DYING FOR HELP: ARE PATIENTS NEEDLESSLY SUFFERING DUE TO THE HIGH COST OF MEDICAL LIABILITY INSURANCE?

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RIGHTS AND WELLNESS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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DYING FOR HELP: ARE PATIENTS NEEDLESSLY SUFFERING DUE TO THE HIGH COST OF MEDICAL LIABILITY INSURANCE?

WEDNESDAY, OCTOBER 1, 2003

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RIGHTS AND WELLNESS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2154, Rayburn House Office Building, Hon. Dan Burton (chairman of the subcommittee) presiding.

Present: Representatives Burton and Watson.

Also present: Representative Waxman.

Staff present: Mark Walker, chief of staff, Mindi Walker, Brian Fauls, and John Rowe, professional staff members; Nick Mutton, press secretary, Danielle Perraut, clerk; Michael Yeager, minority deputy chief counsel; Sarah Despres and Tony Haywood, minority counsels; Richard Butcher, minority professional staff member; Earley Green, minority chief clerk; and Cecelia Morton, minority office manager.

Mr. BURTON. Good afternoon. A quorum being present, the Subcommittee on Human Rights and Wellness will come to order, and I ask unanimous consent that all Members' and witnesses' written opening statements be included in the record. Without objection, so ordered.

I ask unanimous consent that all articles, exhibits, and extraneous or tabular material referred to be included in the record. Without objection, so ordered.

And in the event that other Members attend the hearing, I ask unanimous consent that they be permitted to serve as a member of the subcommittee for today's hearing. Without objection, so ordered.

The Subcommittee on Human Rights and Wellness is convening today to examine the influence of medical liability insurance premiums on the access and overall quality of health care that doctors in the United States provide.

Initially the medical liability system was set up to protect victims of negligence. Today malpractice litigation is one of the most feared situations in the medical profession and, I might add, in other areas as well. Over the past several years, doctors have experienced a considerable increase in the cost of medical liability insurance premium rates as a result of medical malpractice litigation. Between 1994 and 2001, the typical medical malpractice

award increased by an astounding 176 percent to an average of $1 million per court case.

The result has been outrageously high malpractice insurance premiums for health care providers, which in turn has led to higher costs for the overall U.S. health care system as well as reduced access to medical services. In 2001, total premiums for medical malpractice insurance topped $21 billion, more than double the amount from 10 years earlier.

These outrageously high liability insurance premiums and losses have caused many doctors who offer life-saving services to relocate their practices, change specialties or retire from medicine altogether, thus limiting patients' access to quality medical care. Among the many medical practitioners who have fallen victim to exorbitant medical liability rates, the two most endangered specialties are OB/GYNs and trauma surgeons, whose successful execution of their duties often makes the difference between life and death.

According to a June 9 article in Time Magazine, the medical malpractice and liability crisis is forcing a growing number of doctors and medical students to switch from lawsuit magnet specialties like obstetrics, neurology and pulmonology to "safer" ones like dermatology and ophthalmology, in effect severely limiting the number of doctors willing to perform high-risk procedures like delivering babies and operating on spines.

To further illustrate the gravity of this problem, in south Florida today, where there are no tort reform measures in place, an obstetrician can pay up to $210,000 a year for medical liability insurance. In Los Angeles, CA, the home of my colleague Ms. Watson, and where reforms are in place, that same physician would only pay $57,000 for that same coverage. That kind of disparity in premiums is a driving force behind this increasingly difficult nationwide problem.

And Florida is certainly not the only State in danger of losing specialized physicians. According to an annual study released by the American Medical Association, 19 States are already in a medical liability crisis, and numerous other States are showing signs that they could be headed in that direction.

Fortunately, my home State of Indiana is not one of them and is currently showing signs that the medical liability crisis sweeping across the country has not arisen in Indiana because the State legislature has already passed legislation that would limit doctors' exposures to liability. At this time our State code does not place caps on noneconomic damages, which may result in higher medical liability premiums in the future, and this is the cause of great concern to me and my Hoosier constituents.

What we have to ask ourselves is this: Is it sound public policy to require a patient to travel up to double the normal distance to access health care during an emergency situation because all of the local doctors in their area have moved out of State? To help gain perspective on this question, the subcommittee will hear today from an OB/GYN from Salt Lake City, UT, and the President-Elect of the American Medical Association, Dr. John Nelson, who will discuss how exorbitant medical liability premiums are affecting doctors in the United States.

In addition, Dr. James Tayoun a vascular surgeon based in Philadelphia, PA, will testify about his experiences with medical malpractice premium hikes and how they led him to create the "Politically Active Physicians Association," a conglomeration of Pennsylvania doctors who are working together to address the unfortunate medical liability situation in Pennsylvania.

In an attempt to address this problem, my colleagues and I here in the U.S. House of Representatives passed the "Health Act of 2003;" that is, the Help Efficient, Accessible Low-Cost, Timely Healthcare Act, H.R. 5 in March of this year. This legislation, modeled after California's tort reform laws, would place caps on the amounts that claimants can be awarded on noneconomic damages, pain and suffering, which, according to a U.S. General Accounting Office report, is what has fueled the drastic increase in medical malpractice premiums. Representatives from the GAO are here to share their insights from the findings of this study on this issue.

Unfortunately our colleagues in the lower body, the Senate—I will tell you about that later—have yet to pass similar legislation, leaving thousands of doctors vulnerable to additional premium hikes.

The subcommittee has the pleasure of having with us today former U.S. Attorney General and the former Governor of the State of Pennsylvania, the Honorable Dick Thornburgh with us. He is here to provide insight into how the medical liability crisis is adversely impacting his home State and other areas of the country, as well as to address the need for tort reform. Mr. Sherman Joyce, the president of the American Tort Reform Association, is also on hand to discuss possible solutions to this problem.

Nationwide tort reform measures could go a long way toward helping slow the increase of liability insurance premium costs. According to a Department of Health and Human Services report released on July 24, 2002, it is estimated that by putting into place common-sense liability reforms, such as placing reasonable limits on noneconomic damages, annual health care costs in the United States could be reduced by 5 to 9 percent. That doesn't sound like much when you put it in percentages, but that could save the Federal Government $60 to $108 billion a year. And with the problems we are facing with the prescription drug issue and Medicare, that would go a long way toward helping to solve those problems.

I believe it is one of our highest duties as Members of Congress to strive to find the best possible public policy solutions for ensuring all Americans access to the highest quality health care system in the world. It is my sincere hope that the information shared today will inspire our friends in the Senate and our counterparts in the State legislatures to pass common-sense legislation to help alleviate some of the burdens of medical liability on our Nation's physicians while at the same time protecting the overall quality of the American health care delivery system. And with that, I will be happy to yield to my colleague Ms. Watson.

Ms. WATSON. I want to sincerely thank the chairman for addressing the issue and holding the hearing. We are here today to get to the truth. And the question for me is do increased medical malpractice insurance costs restrict patients' access to care?

During my 17 years in California as Chair of the Senate Health and Human Services Committee, I listened to doctors from all over the State. Now, from those that I heard, the No. 1 complaint was about the for-profit HMOs making business decisions and forcing doctors to conform.

In order to have meaningful legislation regarding tort law, we need to understand the facts. We need to listen to both the doctors and the victims and then request full disclosures from the middleman, the insurance companies.

Mr. Chairman, this hearing is very important in an effort to uncover the truth. A few days ago some folks representing tort reform made an attempt to undo GAO's findings by having a group supporting insurance—insurers—the Alliance for Health Care Reform released a study based on the same faulty statistics the GAO identified in its August report. Congress and the American public should not be deceived. We want to look at the facts, then work to address the high cost of health care and health insurance in a framework of being behind quality health care delivery.

Now, I know those who support tort reform want to cap medical malpractice noneconomic damage awards. Placing a cap on noneconomic damages will affect an injured patient's ability to cover losses by confusing the debate. Any limit on noneconomic damages has a disproportionate impact on low-wage earners, who are more likely to receive a greater percentage of their compensation in the form of noneconomic damages if they are injured. Proponents of medical malpractice liability reform attempted to place an arbitrary cap on the amount of money an injured patient could be compensated via H.R. 5 earlier in this Congress.

Chairman Tauzin requested that GAO study and report on whether or not the high cost of medical liability insurance is affecting patients' access to care. The GAO's response was a resounding no. It is a tragic and unfair fact that minorities are frequently forced to bear a disproportionately large share of America's health and safety problems. Unfortunately, so-called tort reform proposals that would provide wrongdoers greater immunity for their misconduct also have the impact of severely weakening the protections and rights afforded to these different minorities in our country.

So, Mr. Chairman, I look forward to the testimony of all the panelists, and I'd like to get down to what is affecting in actuality the skyrocketing medical malpractice insurance rates. Doctors, victims and every American will benefit from us getting to the truth. I yield back and thank you, Mr. Chairman.

Mr. BURTON. Thank you, Ms. Watson.

[NOTE.—The GAO reports entitled, "Medical Malpractice, Implications of Rising Premiums on Access to Health Care," and "Medical Malpractice Insurance, Multiple Factors Have Contributed to Increased Premium Rates," may be found in subcommittee files.]

Mr. BURTON. I appreciate all of our witnesses being here today. I know you probably have other things that are important to do, but as Ms. Watson said, this is a very important issue to discuss.

Our first panel, and I wish you would come forward, is Kathryn G. Allen. She is the Director of Health Care for Medicaid and Private Health Insurance Issues, with the General Accounting Office; and Richard J. Hillman, Director of Financial Markets and Com-

munity Investment, with the U.S. General Accounting Office. Would you stand, please, and be sworn.

[Witnesses sworn.]

Mr. BURTON. Being a gentleman, which sometimes is questioned, I will start with. Ms. Allen.

Ms. ALLEN. Mr. Chairman and Ms. Watson, we have agreed between the two of us that Mr. Hillman will give our short statement, so I defer to him.

Mr. BURTON. I tried.

STATEMENT OF RICHARD J. HILLMAN, DIRECTOR, FINANCIAL MARKETS AND COMMUNITY INVESTMENT, U.S. GENERAL ACCOUNTING OFFICE; AND KATHRYN G. ALLEN, DIRECTOR, HEALTH CARE, MEDICAID AND PRIVATE HEALTH INSURANCE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Mr. HILLMAN. Mr. Chairman and Ms. Watson, the GAO's pleased to be here to discuss the results of two recent work efforts.

I led an effort by our Financial Markets and Community Investment Team to determine the reasons behind recent increases in some medical malpractice rates. Kathy Allen, to my left, led an effort by our Health Care Team to assess the implications of rising premiums on access to health care. Both efforts resulted in separate reports on these subjects, and we are pleased with your permission that these full reports are entered into the record of the hearing.

Our testimony today summarizes these efforts and, as requested, focuses on, one, the factors that have contributed to the recent increases in insurance premium rates; and, two, the differences in rates amongst States that have passed varying levels of tort reform laws. In summary, we found that multiple factors have contributed to recent increases in premium rates in the seven sample States that we reviewed, but losses on medical malpractice claims, which make up the largest part of insurers' costs, appear to be the primary driver of rates in the long run.

We also found that nationwide premium growth has been lower on average in States that have enacted tort reform with stricter caps on noneconomic damages than on States with more limited reforms. Since 1999, medical malpractice premium rates for physicians in some States, but not all, have increased dramatically, but before I get into the factors that contributed to these increased rates, it is important to understand that both the extent of the increases and the premium levels themselves vary greatly not only from State to State, but across medical specialties and even among areas within States.

For example, the largest writer of medical malpractice insurance in Florida increased premium rates for general surgeons in Dade County by approximately 75 percent from 1999 to 2002, while the largest insurer in Minnesota increased premium rates for the same specialty by only about 2 percent over the same period. The resulting 2002 premium rate quoted by the insurer in Florida was $174,000 a year, this being more than 17 times the premium rate quoted by the insurer in Minnesota. Moreover, even within Florida, the rate quoted by the same insurer for the same coverage for gen-

eral surgeons outside Dade County was $89,000 a year, or about half the rate quoted inside Dade County.

Moving on to our first objective on the factors contributing to the premium rate increases, we found there were multiple factors. First, since 1998, insurers' losses on medical malpractice claims have increased rapidly in some States. While we found that the increased losses appear to be the greatest contributor to the increased premium rates, a lack of comprehensive data at the national and State levels on insurers' medical malpractice claims and on the associated losses prevented us from fully analyzing the composition and causes of those losses.

Second, from 1998 through 2001, medical malpractice insurers experienced decreases in investment income as interest rates fell on bonds that generally made up around 80 percent of these insurers' investment portfolios. While almost no insurer experienced net losses on their investment portfolios over this period, a decrease in investment income meant that income from insurance premiums had to cover a larger share of their costs.

Third, during the 1990's, insurers competed vigorously for medical malpractice business, and several factors, including high investment returns, permitted them to offer prices that in hindsight did not completely cover the ultimate losses that some insurers experienced in that business. As a result some companies became insolvent or voluntarily left the market, reducing the downward pressure on premium rates that had existed throughout the 1990's.

Fourth, beginning in 2001, reinsurance rates for medical malpractice insurers also increased more rapidly than they had in the past, raising insurers' overall costs.

In combination, each of these four factors have contributed to the movement of medical malpractice insurance market through what are called hard and soft phases similar to the cycles experienced through property casualty insurance markets as a whole, and premium rates, therefore, had fluctuated upward or downward as the phases predicted.

In an attempt to constrain increases in medical malpractice premium rates, States have adopted various tort reform measures. Of particular focus recently have been—tort reform measures have included placing caps on monetary awards for economic damages such as pain and suffering that may be paid to plaintiffs in a malpractice suit.

Available data, while somewhat limited in scope, indicate that rates of premium growth have been slower on average in States that have enacted tort reforms that include noneconomic damage caps than in States with more limited reforms. Premium rates reported by three specialties, general surgery, internal medicine and OB/GYN, were relatively stable on the average in most States from 1996 through 2000 and then began to rise, although more slowly for States with certain noneconomic damage caps. For example, for 2001 through 2002, average premium rates rose approximately 10 percent in the 4 States with noneconomic damage caps of $250,000, but rose approximately 29 percent in States with more limited tort reforms.

As we have discussed, premium rate increases are influenced by multiple factors, and our analysis did not allow us to determine the

extent to which these differences in the average rates of increases at the State level could be attributable to tort reform laws or to other factors.

In conclusion, Mr. Chairman, as we have discussed, multiple factors have contributed in recent increases in premium rates across the States and across specialties. Tort reforms, particularly those that limit noneconomic damages, have frequently been proposed as a means of controlling increases in medical malpractice insurance premium rates. These reforms and other actions, to the extent that they are effective in reducing insurers' losses below what they otherwise would have been, should ultimately slow the increase in premium rates if all else holds constant. However, any evaluation of effective tort reforms, insurance cycles or other factors in premium rates require sufficient data. In order for Congress and others to better understand conditions in the medical malpractice market and the effects of the actions that have already been taken or will be taken, better data needs to be collected, including more comprehensive data on insurers' losses, jury verdicts in malpractice cases, and conditions in the health care sector that might affect the incidence and severity of medical malpractice suits.

Mr. Chairman, this concludes our prepared remarks, and Kathy and I would be pleased to answer any questions you or other Members may have at the appropriate time.

[The prepared statement of Mr. Hillman follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Wellness and Human Rights, Committee on Government Reform, House of Representatives

For Release on Delivery
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MEDICAL MALPRACTICE INSURANCE

Multiple Factors Have Contributed to Premium Rate Increases

Statement of

Richard J. Hillman, Director
Financial Markets and Community Investment

Kathryn G. Allen, Director
Health Care - Medicaid and Private Health Insurance Issues

GAO-04-128T

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our work examining recent increases in premium rates for medical malpractice insurance and the effect of certain tort reform laws on premium growth. Since the late 1990s, medical malpractice insurance rates have increased dramatically for physicians in certain specialties in some states. These increases have heightened concerns that some health care providers may no longer be able to afford malpractice insurance, resulting in shuttered practices and reducing access to high-risk services. In response, some states have recently revised or have considered revising their tort laws, sometimes placing caps on damages in malpractice lawsuits, and the Congress is considering similar legislation.[1]

Our testimony today will focus on the factors that have contributed to the recent increases in insurance premium rates and the differences in rates among states that have passed varying levels of tort reform laws. Our findings are based on two reports we recently issued addressing various aspects of the recent increases in medical malpractice insurance rates.[2] Recognizing that the medical malpractice market varies considerably across states, as part of these reviews we judgmentally selected a number of states and conducted more in-depth reviews in each of those states.[3] Both our analyses and our conclusions are based in part on data and information we received from the states we visited and in part on analyses of national data from various sources.

In summary, multiple factors have contributed to the recent increases in medical malpractice premium rates in the states we analyzed. First, since 1998, insurers' losses on medical malpractice claims have increased rapidly in some states. We found that the increased losses appeared to be the greatest contributor to increased premium rates, but a lack of

[1]For example, on March 13, 2003, the House of Representatives passed the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003 (H.R. 5); on June 27, 2003, a similar version (S.11) of this bill was introduced in the Senate.

[2]U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (Washington, D.C.: June 27, 2003), and *Medical Malpractice: Implications of Rising Premiums on Access to Health* Care, GAO-03-836, (Washington, D.C.: Aug. 8, 2003).

[3]The states we visited were, for GAO-03-702, California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, and Texas; and for GAO-03-836, California, Colorado, Florida, Minnesota, Mississippi, Montana, Nevada, Pennsylvania, and West Virginia.

comprehensive data at the national and state levels on insurers' medical malpractice claims and the associated losses prevented us from fully analyzing the composition and causes of those losses. For example, data that would have allowed us to analyze claim severity at the insurer level on a state-by-state basis or to determine how losses were broken down between economic and noneconomic damages were unavailable. Second, from 1998 through 2001, medical malpractice insurers experienced decreases in their investment income[4] as interest rates fell on the bonds that generally make up around 80 percent of these insurers' investment portfolios. While almost no medical malpractice insurers experienced net losses on their investment portfolios over this period, a decrease in investment income meant that income from insurance premiums had to cover a larger share of costs. Third, during the 1990s, insurers competed vigorously for medical malpractice business, and several factors, including high investment returns, permitted them to offer prices that, in hindsight, did not completely cover the ultimate losses some insurers experienced on that business. As a result, some companies became insolvent or voluntarily left the market, reducing the downward competitive pressure on premium rates that had existed through the 1990s. Fourth, beginning in 2001, reinsurance rates for medical malpractice insurers also increased more rapidly than they had in the past, raising insurers' overall costs.[5] In combination, all of these factors have contributed to the movement of the medical malpractice insurance market through hard and soft phases—similar to the cycles experienced by the property-casualty insurance market as a whole—and premium rates have fluctuated with each phase.[6] Cycles in the medical malpractice market tend to be more extreme than in other insurance markets because of the longer period of time required to resolve medical malpractice claims, and factors such as changes in investment income and reduced competition can exacerbate the fluctuations.

[4]In general, state insurance regulators require insurers to reduce their requested premium rates in line with expected investment income. That is, the higher the expected income from investments, the more premium rates must be lowered.

[5]Reinsurance is insurance for insurance companies. They routinely use reinsurance as a way to spread the risk associated with the insurance they sell.

[6]Some industry officials have characterized hard markets as periods of rapidly rising premium rates, tightened underwriting standards, narrowed coverage, and the withdrawal of insurers from certain markets. Soft markets are characterized by relatively flat or slow rising premium rates, less stringent underwriting standards, expanded coverage, and strong competition among insurers.

In an attempt to constrain increases in medical malpractice premium rates, states have adopted various tort reform measures.[7] Of particular focus recently have been tort reform measures that include placing caps on monetary awards for noneconomic damages—such as pain and suffering—that may be paid to plaintiffs in a malpractice lawsuit. Available data, while somewhat limited in scope, indicate that rates of premium growth have been slower on average in states that have enacted tort reforms with noneconomic damage caps than in states with more limited reforms. Premium rates reported for three specialties—general surgery, internal medicine, and obstetrics and gynecology—were relatively stable on average in most states from 1996 through the late 1990s and then began to rise, but more slowly, in states with certain noneconomic damage caps. For example, from 2001 through 2002 average premium rates rose approximately 10 percent in the four states with noneconomic damage caps of $250,000 but approximately 29 percent in states with more limited tort reforms. As we have discussed, premium rate increases are influenced by multiple factors, and our analyses did not allow us to determine the extent to which the differences premium rate increases at the state level could be attributed to tort reform laws or to other factors.

Overall, adequate data do not exist that would allow us and others to provide definitive answers to important questions about the market for medical malpractice insurance, including an explanation of the causes of rising losses over time and the precise effect of tort reforms on premium rates. This lack of data is due, in part, to the nature of regulatory reporting requirements for all lines of insurance, which focus primarily on the information needed to evaluate a company's solvency. However, comprehensive data on individual awards actually paid in malpractice cases are also lacking, as are data on conditions in the health care sector that might affect the incidence and severity of medical malpractice suits.

Background

Nearly all health care providers buy medical malpractice insurance to protect themselves from potential claims that could otherwise cause financial distress or even bankruptcy. Under a malpractice insurance

[7]Medical malpractice lawsuits are generally based on principles of tort law. A tort is a wrongful act or omission by an individual that causes harm to another individual. To reduce malpractice claims payments and insurance premiums and for other reasons, some have advocated changes to tort laws, such as placing caps on the amount of damages or limits on the amount of attorney fees that may be paid under a malpractice lawsuit. These changes are collectively referred to as "tort reforms."

contract, the insurer agrees to investigate claims, to provide legal representation for the health care provider, and to accept financial responsibility for payment of any claims up to a specified monetary level during an established time period. The insurer provides this coverage in return for a fee—the medical malpractice premium. The most common physician policies provide coverage limits of $1 million per incident and $3 million per year.

Since 1999, medical malpractice premium rates for physicians in some states have increased dramatically. Among the states that we analyzed, however, we found that both the extent of the increases and the premium levels varied greatly not only from state to state but across medical specialties and even among areas within states. For example, the largest writer of medical malpractice insurance in Florida increased premium rates for general surgeons in Dade County by approximately 75 percent from 1999 to 2002, while the largest insurer in Minnesota increased premium rates for the same specialty by about 2 percent over the same period. The resulting 2002 premium rate quoted by the insurer in Florida was $174,300 a year, more than 17 times the $10,140 premium rate quoted by the insurer in Minnesota. In addition, the Florida insurer quoted a rate of $89,000 a year for the same coverage for general surgeons outside Dade County, or about half the rate it quoted inside Dade County.

In order to improve the affordability and availability of malpractice insurance and to reduce pressure on providers who could be faced with heavy liabilities, all states have adopted varying types of tort reform legislation. Tort reforms are generally intended to limit the number of malpractice claims or the size of payments in an effort to reduce malpractice costs and insurance premiums. Among the various types of tort reform measures adopted by states during the past three decades, caps on noneconomic damage awards have been the focus of particular interest. They have also been an issue of some debate.[8] Noneconomic

[8]Other tort reform measures adopted by states include placing caps on economic and punitive damages; abolishing the "collateral source rule" that prevents a defendant from introducing evidence that the plaintiff's losses and expenses have been paid in part by other parties such as health insurers or prevents damage awards from being reduced by the amount of any compensation plaintiffs receive from third parties; abolishing "joint and several liability" to ensure that damages are recovered from defendants in proportion to each defendant's degree of responsibility, not each defendant's ability to pay; placing limits on fees charged by plaintiffs' lawyers; imposing stricter statutes of limitations that shorten the time injured parties have to file a claim in court; and establishing pretrial screening panels to evaluate the merits of claims before proceeding to trial.

damages are awarded to plaintiffs in a medical malpractice suit to compensate for harm that is not easily quantifiable, such as pain and suffering. Proponents of caps believe that such limits can help reduce the rate of growth in malpractice insurance premiums by, among other things, helping to prevent excessive awards and overcompensation and by ensuring more consistency in jury verdicts. In contrast, opponents of these caps believe that factors other than award amounts affect malpractice insurance premiums and that caps can result in undercompensation for severely injured persons. Congress is currently considering federal tort reform legislation that includes several of the measures states have adopted, including placing caps on noneconomic and punitive damages.

Multiple Factors Have Contributed to the Increases in Medical Malpractice Premium Rates

Among the factors that have contributed to increases in medical malpractice premium rates are insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates. We found that increased losses appeared to be the greatest contributor to premium rate increases, but a lack of comprehensive data at the national and state levels on claims and associated losses prevented us from fully analyzing the composition and causes of those losses at the insurer level.

Rising Paid Losses Increase Insurers' Expectations of Required Premiums

In the long term the price insurers need to charge for their premiums is the sum of actual paid losses and expenses, plus a reasonable return in a competitive market.[9] Paid losses, one of the two ways that insurers define losses, are the cash payments insurers make in a given year, irrespective of the year in which the claim giving rise to the payments occurred or were reported. Most payments made in any given year are for claims that were reported in previous years. Medical malpractice insurers saw these losses begin to rise rapidly in 1998.

Short-term changes in rates—from year-to-year—are affected by incurred losses, which, in contrast to paid losses, reflect an insurer's expectations of the amounts it will have to pay on claims reported in that year and any adjustments, whether up or down, to the amounts the company expects to

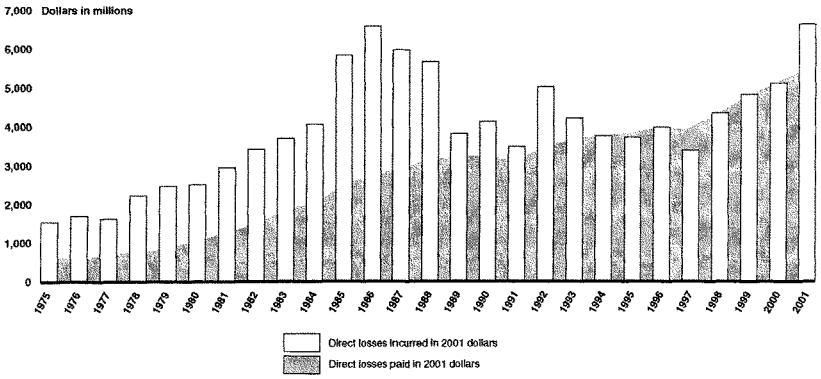
[9] We identified several factors suggesting that this market was not anticompetitive. That is, these factors suggested that insurers in this market were not charging premium rates that were inconsistent with expected losses.

pay out on claims from previous years that are still pending.[10] Incurred losses are the largest component of medical malpractice insurers' costs. For the 15 largest medical malpractice insurers in 2001—whose combined market share nationally was approximately 64.3 percent—incurred losses (including both payments to plaintiffs to resolve claims and the costs associated with defending claims) accounted for around 78 percent, on average, of the insurers' total expenses.

Figure 1 helps illustrate the relationship between incurred and paid losses and between short-term and long-term determinants of changes in premium rates. The figure shows paid and incurred losses for the national medical malpractice market from 1975 to 2001, adjusted for inflation. After adjusting for inflation, we found that the average annual increase in paid losses from 1988 to 1997 was approximately 3.0 percent but that this rate rose to 8.2 percent from 1998 through 2001. Inflation-adjusted incurred losses decreased by an average annual rate of 3.7 percent from 1988 to 1997 but increased by 18.7 percent from 1998 to 2001.

[10] That is, as more information becomes available on a particular claim, the insurer may find that the original estimate was too high or too low and must make an adjustment. If the original estimate was too high, the adjustment will decrease incurred losses, but if the original estimate was too low, the adjustment will increase them.

Figure 1. Inflation-Adjusted Paid and Incurred Losses for the National Medical Malpractice Insurance Market, 1975–2001 (Using the CPI, in 2001 dollars)



Source: GAO analysis of A.M. Best data.

The recent increases in both paid and incurred losses among our seven sample states[11] varied considerably, with some states experiencing significantly higher increases than others. From 1998 to 2001, for example, paid losses in Pennsylvania and Mississippi increased by approximately 70.9 and 142.1 percent, respectively, while paid losses in Minnesota and California increased by approximately 8.7 percent and 38.7 percent, respectively.

According to actuaries and insurers contacted with, increased losses affect premium rates in several ways. First, increasing levels of paid losses on claims reported in current or previous years can increase insurers'

[11]For analysis of the medical malpractice insurance market, we visited seven states—California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, and Texas. We selected these states because they contained a mix of characteristics, including the extent of any recently reported increases in premium rates, status as a "crisis" state according to the American Medical Association, presence of caps on noneconomic damages, state population, and aggregate loss ratios for medical malpractice insurers within the state.

estimates of what they expect to pay out on future claims. Insurers then raise premium rates to match their expectations. In addition, large losses on even one or a few individual claims can make it harder for insurers to predict the amount they might have to pay on future claims. Some insurers and actuaries we spoke with told us that when losses on claims are hard to predict, insurers will generally adopt more conservative expectations regarding losses—that is, they will assume losses will be toward the higher end of a predicted range of losses. Further, large losses on individual claims can raise plaintiffs' expectations for damages on similar claims, ultimately resulting in higher paid losses for both claims that are settled and those that go to trial. As described above, this tendency in turn can lead to higher expectations of future losses and thus to higher premium rates. Finally, an increase in the percentage of claims on which insurers must make payments can also increase the amount that insurers expect to pay on each policy, resulting in higher premium rates. That is, insurers expecting to pay out money on a high percentage of claims may charge more for all policies in order to cover the expected increases.

Declining Investment Income Has Affected Premiums

State laws restrict medical malpractice insurers to conservative investments, primarily bonds. In 2001, the 15 largest writers of medical malpractice insurance in the United States[12] invested, on average, around 79 percent of their investment assets in bonds, usually some combination of U.S. Treasury, municipal, and corporate bonds. While the performance of some bonds has surpassed that of the stock market as a whole since 2000, annual yields on selected bonds have decreased steadily since 2000. We analyzed the average investment returns of the 15 largest medical malpractice insurers in 2001 and found that the average return fell from about 5.6 percent in 2000 to an estimated 4.0 percent in 2002. However, none of the companies experienced a net loss on investments at least through 2001, the most recent year for which such data were available. Additionally, almost no medical malpractice insurers overall experienced net investment losses from 1997 to 2001. We roughly estimated that, all else held constant, the 1.6 percent decrease in average investment return from 2000 to 2002 would have resulted in an increase in premium rates of approximately 7.2 percent over the same period.

[12]As reported by A.M. Best. These insurers included a combination of commercial companies and non-profit physician-owned insurers. Some of these insurers sold more than one line of insurance, and changes in returns on investments might not be reflected equally in the premium rates of each of those lines.

Medical malpractice insurers are required by state insurance regulations to reflect expected investment income in their premium rates. That is, insurers are required to reduce their premium rates to consider the income they expect to earn on their investments. As a result, when insurers expect their returns on investments to be high, as returns were during most of the 1990s, premium rates can remain relatively low because investment income will cover a larger share of losses on claims. Conversely, when insurers expect their returns on investments to be lower—as returns have been since around 2000—premium rates rise in order to cover a larger share of losses on claims. During periods of relatively high investment income, insurers can lose money on the underwriting portion of their business but still make a profit. Although losses from medical malpractice claims and the associated expenses may exceed premium income, income from investments can still allow the insurer to operate profitably. Insurers are not allowed to increase premium rates to compensate for lower-than-expected returns on past investments but must consider only prospective income from investments.

Downward Pressure on Premium Rates Has Decreased as Profitability Has Declined

Since 1999, the profitability of the medical malpractice insurance market as a whole has declined—even with increasing premium rates—causing some large insurers to pull out of the market in some states or even nationwide. With fewer insurers offering this insurance, there is less price competition and thus less downward pressure on premium rates. According to some industry and regulatory officials in our seven sample states, premium rates were kept from rising between 1992 and 1998, in part, by price competition, even though losses generally did rise. In some cases, premium rates actually fell. For example, during this period premium rates for obstetricians and gynecologists covered by the largest insurer in Florida—a state where these physicians are currently seeing rapid premium rate increases—actually decreased by approximately 3.1 percent. Some industry participants we spoke with told us that, in hindsight, premium rates charged by some insurers during this period might have been lower than they should have been. As a result, the premium increases that began in 1998 were actually bringing premiums more in line with insurers' losses on claims. Some industry participants also pointed out that the pricing inadequacies of the 1990s were to some extent masked by insurers' adjustments to expected losses on claims reported during the late 1980s and by their high investment income.

According to industry participants and observers, as the competitive pressures on premium rates decreased, insurers apparently were able to raise premium rates to a level more in line with their expected losses

relatively quickly and easily. That is, absent the competitive pressure that may have caused insurers to keep premium rates lower, insurers were able to raise premium rates to match their loss expectations.

Reinsurance Premium Rates Have Increased

The rising cost of reinsurance was an additional reason for the recent increases in medical malpractice premium rates in our seven sample states. Insurers in general purchase reinsurance to protect themselves against large unpredictable losses. Medical malpractice insurers, particularly smaller insurers, depend heavily on reinsurance because of the potentially high payouts on medical malpractice claims.

The Medical Malpractice Market Moves through Hard and Soft Insurance Cycles

The medical malpractice insurance market appears to roughly follow the same "hard" and "soft" cycles as the overall property-casualty insurance market. However, the cycles tend to be more volatile—that is, the swings are more extreme—because of the length of time involved in resolving medical malpractice claims and the volatility of the claims themselves. Hard markets are generally characterized by rapidly rising premium rates, tightened underwriting standards, narrowed coverage, and often by the departure of some insurers from the market. In the medical malpractice market, some market observers have characterized the period from approximately 1998 to the present as a hard market. (Previous hard markets occurred during the mid-1970s and mid-1980s.) Soft markets are characterized by slowly rising premium rates, less stringent underwriting standards, expanded coverage, and strong competition among insurers. The medical malpractice market from 1990 to 1998 has been characterized as a soft market.

States with Tort Reforms that Include Certain Noneconomic Damage Caps Had Lower Recent Growth in Malpractice Insurance Premium Rates

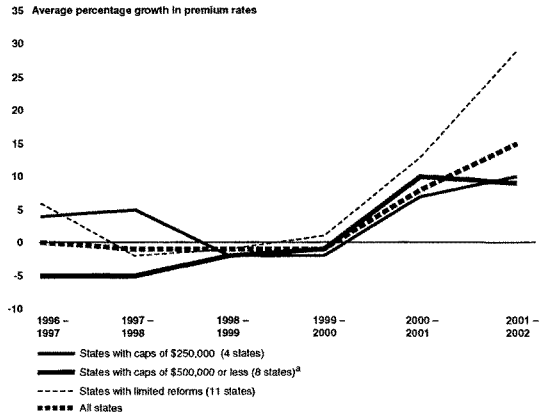
In order to constrain the rate of growth in malpractice insurance premiums, states have adopted various tort reform measures, some of which include placing caps on monetary awards for noneconomic damages. Premium rates reported for the physician specialties of general surgery, internal medicine, and obstetrics and gynecology—the only specialties for which data were available—were relatively stable on average in most states from the mid- to late 1990s and then began to rise, but more slowly among states with certain noneconomic damage caps.[13] From 1996 to 2000, average premium rates for all states changed little, as did average premium rates for states with certain caps on noneconomic damages and states with limited reforms, increasing or decreasing annually by no more than about 5 percentage points on average.[14] After 2000, premium rates began to rise across most states on average, but more slowly among states with certain noneconomic damage caps. In particular, from 2001 to 2002, the average rates of increase in the states with noneconomic damage caps of $250,000 and $500,000 or less were 10 and 9 percent, respectively, compared with 29 percent in the states with limited reforms (see fig. 2).[15]

[13]Premium rate data are reported by the Medical Liability Monitor (MLM). MLM is a private research organization that annually surveys professional liability insurance carriers in 50 states and the District of Columbia to obtain their base premium rates for the specialties of internal medicine, general surgery, and OB/GYN.

[14]We focused our analysis on those states with noneconomic damage caps as a key tort reform because such caps are included in proposed federal tort reform legislation and because published research generally finds these caps to have a greater impact on medical malpractice premium rates and claims payments than some other tort reform measures.

[15]Because research suggests that any impact of tort reforms on premiums can be expected to follow the implementation of the reforms by at least 1 year, we grouped states into their respective categories based on reforms in place as of 1995 and reviewed premium rate data for the period 1996 through 2002. Four states had noneconomic damage caps of $250,000 (California, Colorado, Montana, Utah), 8 states had noneconomic damage caps of $500,000 or less (Hawaii, Louisiana, Massachusetts, Michigan, Missouri, North Dakota, South Dakota, and Wisconsin), and 11 states had limited reforms, defined as no damage caps of any type or collateral source reforms (Arkansas, District of Columbia, Kentucky, Mississippi, Nevada, Ohio, Oklahoma, Pennsylvania, South Carolina, Vermont, and Wyoming). We categorized the remaining 28 states as "other reforms" for analysis purposes, indicating they had a noneconomic or total damage cap greater than $500,000, any punitive damage cap, or any collateral source rule reform.

Figure 2: Premium Rates for Three Physician Specialties Rose After 2000, but to a Lesser Extent in States with Noneconomic Damage Caps



Source: MLM.

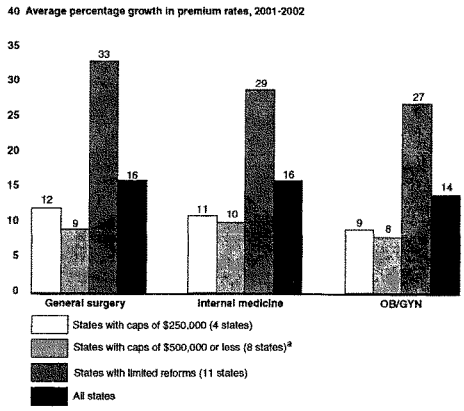
Notes: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

Premiums are adjusted for inflation to 2002 dollars.

[a]This category excludes states with caps of $250,000.

The recent increases in premium rates were also lower for each reported physician specialty in the states with these noneconomic damage caps. From 2001 to 2002, the average rates of premium growth for each specialty in the states with these noneconomic damage caps were consistently lower than the growth rates in the limited reform states (see fig. 3).

Figure 3: Recent Premium Growth Was Lower for Three Physician Specialties in States with Noneconomic Damage Caps



Source: MLM.

Note: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

Premiums are adjusted for inflation to 2002 dollars.

[a]This category excludes states with caps of $250,000.

Other studies have found a relationship between direct tort reforms that include noneconomic damage caps and lower rates of growth in premiums.[16] For example, in a recent analysis of malpractice premiums in states with and without certain medical malpractice tort limitations, the Congressional Budget Office (CBO) estimated that certain caps on damage awards in combination with other elements of proposed federal tort reform legislation would effectively reduce malpractice premiums on average by 25 to 30 percent over the 10-year period from 2004 through

[16]Direct reforms are limits on amounts that can be recovered in a malpractice action including caps on noneconomic or total damages, abolition of punitive damages, collateral source rule reforms, and abolition of mandatory prejudgment interest.

2013.[17] A 1997 study that assessed physician-reported malpractice premiums from 1984 through 1993 found that direct reforms, including caps on damage awards, lowered the growth in malpractice premiums within 3 years of their enactment by approximately 8 percent.[18]

Differences in malpractice premiums across states are influenced by several factors other than noneconomic damage caps. First, the manner in which damage caps are administered can influence the ability of the cap to restrain claims and thus premium costs. Some states permit injured parties to collect damages only up to the specified level of the cap regardless of the number of defendants, while other states permit injured parties to collect the full cap amount from each defendant named in a suit. Malpractice insurers informed us that imposing a separate cap on amounts recovered from each of several defendants increases total claims payouts, which can hinder the effectiveness of the cap in constraining premium growth. Second, tort reforms unrelated to caps can also affect premium and claims costs. For example, California tort reform measures include not only a $250,000 cap but also allow other collateral sources to be considered when determining how much an insurer must pay in damages and allow periodic payment of damages rather than requiring payment in a lump sum, among other measures. Malpractice insurers told us that these provisions, in addition to the cap, have helped to constrain premium growth in that state. In contrast, while Minnesota has no caps on damages, it has experienced relatively low growth in premium rates. Trial attorneys say this development is the result of mandatory prescreening requirements that have reduced claim costs, and thus premiums, by preventing some meritless claims from going to trial. Third, state laws and regulations unrelated to tort reform, such as premium rate regulations, vary widely and can influence premium rates. Finally, insurers' premium pricing decisions are affected by their losses on medical malpractice claims and income from investments, and other market conditions as we previously discussed. Because of these various factors, we could not determine the extent to which differences in premium rates across states were attributable solely to damage caps or also to these additional factors.

[17]U.S. Congress, Congressional Budget Office, *Cost Estimate: H.R. 5 – Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003* (March 2003).

[18]Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," *Law and Contemporary Problems*, vol. 670, no. 1 (1997): 81-106.

Comprehensive Data on the Composition and Causes of Increased Losses Were Lacking

A lack of comprehensive data at the national and state levels on medical malpractice claims filed against various insurers and the losses associated with these claims prevented us from answering important questions about the market for medical malpractice insurance, including exactly why losses are rising over time and, as just noted, the extent to which tort reforms may have affected premium rates. For example, comprehensive data that would have allowed us to fully analyze the frequency and severity of medical malpractice claims at the insurer level on a state-by-state basis did not exist. As a result, we could not determine the extent to which increased losses were the result of an increased number of claims, larger claims, or some combination of both. In addition, data that would have allowed us to analyze how losses were divided between settlements and trial verdicts or between economic and noneconomic damages were not available. Insurers do not submit information to the National Association of Insurance Commissioners on the portion of losses paid as part of a settlement and the portion paid as the result of a trial verdict, and no other comprehensive source of such information exists. As a result, we could not analyze the effect of certain tort reforms on noneconomic losses, and thus on premium rates.

While more complete data on the insurance industry would help provide better answers to questions about how the medical malpractice insurance market is working, other data are equally important to analyzing the underlying causes of rising malpractice losses and associated costs. These data relate to factors outside the insurance industry, such as policies, practices, and outcomes in both the medical and legal arenas. However, collecting and analyzing such data were beyond the scope of our reviews.

Conclusions

As we have discussed, multiple factors, including falling investment income and rising reinsurance costs, have contributed to recent increases in premium rates in our sample states. However, we found that losses on medical malpractice claims—which make up the largest part of insurers' costs—appear to be the primary driver of rate increases in the long run. And while losses for the entire industry have shown a persistent upward trend, insurers' loss experiences have varied dramatically across our sample states, resulting in wide variations in premium rates. In addition, factors other than losses can affect premium rates in the short run, exacerbating cycles within the medical malpractice market.

We have also seen that the severe premium rate increases of the last few years followed a period of relatively stable premium rates in the early 1990s, when insurers had excess reserves and sufficient investment

income to keep rates low. But by the mid- to-late 1990s, as insurers exhausted their excess reserves and investment income fell below expectations, the profitability of malpractice insurance had declined. Regulators found that some insurers were insolvent, and in 2002 one of the two largest medical malpractice insurers, which had been selling insurance in almost every state, stopped selling medical malpractice insurance altogether. Other companies reduced the amount of insurance they sold and consolidated their markets, resulting in large rate increases in many states. It remains to be seen whether these increases will be found to have exceeded those necessary to pay for future claims losses, as they did in the 1980s.

Tort reforms, particularly those that limit noneconomic damages, have frequently been proposed as a means of controlling increases in medical malpractice insurance premium rates. While the limited available data indicate that premium rates have grown more slowly in states with tort reform laws that include certain caps on noneconomic damages, a lack of comprehensive data prevented us from determining the exact effects of these laws on premium rates. Tort reforms and other actions that reduce insurer losses below what they otherwise would have been should ultimately slow the increase in premium rates, if all else holds constant. But several years may have to pass before insurers can quantify and evaluate the effect of the laws on losses from malpractice claims and before an effect on premium rates is seen.

More time is also needed before we can determine whether the medical malpractice insurance market will continue its cycle from the current hard to a soft phase and thus are better able to understand the part the cycle itself has played in the rise in premium rates. However, any evaluation of the effect of tort reforms and cyclical behavior on premium rates requires sufficient data. In order for Congress and others to better understand conditions in the medical malpractice market and the effects of the actions that have already been or will be taken, better data need to be collected, including more comprehensive data on insurers' losses, jury verdicts in malpractice cases, and conditions in the medical industry that might affect the incidence and severity of medical malpractice suits. Without question, the absence of such data complicates the ability of insurers, regulators, and the Congress to understand current market conditions and to formulate effective, sustainable solutions.

Mr. Chairman, this concludes our prepared statement. We would be pleased to answer any questions you or other members of the subcommittee may have at this time.

Contacts and Acknowledgements

For further information regarding this testimony, please contact Richard J. Hillman at (202) 512-8678 or Kathryn G. Allen at (202) 512-7059. Individuals from our Financial Markets and Community Investment team making key contributions to this testimony include Lawrence Cluff, Patrick Ward, Melvin Thomas, and Andrew Nelson. Individuals from our Health Care team making key contributions to this testimony include Randy DiRosa and Corey Houchins-Witt.

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Mr. BURTON. Mr. Hillman, I find it a little troubling. I was an insurance underwriter for a casualty company at one time in my previous life, and I was also an insurance agent, and the losses that insurance companies, whether they are medical malpractice companies or casualty companies, is pretty much open. And you indicated that there needed to be more research to get these—this information. If GAO did this study, I can't understand how they couldn't have found the information regarding these losses and be able to very quickly figure out what the problem is.

I mean, insurance companies use what they call a loss and expense constant. The loss plus the expenses of taking care of the administrative parts of settling claims and paying the overhead for clerical workers and so forth, plus a small margin for profit, is how they figure out what their costs are and what the premium should be. And when I was an underwriter early on, they didn't figure outside income as part of the overall equation. Either you made money from the insurance risk, or you didn't. And if you didn't make money, you had to raise the rates. And if you made money, you lowered the rates. That's why we had State insurance commissioners that dealt with these things.

But the question I have for you, why is it, if GAO did a thorough study on this, why couldn't they have looked at this information that the insurance companies have to find out whether or not there was another problem besides the need for tort reform?

Mr. HILLMAN. Well, we did, chairman, look at the data that was made available to us from the National Association of Insurance Commissioners, and you are right, we have available to us some national data of what is happening across the medical malpractice insurance itself with both paid losses, those losses that are incurred in the year under review, as well as incurred losses being those losses that they expect to incur over the next period and some adjustments that might take place. And I have a chart that I would like to show you that shows what is happening with paid losses and incurred losses since 1975 through 2001.

Mr. BURTON. I probably should have those reduced. I don't want this young man breaking his back moving those things around.

Mr. HILLMAN. A copy of this is also shown in figure 1 in our prepared statement, if you would like to see a copy in front of you. But what we have here shown in the blue lines are the paid losses that are being incurred in the medical malpractice insurance market nationwide adjusted, using the CPI in 2001 dollars for 1975 through 2001. The bars going up reflect the incurred losses. Those are the losses the insurers anticipate—may anticipate within the next year or so plus adjustments from prior periods.

Mr. BURTON. So they set up a reserve for those losses, and that reserve is figured into the overall equation?

Mr. HILLMAN. That's correct, sir.

Mr. BURTON. Well, the answer, according to your research, I presume, and yours as well, Ms. Allen, is that we need to come up with some kind of a tort reform formula that's fair to the lawyers, the patients who have been damaged and the doctors. That sounds like a Gordian knot that needs to be chopped in two. Can you give me an equation to solve that problem?

Mr. HILLMAN. I wish I had the silver bullet, and I am sure most others do as well. When you look at premium rates in the insurance industry, the Congresswoman wanted to get to the facts. Well, the facts as we understand them are paid losses and incurred losses are the primary driver of those rates. If Congress wants to do something to reduce medical malpractice premium rates, we need to look at those paid losses. There's a couple of ways of addressing them.

Mr. BURTON. Paid plus incurred.

Mr. HILLMAN. Paid plus incurred.

Incurred losses for the 15 largest insurance underwriters that we visited and talked to, which comprise about 64 percent of the marketplace in medical malpractice insurance, incurred losses are about 80 percent of their total expenses. So you really need to look at incurred losses. And in medical malpractice what you need to do is look at frequency of claims, look at severity of claims. Addressing frequency of claims, tort reform, effective tort reform—looking at severity of claims, effective tort reform could address that by reducing jury verdicts and not putting caps on noneconomic damages. That's one side of the equation. Another side of the equation would be the frequency, looking at the patient care, doctors quality of care and trying to come up with solutions to address the frequency of claims.

Mr. BURTON. I am going to let Ms. Watson ask questions, but let me make one more statement. I presume from your studies that there's no doubt that you are going to continue to have the flight of doctors from States that don't do something to deal with the exorbitant premiums they have to pay. And if that continues to happen, those States that don't enact some kind of reforms that are going to deal with this problem are going to see fewer doctors and higher medical costs in all probability, and a lowering of the quality of health care, which means a lowering in the quality of life for those who need help. So the bottom line, we got to do something about it, right?

Mr. HILLMAN. I agree. Problems in some States are very severe, and while States have done what they can do to implement their own reforms, they aren't all the same, and therefore you are seeing some States continuing to have large problems while other States are moderate.

Mr. BURTON. You are making the case that we need some Federal legislation.

Mr. HILLMAN. A national system seems to be one of the best ways to curb that problem.

Mr. BURTON. Ms. Watson.

Ms. WATSON. Thank you, Mr. Chairman.

And we don't take what you have presented to us lightly. I do appreciate you looking across the spectrum.

