Indiana, when they were looking at their case, they said—here is what the insurers said, We don't settle frivolous cases. The insurers' policy on frivolous cases is based on the belief that if they begin to settle just to make them go away, their credibility will be destroyed and this will encourage more litigation. Is that true?

Mr. SMARR. I believe in that, yes, I do.

Mr. STUPAK. So you don't settle frivolous claims? The only cases settled are valid claims?

Mr. SMARR. By and large, that is true. There are exceptions.

Mr. STUPAK. I have got to stop now. I was just having fun.

Mr. BILIRAKIS. Let's see.

Mr. Shadegg for 8 minutes.

Mr. SHADEGG. Thank you, Mr. Chairman. I want to thank each of our witnesses for being here today. I think it is a very interesting discussion. As is often the case, I just come at this from a different perspective, perhaps, than anybody else. I am deeply troubled by the crisis we face in the tort system in medical malpractice right now, but I am also deeply troubled by the notion of hard dollar caps. I just can't get beyond the notion that that is government price fixing.

When Ms. Lewinski sits here and you think about the application of a government-set cap to her circumstance, it is a very, very difficult situation. I have supported this legislation in the past, and I may support it again, but I simply believe we are going in the wrong direction.

I want to follow up on some of the questioning that Mr. Stupak just asked. Is there anybody in this room that doesn't believe that, in fact, we are—that there are many claims in which settlement is paid at some cost higher than its merit to avoid the cost of defense?

That is, does anybody in this room believe that the ability of someone to bring a lawsuit in the United States and to know that since we do not have loser pay, there is no penalty, isn't used to extort settlements for some cases that lack merit?

Does everybody agree that that does, in fact, happen?

Mr. ROSENFIELD. Are you discussing medical malpractice or all tort laws?

Mr. SHADEGG. Let's stay with medical malpractice. That is the topic. You believe that does not happen?

Mr. ROSENFIELD. I can tell you definitively in California it is simply not feasible for an attorney. It would be economic insanity for an attorney who is paid on a contingency basis—unless they are being paid on an hourly basis like defense lawyers. If you are being paid on a contingency, there is no economic advantage to bring such a case.

Mr. SHADEGG. If you get a settlement in that case, you don't get the gain of that settlement?

Let me ask a different question. Does anybody on the panel believe, for example, that meritorious claims should not be paid? Does anybody believe that if you have got a meritorious claim, you should not be able to recover?

All right. Does anybody believe that frivolous claims should be paid?

I think that takes us to a reform that we are not contemplating in this proceeding today and that we should be, and that is some form of loser pays.

First of all, I believe the United States is the only Nation in the world—at least to my knowledge; there may be one or two others I am not aware of, and maybe one of you can bring it to any knowledge—the only Nation in the world that abides by a strict American rule in which losers are not accountable for the cost of the defense of the prevailing party. We call it the English rule, but in fact, it is the rule in all the rest of the world that if you bring a lawsuit and you lose, you are required to pay the attorneys' fees.

It seems to me that the reason—and I have done some review of the literature. This is a Law Review article by the Arizona Journal of International Comparative Law; and in it, it has a lengthy discussion of loser pays and of the so-called "American rule" versus the so-called "English rule," the English rule, in fact, being the rule of the rest of the world, which is losers do pay.

And in that discussion one sentence stuck out at me as something very, very impressive. It said—at the end of the day, basically it said, we are a society that really does not want people to be denied justice because they are not rich enough to pay for it. And I think that is exactly right; I think there is a sense that when you have a loser-pay rule, it would mean that those who cannot afford to bring the lawsuit cannot bring the lawsuit. For that reason, out of fairness, we don't go to a loser-pay rule.

But I would argue that that is making a mistake. I would argue that we should look at loser-pay and say, you know what, there are serious potential problems with loser-pay because it could discourage people without financial resources from bringing meritorious lawsuits.

So why is it we do not proffer language that says the loser shall pay provided, however, that the court shall look at the merits of the claim at the time it was brought, at the reasonableness of the conduct of the attorney who brought it, at the reasonableness of the conduct of the attorney in pursuing it through the litigation itself and may make an award, and take all those factors into consideration? Because it seems to me that in America we do not want to discourage anyone, whether they are wealthy or not wealthy, from bringing a meritorious lawsuit.

But it also seems to me that it is undeniable that the current American rule, which says you can bring this lawsuit and no matter how meritless the claim is, you can take your shot at extorting some kind of settlement and there is no consequence for it—are any of you aware of any State or any country that has looked at some form of a modified loser-pay, that looks at the merits of the claim in determining an award against the losing party?

Mr. ROSENFIELD. Congressman, in California that actually was raised as a possibility, that proposal. And they could not work out language in the legislature that adequately protected against those situations in which it was a legitimate case; that, for one reason or another, was not successful. It was that danger that caused the proposal to fail.

Mr. SHADEGG. It seems to me what we are talking about is fundamental reform of the system. It is a system that is abused, but it is a system I believed in. I worked in a tort law firm for a number of years, and I am very painfully aware that the tort system helps people who need help, who don't have resources.

Mr. ROSENFIELD. I just want to say, Congressman, that you nailed the fundamental problem with the cap, which is the cap, by definition, affects a nonfrivolous case.

Mr. SHADEGG. That is right. Ms. Lewinski's case is a classic example of why hard dollar caps create very, very serious problems.

I want to ask another question. It seems to me you could also submit a jury instruction which educates the jury on where the proceeds that pay any claim will come from, fundamentally explain to the jury, look, if you make an award in this case, you must understand it will likely come from a fund established by contributions, insurance payments paid by everybody, we all pay for them, so you bring some rationality to their deliberation process.

They could then go on and say, you know what, this is a meritorious case, and I don't care where that fund comes from, it may come from all people who get medical services, but in this case this doctor did something outrageous, such as with Ms. Lewinski, and by gosh, we are going to award a judgment and we are going to award a big judgment in this case, something far in excess of $250,000, a pretty small sum of money for some of the outrageous kinds of injuries that can occur.

It just seems to me that when we pursue only arbitrary caps as a way to address the kind of problems that exist in this system we are making a grave mistake.

Dr. Palmisano, do you want to make a comment on that? Would your organization be willing to look at other remedies besides regulatory caps?

Mr. PALMISANO. Yes, sir, the American Medical Association, as I stated earlier, has a policy in favor of the MICRA law.

But we also have—last year we formed a committee to look at all possibilities as we go forward. We believe the MICRA law needs to be implemented now. We believe there is an emergency in the United States, certainly in 12 States. We are looking at a number of things.

On loser-pays, we do have a policy on that. We would glad to submit that.

Mr. SHADEGG. I would like to see it.

In the 6 seconds I have, I want to make it clear, I intend to offer a loser-pays amendment. I intend to offer an amendment I offered a year ago on EMTALA, saying if a doctor is forced to give care under EMTALA and that care is not compensated, that it should be the Federal Government that responds in any damages that are awarded against that doctor.

I may offer some form of an amendment dealing with a jury instruction to instruct the jury about awards. It may be, what we ought to be doing is looking at not having the contingent fee come out of the award, but submit the issue of attorneys' fees to the jury after the fact.

I don't quite know why you wouldn't say after a defense verdict, let's—turn to the jury and say, you awarded the defense verdict in this case. Do you, the jury, believe this was a frivolous lawsuit that shouldn't have been brought, in which case you are going to award attorneys' fees against the losing party; or do you, the jury, believe when they brought this lawsuit, it appeared to be a pretty meritorious lawsuit and the plaintiff's attorney was reasonable and you are not going award any attorneys' fees against the losing party and in favor of the defense party?

It seems to me we can be more creative in this process. I appreciate the time.

Mr. GREENWOOD [presiding]. The gentlelady from California, Mrs. Capps.

Mrs. CAPPS. I think it is so important for Congress and this committee to address barriers to the access to health care. Thank you for holding the hearing. I thank my ranking member Mr. Dingell for yielding his time to me, so I could go ahead.

One emerging barrier seems to be the rise in medical malpractice insurance rates that are taking place in various parts of this country. I want to associate myself with the remarks made by Henry Waxman and Anna Eshoo, my colleagues from California, and also my colleague from Texas, Mr. Green, that these are cases which are tried in State courts. Doctors are licensed by States; I think it is appropriate that this matter be handled by States, as it isn't very many.

And also my colleague, Ms. Eshoo, who noted that if there is great inertia when setting caps or fixed awards, inertia about raising them according to the adjusted cost of living, that the $250,000 cap in California is actually worth about $68,000 in today's money.

That being said—and, Dr. Palmisano, I am pleased that you are here representing the AMA and doctors in our country, many communities are asking serious questions about how they can keep their doctors in their communities. And the question we have to

ask is why doctors are increasingly leaving the field and showing their dissatisfaction.

Your counterpart in California, the medical association, recently surveyed doctors; 75 percent of those who responded described the practice of medicine as being less satisfying now than it was 5 years ago, only 9 percent find it more satisfying. Another finding: 53 percent who are dissatisfied cite low reimbursement rates and 53 cite managed care hassles as the causes, both topics in which we have a role to play in Congress.

I live in California. This is very disturbing news for those of us who get our medical care in that State. Yet this is the State where we have had medical injury compensation reform, MICRA, for almost 30 years. Now, there is still serious debate, and I am happy we are engaging in it, about why premiums are rising and what should be done to stem that growth. Insurance companies argue that we need to limit noneconomic damages to patients who have been harmed by a doctor's mistake or negligence.

At this point I want to thank all of our expert witnesses for your testimony today, but I want particularly to thank Heather Lewinski. Your bravery did not go unnoticed by me. And if it is your family that is with you, they can be very proud of what you have done with a very horrible experience in your life. You are sitting before us, and testifying is hard, it is nerve-wracking—it is even for me, being on this side of the aisle—not for any gain that will benefit you, but because of what you personally have gone through. And you are, to me, such a fine example of someone whose true spirit comes from within and who will take a very horrible time in your life and experience and negligence and make something positive for someone else out of it.

And I hope that is the case, and I wish you well. You are such an example to me of how this legislation could penalize innocent victims of medical negligence.

Discriminating as it is against children, moms who stay at home, people who have disabilities and people who earn low wages. It says what we are going to do if we pass this legislation is that the health and well-being of a corporate CEO is worth more than the health of a janitor or a janitor's child. Because economic damages are based on wages, the CEO would get more money in damages.

Noneconomic damages would make—are the only real guarantee for to us make sure that everyone can be treated fairly.

There is a very prominent case in the news now that is going to really provoke a lot of discussion on this topic. If I could turn to you again Dr. Palmisano, you are a doctor, and I don't have to remind you of your Hippocratic Oath. I am a nurse, and I think we see things very clearly in this arena. You have just heard the story of Heather Lewinski; you know there are other stories like hers.

I will ask you point-blank so you can answer for the record: Do you think she was well served by her doctor?

Mr. PALMISANO. Well, obviously, from what she has told us, she was not well served by her doctor. It is tragic whenever someone is hurt through negligence.

Mrs. CAPPS. All right.

To go on, her doctor and his insurer paid the damages. Do you think he should be allowed to continue to practice medicine after

what has happened to Heather and her family? Do you think there should be have been any disciplinary action taken against him?

Mr. PALMISANO. I think the American Medical Association supports strong State board medical examiners to review, in fact, in every case where there is payment in a medical malpractice case, that goes before the State board of medical examiners. It is mandatory reporting. We should have State boards to look and see whether or not a doctor needs to be removed from practice.

Mrs. CAPPS. With the number of cases before us in this country, a small percentage of which are reported and acted upon, perhaps that is something that should be strengthened. But in this case, Heather's story, she received no economic damages in her suit because of her age. Under the proposal and the legislation before us, she would have received only $250,000. Instead, the court awarded her noneconomic damages of more than a million because the jury and the court system that saw and tried this situation felt that that was appropriate. Do you think it was too high?

Mr. PALMISANO. As far as—do I think what was too high?

Mrs. CAPPS. The award that she was given.

Mr. PALMISANO. I don't know what the award was.

Mrs. CAPPS. It was a million dollars. Am I right?

Ms. LEWINSKI. The jury awarded me $3 million.

Mr. PALMISANO. Well, you can't put a price on life. You can't put a price on serious injury. What you have to do is try to balance what you are going to do if you can't compensate—if you can't take care of the rest of the American public.

Mrs. CAPPS. I want to underscore the sentence you just said. You can't put a price. But that, in effect, is what this Congress is attempting to do with this.

And it is my understanding, Ms. Lewinski, that you actually had to settle for quite a bit less.

Ms. LEWINSKI. Yes, because of the lack of insurance that the doctor had.

Mrs. CAPPS. Because of the amount of insurance that the doctor had. Keeping in mind that you have had 14 subsequent surgeries, and who knows what will be awaiting you in the future of your life? This is something that only you know.

Again, we have a jury system that is designed for the story to come before a jury of your peers or of your parents' peers to make this case.

If I could now turn to you, Mr. Rosenfield, and ask you about sincere—my California, one of my California representatives there to see—and I don't have much time left—since MICRA—would you say this again, what have the rates of malpractice insurance done in those first 13 years?

Mr. ROSENFIELD. The premiums for doctors went up 450 percent after MICRA was passed, through 1988.

Mrs. CAPPS. Is there anyone on this panel who believes that MICRA by itself capped—did anything to affect the insurance premiums in California?

You do. Okay. Well, that is a little bit of a pull right there.

For some reason, Mr. Rosenfield—and you were instrumental in this—Proposition 103 passed, which meant that all of the voters in the State of California had to approve something, which meant

they didn't quite trust this insurance industry as it was self-regulated.

After Prop 103, was there any sign of malpractice insurance companies leaving the California market in response to this effort to control them?

Mr. ROSENFIELD. No.

Mrs. CAPPS. Thank you very much. Thank you for my time. And I will yield back what I don't have left. Thank you.

Mr. GREENWOOD. Mr. Buyer is recognized for 8 minutes.

Mr. BUYER. Mr. Waxman brought up a point—you know, both political parties have to be relatively honest here. We do like to pick and choose when the Federal Government should act and when they shouldn't. We really do. And so Republicans are no different than when Democrats were in the majority. They would pick and choose and use the Commerce Clause when to act and when to defer to the States.

One thing that has worked well—as I have observed as I look at Mr. Dingell that I am a relatively young bird here, but he has seen this in his lifetime—when you look at how we establish EPA, you set out the guidelines, then you turn to the States and you let them go ahead and conduct their own environmental, but they can have stricter standards. It is a system that sort of works well. So all we do pick and choose.

I am not going to get sucked into this debate today about cap and a cap, only a cap.

I am somewhat bothered by where the debate has really gone today. I come from a State where I am very pleased that the atmosphere is pretty good. When I look back on this one, medical malpractice in the 1960's was liberalized by legislatures. There was a destablization that was occurring in the early 1970's. Indiana responded because we had an exodus of doctors. So in 1975—we had a Governor at the time who was an M.D., Dr. Otis Bowen—and I believe that what came out of that legislature is really a model.

Now, I am not king and, boy—but if I could say what would be wonderful—obviously, I come from Indiana—boy, if every State had what Indiana has, Congress wouldn't need to act.

So I guess we have members from different States today that have been saying unto this panel, Oh, comment on this particular cap and tell me why the premiums have increased and why they haven't. It isn't just about caps. I sat here and sort of made some notes as I was pondering about this, and I think that there is just a series of interrelated problems that involve regulation, that involve the social control of medical practice. There is the quality of care, of insurance markets, there is consistent assessment liability laws, there is the existing paradigm of the social attitudes toward the practice of medicine.

So the question of the equitable and efficient solutions to the series of problems involves, I think, action on multiple fronts. So you can't just say, well, legislature, what you ought to do is just throw out a cap there.

So Indiana didn't just throw out a cap. Some States may have just thrown out a cap. What we did was, we intensified the peer review system. So I tell you what, in Indiana we—yes, there are some limitations on claims, but we went ahead and we placed a

limit and said, it should be no more than $1.25 million. But then we come in and go, you know what, we are going to create a compensation fund.

So we have this government-sponsored system whereby the doc is responsible for the first 100,000 and his insurance company, but we then have a patient's compensation fund.

We also have a medical review panel. So we are focusing on uplifting the standards of practice also.

So this whole question today about changes in legal doctrine may not likely reverse the current trend. That is the reason some of my colleagues threw up a chart earlier and said, look at all these different States out there that have caps. There is no impact on premiums whatsoever. What are we doing with caps? My gosh, if those States out there are unwilling to take on multiple fronts—well, of course.

But I do have a chart. Would you throw up my chart? Who has got it? If the panel would turn around and look at this for just a second, what I have attempted to do here is look at Indiana and our contiguous States. Now this comes from the Medical Monitor, the Liability Monitor everybody is citing, and these are, I apologize, 2000 figures. But what I attempted to do here was use the lower numbers.

[The chart follows:]

Annual Medical Liability Rates*

- Michigan
  - OB - $46,976
  - Surgery - $38,821
  - Internist - $12,656

- Illinois
  - OB - $34,814
  - Surgery - $24,010
  - Internist - $7,939

- Indiana
  - OB - $13,874
  - Surgery - $9,781
  - Internist - $2,959

- Ohio
  - OB - $58,363
  - Surgery - $41,349
  - Internist - $12,992

- Kentucky
  - OB - $57,086
  - Surgery - $42,251
  - Internist - $7,746

* 2000 rates as reported by, *Medical Liability Monitor*, Vol. 25, No. 10, October 2001

Mr. BUYER. For Illinois, for example, you could go to Cook County, Chicago, and the OB is like 89,000; surgery was 54,000, and internist was 22. I tried to use the lower numbers.

But here is my point. What is occurring in Indiana where we have a good system that addresses not only costs but medical review, peer review, quality assurance; not just throwing out some form of a cap, but a compensation fund system, look at the impact it is having. So where before we had doctors leaving our State, when you look at having a system like this and you have contiguous States, guess what we have? We have an influx of doctors to Indiana. That is a problem.

So I am challenged at the moment, because I love States' rights. And now we are having to review this, saying, well, we are going to have the Federal Government come in and set standards, but look at the mess we are creating out there across the country. And I just think it is horrible.

I want to ask, is anyone on the panel familiar with Indiana's laws? Are you? And I appreciate your comments on my comments today.

Go ahead, please.

Mr. PALMISANO. Well, we are very familiar with the Indiana law as was originally proposed, because that is where Louisiana, Dr. John Cooksey, who was formerly in Congress, he got the idea of bringing Senator Benjamin down to Louisiana. And several of us met with Senator Benjamin. He explained how your law was passed, and we then introduced that law into Louisiana as Act 1465 and it became Act 817 of 1975. It was a total cap on all damages as was the law in Indiana.

It also had the medical review panel, so before you could file a claim, you had to go before a medical review panel. The plaintiff would pick one doctor in the same specialty, the defendant would pick one doctor, the two doctors would pick a third. Then there was an attorney who had no vote to make sure that everything went by the appropriate statutory requirements.

And then—so you have a patients' compensation fund. You paid a percentage of your premium for—the first 100,000 went into the patients' comp fund. That was a total cap. That gave another $400,000.

Since that time—I don't know if I am saying too much—but Louisiana, we then modified our law more like New Mexico, where we pay all medicals as incurred.

Mr. BUYER. There are some saying if you have a medical review panel, you will have an increase in scrutiny, and all that is going to do is lead to costs because you will have defensive medicine, you will have doctors asking for more tests and procedures.

But, you know what, the reverse has happened in Indiana. These doctors are now focusing more on their patients and not having to worry about that. So you may have some States out there, I am just—my editorial comment, people throwing out, this State has this particular cap and you have got this cap and you have got this cap. If you are not addressing this continuum, obviously you are not going to affect these insurance rates whatsoever. This is my own feeling.

So I am glad to see what Louisiana has done and Indiana. And these States have to do more than just throw out some cap on something.

Do you have a comment, Mr. Smarr?

Mr. SMARR. Yes, sir, I do.

The Indiana cap right now is a $1.25 million cap on all damages of any kind. And I believe the primary insurance carrier provides the first $250,000 in coverage and then the compensation fund provides a million in coverage on top of that.

Just a word about compensation funds. Your fund in Indiana is unfunded, basically. It is a pay-as-you-go mechanism. It has a huge outstanding incurred loss for claims that are going to be reported to it for coverage that is offered. There is a similar fund in Pennsylvania that ran into huge problems with its unfunded liability and the surcharges to fund that fund became astronomical.

Mr. BUYER. Our legislature addressed that. I know my time has expired, but we have addressed the underfunded.

Thank you, Mr. Chairman.

Mr. GREENWOOD. The Chair thanks the gentleman.

The gentleman from Michigan, the ranking member, Mr. Dingell.

Mr. DINGELL. I commend you for holding this hearing.

I want to begin by saying, Ms. Lewinski, we appreciate your courage and your presence this morning. I believe it is very important that this hearing reflect some of the human experiences which are involved in the questions before us.

I want to welcome you, Dr. Palmisano. I have great sympathy for the concerns that you have expressed as you very well know.

I want to thank you, Ms. Rosenbaum, for being here. And Mr. Rosenfield, you have been of help to us before.

Ms. Rosenbaum, I will direct my first question to you. Ms. Rosenbaum, you are a law professor. You have tried lawsuits. How long have you been in this business?

Ms. ROSENBAUM. I have been a lawyer now for almost 30 years.

Mr. DINGELL. Your comments were very interesting about how this bill preempts State and Federal law and literally preempts any possible lawsuit against almost anybody. And I found your testimony with regard to who gets out from under these lawsuits to be very interesting.

In the case of State laws, you referred to questions relating to fraud and deceit, unfair trade practices, civil rights laws, labor law, including workers' rights protections, criminal law, consumer protection, antitrust laws and environmental laws.

Are you sure you are right on that?

Ms. ROSENBAUM. I can only testify to what I read in this bill.

The charge to me as a witness was to take a close look at the legislation. And reading the legislation, the kind of health law I teach has me spending a great deal of time on the text of legislation. Reading the text of this legislation which is very broad and with very few definitions——

Mr. DINGELL. Let me try to make this a little quicker. It is almost—there is no exemption——

Ms. ROSENBAUM. Exactly.

Mr. DINGELL. [continuing] from any of these things with regard to the States; is that correct?

Ms. ROSENBAUM. That is correct. And, for example, the word "any person" is not modified to take public officials out of the phrase, "any person."

Mr. DINGELL. So then I note that you have here examples of—Federal law. Apparently covered are fraud and abuse, RICO, false claims, antitrust, Sherman-Clayton Act, civil rights laws, criminal statutes, Federal food and drug laws, Federal environmental health laws, Federal labor laws, Federal contract enforcement laws that provide for liquidated damages, restitution to the extent that restitution is not understood to be a part of economic damages.

Do you make the same statement with regard to Federal laws too?

Ms. ROSENBAUM. I do.

Mr. DINGELL. Now, Dr. Palmisano, I can sympathize with the problem that you and the members today at the AMA may have. I have had many of my doctor friends, who have talked to me about their concerns. I believe that they are legitimate and real. You are not here advocating that we go beyond addressing the problems of health, are you?

Mr. PALMISANO. No, sir.

Mr. DINGELL. Are you familiar with the testimony of Ms. Rosenbaum?

Mr. PALMISANO. Just what I heard today. I haven't reviewed it in advance.

Mr. DINGELL. You don't endorse that kind of broad exemption, do you?

Mr. PALMISANO. No, sir. We talk about what is on page 19 of the bill that relates to the diagnosis, prevention, treatment of any human disease or impairment of the assessment of the health of human beings. In other words——

Mr. DINGELL. Your concern here is about legitimate questions of health and legitimate protection of people who are legitimate deliverers of health care; is that right?

Mr. PALMISANO. Yes, sir.

Mr. DINGELL. Now, Mr. Smarr, I found your comments to be very interesting. You are appearing on behalf of the insurance industry, is that right, and are active in one of the associations which addresses the problems of insurance, is that right?

Mr. SMARR. Yes, I am appearing on behalf of the provider-owned or -operated malpractice insurance company.

Mr. DINGELL. Now, are you advocating the kind of broad exemption here that Ms. Rosenbaum has defined as being a real possibility?

Mr. SMARR. No, sir, we are not.

Mr. DINGELL. That would be wrong, wouldn't it, to give exemption from civil rights laws, environmental laws, consumer protection laws, labor laws, antitrust laws, fraud and abuse under RICO, or the False Claims Act, Federal environmental laws, Federal labor laws? We shouldn't give exemptions there, should we?

Mr. SMARR. This is the first time that I have heard of these issues, and so I am hesitant to comment on it. But on the face of it, yes, you are correct it would be wrong to exempt people from those laws.

Mr. DINGELL. You have read the bill and they apparently snuck this in on you too, didn't they?

Mr. SMARR. Well, I don't know that that's what the bill says. I would have to have a read of it.

Mr. DINGELL. You didn't see it there?

Mr. SMARR. I didn't see it there.

Mr. DINGELL. But I don't detect that you are ready to argue with the professor of law, are you?

Mr. SMARR. No, sir, I am not.

Mr. DINGELL. Now, Mr. Rosenfield, what do you think about this? Is it your view that this is something which relates to the matters that have been discussed by Ms. Rosenbaum?

Mr. ROSENFIELD. Well, it reminds me of that little deal that the Senate passed exempting in the Homeland Security bill, exempting certain manufacturers of vaccines. I think it is something that is stuck in there and everybody hoped that we wouldn't see it until was too late. I am glad you are calling attention to it.

Mr. DINGELL. Would you generally agree with what it is that Ms. Rosenbaum has said here with regard to this piece of legislation?

Mr. ROSENFIELD. That is our analysis, yes.

Mr. DINGELL. I read it, and with profound regret, I think that somebody is trying to pull the wool over the eyes of the committee here. And it looks like there may have been some sneaky draftsmanship here.

Not referring to you, Mr. Chairman. I have great respect for you.

But that some slippery soul outside the committees' tutelage may have engaged in a little bit of doubtful practice here. And I find that to be a very troubling, very troublesome situation.

I would note, Ms. Rosenbaum, that at page 21 I see here other Federal law, "Except as provided in this section, nothing in this act shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of law." That would tend to add to the sweep and the breadth of this exemption in all kinds of wrongdoing which we have seen in the bill before us; am I correct?

Ms. ROSENBAUM. That and the saving of the vaccine injury claims led me to my conclusion that everything else was preempted.

Mr. DINGELL. In other words, we would use here the old legal interpretation of expressio unius est exclusio alterius; is that right?

Ms. ROSENBAUM. Exactly.

Mr. DINGELL. I wonder, we ought to have—I think Mr. Chairman, we do need to have some more hearings on this matter. And I want to commend you for this hearing. What other witnesses, Mr. Chairman, do we have coming in? Do we have government, somebody from the Attorney General, somebody from HHS who would be able to help us wander through this thicket and perhaps guide us in some appreciation of just whether some really slippery rascals are going to get out from under the law here?

Mr. BILIRAKIS. I would remind the gentleman—your time is up, but I would remind——

Mr. DINGELL. In order to show my respect for the chairman I ask for 2 additional minutes so that you can tell us if we are going to have some more hearings here.

Mr. BILIRAKIS. I plan to go into a second round, very brief second round, hopefully limiting it just to the people who are in the room right now.

Mr. DINGELL. Well, that's splendid, Mr. Chairman, I would observe. But I am profoundly saddened by the fact that our witnesses here agree with me that this is a bad piece of legislation because it gives all of these profound exemptions from law to a bunch of people who are not here to say they need this help, and we don't have the assistance of people from the Attorney General or the Department of HHS or the Federal Trade Commission or the SEC. And I really think we ought to know whether these matters are, in fact, valid because it looks like there is some slipperiness going on here, Mr. Chairman.

Mr. BILIRAKIS. Markup is scheduled next week, as you already know, No. 1. No. 2, we gave the minority the opportunity—I wanted to delve into things like insurance in this particular hearing, and we gave the minority the opportunity. They didn't bring in a single insurance witness that might set out their particular point of view, which is—so——

Mr. DINGELL. Well, you see, we didn't know what Ms. Rosenbaum was going to have to say to us. What she has said here is very, very——

Mr. BILIRAKIS. We have also had other witnesses who have had other things to say to us, who are supportive of the legislation.

The gentleman's time has expired. Let us just go in regular order.

Mr. DINGELL. The other witnesses totally disagree with Ms. Rosenbaum.

Mr. BILIRAKIS. With all due respect, we are going to go into a quick second round limited—you have 8 minutes don't you? That takes care of our second round I think.

Mr. DINGELL. All but me, Mr. Chairman.

Mr. BILIRAKIS. Mr. Strickland has——

Mr. STRICKLAND. I have 8 minutes, Mr. Chairman.

Mr. BILIRAKIS. You have 8 minutes.

Mr. STRICKLAND. And if my good friend will promise me he will limit his remarks to 2 minutes I will yield 2 minutes of my 8 minutes to Mr. Dingell, so that he can continue his questioning.

Mr. BILIRAKIS. You are very free to do that.

Mr. DINGELL. I thank my good friend. I don't want to take the time away from him. I know the chairman is going to very generously give me my additional time on the second round, so that I can continue discussing these matters.

Mr. STRICKLAND. Reclaiming my time, Mr. Chairman, I did not make an opening statement, but I—before I ask my questions, I would like to say something that just, to me, is the core conflict which I face as a legislator in this matter of caps. And if I could settle this inside myself, I think I perhaps could take a different position than I have taken.