In the State of California where we have started on some tort reform, we also, in my tenure, established the department of an insurance commissioner, because there are three major players in all of this, the health delivery system, the doctors and so on, the insurance company and those they insure. And our goal, as I said in my statement, is to be able to provide quality health care, to have the patients' trust in the kind of health care they receive, and be able

to petition when they are injured. And we want to be fair to all in that. We have no intent to want to run our medical providers out of business and out of this State. We have no intent to say to an injured individual that you cannot be compensated. We certainly don't want to say to their attorneys that you have no role to play.

So when I say what is the truth, I ask this question. I think you mentioned that the National Insurance Association—that might not be the accurate and complete title—provided you with information, but are you able to see—do they open up their whole profile of their actuarial data? Do you see that? And it varies from State to State. And until we can get a hand on what's happening in California or what's happening in Florida or Texas, it's going to be very difficult for us to fashion a Federal standard because we've got to take into account the various factors that are present in a particular State.

For example, with our large population of 35 million and growing per day, we are finding people come in with very, shall I say—well, they suffer from a lack of health care when they immigrate into the State of California, Pacific Rim, and those who are older come there and they demand certain kind of treatments, and they are very fragile. And so we have to take in all those factors as we look at malpractice insurance. And so I think actuarial data is essential for you who are looking at the numbers and trying to come up with some results and advise us. So were you able to get into actuarial data?

Mr. HILLMAN. The National Association of Insurance Commissioners does not collect actuarial data that would allow you to assess those on a State-by-State basis.

Ms. WATSON. Thank you, because that goes to the point I was making, that it has to almost be a State-by-State look. You know, we very seldom have a clear picture of why the premiums were raised, and we have had these debates over a period of years, I mean decades, and I held many of those hearings. And it's not quite clear. But we have an insurance commissioner that is looking into these issues. And I just want to say that as we look at this problem, tort reform is not the only answer, and as we seek the truth in this subcommittee, I appreciate you coming with your testimony today. And, Mr. Burton, thank you for the opportunity.

Mr. BURTON. Let me just ask one more quick question to follow-up on what Ms. Watson was asking. When you talk to the National Association of Insurance Commissioners, did they indicate to you that there was any problem in getting the data from the insurance companies?

Mr. HILLMAN. Well, data that they collect really isn't designed to help look at this problem that Congress is faced with. What they're really looking for is data on the solvency of companies, making sure that they have sufficient income to pay claims associated with insurance.

Mr. BURTON. Right. But in the process of making sure that the companies are solvent, they have to look at the records on loss and expense of that company. Now, they keep records, those companies do, on the losses. Now, my question is was there any indication that the insurance companies were trying to keep that information

from you, or the Federal—National Association of Insurance Commissioners, to try to hide something?

Mr. HILLMAN. No. No. Not at all. We received excellent cooperation from the National Association of Insurance Commissioners as well as a wide range of industry participants, insurance regulators, medical and legal and trial attorney associations. All were very candid with us to try to help us understand what was happening here.

From a data limitation standpoint, though, what we were looking for and unable to find was data on severity and frequency of claims at the insurer level on a State-by-State basis. This information simply did not exist. What the NAIC has is aggregate data that shows you the total loss portfolio and premium income picture, what you expect from an investment return standpoint, what your marginal profit might be associated with those estimates to give you some sense of solvency of the institution, and that is what they rely on. To break it down on a line of insurance business which would break out information showing frequency of claims at the policyholder level, severity of those claims is the type of data that we would like to have in order to better evaluate what's going on here.

Mr. BURTON. Well, does GAO have the ability to subpoena documentation like that and information like that?

Mr. HILLMAN. No, Congressman. As a matter of fact, GAO's audit authority primarily goes to the Federal agencies that implement the Federal programs in the executive branch. In the insurance industry there is no Federal agency—individual State regulators, and we have no direct access to compel them to provide us information.

Mr. BURTON. Each State has an insurance commissioner.

Mr. HILLMAN. Correct. And they cooperated with us to the extent they can.

Mr. BURTON. I was on the committee that dealt with our insurance commissioner when I was on the State legislature in Indiana. We had no problem whatsoever of getting information on insurance companies and the ratemaking procedures they used. And it just seems to me that if the GAO—and we may ask you to do this—if they talk to each individual State, there are 50 of them——

Mr. HILLMAN. Correct, four territories.

Mr. BURTON. Check them out, too, but if you talk to each individual State, and that would be a big job, no question about it, I think you could get the statistical data you require in order to make some kind of an assessment like that, because I think it's very, very important that we have all the facts before we conclude this thing, because you're going to get from insurance companies one picture, and you are going to get from the doctors another picture, from the victims another picture, and from the trial lawyers another picture. And the only way we are to be able to come up with a formula that is going to be fair to everybody is to get that statistical data compiled, and if you can't get it from the National Association of Insurance Commissioners, you're going to have to get it from each individual State. And I know it's there. You can get it. You just have to ask for it.

Ms. Watson.

Ms. WATSON. Mr. Hillman, I want to commend you because I think you put your finger on your problems, and I appreciate the Chair being able to identify where the problems really are.

We understand your relationship to your Federal Government, but when it comes to States, because we have had plenty of trouble with our insurance commission and commissioners in the State of Florida—I won't tell you about the horror stories in terms of earthquake insurance. And I know that you are just stumped, because you have no way of getting that information.

And so this is just the beginning, Mr. Chair, of trying to look at what we can do from a Federal level. But if the GAO had to tap into every 1 of the 50 States and territories, this would be an endeavor that would take over a period of years, because there's a cost to it as well, and it's very time-consuming, and I don't think you are going to get the kind of cooperation out of some States as you would out of others and out of the Federal department, because you're going into the private insurance companies' confidential records.

If you asked to open your actuarial data file, I don't know if you're going to get the kind of cooperation, because it might be a bad investment somewhere else that you're going to pay for as an end result through premiums. So I'm just suggesting that if we want you to do this, we are going to have to be sure there are resources there, and that there is personnel there, and you have the time to do it.

Mr. HILLMAN. Quite frankly, in addition to insurance data, which is sorely needed to better understand what is going on with premium rate increases, there's also data that's needed in the legal system and medical system. Data on settlements and trial verdicts, breaking out information between economic and noneconomic damages, largely also not available, judgments on amounts obtained at trial are reported, sometimes very large amounts, and insurers told us, however, that most often they do not pay those amounts beyond policy limits. So data on the final amounts an insurer pays on individual judgments is not being publicized or available, and it ends up what the insurers end up having to pay on these highly publicized claims.

Mr. BURTON. What's the answer, then, for the Federal Government if we're going to try to pass a bill that would augment what the States are trying to do, or where those States have not done something, you know, solve the problem? And I rather this be done by individual States, but the States aren't doing it, and you are having the flight of doctors out there. It seems to me something has to be done. You can't let the health of one segment of the country just go down the tubes because the price of insurance is too high. So what do you think the answer is if it's difficult to get this information? Seems like you could work with the State insurance commissioners to get this, but assume that you can't. What do you think the answer is?

Mr. HILLMAN. Well, I go back to our major finding as shown in this table that I have presented in figure 1 of my written statement for the record. The major contributing factor to increasing premium rates in the medical malpractice insurance market today appears to us to be paid and incurred losses. And looking at how to reduce

those at the insurance level may give us some hope in helping to ferret out how best to reduce those rates. In doing so we need to look at the frequency of claims and the severity of claims at the insurance line level and a State-by-State basis and each insurer to better understand what is happening in those States, what types of measures they have in place to combat that problem—many States have many different things going on out there—and assess which among those things are working best.

You're right, that is a herculean task. What we have done as part of this review was identify those factors. Interest, investment income, paid losses, reinsurance rates that insurers have to pay to level out their risk are the major contributing factors to the premium rate increases.

Mr. BURTON. We may wrestle with this further and try to get back to you with a request to augment what you have already done.

Mr. HILLMAN. We would be pleased to do so.

Ms. WATSON. When the Chair asked the question what can we do, and I was thinking ahead of that as a herculean task, maybe we can at the Federal level ask the States to report on what steps they are taking. I represent a district where we were red-lined, and we found out that there were gangs out there who were faking accidents, you know, running into the backs of people and having people making claims and so on. And you know, so premiums went up. We were red-lined because the accidents happened in the district.

I think back to when I was in Okinawa they would say, "Muchie too accident in the area." We had the "muchie" accident area. People going down to, say, Orange County had their accidents, you know, in our area, and then our premiums went up. That is on the automobile insurance side.

So there are all kinds of factors within a State that we have to look at. And maybe we can put, you know, the mandate, Mr. Chairman, on the States to start looking at all of these factors, not just the insurance section, but the legal section as well as the victims in all of the kinds of con games that go on as well.

It would be frightening to think that medical malpractice insurance was growing because the professionals were practicing faulty medicine. I mean, that would be a very frightening thing.

But as you were testifying, I was thinking that we had a case where the chair of business and professions was giving these doctors coming from other countries reciprocity and collecting 25,000 for each one he got out of his committee. I was on his committee, and he would come to my name and he would say, Watson, aye, and I didn't open my mouth, and out would go the bill. And this guy would be practicing without taking the boards. He ended up in prison, of course, this member.

But I'm just saying, each State has its own set of problems, and there's no way that, from a Federal level, you could impact or affect that. We are not ready for that. But what you can do is see that each State is making strides to look at the issue.

Mr. HILLMAN. Your remarks are very consistent with where we came out in our report that we had done. We included matters for congressional consideration which says that Congress may wish to consider taking steps to ensure that additional and better data are

collected. Specifically Congress may want to consider encouraging the NAIC and State insurance regulators to identify the types of data that are necessary to properly evaluate the medical malpractice insurance market, specifically the frequency, severity and the causes of losses, and begin to collect these data in the form that would allow for appropriate analysis. That's essentially what we were saying as well.

Mr. BURTON. We have been joined by the ranking member of the full committee Mr. Waxman. Do you have any questions?

Mr. WAXMAN. Thank you very much.

Medical malpractice insurance premiums have risen dramatically for some health care providers in some parts of the country. That much seems to be clear. But there has been a great deal of debate and great deal of miscellaneous information about the causes of these premium hikes and impact they have had on access to health care.

Some of my colleagues on the other side argue that greedy trial lawyers and runaway juries are the sole cause of a rampant problem around the country, and they have argued we can solve this problem by imposing drastic national limits and the ability of courts and juries to decide which malpractice claims have merit and which do not.

I don't think that view is supported by the facts, and I am glad GAO is here to set the record straight.

I have a few questions about what GAO found in its two recent reports on this subject. GAO found that there wasn't one single cause with multiple factors that cause premium increases for some physicians in some States; is that correct?

Mr. HILLMAN. That's correct.

Mr. WAXMAN. And they included insurance company competition, particularly in the soft market of the 1990's to cut rates and win a greater share of the physician market; is that correct?

Mr. HILLMAN. That's correct.

Mr. WAXMAN. Another factor is the rising cost of reinsurance rates, correct?

Mr. HILLMAN. That's correct.

Mr. WAXMAN. And the remaining factor you cite is the increase in insurer losses; is that correct?

Mr. HILLMAN. That's correct. We believe that is one of the major contributing factors in increases in premium rates.

Mr. WAXMAN. On increasing insurer losses, GAO reported that it lacked comprehensive data that would allow you to analyze claims severity or show how losses were broken down between economic and noneconomic damages; is that correct?

Mr. HILLMAN. Yes.

Mr. WAXMAN. GAO could not conclude and did not conclude that runaway jury verdicts would cause an insurance crisis throughout the country; is that a correct statement?

Mr. HILLMAN. We weren't asked to evaluate that, but what we identified were major factors that contributed to increases in premium rates.

Mr. WAXMAN. Seems to me if runaway jury verdicts aren't the main problem, that we have no business in imposing national limits on the ability of injured victims to bring claims to court. GAO

reports that this problem is as much about the business of insurance as it is about the rising cost of claims and legal defense, and that is the subject better left for the States to address. After all, States have always had the responsibility for regulating the business of insurance through licensing professionals, for establishing appropriate standards of care, and for punishing professional misconduct by health care providers. They are in a far better position than Congress here in Washington to say, we know what's best for everybody, and to impose one-size-fits-all solutions to address the problem. That is pretty complicated and has different aspects to it.

Thank you very much, Mr. Chairman.

Mr. BURTON. You sound a little bit like a Republican when you talk about States rights.

Mr. WAXMAN. Strom Thurmond took that very same position on a lot of issues, but on this issue he saw that this was a States rights issue.

Mr. BURTON. I think it is a States rights issue, what kind of guidance the Federal Government might give to the States that aren't responding to this problem and maybe encourage in some way to get on with it. In 1974, you worked on this bill that dealt with this.

Mr. WAXMAN. That is not correct. I chaired the Select Committee on Medical Malpractice for the California State Assembly, and many of the recommendations that we put forward were put into the what is called microlegislation, and microlegislation was adopted after I came back to Congress, and I didn't have an opportunity to vote one way or the other.

Mr. BURTON. Were your recommendations made in 1974?

Mr. WAXMAN. They were made in 1974, which is the year I was elected in Congress. The bill was adopted in 1975. So I was already back here. But I thought we played a constructive role in making our recommendations.

And I think California law is one of the many States that we try to emulate, and sometimes they have adopted it in toto, and sometimes they decided other strategies, because I think we have had a view that democracy is at the State level, and I don't think they need us to give them guidance. But I don't think they need Washington to tell them what to do on an issue like this, particularly where it is not so clear-cut as the GAO reports out, that this is a more complicated problem than the glib answer of this is the solution, because this is the only reason those insurance rates are going up. That is the point I wanted to make.

Mr. BURTON. Thank you. I think that your reports are very well done and might ask you to do a little bit more, as I said earlier. And with that, we'll excuse you and get back to you later. Thank you very much.

Our next panel is our good friend, the Honorable Dick Thornburgh, who was the Attorney General of the United States from 1988 to 1991 and the Governor of Pennsylvania from 1979 to 1987; as well as Dr. John C. Nelson, President-Elect and executive board member of the American Medical Association; Mr. Jay Angoff, former insurance commissioner for the State of Missouri; Mr. Sherman Joyce, president of the American Tort Reform Association, and Dr. James Tayoun, who's a vascular surgeon and presi-

dent of the Politically Active Physicians Association, I believe of Pennsylvania, if I'm not mistaken; is that correct?

Mr. TAYOUN. Correct.

Mr. BURTON. OK. Very good. Have a seat.

Would you please rise? Our custom is to swear everyone in, so would you raise your right hands.

[Witnesses sworn.]

Mr. BURTON. In deference to our former Attorney General, I'd like to start with Mr. Thornburgh.

How are you?

STATEMENTS OF DICK THORNBURGH, FORMER ATTORNEY GENERAL OF THE UNITED STATES AND GOVERNOR OF PENNSYLVANIA; JOHN C. NELSON, M.D., MPH, FACOG, FACPM, PRESIDENT-ELECT AND EXECUTIVE BOARD MEMBER, AMERICAN MEDICAL ASSOCIATION; JAY ANGOFF, ESQ., FORMER INSURANCE COMMISSIONER, STATE OF MISSOURI, AND DEPUTY INSURANCE COMMISSIONER, STATE OF NEW JERSEY; SHERMAN JOYCE, J.D., PRESIDENT, AMERICAN TORT REFORM ASSOCIATION; AND DR. JAMES TAYOUN, VASCULAR SURGEON AND PRESIDENT, POLITICALLY ACTIVE PHYSICIANS ASSOCIATION

Mr. THORNBURGH. Fine, Mr. Chairman.

Thank you very much for the invitation to speak with you today about a topic that I think is important to not only those present, but to all Americans. I want to emphasize that I appear here today as a representative of no one save myself. It's because of my longstanding interest in civil justice reform that dates back to my service as Governor and as Attorney General.

We can all agree, I think, that there's a significant problem with increasing rates for medical malpractice insurance. My home State of Pennsylvania is one of the hardest hit. Just this past summer the GAO report noted that cash payments by insurers to medical malpractice plaintiffs in Pennsylvania jumped more than 70 percent between 1998 and 2002, a 5-year period.

Doctors in Pennsylvania pay malpractice insurance premiums that are sharply higher than the national average. A number of major insurance carriers have failed and others have opted out of insuring doctors or have refused to issue new policies. The Pennsylvania Department of Insurance reported just this past summer that 2002 marked the 4th consecutive year in which insurers lost money on medical malpractice insurance policies issued in Pennsylvania. As a result, one professional organization estimates that Pennsylvania, home to the first medical school and the original 13 States, and now home to some of the finest medical schools and hospitals in the Nation, has lost nearly 1,000 doctors who have decided that practice there just doesn't pay.

The problem is not Pennsylvania's alone. Just last year, the Trauma Center at the University of Nevada Medical Center in Las Vegas had to close for 10 days because surgeons quit in the face of huge increases in their malpractice premium. Such stories are legion, and I do not propose to rehearse them all today. They arise from across the country.

The flight of doctors from the profession or from high-exposure specialties or geographic areas threatens Americans' continuing access to quality health care—women without doctors to deliver babies, accident or crime victims turned away from crime centers, increasing practice of defensive medicine, these are the realities of a worsening national crisis.

As I said, few could question the diagnosis. The debate grows heated, however, when we try to settle on a cure. Many of us, including President Bush, believe that one important step must be a comprehensive nationwide reform of medical malpractice law. There are simply too many meritless medical malpractice suits filed and there are too many overly generous jury awards. Faced with that uncertain and potentially unlimited exposure, insurance companies feel compelled to protect themselves and raise their rates, meaning full reform should include caps on awards for noneconomic damages, that ethereal category of damages that includes such intangibles as pain and suffering. It should include limits on the fees lawyers can recover, and it should raise the burden of proof and include caps for recovery of punitive damages.

The thrust of each of these measures would be to strike a balance between the legitimate need to provide redress to injured patients and the insurance industry's need for greater certainty about its potential exposure.

House bill 5 referred to earlier, sponsored by Pennsylvania's James Greenwood and passed by the House more than 6 months ago, included each of these provisions and more. Unfortunately, that legislation, like other similar measures in years past, was unable to make appreciable headway in the Senate.

While we cannot be assured that these reform measures will alleviate the crisis, there is sound empirical evidence to give us hope. As the chairman reminded Representative Waxman, California, for example, enacted a comprehensive reform plan nearly 30 years ago. Since then, insurance premiums there have risen at less than half the average national rate. Other States that have enacted substantive reform report similar success.

Opponents of these reforms will tell you that there are other causes for skyrocketing malpractice premiums, such as poor investment decisions by insurance companies. That explanation, whether true or not, ignores the significant differences in rates between States that have enacted real reforms and those that have not. If the problem were simply poor investments, we would expect to see similar rate increases across the board without regard for geography.

In addition, that Pennsylvania Department of Insurance study I mentioned a moment ago made a very helpful distinction. It explained that in the decade between 1992 and 2002, Pennsylvania medical malpractice claims payments almost tripled, premiums more than doubled, but investment income for insurers declined by only a third. The Pennsylvania study noted that in 2002 medical malpractice insurers in Pennsylvania earned more than $46 million on their investments. However, because of malpractice claims, which comprise more than 61 percent of all insurer costs in Pennsylvania, those insurers still ended the year with an $18 million loss.

Considering that data and similar information from six other States, the GAO concluded in June, as you've heard, as Mr. Hillman has already testified, that losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term. Even if the poor investment argument were to some degree correct, it would still miss the point.

Study after study tell us that malpractice litigation is, at the least, a substantial contributor to the insurance crisis. Reform opponents seem to believe that a problem can only have one cause and, correspondingly, one solution. Of course, that's not so. If litigation reform could slow the pace of insurance rate increases, it would be well worth it. The trial lawyers point a finger at the insurance industry, at least in part, I suspect, because meaningful tort reform might well hit those lawyers in the pocketbook.

There is then the issue of whether the reform should be at the national or local level. Mr. Waxman discussed that at some length. As a former Governor, I have great faith in State governments and their ability to react to the needs of their citizens. Several States, Pennsylvania included among them, have enacted reforms. With rare exception, however, those laws are too often the cobbled-together results of political battles between doctors' groups and trial lawyers. As a result, they reach the statute books so diluted as to be nearly useless.

Mr. Chairman, the medical malpractice problem is national in scope and effect. Many doctors have interstate practices; many insurers provide coverage in more than one State. The Federal Government itself, through direct coverage of members of the military, veterans and others, and through Medicare, Medicaid and community health initiatives, is a major consumer of health care. The crisis affects our national economy through jobs lost when hospitals, medical clinics, and offices close and when productivity is lost through workers' receiving inadequate health care. A national problem, in short, requires a national solution.

I recognize that the same political pressures that have so watered down reform efforts in many States may well prove to be insurmountable as an impediment to this body's lead in passing appropriate Federal reforms, but something must be done, and it must be done nationally and it must be done on a comprehensive basis and it must be done, Mr. Chairman, soon.

Thank you very much for permitting me to appear today.

Mr. BURTON. Thank you, Governor. We appreciate, very much, your comments.

[The prepared statement of Mr. Thornburgh follows:]

PREPARED REMARKS FOR PRESENTATION TO THE HOUSE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON WELLNESS AND HUMAN RIGHTS
OCTOBER 1, 2003
THE HONORABLE DICK THORNBURGH
FORMER ATTORNEY GENERAL OF THE UNITED STATES AND GOVERNOR OF PENNSYLVANIA

Chairman Burton, members of the committee, thank you for the invitation to speak with you about a topic that is important to me and to all Americans.

We can all agree that there is a significant problem with increasing rates for medical-malpractice insurance. My home state of Pennsylvania is one of the hardest hit. Just this past summer, the General Accounting Office reported that cash payments by insurers to medical-malpractice plaintiffs in Pennsylvania jumped more than 70 per cent between 1998 and 2002.

Doctors in Pennsylvania pay malpractice-insurance premiums that are sharply higher than the national average. A number of major insurance carriers have failed and others have opted out of insuring doctors or have refused to issue new policies. The Pennsylvania Department of Insurance reported just this past summer that 2002 marked the fourth consecutive year in which insurers lost money on medical-malpractice insurance policies issued in Pennsylvania. As a result, one professional organization estimates that Pennsylvania – home to the first medical school in the original 13 colonies and now home to some of the finest medical schools and hospitals in the nation – has lost nearly 1,000 doctors who have decided that practice there just doesn't pay.

The problem is not Pennsylvania's alone. Just last year, the trauma center at the University of Nevada Medical Center in Las Vegas had to close for 10 days because its surgeons quit in the face of huge increases in their malpractice premiums. Such stories

are legion, and they arise all across the country. The flight of doctors from the profession or from high-exposure specialties or geographic areas threatens Americans' continuing access to quality health care. Women without doctors to deliver babies. Accident or crime victims turned away from trauma centers. These are the realities of a worsening national crisis.

Few could question the diagnosis. The debate grows heated, however, when we try to settle on a cure. Many of us, including President Bush, believe that one important step must be a comprehensive, nationwide reform of medical-malpractice law. There are too many meritless malpractice suits filed, and there are too many over-generous jury awards. Faced with that uncertain and potentially unlimited exposure, insurance companies feel compelled to protect themselves and raise their rates.

Meaningful reform should include caps on awards for non-economic damages, that ethereal category of damages that includes such intangibles as pain and suffering. It should include limits on the fees lawyers can recover, and it should raise the burden of proof for recovery of punitive damages. The thrust of each of these measures would be to strike a balance between the legitimate need to provide redress to injured patients and the insurance industry's need for greater certainty about its potential exposure. House Bill 5, sponsored by Pennsylvania's Jim Greenwood and passed by the House more than six months ago, included each of these provisions and more. Unfortunately, that legislation, like other similar measures in years past, was unable to make appreciable headway in the Senate.

While we cannot be assured these reform measures will alleviate the crisis, there is sound, empirical evidence to give us hope. California, for example, enacted a

comprehensive reform plan nearly 30 years ago. Since then, insurance premiums there have risen at less than half the average national rate. Other states that have enacted substantive reform report similar success.

Opponents of these sorts of reforms will tell you that there are other causes for skyrocketing malpractice premiums such as poor investment decisions by the insurance companies. That explanation ignores the significant differences in rates between states that have enacted real reforms and those that have not. If the problem were poor investments, we would expect to see similar rate increases across the board without regard for geography. In addition, that Pennsylvania Department of Insurance study I mentioned a moment ago made a helpful distinction. It explained that, in the decade between 1992 and 2002, Pennsylvania med-mal claims payments almost tripled, premiums more than doubled, but investment income for insurers declined by only a third. The Pennsylvania study noted that, in 2002, med-mal insurers in Pennsylvania earned more than $46 million on their investments. However, because of malpractice claims, which comprised more than 61 per cent of all insurer costs in Pennsylvania, those insurers still ended the year at an $18-million loss. Considering that data and similar information from six other states, the GAO concluded in July of this year that "Losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term."

Even if the poor-investment argument were to some degree correct, it would still miss the point. Study after study tells us that malpractice litigation is, at the least, a substantial contributor to the insurance crisis. Reform opponents seem to believe that a problem can have only one cause and, correspondingly, one solution. Of course, that's

not so. If litigation reform could slow the pace of insurance-rate increases, it would be well worth it. The trial lawyers point the finger at the insurance industry at least in part because meaningful tort reform might well hit those lawyers in the pocketbook.

There is then the issue of whether the reform should be at the national or the local level. As a former governor, I have great faith in state governments and their ability to react to the needs of their citizens. Several states, Pennsylvania among them, have enacted reforms. With rare exception, those laws are too often the cobbled-together results of political battles between doctors' groups and trial lawyers. As a result, they often reach the statute books so diluted as to be nearly useless.

The medical-malpractice problem is national in scope and effect. Many doctors have interstate practices. Many insurers provide coverage in more than one state. The federal government – through direct coverage of members of the military, veterans and others and through Medicare, Medicaid and community-health initiatives – is a major consumer of health care. The crisis affects our national economy through jobs lost when hospitals, clinics or medical offices close and through lost productivity caused by workers receiving inadequate health care. A national problem requires a national solution.

I recognize that the same political pressures that have so watered down reform efforts in many states may well prove to be an insurmountable impediment to the Senate's following this body's lead in passing a federal reform bill. But something must be done, and it must be done nationally, comprehensively and soon.

Mr. BURTON. We'll just go right down the line.

Dr. Nelson.

Dr. NELSON. Well, thank you very much. Good afternoon. And Ranking Member Watson, good afternoon to you, too.

I'm John Nelson, the President-Elect of the American Medical Association. I practice obstetrics and gynecology in Salt Lake City, UT. The American Medical Association appreciates the opportunity to discuss how our Nation's medical liability crisis is seriously threatening patients' access to quality health care.

Now, what's a crisis?

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 obstetrician to monitor their pregnancy and deliver their babies or when a community health center has to reduce their services or close their doors because of liability insurance concerns.

You know that a health care system is facing a crisis when efforts to improve patient safety and improve health care quality are stifled because of fear of lawsuits.

Escalating jury awards and the high cost of defending against those suits, even those without merit, are causing medical liability insurance premiums to soar out of sight. Several recent Federal Government and private sector reports referenced in our written testimony confirm this. You just heard the GAO recently verify that losses on medical liability claims, the largest part of liability insurers' costs, appear to be the primary cause of increasing medical liability insurance—not the only cause, the primary cause.

In many cases, over the last 2 years, physicians have been hit with medical liability premium increases of 25 to 400 percent. My own doubled. As medical liability insurance becomes unaffordable or unavailable, physicians are being forced to relocate, close their practice, or drop vital services.

This is a growing national problem that affects more than just physicians and other health care folks. It affects patients, real people, not statistics. This affects their ability to access health care that they actually need.

Every day for the last couple of years there's been at least one major media story on the plight of American patients and physicians as this crisis reaches across the country. The AMA has now identified 19 such States that are in crisis, up from 12 just a year ago, and many others where the crisis is looming.

The GAO evidence studied five crisis States and found, as you heard, examples of reduced access to care affecting emergency surgery and newborn deliveries. In fact, the AMA has no doubt that the GAO would have had even more access to problems found if they had examined the other 14 States.

By written testimony, we believe the GAO could have strengthened its findings; and in good faith, we think if they had looked a little more carefully, a little more across those States, they could better reflect the severity of the crisis.

The AMA believes that when an injury is caused by negligence patients are entitled to prompt and fair compensation, complete compensation—all economic losses, lost wages and legitimate medical expenses. Also appropriate, we believe that patients should re-

ceive reasonable compensation for the intangible noneconomic damages, such as pain and suffering.

Unfortunately, our medical liability system is neither fair nor predictable. It's becoming increasingly an irrational lottery, driven by open-ended damage awards for unquantifiable economic damages. The studies have concluded that the only significant predictor of payment of claims in a medical liability case is injury and not the presence of an adverse event due to negligence; in other words, injuries often lead to settlements or jury awards even when the standard of medical care has been met.

Mr. Chairman, you and others know that if H.R. 5 is one of the answers, it's past due. The question people are asking around the country is: Will my doctor be there?

As a physician I ask: Can I be there?

That is why we worked so hard with HCRA and others to get H.R. 5 passed, and we need the same thing to happen in the Senate.

Of course, you know one of the keys is a limit of $250,000 on noneconomic damages, with flexibility so States can determine their own caps, if need be. And as discussed, it worked very well in California; we know how the premiums in California have not increased as much as elsewhere.

HRQ, the Agency of Healthcare Research and Quality, tells us that the access to physicians, the increase in physician supply—it is increased at a faster rate in States that have passed caps than where they haven't. That's got to continue. We cannot afford the luxury anymore to wait until this liability crisis gets worse because it affects real patients. We have to be like the meteorologist. We cannot tell there's a hurricane here; we have to tell there's a hurricane coming. It's good preventive medicine.

Mr. Chairman, we've got to get some common sense back into courtrooms or there will not be doctors in the emergency rooms and delivery rooms.

Thank you very much.

Mr. BURTON. Thank you, Dr. Nelson.

[The prepared statement of Dr. Nelson follows:]

American Medical Association
Physicians dedicated to the health of America

1101 Vermont Avenue, NW
Washington, DC 20005

Statement

to the

Subcommittee on Wellness and Human Rights
Committee on Government Reform
U.S. House of Representatives

RE: Dying for Help: Are Patients Needlessly Suffering Due to the High Cost of Medical Liability Insurance?

Presented by: John C. Nelson, MD

October 1, 2003

Division of Legislative Counsel
202 789-7426

Statement

of the

American Medical Association

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Subcommittee on Wellness and Human Rights
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RE: Dying for Help: Are Patients Needlessly Suffering Due to the High Cost of Medical Liability Insurance?

Presented by: John C. Nelson, MD, MPH

October 1, 2003

Good afternoon, Mr. Chair. My name is John Nelson, MD, MPH. I am the President-elect of the American Medical Association (AMA) and an obstetrician-gynecologist from Salt Lake City, Utah. On behalf of the physician and medical student members of the AMA, I appreciate the opportunity to appear before you today to discuss how our nation's medical liability litigation system is seriously threatening patients' access to quality health care.

THE CRISIS

Escalating jury awards and the high cost of defending against lawsuits, even meritless ones, have caused medical liability insurance premiums to reach unprecedented levels. As insurance becomes unaffordable or unavailable, physicians are being forced to relocate, close their practices, or drop vital services—all of which seriously impede patient access to care. Emergency departments are losing staff and scaling back certain services such as trauma units. 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.

Throughout 2003, the medical liability crisis has not waned. In fact, it is getting worse. Access to health care is now seriously threatened in 19 states, up from 12 states in 2002.[1] In many other states a crisis is looming—a crisis that not only threatens access to quality medical care, but also stifles medical and scientific innovation, inhibits efforts to improve patient safety, discourages new treatments and procedures, heaps billions of dollars in additional costs upon a health care system already strained to the breaking point, and places lives at risk. Virtually every day for the past two years there has been at least one major media story on the

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

plight of American patients and physicians as the liability crisis reaches across the country. The attached sample of media reports 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.

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as, or even more, devastating to patients and their families as an injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation. This compensation should include, first and foremost, full payment of all out-of-pocket "economic" losses. The AMA also believes that patients should receive reasonable compensation for intangible "non-economic" losses such as pain and suffering and, where appropriate, the right to pursue punitive damages.

Unfortunately, our medical liability litigation system is neither fair nor predictable. Transformed by high-stakes financial incentives, it has become an increasingly irrational "lottery" driven by open-ended damage awards for unquantifiable non-economic damages. Studies have concluded that the only significant predictor of payment to plaintiffs in a medical liability case was disability, and *not* the presence of an adverse event due to negligence.[2] In other words, in our medical liability litigation system, injuries often lead to settlements or jury awards even when there is no negligence.

As the U.S. House of Representatives has recognized by passing H.R. 5, the HEALTH Act, on March 13, 2003, the time for action is past due. Physicians across the country are making decisions now, and more and more patients are wondering, "Will my doctor be there?" 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. This is why the AMA has worked so hard to seek passage of H.R. 5 in the House, and why we continue to join with numerous other members of a broad-based coalition known as the Health Coalition on Liability and Access (HCLA) to seek passage of similar legislation in the Senate.

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. Several reports have been published since the mid-1990s indicating that increases in jury awards lead to higher liability premiums. Additionally, in the last year a growing number of federal government and private sector reports show that increasing medical liability premiums are being driven primarily by increases in lawsuit awards and litigation expenses. These reports, outlined below, clearly show 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 is reduced.

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[2] Troyen A. Brennan, Colin M. Sox & Helen R. Burstin, *Relation between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 N. ENG. J. MED. 1963, 1963 (1996).

Recent Federal Government Reports
Congress' Joint Economic Committee (JEC) determined in a May 2003 study that a key driver of medical liability insurance premium increases is the recent surge in the size of damage awards in lawsuits. The JEC stated that the medical liability system affects access to health care by increasing the cost of health insurance, which reduces the number of Americans with health insurance—especially for employees of small businesses. In fact, the JEC stated that when medical liability litigation increases the cost of health insurance, low-wage workers suffer the most. The JEC also determined that the medical liability system impacts access to health care by reducing the supply of health care professionals available to provide medical services.

On March 3, 2003, the U.S. Department of Health and Human Services (HHS) released its second major report on the medical liability crisis. In this report HHS stated that "The crisis we face . . . is caused by our expensive litigation system, which often finds liability on a random basis and increasingly imposes very large judgments for non-economic damages." HHS also reports that the medical liability system affects access to care by making medical liability insurance premiums unaffordable or unavailable to many physicians, making it more difficult for Americans to find care. HHS lists numerous accounts of physicians and hospitals affected by soaring medical liability insurance premiums.

Further, the 2003 Congressional Budget Office study on H.R. 5 (108th Congress), which includes 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. 5 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law.

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.

- 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.

GAO CONFIRMS THE CAUSE

In the summer of 2003, the U.S. General Accounting Office (GAO) released two reports related to America's medical liability crisis.[3] These reports address several separate but related issues. The first report, released in June 2003, confirms that, since 1999, medical liability premiums skyrocketed in some states and specialties—and increasing settlements and jury awards ("paid claims") are the primary drivers for these increases. The second report, released in August, confirms that America's medical liability crisis is causing access to health care problems in high-risk medical specialties and in select locations throughout America. In the five states studied by the GAO, all previously identified by the AMA as liability crisis states, the GAO found health care access problems. The GAO reports also confirm what the AMA has long held to be true—tort reform works. Medical liability premiums in states with strong caps on non-economic damages grew at a slower rate than states without caps on non-economic damages.

We appreciate the GAO's efforts and note that it, like others who have tried to quantify the medical liability crisis, found that data sources are difficult to locate, inconsistent, and often lagging. We would hope that instead of looking at this work as a one-time project, the GAO will continue to gather data over time so that the impact of the current crisis can be measured. In some fields, such as economic forecasting, the fact that an event has occurred is not determined until after it is over. For example, workers who lose their jobs know that the economy is bad, but a recession is often not declared until after it is over. We cannot afford the luxury of waiting until the liability crisis is over to declare a crisis and take action. Too many patients will be hurt.

[3] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates,* GAO-03-702 (June, 2003); and *Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* GAO-03-836 (August, 2003).

Among its general findings, the GAO confirmed that:

- Increased losses on claims are the primary contributor to higher medical liability premium rates. (GAO 03-702, p.15)
- Premiums were higher (GAO 03-702, p.14) and grew more quickly (GAO 03-836, p.30) in states without non-economic damage caps than in states with non-economic damage caps.
- Physician responses to medical liability pressures in the five crisis states have reduced access to services affecting emergency surgery and newborn deliveries. (GAO 03-836, p.5)
- Similar examples of access reductions attributed to medical liability pressures were not identified in the four non-crisis states. (GAO 03-836, p.5)
- Insurers are not charging and profiting from excessively high premium rates. (GAO 03-702, p.32)
- None of the insurance companies studied experienced a net loss on investments. (GAO 03-702, p.25)

While verifying that the liability crisis has affected access to health care services, the GAO made several determinations in its August report relating to the extent of the liability crisis that the AMA believes do not accurately reflect the severity of the current crisis in real time. Numerous changes to the GAO methodology would strengthen the basic findings of this report. Among the data sources, measures, or analytical methods that could be improved are the following:

- *Examination of all crisis states.* The GAO only examined five of the 19 crisis states. The current medical liability crisis is far more widespread, extending to an additional 14 states as well.
- *Appropriate measurement of physician mobility.* Physician counts were based on state licensure data, which do not accurately reflect the number of physicians practicing in a given location. Actual physician practice location information must be used instead.
- *More accurate counts of physicians by specialties and local markets.* Physician/population ratios that aggregate physicians across local markets and specialties obscure the significant market-specific or specialty-specific changes in the supply of physicians and availability of critically important medical services.
- *Use of multi-payor data to accurately measure access to health care services that Medicare data alone do not capture.* Utilization statistics based exclusively on data from a single payor (Medicare) exclude data for obstetric and emergency care, and fail to capture the impairment of access among other vulnerable populations, such as Medicaid patients.
- *Use of current source of data to capture the magnitude of the access problem in real time.* The GAO accorded no weight to current sources of data which reflect the magnitude of impairment of patient access today.

In addition to our general comments on both of the GAO reports, the AMA has particular concerns relating to the August report. While the GAO verified many examples of impaired access to critical health care services, several of the GAO's conclusions do not logically follow from its analysis, including the following:

The GAO claims that access to care problems are not widespread.

The GAO's measurement of access problems is incomplete. The report uses Medicare claims data to examine changes in the utilization of medical services. Medicare data are inadequate to identify changes in obstetric services because a vast majority of Medicare eligible beneficiaries are beyond reproductive age. Limitations in the data also preclude an assessment of changes in emergency room services. Therefore, the report significantly understates the impact of rising liability insurance premiums because it does not examine the two clinical areas of patient care in which impairment of patient access has been the most severe—obstetric and emergency room services.

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

The GAO concludes that access problems were largely limited to rural areas where there are other factors present that contribute to access to care problems.

It is well documented that access to care is more problematic in rural areas than in urbanized areas. Many rural areas suffered from physician shortages prior to the recent escalation in liability premiums. It is precisely in those areas where access is already threatened that one would first notice the impact of physicians' relocation or curtailment of certain services.

Health care access problems do not have to affect every part of a state to create crisis conditions. Health care by its nature is local, where a loss of just one or a few physicians or other health care providers in a community can have a traumatic impact on the availability of health care services in that community. Mrs. Leanne Dyess, a recent witness before House and Senate committee hearings, found this out when her husband was rushed to the closest hospital after he suffered severe head injuries in a car crash. On that night, that hospital did not have the necessary specialist on duty to treat her husband's injuries because physicians in the community had been forced to close their practices due to the liability crisis. By the time her husband was airlifted to a hospital with the proper staff it was too late—he suffered permanent brain damage.

The GAO states that it was unable to substantiate all of the claims of physician relocation, practice closings, or retirement.

> We are heartened to learn that some hospital departments were able to find temporary solutions to what is likely to be a long-term problem. Nevertheless, many reports of physician relocation, practice closings, and retirement were confirmed and, as the GAO reported, have had a significant impact on patient access to care.
>
> The AMA has verified that, in at least one instance, the GAO relied on inaccurate interpretations of the information it was provided in making this assertion. In particular, the GAO reported it was unable to substantiate a report that Collier and Lee counties in Florida lost all of their neurosurgeons because the GAO found five neurosurgeons practicing in each county. In fact, the information provided to the GAO stated there were no "pediatric" neurosurgeons in those two counties, an important distinction indicative of the lack of critical access for all local children.
>
> Some of the GAO's conclusions are not supported by its facts. For example, the GAO cites a litany of examples where patients' access to health care has been limited in Mississippi, but then relies solely on licensure data—an inappropriate indicator of physician mobility—to assert that there is not an access problem.

In several cases, the GAO implies that (a) because state-level physician to population ratios from state licensing data have remained largely unchanged, or that (b) because the number of physicians departing a state accounts for a small percentage of physicians licensed in the state, that access to care has not been affected.

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

The state licensing board data that the GAO examined runs through 2002, and therefore do not capture changes in physician location that occurred in 2003. Moreover, the decision to retire or relocate is a complicated one in which physicians must weigh their duty to their patients against the financial viability of their medical practice. It is not a decision made lightly, or made overnight. We expect to see the rate of physician retirements and relocation increase over time if premiums continue to escalate.

The GAO's method of measuring physician supply and potential access to care is not appropriate. Access problems are specialty and locality specific and are completely obscured when one looks at state-level physician to population ratios that aggregate physicians across specialties and local markets. Similarly, the number of high-risk sub-specialists that depart from any locality would likely account for only a small percentage of physicians in the state.

The GAO concludes that the cost of defensive medicine cannot be reliably estimated.

Research published in peer-reviewed journals on economics suggests that the reduction in defensive medicine from the adoption of direct tort reforms would reduce selected hospital expenditures by 5% to 9%.[4]

The GAO criticizes reports that extend an estimate of the cost of defensive medicine from data on selected hospital services provided to Medicare patients (it says that results from Medicare data cannot be generalized). Yet, the GAO bases its own conclusion that patient access has not been affected on a widespread basis on the same Medicare data.

The GAO states that it could not determine the extent to which differences in claim payments across states are caused by tort reform laws, such as caps on non-economic damages.

Research published in peer-reviewed journals on economics shows that claim payments in states with caps are lower than in states without caps. These research articles offer the best evidence that caps work because they consider, and rule out, other competing explanations for why claim payments differ across states.

A recent study by two economists at the Agency for Healthcare Research and Quality (AHRQ) shows that between 1985 and 2000 physician supply increased at a faster rate in states that passed caps than in states that did not. This study is even more powerful than the recent examples verified by the GAO because it considers and rules out other competing explanations for why physician supply differs across states. Also, it uses data on where physicians' main practices are located rather than state licensure data.

Long-term premium stability in California, a state with a cap on non-economic damages, shows that caps help keep medical liability premium growth in check.

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[4] Daniel P. Kessler & Mark B. McClellan, *Do Doctors Practice Defensive Medicine*, Quarterly Journal of Economics, 111(2): 353-390 (1996).

According to data from the National Association of Insurance Commissioners, while aggregate medical liability insurance premiums in California increased by 182% over the 1976 to 2001 period, premiums in the rest of the United States increased by 569%.

Further, an examination of recent premium data by various governmental agencies, including the GAO, indicates that growth in claim payments and premiums has been much lower in states with caps on non-economic damages than in states without caps.

H.R. 5, A PRACTICAL SOLUTION

On March 13, 2003, the U.S. House of Representatives passed H.R. 5, the "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act," a bipartisan bill that would bring balance to our medical liability litigation system and bring stability to the medical liability insurance market. This legislation would ensure that all patients who have been injured through negligence are fairly compensated.

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 the 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, as mentioned above, NAIC data shows that aggregate premiums in California increased by 182% over the 1976 to 2001 period, while premiums in the rest of the United States increased by 569%.

CONCLUSION

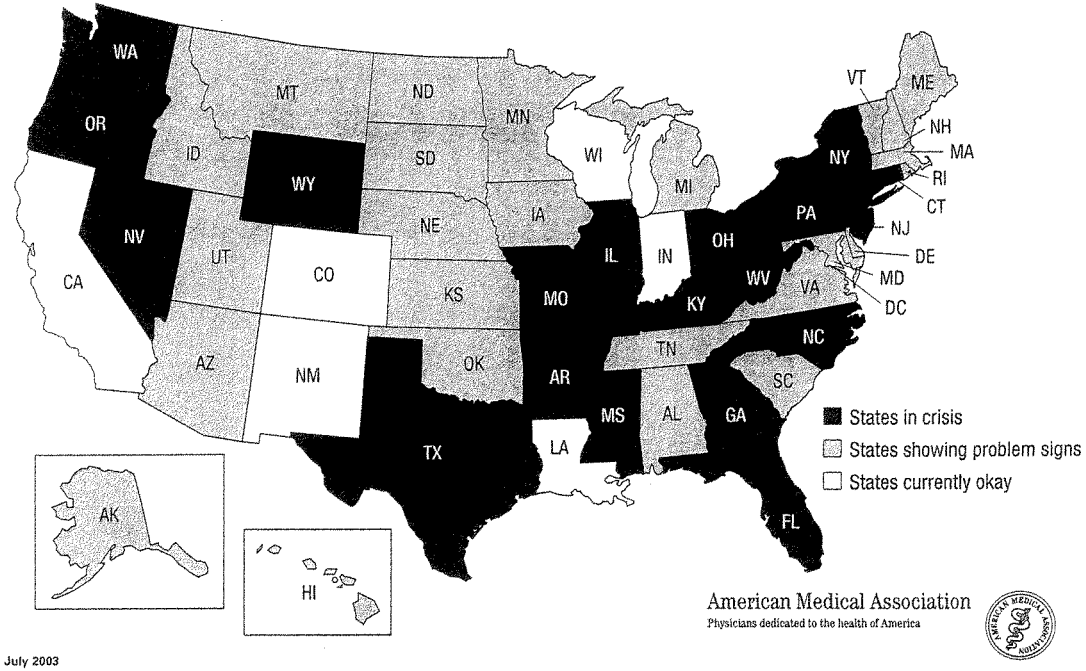
Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an erosion of access to care because their physicians can no longer find or afford liability insurance. States that have enacted reforms similar to those contained in H.R. 5 have experienced greater stability in their medical liability insurance premiums.

By passing H.R. 5, the U.S. House of Representatives has moved our nation one step closer to achieving meaningful medical liability reforms that would 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 AMA will continue to advocate on behalf of patients and physicians for national reforms similar to those already passed by the House. America's patients are the ones who will suffer if the Senate does not act soon. This is a crisis, it is not waning, and without real reforms more patients will be unable to find a doctor to deliver a baby, perform life-saving trauma surgery, or provide other critical care to high-risk patients who need it most.

Thank you.

America's Medical Liability Crisis: A National View



July 2003

EFFECT OF THE MEDICAL LIABILITY CRISIS ON PATIENT ACCESS TO CARE—STATE EXAMPLES

Alabama

- The severe liability crisis in the neighboring States of Mississippi, Georgia and Florida has not left Alabama untouched. *Associated Press State and Local Wire, February 19, 2003.*

- Riverview Regional Medical Center in Gadsden closed its obstetrics unit on March 31, 2003. According to Jeff Raines, the hospital's chief operating officer, one reason for closing the unit is the significant increases in malpractice costs for the hospital. *Naples Daily News, April 6, 2003.*

- Some surgeries and appointments with physicians were delayed for patients because as many as 800 physicians and medical personnel lost liability coverage with the failure of Doctors Insurance Reciprocal (formerly known as Coastal Insurance) that covered these physicians. *Associated Press State and Local Wire, February 19, 2003.*

- Loss of Doctors Insurance Reciprocal leaves the state with mainly one liability insurance carrier, Medical Assurance in Birmingham, along with a few out-of-state carriers that also sell policies in the state. Medical Assurance is now in the position of being able to deny coverage to physicians it considers high risk. One of Southeast Alabama Medical Center's busiest surgeons was told that Medical Assurance would not renew his policy. *Associated Press State and Local Wire, February 19, 2003.*

- Atmore Community Hospital shut its maternity ward in July 2002, in part because the annual liability insurance for its obstetrician jumped from $22,000 to $88,000. Pregnant mothers are now forced to travel at least a half-hour to deliver their babies. *The Washington Post, January 5, 2003.*

Arizona

- Arizona has not been immune to the medical liability crisis. Serious access problems are already developing. *The Wall Street Journal, January 2, 2003.*

- In one 6,000 square mile region of Arizona, high liability premiums have prompted six obstetricians to stop delivering babies. *Time Magazine, June 9, 2003.*

- Many women now have to drive an hour or more to reach a hospital, forcing several patients, like Melinda Sallard, 22, to give birth in the car en route to the hospital. *Time Magazine, June 9, 2003.*

- A baby was born on the side of the road after her mother had passed her community hospital, where the insurance crisis had closed the maternity ward. *The Wall Street Journal, January 2, 2003.*

- The Copper Queen Community Hospital was forced to stop delivering babies in January 2002 after a group of family physicians said they could no longer afford medical liability insurance. The closest maternity ward is now 75 miles away. According to James Dickson, CEO of the hospital, "Women are having babies in their cars on the way to the closest hospital, and they're not getting prenatal care." *Las Vegas Review Journal, May 19, 2002.*

Arkansas

- Without change, many Arkansans will be left without adequate health care, especially in specialties including obstetrics and elderly care. *The Associated Press State & Local Wire, January 8, 2003.*

- Medical liability insurance has become unaffordable or unavailable, so many physicians are changing their practices. Family physicians in rural Arkansas have virtually stopped delivering babies, many physicians are discontinuing nursing home practice and some physicians are retiring early. *The Associated Press State & Local Wire, January 6, 2003.*

- Nearly 400 Arkansas physicians were recently surveyed and nearly half of them have been forced to reduce or discontinue some services (including, surgery, ER care, nursing home care, and obstetrics) in the last two years because of increased medical liability premiums and the threat of outlandish lawsuits. *The Arkansas Democrat-Gazette, February 1, 2003.*

- The same study showed an alarming trend that 50 % of the respondents were having more difficulty recruiting new physicians and 71 % said they were considering early retirement. *The Arkansas Democrat-Gazette, February 1, 2003.*

- Arkansas has only one medical liability insurer, compared to 10 just a year ago. *The Associated Press State & Local Wire, January 6, 2003.*

Colorado

- In the past two years, medical liability insurance premiums have undergone double-digit increases. Many blame the removal of a cap on the size of jury awards for disfigurement and impairment, which occurred in 2001. *Rocky Mountain News, March 21, 2003.*

- An orthopedic surgeon who does spine work will pay about $30,000 a year in medical liability insurance, said Dr. Kirk Kindsfater, president of the Colorado Orthopedic Society. That's about 25% more than 2001. *Rocky Mountain News, March 21, 2003.*

- These rising liability premiums are contributing to a growing shortage of physicians in Colorado. Dr. Kirk Kindsfater, president of the Colorado Orthopedic Society, knows a half-dozen orthopedic surgeons who've left the state in recent years. He believes that this trend will "eventually limit people's access to care." *Rocky Mountain News, March 21, 2003.*

- Doctors see rising medical liability premiums as a key obstacle to their ability to recruit physicians to the state.