But in this country, we use the jury system to make life-and-death decisions. In the State of Texas we execute people frequently, and we are going to execute people in the State of Ohio, based on the decision made by a jury. And in fact, the President has said that he is confident that no one has been executed in Texas that

was not guilty; and he has made that assumption, based on the decision of a jury. And it troubles me that we would allow the jury system to be so valued and utilized in a way that they could actually make a decision regarding taking the life of another person, and yet, when it comes to monetary matters, when it comes to money matters, we don't trust the jury system.

We say, somehow it is flawed, it is broken, it can't be trusted. Now, I don't know how to deal with that. I just don't know how to deal with that personally. I struggle with this matter. And I am open to questions or suggestions or to information that could help me resolve that internal conflict.

Ms. Lewinski, thank you for being here. And I hope you understand how important your testimony was to all of us. As a result of your injury, did you receive any economic compensation?

Ms. LEWINSKI. Strictly pain and suffering, yes.

Mr. STRICKLAND. But not economic compensation?

Ms. LEWINSKI. No, sir.

Mr. STRICKLAND. So the only compensation you received was based upon pain and suffering, which is a noneconomic matter?

Ms. LEWINSKI. Right.

Mr. STRICKLAND. I am going to ask each of the panelists a question, and I think it is a fair question. And I am going to ask you to answer yes or no, or I need more information.

Do you think—and could we just go down the line? Do you think that Ms. Lewinski was entitled to no more than $250,000 as a result of her injuries?

Mr. HURLEY. I am here as an advisor. I would prefer to advise.

Mr. STRICKLAND. But I think you are here to give testimony, which will have an impact upon a decision that we make that could relate to how much compensation someone like Ms. Lewinski gets; and so I believe it is fair to ask for your personal opinion about this matter.

Mr. HURLEY. I am deeply saddened by the experience that Ms. Lewinski had, and I favor patient safety initiatives and all those things to try and make things better from that standpoint.

But I think the dilemma for legislators like you is to determine what the balance is between compensating on noneconomic damages, and any other type of damages for that matter, against providing health care for everyone, and making health care more broadly available. So that is the dilemma.

My opinion is, we need to make a compromise somewhere. I don't know where that compromise is. Unfortunately, that is your decision, not mine.

Mr. STRICKLAND. But would your personal opinion be that that level of compensation should be $250,000?

Mr. HURLEY. I don't have an opinion on what the right number is, sir.

Mr. STRICKLAND. Do you not have an opinion, sir, or do you not want to share it with us?

Mr. HURLEY. I have not formed an opinion about the number, to be honest with you. That is my—that is absolutely my honest answer. I have not formed an opinion about what the right answer is from my standpoint.

Mr. STRICKLAND. Mr. Hiestand.

Mr. HIESTAND. I would like people to get as much money as they could get in an ideal world for their injuries, but I don't believe that that can be done.

And in relation to your earlier concern that you expressed about tying juries' judgment, juries have to make decisions according to the rules of law, as you know; and one of the ironies I have always found in this—as a lawyer, is that if a lawyer commits malpractice on someone, depriving them of their liberty or their property, you know what the limit on noneconomic damages is for that injured party.

Mr. STRICKLAND. You know, sir, I don't. But——

Mr. HIESTAND. Zero.

Mr. STRICKLAND. But I feel like you are avoiding my question. It is a very simple question about a very particular circumstance, and you are here urging us to support H.R. 5, which will have an effect on someone like Ms. Lewinski. You have an obligation, I believe, to answer a simple question. I am asking you a very simple question.

Mr. HIESTAND. I believe that what California did in setting the amount at 250,000, what Congress did at setting it——

Mr. STRICKLAND. You are not answering my question.

Mr. HIESTAND. This is the answer: The 250,000 which Congress also set as a limit for what is paid for noneconomic damages to the survivors of the 9/11, and then currently——

Mr. STRICKLAND. We are not talking about 9/11. I am talking about——

Mr. HIESTAND. I am talking about the amount, 250,000.

Mr. STRICKLAND. With all due respect, sir, I am asking a very simple question.

Ms. Lewinski has provided us with testimony about her circumstances. It is an individual circumstance. The law we are considering will impact individuals, and I am asking you about this individual circumstance.

Do you believe that what has happened to her is a situation that should require her to be paid no more than $250,000? I think that is a simple question. And if you need more information, say, I need more information; I am not going to answer it yes or no.

Mr. HIESTAND. Well, it is a two-step answer, and the first answer is, as a person, as an individual, as I said at the beginning, I favor unlimited compensation for people who have injuries.

If I was a lawmaker, like you are, and I have to make a decision to try to balance how you are going to prevent malpractice or restore people to whole and at the same time keep access to your health care system, I favor setting some limit on noneconomic damages.

Mr. STRICKLAND. Okay. If I can stop you there.

And before I ask the others to respond, do you think MICRA was a good law when it was passed?

Mr. HIESTAND. Yes. It is a good law today.

Mr. STRICKLAND. Do you think the level of compensation was an appropriate level of compensation when it was passed into law?

Mr. HIESTAND. Yes.

Mr. STRICKLAND. Do you favor having that $250,000 indexed so that it would have the purchasing power today that it had at the time was passed into law?

Mr. HIESTAND. No, because that amount today would be in excess of $800,000 if it was indexed.

Mr. STRICKLAND. If the purchasing power is the same, explain to me why the purchasing power when it was passed was appropriate and it would not be appropriate today to have the same——

Mr. HIESTAND. Two answers. First, the experience in California is that even with the limit of 250,000, people who sue for medical malpractice today are getting more adjusted for inflation than they were getting before the $250,000 limit, more in the overall judgment, because the economic damages—lawyers have become very good at getting them up to make up for that.

Mr. BILIRAKIS. You are past your 8 minutes.

Mr. STRICKLAND. Are my 8 minutes up?

Mr. BILIRAKIS. Oh, yes. You are into your 9th minute.

Mr. STRICKLAND. Well, I am sorry because I wish——

Mr. BILIRAKIS. Well, if you hang around, Ted, you will get another shot.

The gentleman's time is up. I am being reminded that I have 3 minutes.

Does anyone disagree that—let's not go into, for the moment, in terms of what the solution might be or should be or whether it should be left completely up to the States or whatever the case may be. Does everyone agree that there are problems out there that would require enacting medical liability reform of some sort?

And we haven't even touched on it here, but when we used to talk about this subject, we quite often talked about how it increases the cost of medical care because of all of the additional tests and whatnot that have to take place, that physicians feel have to take place in order to protect themselves. Do we have any disagreements there?

You disagree? Heather, you have been listening to all of this. I guess it has probably been a little bit of an education to you. Do you—let's not go to 250,000 or 800,000 or whether there should be a cap. But do you understand the need for something to take place because a lot of doctors are leaving professions, a lot of doctors are leaving geographical areas, going to another geographical areas, things of that nature—access, in other words, being a problem. OB/GYNs are not as available these days; do you agree?

Ms. LEWINSKI. Yes, sir. But I think you are going after the wrong people, the victims instead of the real problem.

Mr. BILIRAKIS. And the real problem is the doctors?

Ms. LEWINSKI. I am not—I am just not sure why the doctors don't want to weed out the bad ones. I mean, the majority of doctors are good. Why don't you want to weed out the bad doctors?

Mr. BILIRAKIS. Yes. You said that in your written statement, which is fair.

Mr. Hurley, a real quick comment because I don't have much time. You agree that something has to be done? I believe you do.

Mr. HURLEY. I believe that you need to look at some solutions.

Mr. BILIRAKIS. Yes. Mr. Hiestand?

Mr. HIESTAND. Yes.

Mr. BILIRAKIS. Mr. Rosenfield, I know you don't believe. I don't want to know your answer, you just don't believe, because I don't have time.

Ms. Rosenbaum.

Ms. ROSENBAUM. I would recommend a complete alternative to the current system.

Mr. BILIRAKIS. But something being done, yes.

Ms. ROSENBAUM. Yes.

Mr. BILIRAKIS. Right.

Mr. BILIRAKIS. Mr. Smarr?

Mr. SMARR. Yes, I do believe something needs to be done.

Mr. BILIRAKIS. And Dr. Palmisano?

Mr. PALMISANO. Yes.

Mr. BILIRAKIS. I don't have enough time to ask you to tell me what you think should be done, but I would like to invite you and someone over here—I think asked Ms. Rosenbaum, Mr. Norwood. But I would like to invite you—if you feel that something ought to be done; if you feel that nothing needs to be done, then you don't have to submit anything—give you the opportunity to let us know in writing how you think we ought to approach this.

I mean, you are experts here, and I—you know, we do have biases. We are human beings and many people on the other side have biases and they are accused by many of being for it, in the pocket of the trial lawyers.

Mr. Waxman has already said that the Republicans are basically biased for the insurance companies. There may be some truth in all of that. But I would like to think that we sincerely want to do something that will help to solve the problem. So I invite you to do that.

Having done that, I yield 3 minutes to Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Do you want the 3 minutes now Mr. Dingell? You have that right.

Mr. DINGELL. No, I will wait.

Mr. BILIRAKIS. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

Mr. Smarr, as I understand it, there are different risk groups for doctors and, in fact, in one of the charts Mr. Buyer put up, you saw that some doctors pay much higher insurance rates because they are in different risk groups than other doctors. For example, OB/GYNs, neurosurgeons, folks like that, pay substantially higher insurance rates than, say, family practitioners; is that correct?

Mr. SMARR. That is correct.

Ms. DEGETTE. And a lot of the crisis that we have seen in malpractice insurance rates has been with these doctors who are paying high premiums in high-risk groups, right?

Mr. SMARR. They are experiencing it greater than the others; that is right.

Ms. DEGETTE. Now, as I understand it—and unfortunately, I couldn't be in Pennsylvania; I had another obligation in my district. But as I understand it, some of the conversation in Pennsylvania said, if you spread the risk out among all doctors, that the lowest-rate doctors in Pennsylvania would end up paying like $5,000 to $7,000 more per year in malpractice insurance premiums. But then

the high-risk groups would be lowered if you spread them out over different polls; is that correct, Mr. Smarr?

Mr. SMARR. The direction of change is correct. I am not—I don't know about the order.

Ms. DEGETTE. But, I mean, it makes sense.

And, Mr. Rosenfield, you—even though they say you are not an expert on insurance, I know you are an expert on insurance, so I would just like to set the record straight for that. But my understanding is that if you spread the risk out, some people, some doctors' insurance might go up a little bit, but the highest-risk doctors' insurance would go down substantially; would that be correct? Just very short.

Mr. ROSENFIELD. Yes.

Ms. DEGETTE. Thank you. Because here is what I am sitting here thinking. When I hear Mr. Hurley and Mr. Hiestand and all these folks saying we really think there is a problem—and I agree there is a problem; no one doesn't think there is a problem. The question is, who should bear the burden? And here is the thing I am thinking.

Ms. Lewinski, or the lady who, through medical malpractice, had both of her breasts amputated needlessly, or so many other victims that may not have high economic damages, why should we limit their noneconomic damages to $250,000 arbitrarily when they may have substantially higher damages, but we are limiting them?

But we are saying to doctors, we don't want to make people with low—in low-risk groups just pay a little bit more insurance premiums to help their colleagues in higher risk groups? I think that is appalling that we, as Representatives of the American citizenry in Congress, would make that value judgment to say to these victims, you are arbitrarily capped. You might have noneconomic damages of millions of dollars, but you only get this much.

But doctors, forget it. We don't want you to have to pay higher insurance rates nor do we want to examine the insurance industry.

And I am even more opposed to this bill, if possible, than as I was before. I told my dear friend I would be willing to try to work with them on this, but I just think this is the totally wrong road to go down. Thank you for your comity.

Mr. GREENWOOD [presiding]. Well, and I wanted to make a comment just to respond to my friend, Mr. Strickland, with regard to juries and how much leeway they have. Our jury system is critical and almost sacred in our country, but I would also note that we give juries the right to determine fault and we give the juries the right to determine the ability to determine guilt, but we don't say—we don't give juries, for the most part, unlimited abilities to—with regard to sentencing, for instance. We don't say, you can execute someone for shoplifting and so forth.

Mr. STRICKLAND. Will my friend yield just a moment?

Mr. GREENWOOD. I will yield to you, but just let me finish my thought here, if you would.

So I think, in fairness, this is not about whether we remove the jury system from its deliberations to determine where there is fault in a case and so forth. But what we are trying to do is, as Mr. Hiestand said, set some limits to have justice and affordable health care and available health care.

Mr. STRICKLAND. Can I respond in 10 seconds?

Mr. GREENWOOD. Ten seconds.

Mr. STRICKLAND. Some juries recommended death or life sentences. That is a pretty weighty decision. And I think as long as juries are trusted to make those kind of decisions, they should be trusted to do that.

Mr. GREENWOOD. Reclaiming my time, I understand the gentleman's point. The point I was trying to make is that this is not an alien notion that there would be some limits imposed by lawmakers on the discretion available to juries.

The other point I think that needs to be made is there has been a constant repetition of the $250,000 figure. It needs to be understood that the $250,000 figure is there, in part, because it is what has worked in California. It is there, in part, because the California delegation, many of them, felt that they didn't want us to trump their existing cap, and so we have allowed the States to set that cap wherever they wanted.

So, my friend Mr. Waxman talked about States' rights. We were very clear in this legislation that any State legislature in the country that wants to set noneconomic damage at a number higher than 250, whether it is $500,000 or $750,000 or $1 million, wants to decide to move it periodically with time and so forth, is certainly free to do that.

Now let me try to wedge a question in here for Mr. Smarr, and referring to Ms. DeGette's comment that has to do with rating.

Do you have any recommendations with regard to—because this question comes up a lot. Is it—do we have any structural problems, with the physician-owned companies at least, that have to do with classes of coverage being too small to actuarially rate fairly, with giving different rates to physicians that have more claims paid because of their malpractice than others? How does that work?

Mr. SMARR. Each company looks at its insureds usually by medical specialty and then by a geographical unit, such as a county—and this is true of a lot of lines of insurance; auto insurance, for example—and assigns relativities to each type of insured, based upon the loss experience within their medical specialty, or group of specialties, and within their county or group of counties and territories to try to fairly charge each individual doctor in proportion to his or her losses for the type of practice they have.

In addition——

Mr. GREENWOOD. My time has expired. But—so if physician A has had more losses as a result of settlement or judgments than physician B, and they are in the same county in the same specialty, do they tend to pay different rates?

Mr. SMARR. They indeed can. Through other mechanisms, the insurance companies offer to do merit rating, and that is not an unusual concept.

Mr. GREENWOOD. Thank you. My time has expired.

The gentleman, Mr. Dingell, is recognized for 3 minutes.

Mr. DINGELL. Mr. Chairman, thank you. I wanted to just go into this business, the definition of health care provider who would be sued, or health care organization.

Where is there a limitation on who might fall into that particular category of persons in the legislation? Is there one, anywhere?

Ms. ROSENBAUM. I saw none.

Mr. DINGELL. Maybe—Mr. Smarr, you are our expert on insurance. Do you find any limitation on who that individual might be?

Mr. SMARR. I have not looked at this, so I can't comment sir.

Mr. DINGELL. Should there be a limitation on who would get out from under the liability here, Mr. Smarr?

Mr. SMARR. Well, the legislation, I think——

Mr. DINGELL. No. No.

Mr. SMARR. [continuing] addresses who is covered by——

Mr. DINGELL. The question is quite clear. And there are 13 sections left?

Mr. SMARR. I don't know.

Mr. DINGELL. Who would be able to tell us?

Mr. Rosenfield, maybe you can help us. Do you find any limitations on who gets out under this liability here?

Mr. ROSENFIELD. No.

Mr. DINGELL. Is there anybody that finds any limitations on any fellow that gets out from under it?

Mr. Hiestand, maybe you are a better lawyer than all the rest of us here.

Mr. HIESTAND. I understood Dr. Palmisano is also a lawyer, referring to page 9 of the——

Mr. DINGELL. I am not sure Dr. Palmisano wants to get into this discussion.

Do you want to get into this discussion, Doctor——

Mr. HIESTAND. On page 9 of the bill, it ties it in in terms of medical and health care services and goods.

Mr. DINGELL. But who is defined?

Mr. HIESTAND. Diagnosis and treatment and I think that is the limitation. And I mean, the professor may be right that that is not confining enough. But I think the intent of the legislation was to limit it.

Mr. DINGELL. When I was in law school, I didn't argue with my professor.

Mr. HIESTAND. Pardon?

Mr. DINGELL. Are you a lawyer?

Mr. HIESTAND. Yes.

Mr. DINGELL. You are. Did you ever argue with your professor? I was always taught not to.

Mr. HIESTAND. I sometimes argued with my professor, but you know, it is not a winning kind of thing.

Mr. DINGELL. Where is the language that you would rely on to exempt some person, rather to remove them totally.

Mr. HIESTAND. Dr. Palmisano has it scored in yellow over there at the top of the page. If he could sort of read that——

Mr. DINGELL. If you tell me it is there, it must be there. I am just waiting to hear you tell me what language you rely on here. Dr. Rosenbaum can't find it. Mr. Rosenfield can't find it. I can't find it. The staff can't find it. The chairman of the committee can't find it.

I am sure the legal counsel for the committee, when we get around to holding hearings, won't be able to find it. We don't have any other witnesses who can tell us.

I am just curious who can help me out of this thicket, because I really want to know who this would be.

Mr. HIESTAND. It is page 19, I am sorry, not page 9; I misunderstood him.

The operative definition, as I understand it, on page 18 you have both; 11 is a health care provider and beneath that which—it ties into health care provider—is the health care goods or services.

When you flip over on page 19 of that definition, it says that relates to the diagnosis prevention or treatment of any human disease or impairment or the assessment of the health of human beings. I think that is the limiting language that is supposed to control both the goods and services and who they are provided by.

So I think that was the intent of the drafters here, to make sure it didn't go as broadly.

Mr. DINGELL. To what, though, does that language and that definition refer? I mean, it just sits there in glorious, solitary splendor. I don't think it refers to anything.

Mr. HIESTAND. Well, it might well be tightened up. But it says that relates to—you don't—if you are providing services that relate to diagnosis prevention or treatment of human disease, that eliminates a whole lot of other services.

Mr. DINGELL. I have to assume that you would advocate that if this defect is—as it appears at this time, that it be corrected, wouldn't you?

Mr. HIESTAND. Well, I think one ought to look at it to see if it should be tightened, yeah. I mean, you raise and the professor raises a legitimate point for consideration.

But I am just saying, the bill, I think, does intend to try to relate it, in the language on the top of page, to narrow it, and the language on the top of page 19 reflects that.

Mr. GREENWOOD. The time of the gentleman has expired.

Mr. DINGELL. I would love to see to what it refers, but it doesn't say what it refers to. It just defines. That is different.

Mr. GREENWOOD. If the gentleman from——

Mr. DINGELL. I notice my time has expired, Mr. Chairman.

Mr. GREENWOOD. It has. Perhaps you noticed me telling you that.

Mr. DINGELL. I am sorry, Mr. Hiestand. This has been a fascinating discussion. You haven't helped me, but I know you have tried hard, and I thank you.

Mr. GREENWOOD. Mr. Strickland is recognized for 3 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman. I am going to continue my line of questioning because, you see, you folks come here and I don't think any of you are under a subpoena to do so. You come here willingly to talk with us about this important issue and, hopefully, to affect our thinking about it. So I think we have got a right to explore your thinking. And I think that means you have got a right to answer or an obligation, a responsibility to answer the question.

So I will go on down.

Mr. Rosenfield, do you feel like Ms. Lewinski should have been limited to a compensation of $250,000?

Mr. ROSENFIELD. No.

Mr. STRICKLAND. Thank you. I appreciate that concise, direct, understandable answer.

Ms. Rosenbaum.

Ms. ROSENBAUM. I don't, and I think the distinction between the two kinds of recoveries are a terrible example of legalisms.

Mr. STRICKLAND. Could I ask you this then? Do you think perhaps if we are going to consider capping noneconomic damages, that it is fair to consider capping economic damages?

Ms. ROSENBAUM. I think the issue is that an individual who is damaged or injured should recover. I think the attempt to distinguish is shown in all of its futility in a case like Ms. Lewinski's.

Mr. STRICKLAND. And I think it portrays a utilitarian view of human beings, that I find incredibly offensive.

Mr.—I am sorry, I can't see your name tag.

Mr. SMARR. My name is Larry Smarr.

Mr. STRICKLAND. Larry. Respond.

Mr. SMARR. Well, my short answer is, I need more information. And let me tell you why.

Mr. STRICKLAND. Okay. And that is a fair response.

Mr. SMARR. Well, as I understand it—and I don't know if I heard everything here—the total amount received was $1 million in noneconomic damages, and I would expect under——

Mr. STRICKLAND. It was not, we are being told.

How much it was, Ms. Lewinski?

Ms. LEWINSKI. Well, the jury awarded me $3 million, but because of the lack of insurance of the doctor, I received a substantial amount less.

Mr. STRICKLAND. Did you receive less than $1 million?

Ms. LEWINSKI. Yes, sir.

Mr. STRICKLAND. While I am talking with you, who has paid for your surgeries, your multiple surgeries?

Ms. LEWINSKI. Insurance.

Mr. STRICKLAND. Your father's insurance, I understand.

Ms. LEWINSKI. Correct.

Mr. STRICKLAND. Okay. Continue.

Mr. SMARR. Well, I would expect in most cases—and I am not sure about this one—that there would be considerable economic damages that would be awarded. And that is why I need more information to know the actual amount.

But to get to your question about 250 and is that sufficient for noneconomic damages, I think we are really at a societal question here, and that is whether there is enough money in the system to pay the unlimited awards because——

Mr. STRICKLAND. Can I interrupt you? I have got 15 seconds, and I want to get to the good doctor. And I want to tell you, my very best friend is a pediatric surgeon, and I go through these conversations with him all the time.

I don't want this hearing to end without expressing to you that there is no professional group that I have more respect for and that I value more than those who provide medical services to our people. And so I hope anything that I say is not construed as an attack upon the medical profession that I truly admire and honor. Thank you very much.

Thank you, Mr. Chairman.

Mr. GREENWOOD. Mr. Stupak, if he has caught his breath, is recognized for 3 minutes.

Mr. STUPAK. Thank you, Mr. Chairman. I had to run from the floor, but I appreciate that.

Heather, thank you for testifying; your testimony is certainly helpful to all of us as we try to wrestle with this issue.

Mr. Smarr, you had indicated at one time during testimony today that the $250,000 cap you thought was reasonable and fair. Is that correct?

Mr. SMARR. Yes, sir.

Mr. STUPAK. Okay. In 1975, when California put on their $250,000 cap, did you think it was fair then?

Mr. SMARR. I wasn't aware of it then, but yes, I believe it was.

Mr. STUPAK. Okay. Well, today that $250,000 cap in 1975, by today's value—is $40,389 by today's actual dollars when compared to 1975. Do you think that is fair?

Mr. SMARR. I think that it is very hard to determine a level for noneconomic damages when it is an issue that is just unmeasurable.

Mr. STUPAK. Okay. So yes or no. I am just——

Mr. SMARR. Yes, I think that $250,000 is the correct level for it today.

Mr. STUPAK. Even today?

Mr. SMARR. Today.

Mr. STUPAK. So the $250,000 that California put in in 1975, if you took it to today's value, it is $1,547,461 in 2002 dollars. Is that fair?

Mr. SMARR. Is that calculation fair or is that a fair amount?

Mr. STUPAK. Do you think that is a fair amount for noneconomic damages?

Mr. SMARR. West Virginia has a $1 million limit, which is similar to the number you are citing, and West Virginia is one of the most troubled States in the Nation with regard to medical liability incidents.

Mr. STUPAK. So you don't think that is fair for noneconomic damages?

Mr. SMARR. I think it is too high.

Mr. STUPAK. We have heard a lot of people throw around the figure, or not the figure, but the phrase "noneconomic damages." some have even claimed that they are frivolous, pain and suffering. But this is much more than pain and suffering, isn't it?

Mr. SMARR. Yes. There are different categories of things that are deprived that——

Mr. STUPAK. Well, let me tell you, the standard jury instructions that we use probably everywhere in the State describes noneconomic damages to compensate for real, permanent harms that are not easily measured in terms of money, as we have seen by just the answers there, to compensate for these injuries; and they include noneconomic damage injuries—blindness, physical disfigurement, loss of fertility, loss of sexual function, loss of a limb, loss of mobility, and loss of a child.

Do you think that $250,0000 is a fair cap for those noneconomic damages? That is the real definition of noneconomic damages; it is more than just pain and suffering.

Mr. SMARR. I believe that $250,000 is the appropriate cap for this legislation.

Mr. STUPAK. Okay.

Mr. Hurley, you had indicated in response to Mr. Strickland that you thought health care should be for everyone. All of us up here certainly agree with that and access to it.

But do you believe that the high malpractice premiums for doctors cause patients' health insurance premiums to go up?

Mr. HURLEY. I believe that the high price of malpractice premiums does cost health care—does cause health care costs to go up, yes.

Mr. STUPAK. The Consumer Federation of America, do you know that organization?

Mr. HURLEY. I have heard their name.

Mr. STUPAK. So you don't know if they are a credible group or not?

Mr. HURLEY. I do not.

Mr. GREENWOOD. The time of the gentleman has expired.

Mr. STUPAK. Is it time already?

Mr. GREENWOOD. Time flies when you are having fun, Mr. Stupak.

Mr. STUPAK. I would like to have a little more fun, if you would let me.

Mr. GREENWOOD. You can have as much fun as you want, but not today.

Mr. STUPAK. Could I make a motion though on behalf of this side? Mr. Dingell brought up earlier about the need for having more hearings on this before we go to markup. And I know we are sort of on a fast track, but when we—we are talking about insurance and all that, insurance companies' investments and payrolls and reserve practices and costs of payouts for settlement and claims, it would really be helpful if we had that before we went to a markup, not only to structure amendments, but also to get the full picture out here of insurance premiums, insurance policies.

So I would hope that we would at least get another hearing, at least on the insurance aspect, because as a couple of the members said, we need to look at all the stakeholders here, and the insurance companies certainly are a big one.

I, for one, believe we should take away their antitrust exemption—and to get some competition in here. So could we slow this process down, or—there is no real rush here to do this, other than a calendar that someone created.

Can't we have a hearing on just that aspect of it?

Mr. GREENWOOD. Well, No. 1, I am not empowered. I am not even the chairman of this subcommittee, let alone the chairman of the full committee.

Mr. STUPAK. But you have the Chair right now. You can say that.

Mr. GREENWOOD. I don't think that the gentleman truly means to make a motion to that effect.

Mr. STUPAK. Well, consideration. Do you guys second that motion?

Mr. GREENWOOD. It will be taken into consideration. But you have got two guys here, and I have got just me, so we are not going to vote on it.

Mr. STUPAK. Oh, come on. You mean we can't get democracy in malpractice?

Mr. GREENWOOD. With that objection, I would like to enter the following documents into the record.

One is the National Association of Insurance commissioners' letter to Senator Gregg, dated February 7 of 2003; the Federation of State Medical Boards of the United States of America summary of the 2001 board actions, dated April 9, 2002; the study entitled, Who Pays for Tort Liability Claims: An Economic Analysis of U.S. Tort Liability System, written by the Council of Economic Advisers in April 2002; a study entitled Do Doctors Practice Defensive Medicine, written by Daniel Kessler and Mark McClellan; and a study entitled Did Investments Affect Medical Malpractice Premiums by the Insurance Asset Management Group; as well as documents—exhibits I believe presented by the Democrats, one entitled Medical Malpractice: What Did MICRA Do to California Premiums, and another one entitled California Medical Malpractice Premiums, 1975 to 2001.

Without objection, those documents will be entered into the official record.

We thank the witnesses. You have been here for 4½ long hours without so much as a courtesy break. Thank you for your testimony, every one of you. We appreciate it. This hearing is adjourned.

[Whereupon, at 1:55 p.m., the subcommittee was adjourned.]

[Additional materiial submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

This statement is submitted to the Health Subcommittee of the House Energy and Commerce Committee on behalf of the 93,400 members of the American Academy of Family Physicians. This hearing, entitled "Assessing the Need to Enact Medical Liability Reform," is timely. The current lack of professional liability insurance does threaten patient access to care in some states. The continued trend of increasing insurance premiums drives up the cost of health care and forces physicians to drop certain services when they cannot afford professional liability insurance.

PATIENTS AFFECTED BY THE LACK OF MEDICAL LIABILITY INSURANCE

Medical liability insurers have left the medical insurance market in the past year in alarming numbers. One major reason for this exodus is the unpredictable rise in jury awards that exists in states without adequate tort reforms. According to the Physician Insurers Association of America (PIAA), the last decade has seen a dramatic increase in awards in excess of $1 million even while the number of suits filed has remained the same. As a result of the steady rise in record-breaking awards, most insurers find it more difficult to predict their risk. The remaining insurers have raised rates or refused new applications for insurance. Family physicians are beginning to experience difficulty in finding insurance companies to provide liability insurance or are receiving renewal notices with anywhere between 60 percent and 200 percent increases for the second year in a row.

Stories of family physicians closing their practices because of liability insurance premiums are turning up across the U.S. Recently, for example, *AAFP Direct* reported that AAFP Past President Neil Brooks, M.D., sent a letter recently to the Hartford *Courant,* saying that he was giving up his practice of thirty-two years because the liability premiums had become too expensive.