    - There are at least 30 vacancies statewide in anesthesiology, said Dr. Randall Clark, president of the Colorado Society of Anesthesiologists. The largest anesthesiology groups are trying to hire a dozen or more doctors. *Rocky Mountain News, March 21, 2003.*

    - Jan Sosias, director of human resources for Kaiser Permanente Medical Group, says it's getting difficult to hire doctors in gastroenterology, dermatology, oncology/hematology and cardiology. *Rocky Mountain News, March 21, 2003.*

- Copic—the non-profit company that insures 80% of Colorado doctors—expects to show a loss of $2.5 million when the 2002 figures are finalized, said George Dikeou, executive vice president of Copic. The result, say doctors, is that their malpractice premiums skyrocketed – 14% overall this year, but 27% or higher for some specialties such as neurosurgery. *Rocky Mountain News, March 1, 2003.*

- "Unless changes are made, it's going to put us all out of business," said Dr. Stuart C. Kennedy, a Denver orthopedic whose malpractice rates rose 18% this year, to $30,000. *Rocky Mountain News, March 1, 2003.*

Connecticut

- The rise in medical liability insurance premiums has a disproportionate impact on lower-income and elderly patients, according to Dr. Charles Littlejohn, a colon and rectal surgeon at Stamford Hospital. Doctors, feeling squeezed by increased costs, are less willing to take on patients without insurance or those insured by Medicaid and Medicare, which often pay less than private insurance companies. *Greenwich Time, April 29, 2003.*

- Sally Crawford, MD, of Norwich, said she delivered the last baby of her career on April 21, 2003. Crawford, 55, retired largely because she feared that one big malpractice suit could wipe her out. Although she had never been sued, her liability insurance had cost her $124,000. *Hartford Courant, April 25, 2003.*

- Medical liability insurers have been bailing out of the State. One of the remaining companies, Connecticut Medical Insurance Co. (CMIC), a nonprofit that was created by doctors in 1984, insures most of the State's physicians. In 2002, CMIC paid $42 million to settle claims compared with $19 million six years ago. The $42 million

included 19 jury awards of $1 million or more compared with nine such payments made six years ago. *Hartford Courant, April 3, 2003.*

- As a result of the above stated jury awards, CMIC doctors are paying sharply higher premiums with increases up to 30 percent compared to a year ago. *Hartford Courant, April 3, 2003.*

- Dr. Neil Brooks, a 60 year old family physician from Vernon, said he would retire in May 2003 after 32 years of practice because he cannot afford to work part time and pay $19,500 for medical liability insurance. He started working half-days a year and a half ago; his premium as a part timer was $9,000. He said he had hoped to continue seeing patients for five or 10 more years, but he simply can no longer afford it. *Hartford Courant, March 27, 2003.*

- The crisis has spread to Connecticut as evidenced by the recent decisions of 28 OB-GYNs to stop delivering babies. On average, each obstetrician delivers 100 babies a year, so this means that at least 2,800 patients will be forced to find a new obstetrician. *Hartford Courant, February 3, 2003.*

- Some OB-GYNs in Connecticut are now paying between $120,000-$160,000 per year in insurance premiums, according to state medical society executive Tim Norbeck. *Hartford Courant, January 3, 2003.*

- Connecticut already is on a "watch" list issued by the American College of Obstetricians and Gynecologists. *Hartford Courant, January 3, 2003.*

- Dr. James Watson delivered his last baby on December 30, 2002. After more than 30 years and 3000 babies, the obstetrician will no longer deliver babies due to the rising cost of medical liability insurance. His group practice's insurance is up 44% from a year ago. Dr. Watson said, "The cost of liability insurance is discouraging a lot of young people from going into the specialty, and is causing our more experienced doctors to retire or drop OB." *Women's Health Weekly, January 23, 2003.*

- The average payment made by one of Connecticut's major insurers to resolve a claim rose from $271,000 in 1995 to $536,000 in 2001. *Hartford Courant, November 17, 2002.*

- OB-GYN Jose Pacheco, MD's, insurer stopped offering medical liability insurance, and he had to seek another carrier. However, because of the high cost of new insurance - estimated around $60,000 - combined with "tail" coverage of $80,000, Dr. Pacheco retired after a 27-year career. *Hartford Courant, Nov. 17, 2002.*

- Patients who prefer female OB-GYNs could be in for some bad news, according to Nancy Bernstein, president of Women's Health Connecticut, a network of 157 OB-GYNs. Sharply escalating premiums, which are increasing between 20 to 72 percent, are behind the decision of Jodi Leopold, MD, to give up obstetrics. Instead of paying $64,512, she will only owe $23,900. "It is impossible to live through the stress of

doing obstetrics and know you're losing money doing this," Dr. Leopold said. *Hartford Courant, Nov. 17, 2002.*

Florida

- Shenary Cotter, MD, is the only physician providing prenatal care to poor people in Williston, a rural town between Gainesville and the Gulf Coast. Dr. Cotter pays more than $60,000 a year for medical liability insurance, "That's more money than I make in a year providing indigent care....We've got to do something about the crisis. Real patients will go without care." *Associated Press, June 14, 2003.*

- Orlando Regional Medical Center's Level 1 trauma center has been given a temporary reprieve from its April 1, 2003, closure. Financial contributions from neighboring hospital districts will allow the center to pay physicians for on-call trauma coverage until September 2004. *Orlando Sentinel, February 27, 2003; Orlando Business Journal, June 3, 2003.*

- As one of six Level 1 trauma centers in the state, closure of Orlando Regional would necessitate that patients be flown to the next-closest Level 1 trauma centers (in Tampa, Jacksonville, or South Florida), adding crucial minutes to the transport of people with life-threatening injuries. *Orlando Sentinel, February 27, 2003; Orlando Business Journal, June 3, 2003.*

- The Neuroscience Center, affiliated with Medical Center Clinic and Sacred Heart Hospital in Pensacola, stopped seeing new patients as of June 2, 2003. *Pensacola News Journal, May 31, 2003.*

- Marcus Shmitz, MD, of the Neuroscience Centers said that the group was curtailing its services in response to both the increasing cost and unavailability of liability insurance in the state. "If I can't get malpractice insurance, I can't practice." He said. *Pensacola News Journal, May 31, 2003.*

- The only group of doctors who perform kidney transplants in Central Florida, Winter Park Urology Associates, will no longer be performing such operations at Florida Hospital as of July 1, 2003. *WFTV, May 29, 2003.*

- The transplant team, which ranks amongst the top 30 nationally, is losing its medical liability insurance as of July 1st and a new policy will cost more than half a million dollars. According to one of the physicians, Julio Gundian, MD, "We have never lost a lawsuit. We have never paid out a claim and we have been in practice for more than 30 years." *WFTV, May 29, 2003.*

- Unless Florida Hospital replaces the transplant team soon, Dr. Gundian fears that the State's remaining transplant programs may reach capacity. *WFTV, May 29, 2003.*

- Trauma surgeons at Halifax Medical Center in Daytona Beach have agreed to temporarily remain at the hospital while the state Senate is considering measures for

tort reform. The doctors had been planning to leave the center June 1st, after their contract expired in March, due to increasing costs of medical liability insurance. *News-Journal Corporation, May 28, 2003.*

- Closure of Halifax Medical Center would mean that trauma victims would need to be transported to hospitals in Jacksonville, Melbourne, and Orlando. *News-Journal Corporation, May 28, 2003.*

- Mario Sanguily, MD, chief of surgery at Martin Memorial Medical Center is contemplating taking a job in Louisiana. While he is not happy about the prospect of moving his family from their home in Florida for the past 12 years, he says that the increases in his medical liability premiums leave him no choice. Although he has never been sued before his insurance increased from $24,000 in 2002 to $96,000 in 2003. He is not able to afford another increase, so he is planning to move. *Stuart News, April 26, 2003.*

- Colon and rectal surgeon, George Rittersbach is used to receiving job offers from hospitals all over the country. "I used to throw the offers away, but now I seriously take a look at them." He says. Recently, Dr. Rittersbach has been thinking of closing his practice in Stuart and moving "anywhere out of Florida." *Stuart News, April 26, 2003.*

- Fewer doctors are offering emergency room care, mammography, obstetrics, vascular surgery, orthopedics, and neurosurgery. According to Carol Gormley, Florida Hospital Association Director/Government Relations, the number of physicians offering these services will decrease further if nothing is done to provide medical liability coverage. *Suwannee Democrat, April 24, 2003.*

- According to Gormley, "Rural areas always have trouble recruiting and retaining health professionals, and the liability problem reduces the number of health professionals available to make the choice to serve in a rural area." *Suwanneee Democrat, April 24, 2003.*

- In response to a lack of surgeons due to rising insurance rates, the Jacksonville Orthopedic Institute reduced its services as of May 1, 2003. *WJXT, April 24, 2003.*

- North Florida OBGYN Associates stopped offering non emergency surgeries as of May 2, 2003. In response, patient Dana Cone said, "It will definitely be a crisis if something is not done about this." *WJXX, April 18, 2003.*

- With their liability policy expiring June 30, 2003, North Florida Surgeons of Jacksonville decided to stop conducting surgery and taking on new patients after May 2nd. According to a letter sent to their patients the group stated, "The health care crisis in Florida has forced us to come to the difficult realization that we cannot continue to practice under the current conditions....We had placed our future in the hands of the legislators by informing them of our plight and asking them to help us save health care in Florida." *WJXT, April 3, 2003.*

- One of the group's surgeons retired early in 2003 and two others are considering retiring; the rest of the surgeons are deciding whether to quit surgery or leave the state. *WJXT, April 3, 2003.*

- According to surgeon Jefferson Edwards, MD, "It's excruciating. I have patients who are extremely anxious if I'll be here for them in the future. I know it's the same for my colleagues." *WJXT, April 3, 2003.*

- As of March 25, 2003, Lehigh Regional Medical Center in the southwest part of the state stopped delivering babies due to the high cost of liability insurance. Dr. Robert Strathman, one of the two obstetricians who practiced at Lehigh said the decision saddened him. *Managed Care Weekly Digest, April 14, 2003* and *The Associated Press, March 25, 2003.*

- Scott Marsel, MD, an internist in Ocoee, said his rates are four times higher than a physician in the Los Angeles, CA area practicing the same type of medicine. Although Marsel has never been sued, his rates increased 40 % in 2003. *The Associated Press, March 28, 2003.*

- In a recent American College of Obstetricians and Gynecologists survey:
  ----76.3% of Florida's ob-gyn respondents 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.
  American College of Obstetricians and Gynecologists, February 27, 2003.

- Florida Hospital recently said that its Winter Park Memorial Hospital would have to stop performing emergency surgeries as of April 1, 2003, because its remaining general surgeons will not work in the emergency room. *Orlando Sentinel, February 27, 2003.*

- A Pasco Regional Medical Center psychiatrist, Pius Jacob, MD, has seen his malpractice insurance premiums spiral in the past two years. If they continue to go up, Jacob will be forced to fold his practice or leave Florida. In the past two years, his premiums have gone up between 50 and 75 %. *St. Petersburg Times, February 13, 2003.*

- More than 50 Bradenton (Manatee County) patients had to postpone elective surgeries and more than 100 office visits were canceled because two physicians were unable to obtain liability insurance. *The Bradenton Herald, January 24, 2003.*

- Also in Bradenton, four of the town's five kidney specialists lost their insurance due to their carrier pulling out of Florida on January 1, 2003. The crisis left one physician to care for more than 300 patients on dialysis, while the four physicians scrambled to

secure insurance. *The Bradenton Herald, January 24, 2003; Sarasota Herald Tribune, January 3, 2003.*

- Rene Loyola, MD, a general surgeon in Stuart, is considering quitting medicine and finding another career due to the high cost of medical liability premiums, which rose to $125,000 for him this year. *Palm Beach Post, January 23, 2003.*

- Doctors Hospital of Sarasota closed its obstetrics unit in December 2002. Sarasota Memorial Hospital has had trouble covering emergency room specialists such as neurologists and gastroenterologists, and officials from the hospital worry that obstetrics will be next. *Sarasota Herald Tribune, January 13, 2003.*

- A young obstetrician in her mid-30s is unable to deliver her 6-month pregnant patient's baby because her liability premiums tripled. This physician is quitting obstetrics. *National Public Radio (NPR) Morning Edition, January 10, 2003.*

- South Bay Hospital – a 112-bed facility which services retirees – lost four physicians due to the medical liability crisis. Faced with losing two more, South Bay's board of directors approved a waiver to allow two neurosurgeons to practice without company medical liability coverage due to the physicians' coverage being so high. *Tampa Tribune, January 10, 2003.*

- Women are facing waiting lists of four months before being able to get an appointment for a mammogram because at least six mammography centers in South Florida alone have stopped offering the procedure as a result of increasing medical liability insurance premiums. "This trend is troubling. There are a growing number of older people and less and less people to provide mammograms," said Jolean McPherson, a Florida spokeswoman for the American Cancer Society. *South Florida Sun Sentinel, Nov. 4, 2002.*

- Aventura Hospital in South Florida closed its maternity ward and cited $1,000 in insurance premiums for each delivery as the prime factor. Aventura is one of six maternity wards to close in recent months. Now, patients will be forced to drive to other counties and other facilities. "There may be waits getting into a labor-room floor," said OB/GYN Aaron Elkin, MD. *Miami Herald, Oct. 19, 2002.*

- "Without a doubt, access to health coverage is being affected. Some of our emergency rooms are losing their effectiveness," said Dr. Greg Zorman, neurosurgery chief at Memorial Regional Hospital in Hollywood. His unit gets several patients a week from smaller ERs that have lost neurosurgery coverage. *South Florida Sun Sentinel, February 5, 2003.*

- Port Charlotte cardiologist Leonardo Victores, MD, left for Kansas in the face of medical liability premiums that were going to increase 100 %. "He's moving to Kansas because that state has caps on malpractice awards," said colleague Mark Asperilla, MD. *Sun Herald, Jan. 1, 2003.*

- Despite having no malpractice claims or disciplinary actions on his record, Lakeland OB/GYN John Kaelber, MD, was forced to close his practice and leave the state in the wake of insurance premiums that doubled. *Lakeland Ledger, Nov. 21, 2002.*

- After recently receiving notice of a premium spike coming in July 2002, Vladimir Grnja, MD, decided that he would "go bare" and drop all medical liability insurance coverage. Rates for the Hollywood, FL radiologist were to rise to $112,000 from $35,000 a year (a 220% increase), mainly because of litigation over mammograms. "No doctor wants to go bare," said Dennis Agliano, MD, chairman of the Florida Medical Association's special task force on the Florida medical liability crisis. But with significant premium hikes in Florida for specialties like OB/GYN, neurosurgery, thoracic surgery, radiology and even primary care, "some doctors have no choice," he says. Some neurosurgeons in South Florida, are paying a $200,000 premium for coverage of $250,000 per occurrence, making insurance practically meaningless. The Florida Medical Association reports that more than 1,000 doctors in Florida have no medical liability insurance. *Modern Physician, April 1, 2002.*

- Ob/Gyns in the "Sunshine State" face the highest premiums in the nation, some as high as $210,000. Many surgeons also are facing premiums approaching $200,000. *Medical Liability Monitor, October 2002.*

- And, what's worse $100,000 only buys about $1 million in coverage, a small amount compared to soaring jury verdicts. *Tallahassee Democrat,* June 30, 2002.

- PHICO, the third largest professional liability insurer in Florida was forced into liquidation earlier this year. Zurich American Insurance Co., and Clarendon National also are leaving the Florida market. Remaining insurers are on record as saying they will draw sharper lines between which physician specialty they will and will not insure. *St. Petersburg Times, March 11, 2002.*

- American Physicians Assurance announced on July 17, 2002 that it is leaving the state. *Statement of American Physicians Assurance.*

- In a presentation before FMA, the medical liability insurance carrier, FPIC, presented facts that demonstrate the medical liability crisis in Florida. During 1975, there were 380 health care lawsuits in Florida, resulting in $10.8 million in jury awards and costing $1.5 million to defend. In 2000, there were 880 lawsuits alleging malpractice, resulting in awards of $219 million and costing $36 million to defend. *FPIC presentation to Florida Medical Association.*

- Dr. Oliver Bayouth says his medical-malpractice premiums are skyrocketing. The Orlando obstetrician paid about $100,000 for insurance in 2002, up at least 25 % from the two prior years. Frustrated, Bayouth says he is thinking about moving his practice out of Florida. *Orlando Sentinel, January 20, 2002.*

- In South Florida, where insurers say litigation is the heaviest, ob/gyns pay as much as $202,949 a year--the highest rates in the country, according to Medical Liability Monitor, a Chicago-based newsletter. *Orlando Sentinel, January 20, 2002.*

- Dr. Alan Appley, an Orlando neurosurgeon, moved his practice to Lafayette, Louisiana, last year in part to escape Florida's soaring malpractice rates. *Orlando Sentinel, January 20, 2002.*

- Dr. Joseph Boyer, an Orlando cardiologist, says his rates rose 64.6 %, to $99,000, in 2002. *Orlando Sentinel, January 20, 2002.*

- Central Florida Cardiothoracic Surgery in Orlando says it will pay about $140,000 to insure two surgeons in 2002, compared with about $54,000 in 2001. *Orlando Sentinel, January 20, 2002.*

- Dr. Alexander Jungreis, an Orlando neurosurgeon, said his liability insurance premiums tripled in 2002. *Orlando Sentinel, January 20, 2002.*

- Dr. Jorge Perez, an Orlando internist, said his insurer canceled his policy in 2001 even though he never had a claim filed against him. His new company is charging him $18,000 per year, compared with the $11,000 he previously paid, on top of a $25,000 fee to cover possible lawsuits from prior incidents. *Orlando Sentinel, January 20, 2002.*

- Nationwide, one out of every 12 doctors gets sued each year, while in Florida it's one out of every six, said Bob White, chief operating officer of Jacksonville-based First Professionals Insurance Co., the state's largest provider of medical liability insurance with about 33 % of the market. *Orlando Sentinel, January 20, 2002.*

Georgia

- According to Larry Sanders, chairman and CEO of Columbus Regional Healthcare System, the liability exposure is causing general surgeons, neurosurgeons, and orthopedists to rethink whether or not they can respond to emergency services at they system's medical center. *Columbus Ledger Enquirer, March 13, 2003.*

- The study also indicates that 1,750 physicians reported that they have stopped or plan to stop providing ER coverage and 630 physicians plan to quit practicing or leave the state. In addition, 1 in 5 family physicians and 1 in 3 OB-GYNs reported plans to stop providing high-risk procedures, including delivering babies. *Georgia Board for Physicians Workforce, January 2003.*

- But numbers alone do not tell the whole story; there is a very human side to this crisis. For instance, although she is only in her first year of medical school at Medical College of Georgia, the liability crisis has already caused Thandeka Myeni, 26, to reconsider her preference for obstetrics, one of the specialties hardest hit by

medical liability increases. "I definitely think it could be discouraging," she said. *The Augusta Chronicle, Nov. 13, 2002.*

- Evans Memorial, a rural hospital in Claxton, decided to "go bare"—have no coverage at all—instead of paying what it considered an exorbitant medical liability premium. Only one insurer offered a liability policy for the hospital and its nursing home, and the annual premium for $1 million in coverage would have been $581,000, up from $216,000 last year. "We just thought it was outrageous," said Eston Price, Evans Memorial administrator. *The Atlanta Journal-Constitution, Oct. 7, 2002.*

- The largest hospital in the state's health system has bought a new policy—with a deductible of $15 million—covering 953-bed Grady Memorial, a nursing home and clinics. On each paid claim below that mark, Grady is responsible for every dollar. The $15 million deductible starts again with each claim. "Grady faces open-ended liability," said Timothy Jefferson, Grady Health System executive vice president and chief counsel. *The Atlanta Journal-Constitution, Oct. 7, 2002.*

- Knowing that liability premiums were rising for everyone in the industry, Ty Cobb Health System CEO, Chuck Adams earmarked enough money for a 100 percent increase. The bill arrived by fax in the summer of 2002, just 24 hours before a check was due. Not only was the insurance company increasing his deductible tenfold, but the premium jumped from $553,000 to $3.15 million – a 469 percent increase. "We were numb," said Adams, who eventually got an extension and another cheaper policy at $1.65 million. "There goes our expansions, like a renovation of the Hart County Emergency Room." *The Atlanta Journal-Constitution, Aug. 11, 2002.*

- "Dr. Edmund Wright, a Fitzgerald family practitioner who performed Caesarian sections, has given up that part of his practice. His premiums quadrupled to $80,000 in 2002 and would have been $110,000 if he had continued the surgical delivery procedure. Wright said, "I don't know if I really want to do this anymore." *The Atlanta Journal-Constitution, Aug. 11, 2002.*

- Insurance costs are rising so high and so quickly because of medical liability lawsuits that many doctors are quitting medical practice, said Michael Greene, who has a family practice in Macon. The problem is increasing so fast that Georgia will soon face a critical shortage of physician, Greene said. "It hasn't hit with a tidal wave yet, but the waves are beginning to lap at the shore," Greene continued. *The Macon Telegraph, Aug. 3, 2002.*

- David Cook, executive director of the Medical Association of Georgia, said the liability crisis is driving more doctors into early retirement. "One-third of doctors 55 and older say they plan to reduce their hours or get out altogether," he said. "These are physicians at the peak of their diagnostic powers." *The Times (Gainesville), July 17, 2002.*

- The number of paid claims totaling $1 million or more increased from one in 1990 to 13 in 2000. There was one claim of $2 million or more in 1991, and more than 5 so

far in 2002; according to MAG Mutual, which insures 70% of Georgia physicians. *Atlanta Journal & Constitution, August 11, 2002.*

Illinois

- Pulmonologist, Alexander Sosenko, MD, worries that he will have to move his family and medical practice from Joliet because he and his medical partners can no longer afford liability insurance. *Time Magazine, June 9, 2003.*

- Sosenko and his colleagues are now contemplating changing specialties or moving to a less litigious state, in addition to worrying over their 6,000 patients. If the doctors close their practice, their patients will have to drive over an hour to Chicago to see the nearest lung specialist. "We doctors can move on," says Sosenko, "but our patients can't." *Time Magazine, June 9, 2003.*

- The last remaining neurosurgeon in Joliet is considering either moving to South Dakota or retiring for good, since he's learned that his liability insurance premium will increase from $180,000 to $468,000 a year. *Time Magazine, June 9, 2003.*

- Based at Memorial Hospital in Belleville, obstetrician Lorna O'Young, MD, was shocked to learn that her medical liability premium will double from $69,500 to $139,000 –even though she has never been named in a malpractice lawsuit. *Belleville News Democrat, June 8, 2003.*

- In May 2003, St. Elizabeth's and Memorial hospitals in Belleville cancelled their 24 hour trauma surgery programs. According to a hospital statement, the cancellation was "a direct result of the loss of a neurosurgeon and the high cost of medical malpractice insurance coverage in the region." *St. Louis Post Dispatch, May 30, 2003.*

- Faced with rising medical liability premium costs, Craig Backs, MD, an internist in Springfield, is considering limiting the number of Medicare and Medicaid patients he sees because of delayed and insufficient reimbursements. *Copley News Service, April 30, 2002.*

- In July 2003, 14,000 physicians insured by the Illinois State Medical Society will have their liability insurance rates increase by 35%; high risk specialties like neurosurgery will have a rate increase of 60%. *Belleville News-Democrat, April 29, 2003.*

- David and Janet Hayes cried when discussing the thought of losing neurosurgeon Michael Malek, MD, who saved their son's life after a car accident. Dr. Malek, the last of 4 neurosurgeons in Kankakee, IL, may stop practicing medicine because he is so fed up with the state's rising liability insurance premiums and excessive lawsuits. "My son is alive because Dr. Malek was allowed to do surgery on him," said Mr. Hayes. If he quits, "someone else's son could die." *The Daily Journal, Oct. 31, 2002.*

- Eduardo Barriuso, MD, a Chicago area obstetrician who treats mostly high-risk patients that are Medicaid beneficiaries, pays $104,000 a year for liability insurance and by July 2003 he will encounter a 10-15 % increase. Dr. Barriuso expects insurance costs to overtake his income soon, forcing him to retire five years earlier than he had expected. *Chicago Sun Times, February 27, 2003.*

- Amar Dave, MD, a pediatrician from Ottawa, saw his premiums balloon to $57,000 in 2003. His premium is projected to soar to $114,000 in December 2003. Such a cost will put him out of business. *Chicago Tribune, February 27, 2003.*

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

- Illinois' legislature has enacted meaningful medical liability reforms on three occasions - only to have the laws struck down each time by the Illinois Supreme Court. Illinois, therefore, it does not have the most critical pieces of reforms in place. No limits are placed on non-economic damages and defendants can be held jointly and severally liable. *Best v. Taylor Machine Works,* 689 N.E.2d 1057 (Ill. 1997) Non economic damages cap; *Best v. Taylor Machine Works,* 689 N.e.2d 1057 (Ill. 1997) Joint and Several liability; *Best v. Taylor Machine Works,* 689 N.E.2d 1057 (Ill. 1997).Collateral source; Bernier *v. Burris,* 497 N.E.2d 763 (Ill. 1986) Screening Panels.

- Statewide, in specialties such as neurosurgery and obstetrics, medical liability insurance rates rose by more than 100 % and are projected to climb later in 2003. For all physicians, costs rose 15 % on average in 2002. *Chicago Tribune, Feb. 16, 2003.*

- "We have lost three OB-GYN physicians in the last six months only because of malpractice [rates]," said Memorial Hospital chief executive Harry Maier. "I would say we are going to see another five to seven leave or limit their practice if this is not resolved." *Chicago Tribune, Feb. 16, 2003.*

- The Family Health Partnership Clinic in McHenry County was almost forced to close after seven years because its insurer dropped such coverage. At the 11th hour, the clinic found coverage, but the liability insurance premiums quadrupled from $7,000 to $28,000. The clinic, which runs off the volunteer services of 16 physicians and a yearly grant, provides health care to about 4,500 patients - most of whom have little or no health insurance. *Northwest Daily Herald, Feb. 12, 2003.*

- Dr. David Soo and his two partners in Gurnee are considering closing their family medicine practice after being dropped by their insurance carrier. That would cause

about 10,000 patients in Lake County to switch physicians. *Chicago Tribune, Feb. 16, 2003.*

- Cook County has some of the highest liability insurance rates in the country. *Chicago Tribune, February 7, 2003.*

- Dr. Stephanie Skelly, an OB-GYN in Belleville, is considering a move to her home state, Louisiana, where liability is a fraction of what she now pays. The combined insurance premium for Skelly and her partner, Dr. John Hucker, increased to $200,000 from $100,000. They took out a loan to pay a one-time $250,000 for tail coverage. "Basically we have to work for free this year," Hucker said. *St. Louis Post-Dispatch, Oct. 6, 2002.*

- A Chicago-area OB-GYN is studying to obtain a pharmacist's license and give up his medical career to avoid further escalations of his liability insurance premiums, which have risen to more than $115,000. "I never thought of doing anything else. Now all I'm thinking about is what else I can do." *Chicago Sun Times, Nov. 11, 2002.*

Kansas

- According to KU Med trauma surgeon Michael Moncure, MD, many surgeons are pulling out of care for emergency patients because of medical liability, increasing insurance rates, decreasing reimbursements, and late hours. *Johnson County Sun, April 10, 2003.*

- In 2002, Overland Park Regional Medical Center closed its trauma center. With the April 2003 closing of St. Joseph Health Center's trauma center, patients in southern Kansas City and Johnson County are left without such a center nearby. *Johnson County Sun, April 10, 2003; The Kansas City Channel, April 1, 2003.*

- According to Carondelet Health, which owns the St. Joseph Health Center, lack of neurosurgery coverage was the key reason behind closing the trauma center. Dana Huston, of Leawood, worries, "...they always say the golden hour is so critical in a trauma. We're going to waste time getting [patients] to KU Med or to St. Luke's." *The Kansas City Channel, April 1, 2003.*

Kentucky

- In 2002, Steve Toadvine, M.D., stopped working in the obstetrics department at Knox County hospital because he could no longer afford his medical liability premiums. Four other obstetricians are planning to leave the hospital by July 1st for the same reasons. *The Associated Press, May 23, 2003.*

- Following the January 2003 closure of the obstetrics unit at Our Lady of Belafonte Hospital in Russell, Knox County Hospital is the second hospital in the eastern part of the State where physicians have stopped delivering babies. Patients are being

redirected to other area hospitals as of July 1, 2003. *The Associated Press, May 23, 2003.*

- According to Ingrid Washington, an expectant mother with a June 30th due date, "If I go past my due date, it will be someone I don't know delivering my baby," "To have to see someone new at the last moment is just horrible. You develop a close bond with your doctor, almost like family. You don't want a stranger." *The Associated Press, May 23, 2003.*

- Physicians in the State are considering moving their medical practices to Indiana because it has imposed limits on medical liability awards for pain and suffering while Kentucky has not. *Indianapolis Star, April 16, 2003.*

- Kentucky emergency department physicians have reported an average increase of 204%, with orthopedists facing a 122 % increase; general surgeons facing an 87% average increase, and OB-GYNs seeing an average increase of 64%. *Lexington Courier-Journal, February 7, 2003.*

- State Senator, David Williams (R-Burkesville) recently testified that Kentucky has a real access-to-health-care problem that is developing. "Being a state where the majority of our population lives on the boundaries ... it would be very easy for people to leave this state to practice their chosen profession. This would make access to health care even more difficult." *Lexington Courier-Journal, February 7, 2003.*

- Dr. Susan Coleman, a Danville obstetrician-gynecologist, will stop delivering babies in April 2003 because her coverage will increase to $300,000 (compared to $49,000 for her gynecological practice). Though she never lost a lawsuit or paid a settlement, her rates jumped merely because a patient sued her. *Lexington Courier-Journal, February 7, 2003.*

- At least nine Louisville obstetricians have restricted their practices to gynecology, retired early or moved out of state because of liability insurance premiums. Eight-two of the state's 120 counties have no obstetricians or only one, which makes residents vulnerable. *Lexington Courier-Journal, February 7, 2003.*

- Eleven obstetricians in Eastern Kentucky have recently quit delivering babies or left the state. This has forced women to drive hours for care, which has caused some to develop complications because they are not receiving prenatal care. *Lexington Courier-Journal, February 7, 2003.*

- A Lexington physician who specializes in high-risk pregnancies, Doug Milligan, MD, had his premiums double last year to $80,000 and expects a 50 % increase this year even though he and his two partners have never been sued in more than 10 years. Dr. Milligan is forced to do 100 deliveries a year just to cover the insurance premium. *Lexington Courier-Journal, February 7, 2003.*

Massachusetts

- Since 2002, almost a dozen physicians have given up obstetrics in the Springfield area because of the medical liability crisis. *The Boston Globe, April 6, 2003.*

- Growing shortages exist in radiology, emergency medicine, gastroenterology, neurosurgery, orthopedics, and cardiology because of the increasing cost for liability insurance. *The Boston Globe, April 6, 2003.*

- In the Bay State, eight of 55 OB-GYNs in Springfield, Massachusetts, a state which has broad exceptions to the state limits on non-economic damages, will no longer be offering Obstetrics care to their patients because of sharply escalating liability insurance costs. "I got into obstetrics because it's a very happy specialty. But there comes a point where you can't make ends meet," said James Wong, MD, one of two OB-GYNs at a Western Massachusetts clinic giving up delivering babies. *Boston Globe, Jan. 8, 2003.*

- Kathleen Beith, MD stopped delivering babies in 2003 when her liability premiums increased to $55,000. A single mother, she was paying an *au pair* almost $35,000 a year to care for her children during nighttime deliveries. It was costing her more to do obstetrics than she was making from her practice. *Bloomberg News, January 22, 2003.*

- In Ware, 30 miles east of Springfield, two obstetricians shut their doors due to liability insurance costs. Their patients are forced to seek care in Springfield. The driving distance has forced a few women, who suddenly went into labor, to rush to nearby ERs to give birth. Their Springfield obstetricians called these cases "near misses," saying these women should have given birth in obstetrics suites. *Boston Globe, Jan. 8, 2003.*

- Hospitals in the North Adams area are also having difficulty hiring OB-GYNs. Western Massachusetts is chronically short of physicians, and the liability insurance problem has made these rural regions even more vulnerable. *Boston Globe, Jan. 8, 2003.*

- "The real issue is runaway juries," according to Barry Manual, MD, who serves as insurer ProMutual's chairman, and said the number of $1 million-plus claims paid out doubled between 1990 and 2001. *Boston Globe, Jan. 8, 2003.*

Michigan

- Medical liability rates are among the highest in the nation. Medical experts say this trend could force some physicians to limit services. *The Detroit News, January 12, 2003.*

- Eventually, the high insurance rates will make it harder for patients to receive medical services because doctors who perform a small number of risky procedures will stop doing them to lower their medical liability insurance rates. Dr. Harold Sauer, Interim Chairman of Michigan State University's Department of Obstetrics and Gynecology, said, "Patients are going to lose access to obstetrics in some parts of the state. Women will have to travel long distances to get care for their babies." *The Detroit News, January 12, 2003.*

- American Physicians Assurance, one of two commercial medical liability carriers in the state, quotes a base premium of $75,347 for an OBY-GYN to maintain $200,000 coverage on a single incident and $600,000 for all claims. According to Dr. John Crissman, Dean of the Wayne State University Medical School, "This price tag precludes a new physician from becoming a sole practitioner. You almost have to sign up with a larger group in order to cover the premiums." *The Detroit News, January 12, 2003.*

- According to a survey by the American College of Obstetricians and Gynecologists, 53 percent of OB-GYNs in the state attribute some change in their practice to rising liability rates. *The Detroit News, January 12, 2003.*

Mississippi

- In 2002, 10 physicians left Greenwood Leflore Hospital because of the State's problems with medical liability insurance. Also during 2002, the hospital's liability insurance premium increased from $150,000 per year to $1.3 million. *The Greenwood Commonwealth, June 26, 2003.*

- Approximately 100 doctors have left or plan to leave the State. *Time Magazine, June 9, 2003.*

- The only pediatric specialist in Rolling Fork has moved to North Dakota. *Time Magazine, June 9, 2003.*

- Increasing costs of medical liability insurance has reduced the number of neurosurgeons in the State by one third, creating holes in the State's trauma system. *Greenwood Commonwealth, April 25, 2003.*

- After suffering a massive head injury in a car accident, John Lucas IV, was taken to Delta Regional Medical Center in Greenwood. Since the hospital no longer has 24 hour neurosurgery services, Lucas had to be airlifted to the University Medical Center in Jackson, which delayed surgery to reduce pressure on his brain. *Greenwood Commonwealth, April 25, 2003.*

- According to Carl Hagwood, JD, "We have doctors leaving the state and the problem is that we are an underserved state. If you take doctors out of the system, who are you going to replace them with?" *Clarksdale Press Register, April 10, 2003.*

- Vincent Pisciottia, MD, is not sure how long he will be able to maintain his liability insurance since his rates keep increasing. His rates increased 20 % in 2002, 45 % in 2003, and they are projected to increase 95 % in 2004." *WLOX, April 9, 2003.*

- Alton Dauterive, a vascular surgeon was priced out of the market when his liability premiums more than tripled to $120,000 in two years. Dr. Dauterive is considering moving out of state to practice unless new legislative measures offer a reliable form of relief. He wants to be assured that he can practice medicine in Mississippi 10 years from now. *The Sun Herald, February 3, 2003.*

- Tony Dyess, father of two, was in his mid-40s when he was in an accident during the summer of 2002. He was rushed to a hospital, but no one was able to help him because the nearest neurosurgeon was 6 hours away. Neurosurgeons have left the state in huge numbers because of the massive liability insurance costs. *CNN Crossfire, January 13, 2003.*

- Speaking about Tony, his wife, Leanne Dyess has said, "Like most Americans, I had heard about some of these frivolous suits. But I never asked, 'At what cost?' Well, as I watched Tony's hospital call all over the state –and other states- I finally understood the cost. And believe me, it's a terrible cost to pay." *The Washington Times, April 21, 2003.*

- One major medical liability insurer, St. Paul Cos., left the business, forcing as many as 1,000 physicians to find other insurers. An additional 500 physicians and 46 hospitals may lose their coverage during May 2003 because their insurer, Reciprocal of America was taken over by Virginia regulators after concerns were raised about the company's ability to pay claims. *New Orleans Times Picayune, February 2, 2003.*

- According to the Mississippi State Medical Association, 73 physicians left the state during 2002, leaving many rural areas without enough physicians. *Scranton Times, January 13, 2003.*

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

- Mississippi's only Level I trauma center, the University of Mississippi Medical Center in Jackson, is concerned it may not be able to handle its increased patient load now that so many towns have lost their neurosurgeons. Towns including Columbus, Greenwood and Meridian have lost their sole neurosurgeon, and the Gulf Coast region has gone from five to one. *Modern Healthcare, Sept. 9, 2002.*

- Neurologist Terry Smith, MD said he had applied with 14 companies, and Medical Assurance was his last hope to find coverage before his current policy expired on

Aug. 4, 2002. His premium went from $55,000 a year to potentially $150,000 with a $132,000 tail to his old insurer. "I'm looking at writing a check for $300,000," said Smith, who does brain surgery at three hospitals in Jackson and Harrison counties. *Associated Press, July 11, 2002.*

- Greenwood Hospital – the only trauma center in a 55-mile radius – was unable to keep its Level-II trauma center rating because area neurosurgeons have left, citing the high cost of liability insurance. Greenwood also has lost 2 of its 4 OB-GYNs. *Associated Press, March 18, 2002.*

- Since 1995, Mississippi has been home to 21 verdicts of $9 million or greater. Before 1995, there were none. In the first quarter of this year, $31 million was awarded in such cases. The total for the entirety of last year was $32 million. *Daily Mississippean (Oxford, MS), July 30, 2002.*

- Pediatric specialist Kurt Kooyer, MD, left the small town of Rolling Fork. Dr. Kooyer, the only pediatrician among three physicians in town, arrived in 1994 and was responsible for the infant mortality decreasing from an average of 10 deaths per 1,000 live births to 3.4. Dr. Kooyer now lives in North Dakota. *Clarion Ledger, August 23, 2003.*

- Prior to moving to North Dakota, Dr. Kooyer was the only pediatrician in Sharkey and Issaquena Counties, where the majority of patients live below the poverty level. He originally moved to the Mississippi Delta to serve those who cannot otherwise get medical treatment. *Clarion Ledger, August 23, 2003.*

- In 2001, Bolivar County in western Mississippi had six physicians providing obstetrical care; today it has three. Obstetrics insurance for a doctor in Bolivar County jumped from $28,000 to $105,000, with a $25,000 deductible. *The Wall Street Journal, May 1, 2002.*

- In neighboring Sunflower County, all four physicians who delivered babies have quit private practice. *The Wall Street Journal, May 1, 2002.*

- In the northern half of the state last year there were nine practicing neurosurgeons; now there are just three on emergency call. *The Wall Street Journal, May 1, 2002.*

- Across the State, there is a veritable litigation explosion, in Jefferson County, for example, there are only about 9,740 residents - but the number of lawsuits filed in 1999 numbered 10,000. A year later, in 2000, the number of plaintiffs on the docket increased to 27,000, or nearly three times the number of residents. *The Washington Times, May 11, 2002.*

Missouri

- According to the *St. Louis Business Journal*, access issues are spreading. Dr. John Anstey, an obstetrician/gynecologist, recently faced a difficult choice. He knew he

had to cut expenses after learning his medical liability insurance premium, which cost about $26,000 this year, would jump to $50,000 next year. Consequently, he closed his office in St. Ann effective July 30th. Previously, Anstey and his partner, Dr. Fred Monterubio, Jr., deliver about 400 babies a year through their practice, St. Ann OB-GYN. As a stopgap measure, Drs. Anstey and Monterubio were forced to move their practice to a hospital-based setting where they await news of their 2003 premium by October. *St. Louis Business Journal, September 16, 2002.*

- Dr. Stanley Sides is a blood and cancer specialist with Cape Girardeau Physician Associates. His group's liability insurance increased 34 % – or $80,000 – over the last year. Another physician's insurance doubled to $150,000. Dr. Sides is unsure why the insurance has increased so drastically, since the practice is very low-risk with no surgery." *SE Missourian, January 23, 2003.*

- Intermed Insurance Company, based in Springfield, is the largest provider of medical liability insurance coverage in Missouri. The Missouri Department of Insurance said the company had a 34 % market share in 2001. The company imposed an 18 % hike, effective July 1, and also put a moratorium on writing new business in Missouri. *Missouri Department of Insurance.*

- As a June 30 deadline for lining up new liability insurance neared, the Women's Healthcare Network faced the possibility that it would not be able to get coverage. Such a prospect could have forced the closing of as many as half the birthing centers in the metropolitan area. "We felt desperate," said Dr. Deborah Jantsch, managing partner of Midwest Women's Healthcare PC, an OB-GYN practice with nine physicians. "At that point, we would have paid anything to get coverage." The network's situation caught the attention of insurance regulators in Missouri and Kansas, who wrote letters asking insurance carriers to at least provide quotes to physicians without coverage. Insurance carriers offered policies, but they were at rates as much as 300 % higher than what physicians paid previously. Midwest Women's Healthcare faced a 170 % increase. The practice used to pay about $200,000 a year for liability coverage. It now pays $543,000. *The Business Journal (Kansas City), August 2, 2002.*

Nebraska

- Leaders of the Nebraska Medical Association say one consequence of not having caps on damages would be fewer rural family physicians who deliver babies due to the high cost of liability coverage for obstetrical care. *Omaha World-Herald, January 10, 2003.*

- Some insurers have been dropping coverage of high-risk physicians, including family practitioners who deliver babies and are particularly important in the rural parts of the state. *Omaha World-Herald, April 17, 2002.*

- If premiums become too expensive, physicians in key areas may retire early, while others may lower their insurance by limiting their practices to lower-risk procedures and patients. *Omaha World-Herald, January 10, 2003.*

- The St. Paul Company (the state's largest medical liability insurer) had been one of the only insurers covering retired physicians doing simple medical tests and procedures at clinics that care for indigent patients. However, at the end of 2002, St. Paul pulled its business from the medical liability market leaving the state with one less carrier. *Omaha World-Herald, January 10, 2003, September 29, 2002, April 17, 2002.*

Nevada

- Over 30 obstetricians have ended their practices in the State. *Time Magazine, June 9, 2003.*

- In June 2002, infertility specialist Mark F. Severino, MD, stopped practicing in Las Vegas because his medical liability insurance ran out and he did not want to pay $136,000 to renew it. "I was in practice since 1985, and I never had a claim. I do infertility and that is not high risk." Dr. Severino left the State to join the Aurora BayCare Medical Center in Wisconsin. *Milwaukee Journal Sentinel, April 20, 2003.*

- Mary Rasar lost her father Jim because the State's only level 1 trauma center was closed because of skyrocketing medical liability insurance costs. The next closest level 1 trauma center was over an hour away by airlift. *US Newswire, April 16, 2003.*

- In August 2002, Nevada Governor Guinn called a special legislative session to address medical liability issues. In just four days, Nevada legislators enacted a meaningful liability reform bill. *Numerous media sources.*

- More than 30 private-practice OB-GYNs left Nevada in 2002 and another 20 are poised to leave in 2003. About half of the OB-GYNs in the state are actively interviewing for positions out of state. "Right now it's almost impossible to recruit an obstetrician in Las Vegas," said University Medical Center obstetrician, Warren Volker, MD. *Las Vegas Sun, September 27, 2002.*

- Dr. Shelby Wilbourn, an ex-Las Vegas-area OB-GYN who delivered 24 babies a month was force to move to Maine after 12 years of service to the state due to his insurance premium jumping from $33,000 to $108,000 even though he had never been sued or disciplined. In order to qualify for the $108,000 rate, Dr. Wilbourn would have been allowed to deliver only 125 babies a year. He was forced to leave 8,000 patients behind without any physician willing to buy his practice since other OB-GYNs were also leaving the state and physician residents did not want to remain in Las Vegas upon the completion of their training. *The Associated Press, February 12, 2003.*

- Long-time obstetrician, Frieda Fleischer, MD gave up obstetrics when her premiums rose from $30,000 to $80,000 a year. "So far, I've had about 40 pregnant patients to refer elsewhere and it's been tough." Fleischer's office manager, Dawna Gunning adds, "What do you do when you have patients coming to your door crying and saying they cannot find a doctor and you've called every colleague?" *Las Vegas Review Journal, January 10, 2003.*

- Dr. Joe Rojas Sr. who has been training obstetricians for more than 30 years said, "We've always had three out of the three resident [physicians] stay in Las Vegas the past 20 years. Now only one of the residents finishing up this year might stay here to practice. People used to call me looking for jobs in private practice all the time. Now, nobody ever calls me anymore." *Las Vegas Review-Journal, January 10, 2003.*

- The story of a woman who had to wait six months to have suspicious lumps removed from her uterus and ovaries because she couldn't get an appointment for the surgery illustrates that pregnant women are not the only patients affected by the exodus of Las Vegas obstetricians in recent months. *Las Vegas Review Journal, November 5, 2002.*

- The only Level I trauma center within 400 miles of Las Vegas, which treated more than 11,000 patients in 2001, closed for 10 days in July 2002 because it did not have enough surgeons to staff the center. *Numerous media sources.*

- "There is an unavailability of [medical liability] insurance," said Nevada State Insurance Commissioner Alice Molasky-Arman, at a March 4, 2002 hearing where insurance officials testified they would no longer insure any new obstetricians, surgeons and other high-risk specialists. *State of Nevada, Insurance Commissioner.*

- In Las Vegas, it is expected that more than 10% of the physicians will stop practicing or relocate, further adding to the crisis in the state. *Los Angeles Times, March 4, 2002.*

- Five trauma surgeons and 26 specialty surgeons made the difficult decision to resign or request leave from the University of Las Vegas Medical Center's trauma center. Some plan to leave June 30 and others July 31. This was expected to reduce by half the number of urologists, spinal surgeons, neurosurgeons, orthopedic surgeons, and cardiothoracic surgeons who could be on call to aid patients with life-threatening injuries. *Las Vegas Review-Journal, June 6, 2002.*

- Obstetricians and gynecologists remain particularly hard hit, who, like trauma centers, face premium increases of as much as 500 %. *Las Vegas Review-Journal, March 6, 2002.*

- In summer 2002, President Bush spoke with Jill Barnes, a Nevada resident who is more than two months pregnant. Mrs. Barnes and her husband were recently told by their home physician that he would not be accepting any new obstetrics patients. Unable to find a Las Vegas-area obstetrician to treat her, Mrs. Barnes has been forced to go out of state to find one. "When she goes into labor, she'll have to drive across

the desert for two hours" to Arizona, her husband told the Las Vegas Review-Journal. *The Washington Times, July 31, 2002.*

New Jersey

- The 8,300 doctors and 85% of NJ hospitals insured by Princeton Insurance Co. have gone through 3 premium increases in the past year. Even physicians with no malpractice claims against them report increases of 40% to 90%. In June, the company' s financial rating was downgraded for the third time this year—bringing healthcare providers the prospect of more premium increases. *The Bergen County Record, June 18, 2003.*

- As a result of skyrocketing liability insurance costs, 44% of physician practices surveyed by the Medical Society of New Jersey reported a negative impact their medical practices:
    - 21% ceased providing certain services.
    - 26% deferred the purchase of medically necessary equipment.
    - 12% laid off staff.
    - 6% stopped accepting new patients. *Medical Society of New Jersey Press Release, November 4, 2002.*

- Dr. Jacinto Fernandez has stopped practicing higher-risk obstetrics and limits his work to gynecology because of liability insurance costs. Dr. Fernandez's clinic, the Women's Health Care Group of Teaneck, is struggling to find affordable insurance after the clinic's carrier left the market. But the quotes they are receiving are increases of 50% or more over their previous premiums, according to the practice administrator. *The Record (New Jersey), June 19, 2003.*

- The Delaware Valley OB-GYN and Infertility Group reports that its practice now accommodates 4 times as many patients as they have in the past because so many doctors in Mercer County have dropped OB care. *AP Press State and Local Wire, May 15, 2003.*

- Warren Hospital in Phillipsburg has lost five surgeons and two neurosurgeons to skyrocketing liability insurance premiums, forcing the hospital to refer its patients to other hospitals in the region. *The Express Times, April 20, 2003.*

- Dr. Delores Williams, an OB-GYN in Trenton, stopped accepting new pregnant patients in January so she could stop delivering babies by July. She has watched her malpractice insurance climb from an annual $35,000 to $86,000 in two years. Says one of her disappointed patients, Lori Height of Pleasantville, "She's been my doctor for quite some time, and I feel really comfortable with her. It's a shame." *USA Today, March 5, 2003.*

- A multi-physician practice in Teaneck, NJ, was forced to layoff employees and reduce the number of deliveries it performed because of medical liability insurance

premium increases of more than 120%. "All of my colleagues are experiencing the same pressures," said George Ajjan, MD. *Bergen Record, May 22, 2002.*

- "We have as much to lose as they have," said Joan Hamilton, a patient who attended a recent rally in New Jersey in support of her physician. *Bergen Record, Oct. 6, 2002.*

- One out of every four hospitals—nearly 27%—has been forced to increase payments to find physicians to cover Emergency Departments. Physicians are increasingly reluctant to take on such assignments because of the greater liability exposure. Hospitals report that more and more physician specialties are being hit by the crisis. While a previous New Jersey Hospital Association survey in March 2002 found that OB-GYNs and surgeons were primarily affected, the new survey finds a deepening impact for neurologists/neurosurgeons, radiologists, orthopedists, general practitioners and emergency physicians. *New Jersey Hospital Association, Jan. 28, 2003 news release.*

- After years of only a few large jury awards, New Jersey had 26 awards greater than $1 million in 2001, and is averaging one a week in 2002, MIIX President Patricia Costante told the *Philadelphia Inquirer* on June 4. New Jersey has no limits on non-economic damages in medical liability cases.