In rural Morrow County, Ohio, Brian Bachelder, M.D., President of the Ohio Academy of Family Physicians, decided to stop delivering babies after his liability premium increased by $21,000 last year. Dr. Bachelder was the *only* Morrow County physician providing prenatal and obstetrical care.

In rural Chipley, Florida, Greg Sloan M.D., found his malpractice premium has risen from $4,500 to $13,600 in one year. This was in spite of a 24-year career with-

out a suit being filed against him. Dr. Sloan said it has reached the point that he cannot pay his staff and the liability premiums.

Most state laws, hospital accreditation requirements and managed care contracts mandate that physicians carry medical liability insurance. If family physicians cannot afford insurance coverage, they must choose between shutting down their practice altogether or restricting the range of services they provide. For family physicians in rural settings, this usually means being forced to stop delivering babies or providing prenatal care due to mounting liability premiums.

The tools needed to counteract this alarming trend are derived from state experiences. Last year, the Department of Health and Human Services released a report entitled, "Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System." According to this study, liability premiums have been growing rapidly in states that have failed to place reasonable limits on non-economic damages. While economic losses, such as lost wages, medical expenses and rehabilitation costs are fully compensated, non-economic damages reflect the monies collected for intangible losses. Over the previous two years, states without caps on these non-economic damages have experienced a 44-percent increase in liability premiums. In contrast, states with caps on non-economic damages of $250,000 experienced on average an increase of only 15 percent in medical liability insurance premiums.

The reforms contained in California's Medical Injury Compensation Reform Act of 1975 (MICRA) have already brought stability and fairness to the California legal system for the past 27 years. Californians Allied for Patient Protections (CAPP), a major consumer group supportive of MICRA, found that legal disputes in California are settled 23 percent faster than the national average. At the same time, the number of suits filed in California matches the national average. In the ensuring 27 years, medical liability insurance premiums have risen 505 percent nationwide compared with California's increases of 167 percent.

AAFP SUPPORT FOR H.R. 5, THE HEALTH ACT

But the states cannot, by themselves, resolve this national crisis. The House of Representatives addressed this issue by passing, H.R. 4600, The Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act in the 107th Congress. The HEALTH Act has been reintroduced into the 108th as H.R. 5. The Academy supports H.R. 5, which would bring the same rational reforms contained in MICRA to all states' professional liability systems. The AAFP supports federal legislation to stabilize the medical tort reform systems in the states since spiraling insurance premiums mean increasing numbers of pregnant women in rural areas of the U.S. will not be able to find a physician to deliver their babies.

There is an important additional reason that the AAFP supports The HEALTH Act. H.R. 5 requires that a party pay damages only to the extent that the party was liable for the harm caused. Family physicians provide primary care which is comprehensive and coordinated care for all life stages and both genders. Because they are the overall medical managers for a vast number of patients in the U.S., with responsibility for making referrals to subspecialists, family physicians need the protections of joint and several liability reforms to ensure that they are not held responsible for the clinical decisions of others.

CONCLUSION

The Academy appreciates the opportunity to address the Health Subcommittee of the Energy and Commerce Committee regarding the need to pass medical liability reform. We look forward to working with the Committee to find a workable solution for patients and physicians.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 45,000 physicians dedicated to improving the health care of women, we urge you to bring an end to the excessive litigation restricting women's access to health care.

ACOG resoundingly supports HR 5, the bipartisan HEALTH Act of 2003, and we urge this Committee, and the House of Representatives, to pass this meaningful medical liability reform legislation, which protects women's access to health care.

Across the country, the meteoric rise in medical liability premiums is threatening women's access to health care. Faced with the unaffordability and unavailability of

insurance coverage, ob-gyns are forced to stop delivering babies, reduce the number of deliveries, scale back their practices by eliminating high-risk procedures, or close their doors entirely.

This statement will also highlight how the medical liability crisis is acutely affecting a growing number of states, explaining how access to basic and important women's health care in those states is severely jeopardized because of a liability system gone awry.

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

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

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

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

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

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

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

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

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

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

II. HOW EXCESSIVE LITIGATION COMPROMISES THE DELIVERY OF OBSTETRIC CARE

Obstetrics-gynecology is 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% between 1982 and 1998. The median rate rose 7% in 2000, 12.5% in 2001, and 15.3% in 2002 with increases as high as 69%, according to a survey by Medical Liability Monitor, a newsletter covering the liability insurance industry.

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

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

Although the number of claims filed against all physicians climbed in recent decades, the phenomenon does not reflect an increased rate of medical negligence. In fact, ob-gyns win most of the claims filed against them. A 1999 ACOG survey of our membership found that over one-half (53.9%) of claims against ob-gyns were dropped by plaintiff's attorneys, dismissed or settled without a payment. Of cases that did proceed, ob-gyns won more than 65% of the cases resolved by court verdict, arbitration, or mediation, meaning only 10% of all cases filed against ob-gyns were found in favor of the plaintiff. Enormous resources are spent to deal with these claims, only 10% of which are found to have merit. The costs to defend these claims can be staggering and often mean that physicians invest less in new technologies that help patients.

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

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

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

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

III. WOMEN'S HEALTH CONSEQUENCES OF EXCESSIVE LITIGATION

The medical liability crisis affects every aspect of our nation's ability to deliver health care services. As partners in women's health care, we urge Congress to end the medical liability insurance crisis. Without legislative intervention at the federal level, women's access to health care will continue to suffer.

This crisis is obstructing mothers' access to obstetric care. When confronted with substantially higher costs for liability coverage, ob-gyns and other women's health care professionals stop delivering babies, reduce the number they do deliver, and further cut back—or eliminate—care for high-risk mothers. With fewer women's health care professionals, access to early prenatal care is reduced, depriving women of the proven benefits of early intervention.

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

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

This crisis also means that community clinics must cutback services, jeopardizing the nation's 39 million uninsured patients—the majority of them women and children—who rely on community clinics for health care. Unable to shift higher insur-

ance costs to their patients, these clinics have no alternative but to care for fewer people.

Acting now can save more women from the ranks of the uninsured. Health care costs continue to increase overall, including the cost of private health care coverage. As costs escalate, employers will be discouraged from offering benefits. Many women who would lose their coverage, including a large number of single working mothers, would not be eligible for Medicaid or SCHIP because their incomes are above the eligibility levels. In 2001, 11.7 million women of childbearing age were uninsured. Without reform, even more women ages 19 to 44 will move into the ranks of the uninsured. If fewer doctors are available to deliver babies, the crisis becomes even more acute.

IV. WOMEN'S HEALTH SUFFERS NATIONWIDE

As ob-gyns, our primary concern is ensuring women access to affordable, quality health care. It is critical that we maintain the highest standard of care for America's women and mothers. Currently, ACOG has identified a medical liability crisis in the following nine "Red Alert States": Florida, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Texas, Washington, and West Virginia. In three other states—Ohio, Oregon, and Virginia—a crisis is brewing, while four other states—Connecticut, Illinois, Kentucky and Missouri—should be watched for mounting problems.

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

A. Florida

- According to First Professionals Insurance Company, Inc., Florida's largest medical liability insurer, one out of every six doctors is sued in the state as compared to one out of every 12 doctors nationwide.
- In Dade and Broward counties in South Florida, where insurers say litigation is the heaviest, annual premiums for ob-gyns soared to $210,576—the highest rates in the country, according to *Medical Liability Monitor*.
- In a recent ACOG survey, 76.3% of the Florida ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 21.69% of Florida respondents indicated that they have stopped practicing obstetrics due to the unavailability and unaffordability of liability insurance.
- The liability situation is so severe the state allows doctors to "go bare" (not have liability coverage), as long as they can post bond or prove ability to pay a judgment of up to $250,000.
- Double and triple-digit premium increases have forced some doctors to cut back on staff, while others have left the state or have stopped performing high-risk procedures. Ob-gyns in this state are more likely to no longer practice obstetrics.
- Florida already has some tort-reform laws aimed at protecting doctors. But more recent Florida Supreme Court rulings have weakened such laws, causing the number of lawsuits to climb again. Now, Florida is one of at least a dozen states contemplating another round of legislation.

B. Mississippi

- According to the Mississippi State Medical Association, medical liability insurance rates for doctors who deliver babies rose 20% to 400% in 2002, for various carriers. Annual premiums range from $40,000 to $110,000.
- The *Delta Democrat Times* reported that from 1999 to 2000, the number of liability lawsuits faced by Mississippi physicians increased 24%, with an additional 23% increase in the first five months of 2001.

- According to the *Delta Democrat Times,* 324 Mississippi physicians have stopped delivering babies in the last decade. Only 10% of family physicians deliver babies.
- In a recent ACOG survey, 66.7% of the Mississippi ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 12.82% of Mississippi respondents have stopped practicing obstetrics.
- In Cleveland, Mississippi, three of the six doctors who deliver babies dropped obstetrics in October 2001 because of the increase in premiums.
- In Greenwood, Mississippi, where approximately 1,000 babies are born every year, the number of obstetricians has dropped from four to two. The two remaining obstetricians are each limited by their insurance carriers to delivering 250 babies per year, leaving approximately 500 pregnant women searching for maternity care, reports the *Mississippi Business Journal.*
- Yazoo City, Mississippi, with 14,550 residents, has no obstetrician.
- A Grenada, Mississippi ob-gyn recently stopped taking obstetric patients, leaving two ob-gyns to deliver approximately 700 babies a year.
- Natchez, Mississippi, which serves a 6-county population of over 100,000, has only three physicians practicing obstetrics.
- Days before HB2 (legislation aimed at reducing liability insurance costs and improving access to health care) took effect, there was a rush of medical liability lawsuits filed in Mississippi. State Insurance Commissioner George Dale said these claims will be in the system for a long time and the market for medical liability insurance is not likely to get better any time soon.
- The state's major insurer of hospitals, Reciprocal of America, is facing financial difficulties and recently asked participants to pay $30 million to help keep it afloat, according to the state insurance commissioner's office.

C. Nevada

- In December 2001, The St. Paul Companies, Inc., the nation's second largest medical liability insurer, announced it would no longer renew policies for 42,000 doctors nationwide—including the 60% of Las Vegas doctors who were insured by St. Paul. Replacement policies are costing some Nevada doctors four or five times as much as before: $200,000 or higher annually, more than most doctors' take-home pay, the *Los Angeles Times* reports.
- In Las Vegas, ob-gyns paid premiums as high as $141,760, a 49.5% increase from 2001.
- In the ACOG survey, 86.2% of the Nevada ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 27.59% of Nevada respondents stopped practicing obstetrics.
- As of October 2002, according to Clark County OB-GYN Society, only 80 private practice physicians, 14 HMO physicians, and 12 residents are doing deliveries, totaling 106 doctors. With an estimated 23,000 deliveries expected in Nevada in 2003, each physician will have to deliver 216 babies.
- According to a March article in the *Las Vegas Review-Journal,* many Las Vegas Valley doctors say they will be forced to quit their practices, relocate, retire early or limit their services if they cannot find more affordable rates of professional liability insurance by early summer.
- According to the Nevada State Medical Association, between 200 and 250 physicians will face bankruptcy, close their offices, or leave Nevada this year.
- In February 2002, the *Las Vegas Sun* reported that medical liability cases in Clark County had more than doubled in the past six years. In that period, plaintiffs' awards in the county totaled more than $21 million.
- *USA Today* reports that in the past two years, Nevada juries have awarded more than $1.5 million each in six different medical liability trials.
- Recruiting doctors to Las Vegas is extremely difficult because of escalating medical liability premiums and litigious-ness. Nevada currently ranks 47th in the nation for its ratio of 196 doctors per 100,000 population. The state's medical school produces just 50 physicians a year.
- The Nevada tort reform legislation went into effect in January 2003. In December 2002, the frequency of lawsuits filed against health care providers skyrocketed with 170 suits filed in December 2002 (as compared to 8 suits field in 2001).

D. New Jersey

- In the ACOG survey, 75.6% of the New Jersey ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 19% of New Jersey respondents have stopped practicing obstetrics.
- In February 2002, the *Newark Star-Ledger* reported that three medical liability insurance companies went bankrupt or announced they would stop insuring New Jersey physicians in 2002 for financial reasons. The state's two largest remaining are rejecting doctors they deem high risk.
- MBS Insurance Services of Denville, one of New Jersey's largest medical liability insurance brokers, estimates that approximately 300 to 400 of the state's doctors cannot get insurance at any price.
- According to the Medical Society of New Jersey, premiums have risen 50% to 200% over last year.
- According to the *Star-Ledger,* "An obstetrician with a good history—maybe just one dismissed lawsuit—can expect to pay about $45,000 for $1 million in coverage. Rates rise if the physician faces several lawsuits, regardless of whether the physician has been found liable in those cases."
- The president of the New Jersey Hospital Association says that rising medical liability premiums are a "wake-up call" that the state may lose doctors. Hospital premiums have risen 250% over the last three years, and 65% of facilities report that they are losing physicians due to liability insurance costs.

E. New York

- New York State faces a shortage of obstetric care in many rural regions. Increasing liability insurance costs will only exacerbate these access problems.
- In the ACOG survey, 67% of the New York ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 19.28% of New York respondents have stopped practicing obstetrics.
- In 2002, an ob-gyn practicing in New York could pay as much as $115,500 for medical liability insurance, according to *Medical Liability Monitor.*
- In 2000, there was a total of $633 million in medical liability payouts in New York State, far and away the highest in the country, and 80% more than the state with the second highest total.
- Increased insurance rates have forced some physicians in New York to "quit practicing or to practice medicine defensively, by ordering extra tests or procedures that limit their risk," according to a recent *New York Times* report.
- Physician medical liability insurance costs have historically been a problem in New York State. The legislature and governor had to take significant action in the mid-1970s and again in the mid-1980s to avert a liability insurance crisis that would have jeopardized access to care for patients.

F. Pennsylvania

- In the ACOG survey, 77.4% of the Pennsylvania ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 21.61% of Pennsylvania respondents have stopped practicing obstetrics.
- Pennsylvania is the second-highest state in the country for total payouts for medical liability. During the fiscal year 2000, combined judgments and settlements in Pennsylvania amounted to $352 million—or nearly 10% of the national total.
- From the beginning of 1997 through September 2001, major liability insurance carriers writing in Pennsylvania increased their overall rates 80.7% to 147.8%, according to a January 2002 *York Daily Record* article.
- Philadelphia and the counties surrounding it are hardest hit by the liability crisis. From January 1994 through August 2001, the median jury award in Philadelphia for a medical liability case was $972,900. For the rest of the state, including Pittsburgh, the median was $410,000.
- One-quarter of respondents to an informal ACOG poll of Pennsylvania ob-gyns say they have stopped or are planning to stop the practice of obstetrics. 80% of medical students who come to the state for a world-class education choose to practice elsewhere, according to the Pennsylvania State Medical Society.

- On April 24, 2002, Methodist Hospital in South Philadelphia announced that it would stop delivering babies due to the rising costs of medical liability insurance. The labor and delivery ward closed on June 30, leaving that area of the city without a maternity ward. Methodist Hospital has been delivering babies since its founding in 1892.
- Some tort reform measures passed the state legislature (House Bill 1802) in 2002. However, the law did not include: caps on jury awards; sanctions on frivolous suits; changes in joint and several liability; limits on lawyers' fees; or a guarantee that a larger share of jury awards will go to injured plaintiffs.
- The rules for venue of court cases in Pennsylvania are very liberal. Recently approved measures only appoint a committee to study venue shopping, but do not limit the practice.
- Since HB 1802 passed, experts predict a 15% to 20% overall reduction in doctors' liability premiums. But with the 50% to 100% premium increases of the last two years, medical officials believe the bill is not enough to stop physicians from leaving practice or to attract new physicians. Nor do they believe new insurers will begin writing policies in Pennsylvania.

G. Texas

- In the ACOG survey, 67.5% of the Texas ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 13.79% of Texas respondents have stopped practicing obstetrics.
- Preliminary results of a recent Texas Medical Association physician survey indicate that:
  - More than half of all Texas physicians responding, including those in the prime of their careers, are considering early retirement because of the state's medical liability insurance crisis.
  - Nearly a third of the responding physicians said they are considering reducing the types of services they provide.
- Medical liability insurance premiums for 2002 were expected to increase from 30% to 200%, according to the Texas Medical Association. In 2001, ob-gyns in Dallas, Houston, and Galveston paid medical liability insurance premiums in the range of $70,00 to $160,000.
- The *Abilene Reporter News* reported on October 13, 2002, that the obstetrics unit at Spring Branch Medical Center is set to close December 20, 2002. The hospital's $600,000 premium for labor and delivery liability was set to increase by 67% next year. In 2001, 1,003 babies were born at Spring Branch Medical Center.
- According to Governor Rick Perry's office, between 1996 and 2000 one in four Texas physicians had a medical liability claim filed against them. In the Lower Rio Grande Valley, the situation is even worse. In 2002, Valley ob-gyns paid liability insurance premiums up to $97,830, a 34.5% increase from 2001.
- According to a February 2001 Texas Medical Association survey, one in three Valley doctors say their insurance providers have stopped writing liability insurance.
- In 2000, 51.7% of all Texas physicians had claims filed against them, according to the Texas Medical Examiners Board. Patients filed 4,501 claims, up 51% from 1990.
- As many as 86% of medical liability claims filed in Texas are dismissed or dropped without payment to the patient. Yet providers and insurance companies must still spend millions of dollars in defense, even against baseless claims.
- According to a Texas Medical Association study, the amount paid per claim in 2000 was $189,849 (average for all physicians), a 6% increase in one year.
- Texas has no limits on non-economic damages in medical liability cases, although the legislature enacted such limits in the 1970s as part of a comprehensive set of reforms. The Texas Supreme Court later rejected them in the 1980s.
- Texas has procedures in place to screen lawsuits for merit and to sanction lawyers who file frivolous suits, but these are not enforced uniformly across the state, according to an April 2002 news release issued by Governor Rick Perry.
- Only about 30% of the medical liability insurance market is served by insurance companies that are regulated by the Texas State Department of Insurance and subject to rate review laws, according to Governor Perry's office.

H. Washington

- According to *Medical Liability Monitor,* in late 2001, the second largest carrier in Washington State announced that it was withdrawing from providing medical liability insurance for Washington physicians. This decision by Washington Casualty Company impacted approximately 1,500 physicians.
- In 2001, state ob-gyns paid medical liability insurance premiums in the range of $34,000 to $59,000. For many physicians, this meant an increase of 55% or higher from the year 2000.
- In the ACOG survey, 57.2% of the Washington ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 15.06% of Washington respondents have stopped practicing obstetrics.
- According to the Pierce County Medical Society, some Tacoma specialists reported 300% increases.
- Unlike California, Washington has no cap on non-economic damages in medical liability cases. The State Supreme Court found a previous cap unconstitutional in 1989.
- In April, *The Olympian* reported that the Washington State Insurance Commissioner's office heard from physicians throughout the state that they might be forced out of Washington because of high medical liability rates or the lack of available insurance.

I. West Virginia

- There are only three carriers in the state—including the state-run West Virginia Board of Risk and Insurance Management—currently writing medical liability policies for doctors. Annual premiums range from $90,700 to $99,800.
- In the ACOG survey, 82.2% of the West Virginia ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 23.66% of West Virginia respondents stopped practicing obstetrics.
- In 2000, many physicians had problems affording or finding insurance. This urgency prompted Governor Bob Wise to issue a request for proposals to commercial insurance carriers asking them to provide terms under which they would be willing to come to the state. The governor's office received no response at all. To date, some carriers previously active in West Virginia are under an indefinite, self-imposed moratorium for new business in the state, according to the West Virginia State Medical Society.
- Legislation eked out during a grueling special session in the fall of 2001 reestablished a state-run insurer of last resort. However, with rates 10% higher than the highest commercial rate, and an additional 50% higher for physicians considered high risk, the state-run insurer does not solve the affordability problem, according to ob-gyns in the state.
- According to an informal survey of ACOG's West Virginia section, more than half of all ob-gyn residents plan to leave the state once they have completed training because of the state's medical liability insurance climate. A majority of private practitioners who provide obstetric care plan to leave the state if there is no improvement in the insurance crisis.
- West Virginia cannot afford to lose more doctors. The West Virginia State Medical Society reports that a majority of the state is officially designated by the federal government as a health professional shortage area and medically underserved.

V. Conclusion

Thank you, Mr. Chairman, for your leadership on this important issue and for the Committee's attention to this crisis. ACOG appreciates the opportunity to present our concerns for the panel's consideration and again urges the passage of HR 5, the HEALTH Act of 2003. The College looks forward to working with you as we push for a solution.

PREPARED STATEMENT OF AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM)—representing 115,000 physicians and medical students—is the largest med-

ical specialty society and the second largest medical organization in the United States. We congratulate the House Committee on Energy and Commerce Subcommittee on Health for holding this important hearing on a subject matter that has more relevance today than ever before. Of the College's top priorities for 2003, addressing the health care liability crisis and its impact on access to care is one of the most critical to our members. ACP-ASIM wishes to thank Committee Chairman W.J. Tauzin and Subcommittee Chairman Michael Bilirakis, Committee Ranking Member John Dingell and Subcommittee Ranking Member Sherrod Brown, and other members, for holding this important hearing to discuss the immediate need to enact meaningful medical liability reform.

BACKGROUND

Doctors across the country are experiencing sticker shock when they open their medical malpractice insurance renewal notices—if they even get a renewal notice. After more than a decade of generally stable rates for professional liability insurance, physicians have seen costs dramatically increase in 2000-2003. And in some areas of the country, premiums have soared to unaffordable levels. According to the *Medical Liability Monitor,* in mid-2001, insurance companies writing in 36 states and the District of Columbia claim to have raised rates well over 25 percent. Unfortunately, rates continue to rise dramatically with no sign of the market beginning to stabilize.

While obstetricians, surgeons and other high-risk specialists have been hit hard, internists have been one of the hardest hit specialties—having seen a record nearly 50 percent average increase over the last two years. In some cases, physicians, even those without a track record of lawsuits, cannot find an insurance company willing to provide coverage. These physicians are being forced to decide whether to dig deeper and pay the steeper bill, change carriers, move out of state, or retire from the practice of medicine.

Of these options, changing carriers may not even be an alternative. Finding replacement coverage won't be as easy as it was in a buyer's market. Companies writing professional liability coverage are fleeing or being chased from the market. As an example, St. Paul Companies, which insures doctors in 45 states and is the second largest medical underwriter in the country, announced late in 2001 that it no longer would write medical liability policies. It plans to phase out coverage as physicians contracts expire over the next 18 to 24 months. Frontier and Reliance are also gone. Other commercials, such as PHICO, CNA and Zurich, are significantly cutting back. Even some provider-owned insurers, committed to this market by their founders, are pulling back from some states in which they extended sales.

THE PERFECT STORM

At a time when the market is squeezing physician and hospital margins, the rise in professional liability insurance may be the deciding factor that contributes to whether physician offices and emergency rooms keep their doors open. Recently, the costs of delivering health care have been driven by increased costs of new technologies; increased costs of drugs that define the standard of care acceptable for modern medicine; the rising costs of compliance under increasing state and federal regulation; the low reimbursement rate under Medicare and Medicaid; and the declining fees from managed care have all been contributing factors that have affected patient access to health care.

Unquestionably, there is real potential that rising insurance rates ultimately will reduce access to care for patients across the country. Indeed, press accounts on a daily basis are demonstrating exactly that from coast to coast. Physician offices and emergency rooms have been closing their doors all across the country due to the exorbitant costs. The states most severely hampered by the spiraling out-of-control rates are: Florida, Georgia, Illinois, Michigan, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. Several other states are just beginning to feel the impact.

Some states have tried to address the dramatic increase in professional medical liability insurance rates with very little success. At best, attempts by the states to solve this problem have resulted in only band-aid approaches to the more underlying problem: the escalation of lawsuit awards and the expense of litigation has led to the increase in medical liability premiums. This fact has resulted in many patients not receiving or delaying much needed medical care—a fact Congress can no longer ignore. ACP-ASIM strongly believes that Congress must act to stabilize the market to avoid further damage to the health care system.

RELIEF FOR PHYSICIANS FROM SOARING MALPRACTICE PREMIUMS

Federal legislation has been introduced in the 108th Congress to help curb the spiraling upward trend in malpractice premiums. **H.R. 5, the "Help Efficient, Accessible, Low Cost, Timely Health Care" (HEALTH) Act of 2003, will attempt to safeguard patient access to care, while continuing to ensure that patients who have been injured through negligence are fairly compensated. ACP-ASIM strongly endorses this legislation as a means to stabilize the medical liability insurance market and bring balance to our medical liability litigation system.** The HEALTH Act achieves this balance through the following common sense reforms:

- Limit on pain and suffering (non-economic) awards. This requirement limits unquantifiable non-economic damages, such as pain and suffering, to no more than $250,000.
- Unlimited recovery for future medical expenses and loss of future earnings (economic) damages. This provision does not limit the amount a patient can receive for physical injuries resulting from a provider's care, unless otherwise restricted by state law.
- Limitations on punitive damages. This requirement appropriately raises the burden of proof for the award of quasi-criminal penalties to "clear and convincing" evidence to show either malicious intent to injure or deliberate failure to avoid injury. This provision does not cap punitive damages, rather, it allows punitive damages to be the greater of two times the amount of economic damages awarded or $250,000.
- Periodic payment of future damages. This provision does not reduce the amount a patient will receive. Rather, past and current expenses will continue to be paid at the time of judgment or settlement while future damages can be funded over time. This ensures that the plaintiff will receive all damages in a timely fashion without risking the bankruptcy of the defendant.
- Elimination of double payment of awards. This requirement provides for the jury to be duly informed of any payments (or collateral source) already made to the plaintiff for her injuries.
- A reasonable statute of limitation on claims. This requirement guarantees that health care lawsuits will be filed no later than 3 years after the date of injury, providing health care providers with ample access to the evidence they need to defend themselves. In some circumstances, however, it is important to guarantee patients additional time to file a claim. For example, the legislation extends the statue of limitations for minors injured before age 6.
- A sliding scale for contingency fees. This provision will help discourage baseless and frivolous lawsuits by limiting attorney incentives to pursue meritless claims. Without this provision, attorneys could continue to pocket large percentages of an injured patient's award, leaving patients without the money they need for their medical care. The sliding scale would look something like this:
  - Forty percent (40%) of the first fifty thousand dollars recovered
  - Thirty-three and one-third percent (33 1/3%) of the next fifty thousand dollars recovered
  - Twenty-five percent (25%) of the next five hundred thousand dollars recovered
  - Fifteen percent (15%) of any amount recovered in excess of six hundred thousand dollars
- Proportionate liability among all parties. Instead of making a party responsible for another's negligent behavior, this requirement ensures that a party will only be liable for his or her own share. Under the current system, defendants who are only 1 percent at fault may be held liable for 100 percent of the damages. This provision eliminates the incentive for plaintiff's attorneys to search for "deep pockets" and pursue lawsuits against those minimally liable or not liable at all.

These common sense recommendations have been proven to work. The HEALTH Act is largely based on provisions contained in the California Medical Injury Compensation Reform Act (MICRA). Since its enactment in the mid-1970's, the MICRA reforms have helped reduce the overall costs of medical malpractice and have contributed to an increase in patient access to care. During this recent malpractice insurance crisis, California's rates have changed only slightly, while other states have spiraled to out of control levels. ACP-ASIM strongly supports the elements contained in MICRA. Further, we believe that any legislation proposed must include these basic, proven elements in order to assure the stabilization of malpractice premiums.

CONCLUSION

ACP-ASIM is pleased that the House Committee on Energy and Commerce Subcommittee on Health agreed to conduct this important hearing to address the serious problem of soaring medical malpractice premiums that physicians are facing across the country. **We strongly urge the House Energy and Commerce Committee to pass common sense reform contained in the HEALTH Act that would allow for greater access to care, while adequately compensating injured patients.** We thank the Committee and appreciate the opportunity to present our views.

PREPARED STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists (CAP) is pleased to submit this statement for the record of the Energy and Commerce Health Subcommittee hearing on the need to enact medical liability reform. The College is a medical specialty society representing more than 16,000 board-certified physicians who practice clinical or anatomic pathology, or both, in community hospitals, independent clinical laboratories, academic medical centers and federal and state health facilities.

Pathologists, like all physicians, face severe hardships resulting from the worsening medical liability insurance crisis. For many, just finding coverage has been an arduous task at best and, for some, nearly impossible. Those who have found willing insurers are paying substantially higher premiums—in some cases, several times the previous year's rates—for coverage plans, regardless of their claims history.

The realities of this crisis are clear: Pathologists and other physicians can no longer offer certain procedures or are leaving their practices altogether because of the exorbitant costs of malpractice premiums. These are desperate decisions brought on by a tort system with no mechanism to restrain runaway "pain and suffering" and punitive awards. Damages rise beyond reason and, in the end, all patients and providers suffer as the nation's health care costs soar and access to quality care declines.