- New Jersey's largest insurer, the MIIX company, declared in May 2002, that is was leaving the medical liability business. Previously, MIIX insured 7,000 physicians – nearly 40% of the state. MIIX previously left the medical liability insurance markets in Ohio, Pennsylvania and Texas, citing those states' out-of-control legal climates as an unacceptable business risk. *New Jersey Record, May 4, 2002.*

- The New Jersey Supreme Court ruled May 29, 2002 that ER doctors are <u>not</u> immune from lawsuits under the state's Good Samaritan law and may be sued for malpractice. *New Jersey Law Journal, June 3, 2002.*

<u>New York</u>

- Payments like the $140 million recently awarded threaten to endanger New York hospitals' ability to provide comprehensive care:

    - Dr. Spencer Foreman, president of Montefiore Medical Center in the Bronx predicts the pricey premiums will prompt many medical centers to drop high-risk services such as obstetrics and gynecology, neonatal care and neurosurgery. Montefiore delivers more than 3,700 babies every year. *Newsday, June 4, 2003.*

- Sixty percent of Long Island physicians say that they have or are considering limiting their practices to reduce their medical liability exposure, according to a survey conducted by the New York Medical Staff Leadership Council. Over 70% of OB-GYNs are considering dropping their obstetrical practice. Over two-thirds of

Orthopedic Surgeons and 62% of General Surgeons are considering restricting their availability for responding to Emergency Room calls.

- Over 95% of surveyed physicians report practicing defensive medicine—ordering extra tests, procedures and visits and limiting high-risk patients—to reduce potential liability. *Business Wire, June 11, 2003.*

- Patients in Long Island are encountering four- to six-month waits for mammograms because many radiologists refuse to do the screening. They fear being sued.

  - Dr. Steven Palter, 36, an OB-GYN in Syosset, says: "My malpractice insurance here is three times what it was in [my practice three months ago in] Connecticut. People told me that I was crazy to practice medicine here. Everyone is leaving New York."

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

- Six of the 19 obstetricians in the East End stopped delivering babies or left the practice because of their inability to afford the premiums, according to Dr. David Kirshy, a radiologist and treasurer of the Suffolk County Medical Society. For example, the annual cost of malpractice insurance premiums is $115,431 for OB-GYNs in Nassau and Suffolk; for neurosurgeons, it's $180,343, according to the Medical Society of New York. *Newsday (Nassau and Suffolk Edition), May 21, 2003.*

- The Niagara Falls area now has only seven obstetricians, down from 13 in 1981 in a decline that far outpaces the area's population decrease. One of the remaining OBs, Dr. David Zornek, cites the liability premium and constant threat of economically-disastrous lawsuits as precipitating factors. "I could lose everything I've worked for," he worries. *Buffalo News, April 27, 2003.*

- Dr. Thomas Murray, a Dutchess County OB-GYN, had to stop delivering babies after 35 years in practice when his medical liability premiums became high enough to consume half of what he earned on each delivery. *Poughkeepsie Journal, April 1, 2003.*

- "The number of doctors leaving Erie County [in 2001] doubled from [2000], a trend that continues in 2002," wrote Donald Copley, MD, an officer of the Erie County Medical Society. "I've watched sadly as valued colleagues have left Erie County and even the profession. A competent young specialist recently quit doing high risk diagnostic procedures to become a business consultant. Several local obstetricians have stopped delivering babies to reduce their insurance expenses. A half-dozen nationally-known doctors have quietly left Western New York. The number of

doctors leaving Erie County last year doubled from the previous year, a trend that continues in 2002. " *Buffalo Business First, April 15, 2002.*

- Many physicians at private hospitals abandoned high-risk practices (obstetrics, neurosurgery, and orthopedics) that traditionally carry the highest liability premiums. *Newsday, February 5, 2003.*

North Carolina

- The state's two largest malpractice insurers, which cover about half of North Carolina's doctors, increased rates an average of 12% and 16% this year, according to the state Department of Insurance. Smaller carriers, which typically cover higher-risk doctors, increased premiums by up to 50%. *News Observer, April 27, 2003.*

- Dr. Lew Stringer, the medical director for Forsyth County Emergency Medical Services for 30 years, resigned that position last week because he could not find liability insurance coverage. Stringer could not find an insurer that would cover his medical director duties. "It's sad after all these years of helping citizens" to be forced to resign for lack of adequate coverage, he said. "What other choice did I have?" *Winston-Salem Journal, June 2, 2003.*

- Facing a 300% increase in her malpractice premiums, Dr. Mary-Emma Beres of Sparta had to stop delivering babies. This left only one obstetrician in this town capable of handling high-risk cases, forcing some women who need C-sections to endure a 40 minute ambulance ride to another hospital. *Time Magazine, June 9, 2003.*

- During the past four years, malpractice premiums have increased 350% for faculty physicians at Wake Forest University Baptist Medical Center, said Karen Richardson, a spokeswoman for the medical center. "The fact that we have these problems in spite of having the buying power of a large institution illustrates why it might be a problem for independent physicians," she said. "We think of it not as a malpractice crisis but as an access-to-health-care crisis." *Winston-Salem Journal, June 3, 2003.*

- Dr. Dana Zanone and Dr. Robyn Sanard of High Point hoped to expand the services in their family practice by performing low-risk deliveries. But the consequential 487% increase in their premiums forced them to abandon the idea. Their office manager explained the effect on patients: "For their family care doctor . . . to also take care of them through their pregnancy and deliver their baby, it's extremely personal. Unfortunately, malpractice insurance is dictating what [the doctors] can do." Zanone worries that this will drive young families away from her family practice. *Archdale Trinity News, April 20, 2003.*

- "We are already experiencing an access problem . . . in Greensboro," explains Dr. Mary John Baxley, president of the Greater Greensboro Medical Society. "Our local doctors have been gracious in their care to indigent patients in this community. However, the need to limit liability exposure may affect these services. We are likely

to see limitations on volunteer services to Healthserve and to Healthcare Sharing Initiative if malpractice insurance premiums continue to skyrocket." *Greensboro News and Record, May 22, 2003.*

- Caldwell Memorial Hospital's premiums rose 366% when its insurer pulled out of the market last year. The institution joined 28 other Lexington and Watauga hospitals to purchase insurance, but their premium still rose more than 300% from last year. This forced the hospital to delay buying new equipment and to cut programs. It closed a subacute care unit for patients moving from the hospital to home. *Winston-Salem Journal, April 9, 2003.*

- Burgaw physician Dr. Conrad Miranda worries: "It's almost to the point where I cannot afford to even open my practice because it will take me eight or nine months just to afford the malpractice insurance." *News 14 Carolina, April 8, 2003.*

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

- Dr. Michael Bryant, a general surgeon, said over the past two years malpractice insurance premiums for the seven doctors in his practice have increased by more than 50%. "We talked with our insurance carrier just yesterday, and the concern is that is will go up 15% to 30% next year," he said. Bryant estimated that malpractice insurance takes 12% to 15% of his net income. That percentage could increase to 20% as the costs go up. "Yes, it's a cost of doing business," he said, "But at some time it becomes prohibitive with respect to practicing." *Charlotte Observer, Nov. 24, 2002.*

- Recently, Dr. John Schmitt, an Ob-Gyn whose insurance premiums tripled from $17,000 to $46,000, causing him to give up his practice to join the medical school faculty at the University of Virginia. Former patient Laurie Peel said, "He was a great doctor. When you are a woman, you try to find a gynecologist who will take you through lots of things in life. I suffered a miscarriage. You develop a relationship with your doctor. To lose someone like that is very hard." *Charlotte Observer, Jul. 25, 2002.*

Ohio

- Ohio ranked among the top five states for premium increases in 2002 , according to the *Medical Liability Monitor.* OHIC Insurance Co., among the largest medical liability insurers in the state, reports that average premiums for Ohio doctors have doubled over the last three years. *Akron Beacon Journal, July 6, 2003.*

- Dr. Robert Norman, a geriatrician in Cuyahoga Falls, saw his annual medical liability premium jump $5,700 to $34,000 last year. He had been warned that it could reach

$100,000 this year if he continued treating patients in nursing homes. But in May he received an unexpected ultimatum from his insurer and every other carrier he queried: agree to stop seeing nursing home patients or lose liability coverage altogether. As a result, 150 of Dr. Norman's patients had to find a new doctor. *Akron Beacon Journal, July 6, 2003.*

- Dr. Stephen Cochran lost his hospital privileges at Akron General Medical Center when his insurer's financial stability rating was downgraded recently. He is seeking another insurer, but meanwhile, he says, "We receive daily phone calls from the patients: 'Why aren't you here? Why aren't you seeing me? I want my doctor,' " he says. "It's been very stressful to a lot of the patients, particularly the geriatric patients . . . This (the malpractice crisis) has probably changed the nature of our practice more than anything that has happened in the last 10 to 20 years." *Akron Beacon Journal, July 6, 2003.*

- After practicing for 15 years—their entire careers—in Cleveland, Dr. Christopher Magiera and his wife, surgeon Patricia Galloway, decided to leave Ohio to seek refuge from overwhelming liability premiums. Their insurance agent warned them that both would soon be paying $100,000 in annual premiums, up from $30,000 this year. Magiera and his wife decided to "get out before the situation became hopeless," he said. They resettled in Wisconsin. *Journal Sentinel, April 20, 2003. Milwaukee Business Journal, June 29, 2003.*

- Dr. Perm Jawa, a Cleveland urologist, says that soaring liability premiums leave him in perpetual fear of career-ending lawsuits. "I shy away from major cases now. Sometimes you know what the best thing is but you don't want to be doing it because there are potential complications with it," Jawa said. "You're not as aggressive as you should be." *AP State and Local Wire, June 10, 2003.*

- Dr. Geoff Cly, an obstetrician-gynecologist practicing in Dayton, said he's leaving Ohio for Indiana in July due to the burden of Ohio's $50,000 to $55,000 a year for malpractice insurance and managed care. *AP State and Local Wire, June 10, 2003.*

- In Morrow County, rising medical liability premiums forced Dr. Brian Bachelder to stop the obstetrics portion of his practice on January 1. *Marion Star, April 27, 2003.*

- In Columbus, Dr. David Stockwell has seen coverage for his two-physician OB-GYN practice climb to over $100,000 a year. And he expected his premiums to rise 20-25% in May. *Columbus Dispatch, April 26, 2003.*

- The Ohio Supreme Court has overturned three tort reform measures in the past 15 years. Following the state Supreme Court's 1995 overturning of the state's tort reforms, premium increases and jury verdicts began rising. Family physicians in rural areas are increasingly no longer performing obstetrical services. Recently, Ohio again enacted medical liability reforms, but it is too soon to tell if the courts there will let these reforms take root. *State ex rel. Ohio Academy of Trial Lawyers v. Sheward, 86 Ohio 3d 451, 715 N.E. 2d (1999).*

- According to Daniel J. McLaughlin, a vascular surgeon in Cleveland, some specialists in the region have seen their malpractice premiums increase 600% this year, and typical premiums for surgeons with just three or four years of experience have doubled or tripled, from $50,000 a year to as much as $100,000 or more. *Health Leaders Magazine, Sept. 2002.*

- Brian Bachelder, MD is the only doctor in Morrow County delivering babies, and soon he might stop, too, "My insurance for obstetrics cost $16,000 last year, and as of Jan. 1 [, 2003] they told me it will go up to $38,000, " Bachelder said. "I haven't had any lawsuits or problems in the past seven years. " *The Marion Star, Oct, 13, 2002.*

- After over 20 year in business, Dr. Paul Bartulica will be closing his now-empty OB-GYN practice. "They just shot my practice, my livelihood, out from under me," said Bartulica. "There are different ways of killing a person." Bartulica had trouble last year paying his insurance premium of $72,000. This year costs skyrocketed to $147,000, so he has not seen any patients since Feb. 15, 2002. "[In 2001,] I ended up not paying myself for half a year. I lived from my savings," he said. "I was hoping something would turn around in 2002, but my insurance doubled. There's no way I can pass that cost on to my customers." *MorningJournal.com, Nov. 14, 2002.*

- In July, Westlake oncologist Dr. Romeo Diaz was faced with an insurance premium of $80,000 – double what he paid last year. He would have gone out of business had it not been for his patients, who raised the needed $40,000 to help Diaz stay insured. "At first I thought he was playing," said Kathy Fritsch, a patient of Diaz for 10 years. "But when he looked up at me, he was crying. He said his insurance rose from $40,000 last year to $80,000 this year. It used to be $20,000." *Morning Journal, July 31, 2002.*

- Dr. David Burkons and his two partners at University Suburban Gynecology, Inc. in South Euclid simply could not afford to pay a combined $360,000 for a year of malpractice coverage. On Nov. 1, 2002, they stopped delivering babies and limited their practice to gynecology. *The Plain Dealer, Oct., 20, 2002.*

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

- "If I were advising medical students now, I would tell them to take a real hard look at going into some of these high-risk specialties," John Bastulli, MD, told the *Plain Dealer, February 18, 2002.*

Oklahoma

- The Physician Liability Insurance Co., a not-for-profit insurance company owned by the Oklahoma State Medical Association (OSMA), writes nearly 90% of physician liability insurance in Oklahoma. From 1991 to 2000, the average annual amount that Physician Liability Insurance Co. paid to patients was $18 million. It jumped to $33 million last year, according Dr. Jack Beller, an orthopedic surgeon from Norman and president-elect of the OSMA. The nonprofit company is owned by doctors and does not invest in the stock market. *The Tulsa World, March 3, 2003.*

- To keep up with the judgments, the insurance company raised its rates 60% in the last year. Doctors found out about the increase Dec. 1 and were required to pay by the end of the month. *The Tulsa World, March 3, 2003.*

- Dr. Melanie Blackstock, an OB-GYN in Tulsa, pays $46,000 a year in liability insurance -- up from $28,000 last year. Responding to the prospect of another 60% increase, Dr. Blackstock says: "If that happens, I might very well not deliver anymore because that is economically not feasible." *The Tulsa World, March 3, 2003.*

- Tulsa OB-GYN, Dr. Pat Lodes saw her premiums increase from $23,000 in 2002 to $40,000 in 2003. *The Oklahoman, February 27, 2003.*

- Saint Simon Episcopal Home in Tulsa paid $42,600 for $10 million in liability coverage in 1998. In 2002, $313,800 bought $5 million in coverage. *The Oklahoman, Feb. 27, 2003.*

- Stigler family physician Dr. Mark McCurry wants to deliver babies as part of his Eastern Oklahoma medical practice, but cannot afford the skyrocketing liability insurance premiums. Instead, he advises his Haskell County patients to arrange for their deliveries 45 to 60 minutes away in Muskogee, McAlester or Fort Smith, Arkansas. *The Sunday Oklahoman, February 16, 2003.*

- Lt. Governor Mary Fallin is concerned that physicians will leave the state, retire early, or cut back on their practices because they cannot afford to purchase liability insurance. The state's rural communities, where physicians are already in short supply, are of especially critical concern, says the Lt. Governor. *The Oklahoman, February 27, 2003.*

- Family physicians trained to deliver babies, especially in rural areas, are no longer delivering babies due to the cost of insurance. Surgeons have stopped performing surgery. Primary care physicians have stopped performing minor surgeries due to the cost of liability insurance. *Oklahoma Business News (Oklahoma City), February 6, 2003.*

Oregon

- The two largest medical liability insurance carriers in Oregon are imposing substantial premium increases.

    - CNA, which provides insurance for 2,000 of Oregon's 9,000 doctors, reports that their premiums rose an average of 37% in May 2003. This follows 16% and 60% increases in 2001 and 2002, respectively.
    - Northwest Physicians Mutual, which covers 2,300 Oregon doctors, charged obstetricians and neurosurgeons $21-23,000 in 1999 and now charges them $61-62,000. Jim Dorigan, CEO of Northwest Physicians, explains: "It's primarily due to the increased indemnity payments, which are primarily attributed to the loss of a cap." *The Bulletin, April 27, 2003; The Hillsboro Argus, April 24, 2003.*

- "Rising medical malpractice premiums, declining reimbursement rates and increasing numbers of uninsured Oregonians are causing many surgeons to stop taking trauma calls completely or to limit their practice to non-emergencies only. An increasing number of patients with severe brain injuries are being transferred to Portland. There will be a morbidity and mortality associated with the transfers. This jeopardizes the integrity and intent of the previously high quality Oregon Trauma System." -- William Long, M.D., State Trauma Advisory Board Chair and Trauma Medical Director of Legacy Emanual Hospital. *OMA Report: Is There a Doctor in the House?, June 2003.*

- Of health professionals in the state that deliver babies, 125 have stopped providing this service over the last four years, according to a 2003 Oregon Health and Sciences University Survey. This represents 22% of all Oregon providers that deliver babies. *OHSU News, March 5, 2003 -- http://www.ohsu.edu/news/2003/030303survey.html*

- Dr. Peter Palacio, an OB-GYN in Bend, has seen his premiums increase by 300% in the last two years. Palacio worries: "It's a big portion of our outlay and without any end in sight." *The Bulletin, April 27, 2003.*

- After Reedsport lost a local surgeon that served as a backup for C-sections, the town's family practice could not recruit another surgeon due to high liability premiums. Pregnant women now have to travel 30-40 minutes to Florence or Coos Bay to receive care.

    - "We are very concerned about the loss of timely care and the risks to our community's pregnant mothers and children. We wanted to continue deliveries as a community service," explained Dr. Robbie Law. "It's important for our patients and it impacts the health and economic viability of Reedsport as well."

    - Tammi Dunlap, pregnant with her fourth child, was one of Law's obstetric patients. Now she travels 45 minutes on windy, often wet roads for

prenatal care. "It's horrible," she stated. "Dr. Law has been my doctor with all my children." As to labor? "That's my biggest worry," she said. "Hopefully, we'll make it." *OMA Report: Is There a Doctor in the House? June 2003; OHSU News Release, March 3, 2003.*

- In 2002, Dr. David Evans and 3 of his obstetrician colleagues at the Madras Medical Clinic in Central Oregon faced an 85% increase in their medical liability premiums. In exchange for help with their $76,000 premiums, the doctors agreed to provide some services to nearby Mountain View Hospital. But many of their colleagues have not been able to find such fortunate arrangements. "Without that arrangement we would be out of business," said Evans. *The Bulletin, April 27, 2003.*

- Rural families in John Day, Hermiston, and Roseburg counties have either lost obstetric care or have seen services drastically reduced. *The Business Journal of Portland , Jan. 10, 2003.*

- "No one with $100,000 in debt from medical school wants to start a practice in a place where they could find themselves completely broke and having to pick up and go somewhere else to start all over again, " said Rosemari Davis, CEO of Willamette Valley Medical Center, who has seen three of her center's family practitioners stop delivering babies. *The News Register, Jan. 28, 2003.*

- Rural patients in Oregon are being particularly hard hit. A small town clinic, Roseburg Women's Healthcare, which delivered 80% of the babies for the area, closed its doors in May 2002 because its liability insurance was canceled after one large lawsuit. "We consider this a medical crisis for the community," said Mercy Medical CEO Vic Fresolone.

    - The Roseburg clinic physicians paid $17,000 per physician per year in 2001 for medical liability insurance and are now receiving quotes for $80,000 -100,000 per physician. *The Oregonian, June 26, 2002.*

- A major liability insurer, Northwest Physicians Mutual Insurance Company, announced in 2002 it would not write new policies to obstetricians. Remaining insurers are raising rates by 60% or more.

    - "We lost $12.5 million last year (2001)," Jim Dorigan, CEO of Northwest Physicians Mutual, told the *Portland Business Journal* on June 21, 2002. Dorigan also said the company no longer is renewing policies for any physician who delivers babies.

- Only by dropping obstetrics were two Hermiston physicians able to afford their liability insurance premiums. "It's something you don't like to tell patients," said Dr. Doug Flaiz. *The Oregonian, Oct. 29, 2002.*

- **Physicians in every region of Oregon are closing or substantially limiting their practices in response to skyrocketing medical liability insurance premiums:**

Fearful of frivolous or excessive lawsuits . . .	Physicians have started referring complex cases to other doctors	Physicians have stopped or will stop providing certain services
Southern Oregon	31 % (80% of neurosurgeons)	25% (60% of neurosurgeons)
Eastern Oregon	30%	30%
Southwest Oregon	20%	30%
Northwest Oregon	29%	30%
Central	19%	21%
Mid-Willamette Valley	28%	20%

***Source: Oregon Medical Association 2003 Statewide Workforce Survey*

- **Southern Oregon.** Almost 31% of the physicians practicing in Southern Oregon report they had increased referral of complex cases (such as brain surgery) or plan to do so. Almost one in four report they have stopped or will stop providing certain services. Twenty-five percent of the obstetricians said they have stopped or will stop providing certain services; 31% report they will increase referral of complex cases. A whopping 60% of the area's neurosurgeons report they have stopped or will stop proving certain services; 80% say they have increased or will increase referral of complex cases.

- **Eastern Oregon.** About 30% report they have stopped or plan to stop providing certain services. About 13% say they are stopping or plan to stop providing direct patient care. Twelve percent report they have sold or closed their practices or plan to do so. Nearly one third are considering relocating their practice.

- **Southwest Oregon.** Almost 30% report they have stopped providing or will stop providing certain services. One in five report they are increasing referral of complex cases or plan to do so. Almost 11% report they had already sold or closed their practices or that they definitely will do so. More than one third plan to retire within the next five years.

- **Mid-Willamette Valley.** Almost 20% of physicians report they have stopped or will stop providing certain services. About 28% report they have increased referral of complex cases or plan to do so.

- **Northwest Oregon.** Almost 30% report they have stopped or will stop providing certain services. About 30% report they have increased or plan to increase referral of complex cases.

- **Central Oregon.** Almost 21% of the area's physicians report they have stopped or will stop providing certain services. About 19% currently are referring complex cases or plan to do so in the near future.

Pennsylvania

- Since January 2001, at least 1,117 physicians have either closed their practices, limited services, or left the state due to unaffordable liability insurance, according to records maintained by the Pennsylvania Medical Society. According to a federal study, the state now has 729 "medically underserved" communities. *The Times Leader, May 17, 2003. The Philadelphia Daily News, February 11, 2003.*

- A Pennsylvania Medical Society study recently reported that significant portions of the state's specialist pool are leaving Pennsylvania. Between 1997 and 2002, the state lost:

    - 600 general surgeons—36% of the state's total.
    - 125 orthopedic surgeons and 35 neurosurgeons—16% of the total in each group. *The Patriot-News, June 18, 2003.*

- According to the same study, 20 of Pennsylvania's 67 counties have a shortage of primary-care doctors. Nine more are approaching a shortage. *The Patriot-News, June 18, 2003.*

- Forty Lackawanna County physicians limited their practices and considered closing them due to unaffordable medical liability premiums in the final months of 2002.

    - This included Drs. Debra and Nick DeAngelo, anesthesiologists who are closing their 10-physician Pain Management Specialists P.C. They accepted temporary in-state positions but are pursing out-of-state jobs but are having trouble locating states with affordable premiums and open positions. "This is the hardest month of my life," lamented Dr. Debra DeAngelo. "I get very attached to my patients. I had to say goodbye to basically family."

    - Dr. DeAngelo's patients are just as concerned. Mr. Joey Lee, who suffers a chronic pain disorder, depends on the doctor to replenish his pain and anti-spasm medication pump every 18 days. "It's a pretty scary situation for me," worried Mr. Lee. "If the pump runs out I'll be in a little bit of trouble because Dr. DeAngelo won't be here." *Scranton Times, January 31, 2003.*

- Dr. Tom Unruh, a vascular surgeon in Wilkes-Barre, plans to close his practice in July 2003 after practicing for 10 years in the area. He blamed excessive liability insurance premiums—including $65,000 in back coverage required by his new insurer—for his decision to move to Delaware. His former insurance company left the Pennsylvania market in early 2003. Three other vascular surgeons have left his

county because of liability premiums in the last 18 months, according to Unruh. *The Times Leader, June 21, 2003.*

- Dr. Shawn Hennigan, the only shoulder surgery specialist north of Philadelphia, will be leaving his 1,000-patient practice in July 2003. His medical liability premium was to rise 75% in the coming months; paying the insurance would have consumed nine months worth of his annual earnings. He and his wife, born and raised in Pennsylvania, will move their family to Wisconsin, where he will receive twice as much coverage for a quarter of the cost. *Journal Sentinel, April 20, 2003. WNEP-TV of Wilkes Barre, April 22, 2003.*

- Doctors at the Women's Health Care Clinic in Wayne County have watched their liability insurance premiums climb 30% a year. These rising premiums drove them to close three satellite offices—in Hamlin, Carbondale, and Narrowsburg, NY—and consolidate their practice. Their practice administrator shared the concerns of the physicians: "What the general public hasn't realized is the impact of these huge malpractice awards given to patients for non-economic damages that are severely impacting the ability of medical practice specialists to continue to be able to serve the general public. Doors are going to close; patients are going to have to look to going hours for access to medical care, if not [to other] states." *Northeast Pennsylvania Business Journal, April 1, 2003.*

- Dr. Anthony Clay never thought he would have to leave Philadelphia. He has spent his whole life there—growing up and attending college, medical school, and residency to become a cardiologist. He treats families he has known since boyhood. He likes knowing where his patients live, work, and shop. All nine of his siblings still live there. But, Dr. Clay is leaving his practice in Philadelphia this spring because of surging malpractice insurance rates. He is starting over in Delaware, where his insurance costs will drop from roughly $70,000 a year to $8,000. "It's been terrible," said Dr. Clay, 40. "In this field, you've been with the patient, and also the family, in some of their most life-defining moments - in the throes of a heart attack with no blood pressure. Wrongly or rightly, the patient credits you with being there when they weren't doing so well. You realize you've created a bond. I take that very seriously." *Baltimore Sun, February 5, 2003.*

- About 100 Delaware County physicians have moved to other states or have stopped practicing since 2001 because their insurance reimbursement rates for services are among the lowest in the nation and their medical liability costs are among the highest. *Delaware County Times, January 6, 2003.*

- Dr. Seth Krum, an orthopedic surgeon at Warminster Hospital outside of Philadelphia is considering leaving the state. Although he has developed a great practice and does not want to leave, he says, "This just can't continue." He has interviewed with out-of-state medical facilities where insurance costs would be lower. *Associated Press, January 2, 2003.*

- Dr. Brian Holmes is one of an estimated 18 percent of Pennsylvania neurosurgeons to have left the state, retired, or limited his or her practices because of the medical liability crisis. "It saddened me to move, but I had no choice. It was either move or go out of business." *Philadelphia Business Journal, Sept. 25, 2002.*

- OB/GYN Lawrence Glad, MD, used to deliver about 500 babies a year - 40 percent of all the babies born in Fayette County annually. After his premiums skyrocketed from $57,000 to $135,000, however, he closed his practice in the fall of 2002. *Pittsburgh Business Times, Nov. 18, 2002.*

- Mercy Hospital chief of surgery Charles Bannon, MD, has watched numerous physicians leave Scranton and Lackawanna County - creating a shortage of surgeons, fewer medical school applications and residencies. "It will take generations to get back the quality of medicine in Philadelphia." *Scranton Times, Nov. 20, 2002.*

- The Level-II trauma center at Brandywine Hospital in Coatesville closed June 10th, because of rising malpractice insurance rates. Area trauma patients are now being transported more than 30 miles away to hospitals in Philadelphia and Lancaster. *The Washington Times, July 17, 2002.*

- Dr. Margaret Hawn will stop delivering babies in June 2003 because of high medical liability insurance premiums and a legal climate that inspires fear in well-meaning doctors. Hawn is the fifth obstetrician among those at her clinic and at a neighboring practice to give up caring for pregnant women over the last two years.

    - Fellow obstetrician Dr. Robert DelRosario says that he knows of no new obstetricians who have come to their area in the last three years. And he believes most area obstetricians already average about a dozen deliveries a month, which is the upper limit recommended by the American College of Obstetricians and Gynecologists. *The Patriot News, June 11, 2003.*

- Dr. Lawrence Glad and Dr. Christine Wilson, OB-GYNs from Hopwood, Pennsylvania, decided to stop delivering babies because of their daunting premiums. Dr. Glad's practice, which delivers 40% of babies in his county, had been paying $150,000 annually. Glad told an interviewer: "We were given quotations from the insurance companies of about $400,000, which was over a 250% increase." Lisa Sefchik, a pregnant nurse practitioner in the doctors' office, now has to travel almost 50 minutes for prenatal care. Says Sefchik: "It's been stressful . . . and, of course, being ready to deliver soon, it becomes more stressful as time goes on trying to prepare to get there in time." *Good Morning America ABC, April 29, 2003.*

- Dr. Jose Manjon, an OB-GYN in the Camp Hill area, stopped delivering babies in January 2003. His medical liability insurance premiums had climbed to $70,000, from about $20,000 a few years ago. He had been delivering 120 babies a year but felt forced to stop because it was no longer financially viable. "We're just crying out for help," said Manjon. *The Patriot News, April 29, 2003.*

- Dr. Carol Ludolph, a neurosurgeon in Philadelphia, said that $170,000 liability insurance premiums forced her to stop performing brain surgeries last year. Now she sees only neurology patients in her office, but she worries that insurance bills still may force her to close her office. She is especially concerned about the impact of this crisis on her patients: "They 're already complaining about how long it takes them to get an appointment with their primary doctor, and how much longer they have to wait when they get to the doctor's office," she said. *Philadelphia Daily News, April 25, 2003.*

- In Fayette County, in the western part of the state, three obstetricians who had been delivering nearly half the county's newborns stopped treating pregnant women after learning that annual premiums for the practice would rise from $150,000 to $400,000. *Baltimore Sun, February 5, 2003.*

- Abington Memorial Hospital, in the Philadelphia suburbs, had to send trauma patients to other hospitals for nearly two weeks in December 2002 because it had too few surgeons to treat the most severely hurt patients. Late in 2002, Easton Hospital in the Lehigh Valley went for a month without a neurosurgeon on staff. *Baltimore Sun, February 5, 2003.*

- After 25 years of practice, OB/GYN Michael Horn, MD, stopped delivering babies in 2002 because of the fear of getting sued. "It's just the potential, the not knowing if someone will seek an outlandish reward. I don' t want to expose myself or my family." *Burlington County Times, Oct. 2, 2002.*

- Howard A. Richter, a neurosurgeon and president of the Pennsylvania Medical Society, said a 2001 survey by the medical society showed that 72% of doctors have either deferred the purchase of new medical equipment or have not hired needed staff because of "sudden and sharp increases" in insurance rates. *Best's Insurance News, January 21, 2002.*

- Dr. Shripathi Holla, a neurosurgeon in Scranton, has watched his liability insurance payments double to $150,000 in the last few years. This unaffordable increase forced several of his colleagues to stop practicing or move out-of-state. Unable to recruit new neurosurgeons to his town, Holla is on-call at 3 area hospitals on any given night. He is sometimes the only surgeon willing to perform risky operations that trauma centers now shy away from. *The American Prospect, July/August 2003.*

- Dr. William Crombleholme, residency director at Magee-Womens Hospital, has seen unaffordable liability insurance drive young doctors' decisions about where to practice. In the past two years, he said, concerns about premiums have prompted four or five young physicians to leave Pittsburgh for other states. "I tell them, 'This is, right now, probably an equally important element in your contract as your salary. It doesn't matter what they pay you; if you can't get insured, you can't work," explained Crombleholme. *Pittsburgh Post-Gazette, June 29, 2003.*

- Neurosurgeons in Lancaster blame high liability insurance costs for their inability to recruit an additional surgeon and two neurologists to their practice. In 2002, their group saw 10,000 patients, and their surgeons performed 2,000 procedures at Lancaster hospitals. In addition, they assisted in 650 emergency room cases. Dr. Perry Argires, one of the physicians in the group, worries that this physician shortage could compromise their ability to treat patients. *Lancaster Sunday News, May 18, 2003.*

- This crisis is threatening to create a shortage in the state's next generation of physicians, in addition to the current exodus. According to the Pennsylvania Medical Society, the state ranks 41st in the percentage of their physicians that are under the age of 35, despite the eight medical schools within its borders. There are only 3 orthopedic surgeons under 35 in the entire state. In high-risk specialties, the state has historically retained 40% of residents from its medical school; it currently retains 14%. *Pennsylvania Medical Society news release, June 13, 2003; Northeast Pennsylvania Business Journal, April 1, 2003.*

- Medical students are less likely to seek residencies in Philadelphia, and residents are less likely to stay and practice in the area because of "prohibitively high" medical liability insurance rates, according to Jefferson Medical College professor Stephen L. Schwartz, MD. *Associated Press, Oct. 4, 2002.*

- Ear, nose, and throat specialist Dr. Tom Boran and his partner, who practice in Pottsville, saw their annual malpractice insurance premiums rise from $54,000 to $92,000 this year. Neither has ever lost a lawsuit. They are accepting more patients to defray these costs, but this leaves them physically and mentally exhausted by the end of the day. "You get to the point where a lot of physicians say, 'Life has to be better than this,' " said Boran. *Associated Press, June 30, 2003.*

- Drs. Judy and Gary Pryblick saw their liability insurance premiums climb 128% from last year. They worry that continuous increases of this magnitude will force them out of practice. "We don't want to panic patients," said Dr. Judy Pryblick. "They grab on to you and say, 'Please don't leave,' but they understand we have to pay the bills." *Allentown Morning Call, May 4, 2003.*

- Medical liability insurance costs have increased an average of 73% this year for surgeons practicing with the Lancaster NeuroScience and Spine Associates. *Central Penn Business Journal, April 25, 2003.*

- Dr. Terri Hellings, a Levittown neurologist who makes house calls to elderly patients is fed up with the state's skyrocketing liability premiums. She has thought about leaving the state. "I save patients from having to pay for ambulances; I save sons and daughters taking care of elderly [parents] at home from having to lose days at work to take them to the doctor. I go to them. I save trouble for families. And you will lose doctors like me." *The Philadelphia Daily News, February 11, 2003.*

- General surgeon, Dr. Gregory Saracco, had to borrow money twice in 2002 to pay $73,000 for liability insurance. The costs will rise to $100,000. He says that he cannot operate in the state if he does not get some help. *Associated Press, January 2, 2003.*

- "Virtually every medical liability insurance carrier increased their rates in recent years. From the beginning of 1997 through September 2001, major liability insurance carriers writing in Pennsylvania increased their overall rates between 80.7 percent and 147.8 percent." *York Daily Record, January 20, 2002.*

- Statistics compiled for the Pennsylvania Medical Association by Caso Consulting indicate it costs $96,199 to cover an orthopedic surgeon in Pennsylvania, compared with $37,783 in Delaware, and $36,291 in New Jersey. *Best's Insurance News, January 7, 2002.*

- Inpatient and emergency-room services were terminated July 1 at Lancaster General Hospital Susquehanna Division because medical liability insurance rates have skyrocketed. Lancaster General CEO Michael Young said the Columbia facility will lose these services because liability insurance premiums have gone from $85,000 a year several years ago to $900,000 this year. "It is no longer feasible to provide inpatient and emergency-room services for the folks in the western end of the county when malpractice (insurance) costs more than nursing," Young said.

    - 100 of the 180 jobs at the hospital will be lost. Most of those are full-time positions. Administrators will try to find these employees work elsewhere in the Lancaster General system. *Lancaster Sunday News, March 23, 2003.*

- Liability premiums at LeHigh Valley Hospital increased from $3.8 million in 2000 to $14 million in 2003. *Allentown Morning Call, May 4, 2003.*

- Premiums reaching almost $40 million annually are forcing Geisinger Health System to restructure services and limit liability exposure. Geisinger closed community-based obstetrics practices at Bloomsburg and Sunbury hospitals. Now pregnant patients must travel to Danville for delivery. *Northeast Pennsylvania Business Journal, April 1, 2003.*

- Methodist Hospital in South Philadelphia closed its maternity ward and prenatal program in 2002 because of unaffordable medical liability insurance rates. This action will result in the elimination of 91 full and part-time positions, though administrators will try to relocate employees. *Thomas Jefferson University Hospital press release, April 24, 2002.*

- Jefferson Health System in Philadelphia eliminated 91 full and part-time jobs after closing their maternity ward because of skyrocketing liability insurance premiums. The Einstein Network laid-off 127 workers and eliminated 52 vacant positions in

April 2002, citing rising liability costs as the prime factor. *AP State and Local Wire, April 11 and 24, 2002.*

- From Gov. Rendell's task force report: "Three of the five major medical liability insurance companies are no longer writing policies in Pennsylvania. The total cost of mandated medical liability coverage . . . has doubled in the past ten years. The high-risk subspecialties of general surgery, orthopedics, OB-GYN, and neurosurgery have been particularly hard hit by the decrease in affordable and available insurance. Medical liability coverage costs for hospitals and health systems have increased by 86% over the past 12 months." The report stated that insurance companies suggested in conversations that: "The economy in general was not of major significance in [each company's] decisions. All the insurers' representatives noted that their investments are heavily regulated and invested in interest-bearing securities, rather than equities." *Pittsburgh Post-Gazette, April 5, 2003.*

- Thirty-one percent of Pennsylvania physicians in high-risk specialties had their existing liability insurance cancelled or non-renewed for 2002. Of these physicians nearly, 22% of them had not been able to secure new insurance for 2002. The survey, conducted by Susquehanna Polling and Research for the Pennsylvania Medical Society, polled 855 orthopedic surgeons, obstetrician/gynecologists, neurosurgeons, plastic surgeons, and cardiologists. *Cleveland Academy of Medicine Press Release, January 12, 2002.*

- 414 medical liability lawsuits were filed in Philadelphia County in February 2002 – five times the average number filed during the month over the previous decade, reported the *Philadelphia Inquirer.*

- Driving premiums through the roof are excessive sums awarded in lawsuits. Medical liability payments for physicians in 2000 totaled $3,908,113,303. *York Daily Record, January 20, 2002.*

South Carolina

- The state-run Joint Underwriting Agreement and the Patients' Compensation Fund, the two largest malpractice insurers in South Carolina, will increase premiums rates by an average of 24.1% in June. Premium rates for physicians in higher-risk specialties will increase by about 60%. *Charleston Post and Courier, May 15, 2003.*

- In 1999, these state insurance programs paid out $34 million in malpractice payments and expenses. By 2001, that figure had grown to $61 million. Director of the two funds, Richard Lane, expects 2002's payouts to be even bigger, because the number of claims rose by 25 percent. "We don't invest in real estate, we don't invest in the stock market" as commercial insurers do, Lane said. "We pay our claims right out of membership fees. Our losses are up significantly, so we have to have a rate increase to meet financial obligations." *Charleston Post and Courier, May 15, 2003.*

Specialty	% Increase in 2003 Liability Insurance Rates (compared to 2002)
Nephrology/Surgery	58.5%
Emergency	51.3%
General Surgery	42.7%
Obstetrics	30.2%
Cardiac Surgery	30.1%
Neurosurgery	26.8%

Source: http://www.scmanet.org/JUA/JUA%20Rates%20June%202003.htm

- "[This increase] is going to create a crisis in access," predicted Bill Mahon, CEO of the South Carolina Medical Association. "We already have a problem with trauma care in the state. This is only going to aggravate it." *Charleston Post and Courier, May 15, 2003.*

- Dr. Dahlmon Smoak, a 58-year-old OB-GYN who practices in James Island and North Charleston, said the increasing rates could push him to an early retirement. "I still feel like I can be of some benefit to people," he said. "I'm healthy, vigorous and I like to practice. But I'm not going to continue if these rates keep going up like this." *Charleston Post and Courier, May 15, 2003.*

- In fact, a handful of physicians have stopped delivering babies. Patients are now suddenly confronted with having to find new physicians, a complicated situation in more rural areas. *Charleston Post and Courier, January 26, 2003.*

- According to the South Carolina Medical Association, the average medical liability rates in the state have increased 665 percent since 1998. *Charleston Post and Courier, January 26, 2003.*

- In Oconee County, a largely rural county on the western border, a number of family physicians stopped delivering babies due to the high cost of insurance rates. This has left the county with only four physicians who do such work. There were 11 physicians delivering babies a year ago. *Charleston Post and Courier, January 26, 2003.*

- Dr. Thomas Litton's North Charleston four-surgeon practice paid about $3,500 a year per physician in the early 1990s for liability insurance. Today, he pays about $90,000 for the practice. "That's the low end of what I've heard," Litton said. *The Associated Press State & Local Wire, January 8, 2003.*

Tennessee

- Tennessee doctors are worried that their liability insurance premiums will force them to leave rural areas and cut down on services, as they have seen their colleagues in neighboring states do. Average liability premiums in Tennessee have increased 50%

in the last three years and will rise significantly again in 2003. *Chattanooga Times/Free Press, March 9, 2003.*

- Dr. Sigrid Johnson, a family practitioner in Sweetwater, reports that many obstetricians in Southeast Tennessee are leaving the area or refusing to accept high-risk patients. Since she continues to perform high-risk deliveries, she pays $18,000 a year for malpractice insurance. And she is facing a 15-20% increase in 2003. If she stopped accepting high-risk deliveries, her insurance would plummet to $4,000. *Chattanooga Times/Free Press, March 9, 2003.*

- In May 2003, Davidson County Chancery Court approved the state insurance regulator's request to liquidate three state-chartered liability insurers affiliated with Reciprocal of America (ROA), which is $209 million in debt and also in liquidation proceedings. These affiliates covered thousands of doctors, hospitals and lawyers, who may now be personally liable for any outstanding claims if ROA does not have money to pay them. *The Tennessean, June 5, 2003.*

- Awards in personal injury and wrongful death cases are dramatically increasing. Tennessee's Administrative Office of the Courts reported that in FY 2001, even though fewer cases were disposed of in Tennessee than in the previous fiscal year, damages awarded statewide were more than $94 million, representing an increase of more than $51 million over the previous year. These totals were the largest since the courts began reporting these statistics. *Administrative Office of the Courts.*

- According to the same report, the average award for FY01 was $209,284, up $95,064 from the previous year. *Administrative Office of the Courts.*

Texas

- In a survey of 615 physicians conducted in 2002 by the Texas Medical Association, 51% said they were planning to retire early because of liability-premium increases. *Austin Business Journal, June 9, 2003.*

- More than 70% of the physicians surveyed indicated skyrocketing premiums for medical liability insurance had caused them to increase "defensive medicine practices." About 40% said they were imposing new or tighter limits on patients they would accept, nearly a third said they were reducing the types or kinds of services they provide, and nearly one-fourth said they were seeing difficulty in recruiting or retaining physicians. *Austin Business Journal, June 9, 2003.*

- In 25 years as a physician, Dr. Tom Baxter of Houston has never been sued nor had a problem with the colorectal cancer screenings he performs for his patients. But in 2002, his liability insurance carrier said that he would have to pay $20,000 extra in premiums if he continued doing the screenings. This would be in addition to his existing premiums, which have quadrupled over the past 4 years. Baxter is proud to have diagnosed and successfully treated several patients with the disease. But it would cost him more to pay for the insurance than he generates in fees to do the test.

Thus, Baxter will refer his patients elsewhere for the screening—but he worries that this extra inconvenience will prevent many of them from following-up. Insurance costs are impacting the appropriate delivery of care. *Houston Chronicle, April 20, 2003.*

- Christus Spohn Health System in Corpus Christi saw a $7 million increase in their liability insurance premiums from FY02 to FY03, bringing their costs to $23 million. "It's put a tremendous burden on the health care system," explained Kathryn McDonagh, the system's president and CEO. "Think how much patient care could be provided (with $23 million)." *Corpus Christi Caller Times, April 20, 2003.*

- One of the three neurosurgeons in Texarkana has opted out of trauma care because of unaffordable medical liability premiums. This forced Wadley Regional Medical Center to give up its status as a trauma center as of July 1, 2003 because they will not have a neurosurgeon on-call 24 hours a day. Patients with severe head injuries will have to be transported to hospitals in Tyler, TX or Little Rock, AR. "The longer the interval between the injury and [surgery], the less chance they'll survive," says Darryl Coontz, director of the region's ambulance service. *Texarkana Gazette, April 24, 2003. Wadley Regional Medical Center press release, June 27, 2003.*

- After practicing medicine for 42 years, surgeon Dr. Bohn Allen of Arlington can no longer afford his malpractice premiums. His annual premium climbed 33% this year to $36,000, and he had to borrow money for his coverage last year. Dr. Allen laments: "I love operating. I love taking care of my patients. I have had a lot of anguish over [closing my surgical practice]." Allen said he has never been sued for malpractice. *Fort Worth Star Telegram, June 16, 2003. Dallas Morning News, March 13, 2003.*

- "To make up for this, doctors must see three times as many patients and work 100 hours a week to maintain their offices and keep up with liability insurance premiums that have increased by 400%," he said. *El Paso Times, June 13, 2003.*

- Some Rio Grande Valley doctors have seen malpractice insurance premiums rise as much as 400% in the past few years, an increase they associate with the multimillion dollar awards for which South Texas juries have become known. Hospital administrators say the problem is so acute they can't recruit doctors. *Associated Press, June 12, 2003.*

- One in four Valley doctors reported being sued between 1996 and 2000, and medical malpractice claims against Valley doctors are about 60% more frequent than elsewhere in the state. Many of the lawsuits are thrown out as frivolous, but not before doctors spend time and money defending themselves. *Associated Press, June 12, 2003.*

- Texas Medical Liability Trust president W. Thomas Cotton reported that an OB-GYN in North Texas pays $47,500 annually for $500,000 in coverage, while his Rio Grande Valley counterparts pay $82,300. Neurosurgeons pay even higher premiums. *The Dallas Morning News, January 20, 2002.*

- A February 2001 survey by the Texas Medical Association found that 1 in 3 Valley doctors say their insurance providers have stopped writing liability insurance. *The Dallas Morning News, January 20, 2002.*

- The survey reported that half of Valley physicians admitted to being inclined to leave the area or to retire. Some physicians are even hesitant to respond to a "code blue," which indicates a medical crisis, in a hospital. Dr. Carlos Cardinez, a gastroenterologist in McAllen, said he doesn't want to respond anymore because of the legal uncertainty. *The Dallas Morning News, January 20, 2002.*

- Over the past three years, medical liability insurance premiums have increased by 200% or more for many of the 36,000 doctors in Texas. From 2002 to 2003, the average premium paid by hospitals more than doubled. *Critical Condition; Texas Public Policy Foundation Report, April 2003.*

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

- Dr. Richard Wood, chief of heart surgery at Baylor University Medical Center, was left searching for a new insurer after the New Jersey company that had covered him for several years pulled its business out of the state. Despite having no legal problems, Dr. Wood expected to pay 5 to 6 times more than he has previously paid. *Dallas Business Journal, January 10, 2003.*

- In the past two years, four South Texas patients with head injuries died before they could be flown out of the area for medical attention. As reported in a July 10, 2002, article in *The Courier,* a community family practice clinic in Conroe (just north of Houston) was recently forced to turn away half of its normal patient load because its liability insurance provider would not provide coverage while "highly lawsuit-risky obstetrics training was conducted."