Real-world examples in the laboratory community highlight the problem:

- The chief executive of a small, rural Pennsylvania hospital recently told a Senate Appropriations subcommittee that he nearly was forced to close the facility when an insurer declined to renew a malpractice policy for his pathologist, a 17-year practice veteran with no claims history. Only through a last-minute joint underwriting agreement was the pathologist able to retain insurance coverage, which allowed the hospital to continue offering laboratory, blood banking and surgical pathology services and remain open, the executive said.
- A pathology group that provides services to all Hawaii's outer island hospitals and five facilities on Oahu—about 20 pathologists, in all—is, like many physician practices, shopping for a new insurance carrier. The group's current insurer recently sent a renewal notice quoting a four-fold increase in premiums compared with 2002 rates.
- In general, malpractice insurance premiums for pathologists have doubled in the past year, reports JLT Services Corp., the College's member insurance broker. In some locations, particularly urban areas, the increases have been significantly higher. Pathologists have been particularly hard hit by The St. Paul Companies' December 2001 decision to leave the medical liability insurance marketplace. The St. Paul, which provided about 9 percent of all malpractice insurance nationwide at the time, had been the underwriter of the CAP-endorsed Professional Liability plan.

Pathologists and other physicians are increasingly hard-pressed to continue providing services, given the heavy burden rising insurance premiums have placed on their practices. Insurance rates of $200,000 or more for some high-risk specialties have forced many physicians to limit services, retire early or move to states where reforms have brought greater stability to premiums. The skyrocketing cost of liability insurance comes at a particularly critical time for physicians, who also face a widening gap between Medicare reimbursements and practice costs.

Severe patient access problems brought on by the liability insurance crisis have been documented in at least a dozen states and it is expected that 30 more soon will join that list. In the crisis states, obstetrician-gynecologists have been forced to stop delivering babies, trauma centers have closed and many physicians are grappling with how they can continue to provide other high-risk procedures.

Congress must act now to bring commonsense reforms to America's medical liability system. The CAP strongly supports the approach contained in subcommittee

member Rep. Jim Greenwood's bill, the "Help Efficient, Accessible, Low-Cost, Timely Healthcare Act (HEALTH Act) of 2003" (H.R. 5). This critically important bill would:

- place a reasonable limit ($250,000) on non-economic damages and no limit on economic damages;
- create mechanisms to ensure that only justifiable punitive damages are paid, with a guideline to limit punitive damages to two times economic damages or $250,000, whichever is greater;
- structure settlements to be paid in increments, rather than lump-sum payments, so that expenses are reimbursed as they occur and earnings, as they would have accrued;
- establish a three-year statute of limitations, with special provisions for minors.
- establish criteria to ensure that defendants would pay damages in proportion to their fault;
- ensure that states with damage caps in place would be permitted to retain them; and
- set a sliding scale for attorney contingency fees to discourage frivolous lawsuits.

The HEALTH Act can work because it is modeled on a California law that has worked well for nearly three decades. It was enacted in circumstances much like those the nation faces today. California suffered a meltdown of its health care system in the early 1970s and physicians saw their premiums soar more than 300 percent. Liability carriers left the state and some physicians closed their office doors. The Medical Injury Compensation Reform Act, or MICRA, which came into effect in 1976, provided a $250,000 limit on non-economic damages, unlimited economic damages, a statute of limitations on claims, sliding-scale limits on contingency fees, advance notice requirements before claims were filed, binding arbitration of disputes and periodic payment of future damages.

The effect of this legislation was dramatic. The average liability premiums decreased 40 percent in the 25-year period ending in 2001 (expressed in constant dollars). In 2001, the Medical Liability Monitor published data that demonstrated that the average premium paid by California physicians practicing internal medicine, general surgery and obstetrics/gynecology ranged from 43 percent to 51 percent of the average premiums of their counterparts in Florida, Illinois, New York, Texas and Michigan. This was supported by a 53 percent lowering in the dollar amounts of settlements in California, compared with the nation as a whole.

Our current liability crisis is not one of increasing litigation, but one of unreasonably high judgment amounts. Patients are not eager to sue their doctors. In fact, in 1991, the New England Journal of Medicine reported that only 1.53 percent of those injured by possible medical actions even file a claim. Severity of awards is the problem, and that is what the HEALTH Act of 2003 is designed to address.

The College supports such reforms to promote the basic goal of ensuring access to a wide range of health care services and promoting patient safety and quality medical care. In particular, the College strongly supports the bill's establishment of limits on non-economic and punitive damages. These provisions, combined with a sliding scale limit on contingency fees, make for a strong, positive step toward reforms that benefit the whole health care system and protect patient access to affordable, quality care.

The College thanks Rep. Greenwood and other Energy and Commerce members for their leadership on the medical liability reform issue. The CAP appreciates the opportunity to present its views to the Health Subcommittee and offers its support and continued assistance as Congress works to meet the challenge posed by the nation's liability insurance crisis.

PREPARED STATEMENT OF MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

Our liability system is broken. If it is not fixed soon, it will break our health care system as well.

One of the founding principles of the Healthcare Leadership Council (HLC) B which represents the CEO's of the nation's leading health care companies and organizations B is that patients should have access to high quality health care. Skyrocketing liability costs threaten patient access to quality care. This is no longer simply about lawyers and doctors. This is about patients.

The cost of excessive jury awards is causing staggering increases in medical liability premiums. Between 1996 and 1999, average jury awards in medical liability cases have increased by 76 percent. These spiraling increases add directly to the

cost of health care, contributing significantly to premium costs and the growing number of uninsured Americans.

Just as harmful to patients and consumers, however, are the indirect costs of the crisis. Patients are increasingly "paying" for excessive litigation by losing access to medical specialists such as obstetricians and surgeons. An estimated 1 in 11 obstetricians/gynecologists say they have strictly limited their services solely to gynecology due to the malpractice crisis. In some areas, the situation is far worse. In Miami, average annual malpractice premiums for Ob-Gyns are $210,578, while the average salary for an Ob-Gyn in Florida is $118,435. In Wyoming, premiums average $116,000, while average salaries for Ob-Gyns are $108,700.

As medical malpractice insurance rates skyrocket B or become unavailable B medical specialists such as neurosurgeons, orthopaedic surgeons and obstetricians/gynecologists are leaving states such as Pennsylvania, Mississippi, West Virginia, New Jersey, Florida and others. While these states have been in the news lately, the crisis goes far beyond the 13 "crisis" states. It is estimated that as many as 30 other states are in "near crisis" and will soon join the ranks of states where patient access is endangered.

Patients also are losing access to nearby hospitals, trauma centers, and other facilities as a result of the crisis. Patients are subjected to, and pay for, unnecessary tests and procedures as physicians must practice "defensive medicine.'" In addition, patients ultimately are the ones who suffer when new drug therapies and medical technologies are not developed due to litigation or the fear of it.

The cause of the liability crisis is clear. Medical malpractice insurance rates are set prospectively. These rates are set primarily on the basis of projections of jury awards. This trend line is in one direction: straight up. Solving the cost problem requires dealing with the size and unpredictability of these awards. The bottom line is that medical malpractice premiums cannot keep up with claims. A typical state is Oregon, where a Governor's task force reported that medical liability insurers paid out $71 million in losses and defense costs, while receiving $50 million in premiums over the same period. In Ohio, medical malpractice insurers are losing $1.62 for every $1 in premiums. Clearly these trends are unsustainable and will drive more physicians out of practice.

The only proven way to bring these costs under control B while actually enhancing patients' ability to recover economic damages for injuries B are reforms which include capping non-economic and punitive damages, establishing reasonable levels for attorneys' fees, and setting fair share rules for joint and several liability.

HLC strongly supports these and other reforms embodied in the Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003 (H.R. 5).

We stand ready to work with you to address this growing crisis.

PREPARED STATEMENT OF RODNEY C. LESTER, PRESIDENT, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Chairman Bilirakis and Congressman Sherrod Brown, I am Rodney C. Lester, CRNA, PhD, President of the American Association of Nurse Anesthetists (AANA). I appreciate the opportunity to submit for the record a statement on issues surrounding medical liability reform, which are the most challenging facing healthcare today.

For those of you who may be unfamiliar with the AANA, we represent approximately 30,000 Certified Registered Nurse Anesthetists (CRNAs) across the United States. In the administration of anesthesia, CRNAs perform virtually the same functions as anesthesiologists and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations' facilities, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer approximately 65% of the anesthetics given to patients each year in the United States. CRNAs are the sole anesthesia provider in at least 65% of rural hospitals, which translates into anesthesia services for millions of rural Americans.

CRNAs have been a part of every type of surgical team since the advent of anesthesia in the 1800s. Until the 1920s, nurses almost exclusively administered anesthesia. In addition, nurse anesthetists have been the principal anesthesia provider in combat areas in every war the United States has been engaged in since World War I. CRNAs provide anesthesia services in the medical facilities of the Department of Defense, the Public Health Service, the Indian Health Service, the Department of Veterans Affairs, and countless other public and private entities. Given the current state of affairs with Iraq and Afghanistan, it is not surprising that our deployed forces depend greatly upon the services and skills of CRNAs.

You may be aware of the widely publicized nursing shortage. While we do not have enough rank and file nurses there is an increasingly acute shortage of CRNAs. Quite simply, there are not enough CRNAs to fulfill the demand. Our News Bulletin tends to be chock full of advertisements for vacant positions. Quite simply if the rest of the economy was similar to the employment situation for CRNAs, our nation would be at full employment.

Hardly a day goes by for most anesthesia practices when a CRNA is not called by an employment recruiter attempting to entice them into seeking additional pay at another group or hospital. Practices are offering bonuses, attractive benefits, and higher pay in order to recruit CRNAs.

We graduate approximately 1,000 students per year and it is not enough to fill the demand. Our Foundation has recently funded a manpower shortage study and its results are expected shortly.

HOW ARE CRNAS DIFFERENT FROM ANESTHESIOLOGISTS?

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists receive medical education while CRNAs receive a nursing education. However, the anesthesia part of the education is very similar for both providers, and both professionals are educated to perform the same clinical anesthesia services. CRNAs and anesthesiologists are both educated to use the same anesthesia processes and techniques in the provision of anesthesia and related services. The practice of anesthesia is a recognized specialty within both the nursing and medical professions. Both CRNAs and anesthesiologists administer anesthesia for all types of surgical procedures, from the simplest to the most complex, either as single providers or in a "care team setting".

WHAT IS OUR EXPERIENCE ON MALPRACTICE INSURANCE?

For the past several years, CRNAs have relied largely on two main major malpractice carriers—St. Paul and TIG. On December 12, 2001, AANA Insurance Services—a wholly owned subsidiary of the AANA—was notified by the St. Paul Companies that it would exit this market and would seek to sell their malpractice book and eventually transition out of the medical malpractice market. We were advised that this difficult decision was based upon "its anticipated worst annual loss in its 148-year old history." The St. Paul further stated that the decision is part of an overall plan "that will put St. Paul on sound financial footing so that they can continue serving their thousands of customers in their other businesses." Their news release goes into more detail concerning losses relative to its losses in malpractice, other insurance lines and those associated with the September 11 terrorist attack.

AANA Insurance Services worked to prepare and assist its policyholders in this transition period and kept them informed of developments relative to their continuing insurance coverage.

The AANA and AANA Insurance Services Staff prepared strategies to respond to this situation proactively to assure a smooth transition for our members insured through St. Paul. We contacted our other carrier at the time, TIG Insurance, to seek support from them assessed other potential medical malpractice carriers to assure that our members have more than one choice for professional liability insurance as we have in the past.

While we were aware that St Paul Companies were experiencing difficulties along with the rest of the insurance industry, we—along with many other providers and perhaps the general public—were surprised by the sudden decision to withdraw completely from the medical malpractice market. St Paul stated that they would do everything possible to make the transition smooth. We had an excellent relationship with the St. Paul and this transition continues.

Following this announcement, we worked even closer with TIG Insurance Company to ensure a smooth transition for the policyholders of AANA Insurance Services. A few months ago, TIG Insurance Company announced it would no longer be providing medical malpractice insurance. Coverage for CRNAs through TIG will not be available after June 30, 2003. TIG's announcement comes almost exactly a year after St. Paul's announcement that it was withdrawing from the medical malpractice marketplace.

On Monday, December 16, 2002, Fairfax Financial Holdings Limited announced that it would be restructuring TIG. Fairfax, the parent company of TIG, is a financial services holding company which, through its subsidiaries, is engaged in property, casualty and life insurance, reinsurance, investment management and insurance claims management.

As part of the restructuring, TIG indicated that it will be discontinuing its program business. Program business, a specialty of TIG's that represents a majority of

its business, is defined as insuring large groups of insured with very similar characteristics. According to Fairfax, TIG's program business was not meeting Fairfax's financial expectations. Unfortunately, all of TIG's medical malpractice business, including the coverage it provides to CRNAs, falls into this program business category.

It should be noted that medical malpractice only accounted for 25% of TIG's program business and TIG's CRNA program was only a small part of the medical malpractice business. Fairfax representatives have informed AANA that the decision to restructure TIG was based neither on the performance of its medical malpractice business in general or its CRNA business in particular.

It is no secret that the number of insurance companies willing to offer medical malpractice coverage has shrunk dramatically over the past few years. Although it's of little consolation, there are many classes of healthcare providers who are facing even greater insurance challenges than CRNAs. While TIG's decision is disappointing, it is not surprising considering the current medical malpractice environment.

Unlike when St. Paul exited from the medical malpractice marketplace, TIG's withdrawal won't be as immediate. TIG will continue to offer both new and renewal policies to AANA members through June 30, 2003. After June 30, 2003, TIG will not provide coverage to new applicants.

Currently AANA Insurance Services provides coverage for members through CNA Insurance Company. It is our understanding that CNA has been approved to do business in 43 states and the District of Columbia. CNA is awaiting approval in the states of Alaska, Nebraska, Nevada, New Hampshire, New York, Vermont and Washington. AANA Insurance Services expects CNA to have approval in all these states by June 30, 2003.

Obviously this has become extremely troubling to our members. While we have an excellent relationship with CNA Insurance Company, CRNAs are increasing concerned that with only one major medical malpractice carrier remaining, issues of coverage could become problematic. It should be noted that unless a CRNA had a particular issue with claims or licensure, coverage could easily be found, whether it was with St. Paul or TIG. That remains relatively true today with the CNA Insurance Company. But with more carriers leaving the marketplace, what does that do to providers? More importantly, what does it mean to patients and consumers? How do we attract more carriers to this market? Without major reforms, will carriers have any reason to go into the market?

PATIENT SAFETY

Given the strong safety record of CRNAs, we had no reason to believe then, nor do we now, that there was any nexus between the decision of either St. Paul or TIG to exit the medical malpractice market due to bad claims from CRNAs.

America's CRNAs are committed to advancing patient safety so that actual instances of malpractice are reduced. These commitments including active membership in the cross-disciplinary National Quality Forum (NQF) and the National Patient Safety Foundation (NPSF), closed-claims research that transforms tough cases into educational and practice improvements, and the most stringent continuing education and recertification requirements in the field of anesthesia care. *With CRNAs providing two-thirds of all U.S. anesthetics, the Institute of Medicine reported in 1999 that anesthesia is 50 times safer today than 20 years ago.*

OUR DILEMMA

Educational programs that prepare nurse anesthetists rely solely on hospitals, surgery centers and even office based surgical practices to provide students with the required clinical experiences to enable them to become competent anesthesia providers. These healthcare facilities rely on surgeons and other high-risk specialties for their patient admissions. As these high-risk specialties leave, operating rooms close and patients have less access to needed care, and students have less access to patients for clinical training.

Looking at Pennsylvania as an example, the hospitals and surgeons who are part of a healthcare system located in Southeast Pennsylvania have seen their primary premiums increase more than 60 %, their CAT fund increase more than 30%, and their excess premiums increase more than 600%, all within the last year.

The Medical Professional Liability Catastrophe Loss Fund (commonlyreferred to as the CAT Fund) was established to ensure that victims of medical malpractice are compensated and that medical malpractice insurance is available to health care providers. Health care providers (physicians, surgeons, podiatrists, hospitals and nursing homes) are required to carry a set minimum amount of primary coverage. The

health care providers then must pay a surcharge to the CAT Fund in order to fund a layer of insurance above the primary insurance coverage. Failure to comply with this requirement may result in revocation of one's license.

This is reflective of what other healthcare systems in Pennsylvania are experiencing. In addition that system has seen its high-risk specialty physicians relocate out of Pennsylvania or give up the surgical part of their practice. Each time a physician closes his/her office or reduces practice, employees of their practice lose their job. Fewer high-risk specialists mean fewer cases requiring anesthesia are performed. These are exactly the specialties that nurse anesthesia educational programs rely on to provide their students with the required clinical cases.

As surgeons leave the state or reduce surgery because they can not afford the malpractice insurance there are fewer surgical cases, operating rooms are closed, daily operating room schedules are prolonged, overtime costs increase, hospitals' earn less money, layoffs occur and hospitals close. This directly affects patients' access to needed and timely care, and the ability of our educational programs to provide the necessary clinical experiences to educate nurse anesthetists. If this trend continues unabated, nurse anesthesia educational programs (and other healthcare educational programs) will face accreditation issues, declines in student enrollment and delays in graduation as they struggle to find enough clinical experiences for their students. All of this occurring during a time when there is a critical shortage of anesthesia providers nationwide to provide care to an older and sicker population.

The medical malpractice crisis affects all levels of society. Unlimited individual awards for pain and suffering will severely limit the availability and access to care for the majority. The value we place on timely and complete access to care for all our citizens is reflected in our allowance of an individual's unlimited right to take precedence over the needs of all our people. To insure a healthy society, we must insure access to health care even if it means we place limits on a single category of damages to the individual.

If carriers continue to leave the market and if there should be in difficulty obtaining coverage, it could ultimately mean a slow down for hospitals in providing surgeries. In addition, when CRNAs are employed by hospitals or group practices, these entities have to pick up the tab. If increasing rates continue to become an issue, hospitals will increasingly have to make difficult choices. In those rural hospitals where CRNAs are the sole anesthesia provider, hospitals have no choice if they wish to keep their doors open.

That is why the AANA supports medical liability reform. Many can point an accusatory finger as to why carriers exit the market. However, it makes no sense for an insurer to remain in a market if it cannot do so profitably. High costs and runaway juries and large malpractice awards have become unrealistic and disproportionately high. This is not to say that providers, be they nurses or physicians, should not be held responsible for their actions. All providers must take responsibility. And those providers who may be disproportionately responsible for rate hikes because they have had more than one claim must increasingly take responsibility for their actions as do the nursing and medical boards regulating providers. But by the same token, awards have become too high and many insurers have decided that with the unpredictability of determining how to insure a risk that is seems to be increasingly incalculable, they simply exit the market.

In the last Congress, the AANA was pleased to support Rep. Jim Greenwood's (R-PA) legislation, H.R. 4600. The HEALTH Act would permit individuals to recover unlimited economic damages and allow for non-economic damages or "pain and suffering" up to $250,000. The states would have the flexibility to establish or maintain their own laws on damage awards. Other provisions in the HEALTH Act address the percentage of damage awards and settlements that go to injured patients as well as allocate damage awards fairly and in proportion to a party's degree of fault and works to decrease the time it takes for a case to settle or go to trial. Similar legislation will be considered in the 108th Congress.

Ultimately, it will be incumbent upon insurers, providers, and yes the trial lawyers to work together to find a common solution that works for consumers and patients.

Again, thank you for the opportunity in allowing us to share our views on medical liability reform with the members of this subcommittee.

[The chart follows:]

Greenwood

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

EXECUTIVE HEADQUARTERS
2301 McGee Street
Suite 800
Kansas City MO
64108-2662
voice 816-842-3600
fax 816-783-8175

FEDERAL AND INTERNATIONAL RELATIONS
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Suite 701
Washington DC
20001-1509
voice 202-624-7790
fax 202-624-8579

SECURITIES VALUATION OFFICE
1411 Broadway
9th Floor
New York NY
10018-3402
voice 212-398-9000
fax 212-382-4207

WORLD WIDE WEB
www.naic.org

February 7, 2003

Honorable Judd Gregg
Chairman
Committee on Health, Education,
Labor, and Pensions
United States Senate
Washington, DC 20610-6300

Dear Chairman Gregg:

On behalf of the National Association of Insurance Commissioners (NAIC), I am pleased to respond to your letter of January 31, 2003 requesting information on medical malpractice insurance. Many states are experiencing escalating premium costs for this critical insurance coverage for doctors, while also encountering problems of availability and insufficient capacity to support a healthy competitive market.

State insurance commissioners share the concerns you and other Members of Congress are raising about improving the availability and affordability of medical malpractice insurance. We are vested with the responsibility of protecting the rights of consumers and assuring that insurers remain financially solvent and able to meet their claims obligations. While the recent trends in some states over limited availability and escalating premiums make oversight critical, we would caution that any reforms be considered carefully, especially in recognition of reforms already enacted in several states.

In September 2002, we established a Market Conditions Working Group to look at these issues more closely and based upon that review make recommendations to regulators. The working group has scheduled a public hearing on Saturday, March 8, 2003. We are hopeful this hearing and other efforts will help guide state and federal policymakers as they work to explore potential solutions. We will look forward to sharing with you the results of this hearing.

Our responses to the questions in your letter are as follows:

(1) Are medical malpractice insurance rates subject to state law prohibitions on excessive, inadequate, or unfairly discriminatory rates?

Almost all states have rating laws for property and casualty insurance, including medical malpractice. These rating laws require that insurance rates not be excessive, inadequate, or unfairly discriminatory.

(2) If a state determines that a rate is excessive, inadequate, or unfairly discriminatory, does the insurance regulator have the authority to reject or modify such a rate?

If a state receives a filing from an insurer that contains a rate that is believed to be out of compliance with the statutory rating standards, there are remedies available to address the problem. The most common regulatory approach available to insurance regulators is the ability to order a hearing on the non-complying rate. In states with prior approval laws, the commissioner generally has authority to disapprove the non-complying rate, however the insurer is generally provided an opportunity for a hearing if it disagrees with the commissioner's decision. Only in rare instances does an insurance commissioner have authority to unilaterally modify a filed rate. Because of extremely high loss ratios in many states, regulator concerns have been with rate inadequacy, and not excessiveness or unfair discrimination.

(3) If states do have this authority, can you provide any examples where a state insurance regulator has rejected or modified an excessive or unfairly discriminatory medical malpractice insurance rate?

We are not aware of any recent state actions in this regard. State insurance regulators generally do have the authority to prevent anti-trust activities by insurers. These state laws are based on the NAIC model rating laws, which contain the following provisions.

> "No insurer or advisory organization shall attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market or engage in a boycott, on a concerted basis, of an insurance market."
>
> "No insurer shall agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to facilitate the reporting of statistics to advisory organizations, statistical agents or the commissioner. The fact that two or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, prospective loss cost, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists."
>
> "No insurer or advisory organization shall make any arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of unreasonably restraining trade or lessening competition in the business of insurance."

States generally have adopted the NAIC model law provisions or equivalent provisions, thus comparable authority currently exists. Again, due to extremely high loss ratios, the concern has been with rate inadequacy.

(4) The Leahy legislation presumes that medical malpractice insurance carriers are engaging in "price fixing, bid rigging, and market allocation." Does the NAIC, or any of your members have evidence that medical malpractice insurance carriers are engaging in these types of criminal behaviors? If so, could you detail that information for us?

No. To date, insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation. The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices. A July 2002 report prepared by the Department of Health and Human Services also cites the impact of litigation and defense costs on this line of insurance.

(5) Notwithstanding the McCarran-Ferguson exemption from federal anti-trust laws, do state insurance regulators and attorneys general have the authority to prevent "price fixing, bid rigging or market allocations" under current state law? If so, could you explain the deficiencies in those laws and provide us with proposed remedies?

As noted in the previous question, states have strong laws that prohibit price-fixing and anti-competitive practices by insurers. The sharing of loss data among insurers is permitted, however, because it is necessary to encourage competition by giving potential new entrants to the marketplace and smaller insurers enough underwriting and rate-setting information to enter and remain viable in the medical malpractice marketplace. Again, the evident points to high loss ratios, not price-fixing, as the primary driver of escalating premiums.

(6) What percentage of the medical malpractice insurance market is composed of non-profit physician-owned mutuals? What incentive or incentives, if any, do you think these types of medical malpractice carriers face that would cause them to engage in "price fixing, bid rigging or market allocations?"

Non-profit physician-owned mutual insurers have developed in response to market availability concerns. Since the owners of these mutuals are also the customers, it would appear on the surface that market allocation might be occurring. Careful inspection will show that a mutual insurer is concerned with its policyholders' interests. Since each policyholder is also an owner of the company and the company is a non-profit entity, the goal of the mutual insurer is to deliver medical malpractice insurance to its policyholder/owners as inexpensively as possible. To do otherwise would contradict the goals of the mutual and jeopardize its non-profit status

(7) Finally, if the Leahy legislation were to be enacted, would it lower the underlying medical malpractice claims costs and stabilize medical liability insurance premiums? If yes, in what way would it do so?

No, we do not believe enactment of the Leahy legislation as originally drafted would change the underlying costs of malpractice claims or premiums. We now understand this language is being modified. The reason insurers are not writing, or are pulling back from medical malpractice insurance, is because there are many other lines of insurance that offer more opportunities for profit at a lower risk. The uncertainties and historical return in this line of business lead many commercial insurers to commit capital in other lines of commercial insurance. It is our experience this market will remain volatile in some states until such time as claims costs stabilize.

Finally, while we are seeing difficult market conditions in some states, it is by no means widespread in all states. Like all insurance markets, medical malpractice insurance markets vary from state to state. However, the cost drivers in all states are closely linked to claims losses.

I hope this information is helpful, and we look forward to being of assistance as your Committee continues its review of these issues. The NAIC and its members stand ready to provide whatever data and resources we have available to help Congress and the states improve the market for medical malpractice insurance.

Sincerely,

Mike Pickens
Commissioner of Insurance, Arkansas
President, NAIC

Greenwood

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of the Rate Rollback and Refund Obligation of NORCAL Mutual Insurance Company, Respondent.	)	File No. REB-2754 STIPULATION AND CONSENT ORDER

The Department of Insurance of the State of California (the "Department") and Respondent NORCAL Mutual Insurance Company ("Respondent") stipulate as set forth herein.

RECITALS

A. Insurance Code Section 1861.01 was enacted by the voters of California on November 8, 1988 as a part of initiative measure Proposition 103. That section, as subsequently modified on May 8, 1989 by the California Supreme Court in CalFarm v. Deukmejian (1989) 48 Cal.3d 805), requires insurers writing specified lines of property and casualty insurance in California to reduce rates and make certain refunds to policyholders. The determination of a constitutionally permissible manner in which to accomplish these rollbacks and refunds has been the subject of administrative and judicial proceedings.

B. The Department claims that, under its specific circumstances, Respondent is obligated to roll back its rates and refund premiums collected for policies in force between November 8, 1988 and November 8, 1989. Respondent denies that it has any such obligation.

C. It is in the best interests of Respondent and Respondent's policyholders to resolve these issues promptly and without further expense. Additionally, Respondent desires a prompt resolution to its rollback liability.

D. The Department wishes now to resolve this matter as regards Respondent, without the need for further hearing or administrative action, except as provided herein. It is in the best interest of the Department and the People of the State of California that this matter be resolved in this manner.

THEREFORE, THE DEPARTMENT AND RESPONDENT STIPULATE AS FOLLOWS:

1) Respondent's Board of Directors in 1991 shall authorize a rollback refund equal to 20% of the premium paid by each policyholder for calendar year 1989. Respondent's 1989 paid premium was $76,581,000 under overall rate levels identical to those prevailing on November 8, 1987, requiring a rollback refund of $15,316,200. Respondent shall pay 10% simple interest on this amount covering the period of time beginning May 8, 1989 until such time as either the entire rollback refund has been paid or the last quarterly credit has been applied as set forth in paragraph 3, below. Interest is $4,558,972 assuming refunds are timely made for a total rollback refund obligation of $19,875,172.

2) The amount specified in paragraph 1, above, including the interest specified therein, shall constitute Respondent's entire rollback refund obligation pursuant to Insurance Code

Section 1861.01. Specifically, in the event of a change in the laws or regulations governing the rollback refund obligations of insurers subject to Proposition 103, or of any other change which might otherwise have affected Respondent's rollback refund obligation, neither the Commissioner nor Respondent shall be entitled to an adjustment in the rollback refund obligation provided for herein.

3) The rollback refund obligation shall be paid to each policyholder issued or renewed a policy by Respondent between November 8, 1988 and November 8, 1989. Where such policyholders are still insured by Respondent, Respondent shall pay the rollback refund obligation by applying it in four quarterly installments as a credit against 1992 premium; however, in the event that 1992 premium is less than the amount of the rollback refund obligation for any such policyholder, the rollback refund obligation in excess of the 1992 premium shall be paid by check no later than December 31, 1992. Where such policyholders have died, retired, become disabled or otherwise will not pay premium to Respondent in 1992, the rollback refund obligation shall be paid by check no later than March 31, 1992.

4) The rate rollback obligation is a return of premium and as such is treated as a policyholder dividend in accordance with customary industry practice. The rollback shall be separately reported as a voluntary rollback refund under Proposition 103.

5) Respondent's rate rollback exemption application filed May 31,

1989 is withdrawn. Respondent's annual rate filings for 1990 and 1991 are hereby granted interim approval by the Department.

6) The rollback refund obligation provided for herein shall not constitute a fine, penalty or adverse administrative action.

7) Upon the execution of this agreement, the Insurance Commissioner shall give notice to the public that, within 20 days of the date of the notice any consumer or his or her representative may request a hearing in which this agreement, or any part of it, may be challenged. That notice shall include a copy of this agreement and this agreement shall not become final until either the expiration of the 20-day period or the disposition of any hearing held thereon, whichever is later.

8) Respondent shall comply with all terms and conditions of this agreement on or before December 31, 1992.