- In 1999, 17 companies offered malpractice coverage to doctors in Texas. Today, the field has dwindled to only four, and Texas is considered the least profitable state for liability carriers. *The Dallas Morning News, September 1, 2002.*

- "Dr. William F. Tucker, an orthopedic surgeon, figured he'd try to curb the cost of his malpractice insurance premium by abandoning spinal surgeries and reducing his emergency room calls. Both decisions cut down on his income but provided him with a greater sense of security as [liability] lawsuits against doctors become more common in Texas and the nation. Then came the shocking news that his premium would rise by 63% to $38,000." *The Dallas Morning News, January 20, 2002.*

- In South Texas, one jury awarded $43 million to a woman who claimed a diabetes drug damaged her liver, while another gave $15 million to three women who received hip implants. *The Wall Street Journal, May 1, 2002.*

- The second-highest premiums for obstetricians/gynecologists are paid in Houston, Dallas and Galveston, Texas, where the bills amount to some $160,746 a year. *Orlando Sentinel, January 20, 2002.*

- In Texas, about 85% of cases are closed without payment to plaintiff, yet they still cost money to resolve, said Texas Medical Liability Trust president W. Thomas Cotton. *The Dallas Morning News, January 20, 2002.*

- Insurance carriers in Texas paid more than $381 million in claims in 2000, according to the Texas Department of Insurance--costs passed on to policyholders. That's an 87% increase since 1995. Nationally, the median liability award more than doubled from 1994 to 1999, to $800,000. *The Dallas Morning News, January 20, 2002.*

- Texans filed 4,501 claims in 2000, up 51 percent from 1990, according to the Texas Medical Examiners Board. More troublesome is the rise in expenses involved in resolving a case. Each claim cost an average of $68,681 to litigate in 2000, compared with $46,079 in 1995. The figure does not include the amount of settlement or award. *The Dallas Morning News, January 20, 2002.*

Vermont

- According to the Vermont Medical Society, malpractice premiums are rising at such a rate that physicians could be forced out of the profession in Vermont. *The Associated Press, January 12, 2003.*

- Medical Mutual, one of Vermont's largest malpractice insurers, is proposing a 15% increase in premiums for Vermont physicians this year. A second large company, ProMutual Group of Boston, is raising its rates by 18.5%. *The Associated Press, January 12, 2003.*

- "It's the big losses, the big verdicts that are driving (the rates)," Dr. Patrick Dowling, president of Medical Mutual, said of his company's increase. *The Associated Press, January 12, 2003.*

- The failure of medical liability insurer, PHICO, which was shut down by the Pennsylvania Insurance Department on February 1 of 2002, left more than a quarter of Vermont's physicians plus four small hospitals and clinics scrambling for medical liability insurance. *AP State and Local Wire, February 24, 2002.*

Virginia

- Approximately 2,200 physicians have been trying to find coverage since their insurer, Doctors Insurance Reciprocal (DIR) collapsed in January 2003. *The Washington Post, May 10, 2003.*

- According to Lawrence E. Smarr, president of the Physician Insurers Association of America, "I do know we have doctors calling here literally every day looking for a new insurance carrier. Radiologists who are doing mammograms are having a particularly hard time finding new carriers." *The Washington Post, May 10, 2003.*

- Physicians in Virginia are starting to see the warning signs of a full-blown medical liability crisis that has engulfed their neighbors to the north in West Virginia, Pennsylvania and other States. The telltale sign is a sharp upswing in liability premiums. Over the past two years physician premiums have increased on average over 30 %. *Roanoke Times & World News, February 9, 2003.*

- For some specialists, medical liability premiums in Virginia have increased upwards of 60 % for this same recent two-year period. *Roanoke Times & World News, February 9, 2003.*

- A case in point is Manuel Belandres, MD, a general surgeon who was is in the twilight of his career but still practicing until recently when he was unable to obtain tail coverage. He subsequently closed his practice rather than expose himself to open-ended future liability. *Roanoke Times & World News, February 9, 2003.*

- A Roanoke physician quit practicing in January 2003 when his liability insurance premiums nearly quadrupled from $47,000 to $176,000 a year. *Roanoke Times & World News, February 9, 2003.*

Washington

- Dr. Barbara Pringle, her husband, and three of their obstetrician colleagues in Mount Vernon stopped practicing obstetrics due to their soaring liability insurance rates. "Of the nine obstetricians in our community, six have stopped delivering babies or left the area," Dr. Robert Pringle said. *New York Times, May 29, 2003.*

    - The Pringles have never been sued in relation to any of the 4,000 deliveries they have performed over the last 20 years. When he began his practice, Robert Pringle paid $1,000 a year for medical liability insurance. "Now it's in the neighborhood of $60,000," he said. *Puget Sound Business Journal. New York Times, May 29, 2003.*

    - Shannon Minor, one of the Pringles' patients, felt "lost" when she found out that her doctors would not be able to help her through her second pregnancy. "I was so upset about it," said Minor. "There were hardly any doctors available." Minor eventually found an OB 34 miles away in

Everett. In addition to increased waits for appointments, the distance created other difficulties for Minor: "For three months, I sat there and stressed and stressed . None of that would have happened at the Pringles . . . It was a rough haul." *New York Times, May 29, 2003.*

- A group of 10 neurosurgeons has been dropped by their medical liability insurer, creating a potential shortage of brain and spine surgeons around the Puget Sound region. The doctors, members of Neurosurgical Consultants of Washington, include four from Swedish Medical Center, two at Northwest Hospital, and others in nearby communities. Dr. Nancy Auer of Swedish noted that King County, with eight members of the consulting group, already has a low number of such surgeons relative to its population size. Only 2 of the 10 surgeons ever paid settlements or judgments for malpractice lawsuits, and most of the payouts were to defend doctors later cleared of wrongdoing. *AP State and Local Wire, May 31, 2003.*

- Dr. Bill Peters of Spokane said he had delivered 3,000 babies in his career, but as of Sept. 1, 2003 he would deliver no more. He said the insurance premiums for a delivery are $1,000 more than he receives for the job. *AP State and Local Wire, May 29, 2003.*

- Dr. Jay Rudd, an ophthalmologist and member of the Thurston-Mason Medical Society, has seen his liability insurance rates rise 75% in the past year. In addition to making it more difficult to sustain his own practice, explains Rudd, this makes it harder to recruit doctors to Washington. And this could limit patients' access to care. "I'll be able to go and find a job in Idaho or Oregon if it comes to that," Rudd said. "It's the patients who stay here and can't find a doctor that are going to suffer." *The Olympian, April 28, 2003.*

- Dr. Stephen Albrechy, a physician at Olympia Family Medicine, said his practice has seen a 35% increase in insurance costs from last year to this year. "We can't keep it up if it's 35% every year. It's not sustainable," said Albrecht. *The Olympian, April 23, 2003.*

- "Patients in many communities are finding that their physicians have either started limiting their services or have closed their doors completely due to rising malpractice premiums," said Dr. Maureen Callaghan, president of the Washington State Medical Association. *PR Newswire, Feb. 3, 2003.*

- "I went through my mourning and my grieving, and now I have to find a place for my [380] patients," said Dr. M. Person-Nydam, a South Send internist who has not been sued but can no longer afford liability insurance coverage. Last year she paid $1,000 in malpractice insurance for her part-time practice through Washington Casualty, a company that stopped providing malpractice coverage this year. "The only insurance I could get wanted $10,000 right now," Person-Nydam said. "That's pretty much my salary." *The Olympian, June 1, 2002.*

- Dr. Chuck Heffron stopped delivering babies in December, after 25 years as an obstetrician, as climbing malpractice insurance rates and decreasing payments for care sapped the viability of his obstetric practice. "I'm giving it up probably 10 years before I would have," said Heffron, who now works part time as a gynecological surgeon and pays $30,000 less in malpractice insurance than he did while delivering babies. *The Olympian, May 7, 2002.*

- The Steck Medical Group, which serves 60,000 patients in mostly rural Washington, was forced to close its doors for a few days this year because it could not find liability insurance coverage. It re-opened only after the state insurance commissioner intervened, but the new policy was at a 160% increase. *The Olympian, April 11, 2002.*

- Skyrocketing liability insurance rates forced Dr. Sarah Reade to close her internal medicine practice in Olympia. Reade, who treats about 500 patients, was told her malpractice insurance costs would more than quadruple -- from $5,300 a year to $30,000 a year. "I don't have it. I have to close my practice," said Reade. *The Olympian, March 18, 2002.*

- Between 2001 and the first half of 2002, the average paid claim at Physicians Insurance rose 48.5%. In 2001, in Washington alone, seven medical malpractice verdicts or settlements were reported in excess of $1 million; they totaled $44.7 million, ranging from $1.2 million up to $16.2 million. *Washington State Medical Education and Research Foundation Report, September 2002.*

- The state's major medical liability insurers have left the state in the last five years, leaving physicians scrambling to find competitive and affordable coverage.

    - In 1997, CNA pulled out of the Washington market, leaving about 1,100 physicians seeking coverage.
    - Late in 2001, Washington Casualty Company, then the second largest carrier for physician business in Washington state, decided to pull out of the physician market, leaving approximately 1300 physicians seeking coverage.
    - Shortly thereafter, St. Paul Insurance Company announced it would cease underwriting medical liability nationwide. This especially impacted hospitals, nursing homes, and various other health care facilities insured by the company. Nationwide, St. Paul had represented over $500 million in annual premiums. *Washington State Medical Education and Research Foundation Report, September 2002.*

- Washington's Supreme Court overturned the state's tort reform law in 1989. As a esult skyrocketing medical liability insurance premiums are forcing physicians to limit patient loads and services. *Sophie v. Fiberboard Corp., 771 P. 2d 711 (Wash. 1989).*

- "There is a growing crisis in medical malpractice in Washington state and nationally," state insurance commissioner Mike Kriedler said in an April 2002 news release.

West Virginia

- Dr. Jamal Khan, a Charleston heart surgeon, currently pays about $ 6,000 a month in premiums. Rising insurance costs made retirement more attractive to him that continued practice. During thirty years and 6,000 surgeries at Charleston Area Medical Center, Khan helped bring CAMC's cardiac program from small beginnings to national prominence. "In the old days, [older doctors] used to hang around, pass on their experience to younger people and still be involved," he said. Khan would have liked to stay around for the occasional procedure and perhaps to teach, but he said malpractice insurance costs made it financially impossible. *Charleston Gazette, June 2, 2003.*

- Fairmont OB-GYN Dr. Stanard Swihart, who had to borrow money from his retirement account to pay for medical liability insurance, is retiring from private practice. "It is a gut-wrenching decision for me to leave a practice I have helped to build over the last 27 years," Swihart said. Swihart will work for a VA hospital because the institution will cover his liability premiums. *Charleston Daily Mail, May 12, 2003.*

- The American College of Obstetricians and Gynecologists (ACOG) reports that medical liability insurance costs $182,600 annually for West Virginia OB-GYNs. This represents a 91% increase over their 2002 rates. Informal ACOG surveys show that, without liability reform, over half of all OB-GYN residents and a majority of private practice OB-GYNs planned to leave West Virginia. *Reuters, April 28, 2003.*

- Dr. Julie McCammon, an OB-GYN in Harrison County, has testified to a Harrison County Circuit Judge that an anticipated increase of her liability insurance premiums to $120,000 a year will put her out of business. "I've spent my life in this," said McCammon, who has been twice sued but has never been required to pay damages. "This is what I have done, and I have been penalized . . . My life has been ruined by the activities of the trial lawyers." *Clarksburg Exponent Telegram, April 4, 2003.*

- Charleston Area Medical Center has lost, and been unable to replace, 40 doctors in recent years, according to hospital president David Ramsey. In a survey conducted by the Charleston Gazette, 1/3 of 80 doctors who retired from or left area hospitals said medical liability insurance factored into their decision. *Charleston Gazette, March 5, 2003.*

- In early 2003, only two insurance carriers, plus the state-run Board of Risk and Insurance Management, wrote liability policies for West Virginia doctors. *Reuters, April 28, 2003.*

- General surgeon Gregory Saracco, MD, only 49 years old, was forced to borrow money twice in 2002 to pay $73,000 for his liability insurance. His premiums for 2003 are expected to rise to $100,000. He is considering leaving West Virginia and while he has taken time away from his practice this year to decide what his options are, he said "my job is to help people - couldn't drive past an accident on the road and not stop. I don't know any doctor that could." *Associated Press, Jan. 2, 2003.*

- According to the West Virginia State Medical Association, some 100 doctors have already retired early or moved out of the state within the previous two years. That has helped drive 1 out of every 20 doctors out of West Virginia or into early retirement in the past two years. *CNN, Jan. 2, 2003.*

- Although orthopedic surgeon George Zakaib, MD, grew up and went to school in Charleston, WV, he and his family left because of the state's medical liability crisis. Dr. Zakaib's premiums had increased to $80,000 plus $94,000 in "tail" coverage. *Charleston Daily Mail, July 27, 2002.*

- Fourth-year medical school student Jennifer Knight isn't sure she'll stay in West Virginia. The Charleston Area Medical Center says fewer medical students are applying to its residency programs, and fewer students are applying to Marshall University's medical school. "I think the problem is, we have too many frivolous lawsuits," said Ms. Knight. *Sunday Gazette-Mail, Nov. 24, 2002.*

- In 2002, the Charleston Area Medical Center (CAMC) was able to keep its level-I trauma center open only after agreeing to help surgeons pay their liability premiums. The one part-time and three full-time surgeons are paying $800,000 in liability premiums this year, according to a report in the April 25, 2002 *Charleston Gazette.*

- The Medical Liability Monitor reported that West Virginia surgeons paid premiums of $36,094 to $56,371 a year in 2001 -- the seventh highest in the nation. *The Charleston Daily Mail, August 29, 2002.*

Wyoming

- According to Stephen Brown, president of the Wyoming Medical Society, existing medical liability insurance rates may deter doctors from coming to the state to replace physicians who are leaving. Ken McBain, president and CEO of the Community Health Center of Central Wyoming, agrees: "The [liability insurance] rates are going to enter into the consideration of any physician when he looks at his options." *Casper Journal, June 5-11, 2003.*

- In May 2003, general surgeon Brook Redd, MD, moved his practice in Casper to a clinic in Minnesota. Dr. Redd, who had been in Casper for nine years, attributed the move to the increased cost of medical liability insurance. *Casper Star-Tribune, May 3, 2003.*

- According to Steve Bailey, chairman of Campbell County Memorial Hospital board's physician recruitment and retention committee, increasing medical liability premiums -20 to 30 percent a year- have made it tough to retain physicians. *The Associated Press, April 16, 2003.*

- Wyoming faces a medical liability crisis. Dr. Sarvjit Gill, president of Larimer County Medical Society (just across the border in Colorado) explained: "Torrington has lost its only general surgeon and Wheatland will soon lose its only OB doctor because the state has no cap on pain and suffering awards." *The Coloradoan, April 6, 2003.*

- Wheatland obstetrician Willard Woods, MD, says, "I love delivering babies...I really love delivering the babies of women I delivered a couple of decades ago. And I know this community needs an obstetrician. But you can't practice without [liability] insurance. And I can't get coverage for deliveries anymore." *The Washington Post, February 3, 2003.*

- Platte County has a population of less than 9,000 and only five doctors. Dr. Woods' inability to practice, as mentioned above, has left his patients in a lurch. According to patient Kori Wilhelm, "...you have to go to Cheyenne now – and it's a three-hour round trip –to get the specialized treatment we used to get right down the street at Dr. Woods' clinic." *The Washington Post, February 3, 2003.*

- Dr. Woods' partners, both family practitioners, have had their liability premiums increase sharply, even though neither of them has been sued. They are also struggling with the demands of being the only two doctors who can deliver babies in the area. *The Washington Post, February 3, 2003.*

- According to Dr. Wood's partner, Steve Peasley, MD, since Dr. Woods no longer practices obstetrics "...each of us has to be on call every other day. That means you can't leave town. You can't have a beer at the barbecue. And after a full day of regular practice, you get a call from the hospital at 3 a.m. saying somebody's in labor." *The Washington Post, February 3, 2003.*

- Doctors across the state say that they are thinking of relocating to another state where liability premiums are more affordable. *Wyoming Tribune-Eagle, January 28, 2003.*

- Due to the striking increases in liability premiums, as many as 25 out of 400 physicians say they are planning to stop practicing medicine in the state –either by retiring or moving to another state. *Wyoming Tribune-Eagle, January 24, 2003.*

- Brook Redd, MD, who practices in Riverton says that he will most likely accept a position in Steamboat Springs, Colorado. One of his main reasons for making the move is to lower his liability premiums. *Wyoming Tribune-Eagle, January 24, 2003.*

- According to Doug Schmitz, MD, of Torrington, one recent physician recruit accepted a job in South Dakota because his liability insurance premium was $8,000 a year compared to rates of $32,000 plus in Wyoming. *The Associated Press, January 23, 2003.*

- Gynecologist Jodi Kaigh, MD, of Casper, is seriously considering offers in other states because of the liability issue -- even though she loves living in Wyoming. *The Associated Press, January 23, 2003.*

- Jim Gardner, president of Wyoming Medical Center in Casper, said the hospital's liability rates recently increased from $400,000 to $1.7 million per year. Despite the increase, the hospital is trying to keep patient rates from rising. *The Associated Press, January 23, 2003.*

Mr. BURTON. Mr. Angoff.

Mr. ANGOFF. Thank you very much, Mr. Chairman, Congresswoman Watson.

I'm Jay Angoff. I'm a lawyer from Jefferson City, MO. I was the director of the Missouri Insurance Department between 1993 to 1998; and, Mr. Chairman, I'd like to start out by answering a question you asked to the first panel, which is, exactly what kind of data do the States collect at the department level and what kind of data does the NAIC collect?

As the representative of the GAO said, most States and the NAIC collect the data from the States, will collect data from the companies, as to their aggregate paid losses, their aggregate written premiums, their aggregate earned premiums, their aggregate incurred losses; but in general, the States do not collect case-by-case data, and I think that's what the GAO is looking for.

However, we did begin collecting case-by-case data in 1987. A law was passed requiring our insurance department to collect data on medical malpractice cases on a case-by-case basis, and so we've done that every year. In the 6 years that I was the commissioner, we had great experience. Filed claims went down, reported claims went down, and, in those 6 years, we had an excellent malpractice market. Rates generally stayed the same or even went down in certain years.

After I left the department, we continued to collect this data and we continued to have good experience, and in 2001, we had particularly good experience. Between 2000 and 2001, closed claims went down by 19 percent, filed claims went down by 31 percent, and the average payment per claim also went down. For example, in cases of very serious injury, such as quadriplegia and paraplegia, the average payment per claim went down from $325,000 to $250,000. So, between 2000 and 2001, filed claims went down, closed claims went down, the average payment per claim went down.

What do you think happened to malpractice insurance rates in 2002? Well, they went up. They went way up. Obviously, this cannot have anything to do with paid claims because those have gone down.

What it does have to do with is the insurer's estimates of incurred losses, and I'll get to a more technical explanation of that at the end of my statement. It's technical, so I'd rather not get into it and take the risk of putting everybody to sleep now, but it's just important to recognize that insurance rates are based on not the amounts that insurance companies actually pay out, but the amount that they project that they'll pay out in the future, and I'll return to that. So, in any event, that's what our data showed in Missouri.

Now, Mr. Chairman, you said and I know it to be correct from my own experience, that Indiana has very low rates, relatively low malpractice rates, and it also has a cap on noneconomic damages.

Other States also have very low malpractice rates, and they include Minnesota, Iowa, and North Dakota. Those States do not have caps on noneconomic damages.

I believe, Mr. Chairman—I don't pretend to have done any scientific study on this, but I believe it's cultural to a certain extent. I believe if a study was done, and maybe this is something that the

GAO would be very equipped to do, the factor that correlates the most with high losses, high paid claims, is percent urban. I think in the upper Midwest and Midwest—particularly in the upper Midwest—people are pretty conservative, juries are pretty conservative; and whether or not there's a cap, I think rates there are relatively low. So the main factor, I believe, that correlates with relatively high payouts is percent urban.

But that leads to the question, Mr. Chairman, what about California?

California, obviously, is a very heavily urban State, and I think that there's no disagreement that insurance premiums, malpractice insurance premiums in California since 1975, when MICRO was enacted, have increased at a substantially lower level, lower rate, than premiums across the country. But if you look at the data year by year, Mr. Chairman, what you see is that in the mid-1980's, despite MICRA, insurance premiums, malpractice premiums, in California shot way up, way up. They tripled between 1982 and 1988 despite MICRA's being in effect.

Then, beginning in 1989—1988 was the peak. Beginning in 1989, insurance premiums, malpractice premiums, began to fall and moderate; and they moderated so much that in 2000, 12 years after the peak in 1988, malpractice premiums were less, even without accounting for inflation, than they were in 1988.

So that leads to the question: What happened in 1988?

In 1988, in California—and obviously they do things differently in California—the public voted, enacted a very, very extreme regulatory measure, called Proposition 103, which heavily regulated insurance companies. It required prior approval of all rates. It required a hearing, an automatic hearing, anytime an insurance company asked for a rate increase of more than 15 percent. It repealed the antitrust exemption for the insurance industry, and it required all companies to roll back their rates by 20 percent unless they could show that they wouldn't be able to earn a fair rate of return under the rollback rate.

This is a very extreme initiative. It wouldn't have gotten off the ground in Missouri; I do not think it would have gotten off the ground in Indiana. But it passed in California. And there's no way to prove a cause-and-effect relationship, but you can prove the association, and the association is, after Prop 103 was enacted, malpractice rates in California went way down.

Just one or two other points, Mr. Chairman. Let me talk briefly about the difference between incurred losses and paid losses.

Paid losses, as the name indicates, they announced that insurance companies actually pay out of the incurred losses, which is the term, as you know, that is always used in the insurance industry, but to the layman it seems sort of misleading because these are the—these aren't really losses. They're the amounts that insurance companies project that they'll pay out in the future, and they may or may not actually pay out that much.

Now, when you saw the GAO's chart over there, it showed paid losses increasing at a moderate rate. If they used the medical CPI, it would have increased at a much more moderate rate, it would have been flatter; and if they take into consideration the growth in the number of doctors, it would have been still flatter. But those

are quibbles. Pay rates increase at sort of a moderate rate, but what you saw with the incurred losses is—they went like this: They went way up in the mid-1980's, and then today, in 2002, they went way up again. We won't know.

As you know, Mr. Chairman, we won't know whether the incurred loss estimates that insurance companies are making today are accurate for another 8 or 10 years, but what we do know is—we do know how accurate the incurred loss estimates insurance companies made in the mid-1980's were and we know—and that chart gives you a clue—we know that those estimates turned out to be way, way overstated, not necessarily because of any bad faith, but they turned out to be way overstated. And you can—and there's the reason we know; that is, the paid losses have now come in, so we can tell that the incurred loss estimates insurance companies made in 1986 and 1987. Based on those losses being paid over the next 10 years, we now know that those incurred loss estimates were about 30 percent excessive.

We won't know, as I said, whether today's loss estimates were excessive until 2012 or so, but based on past experience, I believe that they will prove to be excessive.

And I'd just like to conclude Mr. Chairman; I appreciate your patience. I guess I'd just like to conclude by saying, there are a lot of things the States can do to try to solve this problem, fewer that Congress can do. The reason is that insurance is the one industry which is regulated solely at the State level. That is a prerogative. The State insurance commissioners are very jealous of that, so there's not that much that Congress can do; but I guess whether it's Congress or the States that'll take this action, I think that the single most important reform that could be enacted is one which would set standards that insurance companies have to follow in making their incurred loss estimates, so that we wouldn't have these wild swings.

You know, there was—rates are going way up today, rates went way up in the mid-1980's, rates went up in the 1970's. We wouldn't have these wild swings. Doctors would be able to handle it much more easily.

Thank you, Mr. Chairman.

Mr. BURTON. We'll get to that, those questions, in a little bit, because I know how they set those reserves; and some of the companies do do that in an excessive way. But if you've got a State insurance commissioner and he's watching that, they can usually cope with that. But we'll talk about that in a minute.

[The prepared statement of Mr. Angoff follows:]

STATEMENT OF JAY ANGOFF

before the

Human Rights and Wellness Subcommittee

of the

House Government Reform Committee

on

Medical Liability Insurance Costs

October 1, 2003

Mr. Chairman and members of the Committee, my name is Jay Angoff and I am a lawyer from Jefferson City, Missouri. I served as insurance commissioner of Missouri between 1993 and 1998, and I have also served as deputy insurance commissioner of New Jersey and director of the Private Health Insurance Group at the U.S. Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). I appreciate the opportunity to testify here today on the question whether patients are needlessly suffering because of the high cost of liability insurance.

One way, and perhaps the best way, to answer this question is to seek to quantify any changes in access to health care and to determine the causes of access problems in states in which such problems have been reported. This is what the GAO did in its August 2003 Report entitled Medical Malpractice: Implications of Rising Premiums on Access to Health Care ("GAO Access Report"). As you know, the GAO found only scattered access problems in the five states it analyzed with reported problems, and it found that such problems typically existed only in rural areas and that there were long-standing causes of these problems. GAO also emphasized that reports of access problems were often exaggerated. It summarized its findings as follows:

> "GAO also determined that many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis. For example, although some physicians reported reducing certain services they consider to be high risk in terms of potential litigation, such as spinal surgeries and mammograms, GAO did not find access to these services widely affected, based on a review of Medicare data, and contacts with providers that have reportedly been affected."

The Executive Summary from the GAO Access Report is attached as Exhibit 1.

Another way to answer the question whether high malpractice premiums are a likely cause of access problems is to determine the percentage of doctors' incomes that is accounted for by malpractice premiums: the higher this percentage, the more likely it is that an increase in this percentage could result in a doctor restricting his practice in order to reduce his malpractice premium. The magazine Medical Economics publishes data relevant to this issue. For example, Medical Economics does an annual survey of doctors' incomes by specialty and by region, and has also done a recent survey of the average malpractice premium paid by specialty. In November 2002 Medical Economics found that the average doctor's net income--after malpractice premiums and other expenses--ranged from $146,601 for family practitioners without obstetrics to $362,208 for invasive cardiologists. See Exhibit 2. It also found that doctors' incomes were highest in the south, and lowest in the west: for example, the average gastroenterologist made $354,680 in the south, but only $251,252 in the west. See Exhibit 3. Medical Economics also found that malpractice premiums accounted for between 1.2% and 5.5% of a doctor's gross receipts, with cardiologists paying the lowest malpractice premiums as a percentage of their gross and ob-gyn's paying the highest. See Exhibit 4.

The Medical Economics surveys were conducted before the malpractice insurance increases of the last two years. As I will explain, these increases are likely to prove to be excessive, just as the malpractice insurance increases during the mid-1980's have proven to be excessive. Nevertheless, even assuming 100% increases in insurance premiums for all doctors since the Medical Economics surveys were conducted, and even assuming that no doctor's gross compensation increased, malpractice premiums today have reduced doctors' net incomes by only 1.2% (for cardiologists) to 5.5% (for ob-gyn's). Reductions

in compensation of these magnitudes--particularly when doctors' average net incomes range from $147,000 to $362,000--would not appear likely to have a material adverse impact on doctors or their patients.

Both the findings of the GAO and the level of malpractice premiums in relation to doctors' incomes indicate, therefore, that the level of malpractice premiums is not having an adverse effect on access to care. Nevertheless, there is no denying that malpractice insurance rates have increased sharply in the last two years, just as they did in the mid-1980's, and just as they did in the mid 1970's. To a certain extent, short periods of sharp increases in insurance rates are an inevitable result of the insurance cycle, as the GAO found in its June 2003 Report entitled Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates ("GAO Multiple Factors Report"). Nevertheless, Congress, state legislatures and state insurance commissioners can take certain actions to reduce these periodic sharp increases in rates and moderate the insurance cycle. They include the following:

1. Compress the rating categories, and more heavily weight experience within categories. Malpractice insurers typically charge the specialties paying the highest premiums--such as ob-gyn's--between 800% and 1300% of what they charge specialties paying the lowest premiums--such as psychiatrists and dermatologists. Conversely, malpractice insurers typically charge doctors with incidents no more than 200 to 300% of what they charge doctors with clean records. By reducing the differential in rates between categories and possibly combining certain categories, and by giving greater weight to experience within the categories, rates for doctors with clean records who are today paying the highest premiums--such as ob-gyn's--could be materially reduced.

2. Establish strict prior approval for both rate increases and rate decreases. In most states today malpractice insurers can implement rate changes--both increases and decreases--without first obtaining the approval of the state insurance department. Allowing insurers to unilaterally implement rate changes enables insurers to respond to competitive pressures, and made it easy for malpractice insurers to cut their prices during much of the 1990's when their investment income was high--which obviously benefited the doctors buying the insurance. On the other hand, the ability of insurers to increase their rates without first getting the insurance department's approval--particularly in

combination with the insurance industry's antitrust exemption--makes it easy for insurers to substantially raise their rates when their investment income is low, as is the case today. If conscientiously enforced by insurance commissioners, strict prior approval systems would moderate both price-cutting when investment income is high and price increases when investment income is low.

3. Require automatic hearings on any proposed rate increases of more than 15%. This is one of the many reforms included in California's Proposition 103, which was approved by the voters in 1988. It has had the practical effect of limiting proposed malpractice increases to less than 15%.

4. Repeal the antitrust exemption for the insurance industry. This is another of the reforms contained in California's Proposition 103. Insurers are exempt from the federal antitrust laws under the McCarran-Ferguson Act; in addition, most states both expressly exempt the business of insurance from their antitrust laws, and authorize conduct that would otherwise violate the antitrust laws in their insurance rating laws. Proposition 103 makes insurers subject to California's antitrust laws, as well as to its unfair business practices laws. While the effect of the antitrust exemption should not be overstated--it does not, for example, prevent insurers from cutting price when their investment income is high--it does permit insurers to raise their prices collectively when investment income is low. And Prop 103 does appear to have had the effect of reducing premiums: malpractice premiums tripled in California in the seven years before Prop 103 was enacted in November 1988, but thereafter they decreased, and even in 2000--12 years after the enactment of Prop 103--they were lower than they were in the year in which 103 was approved. See Exhibit 5.

5. Establish a state-authorized insurer to write medical malpractice insurance. Missouri established such an insurer for workers compensation insurance in 1994 with a $5 million loan from the state, and that insurer has been a success: it paid back its loan ahead of schedule, and it is now a significant player in the Missouri workers compensation market. It initially was exempted from certain solvency requirements in order to facilitate its growth, which was controversial; it is no longer exempt from such requirements. Establishing a state-authorized medical malpractice insurer would also be controversial, and might also require certain start-up exemptions. But it potentially could be a major player in a state medical malpractice market, just as Missouri's workers comp insurer is in the Missouri workers comp market.

6. Establish standards that insurers must follow in estimating their "incurred losses." Perhaps the most fundamental reason for periodic sharp increases in insurance rates is that insurers base their rates not on the amounts they have actually paid out in the past but on the amounts they estimate they will pay out in the future, and insurers have virtually unlimited discretion in determining those estimates. Thus, the rates insurers are charging today are based not on what they are paying out today, but on what they estimate they will pay out in the future for claims covered by policies in effect today. We therefore will not know whether the rates insurers are charging today are excessive until

they pay all the claims covered by policies in effect today--and that will not happen for another 10 years.

On the other hand, we do know today that the rates malpractice insurers charged during the last insurance crisis were excessive, since according to data from Best's Aggregates and Averages, the amount they predicted they would pay out on claims-made policies in effect in 1986 and 1987 turned out to be 26.4% and 31.3% more than the amount they actually paid out on those policies; and the amount they predicted they would pay out on occurrence policies in effect in 1986 and 1987 turned out to be 32.2% and 37.8% more than the amount they actually paid out on those policies. Or as GAO put it, "insurer losses anticipated in the late 1980s did not materialize as projected, so insurers went into the 1990s with reserves and premium rates that proved to be higher than the actual losses they would experience." GAO Multiple Factors Report at 44. We can not know definitively today whether the rates malpractice insurers are charging today are excessive: as GAO put it, "it remains to be seen whether these increases will, as occurred in the 1980s, be found to have exceeded those necessary to pay for future claims losses, thus contributing to the beginning of the next insurance cycle." Id. at 45. Nevertheless, based on the precedent of the mid-1980's--as well as the dramatic difference between malpractice insurers' actual current payouts and their estimated future payouts--no one should be surprised if in 2012 or so the rates malpractice insurers are charging today are revealed to be materially excessive.

In short, incurred losses fluctuate substantially year-to-year because insurers have virtually unlimited discretion in establishing their incurred loss estimates. The substantial fluctuations in these estimates, combined with fluctuations in investment income and reinsurance rates, cause substantial fluctuations in insurance rates. If states enacted standards that insurers were required to follow in establishing their incurred loss estimates, these fluctuations could be reduced.

In conclusion, the GAO Multiple Factors Report found that "the medical malpractice insurance market appears to roughly follow the same cycles as the overall property-casualty insurance market, but the cycles tend to be more volatiles," GAO Multiple Factors Report at 33, and that "the year-to-year increase in premium rates can very substantially because of perceived future losses and a variety of other factors, including investment returns and reinsurance rates." Id. at 43. Those findings are supported by the evidence, as is the finding of the GAO Access Report that malpractice rates are not substantially affecting access to health care. I have tried in my testimony to set out an alternative method of measuring the likely affect of malpractice rate increases

on access to health care, and to set out ways to moderate the insurance cycle so that periodic sharp increases in medical malpractice insurance rates do not continue to occur in the future as they have in the past.

I appreciate the opportunity to testify here today and I would be happy to answer any questions the committee may have.

Mr. BURTON. Mr. Joyce.

Mr. JOYCE. Mr. Chairman, thank you very much. And Ranking Member Watson, thank you. I appreciate the opportunity to be here.

I know time is short, and, as a former congressional staffperson, I know the golden rule to be brief, and I will attempt to do that.

At the outset, I'd like to associate myself with General Thornburgh and Dr. Nelson, in particular, in highlighting the problems that our health care liability system poses for patients, for physicians, and health care providers in general.

Let me just say, though, I would go even one step further and remind the subcommittee—and I would certainly say this to members of the State legislature, as well—that there are institutions in our health care system that are critical as well, that are facing similar problems. Hospitals rely on physicians to staff their emergency rooms, and trauma surgeons, as the chairman mentioned, are in short supply; and they are all feeling the pinch.

It extends even to nursing homes long-term care providers. They need medical providers. They need the top of the profession to assist them. Without those officials, they cannot provide the health care that we all expect and need. The whole continuum of care really is at stake here, and I encourage the subcommittee to take that into account.

We at ATRA are strong supporters of MICRA. We would hail that and do hail that as the benchmark and the model for State legislatures and for the Congress to consider as the civil justice reform for the health care arena. As other witnesses have said, there are other issues in health care, and certainly with respect to insurance, but I think the evidence is overwhelming that the excessive costs, as reflected in liability insurance for health care providers makes this a critical component of any effort to deal with health care in the Congress and at the State level.

Let me add, in terms of the picture Mr. Angoff talked about, California's experience. I think he made some interesting points, but I think it's instructive for the subcommittee to look at the history of MICRA and to look at the rise in insurance rates for health care providers in the aggregate, for physicians in California versus the rest of the country. From 1976 to 1999, California practitioners saw an increase of 167 percent. By craft, physicians in the rest of the country saw an increase of slightly over 500 percent, so roughly a three-to-one ratio. I think that, in and of itself, is quite compelling.

Mr. Chairman, you mentioned the disparity in costs that practitioners in Miami versus Los Angeles, in the OB/GYN field, experienced. A similar experience would be the case for a general surgeon. In Los Angeles, according to the Medical Liability Monitor in 2002, a surgeon would pay insurance premiums of $36,740; by contrast, in Miami, it would be just over $174,000. Again, this is money that has to come from somewhere, and while there may be other issues to deal with, clearly the experience of MICRA demonstrates that this is a powerful factor.

Let me mention also, because we've heard about the States, and we certainly are advocates of State civil justice reform, that Texas took a very aggressive step this year in following the lead of Cali-

fornia with the MICRA law and passed comprehensive legislation. But Texas did something else which is very important to keep in mind. Just as, I believe it was last week, Texas voters passed a proposition, Proposition 12, which cleared the way to ensure that a judicial challenge to the Texas medical liability law will not result in its being overturned.

We've heard about States' rights, and I would suggest respectfully to the subcommittee that there is a concerted effort by proponents of civil justice reform at the State level to undo what State legislators have done. It hasn't worked in every instance, but noneconomic damage limits in Illinois and Ohio have been overturned by State Supreme Court in those States, and that's something that again, as you contemplate your role in fashioning liability law, you should certainly keep in mind.

Let me mention also that with respect to tort reform, not every reform proposal will have an impact on insurance rates, certainly not immediately. We do not hesitate to say that when, in fact, that's the case and that has been the case. A proposal to limit punitive damages or simply to say that the standards should be raised to clear and convincing evidence will not have an immediate impact, in all likelihood, on insurance rates. However, limiting the outer—establishing an outer limit on noneconomic damages, I think common sense tells us, will in fact have that benefit.

Let me conclude by saying, Mr. Chairman, that you and Members of the House have taken the right step in enacting H.R. 5. That's a sweeping proposal and it addresses the issue, we think, in a balanced way. And we also want to commend you not only for covering doctors who clearly are the backbone of our health care system, but all segments of the health care community.

Many thanks.

Mr. BURTON. Thank you Mr. Joyce.

[The prepared statement of Mr. Joyce follows:]

TESTIMONY OF

SHERMAN JOYCE, PRESIDENT
AMERICAN TORT REFORM ASSOCIATION
WASHINGTON, D.C.

BEFORE THE

SUBCOMMITTEE ON HUMAN RIGHTS AND WELLNESS

OF THE COMMITTEE ON GOVERNMENT REFORM

UNITED STATES HOUSE OF REPRESENTATIVES

REGARDING:
Dying for Help: Are Patients Needlessly Suffering Due to the High Cost of Medical Liability Insurance?

ON

OCTOBER 1, 2003

Mr. Chairman, Representative Watson, and Members of the Subcommittee, thank you for inviting me to speak today on behalf of the American Tort Reform Association (ATRA).

ATRA is a Washington, DC-based membership association of more than 300 large and small businesses, physician groups, nonprofits, and trade and professional associations having as its mission the establishment of a predictable, fair, and efficient civil justice system through the enactment of legislation and through public education.

Introduction

There is no doubt that the American healthcare system is the finest in the world. We have the best doctors, hospitals, and medical schools. American pharmaceutical companies are the engine of innovation in creating life-saving medicines. America has conquered polio, developed cures for serious diseases that were once death sentences, and created technologies and therapies that have not only improved the American people's health, but also the world's.

Unfortunately, we also know that our healthcare system costs are a major issue for consumers and elected officials, with annual costs increasing at double digit rates. This increase threatens the very greatness of our healthcare system, and ultimately the American people's access to world class medical care. While elected officials at the federal and state level discuss possible solutions to this problem, be they medical savings accounts or a single-payer healthcare system, one of the contributing factors to the healthcare cost problem is the crisis in our medical liability system. ATRA believes that Congress should consider reforms to our medical liability system as one of the critical elements to reform our healthcare system.

The Problem: The Current Medical Liability System Is Inadequate

An effective medical liability system should provide predictability and fairness, guided by the over-arching principle of fairly compensating those who are truly injured by medical negligence.

Unfortunately, our medical liability system comes up short.

In our system, costs are escalating astronomically. According to *Jury Verdict Research*, a national verdict reporting service, the median medical liability verdict in 2001 was $1,000,000. The mean verdict was $3,902,058, an increase of 34 percent from 1998. As a result of this system, it was reported that in 2001 doctors practicing medicine in twelve states saw physicians' insurers raise their rates by more than 25 percent. Eight states saw rate increases by more than 30 percent.[1] As the *Sacramento Bee* correctly noted, healthcare costs and patient access are inextricably linked, "Every dollar in higher awards to people injured in malpractice will mean one less dollar available for care."[2]

In addition to sharp escalation in costs, however, the medical liability system is highly inefficient.[3] Prompt and full compensation to injured plaintiffs are the exception and not the rule. A full 70 percent of medical liability claims result in no payment to the plaintiffs. These claims, on average, cost $66,767 to adjudicate, further driving up healthcare costs.[4]

In addition to being expensive and inefficient, the system does a poor job of promoting patient safety. Only 1.53 percent of patients injured by medical error file claims and most claims that are filed do not involve medical

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[1] *See* AMERICAN MEDICAL NEWS, January 7, 2002.
[2] *Opinion*, SACRAMENTO BEE, June 5, 1999, at B6.
[3] Fifty-eight cents from every dollar recovered goes to administrative and defense costs, as well as attorney's fees. *See* COUNCIL OF ECONOMIC ADVISERS, WHO PAYS FOR TORT LIABILITY CLAIMS? AN ECONOMIC ANALYSIS OF THE U.S. TORT LIABILITY SYSTEM 9 (April 2002).
[4] *See* Karen Ignagni, *The Malpractice Mess; Runaway Litigation Is Plaguing Doctors and Hampering Patients,* THE CHARLOTTE OBSERVER, January 21, 2002, at 12A.

malpractice.[5] Such a system plainly fails to serve the interests of all parties to litigation.

Negative Policy Implications of the Status Quo

Doctors routinely order unnecessary tests and procedures to guard against the possibility of litigation in the aftermath of a bad outcome. According to a study published in the *Quarterly Journal of Economics*, the excess cost of defensive medicine contributes $50 billion annually to the cost of our healthcare system.[6] Through programs such as Medicare and Medicaid, the federal government pays tens of billions of dollars to pay the costs associated with defensive medicine. According to a recent HHS report, between $28.6 and $47.5 billion per year in taxpayer funds is spent indirectly subsidizing this system.[7] These increased costs in a financially overburdened healthcare system reduces both the access to and quality of healthcare. The root of this problem is an unpredictable litigation system where the volatile nature of jury verdicts provides no clear signals and predictability to healthcare providers and insurers.

Impact On Physicians

The current costs of the litigation system impose burdens on taxpayers and individual physicians. This compromises innovation in delivering improvements to patient safety. The result is a medical liability system that is too costly, offers little deterrent value, and, at best, does little to promote improvements in patient safety. For example, after 25 years of doing biopsies, lumpectomies, mastectomies and other breast surgery, Cleveland General Surgeon Dr. Joan Palomaki closed her practice on June 30, 2001, the day before

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[5] *See* OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING MEDICAL COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 11 (Jul. 24, 2002) [hereinafter "HHS REPORT (2002)"] .

[6] David Kessler and Mark McClellan, *Do Doctors Practice Defensive Medicine?* QUARTERLY JOURNAL OF ECONOMICS, May 1996, at 387-388.

[7] *See* HHS REPORT (2002), *supra* note 5, at 7.

the price she pays for medical liability insurance would have jumped 80 percent, to about $45,000 a year. Had she chosen to stay in medicine, Dr. Palomaki says she would have had to clock 1,000 office visits - about half a year's work - just to cover the cost of insurance.[8] And, in Mississippi, Gulf Coast vascular surgeon Dr. Alton Dauterive and his partner closed down their practice after they were scheduled to see their combined premiums double to $180,000 -- the second year in a row premiums would have doubled.[9] The irrationality of the system is too often driven by a litigation culture that is motivated by the pursuit of high verdict claims rather than by fair recovery for true medical negligence and the promotion of stability that benefits physicians, insurers, and most importantly, patients.

Patient Access to Healthcare is Compromised by Current Liability System

A survey of physicians showed that over 76 percent believed malpractice litigation affected their ability to provide quality healthcare.[10] According to the American Medical Association (AMA), 19 states are in the midst of a healthcare liability crisis, while another 23 states show problem signs that indicate a crisis is imminent. ATRA believes that this litigation environment has resulted in many physicians stopping the practice of medicine, abandoning high-risk parts of their practices, or moving their practices to other states. President Bush summarized the situation in his State of the Union Address in January saying, "Because of excessive litigation, everybody pays more for health care, and many parts of America are losing fine doctors."[11]

For example, on July 3, 2002, the only Level-1 trauma center in Las Vegas temporarily closed when trauma surgeons were unable to obtain insurance. As a

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[8] *See* Roger Mezger, *Insurance Costs Force Doctors To Quit*, THE CLEVELAND PLAIN DEALER, February 18, 2002 at A1.
[9] *See* David Tortorano, *Surgeons Set Walkouts Over Insurance,* THE SUN HERALD, January 21, 2003.
[10] *See* HHS REPORT (2002), *supra* note 5, at 4.
[11] *The President's 2003 State of the Union Address, Presented to the U.S. Congress, U.S. Capitol, Washington* (January 28, 2003) (statement of George W. Bush).

result, patients with serious injuries were to be flown to similar facilities in California and Arizona. Fortunately, the center reopened when the Governor temporarily reclassified trauma center physicians as government employees.[12] The Nevada Legislature later enacted modest reforms in response to this situation.

In December 2002, Doctors Hospital of Sarasota (Florida) closed its obstetrics unit. Deliveries were shifted to other area hospitals, including Sarasota Memorial which already had difficulty covering emergency room specialists, such as neurologists.[13] Statewide, 43 percent of counties in Pennsylvania have reached or are close to reaching a shortage of primary care physicians.[14] These examples are by no means unique; other states, such as Arizona, Georgia, Mississippi, and New Jersey also have experienced problems.

Solution

Fortunately, there are proven policy changes that Congress can enact to abate this liability crisis. These laws can ensure Americans will continue to enjoy high quality medical care. At the same time, these reforms will protect the rights of patients in cases of true medical negligence.

In fact, the solution to the medical liability problem was devised over 25 years ago in California with reforms called the Medical Injury Compensation Reform Act, better known as MICRA. Like much of the United States today, California experienced a medical liability crisis in the early 1970s. By 1972, a sharp increase in litigiousness ensured that California medical malpractice insurance carriers were paying claims well in excess of dollars that they collected

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[12] *See* Joelle Babula, *Liability Concerns: Trauma Center Closes; ERs Gear Up*, LAS VEGAS REVIEW JOURNAL, July 4, 2002, at 1A.
[13] *See* Corry Reiss, *Malpractice Debate Now A Blame Game*, SARASOTA HERALD-TRIBUNE, January 13, 2003, at A1.
[14] *See* Press Release, Pennsylvania Medical Society, New Study Provides Evidence of Doctors Going, Going Gone from Pennsylvania (June 11, 2003).

in premiums. The crisis continued to worsen. By 1975, two major malpractice carriers in Southern California notified physicians that their coverage would not be renewed. At the same time, another insurer announced that premiums for Northern California physicians would increase by 380 percent.[15] In response to the crisis, then-Governor Jerry Brown called the California Legislature into special session to develop solutions. The result was MICRA.

Signed by Governor Brown in 1975, MICRA's centerpiece is a single cap of $250,000 on noneconomic damages.[16] Other provisions of MICRA include: (1) allowing collateral source benefits to be introduced into evidence; (2) permitting the periodic payment of judgments in excess of $50,000; (3) allowing patients and physicians to contract for binding arbitration; and (4) limiting attorney contingency fees according to a sliding scale.

California – A Comparison

Evidence indicates that MICRA's success has stabilized insurance rates in California by limiting overall damages and by substantially diminishing the unpredictability – the volatility – of judgments.

- From 1976 through 1999, malpractice premiums in California rose 167 percent. In the rest of the country, premiums increased 505 percent;[17]
- Medical liability lawsuits in California settle on average in 1.8 years, while the same lawsuits in states without limits on noneconomic damages settle on average in 2.4 years -- 33 percent longer;[18] and

[15] *See* Californians Allied for Patient Protection, MICRA Information, July 1, 1995, at 10.
[16] Noneconomic damages are monetary awards intended to compensate the plaintiff for subjective losses such as physical pain and suffering, mental anguish, loss of body function, disfigurement, or emotional distress. This differs from economic damages which are monetary awards intended to compensate the plaintiff for objective quantifiable losses such as property loss, medical expenses, lost wages, or lost or impaired future earnings capacity.
[17] *See Patient Access: The Role of Medical Litigation Before a Joint Hearing of the United States Senate Judiciary Committee and Health, Education, Labor and Pensions Committee* (Feb. 11, 2003) (statement of Lawrence E. Smarr, President, Physician Insurers Association of America) [hereinafter "Smarr Statement"].
[18] *See* The Doctors' Company, What is MICRA?, available at http://www.thedoctors.com.

- Medical liability lawsuits in California settle for an average of $15,387; the same lawsuits in states without limits on noneconomic damages settle for an average of $32,714 -- 53 percent more.[19]

While these figures make the case that MICRA has worked, an even more compelling argument for its success can be made by comparing malpractice rates for California physicians with their counterparts in other major metropolitan areas of states without MICRA-style reforms.[20] For example:[21]

- A Los Angeles area internist pays $11,164; an internist in Chicago pays $26,404, and in Miami pays $56,153;
- A Los Angeles area general surgeon pays $36,740; a general surgeon in Chicago pays $68,080, and in Miami pays $174,268; and
- A Los Angeles OB/GYN pays $54,563; an OB/GYN in Chicago pays $102,640, and in Miami pays $201,376.

MICRA has ensured that those injured by medical negligence receive fair compensation, but it also has ensured that the market for medical liability insurance has remained stable and affordable. As a result, California has been largely immune from the liability crisis endemic to other states.[22]

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[19] *See* Californians Allied for Patient Protection, MICRA: A Successful Model for Affordable and Accessible Health Care, available at http://www.micra.org.