9) Respondent shall submit quarterly compliance reports commencing with the last day of the calendar quarter in which the order adopting this agreement is entered and until all terms and conditions of this agreement are satisfied. These reports shall include, at a minimum, (1) total principal and interest amounts refunded by check, total principal and interest amounts credited to policyholder accounts, and (2) the names, last known addresses and principal and interest amounts due policyholders whom Respondent has been unable to

locate.

10) Respondent shall make disclosure of its rollback plan in its Annual Statement to the Insurance Commissioner of the State of California and in its Annual Report to Members.

11) Respondent shall provide, within a reasonable time, any information requested by the Department regarding Respondent's rollback refund obligation.

12) Respondent shall dismiss all pending administrative and judicial actions challenging the Commissioner's rate rollback regulations.

13) Respondent shall escheat all unpaid rollback refunds to the State of California in compliance with applicable California law.

14) Nothing contained herein shall limit the Commissioner's ability to bring any actions that he may deem necessary to enforce other provisions of law relating to Respondent or its rates, rating plan, rating system or underwriting rules.

Date: 10/4, 1991

NORCAL Mutual Insurance Company

By: Albert C McCaul

Title Pres/CEO

Date: 10/6, 1991

JOHN GARAMENDI
Insurance Commissioner
State of California

BY: Steven Miller

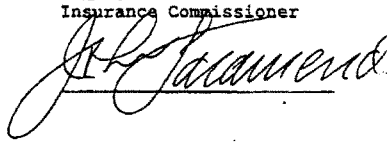
Steven Miller
Deputy Commissioner

ORDER

The terms of the foregoing stipulation are hereby adopted as the order of the Insurance Commissioner of the State of California in the above-entitled matter.

Date: 12/3/, 1991

JOHN GARAMENDI
Insurance Commissioner



BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of the Rate Rollback and Refund Obligation of Southern California Physicians Insurance Exchange, Respondent.	File No. REB-1242 STIPULATION AND CONSENT ORDER

The Department of Insurance of the State of California (the "Department") and Respondent Southern California Physicians Insurance Exchange ("Respondent") stipulate as set forth herein.

RECITALS

A. Insurance Code Section 1861.01 was enacted by the voters of California on November 8, 1988 as a part of initiative measure Proposition 103. That section, as subsequently modified on May 8, 1989 by the California Supreme Court in Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d 805, requires insurers writing specified lines of property and casualty insurance in California to reduce rates and make certain refunds to policyholders. The determination of a constitutionally permissible manner in which to accomplish these rollbacks and refunds has been the subject of administrative and judicial proceedings.

B. The Department claims that, under its specific circumstances, Respondent is obligated to roll back its rates and refund premiums collected for policies in force between November 8, 1988 and November 8, 1989. Respondent denies that it has any such obligation.

C. It is in the best interests of Respondent and Respondent's policyholders to resolve these issues promptly and without further expense. Additionally, Respondent desires a prompt resolution to its rollback liability.

D. The Department wishes now to resolve this matter as regards Respondent, without the need for further hearing or administrative action, except as provided herein. It is in the best interest of the Department and the People of the State of California that this matter be resolved in this manner.

THEREFORE, THE DEPARTMENT AND RESPONDENT STIPULATE AS FOLLOWS:

1) Pursuant to the Department's regulations, Respondent's constitutional rollback amount is $24,706,146. Respondent's Board of Governors in 1991 shall authorize a rollback refund in this amount. Respondent shall pay 10% simple interest on the unpaid balance of this amount covering the period of time beginning May 8, 1989, until such time as either the entire rollback refund has been paid or the last quarterly credit has been applied as set forth in paragraph 3, below. As of October 15, 1991, accrued interest is $6,024,238.

2) The amount specified in paragraph 1, above, including the interest specified therein, shall constitute Respondent's entire rollback refund obligation pursuant to Insurance Code Section 1861.01. Specifically, in the event of a change in the laws or regulations governing the rollback refund

obligations of insurers subject to Proposition 103, or of any other change which might otherwise have affected Respondent's rollback refund obligation, neither the Commissioner nor Respondent shall be entitled to an adjustment in the rollback refund obligation provided for herein.

3) The rollback refund obligation shall be paid to each policyholder issued or renewed a policy by Respondent between November 8, 1988 and November 8, 1989, in the proportion the premium paid by each such policyholder for calendar year 1989 bears to the total premiums paid by all such policyholders for calendar year 1989. Each payment calculation shall be rounded to the nearest dollar. Where such policyholders are still insured by Respondent, Respondent shall pay the rollback refund obligation by applying it in quarterly installments as a credit against 1992 and 1993 premiums; provided, however, that Respondent shall return at least $20,000,000, including interest, during 1991 and 1992, and, in the event that 1992 and 1993 premium is less than the amount of the rollback refund obligation for any such policyholder, the rollback refund obligation in excess of the 1992 and 1993 premium shall be paid by check no later than December 31, 1993. Where such policyholders have died, retired, become disabled or otherwise will not pay premium to Respondent in 1992, the

201

rollback refund obligation shall be paid by check no later than March 31, 1992.

4) The rate rollback obligation is a return of premium. The rollback shall be separately reported as a voluntary rollback refund under Proposition 103.

5) Respondent's rate rollback exemption application filed June 1, 1989 is withdrawn. Respondent's annual rate filing for 1991 is hereby granted interim approval by the Department.

6) The rollback refund obligation provided for herein shall not constitute a fine, penalty or adverse administrative action.

7) Upon the execution of this agreement, the Insurance Commissioner shall give notice to the public that, within 20 days of the date of the notice any consumer or his or her representative may request a hearing in which this agreement, or any part of it, may be challenged. That notice shall include a copy of this agreement and this agreement shall not become final until either the expiration of the 20-day period or the disposition of any hearing held thereon, whichever is later.

8) Respondent shall comply with all terms and conditions of this agreement on or before December 31, 1993.

9) Respondent shall submit quarterly compliance reports commencing with the last day of the calendar quarter in which the order adopting this agreement is entered and until all terms and conditions of this agreement are satisfied.

These reports shall include, at a minimum, (1) total principal and interest amounts refunded by check, total principal and interest amounts credited to policyholder accounts, and (2) the names, last known addresses and principal and interest amounts due policyholders whom Respondent has been unable to locate.

10) Respondent shall make disclosure of its rollback plan in its Annual Statement to the Insurance Commissioner of the State of California and in its Annual Report to Members.

11) Respondent shall provide, within a reasonable time, any information requested by the Department regarding Respondent's rollback refund obligation.

12) Respondent shall dismiss all pending administrative and judicial actions challenging the Commissioner's rate rollback regulations.

13) Respondent shall escheat all unpaid rollback refunds to the State of California in compliance with applicable California law.

14) Nothing contained herein shall limit the Commissioner's ability to bring any actions that he may deem necessary to

enforce other provisions of law relating to Respondent or its rates, rating plan, rating system or underwriting rules.

Date: October 15, 1991

SOUTHERN CALIFORNIA
PHYSICIANS INSURANCE
EXCHANGE

By: _____
DONALD J. ZUK
President and Chief
Executive Officer

Date: October 15, 1991

JOHN GARAMENDI
Insurance Commissioner
State of California

BY: _____
STEVEN MILLER
Deputy Commissioner

ORDER

The terms of the foregoing stipulation are hereby adopte the order of the Insurance Commissioner of the State of California in the above-entitled matter.

Date: 12-12, 1991

JOHN GARAMENDI
Insurance Commissioner

_____

RECEIVED
FEB 14 1992
OFFICE OF INSURANCE

BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of the Rate Rollback and Refund Obligation of THE DOCTORS' COMPANY, Respondent.	File No. REB-5746 STIPULATION AND CONSENT ORDER

The Department of Insurance of the State of California (the "Department") and Respondent The Doctors' Company ("Respondent") stipulate as set forth herein.

RECITALS

A. Insurance Code Section 1861.01 was enacted by the voters of California on November 8, 1988 as a part of initiative measure Proposition 103. That section, as subsequently modified by the California Supreme Court in *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805, requires insurers writing specified lines of property and casualty insurance in California to reduce rates and refund certain funds to policyholders. The determination of a constitutionally permissible manner in which to accomplish this rollback and refund has been the subject of administrative and judicial proceedings.

///

1 B. The Department claims that, under its specific
2 circumstances, Respondent is obligated to roll back its rates and
3 refund premiums collected for policies in force between November
4 8, 1988 and November 8, 1989 ("Rollback Year.") Respondent
5 denies that it has any such obligation.
6 C. It is in the best interests of Respondent and
7 Respondent's policyholders to resolve these issues promptly and
8 without further expense. Additionally, Respondent desires a
9 prompt resolution of its rollback liability.
10 D. The Department wishes now to resolve this matter as
11 regards Respondent, without the need for a hearing or for further
12 administrative action, except as provided herein. It is in the
13 best interest of the Department and the People of the State of
14 California that this matter be resolved in this manner.
15 THEREFORE, THE DEPARTMENT AND RESPONDENTS STIPULATE AS
16 FOLLOWS:
17 1. Pursuant to the regulations proposed by the Department
18 and identified as Title 10, Chapter 5, Sections 2641.1 - 2647.1,
19 Respondent's statutory rollback amount is $14,333,178.
20 Respondent's Board of Governors shall authorize a rollback refund
21 in this amount. Respondent shall pay 10% simple interest on this
22 amount covering the period of time beginning May 8, 1989 until
23 such time as either the entire rollback refund has been paid or
24 the last quarterly credit has been applied as set forth in
25 Paragraph 5, below. Interest on that amount is $4,186,066
26 ///
27 ///

1 assuming that all refunds are made by April 8, 1992, for a total
2 rollback obligation of $18,519,217.
3 2. The amount specified in Paragraph 1, above, including
4 the interest specified therein, shall constitute Respondent's
5 entire rollback obligation pursuant to Insurance Code Section
6 1861.01. Specifically, in the event of a change in the laws or
7 regulations governing the rollback obligations of insurers
8 subject to Proposition 103, or of any other change which might
9 otherwise have affected Respondent's rollback refund obligation,
10 neither the Insurance Commissioner nor Respondent shall be
11 entitled to an adjustment in the rollback refund provided for
12 herein.
13 3. The rollback refund shall be paid to the holder of each
14 policy issued or renewed by Respondent during the Rollback Year
15 in the proportion the premium paid by each such policyholder
16 during the Rollback Year bears to the total premiums paid by all
17 such policyholders during the Rollback Year. Nothwithstanding
18 that Respondent's total rollback obligation reflects certain
19 payments of dividends to some such policyholders, each such
20 policyholder is entitled to, and shall receive, a total rollback
21 refund, including actual dividend payments, equal to no less than
22 19.24%.
23 4. For policyholders who are still insured by Respondent,
24 Respondent shall pay the rollback refund by applying it in
25 quarterly installments as a credit against premiums due prior to
26 March 31, 1993; however, in the event that premiums due from a
27 policyholder prior to March 31, 1993 are less than the amount of

1 the rollback refund due to such policyholder, then the rollback
2 refund amount in excess of those premiums shall be paid by check
3 no later than March 31, 1993. For policyholders who have died,
4 retired, become disabled or who otherwise will not pay premiums
5 to Respondent in 1992, the rollback refund shall be paid by check
6 to the policyholder by April 8, 1992. All rollback refunds and
7 all interest which has accrued thereon shall be paid or credited
8 in full no later than March 31, 1993.
9 5. To the extent that any policyholder's rollback refund
10 obligation is not satisfied by April 8, 1992, interest shall
11 continue to accrue on the amount of the rollback refund that is
12 unpaid, and the total amount of interest to be paid by Respondent
13 shall exceed the amount set forth above in Paragraph 1.
14 6. The rate rollback obligation specified herein is a
15 return of premium and as such is treated as a policyholder
16 dividend in accordance with customary industry practice. The
17 rollback refund shall be separately reported as a voluntary
18 rollback refund under Proposition 103.
19 7. Respondent's rate rollback application dated June 2,
20 1989 is hereby withdrawn.
21 8. The rollback refund and interest provided for herein
22 shall not constitute a fine, penalty or adverse action.
23 9. Upon the execution of this agreement, the Insurance
24 Commissioner shall give notice to the public that, within 20 days
25 of the date of the notice, any consumer or his or her
26 representative may request a hearing in which this agreement, or
27 any part of it, may be challenged. That notice shall include a

1 copy of this agreement and this agreement shall not become final
2 until the expiration of the 20-day period or the disposition of
3 any hearing held thereon, whichever is later.
4 10. Respondent shall comply with all terms and conditions
5 of this agreement on or before March 31, 1993.
6 11. Respondent shall submit quarterly compliance reports
7 commencing with the last day of the calendar quarter in which the
8 order adopting this agreement is entered and until all terms and
9 conditions of this agreement are satisfied. These reports shall
10 include, at a minimum, 1) the total principal and interest
11 amounts refunded by check and total principal and interest
12 amounts credited to policyholder accounts, and 2) the names, last
13 known addresses and principal and interest amounts due
14 policyholders whom Respondent has been unable to locate.
15 12. Respondent shall make disclosure of its rollback plan
16 in its Annual Statement to the California Department of Insurance
17 and in its Annual Report to Members.
18 13. Respondent shall provide, within a reasonable time, any
19 information requested by the Department regarding the rollback
20 refund.
21 14. Respondent shall dismiss all pending administrative and
22 judicial actions challenging the Insurance Commissioner's rate
23 rollback regulations.
24 15. Respondent shall escheat all unpaid rollback refunds to
25 the State of California in compliance with applicable California
26 law.
27 16. Nothing contained herein shall limit the Insurance

Commissioner's ability to bring any actions that he may deem necessary to enforce other provisions of law relating to Respondent or its rates, rating plan, rating system or underwriting rules.

DATE: February 13, 1992

THE DOCTORS' COMPANY

By: Joseph Gubellini
Name

President
Title

DATE: February 20, 1992

JOHN GARAMENDI
Insurance Commissioner
State of California

By: Steven Miller

Steven Miller
Deputy Commissioner

ORDER

The terms of the foregoing stipulation are hereby adopted as the order of the Insurance Commissioner of the State of California in the above-entitled matter.

DATE: ~~February~~ March 4, 1992

J. Garamendi

JOHN GARAMENDI
Insurance Commissioner

California Department of Insurance
John Garamendi, Commissioner
News Release

FOR IMMEDIATE RELEASE:
October 9, 1991

CONTACT:
Bill Schulz/Elena Stern
213/736-2381

FIRST INSURANCE COMPANY TO VOLUNTARILY COMPLY WITH PROPOSITION 103

NORCAL Mutual Agrees to 20 Percent Policyholder Refund Totalling $19.9 Million

In the first action of its kind, NORCAL Mutual Insurance Company has agreed to voluntarily comply with the rollback provisions of Proposition 103 enacted by California voters nearly three years ago, and will return to policyholders a 20 percent rebate totalling $19.9 million, announced Insurance Commissioner John Garamendi.

"NORCAL Mutual has wisely decided to fulfill the letter and spirit of Proposition 103, place the interests of its policyholders first, and put their rollback liability behind them," said Garamendi. "While NORCAL Mutual is a unique company with a specialized niche market, I hope their decision will serve as an example to other insurers that Proposition 103 can be fully, fairly and quickly implemented."

According to a stipulation between NORCAL Mutual and the Department of Insurance, the company will pay a refund of $15,316,000 and an additional estimated $4,558,972 in interest. The rebate is based on the company's 1989 total premiums of $76,581,000, plus interest calculated at 10 percent since May 8, 1989 (the date the California Supreme Court upheld the legality of Proposition 103).

Refunds will be paid to policyholders of the company between November 8, 1988 and November 8, 1989. Current policyholders will receive four quarterly installment credits applied to their 1992 premium. If no longer insured by the company, policyholders will receive the entire refund by March 31, 1992.

The San Francisco-based mutual insurance company provides medical malpractice coverage to physicians and, as a mutual company, is owned by the doctors it insures. NORCAL Mutual has 9,000 policyholders in California.

. August 15, Garamendi announced that Californians are owed a total of $2.5 billion in Proposition 103 rebates. On Monday, October 7, Governor Wilson over-ruled his administration's prior rejection of Garamendi's new emergency regulations that trigger the rollbacks mandated by Proposition 103.

The Department of Insurance is now in the final stages of determining the rollback amounts each insurance company will be required to rebate their policyholders.

On October 16, Garamendi will announce the first of numerous individual company rollback amounts to be rebated to California policyholders.

# # #

Greenwood

Who Pays for Tort Liability Claims?
An Economic Analysis of the U.S. Tort Liability System

Council of Economic Advisers
April 2002

Executive Summary

With conservatively estimated annual direct costs of $180 billion, or 1.8 percent of GDP, the United States tort system is the most expensive in the world, more than double the average cost of other industrialized nations. Whereas an efficient tort system has a potentially important role to play in ensuring that firms have proper incentives to produce safe products, poorly designed policies can mistakenly impose excessive costs on society through forgone production of public and private goods and services. To the extent that tort claims are economically excessive, they act like a tax on individuals and firms. This paper pursues this analogy between inefficient tort litigation and taxes, and examines the question of "who pays" for excessive tort costs. It finds that the cost of excessive tort may be quite substantial, with intermediate estimates equivalent to a 2 percent tax on consumption, a 3 percent tax on wages, or a 5 percent tax on capital income. As with any tax, the economic burden of the "tort tax" is ultimately borne by individuals through higher prices, reduced wages, or decreased investment returns.

Introduction

With estimated annual direct costs of nearly $180 billion,[1] or 1.8 percent of GDP, the U.S. tort liability system is the most expensive in the world, more than double the average cost of other industrialized nations that have been studied.[2] This cost has grown steadily over time, up from only 1.3 percent of GDP in 1970, and only 0.6 percent in 1950. The current cost amounts to nearly $650 for every citizen of the United States, and is one reason that many commentators have called for reform of the tort liability system. The cost is especially troubling because only 20 percent of these dollars actually go to claimants for economic damages, such as lost wages or medical expenses.

Defenders of the status quo argue that the existing system protects consumers by making firms responsible for damages caused by their products and services.[3] Indeed, the underlying notion that firms are induced to recognize the full social cost of their products is one economic rationale for an *efficient* tort system.[4] That is, just as firms must pay compensation to employees and suppliers as part of the cost of producing output, ideally tort liability forces the firm to consider the potential for damage that the firm's products may cause. In this sense, it is analogous to "making polluters pay."

However, poorly designed policies can mistakenly make polluters pay too much and impose excessive costs on society through forgone production of public and private

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[1] Direct costs include awards for economic and non-economic damages, administration, claimants' attorney fees and the costs of defense.
[2] Tillinghast-Towers Perrin, "U.S. Tort Costs: 2000, Trends and Findings on the Costs of the U.S. Tort System," February 2002.
[3] Throughout this paper, we use the term "firm" to refer to any producer of goods and services.
[4] Another economic argument sometimes used to support tort liability is that the right to sue provides consumers with "insurance" in the event of an accident. For a discussion of the limitations of this view, see Paul Rubin, *Tort Reform by Contract*, Washington, D.C.: The AEI Press, 1993. For purposes of this paper, it should be noted that regardless of the rationale for the system, the cost is still borne by individual consumers, workers, or investors.

goods and services. Tort law alters firm behavior in a socially desirable manner if tort liability claims are optimal. If claims are excessive and fail to provide proper incentives, then these claims are a drain on resources that can deter the production of desired goods and services and reduce economic output. The United States bears the burden of an expensive and inefficient liability system through higher prices, lower wages, and decreased returns to investment, as well as lower levels of innovation.

The similarity between inefficient tort litigation and taxes suggests that the economic costs of the tort liability system may be better understood by pursuing the analogy between the expected costs arising from the tort system and taxes on firms. As with a tax, it is possible to examine the question of who bears the incidence of – that is, who pays for – excessive tort costs. An important lesson in the economics of taxation is that *people* pay taxes; firms are legal entities that can bear no real burden. Put differently, the burden of any tax depends not on who writes the check (the legal liability), which may be the firm, but rather on the market outcomes that shift the cost to workers, consumers or owners of capital.

What Are the Role and Limits of Liability Laws in a Market Economy?

The production and sale of nearly every economic good or service entails a degree of risk, however small, that the product may cause unintended harm. Children can be injured playing with toys, patients may have adverse reactions to medications or medical procedures, and workers may fall off ladders or be injured by machinery. Because consumers often have less than perfect information about these risks and are generally unable to insure against them, the government plays a potentially important role in promoting health and safety.

Many policy tools are available to address such risks, including a reliance on market forces, contracts, direct regulation, social insurance, and the legal liability system. Each approach has its relative strengths and weaknesses, and reliance on any

single one may not be desirable.[5] In the United States, the tort system of legal liability is sometimes viewed as contributing to overall social objectives by ensuring that firms consider more fully the health and safety aspects of their products.

A guiding insight is that competition in private markets for goods and services pushes firms to produce the kinds of goods that consumers prefer using the most efficient combination of labor, capital and other inputs. If consumers and firms are already faced with incentives to weigh the social costs and benefits of their respective consumption and production decisions, the burden of government policy is to preserve economic efficiency by avoiding intervention.

For some transactions, however, it may be infeasible to account fully for all of the relevant benefits and costs. A consumer purchasing a new car, for example, may have neither the technical expertise nor the information necessary to fully evaluate the risk of injury posed by a particular design feature. It could also be costly to obtain complete information on every key aspect. Alternatively, a patient purchasing a medical procedure, for example, may be unlikely to fully understand the complex risks, costs and benefits of that procedure relative to others. Such a patient must turn to a physician who serves as a "learned intermediary," though there remains the problem that the patient may also not be able to judge the skill of the physician from whom the procedure is "purchased." In such a case, the ability of the individual to pursue a liability lawsuit in the event of an improper treatment, for example, provides an additional incentive for the physician to follow good medical practice. Indeed, from a broad social perspective, this may be the least costly way to proceed – less costly than trying to educate every consumer fully. In a textbook example, recognition of the expected costs from the liability system causes the provider to undertake the extra effort or care that

[5] For broader discussion of the role of each of these approaches, see W. Kip Viscusi, "Toward a Diminished Role for Tort Liability: Social Insurance, Government Regulation, and Contemporary Risks to Health and Safety," *Yale Journal on Regulation*, Winter 1989.

matches the customer's desire to avoid the risk of harm. This process is what economists refer to as "internalizing externalities." In other words, the liability system makes persons who injure others aware of their actions, and provides incentives for them to act appropriately.

Central to this view, however, is the notion that the exposure of firms to potential tort liability costs provides proper incentives. In the specific context of punitive damages, Professor W. Kip Viscusi of Harvard University makes the point that "the linchpin of any law and economics argument in favor of punitive damages is that these awards alter incentives."[6] In his research on corporate decisions regarding environmental and safety torts, Viscusi evaluates the effect of punitive damages "by examining the risk performance in the four states that do not permit punitive damages as compared with other states that do." He finds that "this detailed effort to detect a deterrent effect yielded no evidence of any safety incentive role. This lack of evidence is consistent with the proposition that punitive damages are random." If punitive damages are essentially random, then they will not provide proper incentives for risk mitigation. Instead, they will operate purely as a "tax" on firms -- a cost with no corresponding benefit.

Some scholars disagree with Viscusi's conclusion. For example, Professor David Luban of Georgetown University argues that one should consider the "retributive aims of punishment" as well as the deterrent aims.[7] However, tort liability only achieves a goal of retribution if the economic burden of the punishment is borne by the responsible party, which may not be the case if the costs are ultimately passed through to investors, workers or consumers, or if punitive damages are essentially random, as Viscusi argues. Professor Theodore Eisenberg of Cornell Law School and several co-authors take an alternate view, claiming that tort liability is largely predictable and is

[6] W. Kip Viscusi, "Why There is No Defense of Punitive Damages," *Georgetown Law Journal*, November 1998.
[7] David Luban, "A Flawed Case Against Punitive Damages," *Georgetown Law Journal*, November 1998.

therefore capable of providing proper incentives to firms.[8] However, while both authors question Viscusi's findings, neither provides direct empirical evidence to indicate that punitive damages actually have a deterrent effect. In fact, the empirical evidence that Eisenberg and co-authors do offer is consistent with the possibility that punitive damages are awarded on a random basis, as noted by Professor A. Mitchell Polinsky of Stanford University.[9]

Other research has examined the effect of expected tort liability costs on innovation and investments in safety. At lower levels of expected liability costs, Viscusi and Professor Michael Moore of Duke University[10] find that firms have incentives to invest in product safety research in an effort to reduce liability costs while still bringing a particular product to market. At higher levels of expected liability costs, however, firms will choose to forgo innovation or to withhold a product from the market, resulting in a net negative effect of expected liability costs on innovation. Based on their estimates, Viscusi and Moore identify many industry groups for which high liability costs exert a net negative effect on innovation.

Industry-specific studies by other authors have generally supported the results of Viscusi and Moore, documenting negative effects of liability on innovation in many areas, such as general aviation, chemicals, pharmaceuticals, and medical practice. The evidence of direct linkages between liability and safety in industry-specific analyses has been weak. Other factors, such as regulation and the fear of bad publicity, may provide stronger incentives to improve safety features than does legal liability, though liability

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[8] Theodore Eisenberg, John Goerdt, Brian Ostrom, David Rottman, and Martin Wells, "The Predictability of Punitive Damages," *The Journal of Legal Studies*, June 1997.

[9] A. Mitchell Polinsky, "Are Punitive Damages Really Insignificant, Predictable, and Rational? A Comment on Eisenberg, et al.," *The Journal of Legal Studies*, June 1997.

[10] W. Kip Viscusi and Michael Moore, "Product Liability, Research and Development, and Innovation," *Journal of Political Economy*, 1993.

may play an indirect role by encouraging the spread of safety-related information and by bringing potential hazards to the attention of regulators[11].

Reconciling these alternative views is beyond the scope of this paper. Instead, recognizing the controversy that exists about the incentive effects of tort liability in general, and punitive damages in particular, this paper will consider several scenarios. For our most cautious estimates of the size of the "litigation tax," we make the very strong assumption that both economic (e.g., loss of wages, medical expenses) and non-economic (e.g., pain and suffering, loss of consortium, punitive) damages are currently set at an optimal level. We then consider an intermediate case that treats non-economic damages as essentially random and therefore part of the litigation tax. Finally, we consider the case in which all of the costs of the U.S. tort system are treated as economically excessive, which would result if both economic and non-economic damages were largely random and failed to provide proper incentives.

What Are the Direct Costs of the U.S. Tort Liability System?

In the year 2000, according to a study by Tillinghast-Towers Perrin, the U.S. tort system cost $179 billion. This includes $128 billion of "insured" costs derived from financial data for the U.S. insurance industry. These data "are considered highly reliable in that they are subject to audit and reviewed by state regulatory agencies."[12] The costs include benefits paid to third parties or their attorneys, claim handling, legal defense costs and insurance company administrative costs. Tillinghast estimates that $30 billion in costs is paid by firms that insure themselves. Finally, they estimate that an additional $21 billion is due to medical malpractice. We will make use of these Tillinghast estimates for illustrative purposes in this paper, although the main conceptual

[11] Peter Huber and Robert Litan, eds., *The Liability Maze: The Impact of Liability Law on Safety and Innovation*, Washington, D.C.: The Brookings Institution, 1991.
[12] Tillinghast-Towers Perrin, "U.S. Tort Costs: 2000, Trends and Findings on the Costs of the U.S. Tort System," February 2002, page 8.

contribution of this paper – that excessive tort claims act as a tax paid by individuals – would hold with equal force with any alternative measure of direct costs.

The estimate of nearly $180 billion in direct costs of the U.S. tort system is likely to understate substantially the actual costs of the tort system for several reasons. First, the $180 billion estimate pre-dates September 11. The terrorist attacks have increased the uncertainty surrounding legal liability claims. Insurance companies, uncertain how to assess new liability risks, are raising premiums and capping or denying coverage. As such, the cost of the tort system in the future will likely be even greater than the year 2000 estimates employed herein. Second, this estimate ignores the many economic distortions that arise as a result of individuals and firms trying to avoid lawsuits. These costs, which will be discussed in more detail below, can include distortions to labor markets (e.g., doctors deciding not to practice certain specialties or in particular communities for fear of being sued), the practice of "defensive medicine," or the decision by manufacturers to keep products off the market.[13] Third, this estimate also ignores the potential deleterious effect of excessive tort claims on innovation. In product areas where litigation is frequent and costly, the prospect of high liability claims may be enough to ward off any potential new entrants.

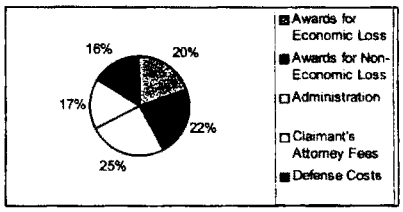
Lacking a more comprehensive estimate of total costs, however, we will use the $180 billion as an initial conservative estimate of total tort costs. An even more difficult issue is deciding how much of this $180 billion is economically "excessive." There is no easy or widely accepted empirical answer to this question. To the extent that awards are largely "random" and fail to provide incentives to firms, most, or even all, of the tort expenses are excessive. Alternatively, to the extent that damages awarded to claimants are a good proxy for the actual damages caused, the fraction of tort costs that

[13] Some anecdotal evidence of these costs can be found in Michael Freedman's "The Tort Mess," Forbes.com. May 13, 2002.

go to claimants to compensate for damages, plus reasonable "transactions costs," could be loosely viewed as the "right" level, and costs above this amount as being excessive.