[20] The Florida Legislature passed medical liability reform, CS SB 2-D, during special session in August 2003. The bill contained a high cap on noneconomic damages. CS SB 2-D became effective on September 15, 2003.

[21] Rates are for 2002, $1/$3 million coverage as reported by MEDICAL LIABILITY MONITOR. Los Angeles rates reported from The Doctors Company, Chicago rates reported from ISMIE Mutual Insurance Company, and Miami rates reported from First Professional Insurance Company.

[22] In addition to the 25-year legacy of success enjoyed by California, other states have acted. Just this year, 10 states passed reforms to their medical liability systems. On September 13, 2003 Texas, took the added step of amending its state constitution to permit limits on damages. Unfortunately, personal injury lawyers in other states continue to seek to have medical liability reforms "undone" by activist state Supreme Courts, as happened in 1997 and 1999 in Illinois and Ohio, respectively. For this reason, insurers are often reluctant to roll back rates until they are certain that a particular state's medical liability statute will "survive" constitutional scrutiny, a litigation process that in California was not completed until 1985, a full ten years after MICRA was enacted.

Opponent Arguments Are Incomplete

Opponents of medical liability reform claim that the "access to healthcare" problem is a myth and that MICRA-style reforms are not the solution to rising malpractice premiums. One of the most common arguments they advance is that malpractice rates are increasing because insurance companies are making up for investment losses suffered in the stock market bubble in the late 1990s. They further argue that insurance carriers are gouging doctors with rate increases to boost profits.

A brief examination of the evidence, however, suggests otherwise. A report released by the investment and asset management firm Brown Brothers Harriman examined the investment mix of medical liability insurance carriers and the effect those investments had on premiums. The Brown Brothers report found no relationship between losses suffered by carriers in the stock market and rising premiums, "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."[23]

In addition, more than 60 percent of physicians obtain insurance through physician owned and operated companies.[24] These companies began to form in the 1970s when commercial carriers were exiting the medical liability insurance market due to unexpected losses, leaving healthcare providers no other options but to form their own insurance companies. These companies compete with commercial carriers and return excess revenue to policy holders, the owners of the companies. The contention that malpractice premiums are increasing in an effort to boost profits is, in essence, asking us to believe that a majority of doctors are "gouging" themselves and picking their own pockets. A reasonable

[23] Raghu Ramachandran, Brown Brothers Harriman & Co., Did Investment Affect Medical Malpractice Premiums? (January 21, 2003).
[24] *See* Smarr Statement, *supra* note 17.

examination can reach only one conclusion: medical liability insurance premiums are increasing because of higher costs and instability of our current litigation system, which does not allow carriers to accurately predict future losses and provide reasonable pricing of liability policies. Insurers price their product on cost and risk. It is logical to infer that a medical liability system that is more expensive and more volatile will necessarily be more expensive to insure.

Recently the Government Accounting Office (GAO) released a study examining the impact of the medical liability system on access to healthcare. The report acknowledges that states that limit noneconomic damages have enjoyed a lower rate of increase in medical liability insurance rates than states with more limited reforms.[25] As our opponents are quick to point out, however, the report also alleges that there is little evidence to suggest that states with no limits on damages have a healthcare access problem.[26]

The report is incomplete. GAO examined only a limited number of states, 5, and not the entire 18 in crisis, as identified by the AMA at the time that the GAO conducted its examination. It has never been ATRA's position that the effects of the medical liability crisis are uniform. Many variables drive the crisis, including the type of medical specialty, the physician's location (urban, rural, or suburban), and the overall litigation environment of a particular region. In some areas and among some specialties, the effects of the current crisis are minimal; in other areas, and many other specialties, the effects of the crisis are profound.

Conclusion

Members of Congress should examine the medical liability system and assess the effects that current cost escalation and litigation will have on the future. ATRA believes such an examination inevitably leads to the conclusion

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[25] *See* GOVERNMENT ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 6 (August 2003) [hereinafter "GAO Report (2003)."

[26] *See* GAO Report (2003), *supra* note 25, at 5.

that the costs associated with the current system are unsustainable and that MICRA-style reforms must be enacted. Such reforms are in the best interests of patients, taxpayers, physicians, and plaintiffs. As Californians can attest, strong medical liability reforms create a system that strikes the correct balance between fairly compensating victims of medical negligence with a liability market that stabilizes premiums for physicians. This reform will go a long way toward enhancing and protecting access to healthcare. Lawmakers should not wait to act until a full-blown crisis is verified by a government report. It is the responsibility of elected officials to take remedial and, if necessary, preventive action to ensure that such a crisis never occurs.

Thank you for your attention, and I would be happy to answer any questions.

Mr. BURTON. Mr. Tayoun.

Dr. TAYOUN. Chairman Burton, Ms. Watson, thank you for giving me the opportunity to speak. I am a board certified vascular and general surgeon in Philadelphia. I am president of the Politically Active Physicians Association, which formed approximately 1 year ago. I'm here to tell you—to kind of add a face to what is going on.

I first started my practice in 1997. I purchased medical liability insurance for $28,789. In 1 year, the same policy with no claims history increased to $44,000. To sum it up, between the years 1997 to 2001, my insurance increased over 500 percent. By the year 2002, with only two claims against me—both dropped, however—my insurance went to $133,000, and adding insult to injury, the insurance company that was providing me with this said, oh, by the way, we're going to leave the State. So I was left without insurance and looking for somehow, from anyone above—we formed the Politically Active Physicians Association to help legislators in our State, which is Pennsylvania, to take a hard look at what is happening, because when I leave, I leave thousands of patients behind who cannot follow me.

Now, I took some research and looked into where am I going to practice, because I cannot afford $133,000 and there is no insurance company at all for me. I looked into New Jersey, which is 10 minutes from where I practice now, and I found the same insurance company would give me a $34,000 policy. I found that if I went 20 minutes into a different State, Delaware, my insurance policy was quoted at $7,500—same surgeon doing the same surgical procedures with such a dramatic fluctuation.

There's a problem, and it's a problem that's across America and needs to be addressed on a Federal level, I feel.

I can go into multiple examples in our State of physicians who left, and our organization had put a poll out to 150 hospitals, asking for data on the youngest surgeon in the high-risk specialties because, as you might not know, and I'll explain to you, when a general surgeon enters the field right out of residency training it takes approximately 10 to 15 years for that surgeon to become honed, to be able to handle any emergency that comes into that hospital; and we do that by having senior surgeons directing us and guiding us and being able to bounce questions off of.

The problem is, most of the physicians in Pennsylvania now are 50 years or older. The orthopedic surgeons, less than 35 years of age, in Pennsylvania, are less than three.

The base of—the foundation of the whole infrastructure to the medical system in Pennsylvania has been gutted and ripped out and will fall; and when we do actually realize it and when it hits like—the hurricane actually hits, it's going to be too late to fix that; and it's going to take at least 30 years to get better physicians back.

We have world renowned institutions in Philadelphia. We train most of the doctors in America, but we cannot retain them. The Pennsylvania Medical Society has shown that Pennsylvania ranked 12th in youngest physicians in the country, and it's dropped to 41st in a matter—from 1996 to the year 2000. And we actually think we have zero in 2003, but they're still working on the study.

In short, who loses is not the doctor; it's the patient. Doctors can get up and leave. My patients cannot follow me. I take care of the needy. I take care of the elderly. They cannot follow me; and they've told me this time and time again. And with this, we've put together our organization to try to help educate our patients, to help our elected officials to do the right thing—in fact, nationwide tort reform which is needed to allow physicians to continue practicing in the needy areas and to help our elderly.

That's it.

Mr. BURTON. Thank you, Doctor.

[The prepared statement of Dr. Tayoun follows:]

October 1, 2003
"Dying for Help: Are Patients Needlessly Suffering Due to the High Cost of Medical Liability Insurance?

Presented by: Dr. James J. Tayoun,
1332 Ritner Street
Philadelphia, PA 19148

Chairman Burton and distinguished Ladies and Gentlemen of the committee, I thank you for your concern and interest into the malpractice crisis affecting America.

My name is James Tayoun; I was born and raised in Philadelphia where I currently practice surgery. I am a Board Certified General Surgeon and Board Certified Vascular Surgeon in private practice. I am Chairman of the Department of Surgery at St. Agnes Medical Center and Burn Center. I am Director of Vascular Surgery Fellowship at Philadelphia College of Osteopathic Medicine and serve as the president of the Politically Active Physicians Association.

I started my practice in 1997 and purchased Medical liability insurance for $28,789.02. In one year the same policy with no claims increased to $44,080.40. I changed companies in 1999 for a savings of $50.00 paying $43,980.40. This increased in the year 2000 to $54,639.60 followed by another increase in 2001 to $65,414.85. In short, just from 1997 to 2001 my insurance increased over 500%. By the year 2002, with two claims made but dropped by the plaintiffs, my insurance went to $133,437.69. Adding insult to injury my insurer also informed me they will no longer be offering insurance forcing me into what is called a "claims made policy".

At this point in my career, I researched other areas where I could obtain affordable insurance. I found I could get insurance from the same company that left Pennsylvania for $34,000 by moving my practice ten minutes from my present location into New Jersey. If I moved my practice twenty minutes into the state of Delaware, my rate was quoted at $7,500. How can it be the same surgeon, performing the same procedures but in different states face such a dramatic fluctuation in malpractice insurance?

The malpractice system is now propelled by runaway verdicts causing increases in frivolous lawsuits. This cause private insurance carriers to leave the state allowing for the few remaining to gouge the captive market of physicians. With this plight we turned to our elective officials for help. In Pennsylvania this was met with pessimism at first, followed by small attempts at relief. The legislative assistance was too little and too late. Because of that physicians in Pennsylvania realized that we can no longer stay on the sidelines and allow others to direct our profession. So in July of 2002, we formed the Politically Active Physicians Association (P.A.P.A.).

P.A.P.A. believes in preserving access to high quality healthcare. We will accomplish this goal by educating our elected officials and patients. We are now doing this by supporting those candidates who believe in this philosophy. In one year PAPA has grown to 5000 physician members and has now opened membership to non-physicians in the form of P.A.P.A. Auxiliary.

P.A.P.A. is recruiting a physician captain at every hospital in each municipality where we now have chapters. The captain will help inform and organize the physicians at their designated hospital and will connect with other captains through the county coordinator responsible for that region. P.A.P.A. is providing information and training to help members better educate their patients on the crisis effecting their access to quality health care. P.A.P.A. has formed a PAC, which now distributes literature supporting candidates who have won P.A.P.A.'s approval. These candidates fully understand the nature of the crisis or have shown that understanding through their actions in elected office.

Pennsylvania has eight medical schools and is home to world renowned universities training doctors in all specialties. Despite this great resource for developing young physicians, the state of Pennsylvania has dropped in rank from 12th in 1996 to 41st in the nation by the year 2000 for retaining young physicians. The age of the average practicing surgeon in Pennsylvania is now 50 years old. It takes a new surgeon approximately 15 years of practice, with the support of senior physicians on staff for guidance, to become seasoned, thoroughly competent and to skillfully meet any emergency.

To understand the crisis of no young physicians staying in Pennsylvania, P.A.P.A. sent a survey to 150 hospitals throughout the state requesting the age of the youngest physician in several different categories. The following charts represent the youngest physician actively on staff at 32 hospitals who responded.

Chart One represents the youngest general surgeons. Philadelphia's Mercy Hospital youngest surgeon is 54 years old. Philadelphia Mercy Hospital is located in a poor rural neighborhood. When a physician in Philadelphia does the same job as a physician in the Mayo Clinic, the Philadelphia physician is penalized by Medicare for being in a heavily populated region and their reimbursements are greatly reduced. I ask you, why should a young physician take a position where they will earn substantial less than most every other area in the country, and have the highest malpractice premiums?

Chart Two represents the youngest neurosurgeon. Out of the 32 hospitals responding only 15 had neurosurgeons actively on staff. Lower Bucks Hospital's youngest neurosurgeon is 55 years old, with Philadelphia Mercy Hospital and Mercy Fitzgerald, both in poor areas coming in a close second, with their youngest neurosurgeons being 54 years old. The malpractice cost have skyrocketed 1500% while reimbursements have decreased steadily from Medicare and private insurers. Again, I ask why would a young physician stay in Pennsylvania?

Chart Three represents the youngest urologist from the 32 hospitals who responded. 19 of the youngest physicians are over the age of 40, with Charles Cole Hospital's youngest urologist being 62 years old. Physicians have struggled for years to make ends meet with the continually decreasing reimbursements and climbing cost. Any reasonable person can see there are no young physicians choosing to set up practice in Pennsylvania.

Chart Four represents the youngest ENT physicians. Charles Cole is again hit hard with their youngest active physician being 59 years old. There are only 21 ENT's under the age of 40.

Chart Five is the most frightening. Of the 32 hospitals responding only 4 have a trauma surgeon available. If you have an auto accident in Pennsylvania, and your loved ones in the car, I pray its near one of these few hospitals that can still perform emergency trauma surgery. The youngest trauma surgeon at Robert Packer Hospital is 48 years old, but they count themselves as one of the lucky few, for having this skilled individual available for patients.

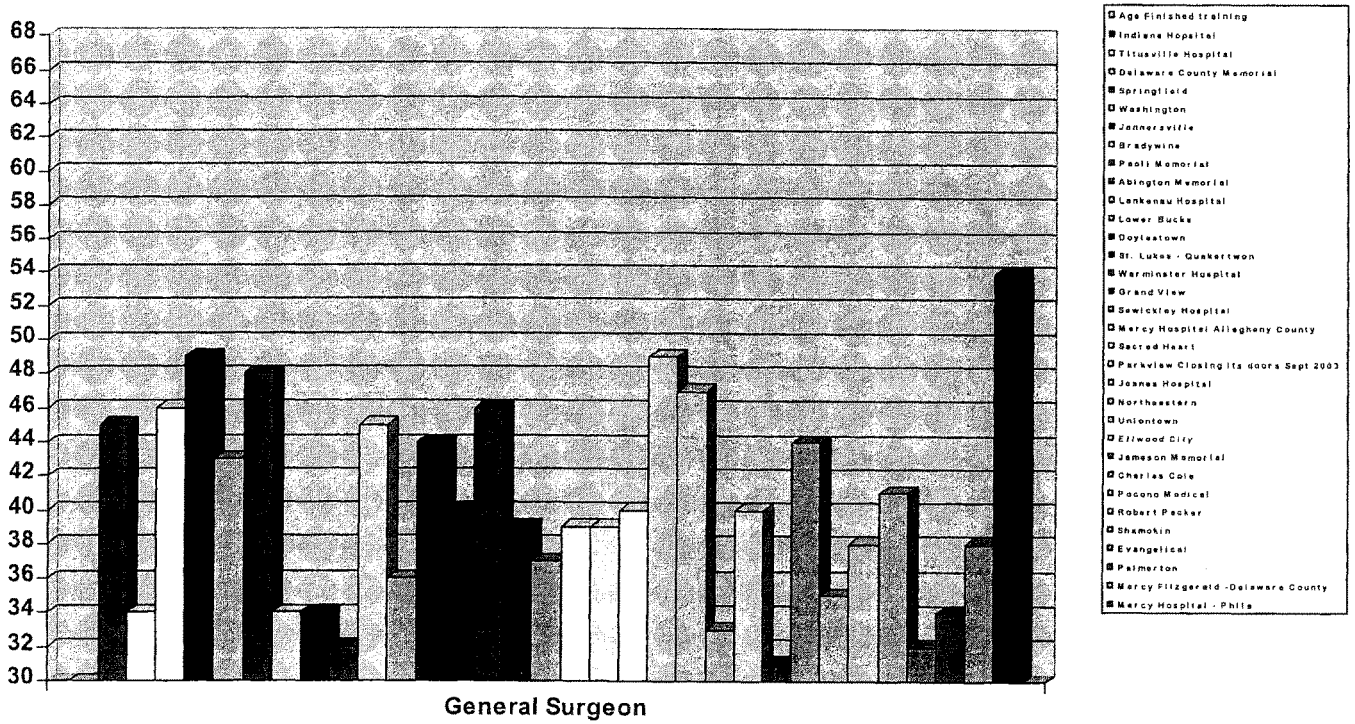
These numbers reveal the destruction of the very foundation of medical care being offered in Pennsylvania. Once this base is removed, there is no possible way to build or continue world renowned medical care, training and education. Our state and nation loses.

The present tort system offers no solution. It punishes the innocent patients and doctors. The current system offers no improvement to the way medicine is practiced. It raises cost by increasing the amount of tests and consults ordered, many which are not clinically necessary, but will protect you from losing a frivolous law suit.

It is time for you to mandate by legislation patients need not to have their doctors forced out of practice because they can not afford existing premiums. We need the most obvious fact turned into legislation; caps on non economic damages.

I have watched excellent physicians leave the hospitals at which I practice. I have watched hospitals decrease services to the communities in which they serve.

And the one fact, I ask you all to note that is going unnoticed, is physicians can leave but patients can not. Pennsylvania has the second oldest population in the country. The senior citizens do not have the resources to follow their physician across state lines. It is the elderly and needy throughout America who will suffer.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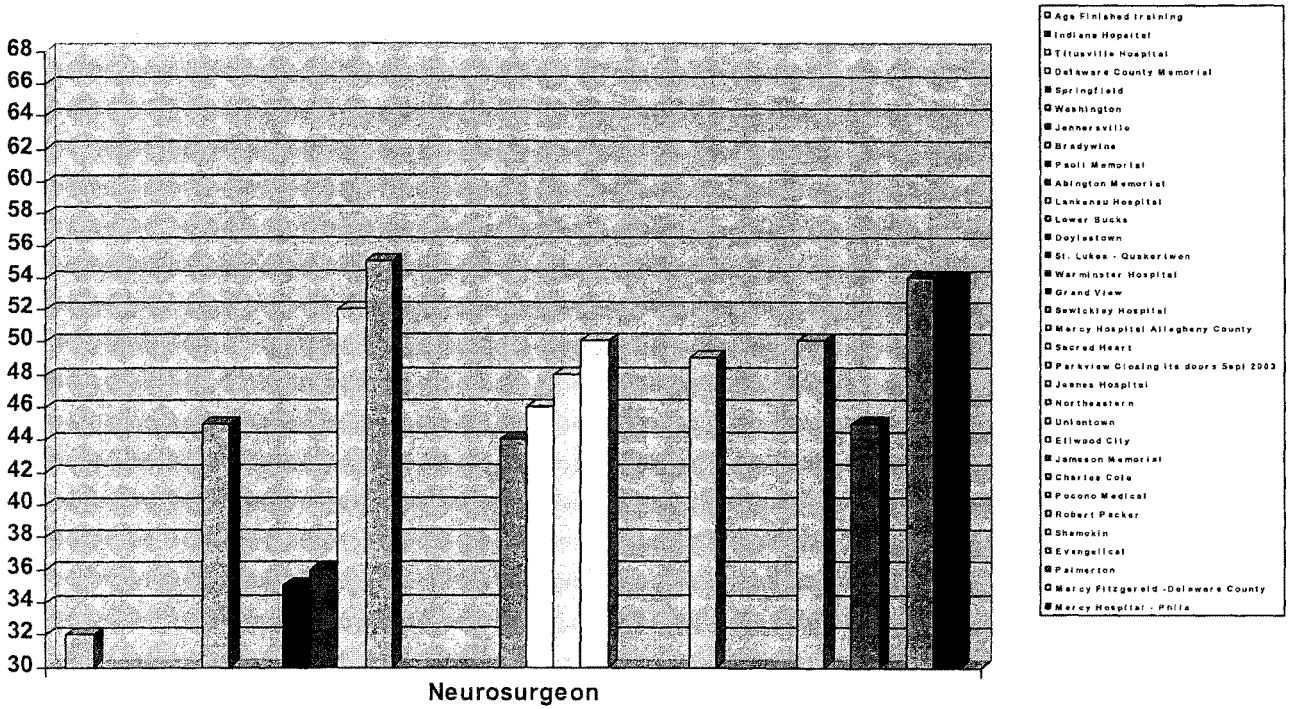
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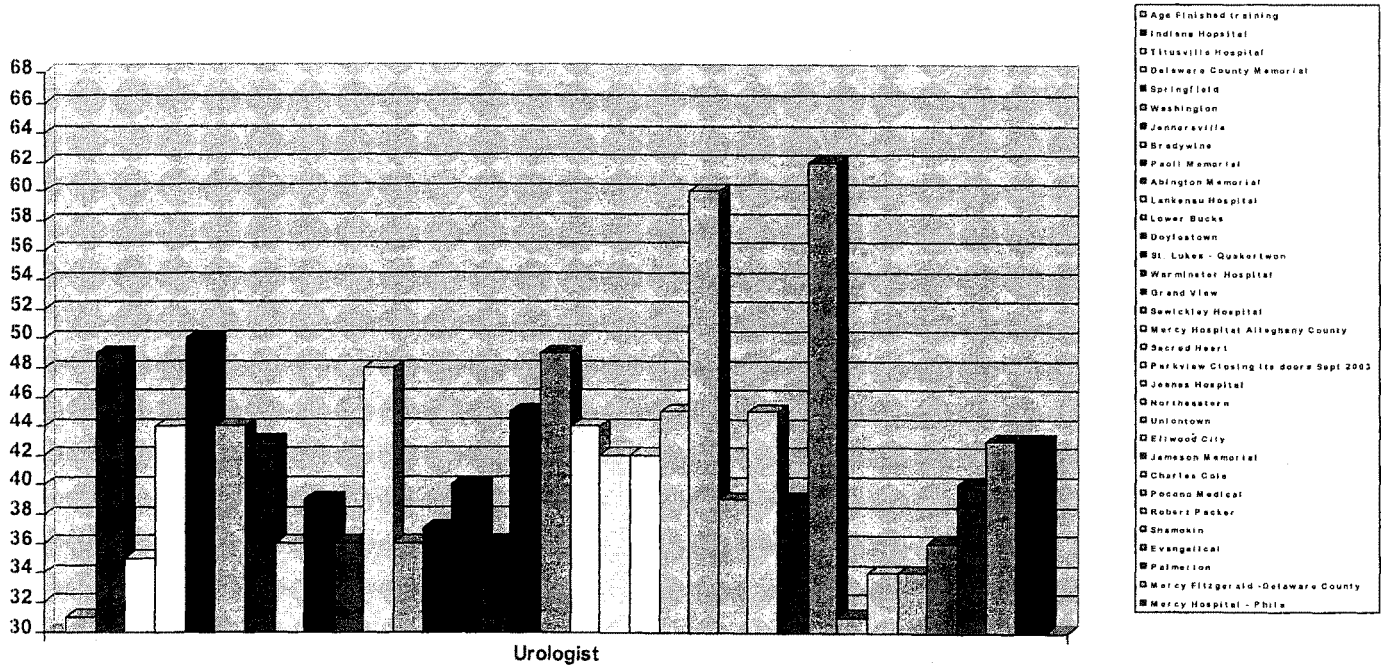
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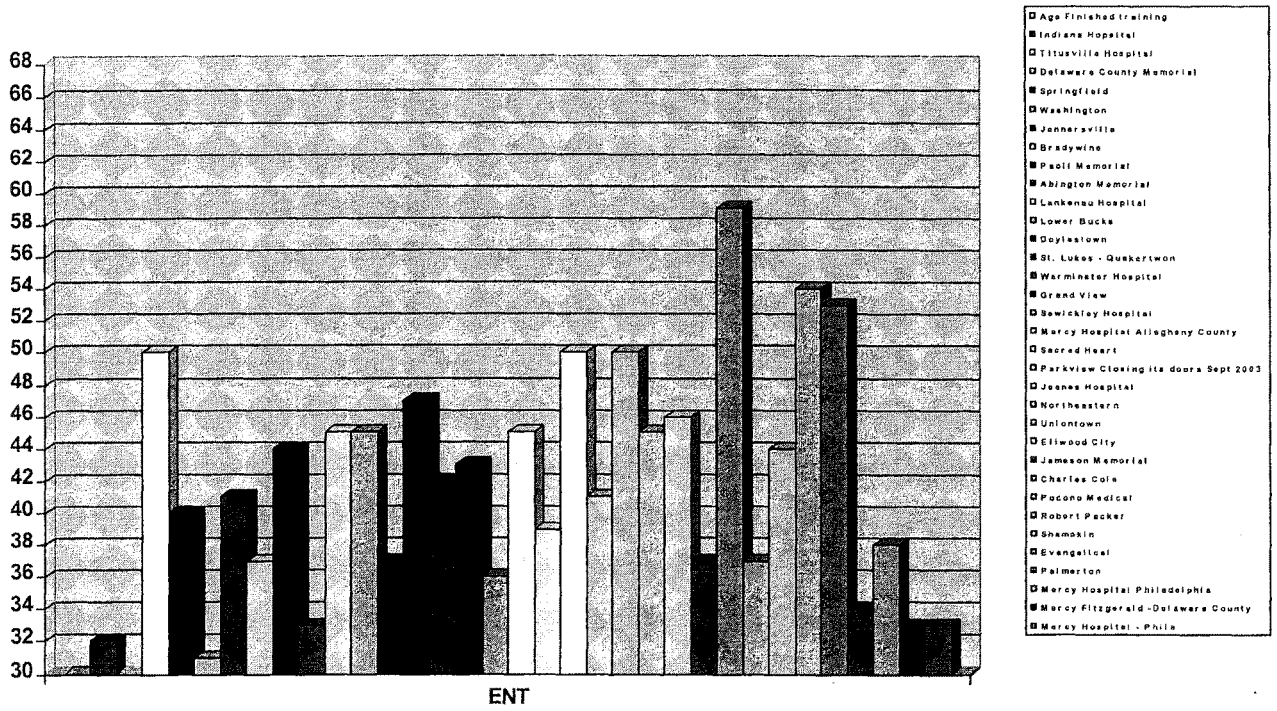
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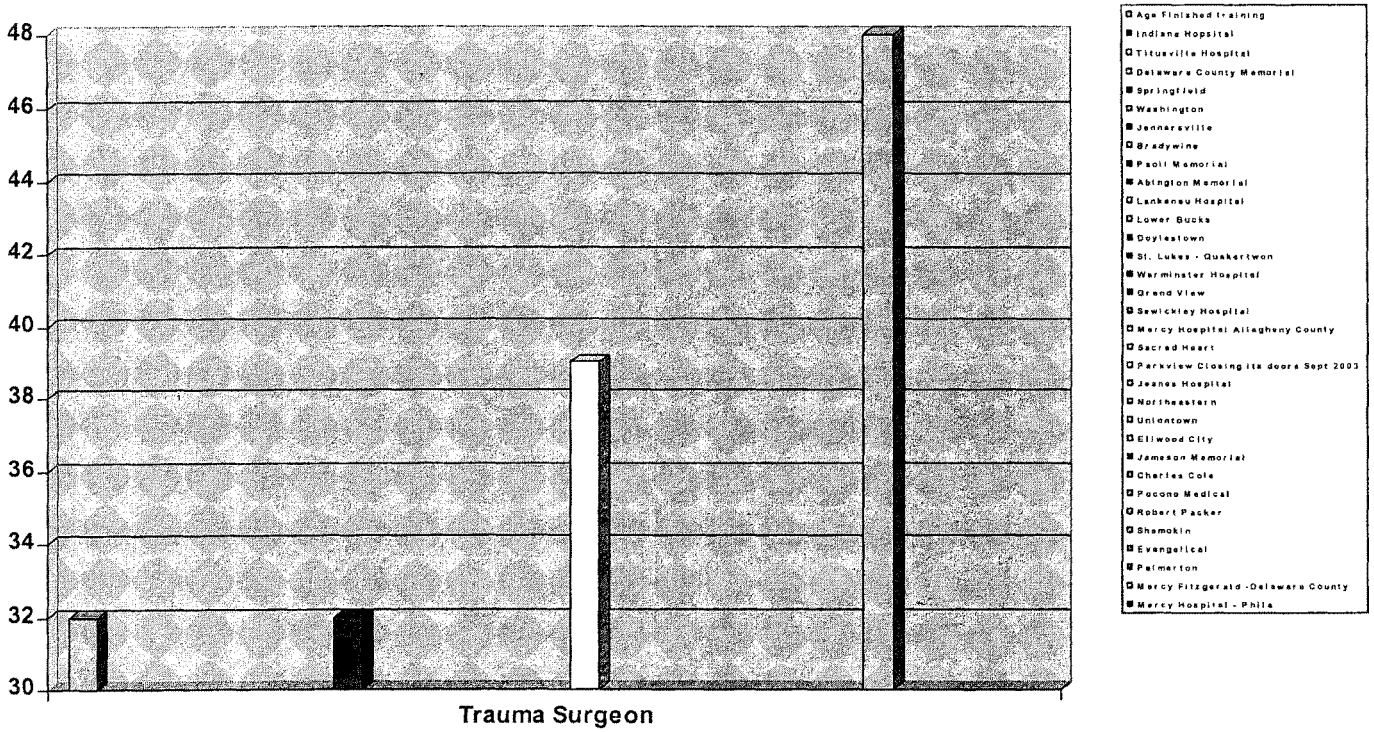
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Mr. BURTON. I want to thank all of you.

Let me start with you, Doctor. What kind of political pressures have you had to deal with in getting tort reform passed through the Pennsylvania legislature?

Dr. TAYOUN. We have had to hold rallies, we have had to stop working to protect up at Harrisburg. We've pushed and fought. We've had our patients on buses with us at different locations. We've organized the cities from Philadelphia to Harrisburg to Pittsburgh, and we finally got legislation passed through the house of representatives, which is now in the senate and stalled.

The problem with Pennsylvania is, we have a constitution which has to be changed first before anything can be enacted, so we're running out of time rapidly.

Mr. BURTON. You have to have a constitutional amendment?

Dr. TAYOUN. Sure, to allow caps in Pennsylvania.

Mr. BURTON. Is that right?

Dr. TAYOUN. Yeah.

Mr. BURTON. And that takes, what, two sessions of the general assembly?

Dr. TAYOUN. Yes.

Mr. BURTON. And then it has to go to the electorate?

Dr. TAYOUN. Yes.

Mr. BURTON. So that's a 6- or 7-year problem, and in 6 or 7 years what would happen?

Dr. TAYOUN. Too late.

Mr. BURTON. Too late. So what you're making, by saying that—and I don't know if that's the case in other States or not, but if that's the case in other States, if you wait 6 or 7 years, the people in that State are going to be without the kind of medical personnel that they need to take care of their health care needs?

Dr. TAYOUN. Correct. Out of the 32 hospitals that responded to our poll, 4 of them had trauma surgeons left.

Mr. BURTON. And if that happens, then it would take how long for you to recover if, finally, the State did deal with it?

Dr. TAYOUN. If the State did deal with it, it would take at least 20 years because it's going to—for the average surgeon coming out of residency, it takes him at least 10 to 15 years under senior, experienced surgeons to help them become polished, so I don't know if you could ever get back to that point, especially in the rural areas of Pennsylvania.

Mr. BURTON. So you make a very strong case that we need some kind of Federal legislation that would circumvent the——

Dr. TAYOUN. State.

Mr. BURTON [continuing]. State legislative problems.

How about the rest of you? Can you tell me what kind of problems that you face?

I'll get to you on reserves in a minute.

Can you tell me of any other States that are having similar problems, as far as getting——

Mr. THORNBURGH. Yeah, this is purely anecdotal, and this is 10 years or so, but I've been kind of a missionary around this State for civil justice reform in general.

Understandably, trial lawyers and plaintiffs' lawyer groups have amassed sizable war chests to resist reform. I would refer you to

a publication of the Manhattan Institute, issued last week, called Trial Lawyers, Inc., which lays out in great detail what those efforts have encompassed. And I have worked with reform groups at the State level in a number of areas to try to enact reform.

Often, when successful, as Mr. Joyce noted in Ohio and Illinois, the supreme courts of those States struck down the reforms as unconstitutional. And I cannot help but note how much effort from the Trial Lawyers Association goes into the election of judges and supreme court justices.

Mr. BURTON. So because of these impediments that were talked about by Dr. Tayoun and you, you feel that—you know, I believe States' rights ought to be paramount, but at some point, if you cannot get something done and the public health is jeopardized, you have to do something at the national level.

Mr. THORNBURGH. I think that's a very practical reason why Federal action is necessary, in addition to the nationwide characteristics of the problem.

Mr. BURTON. We have some votes coming in.

Ms. Watson, let me just recognize you.

Ms. WATSON. Yes.

I'm going to just raise these questions and then go on to the floor. Maybe the response can't be in answers.

It seems like you have a problem in Pennsylvania. You know, from what I'm hearing, the doctor there and Mr. Thornburgh, you have described that Pennsylvania's in trouble.

Dr. TAYOUN. So's Florida.

Ms. WATSON. Florida and Pennsylvania.

Mr. THORNBURGH. We happen to be here by random, but I think if you had representatives from most of the other 49 States, you would hear——

Ms. WATSON. Well, I have a chart here, and we talk about States in crisis, States that are showing problem signs, and States currently OK. My State, California, seems to be currently OK because we had been working for years to deal with the problem.

But the way it has been presented here, that there's some real serious problems in Pennsylvania, I'm wondering what are the component factors that make up the serious crisis that you've got in Pennsylvania, that's No. 1; and No. 2, is tort reform the solution to lowering the premiums? Because I just heard, by the gentleman in the center there, that even with the incidents going down, the premiums still went up.

So if there is an answer to that question, would you please give—it may be in writing—to us. And you can reach me through my office because I'm going to—Rich, I'm going to fly because I understand we have three votes, and that's all the votes for the day.

Thank you very much, Mr. Chairman.

Mr. BURTON. Well, let me pose a couple more questions here and make a comment. The problems that you cited, Governor, in I believe it was Ohio and Illinois—was that it?

Mr. THORNBURGH. Yes.

Mr. BURTON [continuing]. Where the supreme court struck down legislative action, leaves them in a hopeless situation as far as dealing with the problem. Pennsylvania has another situation. Those are just three States right there.

And, Dr. Nelson, you were talking about Florida?

Dr. NELSON. Yes, sir.

Florida's a problem. Mississippi's a problem.

There's a sign on the highway near Tupelo, MS, the home of the largest rural hospital in the country, that says, "Buckle your seat belt; the next neurosurgeon that will help you is in Tennessee."

You know about the story of the circumstances in Las Vegas. West Virginia, little 9-year-old kid gets knocked out in the football game. Not a doc from the State will see him. Has to be airlifted to Columbus, OH.

It goes on and on, and that's why we need a Federal solution. Florida is dying. $300,000 is how much one doctor had to pay, a cardiothoracic surgeon.

$200,000 a year for premiums for my specialty? That's more than I make, Mr. Chairman. I couldn't afford to do that.

Mr. BURTON. And, if you didn't have insurance and you had a claim, you could lose everything you own.

Dr. NELSON. Yes, sir.

Now, things are different in Utah, you have to put a multiplier there. I only pay $72,000, but I make a third less than the doctors in Florida. My premiums doubled in a 2-year span with no suits or threat of suits against me——

Mr. BURTON. And doctors are not going to stay in a State where the insurance is so high they cannot afford it. They're going to leave rather than jeopardize their assets.

Dr. NELSON. Yes, sir, which is why a Federal solution is necessary. Patients go from State to State, doctors go from State to State, and the wisdom of your solution, H.R. 5, would give flexible cap.

Mr. BURTON. Regarding the reserves you're talking about, sometimes companies do set excessively high reserves, there is no question about that. Those reserves should be policed by the State insurance commissioner, and that's something that has to be done on an individual basis.

But with all these problems that they're talking about, Mr. Angoff, and I understand that California dealt with it, it wasn't because of the proposition you talked about; it was because of tort reform they passed a long time ago. But I won't get into a big debate with you, because I think probably you and I have a difference of opinion, but go ahead and make a quick comment.

You'd better make it brief because we're going to have to go on the floor and vote.

Mr. ANGOFF. The reason I say it's Prop 103 and not MICRA is that until Prop 103 was passed and only MICRA was the law, rates still went way up. They tripled in 7 years.

Mr. BURTON. But I don't want to have a big debate about that.

Mr. ANGOFF. And, Mr. Chairman, I agree with you. The insurance commission should police reserves. They try to. They're not always successful. And at certain times insurance companies—I mean, insurance companies can have an incentive to inflate their reserves both in times like this, when investment income is low, when interest rates are at 1 percent. We've also got tax reasons to inflate their reserves.

On the other hand, they've also got a reason to understate their reserves. For example, when companies are in trouble——

Mr. BURTON. I understand.

Mr. ANGOFF [continuing]. Then they've got an incentive——

Mr. BURTON. You're preaching to the choir. That was my business, so I understand everything you're saying, but I've just got a little disagreement with you.

Let me say this to you: We've passed this in the House and we'd like to be able to educate our colleagues in the Senate, who may not be influenced by large amounts of pressure.

What I'd like to have from each one of you is maybe a very concise statement about the situation that you face in Pennsylvania, the situation you talked about in Illinois and Ohio, the situation you talked about in Mississippi and Florida. If you could give that to me, what I'll do is I'll talk to some of my colleagues in the House who feel sympathetic to your situation and try to send a Dear Colleague and a joint letter to my colleagues in the Senate to encourage them to take another look at this bill and try to get this thing passed.

I had some reservations, quite frankly, about the bill when it was in the House. The reservation I had was, what if somebody was severely damaged by a doctor and it was a lifetime problem for them. But my fears were allayed because the damages were going to be paid. It was pain and suffering that had the limits on it.

So I am very sympathetic to you. I would like to help you. I do not think there's much more we can do in the House at the present time unless the Senate acts, but what I'll do—Mr. Angoff may not agree with me, but I will forward to my Senate colleagues your recommendations and make sure that they get it, which might help us get some of it done.

Because then, of course, we've got the problem—you know, Governor—with the conference committee, because they're probably going to make some changes. And then we'll have to fight that battle in the conference committee.

And, Mr. Angoff, at the conference committee, perhaps some of your arguments can be heard and thrown into the mix.

Anyhow, thank you very much, I really appreciate it. I'd like to have—I sincerely would like to have your comments in a very brief letter that I can put into a Dear Colleague to my colleagues in the Senate.

Thank you very much for being here. I really appreciate it. It's been very informative. Thank you.

[Whereupon, at 3:45 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

A Coalition of 13 Medical Societies Representing 170,000 Specialty Physicians in the United States

John D. Barnes, *Chair*
jbarnes@aad.org
(202) 842-3555

Gordon Wheeler, *Vice-Chair*
gwheeler@acep.org
(202) 728-0610

For more information contact:

Katie Orrico, American Association of Neurological Surgeons
202-628-2072; korrico@neurosurgery.org
Kathy Pontzer, American Academy of Orthopaedic Surgeons
202-546-4430; pontzer@aaos.org

Statement

of the

Alliance of Specialty Medicine

Before the

House Government Reform Wellness and Human Rights Subcommittee

On the Subject Of

"Dying for Help: Are Patients Needlessly Suffering Due to the High Costs of Medical Liability Insurance?"

Tuesday, October 1, 2003, 2:00 pm
2154 Rayburn House Office Building

Dying for Help: Are Patients Needlessly Suffering Due to the High Costs of Medical Liability Insurance?

Chairman Burton, and Members of the Subcommittee, the Alliance of Specialty Medicine, a coalition of 13 medical organizations representing 170,000 physicians in the United States, thanks you for holding this hearing and appreciates the opportunity to comment on the causes of the medical liability insurance system and the impact that our current medical litigation system is having on patient access to medical care. The Alliance would also like to take this opportunity to thank you, and other House members, who voted for HR 5, the Help, Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act, which passed the House of Representatives earlier this year. We believe that the reforms contained in HEALTH Act will go a long way to solve the current medical liability crisis.

And it is a crisis. The media now report on a daily basis that the situation has become so critical that many physicians are forced to limit services, move to other states where the medical liability system is more stable, or retire altogether. Much of the "face" of this crisis has centered around the great difficulties that pregnant women are having in finding obstetricians to deliver their babies, but the simple truth is that this is a problem that potentially affects all of our citizens: the mother whose little boy has fallen off of the jungle gym and needs an orthopaedic surgeon to fix his broken arm; the teenager who has been in a serious car accident and needs a neurosurgeon to treat his severe head injury; the woman who needs a pathologist to evaluate her Pap smear to screen for cervical cancer; the elderly man who has a poor heart and needs a cardiologist or cardiothoracic surgeon to unblock a clogged artery or replace a failing valve; the woman who has a family history of breast cancer and needs a radiologist to perform a mammography to make sure she is cancer free; the business man who needs a gastroenterologist to treat his ulcer; the man who needs a urologist to screen for prostate cancer; and the list goes on and on.

Cause of the Crisis: The Current Medical Litigation System is Out of Control

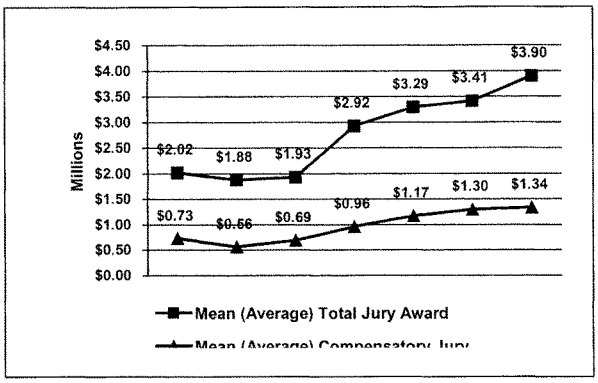
The root cause of this problem is quite simple: the unrestrained escalation of jury awards and settlements, in even a small number of medical liability cases, is driving up doctors' liability insurance premiums and is forcing some insurance companies out of business altogether. This problem is making it difficult, and sometimes impossible, for doctors to obtain affordable liability insurance so they can remain in practice. There is a wide body of evidence to substantiate these conclusions:

- **Medical Liability Awards are On the Rise**

  Medical liability awards have been growing steadily, and according to Jury Verdict Research data, from 1994 to 2000 the median jury award rose by 176 percent. The number of mega-verdicts is also on the rise, with the proportion of million dollar plus awards increasing dramatically over this same time period. In 1996, 34 percent of all jury awards exceeded $1 million. Four years later, the number of million dollar awards increased to 52 percent, and the average jury award in 2000 was nearly $3.5 million.

  Not only are total jury awards rising, but the non-economic damage portion now accounts for a steadily increasing proportion of these awards. According to Jury Verdict Research, from

1995-1997 the proportion of non-economic damages compared with the total award was relatively constant. However, beginning in 1998 and continuing through 2001, non-economic damages accounted for a significantly higher amount of total jury awards.



Finally, overall medical liability tort costs are rapidly increasing, and far outpace the growth in medical costs generally. For example, according to the Insurance Information Institute, from 1990 through 2000, medical liability costs rose 140 percent, which is more than double the 60 percent increase in general medical costs measured over the same period. From 1975 through 2000, medical liability costs exploded by 1,642 percent, as compared to a 449 percent increase for general medical costs.

- **Medical Liability Insurance Premiums are Skyrocketing**

A June 2003 General Accounting Office (GAO) report, entitled "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," confirms what we already know: increased losses on claims are the *primary* contributor to higher medical liability insurance premium rates. Indeed, according to the Insurance Information Institute, which analyzed data from A.M. Best (an independent insurance rating agency that analyzes insurance companies' overall financial strength and creditworthiness), the cumulative underwriting loss for the medical liability insurance sector from 1990-2001 was nearly $10 *billion* and medical liability insurance companies are now paying out approximately $1.40 for every premium dollar collected.

Obviously, this situation is not sustainable, and this trend is therefore forcing insurance companies, which must set their rates based on anticipated future losses, to steeply increase doctors' medical liability premiums to ensure adequate reserves to pay future judgments. As a result, over the past several years, physicians across the country have faced double, and sometimes triple, digit rate increases. Alliance members, including high-risk specialists like neurosurgeons, orthopaedic surgeons, cardiothoracic surgeons and emergency physicians, have been disproportionately affected by these premium increases. For example:

- According to one national survey of neurosurgeons, between 2000 and 2002 the national average premium increase was 63%, from $44,493 to $72,682. A subsequent study found that from 2001 to 2003, premiums rose from an average of $55,500 to $84,100. In some states, neurosurgeons are now paying medical liability insurance premiums in excess of $400,000 per year.

- Utah orthopaedic surgeons have seen medical liability rate increases of 60% since last year and in Texas they are rising by more than 50 percent. In Pennsylvania, a survey conducted in June 2002 revealed rate increases as high as 59 percent. In other areas of the country, orthopaedic surgeons are finding that their premiums have risen by over 100 percent, even if they have never had a claim filed against them.

- Over the past several years, over 95 percent of emergency medicine physicians have experienced medical liability premium increases, with approximately 69 percent facing increases between 60 to 500 percent. This is attributed to the fact that emergency medicine physicians are almost always named in any litigation that arises from a patient encounter that begins in the emergency department. Since most hospital admissions now come through the emergency department, these doctors are experiencing steep premium rises even though the lawsuits against them may have no merit and result in either dismissal or a defendant's verdict.

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

➢ **Medical Liability Insurance is Unavailable**

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

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

- In 2002, nearly 40 percent of orthopaedic surgeons in Pennsylvania were not able to renew their medical liability coverage with the same carrier and 31 percent did not find new coverage. Close to 50 percent of Pennsylvania orthopaedic surgeons have reported that their liability policies will not be renewed for 2003.

- In 2002, 15 percent of dermatologists experienced difficulties securing their liability insurance. In some cases, dermatologists in solo practice who have never even been sued were forced to turn to the state for coverage because the remaining insurers in their area made a blanket decision to no longer insure solo practice physicians, regardless of specialty.

- A recent study found that in the last two years, nearly 33 percent of surveyed neurosurgeons have switched insurance companies, and of these, 41 percent did so because their insurance company failed or withdrew from the market. Today in Mississippi, the only way a neurosurgeon can even be considered for coverage is if he or she joins an existing group that already is covered by the state medical society's insurance company. The other two companies providing insurance coverage in Mississippi will not issue new policies for neurosurgeons at all. In addition, neurosurgeons in Florida have been unable to obtain medical liability insurance at any cost, forcing them to "go bare" or self-insure. Across the nation, even those neurosurgeons who only have one claim against them (regardless of the outcome of the case) are finding it impossible to find insurance coverage.

- Recently one internationally-recognized pathologist, who has never had a claim filed against him, was turned down by three insurers and a fourth offered him a policy that was simply too expensive.

- Three of four insurance carriers with the largest market share in Missouri have stopped writing policies in that state. This means that physicians can often obtain a quote from only one company. For example, one group of 12 cardiologists could get only one quote with an 80 percent increase for 2003.

Result of the Crisis: Patient Access to Medical Care is in Jeopardy

There are many casualties of the current medical liability crisis – but those affected the most are patients. Because the medical litigation system is broken, across the nation patients are finding it harder and harder to get access to the care they need, when they need it. As medical liability insurance becomes unaffordable or unavailable, more and more doctors, especially specialists, are no longer performing high-risk procedures, or they are being forced to move their practices to states with stable medical liability systems, or they are simply retiring from medical practice -- all of which seriously impede patient access to care. According to one recent study of neurosurgeons, over 70 percent of survey respondents made at least one of the following practice changes: referring complex cases, closed practice, moved to different state, stopped providing certain services, stopped providing patient care and/or retired.

The combination of these factors is also now severely straining our nation's already stressed emergency medical system, as patients who have no access to doctors inevitably end up on the emergency department's doorsteps, further exacerbating the hospital emergency department overcrowding problem. This particular problem was confirmed by a September 2003 Center for Studying Health System Change report entitled, "Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places."

Despite the overall conclusions of the August 2003 GAO Report entitled, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care" (asserting, in part, that the rise in medical

liability insurance premiums have not affected access to care on a widespread basis), a growing body of evidence does in fact demonstrate just how serious this crisis has become:

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

  - The August 2003 GAO report did confirm that rising medical liability insurance premiums have contributed to reduced access to emergency surgery services, particularly in rural locations, in the five states it reviewed (Florida, Mississippi, Nevada, Pennsylvania and West Virginia) because certain high risk specialists like neurosurgeons and orthopaedic surgeons are no longer serving on-call to hospital emergency departments.

  - According to a nationwide survey conducted last year, 43 percent of neurosurgeons reported that they are no longer performing high-risk surgery such as treating brain aneurysms, removing brain and spinal tumors, or complex spinal surgery. In addition, many neurosurgeons are no longer serving on-call to hospital emergency departments or operating on children. In one recent case in Illinois, a patient died searching for available neurosurgical care because there were no neurosurgeons available to treat emergencies at several suburban Chicago hospitals.

  - A recent survey found that 55 percent of orthopaedic surgeons nationwide have reduced the type of operational procedures they perform, with 39 percent avoiding performing spine surgery and 48 percent altering their practice in other ways, including eliminating emergency room call or trauma call.

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

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

  - The August 2003 GAO Report also confirmed the closure of several trauma centers in the five states that it reviewed, acknowledging that patients with emergency medical conditions often had to travel great distances to receive emergency medical care.

  - Recent press accounts are replete with stories about the closure of trauma centers in Pennsylvania, West Virginia, Nevada, Mississippi, Missouri and Florida because of a shortage of orthopaedic surgeons, neurosurgeons and other specialists available to provide emergency medical care. Chicago's trauma centers are also now vulnerable to closing or downgrading their status.