To pursue this line of reasoning, recall that more than half of the total annual cost of tort is due to administrative expenses and legal fees. As observed, "viewed as a mechanism for compensating victims for their economic losses, the tort system is extremely inefficient, returning only 20 cents of the tort cost dollar for that purpose."[14] This share of total tort costs that go to direct compensation for victims is lower than in the past. In the late 1980s and early 1990s, economic damages accounted for 22-25 percent of total tort system costs.[15]

Figure 1: Distribution of Liability Costs



Source: Tillinghast-Towers Perrin, February 2002.

As indicated in Figure 1, an additional 22 cents goes to claimants for non-economic damages, such as pain and suffering, loss of consortium and punitive damages. The remaining 58 percent of tort costs go to pay for administration, claimants' attorney fees, and defense costs. However, one should not necessarily view the entire 58 percent as "excessive," because some level of "transactions costs" is required in order to administer any system. As a guide for what is a reasonable level of costs, we use the experience of the Workers' Compensation system in the United

[14] *Ibid.*, page 12.
[15] According to previous studies by Tillinghast-Towers Perrin published in 1995, 1992 and 1989.

States, which is designed to deliver compensation efficiently to workers who are injured on the job. Workers' compensation is a no-fault system, and thus litigation costs will be lower. According to the National Academy of Social Insurance, for every dollar paid to workers' compensation claimants, approximately 23 cents is paid in administrative costs.[16] Using this assumption that "fair" administrative costs should be roughly equal to 23 percent of damages paid to claimants, one can begin to estimate the "excessive" costs inherent in the U.S. tort system.

Even if we start with the extremely cautious assumption that both economic ($36 billion) and non-economic damages ($40 billion) are set at an economically efficient level, and that an additional 23 percent should be spent on administration, an efficient tort system would result in transfers of only $93 billion per year.[17] By this cautious calculation, the current U.S. tort system includes "excessive" tort costs of $87 billion per year.[18] Were one to adapt the assumption that non-economic damages are random, the "litigation tax" would rise to $136 billion per year, even after accounting for reasonable administrative expenses.[19] To the extent that the economic damages awarded by the tort system are not well targeted and therefore fail to provide proper incentives to firms, the entire $180 billion in direct costs is economically excessive.

Another useful perspective is provided by comparing the cost of tort liability in the United States to that of other developed countries. While it is difficult to make cross-national comparisons because of data limitations, estimates by Tillinghast-Towers Perrin suggest that the U.S. tort system is substantially more costly than that of other countries. As shown in figure 2, U.S. tort costs in 1998 were 1.9 percent of GDP, approximately double the average cost of the other nations studied. Only Italy, with

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[16] National Academy of Social Insurance, "Workers' Compensation: Benefits, Coverage and Costs, 1999 New Estimates and 1996-1998 Revisions," May 2001.

[17] (Economic damages ($36 b.) + Non-Economic damages ($40 b.)) * Administrative cost factor (1.23) = Non-excessive tort costs ($93 b.)

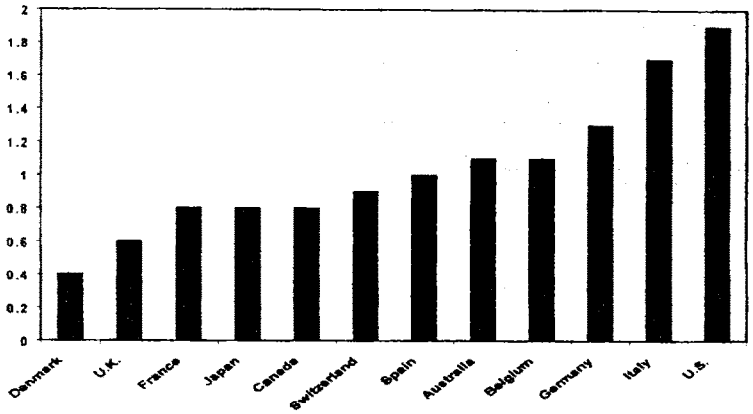
[18] Total tort costs ($180 b.) – Non-excessive tort costs ($93 b.) = Excessive tort costs ($87 b.)

[19] Total ($180 b.) – (Economic($36 b.) *Admin cost factor(1.23)) = Excessive tort costs ($136 b.)

costs of 1.7 percent of GDP, rivaled the U.S. in total direct costs. Tort costs in Denmark, the United Kingdom, France, Japan, Canada and Switzerland are all estimated to be less than 1 percent of GDP.

Figure 2

International Tort Costs as a Percentage of GDP, 1998



Source: Tillinghast-Towers Perrin, "U.S. Tort Costs: 2000"

How Large is the Burden of the Litigation Tax?

Regardless of which estimate of the direct cost presented above is closest to the truth, it is likely to substantially *underestimate* the total economic cost of the U.S. tort system. In the analysis of taxation, economists recognize that the total burden of a tax exceeds the revenue it collects. The excess burden or "deadweight loss" of taxation arises because taxes distort production and consumption decisions. In the current setting, an example of this phenomenon is that physicians may prescribe unnecessary precautionary treatments, often referred to as "defensive medicine," in order to avoid

non-financial litigation penalties such as harm to their reputations and the time and stress associated with a malpractice suit.[20] Some socially desirable products and services are likely never produced due to excessive tort liability claims.

Anecdotal evidence suggests that some products that may have a net benefit to society as a whole are withheld from the marketplace due to excessive concerns of liability from the tort system. For example, concerns over liability have resulted in withdrawals of certain medicines, and halted the production of vaccines such as smallpox and DPT. In trying to gauge the size of these costs, the appropriate measure of loss is the difference between the value of the good that is not produced and the value of the next best alternative. Because only one of these goods is produced in the market, it is difficult to assess this loss. The net economic cost of these types of actions is difficult to quantify, and is not included in the $180 billion estimate.

Despite these difficulties, one can approximate the magnitude of the deadweight loss through the literature on taxation. Recent research by Professor Dale Jorgenson of Harvard University estimates that the marginal deadweight loss per dollar of revenue raised by the corporate income tax in the United States is 27.9 cents.[21] If all tort claims have a comparable deleterious effect on the economy, the deadweight loss resulting from the $180 billion in direct costs would be an *additional* $50 billion. Even using the most cautious estimate that excessive direct costs total $87 billion, an additional 27.9 percent deadweight loss would bring the total cost of the litigation tax to $111 billion. In the intermediate case with direct costs of $136 billion, the total economic burden would be $174 billion annually.

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[20] Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *The Quarterly Journal of Economics*, May 1996.

[21] Dale Jorgenson and Kun-Young Yun, Investment, Volume 3, *Lifting the Burden: Tax Reform, the Cost of Capital, and U.S. Economic Growth*, 2001, Table 7.10, page 287.

Who Pays for Excessive Liability Claims?

Who pays the litigation tax? While a tax may be collected from a firm, its burden must ultimately be borne by individuals through job loss or a reduction in wages (workers), an increase in consumer prices (consumers), a decline in property values (landowners), or a reduction in profits and thus share prices (owners of capital). Of course, these categories are not mutually exclusive. The same person could suffer from lower wages, face higher prices for products, and have lower returns on his pension assets.

Determining the true economic burden, or economic incidence, of a tax is a complex undertaking, as it requires that one consider how wages and prices have adjusted throughout the economy as a result of the tax. If wages fall as the result of a tax, economists say that the tax has been *shifted backward* onto labor. If prices rise, economists say that the tax has been *shifted forward* to consumers.[22] Alternatively, firm profitability could be reduced, in which case the tax burden is borne by participants in private pension plans and owners of stocks and mutual funds.

For example, in the United States, the Social Security system collects 12.4 percent of a worker's wages[23] to support retirement and disability benefit payments. Half of this, or 6.2 percent, is levied on the worker. The remaining 6.2 percent is levied on the employer. However, most of the employer-paid portion of the social security tax is shifted backward so that the employer portion of the payroll tax has the same effect on a worker as does the portion levied directly on the worker. Thus, even though employees *legally* bear only half of the payroll tax, they bear the full – or almost full – economic burden of the tax through lower wages.[24]

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[22] Joseph E. Stiglitz, *Economics of the Public Sector*, Third Edition, New York: W. W. Norton, 2000, page 483.

[23] Up to a maximum taxable amount of $84,900 in 2002.

[24] Joseph E. Stiglitz, *Economics of the Public Sector*, Third Edition, New York: W. W. Norton, 2000, page 483.

analysis at all. OTA makes the assumption that the tax is borne by owners of capital. Traditionally, the CBO has used three different variations: 100 percent by capital, 100 percent by labor, and half by each. The inconsistent set of assumptions and methodologies across agencies highlights the uncertainty about the economic incidence of the corporate income tax. In fact, a recent survey of economists who specialize in public finance found that virtually all of these economists believe that the burden of the corporate income tax is shared by both capital and labor generally, but "there is significant disagreement about the precise division."[26]

To the extent that capital markets are globally linked, allowing capital to flow freely across borders, the after-tax rate of return to capital must be equated across countries. One implication is that if tort liability raises the cost of capital in the United States, mobile capital will seek the relatively higher return available elsewhere, until rates of return are again equalized. The result is that the capital stock in the United States may be smaller with high tort costs than with low tort costs. A smaller capital stock means there is less capital per worker, thus lowering productivity and wages. In this way, the costs of tort may fall on the less mobile factors of production, namely labor. If global capital markets were fully integrated and capital freely mobile, then the entire burden of the costs of excessive tort in the United States could be shifted to labor through reduced real wages and consumers through higher prices.

The relative magnitude of the burden of excessive tort costs in the U.S. is quite substantial. For perspective, in the year 2000, total wage and salary disbursements to private industries (i.e., excluding government workers) totaled just over $4 trillion.[27] Taking the extremely conservative excessive cost estimate of $87 billion – an estimate that treats the current level of economic and non-economic damages as appropriate,

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[26] Victor R. Fuchs, Alan B. Krueger, and James M. Poterba, "Why Do Economists Disagree about Policy? The Roles of Beliefs about Parameters and Values," National Bureau of Economic Research Working Paper No. 6151, August 1997, page 12.

[27] *Economic Report of the President*, February 2002, Table B-29.

allows for a reasonable administrative charge of 23 percent of the award, and ignores the deadweight burden – the litigation tax is equivalent to a 2.1 percent wage and salary tax shifted onto private sector workers. Alternatively, if this $87 billion were shifted forward to consumers through higher prices, this would be equivalent to a 1.3 percent tax on personal consumption.[28] If the excess burden were not passed through to labor or consumers, and instead was borne entirely by capital, then it would be equivalent to a tax on capital income of 3.1 percent.[29] It should be noted that nearly 80 million Americans own corporate stock, either individually or through their pension funds.[30] In fact, over 20 percent of corporate stock in the U.S. is held by public and private pension funds – suggesting that if this litigation tax is not passed through to workers via wage reductions or price increases, workers are still harmed through reduced returns on their retirement saving.

Table 1 below illustrates the "tax equivalence" of tort litigation costs under various assumptions about the incidence of the tax, and the size of the excessive tort costs. As a lower bound on the size of the litigation tax, we treat all economic and non-economic damages as economically appropriate, allow for 23 percent administrative costs, and ignore the deadweight burden. This translates to a litigation tax of approximately $87 billion per year. For an intermediate estimate, we include non-economic damages in the excess cost of tort, following the work of Viscusi. This implies a litigation tax of $136 billion per year, ignoring the deadweight loss. For an upper-bound estimate, we treat *all* tort costs as economically excessive, and also include an estimated $50 billion in deadweight loss.

As illustrated in Table 1, under the assumption that the tax is fully shifted forward through prices, the annual excessive tort costs are equivalent to a tax on consumption

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[28] *Economic Report of the President*, February 2002, Table B-1.
[29] According to unpublished data from the Productivity and Technology Division of the Bureau of Labor Statistics, the capital (non-labor) share of nonfarm business output was $2,762 billion in 2001.
[30] Investment Company Institute, *Equity Ownership in America*, 1999.

ranging from 1.3 percent to 3.4 percent. Alternatively, if shifted backwards onto labor, the "litigation tax" is equivalent to a tax on wages from 2.1 percent to as high as 5.7 percent. If the incidence of the tax falls on investors, it is equivalent to a tax on capital ranging from 3.1 percent to 8.2 percent. The final row of Table 1 illustrates the case in which the burden of the litigation tax is shared by consumers, workers and investors.[31]

Whether it falls entirely on labor, or whether some portion of it also falls on capital owners in the U.S., the cost to the U.S. economy is substantial. For example, in the year 2000, the intermediate cost estimate of $136 billion is more than the Federal government spent on all of the following programs *combined*: Education, training, and employment; general science; space and technology; conservation and land management; pollution control and abatement; disaster relief and insurance; community development; Federal law enforcement and administration of justice; and unemployment compensation.[32] Alternatively, $136 billion is two-thirds the amount of revenue collected from the corporate income tax[33] or nearly half (46 percent) of the amount spent on national defense.[34] Viewed differently, at more than 3 percent of wages per year, the cost of the litigation tax is also far more than enough money to solve Social Security's long-term financing crisis. To a family of average income, three percent of wages is also the cost of more than three months of groceries, six months of utility payments, or eight months of health care costs[35]. That is, $136 billion represents a large drain on the productive resources of the United States.

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[31] The assumed division is 25 percent through prices, 25 percent through wages, and 50 percent through reduced investment returns. This incidence assumption is based on one of the corporate tax incidence scenarios used by Joseph A. Pechman in Who Paid the Taxes, 1966-85, Washington, D.C., The Brookings Institution, 1985, p.35.
[32] *Budget of the United States Government*, Fiscal Year 2003, Historical Tables, Table 3.2, pages 54-69.
[33] *Ibid*, Table 2.1 page 30.
[34] *Ibid*, Table 3.1, page 51.
[35] Bureau of Labor Statistics, "Consumer Expenditures in 1999," May 2001.

Table 1
Size of the Tort Litigation Tax

Incidence Assumption	Equivalent Tax Base	Annual "Excessive" Tort Costs		
		$87 billion	$136 billion	$230 billion
Fully shifted forward Through prices	Consumption Tax	1.3%	2.0%	3.4%
Fully shifted backward Onto workers	Wage Tax	2.1%	3.3%	5.7%
Fully borne by Investors	Capital Tax	3.1%	4.9%	8.2%
25% shifted through prices, 25% shifted through wages, 50% borne by investors	Consumption Wage Capital	0.3% 0.5% 1.6%	0.5% 0.8% 2.4%	0.8% 1.4% 4.1%

Source: CEA calculations. The taxes are calculated by dividing the annual excessive tort costs by the appropriate base. The consumption base is total personal consumption expenditures which totaled $6,728 billion in the year 2000. The wage base is total wage and salary disbursements to private industries, which totaled $4,069 billion. The capital base is non-labor payments in national income, which totaled $2,789 in the year 2000.

Summary

The cost of the U.S. legal liability system has increased substantially over the past several decades. While economic theory suggests a potentially useful role for a tort system in providing proper incentives, excessive tort costs are akin to a tax on firms. Like any tax, this "litigation tax" imposes deadweight losses on the economy in the form of products and services that are never produced as a result of the fear of litigation. Both the direct and indirect costs of excessive tort must ultimately be borne by individuals in the economy through some combination of higher prices, lower wages, and reduced returns to investments.

DO DOCTORS PRACTICE DEFENSIVE MEDICINE?*

DANIEL KESSLER AND MARK MCCLELLAN

"Defensive medicine" is a potentially serious social problem: if fear of liability drives health care providers to administer treatments that do not have worthwhile medical benefits, then the current liability system may generate inefficiencies much larger than the costs of compensating malpractice claimants. To obtain direct empirical evidence on this question, we analyze the effects of malpractice liability reforms using data on all elderly Medicare beneficiaries treated for serious heart disease in 1984, 1987, and 1990 We find that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications. We conclude that liability reforms can reduce defensive medical practices

INTRODUCTION

The medical malpractice liability system has two principal roles: providing redress to individuals who suffer negligent injuries, and creating incentives for doctors to provide appropriately careful treatment to their patients [Bell 1984]. Malpractice law seeks to accomplish these goals by penalizing physicians whose negligence causes an adverse patient health outcome, and using these penalties to compensate the injured patients [Danzon 1985]. Considerable evidence indicates that the current malpractice system is neither sensitive nor specific in providing compensation. For example, the Harvard Medical Practice Study [1990] found that sixteen times as many patients suffered an injury from negligent medical care as received compensation in New York State in 1984. In any event, the cost of compensating malpractice claimants is not an important source of medical expenditure growth: compensation paid and the costs of administering that compensation through the legal system account for less than 1 percent of expenditures [OTA 1993].

The effects of the malpractice system on physician behavior, in contrast, may have much more substantial effects on health

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care costs and outcomes, even though virtually all physicians are fully insured against the financial costs of malpractice such as damages and legal defense expenses. Physicians may employ costly precautionary treatments in order to avoid nonfinancial penalties such as fear of reputational harm, decreased self-esteem from adverse publicity, and the time and unpleasantness of defending a claim [Charles, Pyskoty, and Nelson 1988; Weiler et al. 1993].

On the one hand, these penalties for malpractice may deter doctors and other providers from putting patients at excessive risk of adverse health outcomes. On the other hand, these penalties may also drive physicians to be too careful—to administer precautionary treatments with minimal expected medical benefit out of fear of legal liability—and thus to practice "defensive medicine." Many physicians and policy-makers have argued that the incentive costs of the malpractice system, due to extra tests and procedures ordered in response to the perceived threat of a medical malpractice claim, may account for a substantial portion of the explosive growth in health care costs [Reynolds, Rizzo, and Gonzalez 1987; OTA 1993, 1994]. The practice of defensive medicine may even have adverse effects on patient health outcomes, if liability induces providers either to administer harmful treatments or to forgo risky but beneficial ones. For these reasons, defensive medicine is a crucial policy concern [Sloan, Mergenhagen, and Bovbjerg 1989].

Despite this policy importance, there is virtually no direct evidence on the existence and magnitude of defensive medical practices. Such evidence is essential for determining appropriate tort liability policy. In this paper we seek to provide such direct evidence on the prevalence of defensive medicine by examining the link between medical malpractice tort law, treatment intensity, and patient outcomes. We use longitudinal data on all elderly Medicare recipients hospitalized for treatment of a new heart attack (acute myocardial infarction, or AMI) or of new ischemic heart disease (IHD) in 1984, 1987, and 1990, matched with information on tort laws from the state in which the patient was treated. We study the effect of tort law reforms on total hospital expenditures on the patient in the year after AMI or IHD to measure intensity of treatment. We also model the effect of tort law reforms on important patient outcomes. We estimate the effect of reforms on a serious adverse outcome that is common in our study population: mortality within one year of occurrence of the

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cardiac illness. We also estimate the effect of tort reforms on two other common adverse outcomes related to a patient's quality of life: whether the patient experienced a subsequent AMI or heart failure requiring hospitalization in the year following the initial illness.

To the extent that reductions in medical malpractice tort liability lead to reductions in intensity but not with increases in adverse health outcomes, medical care for these health problems is defensive; that is, doctors supply a socially excessive level of care due to malpractice liability pressures. Put another way, tort reforms that reduce liability also reduce inefficiency in the medical care delivery system to the extent that they reduce health expenditures which do not provide commensurate benefits. We assess the magnitude of defensive treatment behavior by calculating the cost of an additional year of life or an additional year of cardiac health achieved through treatment intensity induced by specific aspects of the liability system. If liability-induced precaution results in low expenditures per year of life saved relative to generally accepted costs per year of life saved of other medical treatments, then the existing liability system provides incentives for efficient care. But if liability-induced precaution results in high expenditures per year of life saved, then the liability system provides incentives for socially excessive care. Because the precision with which we measure the consequences of reforms is critical, we include all U. S. elderly patients with heart diseases in 1984, 1987, and 1990 in our analysis.

Section I of the paper discusses the theoretical ambiguity of the impact of the current liability system on efficiency in health care. For this reason, liability policy should be guided by empirical evidence on its consequences for "due care" in medical practice. Section II reviews the previous empirical literature. Although the existing evidence on the effectiveness of alternative liability rules has provided considerable insights, direct evidence on the crucial effects of the tort system on physician behavior is virtually nonexistent. Section III presents our econometric models of the effects of liability rules on treatment decisions, costs, and patient outcomes, and formally describes the test for defensive medicine used in the paper. We identify liability effects by comparing trends in treatment choice, costs, and outcomes in states adopting various liability reforms to trends in those that did not. We also review a number of approaches to enriching the model, assisting in the evaluation of its statistical validity and

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providing further insights into the tort reform effects. Section IV discusses the details of our data, and motivates our analysis of elderly Medicare beneficiaries for purposes of assessing the costs of defensive medicine. Section V presents the empirical results. Section VI discusses implications for policy, and Section VII concludes.

I. Malpractice Liability and Efficient Precaution In Health Care

In general, malpractice claims are adjudicated in state courts according to state laws. These laws require three elements for a successful claim. First, the claimant must show that the patient actually suffered an adverse event. Second, a successful malpractice claimant must establish that the provider caused the event: the claimant must attribute the injury to the action or inaction of the provider, as opposed to nature. Third, a successful claimant must show that the provider was negligent. Stated simply, this entails showing that the provider took less care than that which is customarily practiced by the average member of the profession in good standing, given the circumstances of the doctor and the patient [Keeton et al. 1984]. Collectively, this three-part test of the validity of a malpractice claim is known as the "negligence rule."

In addition to patient compensation, the principal role of the liability system is to induce doctors to take the optimal level of precaution against patient injury. However, a negligence rule may lead doctors to take socially insufficient precaution, such that the marginal social benefit of precaution would be greater than the marginal social cost. Or, it may lead doctors to take socially excessive precaution, that is, to practice defensive medicine, such that the marginal social benefit of precaution would be less than the marginal social cost [Farber and White 1991]. The negligence rule may not generate socially optimal behavior in health care because the private incentives for precaution facing doctors and patients differ from the social incentives. First, the costs of accidents borne by the physician differ from the social costs of accidents. Because malpractice insurance is not strongly experience rated [Sloan 1990], physicians bear little of the costs of patient injuries from malpractice. However, physicians bear

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significant uninsured expenses in response to a malpractice claim, such as the value of time and emotional energy spent on legal defense [OTA 1993, p. 7]. Second, patients and physicians bear little of the costs of medical care associated with physician precaution in any particular case because most health care is financed through health insurance. Generally, insured expenses for drugs, diagnostic tests, and other services performed for precautionary purposes are much larger than the uninsured cost of the physician's own effort. Third, physicians bear substantial costs of accidents only when patients file claims, and patients may not file a malpractice claim in response to every negligent medical injury [Harvard Medical Practice Study 1990].

The direction and extent of the divergence between the privately and socially optimal levels of precaution depends in part on states' legal environments. Although the basic framework of the negligence rule applies to most medical malpractice claims in the United States, individual states have modified their tort law to either expand or limit malpractice liability along various dimensions over the past 30 years. For example, several states have imposed caps on malpractice damages such that recoverable losses are limited to a fixed dollar amount, such as $250,000. These modifications to the basic negligence rule can affect both the costs to physicians and the benefit to patients from a given malpractice claim or lawsuit, and thereby also affect the frequency and average settlement amount ("severity") of claims. We use the term *malpractice pressure* to describe the extent to which a state's legal environment provides high benefits to plaintiffs or high costs to physicians or both. (Malpractice pressure can be multidimensional.)

If the legal environment creates little malpractice pressure and externalized costs of medical treatment are small, then the privately optimal care choice may be below the social optimum. In this case, low benefits from filing malpractice claims and lawsuits reduce nonpecuniary costs of accidents for physicians, who may then take less care than the low cost of diagnostic tests, for example, would warrant. However, if the legal environment creates substantial malpractice pressure and externalized costs of treatment are large, then the privately optimal care choice may be above the social optimum: privately chosen care decisions will be defensive. For example, increasing technological intensity with a reduced share of physician effort costs relative to total

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medical care costs) and increasing generosity of tort compensation of medical injury would lead to relatively more defensive medical practice.

Incentives to practice defensively may be intensified if judges and juries impose liability with error. For example, the fact that health care providers' precautionary behavior may be ex post difficult to verify may give them the incentive to take too much care [Cooter and Ulen 1986; Craswell and Calfee 1986]. Excessive care results from the all-or-nothing nature of the liability decision: small increases in precaution above the optimal level may result in large decreases in expected liability.

Because privately optimal behavior under the basic negligence rule may result in medical treatment that has marginal social benefits either greater or less than the marginal social costs, the level of malpractice pressure that provides appropriate incentives is an empirical question. In theory, marginal changes to the negligence rule can either improve or reduce efficiency, depending on their effects on precautionary behavior, total health care costs, and adverse health outcomes. Previous studies have analyzed effects of legal reforms on measures of malpractice pressure, such as the level of compensation paid malpractice claimants. To address the potentially much larger behavioral consequences of malpractice pressure, we study the impact of changes in the legal environment on health care expenditures to measure the marginal social cost of treatment induced by the liability system, and the impact of law changes on adverse health events to measure the marginal social benefit of law-induced treatment. As a result, we can provide direct evidence on the efficiency of a baseline malpractice system and, if it is inefficient, identify efficiency-improving reforms.

II. Previous Empirical Literature

The previous empirical literature is consistent with the hypothesis that providers practice defensive medicine, although it does not provide direct evidence on the existence or magnitude of the problem. One arm of the literature uses surveys of physicians to assess whether doctors practice defensive medicine [Reynolds, Rizzo, and Gonzalez 1987; Moser and Musaccio 1991; OTA 1994]. Such physician surveys measure the cost of defensive medicine only through further untestable assumptions about the relationship between survey responses, actual treatment behavior, and

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patient outcomes. Although surveys indicate that doctors believe that they practice defensively, surveys only provide information about what treatments doctors say that they would administer in a hypothetical situation: they do not measure behavior in real situations.

Another body of work uses clinical studies of the effectiveness of intensive treatment [Leveno et al. 1986; Shy et al. 1990]. These studies find that certain intensive treatments which are generally thought to be used defensively have an insignificant impact on health outcomes. Similarly, clinical evaluations of malpractice control policies at specific hospitals have found that intensive treatments thought to serve a defensive purpose are "overused" by physicians [Masters et al. 1987]. However, this work does not directly answer the policy question of interest: does intensive treatment *administered out of fear of malpractice claims* have any effect on patient outcomes? Few medical technologies in general use have been shown to be ineffective in all applications, and the average effect of a procedure in a population may be quite different from its effect at the margin in, for example, the additional patients who receive it because of more stringent liability rules [McClellan 1995]. Evaluating malpractice liability reforms requires evidence on the effectiveness of intensive treatment in the "marginal" patients.

A third, well-developed arm of the literature estimates the effects of changes in the legal environment on measures of the compensation paid and the frequency of malpractice claims. Danzon [1982, 1986] and Sloan, Mergenhagen, and Bovbjerg [1989] find that tort reforms that cap physicians' liability at some maximum level or require awards in malpractice cases to be offset by the amount of compensation received by patients from collateral sources[1] reduce payments per claim.[2] Danzon [1986] also finds

1 Reforms requiring collateral-source offset revoke the common-law default rule which states that the defendant must bear the full cost of the injury suffered by the plaintiff, even if the plaintiff were compensated for all or part of the cost by an independent or "collateral" source Under the common-law default rule, defendants liable for medical malpractice always bear the cost of treating a patient for medical injuries resulting from the malpractice, even if the treatment were financed by the patient's own health insurance. Either the plaintiff enjoys double recovery (the plaintiff recovers from the defendant and his own health insurance for medical expenses attributable to the injury) or the defendant reimburses the plaintiff's (subrogee) health insurer, depending on the plaintiff's insurance contract and state or federal law However, some states have enacted reforms that specify that total damages payable in a malpractice tort are to be reduced by all or part of the value of collateral source payments

2 Estimates of the impact of reforms on claim severity vary over time and across studies Based on 1975–1978 data, Danzon [1982, p 30] reports that states

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that collateral-source-rule reforms and statute-of-limitations reductions reduce claim frequency. Based on data from malpractice insurance markets, Zuckerman, Bovbjerg, and Sloan [1990] and Barker [1992] reach similar conclusions: Zuckerman, Bovbjerg, and Sloan find that caps on damages and statute-of-limitations reductions reduce malpractice premiums, and Barker finds that caps on damages increase profitability.

Despite significant variety in data and methods, this literature contains an important unified message about the types of legal reforms that affect physicians' incentives. The two reforms most commonly found to reduce payments to and the frequency of claims, caps on damages and collateral-source-rule reforms, share a common property: they *directly* reduce expected malpractice awards. Caps on damages truncate the distribution of awards; mandatory collateral-source offsets shift down its mean. Other malpractice reforms that only affect malpractice awards *indirectly*, such as reforms imposing mandatory periodic payments (which require damages in certain cases to be disbursed in the form of an annuity that pays out over time) or statute-of-limitations reductions, have had a less discernible impact on liability and hence on malpractice pressure.

However, estimates of the impact of reforms on frequency and severity from these analyses are only the first step toward answering the policy question of interest: do doctors practice defensive medicine? Taken alone, they only provide evidence of the effects of legal reforms on doctors' incentives; they do not provide evidence of the effects of legal reforms on doctors' behavior. Identifying the existence of defensive treatment practices and the extent of inefficient precaution due to legal liability requires a comparison of the response of costs of precaution and the response of losses from adverse events to changes in the legal environment.

A number of studies have sought to investigate physicians' behavioral response to malpractice pressure. These studies generally have analyzed the costs of defensive medicine by relating physicians' actual exposure to malpractice claims to clinical prac-

enacting caps on damages had 19 percent lower awards, and states enacting mandatory collateral source offsets had 50 percent lower awards Based on 1975–1984 data, Danzon [1986, p. 26] reports that states enacting caps had 23 percent lower awards, and states enacting collateral source offsets had 11 to 18 percent lower awards Based on 1975–1978 and 1984 data, Sloan, Mergenhagen, and Bovbjerg [1989] find that caps reduced awards by 38 to 39 percent, and collateral-source offsets reduced awards by 21 percent

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tices and patient outcomes [Rock 1988; Harvard Medical Practice Study 1990; Localio et al. 1993; Baldwin et al. 1995]. Rock, Localio et al., and the Harvard Medical Practice Study find results consistent with defensive medicine; Baldwin et al. do not. However, concerns about unobserved heterogeneity across providers and across small geographic areas qualify the results of all of these studies. The studies used frequency of claims or magnitude of insurance premiums at the level of individual doctors, hospitals, or areas within a single state over a limited time period to measure malpractice pressure. Because malpractice laws within a state at a given time are constant, the measures of malpractice pressure used in these studies arose not from laws but from primarily unobserved factors at the level of individual providers or small areas, creating a potentially serious problem of selection bias. For example, the claims frequency or insurance premiums of a particular provider or area may be relatively high because the provider is relatively low quality, because the patients are particularly sick (and hence prone to adverse outcomes), because the patients had more "taste" for medical interventions (and hence are more likely to disagree with their provider about management decisions), or because of many other factors. The sources of the variation in legal environment are unclear and probably multifactorial. All of these factors are extremely difficult to capture fully in observational data sets and could lead to an apparent but noncausal association between measured malpractice pressure and treatment decisions or outcomes.

Thus, while previous analyses have provided a range of insights about the malpractice liability system, they have not provided direct empirical evidence on how malpractice reforms would actually affect physician behavior, medical costs, and health outcomes.

III. Econometric Models

Our statistical methods seek to measure the effects of changes in an identifiable source of variation in malpractice pressure influencing medical decision making—state tort laws—that is not related to unobserved heterogeneity across patients and providers. We compare time trends across reforming and nonreforming states during a seven-year period in inpatient hospital expenditures, and in outcome measures including all-cause cardiac mortality as well as the occurrence of cardiac complications

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directly related to quality of life. We model average expenditures and outcomes as essentially nonparametric functions of patient demographic characteristics, state legal and political characteristics, and state- and time-fixed effects. We model the effects of state tort law changes as differences in time trends before and after the tort law changes. We test for the existence and magnitude of defensive medicine based on the relationship of the law-change effects on medical expenditures and health outcomes.

While this strategy fundamentally involves differences-in-differences between reforming and nonreforming states to identify effects, we modify conventional differences-in-differences estimation strategies in several ways. First, as noted above, our models include few restrictive parametric or distributional assumptions about functional forms for expenditures or health outcomes. Second, we do not only model reforms as simple one-time shifts. Malpractice reforms might have more complex, longer term effects on medical practices for a number of reasons. Law changes may not have instantaneous effects because it may take time for lawyers, physicians, and patients to learn about their consequences for liability, and then to reestablish equilibrium practices. Law changes may affect not only the static climate of medical decision making, but also the climate for further medical interventions by reducing pressure for technological intensity growth. Thus, the long-term consequences of reforms may be different from their short-term effects. By using a panel data set including a seven-year panel, our modeling framework permits a more robust analysis of differences in *time trends* before and after adoption.

We use a panel-data framework with observations on successive cohorts of heart disease patients for estimating the prevalence of defensive medicine. In state $s = 1, \ldots, S$ during year $t = 1, \ldots, T$, our observational units consist of individual $I = 1, \ldots, N_{st}$ who are hospitalized with new occurrences of particular illnesses such as a heart attack. Each patient has observable characteristics X_{ist}, which we describe as a fully interacted set of binary variables, as well as many unobservable characteristics that also influence both treatment decisions and outcomes. The individual receives treatment of aggregate intensity R_{ist}, where R denotes total hospital expenditures in the year after the health event. The patient has a health outcome O_{ist}, possibly affected by the intensity of treatment received, where a higher value denotes a more adverse outcome (O is binary in our models).

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We define state tort systems in effect at the time of each individual's health event based on the existence of two categories of reforms from a maximum-liability regime: direct and indirect malpractice reforms. Previous studies, summarized in Section II, found differences between these types of reforms on claims behavior and malpractice insurance premiums (Section IV below discusses our reform classification in detail). We denote the existence of direct reforms in state s at time t using two binary variables L_{mst}: $L_{1st} = 1$ if state s has adopted a direct reform at time t, and $L_{2st} = 1$ if state s has adopted an indirect reform at time t. $L_{st} = [L_{1st}\ L_{2st}]$ is thus a two-dimensional binary vector describing the existence of malpractice reforms.

We first estimate linear models of average expenditure and outcome effects using these individual-level variables. The expenditure models are of the form,

$$R_{ist} = \theta_t + \alpha_s + X_{ist}\beta + W_{st}\gamma + L_{st}\phi_m + \nu_{ist}, \tag{1}$$

where θ_t is a time-fixed effect, α_s is a state-fixed effect, W_{st} is a vector of variables described below which summarize the legal-political environment of the state over time, β and γ are vectors of the corresponding average-effect estimates for the demographic controls and additional state-time controls, ϕ_m is the two-dimensional average effect of malpractice reforms on growth rate, and v_{ist} is a mean-zero independently distributed error term with $E(v_{ist} \mid X_{ist}, L_{st}, W_{st}) = 0$. Because legal reforms may affect both the level and the growth rate of expenditures, we estimate different baseline time trends θ_t for states adopting reforms before 1985 (which were generally adopted before 1980) and nonadopting states. Our data set includes essentially all elderly patients hospitalized with the heart diseases of interest for the years of our study, so that our results describe the actual average differences in trends associated with malpractice reforms in the U. S. elderly population. We report standard errors for inferences about average differences that might arise in potential populations (e.g., elderly patients with these health problems in other years). Our model assumes that patients grouped at the level of state and time have similar distributions of unobservable characteristics that influence medical treatments and health outcomes. Assuming that malpractice laws affect malpractice pressure, but do not directly affect patient expenditures or outcomes, then the coefficients ϕ identify the average effects of changes in malpractice pressure resulting from malpractice reforms.

To distinguish short-term and long-term effects of legal re-

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forms, we estimated less restrictive models of the average effects of legal reforms that utilize the long duration of our panel. These "dynamic" models estimate separate growth rate effects ϕ_{md} based on time-since-adoption:

$$R_{ist} = \theta_t + \alpha_s + X_{ist}\beta + W_{st}\gamma + L_{st}d_{st}\phi_{md} + \nu_{ist}, \tag{2}$$

where we include separate short-term average effects ϕ_{m0} and long-term average effects ϕ_{m1}. We estimate the short-term effect of the law (within two years of adoption) ϕ_{m0} by setting $d_{st0} = 1$ for 1985–1987 adopters in 1987 and 1988–1990 adopters in 1990, and we estimate the long-term effect (three to five years since adoption) ϕ_{m1} by setting $d_{st1} = 1$ for 1985–1987 adopters in 1990.

The estimated average effects ϕ_{md} in these models form the basis for tests of the effects of malpractice reforms on health care expenditures and outcomes, and thus for tests of the existence and magnitude of defensive medicine. In all of these models, there is evidence of defensive medicine if, for direct or indirect reforms m, $\phi_{md} < 0$ in our models of medical expenditures and $\phi_{md} = 0$ in our models of health outcomes. In other words, if a state law reform is associated with a reduction in the growth rate of medical expenditures and does not adversely affect the growth rate of adverse health outcomes through its impact on treatment decisions, then malpractice pressure is too high from the perspective of social welfare, and defensive medicine exists. More generally, defensive medicine exists if the effect of malpractice reforms on expenditures is "large" relative to the effect on health outcomes. Thus, in the results that follow, we test both whether expenditure and outcome effects of reforms differ substantially from zero, as well as the ratio of expenditure to outcome effects.

The power of the test for defensive medicine depends on the statistical precision of the estimated effects of law reforms on outcomes. Consequently, we evaluate the confidence intervals surrounding our estimates of outcome efforts carefully.[3] It is not feasible to collect information on *all* health outcomes that may matter to some degree to individual patients. Instead, our tests focus on important health outcomes, including mortality and significant cardiac complications, which are reliably observed in our study population. Because the cardiac complications we consider reflect the two principal ways in which poorly treated heart disease would affect quality of life (e.g., through further heart at-

3. Again, because all elderly patients with serious heart disease during the years of our study are included, this consideration applies only to extending the results to other patient populations.

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tacks or through impaired cardiac function), estimates of effects on these health outcomes along with mortality would presumably capture any important health consequences of malpractice reforms.

We estimated additional specifications of our models to test whether reform adoption is not in fact correlated with unobserved trends in malpractice pressures or patient characteristics across the state-time groups. One set of specification tests was based on the inclusion of random effects for state-time interactions. To account for any geographically correlated variations in costs or expenditures over time, we included Huber-White [1980] standard error corrections for zip code-time error correlations. We also tested whether our estimated standard errors were sensitive to Huber-White corrections for state-time error correlations.[4]

Another set of specification tests involved evaluating a range of variables W_{st} summarizing the political and regulatory environment in each state at each point in time, to test whether various factors that might influence reform adoption influence our estimates of reform effects on either expenditure or health outcomes. Since the main cause of the tort reforms that are the focus of our study was nationwide crisis in all lines of commercial casualty insurance, it is unlikely that endogeneity of reforms is a serious problem [Priest 1987; Rabin 1988]. However, Campbell, Kessler, and Shepherd [1996] show that the concentration of physicians and lawyers in a state and measures of states' political environment are correlated with liability reforms, and Danzon [1982] shows that the concentration of lawyers in a state is correlated with both the compensation paid to malpractice claims and the enactment of reforms.[5] Consequently, we control for the political party of each state's governor, the majority political party of each house of each state's legislature, and lawyers per capita in all of the regressions, and we tested the sensitivity of our results to these controls.[6]

A third set of specification tests relied on other tort reforms

4 Of course, if such state-time specific effects exist, there is no reason to expect that they would be normally distributed. Normality assumptions in error structures generally have not performed well in models of health expenditures and outcomes However, incorporating such random effects permits us to explore the robustness of our estimation methods to possible state-time specific shifts

5 According to Danzon [1982, 1986], urbanization is a highly significant determinant both of claim payments to and the frequency of claims and of the enactment of tort reforms. We control for urbanization at the individual level, as discussed below

6. Although we did not include controls for the number of physicians per capita in the reported results because of concerns regarding the exogeneity of that variable, results conditional on physician density are virtually identical We

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enacted in the 1980s which should have had a minimal impact on malpractice liability cases in the elderly during the time frame of our study. However, these reforms might be correlated with relevant malpractice reforms if, for example, general concerns about liability pressures in all industries led to broad legal reforms. If such reforms were correlated with included reforms, then our estimates might overstate the impact of the malpractice law reforms that we analyze.

Along these lines, we investigate the validity of our assumption of no omitted variable bias by estimating the impact of reforms to states' statutes of limitations. Statutes of limitations are most relevant in situations involving latent injuries. Malpractice arising out of AMI in the elderly would involve an injury of which the adverse consequences would appear before any statute of limitations would exclude an injured patient. Nonetheless, statutes of limitations are the potentially most important reform not included in our study (23 states shortened their statutes of limitations between 1985 and 1990, and Danzon [1986] finds that shorter statutes of limitations reduced claims frequency). If our models are correctly specified, then statute-of-limitations reforms should have no effect on the treatment intensity and outcome decisions that we analyze. If omitted variable bias is a problem, however, statute-of-limitations reforms may show a significant estimated effect.

Finally, because all of our specifications control for fixed differences across states, they do not allow us to estimate differences in the baseline levels of intensive treatment and adverse health outcomes. Thus, we also estimate additional versions of all of our models with region effects only, to explore baseline differences in treatment rates, costs, and outcomes across legal regimes.

IV. Data

The data used in our analysis come from two principal sources.[7] Our information on the characteristics, expenditures,

include both a current- and a one-year-lagged effect to account for the possibility that past political environments influence current law

7. Data on lawyers per capita for 1980, 1985, and 1988 are from the American Bar Foundation [1985, 1991]. Intervening years are calculated by linear interpolation. Data on state political environments are from the Council of State Governments [1984–1990].

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and outcomes for elderly Medicare beneficiaries with heart disease are derived from comprehensive longitudinal claims data for the vast majority of elderly Medicare beneficiaries who were admitted to a hospital with a new primary diagnosis (no admission with either health problem in the preceding year) of either acute myocardial infarction (AMI) or ischemic heart disease (IHD) in 1984, 1987, and 1990. Data on patient demographic characteristics were obtained from the Health Care Financing Administration HISKEW enrollment files, with death dates based on death reports validated by the Social Security Administration. Measures of total one-year hospital expenditures were obtained by adding up all reimbursement to acute-care hospitals (including copayments and deductibles not paid by Medicare) from insurance claims for all hospitalizations in the year following each patient's initial admission for AMI or IHD. Measures of the occurrence of cardiac complications were obtained by abstracting data on the principal diagnosis for all subsequent admissions (not counting transfers) in the year following the patient's initial admission. Cardiac complications included rehospitalizations within one year of the initial event with a primary diagnosis (principal cause of hospitalization) of either subsequent AMI or heart failure. Treatment of IHD and AMI patients is intended to prevent subsequent AMIs if possible, and the occurrence of heart failure requiring hospitalization is evidence that the damage to the patient's heart from ischemic disease has serious functional consequences. The programming rules used in the data set creation process and sample exclusion criteria were virtually identical to those reported in McClellan and Newhouse [1995, 1996].

We analyze cardiac disease patients because the choice of a particular set of diagnoses permits detailed exploration of the health and treatment consequences of policy reforms. Cardiac disease and its complications are the leading cause of medical expenditures and mortality in the United States. A majority of AMIs and IHD hospitalizations occurs in the elderly, and both mortality and subsequent cardiac complications are relatively common occurrences in this population. Thus, this condition provides both a relatively homogeneous set of patients and outcomes (to analyze the presence of defensive medicine with reasonable clinical detail), and medical expenditures are large enough and the relevant adverse outcomes common enough that the test for defensive medicine can be a precise one. Furthermore, because AMI is essentially a severer form of the same underlying illness

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as is IHD, we can assess whether reforms affect more or less severe cases of a health problem differently by comparing AMI with IHD patients.

In addition, cardiovascular illness is likely to be sensitive to defensive medical practices. In a ranking of illnesses by the frequency of and payments to the malpractice claims that they generate, AMI is the third most prevalent and costly, behind only malignant breast cancer and brain-damaged infants [PIAA 1993]. AMI is also distinctive because of the severity of medical injury associated with malpractice claims: conditional on a claim, patients with AMI suffer injury that rates 8.2 on the National Association of Insurance Commissioners nine-point severity scale, the second-highest severity rating of any malpractice-claim-generating health problem [PIAA]. Cardiovascular illnesses and associated procedures also include 7 of the 40 most prevalent and costly malpractice-claim-generating health problems [PIAA].

We focus on elderly patients in part because no comparable longitudinal microdata exist for nonelderly U. S. patient populations. However, there are other advantages to concentrating on this population. Several studies have documented that claims rates are lower in the elderly than in the nonelderly population, presumably because losses from severe injuries would be smaller given the patients' shorter expected survival [Weiler et al. 1993]. This hypothesis suggests that physicians are least likely to practice defensively for elderly patients. Thus, treatment decisions and expenditures in this population would be the least sensitive to legal reforms. Similarly, relatively low baseline incentives for defensive practices and the relatively high frequency of adverse outcomes in the elderly imply that this population can provide the most sensitive tests for adverse health effects of reforms. These considerations suggest that analysis of elderly patients provides a lower bound on the costs of defensive medicine. In any event, trends in practice patterns over time have been similar for elderly and nonelderly patients (e.g., intensity of treatment has increased dramatically and survival rates have improved for both groups [National Center for Health Statistics 1994]). Thus, we would expect the findings for this population to be qualitatively similar to results for the nonelderly, if such a longitudinal empirical analysis were possible.

Table I describes the elderly population with AMI and IHD from the years of our study. Between 1984 and 1990 the elderly AMI population aged slightly, and the share of males in the IHD

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TABLE I
AVERAGE HEALTH CARE COSTS, OUTCOMES, AND DEMOGRAPHIC CHARACTERISTICS FOR AMI AND IHD POPULATION

	AMI population 1984	1987	1990
1-year mortality	39.9	38 8	35.4
1-year AMI readmit	10.9	11 4	14 6
1-year heart failure readmit	9 6	10 1	11.0
1-year total hospital expenditures	$10,881	$11,996	$13,140
Mean age	75 6	75.9	76 1
(standard deviation)	(7 0)	(7.2)	(7 3)
Female	48 5	49.6	49 6
Black	5.1	5.4	5 5
Rural	29 4	30.3	30.3
Sample size	232,768	227,360	220,550
	IHD population 1984	**1987**	**1990**
1-year mortality	13 5	11 6	10 6
1-year AMI readmit	5 5	4 7	4.3
1-year heart failure readmit	7 8	6 9	7 7
1-year total hospital expenditures	$10,638	$11,187	$12,515
Mean age	74 6	74 3	74.3
(standard deviation)	(6 9)	(6 8)	(6 8)
Female	55 2	53 4	51 4
Black	5 7	5 7	5 8
Rural	30 6	30 4	29 7
Sample size	356,717	372,871	381,222

Hospital Expenditures in 1991 Dollars Outcome measures and demographic characteristics except age in percentage points

population increased slightly, but the characteristics of AMI and IHD patients were otherwise relatively stable. The number of AMI patients in an annual cohort declined slightly (from 233,000 to 221,000), while the number of IHD patients increased (from 357,000 to 423,000). Changes in real hospital expenditures in the year following the AMI or IHD event were dramatic. For example, one-year average hospital expenditures for AMI patients rose from $10,880 in 1984 to $13,140 in 1990 (in constant 1991 dollars), a real growth rate of around 4 percent per year. These expenditure trends are primarily attributable to changes in intensity. Because of Medicare's "prospective" hospital payment system, reimbursement given treatment choice for Medicare patients actually declined during this period. This growth in expen-

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ditures and treatment intensity was associated with significant mortality reductions, from 39.9 percent to 35.3 percent for AMI patients (with the bulk of the reduction coming after 1987) and from 13.5 percent to 10.8 percent for IHD patients (with the bulk coming before 1987). However, the AMI survival improvements—but not the IHD improvements—were associated with corresponding increases in recurrent AMIs and in heart failure complications. This underscores that the role of changes in intensity versus other factors—as well as any role of changes in liability—is difficult to identify directly in all of these trends.

Second, building on prior efforts to collect information on state malpractice laws (e.g., Sloan, Mergenhagen, and Bovbjerg [1989]), we have compiled a comprehensive database on reforms to state liability laws and state malpractice-control policies that contain information on several types of legal reforms from 1969 to 1992.[8] The legal regime indicator variables are defined such that the level of liability imposed on defendants in the baseline is at a hypothetical maximum.[9]

Eight characteristics of state malpractice law, representing divergences from the baseline legal regime, are summarized in Table IIA. We divide these eight reforms into two groups of four reforms each: reforms that directly reduce malpractice awards and reforms that only reduce awards indirectly. "Direct" reforms include reforms that truncate the upper tail of the distribution of awards, such as caps on damages and the abolition of punitive damages, and reforms that shift down the mean of the distribution, such as collateral-source-rule reform and abolition of mandatory prejudgment interest. "Indirect" reforms include other reforms that have been hypothesized to reduce malpractice pressure but only affect awards indirectly, for instance, through restricting the range of contracts that can be enforced between plaintiffs and contingency-fee attorneys. As discussed in Section II above, we chose this division because the previous empirical literature generally found the impact of direct reforms to be larger than the impact of indirect reforms on physicians' incentives through their effect on the compensation paid and the frequency of malpractice claims. Each of the observations in the Medicare data set was matched with a set of two tort law vari-

8. Our data set is partially derived from Campbell, Kessler, and Shepherd [1996].

9. The baseline is defined as the "negligence rule" without any of the liability-reducing reforms studied here and with mandatory prejudgment interest.

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TABLE IIA
LEGAL REFORMS USED IN ANALYSIS

Reform	Description of reform	Predicted impact on liability
Caps on damage awards	Either noneconomic (pain and suffering) or total damages payable are capped at a statutorily specified dollar amount	Direct
Abolition of punitive damages	Medical malpractice defendants are not liable for punitive damages under any circumstances	Direct
No mandatory prejudgment interest	Interest on either noneconomic or total damages accruing from either the date of the injury or the date of filing of the lawsuit is not mandatory	Direct
Collateral-source rule reform	Total damages payable in a malpractice tort are statutorily reduced by all or part of the dollar value of collateral-source payments to the plaintiff	Direct
Caps on contingency fees	The proportion of an award that a plaintiff can contractually agree to pay a contingency-fee attorney is capped at a statutorily specified level	Indirect
Mandatory periodic payments	Part or all of damages must be disbursed in the form of an annuity that pays out over time	Indirect

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TABLE IIA
(CONTINUED)

Reform	Description of reform	Predicted impact on liability
Joint-and-several liability reform	Joint-and-several liability is abolished for noneconomic or total damages, either for all claims or for claims in which defendants did not act in concert	Indirect
Patient compensation fund	Doctors receive government-administered excess malpractice liability insurance, generally financed through a tax on malpractice insurance premiums	Indirect

ables that indicated the presence or absence of direct or indirect malpractice reforms at the time of their initial hospitalization.

Table IIB contains the effective dates for the adoption of direct and indirect reforms for each of the 50 states. The table shows that a number of states have implemented legal reforms at different times. For example, 13 states never adopted any direct reforms, 23 states adopted direct reforms between 1985 and 1990, and 18 states adopted direct reforms 1984 or earlier (adoptions plus nonadoptions exceed 50 because some states adopted both before and after 1985). Similarly, 16 states never adopted any indirect reforms, 23 states adopted indirect reforms between 1985 and 1990, and 18 states adopted indirect reforms 1984 or earlier. Adoption of direct and indirect reforms is not strongly related: sixteen states that never adopted reforms of one type have adopted reforms of the other.

V. Empirical Results

Table III previews our basic difference-in-difference (DD) analysis by reporting unadjusted conditional means for expenditures and mortality for four patient groups, based on the timing of malpractice reforms. Expenditure levels in 1984 (our base

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year) were slightly higher in states passing reforms between 1985–1987 and lower in states passing reforms between 1988–1990. Baseline mortality rates were slightly lower for AMI and higher for IHD in the 1985–1987 reform states, and conversely for the 1988–1990 reform states. Thus, overall, reform states looked very similar to nonreform states in terms of baseline expenditures and outcomes. States with earlier reforms (pre-1985) had slightly higher base year expenditures but similar base year mortality rates. The table shows that expenditure growth in reform states was smaller than in nonreform states during the study years. Altogether, growth was 2 to 6 percent slower in the reform compared with the nonreform states for AMI, and trend differences were slightly greater for IHD. Although mortality trends differed somewhat across the state groups, mortality trends on average were quite similar for reform and nonreform states. These simple comparisons do not account for any differences in trends in patient characteristics across the state groups, do not account for any effects of other correlated reforms, and do not readily permit analysis of dynamic malpractice reform effects. Nonetheless, they anticipate the principal estimation results that follow.

Table IV presents standard DD estimates of the effects of tort reforms between 1985 and 1990 on average expenditures and outcomes for AMI; that is, no dynamic reform effects are included. In this and subsequent models, we include fully interacted demographic effects—for patient age (65–69, 70–74, 75–79, 80–89, 90–99), gender, black or nonblack race, and urban or rural residence—and controls for contemporaneous political and regulatory changes described previously. For each of the four outcomes—one-year hospital expenditures, mortality, and AMI and CHF readmissions—two sets of models are reported. The first set includes complete state and year fixed effects. The second set, intended to illustrate the average differences of states that had adopted reforms before our study began as well as the sensitivity of the results to a more complete fixed-effect specification, includes only time and census region effects. As described in Section II, both specifications are linear, the dependent variable in the expenditure models is logged, all coefficient estimates are multiplied by 100 and so can be interpreted as average effects in percent (for expenditure models) or percentage points (for outcomes models), and the standard errors are corrected for heteroskedasticity and grouping at the state/zip-code level.

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TABLE IIB
CHRONOLOGY OF LEGAL REFORMS*

State	Year effective Direct reform	Indirect reform	State	Year effective Direct reform	Indirect reform
Alabama	1987	1987	Montana	1987	
Alaska	1976, 1986	1988	Nebraska	1960, 1976	1976
Arizona		1988	Nevada		
Arkansas			New Hampshire	1986	
California	1975	1975, 1986	New Jersey	1987	1972, 1976
Colorado	1986	1986, 1988	New Mexico	1976	1976, 1987
Connecticut	1985	1986	New York	1967, 1984	1970, 1985
Delaware		1976	North Carolina		
Florida	1976, 1986	1980, 1985	North Dakota	1987	1987
Georgia			Ohio	1975	1988
Hawaii	1986		Oklahoma		1953, 1978
Idaho	1987, 1990	1986, 1987	Oregon	1975, 1987	1975**,1987
Illinois	1976, 1985	1985	Pennsylvania		1975
Indiana	1975	1975, 1985	Rhode Island	1976	
Iowa	1975		South Carolina		1976
Kansas	1986, 1988	1974, 1976	South Dakota	1976	1988
Kentucky			Tennessee	1975	1975

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Louisiana	1975,***	1975, 1984	Texas	1977	
Maine	1989	1985, 1988	Utah	1985, 1986	1985, 1986
Maryland	1986		Vermont		1970
Massachusetts	1986,***	1986	Virginia	1974	
Michigan	1986	1981	Washington	***	1986
Minnesota	1986		West Virginia	1986	
Mississippi			Wisconsin	1986	1975, 1986
Missouri	1986	1986	Wyoming		1986, 1987

*Except prejudgment interest Montana imposed prejudgment interest in 1985 No other states repealed or imposed prejudgment interest 1985–1990 The following states imposed mandatory prejudgment interest effective before 1984 AK, CO, IA, LA, ME, MA, NH, NJ, NC, OK, RI, UT, WV

**Oregon repealed in 1987 those indirect reforms effective as of 1975

***Common law effective before 1984 prohibits punitive damages

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TABLE III

HOSPITAL EXPENDITURES AND MORTALITY OUTCOMES IN STATES WITH AND WITHOUT DIRECT REFORMS, AMI AND IHD PATIENTS, 1984–1990

	1-year total hospital expenditures					1-year mortality				
	1984	1987	1990	1984–1987 % change	1984–1990 % change	1984	1987	1990	1984–1987 change	1984–1990 change
AMI										
States without direct reforms	$10,194	$11,810	$12,618	15.9%	23 8%	40 2%	39 1%	35 7%	−1.1%	−4 5%
States with direct reforms in effect before 1985	$10,513	$11,722	$13,022	11.5%	23 9%	40.1%	39 0%	35 4%	−1.1%	−4 7%
States enacting direct reforms effective between 1985 and 1987	$11,304	$12,595	$13,186	11.4%	16 6%	39 5%	38 6%	35 3%	−0 9%	−4 2%
States enacting direct reforms effective between 1988 and 1990	$8,960	$9,865	$10,925	10.1%	21 9%	41.9%	39 2%	35 7%	−2.7%	−6 2%
IHD										
States without direct reforms	$9,439	$10,859	$12,083	15 0%	28 0%	14 1%	12 0%	11.0%	−2 1%	−3 1%
States with direct reforms in effect before 1985	$10,331	$11,064	$12,505	7 1%	21 0%	13.5%	11.7%	10.7%	−1 8%	−2 8%
States enacting direct reforms effective between 1985 and 1987	$10,527	$11,315	$12,300	7.5%	16 8%	13 8%	11 6%	10 5%	−2 2%	−3.3%
States enacting direct reforms effective between 1988 and 1990	$9,241	$9,623	$11,421	4 1%	23 6%	14 1%	12 3%	11.5%	−1.8%	−2.6%

Hospital Expenditures are in 1991 Dollars Mortality changes are in percentage points

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TABLE IV

EFFECTS OF TORT REFORMS ON EXPENDITURES AND OUTCOMES OF ACUTE MYOCARDIAL INFARCTION, DIFFERENCE-IN-DIFFERENCE SPECIFICATION

	State- and time-fixed effects				Region- and time-fixed effects			
Variable	1-year hospital expenditures	1-year mortality	1-year AMI readmit	1-year HF readmit	1-year hospital expenditures	1-year mortality	1-year AMI readmit	1-year HF readmit
Difference-in-difference effects of reforms								
Direct reforms	−5.30	0 07	−0 18	−0.07	−6.71	0 05	−0 31	−0 14
	(0.47)	(0 29)	(0 20)	(0 18)	(0.46)	(0.28)	(0.19)	(0.18)
Indirect reforms	1 81	−0 13	−0 04	−0 02	3.37	0 10	−0 09	0 14
	(0.46)	(0 28)	(0.19)	(0 18)	(0.43)	(0 26)	(0 18)	(0 16)
Baseline 1984–1990 growth rate								
	21.01	−5 46	5.02	0.99	22.64	−5 51	4 78	1.10
	(0 70)	(0.46)	(0.32)	(0.29)	(0.76)	(0.44)	(0 31)	(0 28)
Differential 1984–1990 growth rate: states with pre-1985 reforms								
Direct reforms	3 08	0.36	−1.60	0.43	1 24	0.17	−1 25	0 25
	(0 77)	(0.47)	(0 32)	(0.30)	(0.73)	(0 44)	(0 31)	(0 28)
Indirect reforms	2.76	−0.57	0.52	−0 28	4.88	−0 45	0 56	−0 16
	(0.50)	(0.30)	(0 21)	(0.19)	(0.49)	(0.30)	(0 21)	(0.19)
Differential 1984 level, states with pre-1985 reforms								
Direct reforms					4 97	−0.89	−0 08	0.21
					(0 57)	(0.34)	(0.23)	(0 21)
Indirect reforms					1.75	−0.12	0.12	0 32
					(0 40)	(0.24)	(0.17)	(0.15)

Heteroskedasticity-consistent standard errors allowing for zip-code/time grouping are in parentheses Hospital Expenditures are in 1991 dollars Coefficients from 1-year hospital expenditures model × 100 are from regressions in logarithms Coefficients from outcome models are in percentage points All models include controls for the regulatory/legal environment and patient demographic characteristics The baseline growth rate is calculated at the sample average level of regulatory/legal environment characteristics

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The estimates of average expenditure growth rates in both specifications are substantial showing an increase in real expenditures of over 21 percent between 1984 and 1990. The estimated DD effects show that expenditures declined by 5.3 percent in states that adopted direct reforms relative to nonreforming states. The corresponding DD estimate of the effect of indirect reforms, 1.8 percent, is positive but small; these reforms do not appear to have a substantial effect on expenditures. In the region-effect models, the estimated DD reform effects are slightly larger but qualitatively similar. States that adopted reforms prior to our study period had 1984–1990 growth rates in expenditures that were slightly larger, by around 3 percent. The region-effect model shows that these states as a group also had slightly higher expenditure levels in 1984. Because these states generally adopted reforms at least five years before our panel began, our results suggest that direct reforms do not result in relatively slower expenditure growth more than five years after adoption. However, lack of a pre-adoption baseline for and adoption-time heterogeneity among the early-adopting states, as well as the sensitivity of the early-adopter/nonadopter differential growth rates to alternative specifications (as discussed below), complicates interpreting estimates of differential early-adopter/nonadopter growth rates as a long-term effect. In any event, in no case would the differential 1984–1990 expenditure growth rate between adopters and nonadopters offset the difference-in-difference "levels" effect. In total, malpractice reforms always result in a decline in cost growth at least 10 percent.