  - In the case of neurosurgery, in 2001 alone, 327 board certified neurosurgeons retired, representing an alarming 10 percent of the neurosurgical workforce in the United States. Recently, 31 out of 79 surveyed neurosurgeons in Missouri stated that they were weighing early retirement. Indeed, one Missouri neurosurgeon closed his practice rather than pay a $500,000 annual liability insurance premium, forcing two hospitals to cease providing emergency neurosurgical care.

- In the last 18 months, nearly 700 mammography facilities have closed nationwide. The continued and steady closing of mammography facilities throughout the country has led to increased waiting times for women seeking both screening mammograms and diagnostic mammograms. The longer waiting times are now on the brink of affecting clinical outcomes for those women who must wait for a possible diagnosis of breast cancer.

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

Every state that is experiencing a medical liability crisis reports that doctors are leaving in droves in search of another location in which to practice where the medical litigation climate is more favorable. The list of states experiencing the exodus of doctors continues to grow, and as with other elements of this crisis, specialists are most likely to "hit the road" in search of a safe haven state. For instance:

- Pennsylvania has been especially hard hit, and some counties no longer have any practicing orthopaedic surgeons. For example, Bedford County's only orthopaedic surgeon left the state in October 2001, and Pike and Monroe Counties are down from nine to five orthopaedic surgeons. Huntingdon County has just one orthopaedic surgeon remaining to take trauma call at two hospitals. The situation is the same in West Virginia, and a number of orthopaedic surgeons either have left the state or are scaling back their practices. At the end of 2002, five orthopaedic surgeons in Parkersburg moved their practice to Ohio.

- Neurosurgery's survey data show that nearly 19 percent of practicing neurosurgeons either plan to, or are considering, moving their practice to another state where the medical liability costs are relatively stable. Mississippi, for instance, has lost 35 percent of its neurosurgeons in the past two years. This year, 21 out of 79 neurosurgeons surveyed in Missouri stated that they were considering leaving the state, and the flight of neurosurgeons from Pennsylvania and West Virginia mirrors the Mississippi and Missouri experience.

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

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

- Medical licensure data is in no way indicative of the number of physicians actually practicing medicine in a particular state. Rather, it merely means that a certain number of physicians hold a license to practice medicine. Physicians tend to hold multiple state licenses and typically retain their licenses when they relocate or retire from active practice. Thus, taken alone, medical licensure data provides no useful information to prove or disprove the affects of the medical liability crisis on physician supply.

- According to a July 2003 study conducted by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, entitled "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians," states that have

enacted laws capping damage payments in medical liability cases have more physicians per capita than those who have no cap or very high damage caps. The study found that in 1970, before any states had a law capping damage payments, in all states there were virtually identical levels of physicians per 100,000 citizens. Thirty years later in 2000, however, states that had adopted a cap averaged 135 physicians per 100,000 citizens, while states without caps averaged 120.

- A May 2003 study conducted by the U.S. Congressional Joint Economic Committee, entitled "Liability for Medical Malpractice: Issues and Evidence," concluded that "the number of doctors at the state level is sensitive to the malpractice insurance costs: higher premiums reduce the number of practicing physicians."

➢ **The State of America's Health Now and in the Future is at Risk**

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

- When patients can't find a specialist close to home, they must sometimes travel great distances, often going out of state, to get their medical care.

- When fewer specialists are available, hospital emergency departments and trauma centers must shut their doors, and patients with emergency medical conditions lose critical life-saving time searching for an available emergency room.

- When specialists stop performing high-risk medical services, patients are often referred to academic medical centers, and these medical facilities are already overburdened and are ill equipped to handle the increase in patient volume.

- When specialists retire at an early age, the looming shortage of doctors is accelerated, which, if left unchecked will place additional burdens on the health care system as the population ages and requires more medical care from an increasingly shrinking pool of practicing doctors. Once gone, these doctors are hard to replace, and those states currently facing a medical liability crisis are having a difficult time recruiting new physicians to their communities adding to the shortage of doctors in many parts of the country.

- When the practice of medicine becomes so uninviting, fewer and fewer of our nation's best and brightest will want to become doctors, thus jeopardizing our country's status as one of the finest health care systems in the world.

Scope of the Crisis: A National Problem that Requires a Federal Solution

Those who oppose federal legislation to address this crisis cite various reasons to support their contention that this is not a national problem that merits a federal solution. In particular, they note that the regulation of insurance and health care are generally state issues, and therefore principles of Federalism preclude federal legislation to address this problem. They are, however, wrong. The

undisputed truth is that this problem now touches nearly every American and a federal solution is therefore a national imperative. As the following demonstrate:

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

  The AMA has identified 19 states that are in a medical liability crisis for all physicians. These include: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia and Wyoming. For many high-risk specialties, like neurosurgery and orthopaedic surgery, the situation is even more widespread than the AMA reports. A 2002 national survey of neurosurgeons identified 25 states that are in a severe medical liability crisis, with an additional 12 states in potential crisis. In addition to those identified by the AMA, the crisis states for neurosurgery include: Alabama, District of Columbia, New Hampshire, South Carolina, Rhode Island, Tennessee, Utah and Virginia.

- **Every American Pays for the Costs of the Current Medical Litigation System**

  According to the U.S. Department of Health and Human Services (HHS), in its report entitled, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System," the current medical litigation system imposes enormous direct and indirect costs on the health care system. These costs are passed on to all Americans in the form of increased health insurance premiums, higher out-of-pocket medical expenses and higher taxes. The report estimates that enacting federal medical liability legislation could save between $60-108 billion in health care costs each year. These savings would in turn lower the cost of health insurance and make health care more affordable and available to many more Americans.

- **Federal Medical Liability Reform Will Save the Federal Government Money**

  Each year, the Federal Government pays for the increased costs associated with the current medical litigation system through various health care programs, including Medicare, Medicaid, Community Health Centers and other health care programs for veterans and members of the armed forces. Citing the findings of the Department of Health and Human Services and the Congressional Budget Office's (CBO) cost estimate of HR 5, the HEALTH Act, the Congressional Joint Economic Committee concludes that federal medical liability reform legislation that includes a cap on non-economic damages would generate significant fiscal savings for the Federal Government. The combined annual budget savings attributed to decreased direct costs (i.e., medical liability insurance premiums) and indirect costs (i.e., defensive medicine) would total approximately $12.1 billion to $19.5 billion. Over a ten-year period (2004-2013), a total of between $67 billion and $106 billion in savings would accrue to the federal government, if medical liability reform legislation were passed.

- **States Face Significant Barriers to Implementing Medical Liability Reforms**

  Many states face barriers – some legal and some political -- to enacting effective medical liability reform laws. Some states, including Florida, Ohio and Pennsylvania, have enacted medical liability reform laws, only to have their state Supreme Courts strike them down as unconstitutional. New laws passed by Mississippi and Nevada face certain court challenge, and it will be years before it is determined whether these laws pass state constitutional muster. Finally, in some other states, the issue has become a political one, effectively killing any chances for passage. As a

consequence, despite the increasing medical liability crisis in many of these states, they are effectively powerless to act to effectively solve the problem.

Solution to the Crisis: Medical Liability Reform Legislation Patterned After California's MICRA

Fortunately, Congress does not need to start from scratch and identify and implement a solution that is untested. Faced with a similar crisis in the early 1970's, the state of California, with bipartisan support, enacted the Medical Injury Compensation Reform Act or MICRA. The key elements of MICRA include:

- Providing full compensation for all economic damages, including medical bills, lost wages, future earnings, custodial care and rehabilitation;
- Placing a fair and reasonable limit of $250,000 on non-economic damages, such as pain and suffering;
- Establishing a reasonable statute of limitations for filing a lawsuit;
- Allowing for periodic payments of damages rather than lump sum awards; and
- Ensuring that the bulk of any award goes to the plaintiffs, not the attorneys

The clear and simple truth is that MICRA works. For nearly three decades, this law has ensured that legitimately injured patients get unfettered access to the courts and receive full compensation for their injuries, while at the same time providing stability to the medical liability insurance market to ensure that doctors can remain available to care for their patients. Other states, including Indiana, have also seen the value of MICRA and have enacted similar laws, which have proven to be equally effective in addressing the medical liability problem.

Consider the following points about the effectiveness of MICRA:

➢ **MICRA Fully Compensates Injured Patients**

First and foremost, under MICRA, patients receive full compensation for legitimate injuries resulting from medical negligence. Detractors of federal reform legislation are attempting to obfuscate the facts by scaring the public and policymakers into believing that injured patients will only receive a maximum of $250,000 to compensate them for their injuries. This is simply not the case. Patients receive full compensation for all of their quantifiable needs, with up to an additional $250,000 for non-economic damages, such as pain and suffering. To demonstrate this fact, the Californians Allied for Patient Protection recently compiled a sample of total awards (including both economic and non-economic damages) provided to injured patients. For example:

December 2002
$84,250,000 total award
Alameda County
5 year-old boy with cerebral palsy and quadriplegia because of delayed treatment of jaundice after birth.

October 2002
$59,317,500 total award
Contra Costa County
3 year-old girl with cerebral palsy as a result of birth injury.

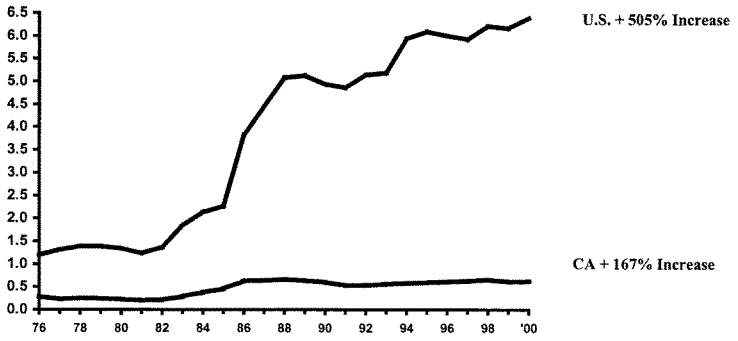
July 2002
$12,558,852 total award
Los Angeles County
30 year-old homemaker with brain damage because of lack of oxygen during recovery from surgery.

November 2000
$27,573,922 total award
San Bernardino County
25 year-old woman with quadriplegia because of failure to diagnose a spinal injury.

➢ **MICRA Significantly Minimizes Premium Increases**

Opponents of reform cite statistics that over the past several years, premiums for doctors in California have also been rising; thus proving that MICRA does not have any impact in holding down the costs of medical liability insurance. While it is true that premiums are on the rise in nearly all states, including California, the rate of increase of premiums for California doctors is significantly lower than in other states, and over time, MICRA has, in fact, stabilized medical liability insurance premiums as compared to the rate of increase in the rest of the country. As the following chart demonstrates, from 1976 to 2000, premiums for physicians in California have risen only 167 percent as compared to an increase of 505 percent for the entire United States.

Premium Growth: California vs. U. S. Premiums 1976-2000



Source: NAIC Profitability Study, 2000

Data collected from high-risk medical specialties from 2000 to 2002 also validate these trends. For example, data from a nationwide survey of neurosurgeons demonstrated that the rate of increase for an individual neurosurgeon in Los Angeles, California, as compared to other neurosurgeons who practice medicine in crisis states where there are no reforms in place, is significantly lower. The average rate of increase for the neurosurgeons in these non-reform states was 143 percent as compared to just 8 percent in Los Angeles, CA.

State/City	2000	2002	Percentage Increase
Los Angeles, CA	**$ 48,000**	**$ 52,000**	**8%**
West Palm, FL	58,000	210,000	262%
Cleveland, OH	75,675	167,941	122%
Oaklawn, IL	110,000	282,720	157%
Philadelphia, PA	90,000	190,000	111%
New York, NY	154,890	251,126	62%

Source: American Association of Neurological Surgeons /Congress of Neurological Surgeons Nationwide Survey April 2002

The Alliance does acknowledge that despite the successful reforms contained in MICRA, the average medical liability claim in California has outpaced the rate of inflation. This is in large part due to the fact that economic damages are not limited under MICRA and have grown as a component of medical liability claims. Notwithstanding this, however, the undisputed fact remains that MICRA prevents runaway juries from awarding outrageous awards for subjective, arbitrary and often unquantifiable non-economic damages, which allows insurance companies to adequately predict future lawsuit awards, bring stability the health care delivery system.

- **Federal Government Validates that MICRA Works**

U.S. Government experts agree that MICRA does in fact hold down the costs of medical liability insurance, and over the years there have been a number of studies that have identified MICRA's $250,000 cap on non-economic damages as a critical element in stabilizing premium costs. For example, dating back to September 1993, the former U.S. Office of Technology Assessment (OTA), in a report entitled, "Impact of Legal Reforms on Medical Malpractice Costs," concluded that caps on damages were consistently found to be an effective mechanism for lowering medical liability insurance premiums. Most recently, the previously referenced HHS report, "Confronting the New Health Care Crisis" and the CBO and JEC reports evaluating the HEALTH Act, came to the same conclusion. Finally, the August 2003 GAO report found that "premium growth was lower in states with non-economic damage caps than in states with limited reforms."

Justification for Federal Reform Legislation: Americans Overwhelmingly Support a MICRA-Style Solution

Americans are becoming acutely aware of the impact that this crisis is having on our nation's health care system, and overwhelmingly favor having Congress pass legislation to reform the current medical liability system and create one that balances the rights of patients to seek and obtain appropriate compensation for injuries caused by medical negligence against the right of all our citizens to have continued access to medical care. Two recent polls clearly demonstrate this support. In January 2003, Gallup conducted a poll on this issue and found the following:

- Americans believe that the medical liability insurance issue is either a major problem (56%) or a health care crisis (18%);
- 72 percent favor passing a law that would limit the amount that patients can be awarded for their emotional pain and suffering; and
- 57 percent responded that they think patients bring too many lawsuits against doctors

These findings were confirmed by a February 2003 study conducted by Wirthlin Worldwide for the Health Coalition on Liability and Access, which found that:

- 84 percent of Americans are concerned that skyrocketing medical liability costs could limit their access to care;
- 76 percent favor a federal law that guarantees injured patients full payment for lost wages and medical costs and reasonable limits on awards for "pain and suffering" in medical liability cases; and
- 61 percent believe the number of medical liability lawsuits against doctors is higher than justified

Conclusion

We have reached a very important juncture in the evolution of the U.S. health care system. At a time when lifesaving scientific advances are being made in nearly every area of health care, patients across the country are facing a situation in which access to health care is in serious jeopardy. Thus, as the Congress deliberates the many facets of this issue, the Alliance urges you to continue to keep in mind that this issue is not about doctors, lawyers and insurance companies. Rather, it is about patients and their ability to continue to receive timely and consistent access to quality medical care. By reforming the medical litigation system, the crisis will ultimately be abated. Patients are calling for reform. Doctors are calling for reform. President Bush is calling for reform. The House of Representatives is calling for reform. And the Alliance is hopeful that the Congress's continued efforts to highlight and debate this crisis will lead the Senate to heed these calls and, at a minimum, pass MICRA-style medical liability reform legislation so all Americans are able to find a doctor when they most need one. Ultimately, when the question "Will your doctor be there?" is asked, the answer must be an unqualified yes.

Thank you for considering our comments and recommendations. The Alliance of Specialty Medicine, whose mission is to improve access to quality medical care for all Americans through the unified voice of specialty physicians promoting sound federal policy, stands ready to assist you on this and other important health care policy issues facing our nation.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Statement to the

House Government Reform Committee

Subcommittee on Wellness and Human Rights

United States House of Representatives

October 1, 2003

Washington, DC

"How Limitless Litigation Restricts Access to Health Care"

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 46,000 physicians dedicated to improving the health care of women, we thank Chairman Burton for holding this important hearing. It is important to continue to examine how the medical liability crisis continues to impact availability of health services. We strongly urge Congress to act this year to bring an end to the limitless litigation restricting women's access to health care.

ACOG resoundingly supported HR 5, the HEALTH Act of 2003, bipartisan legislation passed by the House in March. ACOG deeply appreciates the commitment made by the House to end the crisis that is crippling the health care delivery system in this country.

Across the country, the meteoric rise in medical liability premiums is threatening women's access to health care. Good doctors who have been so important to their patients and their communities are leaving, dropping ob, or closing their practices completely. Medical students who love the idea of ushering tiny lives into this world are turning away from the litigious culture that surrounds ob-gyn. And America's women are left asking "Who will deliver my baby?''

I. Women's Health Consequences of Limitless Litigation

The medical liability crisis is complex, affecting every aspect of our nation's ability to deliver health care services. As partners in women's health care, we believe Congress can end the medical liability insurance crisis. The House has acted to address this crisis and we continue to urge the Senate to follow suit this year.

When confronted with substantially higher costs for liability coverage, ob-gyns and other women's health care professionals stop delivering babies, reduce the number they do deliver, and further cut back-or eliminate-care for high-risk mothers. With fewer women's health care professionals, access to early prenatal care will also be reduced, depriving them of the proven benefits of early intervention.

Access Problems Do Exist

The recent findings of the GAO Report, Medical Malpractice: Implications of Rising Premiums on Access to Health Care (GAO-03-836) significantly understated the medical liability crisis in obstetrics/gynecology. A 2003 Princeton Survey Research poll of ACOG membership shows that in 2002, 27% of ACOG Fellows reduced or stopped obstetrics and 12% curtailed surgery due to the liability crisis. This is just one measure of today's access problem.

The liability crisis also has ominous implications for access to ob-gyn care in the near future. According to the 2003 National Resident Matching Program, fewer US medical student seniors than in years past are entering ob-gyn residency programs. While the number of ob-gyn residency positions has been stable over the last decade, only 68 percent of these positions were filled by US medical school seniors this year, compared with 86 percent 10 years ago.

Limitless litigation threatens women's access to gynecologic care. Ob-gyns have, until recently, routinely met women's general health care needs – including regular screenings for gynecologic cancers, hypertension, high cholesterol, diabetes, osteoporosis, 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 these important preventive measures so important to improving women's care.

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

Allowing the crisis to continue impacts the viability of community health clinics as well. Unable to shift higher insurance costs to their patients, these clinics have no alternative but to care for fewer people, or in some cases close or drop certain physician services. In rural states, this can have a devastating impact on women's access to care. Community clinics serve a valuable role in this society and deliver health care to some of the nation's nearly 44 million uninsured patients--the majority of them women and children--who rely on community clinics for a majority of their health services.

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.

II. How This Crisis 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 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). By 2000, ob-gyn payouts jumped to an average of $399,658.

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 – they cost an average of $34,000 each to defend and result in an emotional toll on the ob-gyn and an untold loss of time for patient care.

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. Today, the median award for medical liability in childbirth cases – $2,050,000 – is the highest for all types of medical liability cases. One recent award in a Philadelphia case reached $100 million. Yet, research has proven that physician error accounts for fewer than 4% of all infant brain injury cases.

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.

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 malpractice. Rather, it demonstrates a lawsuit culture where doctors are held responsible for less than perfect outcomes. And in obstetrics gynecology, there is no guarantee of a perfect outcome, no matter how perfect the prenatal care and delivery.

III. Conclusion

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

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The American College of Obstetricians and Gynecologists
Women's Health Care Physicians
409 12th Street, SW
Washington, DC 20024-2188
(202) 863-2509

Statement of Charles H. Roadman II, MD, CNA
President and CEO
American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL)

October 1, 2003

On behalf of the American Health Care Association (AHCA), the National Center for Assisted Living (NCAL), and the millions of frail, elderly and disabled citizens we care for annually, we thank the Wellness and Human Rights Subcommittee of the House Government Reform Committee for holding this important hearing to follow up on two significant General Accounting Office (GAO) studies on the liability crisis, and its growing impact on patient access to care.

We are pleased the two authors of the GAO report are here today to testify, and we are confident their observations will underscore the fact that, indeed, patient access to long term care is increasingly threatened by the unchecked deluge of lawsuits and the corresponding spike in liability insurance costs.

Specifically, the recent General Accounting Office (GAO) report that looks at the effects rising insurance premiums have had on access to physician-based services finds that, in several of the states examined, there has, in fact, been a reduction in care access, especially in rural areas.

The GAO's Allen and Hillman further found that the greatest contributor to increased premium rates in the states studied was "increased losses for insurers on paid medical malpractice claims." The report specifically mentions nursing facilities when it indicates that, in Florida and Mississippi, physician services in the nursing home setting have been negatively impacted due to the inherent risk associated with the long-term care litigation environment.

The report notes that in 2002, 40 nursing facilities in Mississippi at some point were without insurance due to unaffordable premiums, compared to just 5 facilities in 2001.

We also find pertinent to today's hearing a recent study by Harvard University researchers recently published in the policy journal *Health Affairs*. The study found that with lawsuits against nursing homes now one of the fastest growing areas of health care litigation, concerns are being raised by the researchers about the potential impact of these lawsuits on the quality of care delivered to patients.

In the "high litigation states of Florida and Texas," the Harvard study found, attorneys handled claims worth more than fifteen percent of statewide nursing home expenditures – a staggering level by any reasonable standard, Mr. Chairman.

The report said the most "striking" finding was the fact that "nearly nine out of ten plaintiffs received compensation... and this kind of payment rate is off the scale in the world of personal injury litigation, and probably reflects a tremendous reluctance to bring this claim before a jury."

One other seminal element of this debate that underscores the injustice of the litigation status quo is the systematic plundering of Medicaid to pay for higher lawsuit costs, not to improve patient care.

According to the most recent data from Aon Risk Consultants, an independent public policy research firm, growing lawsuit costs have absorbed 21 percent of the increase in the countrywide average Medicaid reimbursement rate for long term care from 1995-2002.

Consequently, 21 percent of every Medicaid dollar fails to even reach the patient. No one, including opponents of malpractice reform, can justify this diversion of public resources away from the poor, vulnerable and infirm who need and deserve care.

Aon is conducting additional research on these issues, and we will be releasing the data early next year as the drive for reform continues in the next session of Congress.

Mr. Chairman, at a time when Medicaid is struggling under severe pressure to serve more seniors, this nation cannot stand by and allow an ever-increasing amount of tax dollars to go towards paying higher lawsuits costs -- and not toward the actual, intended care of elderly patients.

Seniors and taxpayers are now involuntarily footing the bill to subsidize the few at the expense of the many. This is an injustice every American can plainly see is illogical, wrong and in need of change.

We maintain that the preponderance of objective evidence makes a direct link between the frequency and severity of liability claims, the increase in professional liability insurance costs, and the growing problems faced by America's frail, elderly and disabled in seeking access to quality long term care services.

The need for comprehensive federal medical liability reform has never been more necessary or justified. We appreciate your efforts, Mr. Chairman, and we thank the congressional leadership and President Bush for their work and support on this critical public policy front.

#######

The American Health Care Association and the National Center for Assisted Living represent nearly 12,000 non-profit and for-profit nursing facilities, assisted living residences, subacute centers and homes for persons with mental retardation or developmental disabilities. Members of AHCA and NCAL are long term care providers who believe that the individuals they serve are entitled to a supportive environment in which professional and compassionate care is delivered in a safe and secure setting.

Fact Sheet
Long Term Care Liability Crisis Threatening Patient Care

BACKGROUND

Access to quality care for our nation's most vulnerable populations is being threatened by a growing health care liability crisis. The frail elderly and the disabled who depend on long term care physicians and facilities are feeling the effects of skyrocketing insurance premiums for nursing facilities and the physicians who practice in them. Without dramatic policy changes to reform the long term care medical liability system, the residents of the more than 17,000 nursing homes across the U.S. will fall victim to a shortage of long term care physicians and limited options for quality facilities. The threat of costly lawsuits and the difficulty in obtaining insurance coverage has driven a growing number of physicians to stop practicing in long term care and has forced some nursing homes to close their doors.

FACTS

- "The diversion of substantial resources now required to defend and pay nursing home lawsuits is likely to have an independent, negative impact on quality." *("The Rise of Nursing Home Litigation: Findings From a National Survey of Attorneys," Harvard University, as published in Health Affairs, 2003)*

- Liability costs have *absorbed 21% of the increase in the countrywide average Medicaid reimbursement* rate for nursing facilities from 1995 to 2002; this represents a $4.8 billion diversion of funds out of patient care to cover lawsuit costs. *(Aon Risk Consultants, March 2003)*

- The average long term care liability cost per skilled nursing bed has increased from $290 in 1990 to $2,880 in 2002. National costs are now ten times higher than they were in the early 1990s. Further, the triple digit increases nursing homes have seen in their insurance rates over the last few years have little or no relationship to their claims history. *(Aon Risk Consultants, March 2003)*

- An increasing number of nursing homes across the United States are being forced to operate without liability protection because they cannot afford the premiums or cannot find an insurance carrier to cover them.

- The liability crisis has created a *Catch 22* for nursing homes. All Medicare and Medicaid-certified nursing homes are required by law to have a physician medical director to oversee quality of care in the facility. If a facility is forced to go

without insurance because it's cost-prohibitive, then the medical director in most cases will not be covered. Without coverage, the medical director cannot work at the nursing home. Without a medical director, a nursing home will be cited for violating the law.

- Almost 11% of long term care physicians have been forced to either stop working as a medical director or fear they will have to stop working in nursing homes altogether because carriers are no longer covering the nursing home market. (*2002 Membership Survey of the American Medical Directors Association)*

- In a survey of long term care physicians, more than 27% reported that they were forced to reduce patient care hours, no longer provide certain services, or refer complex cases as a result of the medical liability crisis. (*2002 Membership Survey of the American Medical Directors Association)*

- 88% of all claims filed against long term care facilities result in some kind of payment, with an enormously high rate of claims settled out of court. Compare this to other types of medical malpractice cases, which result in pay outs in only 7 - 8% of the claims. *("The Rise of Nursing Home Litigation: Findings From a National Survey of Attorneys," Harvard University, as published in Health Affairs, 2003)*

- **Almost half** of the total amount of costs paid by insurers for liability claims in the long term care industry is **going directly to attorneys.** *(Aon Risk Consultants, March 2003)*

Contact Jeff Smokler at the American Health Care Association for more information at 202-898-6321.

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HEADLINE: He Sets Your Doctor's Bill;
A Chastened Insurer

BYLINE: Jyoti Thottam

BODY:
You don't have to feel sorry for the insurance industry to appreciate Donald Zuk's predicament. The CEO of SCPIE Holdings, California's second largest malpractice insurer, Zuk launched an ambitious plan in 1996 to expand into new states like Texas and Georgia and into new lines of business, such as insuring dentists and higher-risk doctors. It was a disaster.

Zuk, 66, a burly former football player, found himself fighting a multistate price war, cutting premiums to grab market share and badly underestimating how much his firm would pay out for claims against doctors. "The loss ratios were going through the roof," Zuk says. SCPIE raised premiums for policies outside California about 40% in 2001 and 30% in 2002. Yes, Zuk is one of the people responsible for the malpractice-insurance crisis that is disrupting the lives of so many doctors and patients. But he's not exactly profiteering. His firm has posted $ 96 million in losses over the past two years.

The Los Angeles--based company has retreated to California, pulling out of the malpractice business in other states. Says Zuk: "We knew that there was a risk when you go into a state without tort reform"--limits placed on personal-injury lawsuits and damages. "We thought the rates were sufficient, so we went with it. Today I know what's going on around the country. I won't go into Texas, Florida or any of the states I pulled back from until there's some semblance of tort reform."

Zuk has plenty of company in his malpractice losses and in his zeal for reform. In 2001 **medical-malpractice** insurers paid out $ 1.53 in claims and expenses for each $ 1 in premiums they collected. The industry has lost a combined $ 8 billion since 1995, and its reserves for estimated future claims are underfunded by about $ 4.6 billion. So if insurers aren't profiting from higher premiums, who is? Zuk and his peers point to trial lawyers and frivolous claimants. Insurers are lobbying alongside doctors for caps on noneconomic damages (for pain and suffering), like the ones in California and 18 other states. Rising awards, Zuk says, are bleeding money out of the system and forcing insurers to raise premiums. Cap the damages, and premiums will fall in line, he says.

Not everyone accepts that link. "In theory, tort reform would have an impact on premiums. In reality, that has not been the case," says Martin Weiss, chairman of Weiss Ratings, an independent insurance-rating agency in Palm Beach Gardens, Fla. In a study published this week, Weiss Ratings found that in states without caps on noneconomic damages, median annual premiums for standard **medical-malpractice** coverage rose 36% between 1991 and 2002. But in states with caps, premiums rose even more--48%. In the two groups of states, median 2002 premiums were about the same. Weiss found nine states with flat or declining premiums; two of them had caps, seven didn't. Weiss speculates that regulation of premium increases made the difference. In California, consumer groups argue that the state's tough

oversight of the insurance industry, not its caps on damages, explains why rates have grown more slowly.

Caps on noneconomic damages may not hold down doctors' insurance costs, but they have boosted insurers' profits. In states with caps, the Weiss study found, claims payments grew only 38%, compared with 71% in states without them. By raising premiums, insurers have improved their ratio of claims to premiums, a key measure of profitability, from 110% in 2000 to 89% in 2002. "The caps are great for insurers," Weiss says. "Their payouts will be lower. In a perfect world, they would pass that savings on." But the industry's losses have been so large that lower claims will not reverse them; insurers are likely to keep raising premiums.

Raising rates is exactly what malpractice insurers failed to do in the 1990s, even as claims were rising. Zuk concedes that the industry has to accept some blame. "No one wanted to be the first guy to say, 'We've got to start charging the right premium,'" he says. The insurers feared losing market share, and as long as investment income held up, they could ignore rising claims.

The malpractice-insurance industry went through similar cycles of low rates, squeezed profits and price hikes in the mid-1970s and again in the mid-'80s. Zuk, who enrolled in law school in the '70s just to learn torts, says ballooning malpractice claims make the current crisis worse than previous ones. From 1997 to 2001, the median malpractice jury award doubled, to $ 1 million, but that counts results only in the 1% of lawsuits that are won by plaintiffs. The number of malpractice suits has remained stable, and although some states have seen sharp jumps, the average claim payment has grown about 8% a year, close to the rate of medical inflation.

Industry analysts say insurers' investment losses, not just jury awards, are behind the crisis. In bull markets, insurers count on investment income to offset underwriting losses; that ended when the 1990s' stock bubble burst. Although malpractice insurers make only about 20% of their investment income from stocks, the losses were steep and came in tandem with low bond yields.

Insurance firms, Zuk says, must stabilize the disruptive cycle of cutting rates and then raising them when losses grow too big. Regulators could stop an insurer from underpricing premiums and "protect it from its own stupidity," as Zuk puts it. "The industry has to say, 'Forget investment income. Let's just write to an underwriting profit.'"

Some industry experts suggest national standards for acceptable outcomes in medical procedures. Zuk says a separate malpractice torts system would be a better solution. New standards, he argues, would only put doctors on the defensive. He recalls his own knee replacement in 2001. His doctors, he says, focused on treating him, not providing disclaimers or ordering tests. Zuk is convinced he knows why: "They don't have to worry about me suing them." --By Jyoti Thottam

As long as investment income held up, insurers could ignore rising claims

GRAPHIC: COLOR PHOTO: THOMAS MICHAEL ALLEMAN FOR TIME, HOT SEAT Donald Zuk says he had to raise malpractice premiums to end his insurance firm's massive losses

LOAD-DATE: June 2, 2003

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September 10, 2003

David M. Walker, Comptroller General
U.S. General Accounting Office
441 G Street NW
Washington, DC 20548

Dear Mr. Walker,

The American College of Obstetricians and Gynecologists strongly objects to the conclusions reached in GAO's August 2003 report, Medical Malpractice: Implications of Rising Premiums on Access to Health Care (GAO-03-836), that the liability crisis has had limited affect on women's access to ob-gyn care. We find this report to be a dangerously superficial analysis of access problems to ob-gyn care that, in fact, totally misses the crisis in obstetrics and gynecology. It does the US Congress and the American people a disservice by ignoring significant problems pregnant women and women in need of ob-gyn care face in receiving the care they need.

America's medical liability crisis is in fact severely jeopardizing women's access to obstetrical and gynecological care, including vital prenatal, delivery, and preventive services. New ACOG data shows that 27 percent of our Fellows have reduced their obstetrical practices, and 12 percent have reduced their surgical practices due to the liability crisis. This is only one measure of today's access problem.

The liability crisis also has ominous implications for access to ob-gyn care in the near future. According to the 2003 National Resident Matching Program, fewer US medical student seniors than in years past are entering ob-gyn residency programs. While the number of ob-gyn residency positions has been stable over the last decade, only 68 percent of these positions were filled by US medical school seniors this year, compared with 86 percent 10 years ago.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
409 12TH STREET SW WASHINGTON DC 20024-2188
MAILING ADDRESS: PO BOX 96920 WASHINGTON DC 20090-6920
Phone: 202/638-5577
Internet: http://www.acog.org

Some of our specific concerns include:

1) The report finds that any access to health care qualifies as adequate access to health care. Rather, it should measure whether women have timely meaningful access to quality health care. Today in America, women cannot find a physician to deliver their babies, cannot find gynecological surgeons to handle their high risk cases, or have to travel long distances to deliver. These are serious, and real, access problems.

2) The report focuses on newborn deliveries, and yet assesses access by evaluating Medicare utilization data, a completely inappropriate measurement of obstetric services since Medicare covers only 6,000 deliveries a year. GAO reports that it randomly called physicians to measure access, a system that is no better than the anecdotal reports of access problems discounted by the GAO as unreliable.

3) Timing of the report completely misses major access problems occurring throughout the Nation. The report's conclusions are based on 2001 and 2002 medical liability insurance premium rates and on tort reforms in effect prior to 1995, while access was reviewed between September 2002 and June 2003. Access will be further jeopardized by highly publicized double-digit increases that took effect throughout 2003 and continued high premium increases forecast for 2004.

   The report also ignores the fact that it often takes a year or two to close or change practices. Still other ob-gyns are relying on short-term solutions to survive, but may well be forced to close or significantly change their practices in the near future.

4) The report vastly understates the magnitude of ob-gyn departures and practice restrictions. If, for example, an ob-gyn decided to close a practice because of liability, coupled with other factors, like low Medicare and Medicaid payment rates or that he was nearing retirement age, the closure was not counted.

   Similarly, if an ob-gyn reported that he was still accepting new patients, GAO considered that there was no access problem, without asking the more important questions of whether the practice was accepting ob or high risk patients or whether the obstetrician has been forced to limit the number of hospitals he or she serves. Obstetricians in Clark County, Nevada have been forced to decide between taking risky on-call emergency shifts at multiple hospitals or resigning privileges at hospitals in order to reduce their liability risk.

5) The report states that 8 of the 34 ob-gyns in Nevada who purportedly had closed or altered their practices because of liability were still in practice and accepting new patients and concluded therefore that there wasn't an access problem. The GAO report, though, shows that 23 of the 34 had closed their doors. Similarly, 24 ob-gyns left Pennsylvania due to the liability crisis. GAO found no access problems despite these facts.

6) The report repeatedly characterizes the health care access problem as "isolated," "scattered," and "rural." Yet the crisis in Nevada and Florida is none of these things.

Florida has a unique combination of high population growth, large numbers of annual visitors, many seasonal residents, an expanding international community, and growing senior population – all requiring different and more frequent kinds of health care. Today and for the foreseeable future, Florida will require increased access and availability to quality health care services.

In Nevada, it is well documented by the State Executive and Legislature as well as almost daily press reports since the Winter of 2002 that this crisis, while statewide, is significantly more serious in the southern part of the state, home of urban Clark County and Las Vegas, which has a population of 1.5 million and growing. It was the 10-day closure in July of 2002 of the State's only level 1 trauma center in Las Vegas that propelled the biennial legislature into special session in late July 2002.

7) The report completely discounts reports of ob-gyn departures in Florida, on the grounds that these reports are "anecdotal and not extensive." The GAO investigators, however, based their conclusion that there are no access problems on its own anecdotal reports. Moreover, Florida's information on physicians leaving or changing practices because of the liability crisis is extremely extensive and well documented. The Florida Governor's Task Force report alone catalogues pages and pages of real cases, in addition to which 1600 Florida physicians signed affidavits that they have changed their practices due to the liability crisis.

8) The report determines that 24 ob-gyns leaving Pennsylvania isn't an access problem because the female population in a certain age group in Pennsylvania has declined. It doesn't determine, however, whether the physician loss is in the same areas as the reductions in the female population, if indeed there is a reduction in the total female population, or whether Pennsylvania has lost specialists or access to high risk care altogether.

9) GAO uses inconsistent measures of access as well. It determines there to be no access problem in Pennsylvania since the female population has decreased along with the loss of physicians. It fails to examine population trends in the other four crisis states, however, where the female population has increased even as the number of ob-gyns has declined.

For example, Clark County in Sourthern Nevada is one of the fastest growing counties in the Nation. There was a shortage of ob-gyns before the crisis and Southern Nevada has been losing ob-gyns steadily since this crisis began in 2001. Even the loss of "only" 23 ob-gyns indicates a serious access problem in an already underserved area with a rapidly growing female population.

10) GAO points to extraordinary measures physicians and hospitals have taken to keep doctors in practice and maintain access to care as proof that access has not been reduced. It fails to note that these extraordinary measures, however, are hardly sustainable as long term solutions and demonstrate how extraordinary the access problem is in many areas of the country.

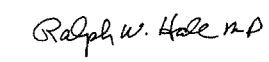
11) The GAO's sample size for access to health care in the five crisis states studied is woefully inadequate. The GAO relied only on state association reports and followed-up with 100 total physicians, an average of 20 in each state, to assess access to physicians. GAO criticized national organization data as "not likely representative of the actions taken by physicians," yet projects "evidence" from contact with 100 physicians in five states to determine that there is no access problem in America.

12) This report makes no effort to address the dynamic nature of this issue. Medical liability insurance is renewed annually. Proposed rate hikes for January 1, 2004 have been filed with various state insurance regulators range that would increase premiums by as much as 125 percent. If granted, these rate hikes will significantly increase the number of states experiencing a crisis and significantly reduce women's access to obstetric and gynecological care even further.

The American College of Obstetricians and Gynecologists is committed to passing major medical liability reform in the 108th Congress because we know that the medical liability crisis is having a devastating effect on our specialty and our patients. We are extremely concerned that this GAO report misleads Congress by not adequately evaluating the data all around us.

We sincerely urge Congress to listen to the real life stories of the effect of this crisis at home, and not rely on this unfortunate snapshot of inconsistent conclusions.

Sincerely,



Ralph W. Hale, MD, FACOG
Executive Vice President

CC: The Honorable F. James Sensenbrenner, Jr.
The Honorable W. J. "Billy" Tauzin
The Honorable Steve Chabot

September 2003

Access to Women's Health Care
America's Medical Liability Crisis
Ob-Gyns Stories

1. **Arizona**

Melinda Sallard gave birth to her child on a desert highway while driving to the only remaining maternity ward in a 6,000 sq. mi. radius. Sallard had been receiving pre-natal care at a hospital which was just minutes from her home, but was forced to close its maternity ward months earlier because of skyrocketing medical liability costs. (NBC Nightly News with Tom Brokaw, May 8, 2002).

Copper Queen Community Hospital closed its maternity ward when all six family physicians able to deliver babies lost their liability insurance coverage. (Jim Dickson, CEO of Copper Queen Community Hospital, April 2003).

2. **Arkansas**

A 13-physician group of obstetricians at Fayetteville's FirstCare Family Doctors was forced to stop delivering babies after the group's primary insurer left the state and affordable insurance was not available. (Arkansas Business, Jan. 13, 2003).

3. **Connecticut**

An ob-gyn in Bridgeport retired in October 2002 because of soaring premiums, forcing the other four doctors in his group to perform more deliveries.

An obstetrician-gynecologist in Avon stopped doing obstetrics in August 2002, when her $23,900 premium was set to rise to $64,512.

Dr. Jodi Leopold was forced to quit her obstetrics practice when her medical liability premiums increase 72%. (The Hartford Courant, Nov. 17, 2002).

Ob-gyn Dr. Michael Morosky has left his 19-year practice after a $30,000 increase in his medical liability insurance premiums. (New York Times, March 23, 2003).

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
409 12TH STREET SW WASHINGTON DC 20024-2188
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4. Florida

A Tallahassee doctor's liability insurance rates rose 30%, with a 50% decrease in coverage. In his practice of 8, 3 doctors are quitting obstetrics. The ob-gyn commented that "recruiting [new ob-gyns] in Tallahassee is very difficult."

A West Palm Beach ob-gyn was forced to drop obstetrics to stay insured with an affordable premium.

A Bradenton ob-gyn's liability premiums increased by 59% in one year, with another 75% hike expected this year. He may have to drop obstetrics and his colleagues are on the brink of doing the same.

A Winter Park ob-gyn dropped his obstetrics practice after his premiums rose from $48,000 to $100,000. At that rate, he would have to work 6 months of the year just to pay his liability premiums. Instead, he, along with 4 other obstetricians, gave up ob altogether.

Lehigh Regional Medical Center closes maternity ward, citing medical malpractice insurance costs. (Associated Press, March 25, 2003).

Jackson Memorial Hospital's neonatal unit for high-risk babies is running consistently over capacity because the vast majority of obstetricians in Miami-Dade County is going without malpractice insurance and is avoiding difficult deliveries. (The Miami Herald, Feb. 14, 2003).

Despite having no malpractice claims or disciplinary actions on his record, Lakeland ob-gyn Dr. John Kaelber was forced to close his practice and leave the state when his premiums doubled. (Lakeland Ledger, Nov. 21, 2003).

Aventura Hospital in South Florida was forced to close its maternity ward, citing $1,000 in insurance premiums for each delivery as the prime factor. Aventura is one of six maternity wards that closed between August and October 2002, forcing patients to drive to other counties and other facilities. (Miami Herald, Oct. 19, 2003).

A 45 member ob-gyn practice in Jacksonville serving 200,000 patients in Nassau, Duval, Clay, and St. John's counties stopped delivering babies and performing non-emergency gynecological surgery in May. (Florida Medical Association, March 2003).

Another Florida ob-gyn's medical liability insurance premiums increased 50% in one year. Moreover, the 50% increase in premium purchased 75% less in total liability coverage.

A West Palm Beach ob-gyn is quitting obstetrics in January 2004 after 27 years in practice. His son, who is studying obstetrics, is now considering internal medicine because of the effect of the medical liability crisis on ob-gyns.

5. Georgia

Dr. Randy Lentz cut back on volunteer and indigent obstetrics work when his medical liability premiums increased 300%. (Press-Sentinel, December 2002).

Dr. Edmund Wright of Fitzgerald was forced to stop performing Caesarian sections as a part of his family practice when his medical liability premiums quadrupled to $80,000. It would have been $110,000 if he had continued the surgical delivery procedure. (The Atlanta Journal-Constitution, Aug. 11, 2002).

6. Illinois

Dr. Andrew Roth has been practicing ob-gyn for 14 years and has never been sued. Dr. Roth sees 150 patients a week and performs roughly 200 deliveries a year, many complicated and high-risk. In January, Dr. Roth's premium increased 15%. This year, it will increase another 50% -- to around $163,000 – one of the best rates available even with his track record. Dr. Roth may have to change his practice completely – drop obstetrics or leave his home state.

Another ob-gyn in a North Chicago suburb started out in a group practice where she paid $42,000 in insurance premiums before switching to a solo practice where her insurance rates doubled to $84,000. In 2003, her rates went up to $105,000 with an expected rate of $135,000 in 2004. Her rates have tripled even though she has never been sued. In order to continue practicing obstetrics, she downgraded to a part-time practice, which decreased her premiums to $65,000. She has 2200 patients – including entire families – and has delivered 150-200 babies per year since 1996. She will likely give up obstetrics entirely in January 2004.

An Illinois ob-gyn practice group recently limited its high-risk obstetrics practice because the group's liability insurance rate has tripled in 2 years. This practice group formerly served a large number of the underserved population, but can no longer afford to see these patients and still cover the skyrocketing costs of the practice.

Another practice group is facing a 56% increase in its insurance premiums in 2004 – at a cost of $320,000 for 3 ob-gyns and 2 nurse practitioners. All of the ob-gyns in this group are in their early 40s, the primes of their careers, yet they are strongly considering dropping obstetrics entirely. Nearly 500 pregnant women would be forced to find another obstetrician.

Memorial Hospital in Belleville, IL lost 3 obstetricians last year and has not been able to replace them. Another 2 ob-gyns might leave because their liability insurance was not renewed. The hospital has not been able to recruit an ob-gyn in 2 years.

A Chicago-area ob-gyn is forced to study to obtain a pharmacist's license and give up his medical career to avoid further escalations of his liability insurance premiums, which had risen to $115,000. (Chicago Sun Times, Nov. 11, 2002).

Harry Maier, Memorial Hospital chief executive, says, "We have lost three ob-gyn physicians in the last six months only because of malpractice [rates]. I would say we are going to see another five to seven leave or limit their practice if this is not resolved." (Chicago Tribune, Feb. 16, 2003).

Dr. Stephanie Skelly, an ob-gyn in Belleville, is considering a move to her home state, Louisiana, where liability costs are about half that of Illinois. The combined premium for Skelly and her partner, Dr. John Hucker, doubled last year to $200,000 from $100,000. They took out a loan to pay a one-time $250,000 for tail coverage. (St. Louis Post-Dispatch, Oct. 6, 2002).

An Illinois reproductive endocrinologist experienced a 30% increase in her medical liability insurance premiums with no claims. As a result, her practice accepts only one HMO and limits the patient workload to keep her premiums at an affordable level.

An Illinois doctor quit obstetrics in July because his group could not get a medical liability insurance quote under $195,000.

An Illinois doctor of 24 years shut down his private practice in July because of an exorbitant malpractice premium of $146,000.

7. Iowa

After more than 19 years as an obstetrician, Dr. Dan Bohle delivered his final baby last year . "A lot of times there is a two-year statute of limitations," Bohle said, "but for [obstetrics] it can be 18 years plus two years." (Telegraph Herald, July 14, 2003).]

Dr. Michael McCoy stated that the growing medical liability crisis in Iowa and the low reimbursement rates has made it extremely difficult for private hospitals to recruit ob-gyns. The liability insurance companies that are left in Iowa are not writing new policies for single practitioners because of the liability crisis.

Dr. Sanford Markham is a member of the ob-gyn department at the University of Iowa Hospital, which serves as a teaching hospital. The ob-gyn department realized a nearly 500% increase in their required contribution to the self-insurance program this year – from $66K in 2002 to $320K in 2003, the equivalent of the starting salaries for 2 new ob-gyns. The hospital had plans to hire at least one new ob-gyn, however the increase in their insurance premiums contribution has made that impossible. The new ob-gyn would have been based within the hospital's Continuity of Care Program which serves mostly indigent patients.

8. Kansas

A Kansas ob-gyn has been forced out of business after 23 years of practice, when one of his insurance companies went bankrupt and he could not find a replacement carrier.

9. Kentucky

One obstetrician in a rural Kentucky town decided to leave the state when he received notice that his insurance premium would double. He and his partner delivered 500 babies per year.

Dr. James Graham, who has been practicing obstetrics and gynecology in Kentucky for 18 years, has suffered a severe premium increase from $22,000 three years ago to $44,000 two years ago and $88,000 last year. (Business First, July 5, 2002).

A University of Kentucky College of Medicine training program for new family doctors was in jeopardy last year because the clinic in which they work had lost its medical liability insurance coverage. The training includes obstetrics, and dozens of pregnant women are counting on doctors in the same clinic to deliver their babies this year. (The Courier-Journal, Jun. 27, 2002).

10. Maryland

A Maryland ob-gyn recently moved from New York after 5 years of practice to escape the rising premium costs. Currently in rural Maryland, her premiums are $120,000. Recently, 8 ob-gyns dropped obstetrics leaving only 2 other ob-gyns in her area.

Dr. Joseph Cutchin Jr., an ob-gyn who delivered more than 430 babies in 2001, literally cannot afford to deliver any more babies due to an increase in his insurance premiums from $44,000 to $155,000. As a result, he leaves 188 pregnant women who were under his care searching for a new ob-gyn. (Baltimore Sun, Nov. 1, 2002).

11. Massachusetts

After experiencing a 100% increase in liability premiums, a Springfield obstetrician has stopped delivering babies, and says that 25% of ob-gyns in the Springfield area are leaving the area or dropping obstetrics from their practice.

12. Mississippi

In only three years, a Mississippi obstetrician's medical liability insurance premium has increased from $30,000 to $197,000. Only 43 years old, in the prime of his career, he can no longer provide high-risk care and has to turn patients away. "I never imagined that all of the years and sacrifice and service would end up like this."

Ambur Peterson was forced to drive 100 miles to Tennessee to deliver her baby because her obstetrician had to stop delivering babies after losing his liability coverage just three weeks before the baby was due. "Essentially, I've lost my job," said Dr. Mark Blackwood, Ambur's former OB. (The Sun Herald, July 11, 2002).

A Grenada, Mississippi ob-gyn stopped taking any obstetric patients with a due date after June 15, 2003, leaving two obstetricians to deliver approximately 700 babies per year.

Another Mississippi ob-gyn group's insurance increased from $50,000 to $180,000 in the past year. The added expense has cancelled the practice's plan to improve its technology, including a new fetal monitor.

13. Missouri

A Missouri doctor's practice incurred astronomical medical liability insurance costs, paying $600,000 for coverage this year, an increase from $150,000 last year. In addition, after paying $500,000 for tail coverage, the coverage company went out of business and he lost the benefit. He has considered dropping obstetrics.