The remaining columns of Table IV describe the corresponding DD estimates of reform effects on AMI outcomes. Mortality rates declined, but readmission rates with cardiac complications increased during this time period, confirming the results of Table I. Outcome trends were very similar in reform and nonreform states: the cumulative difference in mortality and cardiac-complication trends was around 0.1 percentage points. These small estimated mortality differences are not only insignificantly different from zero; they are estimated rather precisely as well. For example, the upper 95 percent confidence limit for the effect of direct reforms on one-year mortality trends between 1984 and 1990 is 0.64 percentage points. Coupled with the estimated expenditure effect, the expenditure/benefit ratio for a higher pressure liability regime is over $500,000 per additional one-year

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AMI survivor in 1991 dollars. Even a ratio based on the upper-bound mortality estimate translates into hospital expenditures of over $100,000 per additional AMI survivor to one year.[10] The estimates in the corresponding region-effect models are very similar. Indirect reforms were also associated with estimated mortality effects that were very close to zero. Results for outcomes related to quality of life, that is, rehospitalizations with either recurrent AMI or heart failure, also showed no consequential effects of reforms. In this case, the point estimates (upper bound of the 95 percent confidence interval) for the estimated effect of direct reforms were −0.18 (0.21) percentage points for AMI recurrence and −0.07 (0.28) percentage points for the occurrence of heart failure. Again, compared with the estimated expenditure effects, these differences are not substantial.

Table V presents estimated effects of malpractice reforms on IHD expenditures and outcomes, with results qualitatively similar to those just described for AMI. IHD expenditures also grew rapidly between 1984 and 1990. Direct reforms led to somewhat larger expenditure reductions for IHD (9.0 percent) and indirect reforms were again associated with relatively smaller increases in expenditures (3.4 percent). The effects of reforms on IHD outcomes are again very small: the effect of direct reforms on mortality rates was an average difference of −0.19 percentage points (95 percent upper confidence limit of 0.10), and the effects on subsequent occurrence of AMI or heart failure hospitalizations were no larger.[11] Estimates from the models with region effects were very similar. Thus, direct liability reforms appear to have a relatively larger effect on IHD expenditures, without substantial consequences for health outcomes.

As we noted in Section III, the simple average effects of liability reforms estimated in the DD specifications of Tables IV and V may not capture the dynamic effects of reforms. Table VI presents results from model specifications that estimate reform ef-

10 That is, (.053*$13,140)/.0064≈$108,000 using the 95 percent upper bound of the estimated mortality effect and (.053*$13,140)/.0007≈$1,000,000 using the actual DD estimate. Both of these ratios are very large; the difference in absolute magnitude of the two estimates results from the denominator being very close to zero

11 Because we were concerned that reforms might affect the rate of IHD hospitalization as well as outcomes among patients hospitalized, we estimated models analogous to the specifications reported using population hospitalization rates with IHD as the dependent variable We found no significant or substantial effects of either direct or indirect reforms on IHD hospitalization rates

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TABLE V

EFFECTS OF TORT REFORMS ON EXPENDITURES AND OUTCOMES OF ISCHEMIC HEART DISEASE, DIFFERENCE-IN-DIFFERENCE SPECIFICATION

	State- and time-fixed effects				Region- and time-fixed effects			
Variable	1-year hospital expenditures	1-year mortality	1-year AMI readmit	1-year HF readmit	1-year hospital expenditures	1-year mortality	1-year AMI readmit	1-year HF readmit
Difference-in-difference effects of reforms								
Direct reforms	−9.02	−0.19	−0.20	−0.12	−10.02	0.05	−0.19	−0.03
	(0.45)	(0.15)	(0.10)	(0.12)	(0.44)	(0.15)	(0.10)	(0.12)
Indirect reforms	3.42	−0.42	0.24	0.19	4.06	−0.61	0.23	0.10
	(0.44)	(0.15)	(0.10)	(0.12)	(0.40)	(0.14)	(0.09)	(0.11)
Baseline 1984–1990 growth rate								
	17.16	−2.78	−0.84	−0.92	18.56	−2.91	−0.98	−1.00
	(0.75)	(0.25)	(0.17)	(0.21)	(0.73)	(0.25)	(0.16)	(0.20)
Differential 1984–1990 growth rate states with pre-1985 reforms								
Direct reforms	−1.41	0.33	−0.39	0.56	−3.06	0.42	−0.21	0.61
	(0.76)	(0.26)	(0.17)	(0.21)	(0.73)	(0.25)	(0.16)	(0.20)
Indirect reforms	−1.04	−0.32	0.11	−0.29	0.87	−0.31	0.01	−0.22
	(0.47)	(0.16)	(0.11)	(0.13)	(0.46)	(0.16)	(0.11)	(0.13)
Differential 1984 level: states with pre-1985 reforms								
Direct reforms					6.88	−0.66	−0.34	−0.61
					(0.57)	(0.19)	(0.13)	(0.15)
Indirect reforms					2.71	−0.24	−0.19	−0.01
					(0.38)	(0.13)	(0.09)	(0.10)

Heteroskedasticity-consistent standard errors allowing for zip-code/time grouping are in parentheses. Hospital expenditures are in 1991 dollars. Coefficients from 1-year hospital expenditures model × 100 are from regressions in logarithms. Coefficients from outcome models are in percentage points. All models include controls for the regulatory/legal environment and patient demographic characteristics. The baseline growth rate is calculated at the sample average level of regulatory/legal environment characteristics.

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TABLE VI

EFFECTS OF TORT REFORMS ON EXPENDITURES AND OUTCOMES

TIME-SINCE-ADOPTION SPECIFICATION

	AMI, state- and time-fixed effects				IHD, state- and time-fixed effects			
Variable	1-year hospital expenditures	1-year mortality	1-year AMI readmit	1-year HF readmit	1-year hospital expenditures	1-year mortality	1-year AMI readmit	1-year HF readmit
Time-since-adoption effects of reforms								
Adopted 1985 to 1990, within the past 2 years or less								
Direct reforms	−3.95	−0.22	−0.25	−0.29	−7.08	−0.15	−0.17	−0.23
	(0.52)	(0.31)	(0.22)	(0.20)	(0.49)	(0.17)	(0.11)	(0.13)
Indirect reforms	1.71	0.10	−0.32	−0.01	3.09	−0.24	0.21	0.31
	(0.48)	(0.29)	(0.20)	(0.18)	(0.46)	(0.15)	(0.10)	(0.12)
Adopted 1985 to 1990, within the past 3 to 5 years								
Direct reforms	−5.80	0.12	0.19	0.03	−8.88	−0.11	−0.16	0.08
	(0.53)	(0.32)	(0.22)	(0.21)	(0.50)	(0.17)	(0.11)	(0.14)
Indirect reforms	−0.14	−0.23	0.06	−0.12	1.43	−0.70	0.21	−0.00
	(0.58)	(0.35)	(0.24)	(0.23)	(0.55)	(0.19)	(0.13)	(0.15)
Baseline 1984–1990 growth rate								
	21.54	−5.51	4.84	0.94	17.11	−2.91	0.98	−1.00
	(0.72)	(0.47)	(0.33)	(0.30)	(0.77)	(0.27)	(0.20)	(0.20)
Differential 1984–1990 growth rate states with pre-1985 reforms								
Direct reforms	3.54	0.39	−1.56	0.47	−0.53	0.37	−0.35	0.67
	(0.77)	(0.47)	(0.32)	(0.30)	(0.76)	(0.26)	(0.17)	(0.21)
Indirect reforms	3.20	−0.52	0.49	−0.25	−0.42	−0.24	0.13	−0.22
	(0.51)	(0.31)	(0.21)	(0.20)	(0.48)	(0.16)	(0.11)	(0.13)

Heteroskedasticity-consistent standard errors allowing for zip-code/time grouping are in parentheses. Hospital expenditures are in 1991 dollars. Coefficients from 1-year hospital expenditures model × 100 are from regressions in logarithms. Coefficients from outcome models are in percentage points. All models include controls for the regulatory/legal environment and patient demographic characteristics. The baseline growth rate is calculated at the sample average level of regulatory/legal environment characteristics.

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fects less restrictively. In these specifications we use our seven-year panel to estimate short-term and long-term effects of direct and indirect reforms on expenditures and outcomes, to determine whether the "shift" effect implied by the DD specification is adequate. The models retain our state and time fixed effects.[12]

We find the same general patterns as in the simple DD models, but somewhat larger effects of malpractice reforms three to five years after adoption compared with the short-term effects. In particular, Table VI shows that direct reforms lead to short-term reductions in AMI expenditures of approximately 4.0 percent within two years of adoption, and that the reduction grows to approximately 5.8 percent three to five years after adoption. This specification also shows that the positive association between indirect reforms and expenditures noted in Table IV is a short-term phenomenon: the long-term effect on expenditures is approximately zero.[13]

As in Table IV, both direct and indirect reforms have trivial effects on mortality and readmissions with complications, both soon and later after adoption. For example, the average difference in mortality trends between direct-reform and nonreform states is −0.22 percentage points (not significant) within two years of adoption, with a 95 percent upper confidence limit of 0.39 percentage points. At three to five years the estimated effect is 0.12 percentage points (not significant) with a 95 percent upper confidence limit of 0.75 percentage points. These point estimates translate into very high expenditures per reduction in adverse AMI outcomes.

The results for the corresponding model of IHD effects over time are presented in the right half of Table VI. Direct reforms are associated with a 7.1 percent reduction in expenditures by two years after adoption (standard error 0.5) and an 8.9 percent reduction by five years after (standard error 0.5).[14] In contrast,

12 Models with region effects only, analogous to the right halves of Tables IV and V, again showed very similar effect estimates

13. We also estimate separate time-trend effects for early-reform (pre-1984) states. This approach may permit the development of some evidence on "long-term" effects of reforms on intensity growth rates. As noted previously, we find no evidence for such effects Of course, our lack of a pre-adoption baseline for the early-adopting states precludes DD identification and makes the long-term conclusion more speculative A follow-up study using more recent expenditure and outcome data would provide more convincing evidence on effects beyond five years

14 In contrast to AMI, the slower rate of expenditure growth between 1984 and 1990 for early-reform states (see Table V) suggests that reforms may have longer term effects on slowing IHD expenditure growth

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mortality trends for states with direct reforms do not differ significantly by two years (point estimate of −0.15 percentage points, 95 percent upper confidence limit 0.18) or five years after adoption (point estimate −0.11 percentage points, 95 percent upper confidence limit 0.22). Direct reforms also have no significant or substantial effects on cardiac complications, either immediately or later. Indirect reforms are again associated with small positive effects on expenditure growth (3.1 percent within two years), but these effects decline over time to a relatively trivial level (1.4 percent at three to five years). Indirect reforms are also associated with slightly lower mortality rates and slightly higher rates of cardiac complications, but the size of these effects is very small (e.g., the upper limit of the 95 percent confidence interval around the estimated effect of indirect reforms three to five years after adoption is 0.47 percentage points for AMI recurrence and 0.29 percentage points for heart failure occurrence). Thus, the pattern of reform effects for IHD is again qualitatively similar to that for AMI, with direct reforms having a somewhat larger effect on expenditures.

Taken together, the estimates in Tables IV through VI consistently show that the adoption of direct malpractice reforms between 1984 and 1990 led to substantial relative reductions in hospital expenditures during this period—accumulating to a reduction of more than 5 percent for AMI and 9 percent for IHD by five years after reform adoption—and that these expenditure effects were not associated with any consequential effects on mortality or on the rates of significant cardiac complications.

We estimated a variety of other models to explore the robustness of our principal results. We tested the sensitivity of our results to alternative assumptions about the excludability of state/time interactions. One set of tests reestimated the models with random state/time effects to determine whether correlated outcomes at the level of state/time interactions might affect our conclusions. Our estimated effects of reforms did not differ substantially or significantly with these methods. Using the model presented in Tables IV and V, the estimated difference-in-difference effect of direct reforms on expenditures for AMI patients, controlling for random state/time effects, is −4.9 percent (standard error 2.1), and for indirect reforms, the estimated effect is −0.6 percent (standard error 2.0). The estimated DD effect of direct reforms on mortality for AMI patients, controlling for random state/time effects, is 0.15 percentage points (standard error

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0.32) and for indirect reforms, the estimated effect is −0.19 percentage points (standard error 0.32). We obtained similar results for IHD patients: direct reforms showed a negative and statistically significant effect on expenditures with an insubstantial and precisely estimated effect on mortality, and indirect reforms showed no substantial effect on either expenditures or mortality. Estimated differential 1984–1990 expenditure growth rates between early-adopters and nonadopters were insignificant in the random effects specification. For AMI patients the differential growth rate for early adopters of direct reforms is 0.61 percent (standard error 3.1). For early adopters of indirect reforms the differential growth rate is 0.61 percent (standard error 2.3). For IHD patients the differential growth rate for early adopters of direct reforms is −1.9 percent (standard error is 3.0). For early adopters of indirect reforms the differential growth rate is −3.2 percent (standard error is 2.2). Another related diagnostic involved estimating the models with Huber-White [1980] corrections for state/time grouped errors instead of corrections for zipcode/time grouped errors. Standard errors corrected for state/time grouping were somewhat larger than those corrected for zipcode/time grouping but smaller than those obtained under the random effects specification.

Although they did have a statistically significant influence on expenditures in some models, the broad set of political and regulatory environment controls that we used did not change our results substantially. Using the models presented in Tables IV and V but excluding controls for the regulatory and legal environment, the estimated DD effect of direct reforms on expenditures for AMI patients is −9.1 percent (standard error is 0.44). For indirect reforms the estimated DD effect is 3.3 percent (standard error is 0.40). In addition, the difference in 1984–1990 growth rates between early-reforming and nonreforming states changes sign from positive to negative for enacting direct reforms before 1985 (Table IV: 3.1 percent with legal environment controls, −3.1 percent without them). The difference in growth rates for states enacting indirect reforms before 1985 remains about the same (Table IV: 2.8 percent with legal environment controls, 3.5 percent without them). These two specification checks, taken together, underscore the points made by Tables IV and V. Direct reforms reduce expenditure growth without increasing mortality, indirect reforms have no substantial effect on either expenditures or mortality, and differential 1984–1990 expenditure growth

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rates for early-adopting states are not robust estimates of the long-term impact of reforms.

Finally, we reestimated the models in Tables IV and V including controls for statute-of-limitations reforms. Statute-of-limitation reforms have a very small positive effect on expenditures and no effect on mortality, which is consistent with their classification as an indirect reform. Using the models presented in Tables IV and V, statute-of-limitations reforms are associated with a 0.96 percent increase in expenditures for AMI patients (standard error is 0.46), and a 0.003 percentage point increase in mortality (standard error is 0.28). Inclusion of statute-of-limitation reforms did not substantially alter the estimated DD effect of either direct or indirect reforms: for AMI patients the estimated effect of direct reforms went from −5.3 percent (Table IV) to −5.5 percent, and the estimated effect of indirect reforms remained constant at 1.8 percent (Table IV).

To explore the sources of our estimated reform effects more completely, we estimated additional specifications that analyzed effects on use of intensive cardiac procedures such as cardiac catheterization, that used alternative specifications of time-since-adoption and calendar-year effects, and that estimated the effects of each type of tort reform separately (see Table IIA). These specifications produced results consistent with the simpler specifications reported here for both AMI and IHD. Specifically, reforms with a determinate, negative direct impact on liability led to substantially slower expenditure growth, somewhat less growth in the use of intensive procedures (but smaller effects than would explain the expenditure differences, suggesting less intensive treatments were also affected), and no consequential effects on mortality.

VI. Policy Implications

We have developed evidence on the existence and magnitude of "defensive" medical practices by studying the consequences of reforms limiting legal liability on health care expenditures and outcomes for heart disease in the elderly. These results provide a critical extension to the existing empirical literature on the effects of malpractice reforms. Previous studies have found significant effects of direct reforms on the frequency of and payments to malpractice claims. Because the actual costs of malpractice litigation comprise a very small portion of total health care expendi-

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tures, however, these litigation effects have only a limited impact on health care expenditure growth. To provide a more complete assessment of malpractice reforms, we have studied their consequences for actual health care expenditures and health outcomes. Our study is the first to use exogenous variation in tort laws not related to potential idiosyncrasies of providers or small geographic areas to assess the behavioral effects of malpractice pressure. Thus, our analysis fills a crucial empirical gap in evaluating the U. S. malpractice liability system, because the effects of malpractice law on physician behavior are both a principal justification for current liability rules and potentially important for understanding medical expenditure growth.

Our analysis indicates that reforms that directly limit liability—caps on damage awards, abolition of punitive damages, abolition of mandatory prejudgment interest, and collateral-source-rule reforms—reduce hospital expenditures by 5 to 9 percent within three to five years of adoption, with the full effects of reforms requiring several years to appear. The effects are somewhat smaller for actual heart attacks than for a relatively less severe form of heart disease (IHD), for which more patients may have "marginal" indications for treatment. In contrast, reforms that limit liability only indirectly—caps on contingency fees, mandatory periodic payments, joint-and-several liability reform, and patient compensation funds—are not associated with substantial effects on either expenditures or outcomes, at least by several years after adoption. Neither type of reforms led to any consequential differences in mortality or the occurrence of serious complications. As we described previously, the estimated expenditure/benefit ratio associated with direct reforms is over $500,000 per additional one-year survivor, with comparable ratios for recurrent AMIs and heart failure. Even the 95 percent confidence bounds for outcome effects are generally under one percentage point, translating into over $100,000 per additional one-year survivor. While it is possible that malpractice reforms have had effects on other outcomes valued by patients, this possibility must be weighed against the absence of any substantial effects on mortality or the principal cardiac complications that are correlated with quality of life. Thus, at the current level of malpractice pressure, liability rules that are more generous in terms of award limits are a very costly approach to improving health care outcomes.

Approximately 40 percent of patients with cardiac disease were affected by direct reforms between 1984 and 1990. Based on

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simulations using our effect estimates, we conclude that if reforms directly limiting malpractice liability had been applied throughout the United States during this period, expenditures on cardiac disease would have been around $450 million per year lower for each of the first two years after adoption and close to $600 million per year lower for each of years three through five after adoption, compared with nonadoption of direct reforms.

While our panel is relatively lengthy for a DD study, it is not long enough to allow us to reach equally certain conclusions about the long-term effects of malpractice reforms on medical expenditure growth and trends in health outcomes. Plausible *static* effects of virtually all policy factors cannot explain more than a fraction of expenditure growth in recent decades [Newhouse 1992], and we have also documented that outcome trends may be quite important. Whether policy changes such as malpractice reforms influence these long-term trends through effects on the environment of technological change in health care is a critical issue. Do reforms have implications for trends in expenditures and outcomes long after they are adopted, or do the trend effects diminish over time? Preliminary evidence on the question from early-adopted (pre-1985, mostly pre-1980) reforms suggest that long-term expenditure growth is not slower in states that adopt direct reforms. On the other hand, subsequent growth does not appear to offset the expenditure reductions that occur in the years following adoption. Moreover, we found no evidence that direct reforms adopted from 1985–1990 had smaller effects in states that had also adopted direct reforms earlier, suggesting that dynamic malpractice policies may produce more favorable long-term expenditure/benefit trends. In any event, our conclusions about long-term effects are speculative at this point, given the absence of baseline data on expenditures and outcome trends in reform states. Follow-up evaluations of longer term effects of malpractice reforms should be possible within a few years, and might help confirm whether liability reforms have any truly lasting consequences for expenditure growth or trends in health outcomes.

Hospital expenditures on treating elderly heart disease patients are substantial—over $8 billion per year in 1991—but they comprise only a fraction of total expenditures on health care. If our results are generalizable to medical expenditures outside the hospital, to other illnesses, and to younger patients, then direct reforms could lead to expenditure reductions of well over $50 bil-

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lion per year without serious adverse consequences for health outcomes. We hope to address the generalizability of our results more extensively in future research. More detailed studies using both malpractice claims information and patient expenditure and outcome information, linking the analysis of the two policy justifications for a malpractice liability system, should be particularly informative. Such studies could provide more direct evidence on how liability rules translate into effects on particular kinds of physician decisions with implications for medical expenditures but not outcomes. Thus, they may provide more specific guidance on which specific liability reforms—including "nontraditional" reforms such as no-fault insurance and mandatory administrative reviews—will have the greatest impact on defensive practices without substantial consequences for health outcomes.

Our evidence on the effects of direct malpractice reforms suggests that doctors do practice defensive medicine. Given the limited relationship between malpractice claims and medical injuries documented in previous research, perhaps our findings that less malpractice liability does not have significant adverse consequences for patient outcomes but does affect expenditures are not surprising. To our knowledge, however, this is the first direct empirical quantification of the costs of defensive medicine.

VII. Conclusion

We have demonstrated that malpractice liability reforms that directly limit awards and hence benefits from filing lawsuits lead to substantial reductions in medical expenditure growth in the treatment of cardiac illness in the elderly with no appreciable consequences for important health outcomes, including mortality and common complications. We conclude that treatment of elderly patients with heart disease does involve "defensive" medical practices, and that limited reductions in liability can reduce these costly practices.

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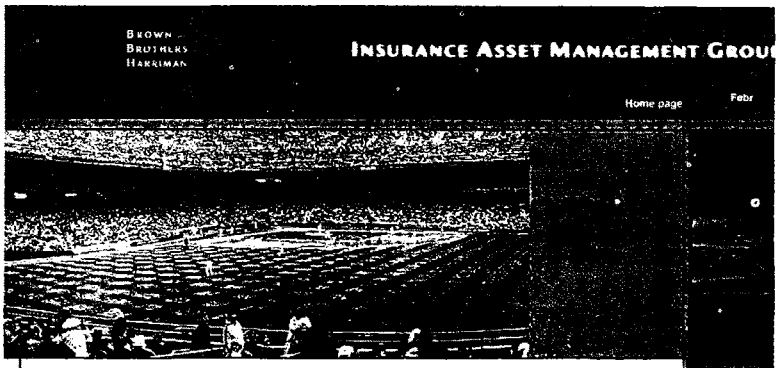


January 21, 2003

Did Investments Affect Medical Malpractice Premiums?

Raghu Ramachandran

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

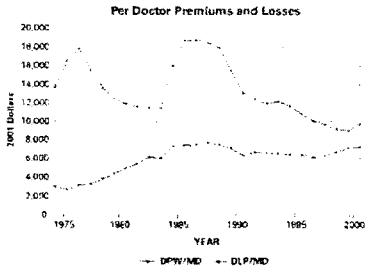
Last July, the only trauma center in Las Vegas was forced to close. At the beginning of this year, doctors in Pennsylvania threatened to go on strike but relented when the incoming governor promised to support legislative reforms to limit jury awards in malpractice suits. Also in January, doctors in 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."[1] 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."[2] 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.

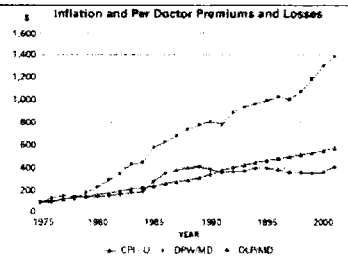


AIR uses the following graph to demonstrate that losses have tracked inflation and that premiums vary because of the economy. The graph attempts to compare two key trends underlying the medical malpractice controversy: premiums per doctor (DPW/MD) and paid losses per doctor (DLP/MD). Both of these variables are expressed in *constant medical dollars*.[3]

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.[4]



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 (r^2); 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 to the right lists the coefficients of determination generated by the regression analysis between the economy, investment yield, and medical malpractice premiums.

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 affect 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.

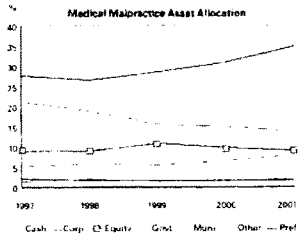
In 64 different regressions between the economy, yield, and premiums, the highest coefficient of determination was 0.1505.[5] Therefore, we can state with a fair degree of certainty that investment yield and the performance of the economy and interest rates do not influence medical malpractice premiums.

Stock Market Effect

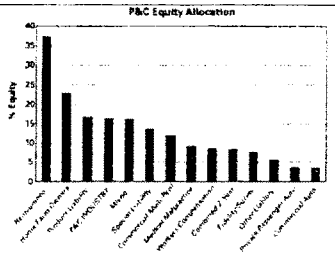
But what about the stock market? How did the drop in the equity markets affect insurance company performance? Are companies raising premiums because they lost money on Enron or WorldCom?

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.[6]



Over the last five years, the amount medial 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.



The green column shows the equity allocation in the medical malpractice sector and the red column shows the equity allocation for the P&C insurance industry as a whole. 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.[7] 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.[8]

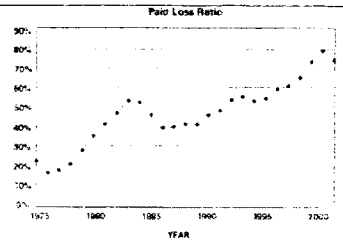
We see that medical malpractice companies had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy.

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.[9] 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.[10]



Over the last 27 years, the average paid loss ratio was 47% and the minimum paid loss ratio was 16%.[11] 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	
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%.

Clearly, increases of this magnitude are intolerable, for both the industry and state regulators. In this regard, St. Paul's[12] 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 had the luxury of falling back on other lines of business. Unfortunately, many specialty 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.[13] 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.

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.

PLEASE SEE THE FOLLOW UP ARTICLE : A Note on Investment Income of Medical Malpractice Companies

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[1] "Medical Malpractice Insurance: Stable Losses/Unstable Rates", Americans for Insurance Reform, October 10, 2002.

[2] Oppell, Jr, Richard A, "Bush Enters Fray Over Medical Malpractice", *The New York Times*, January 16, 2002.

[3] Nominal values discounted using the medical inflation (CPI – U).

[4] Data from AIR report, *op. cit.* Details of the analysis can be found at BBH Insurance website or by contacting the author.

[5] Details of the analysis can be found at BBH Insurance website or by contacting the author.

[6] See Insurance Industry Asset Allocation Study.

[7] See for example http://www.moneychimp.com/articles/risk/portfolio.htm

[8] Bachman, Jim, "Medical Specialty Providers' 2001 Investment Comparative", *The PIAA Insurer*, 4th quarter, 2002.

[9] Data from AIR report, *op. cit.*

[10] Greene Carolyn L., and Mize, John H, "Current Issues in Medical Malpractice Insurance," CAS Special Interest Seminar — The Changing Insurance Market, April 2002.

[11] Data from AIR report, *op. cit.*

[12] Karls, Chad C., "Medical Malpractice: A Market in Transition," Casualty Loss Reserve Seminar, September 23, 2002.

[13] Hurley, James D., "Medical Malpractice — Financial Update," Casualty Loss Reserve Seminar, September 23, 2002.

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