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

An ob-gyn in St. Ann was forced to close his practice last year because of medical liability costs that rose 100%. The practice had delivered about 400 babies a year. (St. Louis Business Journal, Sept. 16, 2002).

A Missouri doctor who has been in private practice for 3 years experienced a 400% increase in his liability premiums over the past 3 years and received a quote for $108,000 in 2004.

14. Nevada

Bonnie Seubert of Las Vegas, who has a history of complicated pregnancies, lost two obstetricians in one year when they could no longer obtain medical liability coverage. She lost the first one during a complicated pregnancy, and the second just days before she was scheduled to undergo a full hysterectomy. (Statement at a Las Vegas rally and news conference sponsored by CARH, May 6, 2003).

It took Elizabeth Gromny six years and countless infertility treatments to conceive her first child. But the day she called to make her first appointment with her obstetrician, the doctor had just capped the

number of deliveries she would perform because her insurance bill would "shoot up" if she exceeded a certain number of births. Gromny was turned away from other obstetricians all over Las Vegas who faced similar limits. (Time, Sept. 16, 2002).

Nancy Allen waited six months to have suspicious lumps removed from her uterus and ovaries. She would have waited longer, but went to her doctor's office and refused to leave until her hysterectomy was scheduled. (Las Vegas Review-Journal, Nov. 5, 2002).

Nicole Lytle told legislators that it took her 60 days to find an obstetrician to deliver her baby earlier this year. "Every single ob-gyn I called turned me away," she said. Nicole was so frustrated that she began talking about her plight during her morning radio show. "Pretty soon women were calling me and crying, saying they couldn't find doctors either." (Las Vegas Review-Journal, March 5, 2003).

Ruth Valentine was forced to leave Las Vegas to find an ob-gyn to care for her after having had to call more than 50 doctors.

Carolyn Faris, with the help of her former obstetrician, called more than 60 Las Vegas-area doctors to find someone to deliver her baby, and only then did she eventually find one because she began experiencing complications. (Las Vegas Review-Journal, Jan. 10, 2003).

Dr. Cheryl Edwards was forced to leave Las Vegas when her premiums more than quadrupled. She now lives in California, a state with medical liability reforms already in place. (Keep our Doctors in Nevada, January 2002).

Dr. Shelby Wilbourn, who left Nevada for Maine to escape high medical liability premiums wonders who will deliver the 500 babies born each week in Las Vegas and if there will be any ob-gyns to take emergency calls. (Associated Press, Feb. 12, 2003).

Mark F. Severino, an infertility specialist, stopped practicing in Las Vegas in June because his medical malpractice insurance ran out. Severina and his family moved to Green Bay, Wisconsin. "I was in practice since 1985, and I never had a claim." (Journal-Sentinel, April 20, 2003).

Dr. Guy Torres will have no choice but to stop delivering babies this fall when his insurance policy runs out. He will face a new annual premium of more than $200,000. (USA Today, April 8, 2003).

Dr. Darren Housel was forced to relocate his ob-gyn practice, which delivers 200 babies a year, from Las Vegas to Utah when his premiums skyrocketed to over $100,000 a year. (Las Vegas Review-Journal, Aug. 29, 2002).

Dr. Warren Volker, chairman of obstetrics at Summerlin Hospital Medical Center, indicated that the hospital is expereinceing tremedous difficulty recruiting no new obstetricians.

A Nevada ob-gyn has limited his obstetrics care because current insurance plan, which increased from $43,000 to $98,000 in one year, limits him to 240 deliveries a year. As a result, he is forced to turn away 20 women a day seeking care.

15. New Jersey

In July 2002, the Childbirth Center in Englewood closed due to rising liability insurance rates for obstetric services. The Center lost its coverage when the Princeton Insurance Company pulled out and obtaining insurance through a new company would have cost the Childbirth Center $325,000 per year compared to $30,000 with Princeton Insurance Company.

16. New York

In light of the recent liability premium increases, a New York ob-gyn is contemplating moving to Tennessee. His premiums have increased to $140,000, up from $105,000 since last year. He follows in the footsteps of his grandfather and uncle and would never have considered a move last year. After 20 years in practice, he would hate to end the family tradition of providing care to New York's women.

The Elizabeth Seton Childbearing Center, the famed natural-childbirth center whose midwives have helped the rich and famous deliver babies, announced that it will be shutting down in September 2003 due to skyrocketing insurance costs. The center delivers about 420 babies annually on-site. (New York Post, Aug. 12, 2003).

Long Island ob-gyn Juliana Opatich delivered babies for almost 20 years, but on July 1, 2002, she gave up that part of her practice. She said rising insurance costs were the final reason for her departure from obstetrics.

Five New York gynecologic-oncologists suffering from an increase in medical liability insurance premiums quit the practice. Now, there is only one gynecologic-oncologist left within 110 miles to provide care. The only other option for patients is to travel a great distance or take a ferry to Connecticut.

17. North Carolina

A North Carolina ob-gyn left his practice of 15 years after a more than 250% increase in medical liability premiums.

Another North Carolina ob-gyn's premiums increased from $40,000 to $150,000. Within the last 18 months he and 2 doctors have left his area.

Dr. Mary-Emma Beres stopped delivering babies after her premiums increased from $17,500 to $60,000, leaving only one doctor in all of Allegheny County who can perform Caesarean sections. (Raleigh News & Observer, March 30, 2003).

Martin Palmeri, a 3rd year medical student at East Carolina, switched from specializing in ob-gyn to Radiology due to the high cost of liability insurance and the risk of getting sued in his state. (East Carolina University, June 2003).

Dr. John Schmitt, an obstetrician, left his private practice in Raleigh last year to take a position with UVA's medical school after his annual liability insurance costs increased. Former patient Laurie Peel said, "When you are a woman, you try to find a gynecologist who will take you through lots of things in life. I suffered a miscarriage. You develop a relationship with your doctor. To lose someone like that is very hard." (Charlotte Observer, July 25, 2002).

An obstetrician at Women's Care, P.A., the largest independent ob-gyn physician group in North Carolina, was forced to stop delivering babies this year due to the 30% increase in medical liability insurance premiums. (North Carolina Medical Society, June 12, 2003).

18. Ohio

The chairman of an ob-gyn residency department in Ohio is unable to train future ob-gyns. Due to high liability premiums, it is difficult to find faculty to teach obstetrics residents. He encourages his students to still choose obstetrics as a profession, with a warning to "pick the right state."

The maternity care clinic at Union Hospital in Dover shut its doors because three out of the five physicians participating in the clinic "have stopped or will stop delivering babies due to increased malpractice insurance costs," according to an October 2002 article in The Times Reporter.

Dr. Walid Kassem stopped delivering babies in 2001 when his liability premiums increased more than 100%. "I can't afford to deliver babies," he said. "I felt guilty to quit. I felt like I'd lost a part of me." (Cox News Service, Aug. 16, 2002).

Dr. Brian Batchelder, a family practitioner who delivered babies for 18 years, was forced to quit that part of his practice after his liability costs more than doubled. He was the only physician in Morrow County delivering babies and providing obstetrical care. "It's one thing to stop voluntarily; it's quite another having it forced upon you," he said. (Mansfield News Journal, March 15, 2003).

Shelly Holt was forced to find a new ob-gyn just four weeks before her due date. Two of Ms. Holt's previous obstetricians had since stopped delivering babies because of the increase in liability insurance premiums. (Ohio News-Messenger, March 5, 2003).

A young ob-Gyn who had planned on practicing in Pennsylvania for her entire career was forced to move to Indiana to get away from the medical liability disaster in Pennysylvania. Her insurance premiums in Indiana, which has enacted medical liability reform, including a cap on damages, are nearly $100,000 less.

21. South Carolina

Only 4 doctors now deliver babies in Oconee County, down from 11 in 2001. (South Carolina Medical Association, Feb. 21, 2003).

Dr. Allan R. MacDonald was forced to discontinue his obstetrics practice when his malpractice insurance premiums rose 400% without notice. His patients had only two days to find another doctor. (Greenville News, Nov. 13, 2002).

A 10-physician ob-gyn group in Columbia had to take out a $400,000 loan this year to continue to provide obstetric services and pay its liability premiums. (South Carolina Medical Association, Feb. 21, 2003).

A family practitioner in Seneca who has practiced for 21 years saw his liability rates go up 400% in one year. Now, only one doctor in his five-partner practice is currently practicing obstetrics. (South Carolina Medical Association, Feb. 21, 2003).

Another family practice group in Seneca was forced to drop obstetric coverage for four of their six physicians because of skyrocketing premiums. There are currently a total of four physicians in Seneca treating pregnant women. (South Carolina Medical Association, Feb. 21, 2003).

A South Carolina ob-gyn will most likely leave the state because of the skyrocketing medical liability premiums. Already, she has limited her practice by not taking Medicare and Medicaid for her gyn patients.

22. Tennessee

A Tennessee high-risk ob-gyn's liability insurance premium increased to $70,000 forcing him to reduce the number of deliveries by more than 50% and limit the types of insurance accepted by his practice.

23. Texas

An Austin doctor has experienced a 300% increase in liability premiums. She, along with several other Austin ob-gyns, decided to drop obstetrics.

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% in 2003. In 2001, 1,003 babies were born at Spring Branch Medical Center.

The Conroe Family Practice Center was forced to shut its door for two days in July 2002 when its malpractice insurance was abruptly canceled by an insurer no longer willing to cover residents who deliver babies. Roughly 120 patients were turned away each day at the clinic before it found insurance at premiums roughly $100,000 higher than budgeted for, said Dr. Charles Alvin Jones, director of the facility's residency program. (Houston Chronicle, Aug. 3, 2002).

Dr. Maryann Prewitt was forced to stop delivering babies at Presbyterian Hospital in Plano due to skyrocketing liability insurance costs. (Dallas Business Journal, Oct. 7, 2002).

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

24. Utah

A Utah doctor described the situation in Utah as critical – the State ranks 49th in the Nation for adequacy of prenatal care and has one of the highest birth rates. About 12% of ob-gyns have dropped obstetrics, and another 25% say they will stop within the next 5 years. 60% of the ob-gyns limit or do not accept Medicaid. Her liability premium has increased from $40,000-$72,000. In 2003 she would have to deliver 256 babies just to pay overhead, including liability premiums, although she only provided obstetric services for 162 patients last year.

At the University of Utah this past year, only 2 out of 100 medical school graduates chose obstetrics for their residency programs. In 2002, none of the graduates chose obstetrics. In prior years, 6 to 10 graduates entered obstetrics.

25. Virginia

An ob-gyn in rural southwestern Virginia recently left the state when his liability premium went from $19,000 to $56,000 in just two years.

26. Washington

A Washington State ob-gyn, a solo practitioner, has never been sued in nearly 25 years of providing ob-gyn care. In addition, he taught clinical ob-gyn to medical students at the University of Washington. In 2002, because of rising insurance costs he had to give up obstetrics, which also forced

him to stop teaching at the university, which was the part of his career that he truly enjoyed. Because of the hostile and litigious environment and the rising liability insurance costs, he has urged family members and his students to consider careers other than medicine or specializing in ob-gyn.

At Sound Women's Care, director Dr. Gordon Hunter said the group's six obstetrician-gynecologists say their medical liability premiums rose $168,000, or 50 percent, over the past two years. Almost half of the clinic's patients were in the state's low-paying program. In May, Dr. Hunter will stop delivering babies and will provide only gynecological care.

The medical malpractice insurance premiums for Seattle ob-gyn Gillian Esser went from $20,000 in 1999 to $108,000 this year – a 400% increase. Five of her colleagues have been forced to quit practice altogether or moved to states with comprehensive medical liability reforms already in place (California and Wisconsin, respectively).

Nineteen family physicians at the Swedish/Providence Medical Group have stopped delivering babies this year because of unaffordable medical liability costs. Eight family physicians at the Rockwood Clinic in Spokane have stopped delivering babies as well. (News Tribune, June 29, 2003).

In Mount Vernon, six of nine ob-gyns have stopped delivering babies; in Tacoma, 10 of 20 ob-gyns have been forced to stop. (KOMO-TV, May 29, 2003).

Dr. Robert Pringle, who runs the North Cascade Women's Clinic in Mount Vernon, said he's seen his yearly liability insurance bill grow to $58,000. If the price continues to rise, Dr. Pringle and his partners will be forced to stop delivering babies. (The Olympian, Oct. 12, 2002).

27. West Virginia

An entire hospital may cross the border into Virginia in order to continue in operation. Bluefield Regional Medical Center doctors voted late in October 2002, to begin plans to move certain services to Bluefield, VA.

The West Virginia State Medical Society reports that the federal government officially designates a majority of the state as medically underserved because of a shortage of health professionals. Losing even one ob-gyn would have a devastating impact on small communities.

28. Wyoming

In Newcastle, three family physicians have been forced to discontinue providing obstetrical care to their patients after their liability costs skyrocketed. Now women must drive between 30-90 miles to find a physician to delivery their babies. (BestWire, July 18, 2003).

Dr. David Burkons and his two partners at University Suburban Gynecology, Inc. in South Euclid could not afford to pay a combined $360,000 for a year of malpractice coverage. As a result, they were forced to stop delivering babies and limited their practice to gynecology. (The Plain Dealer, Oct. 20, 2002).

Dr. Frank Komorowski of Bellevue stopped delivering babies after 20 years when he found out the day after Christmas last year that his liability insurance was tripling to more than $180,000. Komorowski, the only obstetrician in Bellevue, figured it would end up costing him nearly 11 months of his salary to pay the premium increase in addition to taxes and other expenses. (The News-Messenger, March 5, 2003).

19. Oregon

The only surgeon in Reedsport left last year because of the medical liability crisis. No family practitioners in Reedsport are trained to do Caesarean sections. (The Sunday Oregonian, March 2003).

Roseburg Women's Healthcare in southern Oregon closed. The area, with a population of 20,000, was left with only 3 ob-gyns willing to deliver babies, down from eight. Area residents now have to travel more than an hour for obstetrical care. (The Business Journal of Portland, June 21, 2002).

20. Pennsylvania

On June 20, 2002, Mercy Hospital announced it would stop delivering babies as of August 23, 2002. Rising cost of malpractice insurance to cover obstetrics factored into the decision.

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 June 30, leaving that area of the city without a maternity ward. Methodist Hospital has been delivering babies since being founded in 1892.

80% of medical students who come to the state ultimately choose to practice elsewhere, according to the Pennsylvania Medical Society.

Pennsylvania ranks last in the percentage of physicians under the age of 35, despite harboring eight medical schools within its borders. In high-risk specialties, historically Pennsylvania has always retained 40% of the residents from medical schools; it now retains 14%, in large part because new doctors are choosing to practice elsewhere given Pennsylvania's high liability costs and litigious environment. (Northeast Pennsylvania Business Journal, April 1, 2003).

A Pennsylvania ob-gyn who has been in practice for 9 years recently quit obstetrics because of inadequate reimbursements and a 200% increase in malpractice premiums.

September 2003

Wyoming ob-gyns and family physicians who deliver babies pay at least $20,000 to $30,000 more than their counterparts in Colorado, which has a $250,000 cap on non-economic damages. (BestWire, July 18, 2003).

Dr. Amy Trelease-Bell was forced to limit the number of babies each doctor in her practice delivers to 30 per year to avoid astronomical increases in her medical liability coverage. (Wyoming Tribune-Eagle, Dec. 9, 2002).

Dr. Willard Wood, the only ob-gyn serving three Wyoming counties for the past quarter-century, stopped delivering babies earlier this year after his medical liability costs tripled to $116,000. He had delivered more than 1,000 babies, including the entire starting rosters of 2 local high school basketball teams. (Washington Post, Feb. 3, 2003).

Another Wyoming ob-gyn has experienced a more than 50% increase in premiums even though no claims have ever been filed against her.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
409 12TH STREET SW WASHINGTON DC 20024-2188
MAILING ADDRESS: PO BOX 96920 WASHINGTON DC 20090-6920
Phone: 202/638-5577
Internet: http://www.acog.org

Statement of John Thomas
Chairman of the Coalition for Affordable and Reliable Health Care
"Dying for Help: Are Patients Needlessly Suffering Due to the High Cost of Medical Liability Insurance?"

My name is John Thomas, I'm the Chairman of the Coalition for Affordable and Reliable Health Care (CARH, pronounced "care") and the Sr.Vice President/General Counsel of Baylor Health Care System in Dallas, Texas. CARH is an alliance of hospitals, physicians, nursing homes, concerned businesses and others from all 50 states seeking to restore access to health care services through medical liability reform.

Thank you for taking the time to accept and evaluate the information we provide to your deliberations.

The media and policy makers like to describe the current crisis you are evaluating as an "insurance" crisis, a "medical malpractice" crisis, a "trial lawyer" crisis or a "physician" crisis. The "crisis" is not about doctors, hospitals, lawyers, or insurance companies, the crisis is about the dramatic reduction in health care services available to individuals, especially when those individuals are in the most vulnerable condition: mothers and infants, those who need trauma care, and the elderly.

The Crisis has resulted from years of abuse of the civil justice system by personal injury attorneys and a society that has allowed these attorneys to manipulate the jury system. How many more fathers and husbands, like Tony Dyess, have to be brain damaged severely, because neurosurgeons are forced to abandon their practice in his community? How many more babies have to be born in "Third World" conditions on the side of a road, like Melinda Sallard in Arizona, because mothers (fully insured and uninsured alike) can not find an obstetrician and hospitals have to restrict their services, and the mother and father have to drive hours to the next available hospital. This is not an "insurance" crisis, this is a "Patient Access to Care Crisis."

The Crisis has resulted from a dramatic increase in the size of medical liability judgments and settlements driven by personal injury lawyers abusing juries who are provided no standards for measuring compensation, who are not provided all the facts, and who are left with an impression that "big bad insurance companies" pay these awards with no consequence to themselves or their neighbors.

The facts are that hospitals, not insurance companies and not physicians, pay the vast majority of the liability costs drained from the health care system and transferred to a relatively few personal injury lawyers. The facts are that hospitals do not practice medicine, physicians and nurses acting under a physician's orders, practice medicine. When physicians can not absorb their liability costs, in addition to the costs of their staff, their equipment, and their student loans, they stop practicing medicine and hospitals

cannot provide access to care in their community. When hospitals have no physicians, they have no source of revenue, and they lay-off their nurses, lab and radiology techs, and do not purchase the latest pharmaceuticals, the latest cardiac stints and other medical devices, and do not have the resources to invest in technology that can reduce medical errors.

The facts are that hospitals, not their excess insurance carriers, not the malpractice carriers of physicians, bear the greatest burden of the liability costs which have caused this Crisis. Hospitals pay these awards from reserves typically placed in self-insurance trusts and captive insurance companies (wholly owned corporations which are not designed to make a profit, but to provide a mechanism to access "umbrella" reinsurance). The amount of these reserves are set by actuaries, who take into account all relevant factors (other than a profit motive) including loss experience, average judgments reported in the area, and the size and scope of services of the organization. Then auditors, applying stringent Generally Accepted Accounting Principles typically seek to require the hospitals to increase those reserves, to be even more conservative.

The Crisis has resulted from juries who are provided no standards for assessing compensation for "pain and suffering", other than personal injury lawyers who equate "pain and suffering" to the annual income of movie stars and professional baseball players.

The Crisis has resulted from hiding facts from juries, due to rules of evidence which prohibit the jury from knowing that a party may have been reimbursed fully and will continue to be reimbursed for all of their costs for health care services required to address their injury, and the fact that a party may have disability or long term care insurance that is paying all of their lost income and for other needs. Personal injury lawyers are allowed to mislead juries to award money to provide for all of these costs, weather or not the party has an obligation to return any of the funds provided by another source.

The Crisis has resulted from a civil justice system that allows minors to wait until they are 20, 21, or 22 to sue for damages they alleged to have occurred, perhaps even *in vitro*. Today, in many states in this country, people born in 1980 have the right to sue for damages they allege occurred perhaps as early as 1979. Locating the medical records and individuals involved in the care in 1979 alone, make defending these lawsuits extremely challenging, not to mention the 20+ years of pre-judgment interests and the use of today's dollars (not 1979) to calculate relevant damages. If you understand that interest rates reflect the inflation rate, paying judgments in 2002 dollars, plus pre-judgment interest since the date of the injury, means a party is compensated twice for the interest costs on the award.

The Crisis has resulted because juries without standards, juries without the facts, and the requirement to account for 21 years worth of exposure, has made it virtually impossible to price, with any level of confidence insurance coverage for hospitals, physicians and nursing homes. Without an insurance market that can accurately underwrite and price the coverage they provide, hospitals are required to assume more of the risks of loss directly,

and not through insurance which spreads these risks across a broad number of organizations, consequently increasing the total amount of self-insurance they are required to fund. This leaves communities without physicians, hospitals without the resources to employ nurses and purchase the latest technologies, and worst of all, leaves patients without access to health care!

We do not trust juries to determine the penalties to be imposed in our criminal justice system, the most, if anything we ask of juries in criminal cases is their opinion or recommendation. Elected officials establish the range of penalties that can be imposed in the criminal justice system, and that punishment applies regardless of the emotional loss or fear suffered by the victim.

Consider these facts, and the comparison of Baylor Health Care System's self-insurance funding requirements and excess reinsurance costs, with those of a hospital group in California. For fiscal year (FY) 2003, Baylor's self-insurance funding is $47 per patient day. Baylor's total hospital liability cost is $61 per patient day, when we include the cost of reinsurance for claims in excess of $10 million per claim. In other words, Baylor must self-insure the first $10 million of every claim, and our actuaries and auditors require us to fund this potential liability in our self-insurance fund (a wholly owned captive insurance company). Baylor pays additional dollars ($14 per patient day) to commercial carriers for the excess reinsurance. Last year, only 2 companies out of all the companies we contacted in the US, Bermuda, London, Germany and Switzerland were even willing to offer this excess reinsurance coverage, and only if we assumed this first $10 million of exposure per claim.

Compare this trend and these per bed liability costs with those of a respected group of hospitals located in California. The total liability cost per patient day for these hospitals are approximately $35 per patient day, this includes both self-insurance and commercial reinsurance. These California hospitals can get reinsurance for claims in excess of $5 million, 50% less than Baylor. Like the physicians, who pay 70-90% less than their colleagues in Texas for medical liability costs, this data shows the dramatically lower costs paid by hospitals in California than hospitals in Texas. This is proof that California's civil justice system works to compensate fairly those injured and deserving, without bankrupting and eliminating access to health care.

Because of the exposure to large judgments and settlements common in Texas, commercial insurance carriers are unwilling to provide excess "umbrella" reinsurance to Baylor, unless Baylor assumes the first $10 million of liability in every case. The only stop loss coverage we could obtain this past year was set at $30 million, meaning Baylor must lose $30 million before a commercial carrier will fully insure claims in excess of that amount. We are told that we may not be able to retain that stop loss limit this year. This reflects the carriers' respective assumptions that Baylor's liability exposure on any given case is close to $10 million and that their total liability exposure for all cases in a given year is closer to $30 million.

What is causing the actuarial increase in self-insurance funding and the fear of the catastrophic carriers? The answer is very simple. The average judgment in Texas health care liability cases increased from $472,982 in 1989 to over $2.1 million in 1999, an increase of almost 450%. The average award for non-economic damages has grown from 318,000 in 1989 to over $1.4 million in 1999, thus a staggering 66% of all health care liability awards in Texas are determined by juries with no standards provided to them and are more than 200% of the actual economic harm caused to the party.

Reported judgments and settlements paid by hospitals in Texas routinely exceed $10,000,000 and in 2002, a jury awarded over $269 million in one case. When an actuary looks at these trends and an insurance company considers the latest benchmark (in Dallas' unfortunate case, $269 million), their only hope of accuracy is to be extremely conservative and the risk of loss far exceeds any potential profit that can be attained by writing coverage in Texas.

Because hospitals finance large portions of their liability insurance with self-insurance, in Baylor's case, over 77% this year, and that data generally is rolled into hospital financials that are not available routinely to the public, it is difficult to access data and research and compare. But it is relevant directly to the policy decisions Congress is considering.

As I mentioned previously, over 77% of Baylor's liability cost is self-insurance reserves. Actuaries and auditors, applying conservative and strict guidelines, calculate the amount of cash reserves that must be put aside and used solely for the intended purpose (to pay for defense costs and liability payments). With no standards for juries, and routine $10 million judgments and settlements, and a benchmark of $269 million on the books, self-insurance reserves must, under GAAP, be sufficient to meet that potential liability exposure.

There are no insurance companies to regulate. The few that are willing to write "umbrella" coverage simply will exit the US market altogether if they are forced to commit financial suicide and be subject to unlimited exposure in every health care case. In the Texas environment, physicians can not obtain significant amounts of coverage; most of the physicians on Baylor's staff can only obtain $200,000 per case coverage, with $600,000 annual aggregate. If the average judgment exceeds $2.1 million (1999), and the average physician can obtain only $200,000 in insurance, hospitals and other facilities are paying roughly 90% of the average judgment. Those judgments are funded through self-insurance pools and are taken directly from the health care system. Finally, it has been reported that outside of California, 57% of the average judgment goes to the personal injury lawyers, his retained experts and publicist, leaving only 42% of the award to the plaintiff. That means over $1.2 million per average judgment is going to personal injury attorneys and their favored experts, and not the injured party.

For Baylor, when you add the increase in liability costs for the physicians employed by an affiliate of the System and the increase in liability cost for the hospital operations, it exceeds a $20 million increase.

What could Baylor do with that $20 million?

Baylor can operate the largest neonatal intensive care unit in the Southwest, a unit that treated more than 1000 neonates last year, over 50% of which were on Medicaid or had no insurance coverage at all. With that $20 million, Baylor could employ an additional 390 registered nurses per year. With that $20 million, Baylor could install and operate for a year, a computer physician order entry system across all 12 hospitals. With that $20 million, we could buy 9 PET scanners or 250 mammography units and decrease the wait times and increase access to these technologies that are so important to early detection of cancers.

How does Baylor continue its mission of providing care to all who seek access, regardless of their ability to pay? Baylor can not raise our rates overnight on our Medicare patients, but those reimbursement levels will in future years reflect some portion of the $20 million increase this year, and the additional increase next year, and the next—unless the law is changed. Baylor thus has to increase rates on managed care members; we ran the calculations, and a 10% increase in our outpatient managed care rates results in an about $20 million of additional reimbursement. That 10% increase goes straight to fund the increased self-insurance and reinsurance costs, and eventually ends up in the pocket of the personal injury lawyers and their high paid experts. Where do we get the money to pay for new nurses or needed pay raises for the almost 15,000 caregivers we employ? Where do we get the money to pay for the latest pharmaceuticals and medical devices and drug eluding stints for our Medicare patients? Where do we get the money to pay for the increased cost of blood products? Where do we get the money to prepare for bio-terrorism? Where do we get the money to pay for new additional nurses and CPOE technology, both almost all agree are solutions that help improve patient safety and reduce medical errors? Where do we get the money to install electronic medical record technology, technology that can make a patient's entire medical history instantly available to a caregiver, but which is enormously expensive because of all of the security and encryption and hardware and training required? Where do we get the money to provide continuous training and quality assurance programs? Where do we get the resources to provide another $120 million in uncompensated charity care this year?

One state solved this Crisis 27 years ago. Individuals injured by medical negligence should be compensated once, fully, for their out of pocket economic injuries. But public policy should establish a value for pain and suffering, not citizens who are paid $10 per day for their compulsory service, who are provided no training, and who are provided only part of the facts and no objective guidance for determining these emotion packed awards. No one can honestly and in good faith dispute the fact that hospitals and physicians have a fraction of the liability cost in California than their counterparts in Texas, Florida, Pennsylvania, New York, Arizona, West Virginia, Arkansas, New Jersey, Nevada, Mississippi, Alabama, and Georgia, do. Insurance companies must act within the boundaries of fair consumer practices, but they can't be forced to provide insurance at prices that won't cover their exposure.

In conclusion, Congress can adopt a proven solution. Congress can adopt a $250,000 cap on non-economic damages, and the other components of the California model of civil justice that has proven so successful.

C A R H

The Coalition for Affordable and Reliable Health Care

Right now, rising health care costs are undermining the availability of quality medical care...throughout our country. –President George W. Bush

America's health care system is in crisis. Medical professional liability insurance rates have skyrocketed due to years of lawsuit abuse and frivolous legal action, causing major insurers to drop coverage or raise premiums to unaffordable levels. Doctors and other health care providers have been forced to abandon patients and practices, particularly in high-risk specialties such as emergency medicine, neurosurgery, and obstetrics. Excessive litigation is impeding efforts to improve quality of care, and the resulting practice of "defensive medicine" by health care providers as a means of avoiding liability has increased health care costs significantly.

Nationally, the Health Care Liability Alliance reports that the average jury award in medical malpractice cases has tripled to $3.5 million since 1994, driving medical liability insurance premiums up over 500 percent. There were 12 malpractice verdicts in 2001 exceeding $20 million, including a $269 million judgment in Dallas. Trial lawyers are the main beneficiaries of this litigation bonanza, with 58 percent of the average judgment going to attorneys' fees and expenses.

The U.S. Department of Health and Human Services has concluded that with jury standards in place to help control these liability costs, the Medicare program alone will save over $40 billion per year. Employers and other payers for health care services will save an additional $60-108 billion, according to a study by Stanford University economists.

The negative consequences of this medical liability crisis are threefold.

- First, patient access to quality health care is jeopardized. Doctors are leaving their practices at alarming rates because of liability concerns and unaffordable insurance premiums, leaving millions of Americans with little or no access to adequate and affordable care. Hospitals are forced to reduce services and in some cases close their doors, nursing homes are filing for bankruptcy, and health care providers are moving their practices to states with reform legislation already in place. Consequently, people are dying in emergency rooms without ample professionals and facilities, and mothers and babies are left without prenatal and obstetrical care in large parts of the United States. In many areas, women are finding it difficult to get access to vital services like mammograms and obstetric care because more and more doctors performing those services are deciding that the risk of a medical liability lawsuit is simply too high.

Over the past four years, malpractice insurance rates for ob/gyns have jumped as much as 150 percent, prompting 1 in 11 ob/gyns nationwide to scale back their services to gynecology only. One in six refuses high-risk cases, according to the American College of Obstetricians and Gynecologists. A doctor in suburban Las Vegas recently closed her ob/gyn practice after 10 years when her insurance rates jumped from $37,000 to $150,000 a year. She left behind 30 pregnant patients.

- Second, patients shoulder the physical and financial burden of this crisis through higher health benefit costs, excessive tests and procedures resulting from defensive medicine practices by doctors, and in some cases loss of insurance altogether. In terms of the physical burden that patients increasingly must bear, 80 percent of physicians report that a fear of litigation has caused them to order more tests than they would based only on professional judgment of what is medically needed. They more regularly refer patients to specialists, recommend invasive procedures such as biopsies to confirm diagnoses, and prescribe more medications such as antibiotics. Financially, doctors spent $6.3 billion last year to obtain medical liability coverage, with hospitals and nursing homes spending additional billions of dollars. More significantly, however, are the large indirect costs on the health care system imposed by the runaway litigation system. These costs are paid by all Americans through higher premiums for health insurance, higher out-of-pocket payments when care is actually obtained, and higher taxes. One leading study estimates that limiting unreasonable awards for non-economic damages could reduce health care costs by 5-9% without adversely affecting quality of care. This would save $60-108 billion in health care costs each year, savings that would lower the cost of health insurance and permit an additional 2.4-4.3 million Americans to obtain insurance. The litigation crisis is also affecting patients' access to quality care because liability insurance is increasingly difficult to obtain at any price—particularly in non-reform states. Several major carriers have stopped selling malpractice insurance altogether. St. Paul Companies, which was the largest malpractice carrier in the United States, covering 9% of doctors, announced in December 2001 that it would no longer offer coverage. MIXX pulled out of every state except New Jersey. PHICO and Frontier Insurance Group have also left the medical malpractice market, Doctors Insurance Reciprocal stopped writing group specialty coverage at the beginning of 2002, and 15 insurers have left the Mississippi and Texas markets in the past five years.

- Third, health care quality and safety improvement is delayed. Because of high liability costs, providers are unable to invest in new technologies, additional healthcare professionals (including nurses, neonatal nurse practitioners, radiology technologists), and process improvements that would help improve the overall quality and safety of medical care. A recent survey of Pennsylvania doctors found that 72 percent have postponed purchases of advanced medical equipment and deferred the hiring of new staff because of soaring malpractice premiums.

In the early 1970s, California faced a health care access crisis like that now facing many states and threatening others. With bi-partisan support, California enacted the Medical Injury Compensation Reform Act of 1975 (MICRA), which provided comprehensive changes to make its medical liability system more predictable and rational. Signed into law by Governor Jerry Brown, MICRA has proven immensely successful in increasing access to affordable and

reliable medical care. Overall, according to data of the National Association of Insurance Commissioners, the rate of increase in medical professional liability premiums in California since 1976 has been a modest 167%, whereas the rest of the United States has experienced a 505% rate of increase over that same period.

MICRA's reforms include a $250,000 cap on non-economic damages, periodic payment of future economic damages in excess of $50,000, proportionate liability based on responsibility, and limits on the contingency fees lawyers can charge. When caps on non-economic damages are high or do not exist at all, the incentives to litigate weak or marginal claims increases. States with limits of $250,000-$350,000 on non-economic damages have average combined premium increases of 12-15% compared to 44% in states without caps. MICRA's limits on attorneys' fees and other reform measures allow more money to go directly to injured patients.

Increasingly, extreme judgments in a small proportion of cases and the settlements they influence are driving this litigation crisis. This is not an "insurance" crisis. Hospitals and nursing homes, which historically self-insure a large portion of their risk, are facing significantly higher funding requirements in response to actuarial requirements due to the increasing size of jury awards. Moreover, insurance companies have had significant underwriting losses (i.e., the dollar value of judgments and settlements exceeding the net premium received) driving these premium increases and retraction of available coverage. Fortunately, the insurance companies have kept more than 80 percent of their investments in relatively safe fixed income portfolios, lest even higher premiums be required.

With the disparity growing between the costs of medical care in reform vs. non-reform states and doctors closing down their practices in crisis states to avoid exorbitant insurance premiums, medical liability reform is needed on a federal level to ensure affordable access to quality health care for all Americans. Using MICRA as a model with its 25-year track record of success, the U.S. House of Representatives approved the HEALTH Act (H.R. 5) on March 13, 2003. The Senate has since introduced its companion legislation to H.R. 5. This common-sense legislation needs to be passed in the 108th Congress and signed into law by President Bush to make health care delivery more accessible and cost-effective in the United States.

The Coalition for Affordable and Reliable Health Care (CARH) is an organization of hospitals, long term care providers, businesses, health care professionals and concerned citizens that has coalesced around the unified goal of resolving this problem. Our efforts include coordination with the Bush Administration, Congress and the media to educate the public about this escalating crisis and to see national legislation enacted that would result in comprehensive medical liability reform. Accountability is essential to the U.S. health care system, but frivolous medical liability lawsuits and a lack of standards for juries and judges are primary obstacles to high quality, affordable health care.

CARH supports reforms based on California's successful Medical Injury Compensation Reform Act (MICRA), which has a proven track record of reforming that state's previously crippled health care system and ensuring prompt and fair payments to those injured and in need.

For more information on CARH and the medical liability crisis, please visit www.carh.net.

Real People... Real Stories... A Real Crisis.

CARH

The Coalition for Affordable and Reliable Health Care

My name's Leanne Dyess... and on July 5th my family fell victim to a crisis in health care. My husband was in an accident. He was rushed to the hospital, but the surgeons who could have helped him were no longer there. Lawsuits against doctors and hospitals had made it too expensive for them to practice. We didn't get the care we needed, and today we suffer. But you don't have to. Congress can change the law. They can stop supporting the trial attorneys and start supporting us. Tell Congress to support medical liability reform now.

To view advertisements produced and aired by The Coalition for Affordable and Reliable Health Care please go to www.carh.net or call 202.481.6841.

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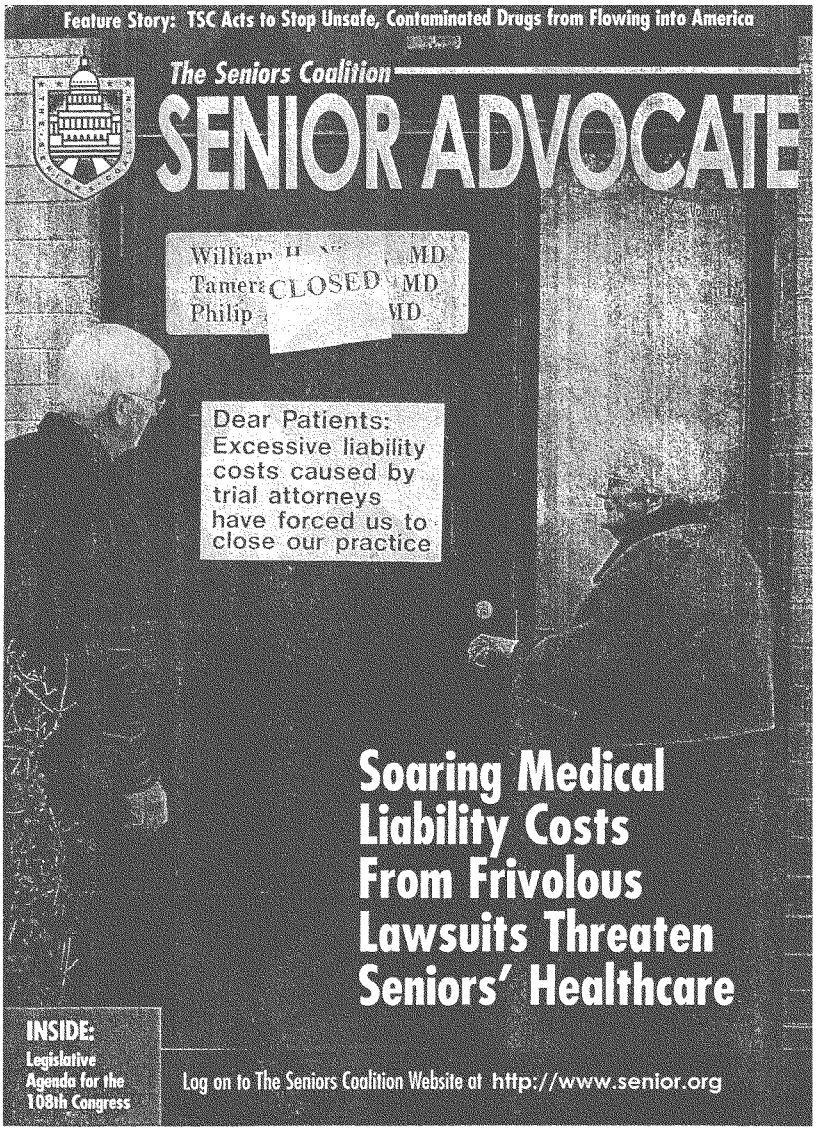
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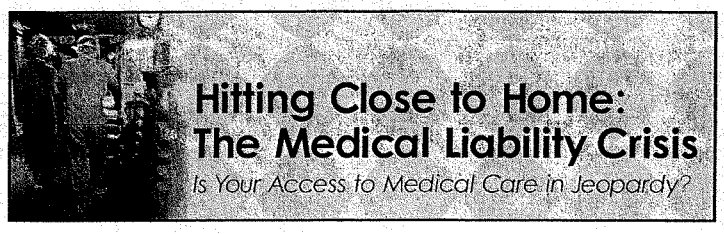


Hitting Close to Home: The Medical Liability Crisis

Is Your Access to Medical Care in Jeopardy?

The escalating medical liability crisis is hitting seniors hard, and unscrupulous personal injury lawyers are showing no mercy as doctors and other healthcare providers are forced to shut their doors to Medicare patients. Experts agree that the problem will limit healthcare choices for seniors and eventually leave whole communities without hospitals, doctors, and other providers.

The problem is real and inflicts tremendous hardship on those deprived of care—a consequence not limited to the elderly.

Tony Dyess of Gulfport, Mississippi, was driving home from his office the evening of July 5, 2002 when disaster struck. He and his wife, Leanne, had just begun a new life for themselves and their two children. They had recently started a new business, and the future was bright.

Then everything changed in an instant. Tony's car veered off the road, striking a tree. He was seriously injured and rushed to the nearest hospital. But the neurosurgeons who had worked there – neurosurgeons who could have helped him immediately – were no longer available.

Why? Because they could no longer afford the exorbitant medical liability insurance premiums that were the result of aggressive trial attorneys and frivolous litigation against doctors, hospitals, and other healthcare professionals.

By the time Tony was airlifted to a hospital with neurosurgeons, six hours had passed. He suffered significant and irreversible brain damage as a result. Today, he is confined to a bed, requires constant care, and is unable to provide for his family.

Tony did not receive the treatment he needed when he needed it, and he and his family suffer the consequences. Unfortunately, Tony is not an isolated case. All across America, doctors are leaving their practices, declining to perform risky procedures, or retiring early because of escalating healthcare costs, leaving millions of Americans – many of them seniors – without access to quality and affordable medical care. Hospitals are closing their doors, nursing homes are filing for bankruptcy, and insurance providers are raising their medical malpractice insurance premiums or dropping coverage altogether. The consequences are devastating for seniors.

Grace Kimes, 86, suddenly and unexpectedly found herself without her doctor last year when he was forced to leave his practice in Pennsylvania because he could no longer afford the exorbitant liability costs. "It's scary losing your doctor, especially at this age," said Ms. Kimes. "I just hope I don't fall or have a serious problem before I'm able to find another doctor."

In Florida, Gadsden Nursing Home announced recently it will close its doors March 21 because of high medical liability rates and concern over being able to retain sufficient staff. The facility's 55 patients will be forced to find care elsewhere. In Texas, the number of nursing home facilities has fallen ten percent over the past five years due to soaring costs. Nationally, the average cost per bed in long-term care facilities is ten times higher than it was in the early 1990s, forcing thousands out of business.

The root of this worsening crisis in healthcare lies in America's expensive – and broken – litigation system, which drives up the cost of medical care and health benefits insurance through frivolous lawsuits and inflated jury awards for damages.

Although most medical malpractice lawsuits never go to trial, defense costs for each claim are still significant. The most dramatic costs, however, stem from the few cases that actually make it to trial and result in huge judgments. The average jury award in medical malpractice cases has tripled to $3.5 million since 1994, driving medical liability insurance premiums up more than 500 percent. There were 12 malpractice verdicts in 2001 exceeding $20 million, including a $269 million judgment in Dallas. These huge "wins" encourage lawyers and plaintiffs, who hope they too can win this litigation lottery.

Consequently, physicians take extra precautions to avoid being

sued. They engage in "defensive medicine," ordering tests and providing treatments that they would not otherwise perform to protect themselves against the risk of possible litigation. This places an undue financial and physical burden on patients. According to the U.S. Department of Health and Human Services, defensive medicine costs taxpayers and employers an extra $60 billion to $108 billion a year. More significantly, it often subjects patients to invasive procedures such as biopsies and other excessive tests and powerful medications.

The system is broken, but there is a common-sense fix. In a January 16 speech, President Bush proposed practical solutions to resolve this crisis. His reforms draw largely on California's successful Medical Injury Compensation Reform Act of 1975 (MICRA). The cornerstone of MICRA is a $250,000 cap on non-economic damages, the so-called "pain and suffering" award that goes beyond actual economic damages. If adopted on a federal level, this cap, combined with several other progressive reforms, could reduce malpractice insurance premiums by as much as 34 percent.

(r to l) U.S. Health and Human Services Secretary Tommy Thompson takes notes as CARH Chairman John Thomas talks about the consequences of soaring medical liability costs to healthcare professionals and their patients, including seniors.

"It's a national problem that needs a national solution," the President said. "Something is wrong with the [medical liability] system. And a broken system like that, first and foremost, hurts the patients and people of America."

Using MICRA as a model with its quarter-century track record of success, the U.S. House of Representatives introduced the HEALTH Act (H.R. 5) February 6. The Senate is expected to introduce its own version of the HEALTH Act soon.

To ensure that the HEALTH Act is passed by Congress and signed into law by President Bush this year, a group of hospitals, long-term care providers, businesses, healthcare professionals, and concerned citizens has formed the Coalition for Affordable and Reliable Health Care (CARH). The Coalition, which recently launched a national media campaign to educate the public about the crisis, is working closely with Congress and the administration to see national legislation enacted that would result in comprehensive medical liability reform.

"America's healthcare delivery system is in crisis," said John Thomas, Chairman of CARH and Senior Vice President and General Counsel of Baylor Health Care System. "Real-life individuals and families are suffering the consequences of excessive litigation, and that shouldn't happen in a country with the best healthcare system in the world.

"What happened to Tony Dyess and his family is tragic and unacceptable. Nobody else should have to suffer the same fate. The time to act is now." ▲

Seniors: Protect Your Healthcare Access Now

Your access to quality and affordable medical care is being threatened. Personal injury lawyers and their huge multimillion-dollar awards against healthcare professionals are driving up the cost of medical liability insurance and forcing hospitals to close their doors, doctors to shut their practices, and nursing homes to file for bankruptcy. Congress can solve the problem by passing the HEALTH Act that places a cap on non-economic damages and limits excessive attorneys' fees.

The Seniors Coalition and the Coalition for Affordable and Reliable Health Care (CARH) need your help to protect seniors' access to quality and affordable medical care. Here's what you can do NOW to ensure that you're not the next victim of this crisis:

- **Send an urgent e-mail message to your representatives in Congress.** Log on to **www.carh.net** to visit CARH's website. Click on "Action Alert for Seniors" under the "Current Issues" headline at the left of the screen. Click on "Take Action," provide the requested "My Profile" information, and follow the instructions to send an e-mail message.
- **Call your representatives in Congress with an urgent message to support the HEALTH Act.** Call the U.S. Capitol switchboard at 202.224.3121 and ask the operator to connect you with your Senators or Representative in the House. ▲

Straight Answers to Wobbly Claims About Medical Malpractice Insurance Rates

By Richard E. Anderson, M.D.

State legislatures across the nation have engaged in complex debates about the whys and woes of high medical malpractice insurance rates. But a June 2003 report by the government's nonpartisan General Accounting Office (GAO) on malpractice premiums concluded that what is fueling those increases is actually pretty simple: Malpractice insurers are paying out more in claims than they collect in premiums.

Reform opponents, particularly trial lawyers, frequently try to divert blame for premium increases elsewhere. Here are some straight answers to the "evidence" that is used to confuse the debate, but that no respectable lawyer would take to court.

MYTH: Huge investment "losses" are behind double-digit rate increases nationally.

Anyone with a 401(k) plan knows the stock market was hit hard over the past few years. But medical malpractice liability providers place the vast majority of investments in secure bonds and their assets continued to grow. According to the GAO study, none of the insurers surveyed lost money on their investments through 2001.

Investment returns are down, but GAO correctly concluded that high returns had subsidized premiums and masked the relationship between premiums and losses. Lower investment returns mean today's rates are more in line with reality. Even in states where premiums have skyrocketed, the GAO found the effect of lower interest rates was only a small part of the equation—usually a single-digit percentage. Moreover, insurance companies have no control over interest rates. Indeed, it is commendable that investment income was used to subsidize rates, not to increase profit.

MYTH: Malpractice insurers keep raising rates because they are "greedy."

Today, more than 60 percent of medical liability insurance is supplied by physician-owned or -operated companies that were created to fill the void when commercial insurers fled the market in the 1970s and 1980s.

Doctors have only one reason to raise rates on themselves: so the company can meet potential losses and remain viable to preserve coverage. When losses are less than expected, money is returned to policyholders as dividends.

the same 10 percent increase, that's $12,000—four times the actual dollar increase in California.

The primary reason rates were and are lower in California is because MICRA created an environment that reduces risk and increases predictability. Patients also benefit: Settlements are reached faster, limits on attorney fees enable the injured to keep more of the award, a patient's right to go to court is protected, and fewer physicians are abandoning their practices which means greater access to care. The California model has been successful for 28 years and is the type of systemic change states in crisis need to stabilize premiums and ensure that quality health care will be available for patients.

Richard E. Anderson, M.D., is an oncologist and chairman of The Doctors Company, a national medical malpractice insurer.

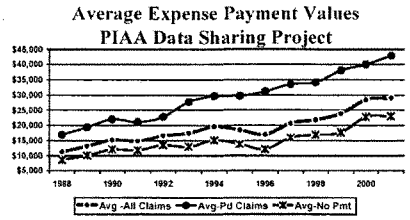
Harming Patient Access to Care: Implications of Excessive Litigation

Presented by Richard E. Anderson, M.D., F.A.C.P.,
Chairman of The Doctors Company for the Physician Insurers Association of America
Before the Subcommittee on Health Committee on Energy and Commerce
U.S. HOUSE OF REPRESENTATIVES
Wednesday, July 17, 2002

Chairman Bilirakis, Representative Brown, and members of the subcommittee, thank you for this opportunity to present to you today our views on the implications of excessive litigation and the need for federal health care litigation reform. My name is Richard Anderson, and I am an oncologist with more than 25 years' experience practicing cancer medicine in California. I am also chairman of The Doctors Company, one of the 45 doctor-owned and/or operated medical liability insurers that comprise the Physician Insurers Association of America (PIAA). Collectively, the PIAA companies insure over 60 percent of the nation's practicing physicians, more than 277,000 doctors and 1,100 hospitals. On behalf of our member companies and their insureds, the PIAA has always supported health care liability reform that more equitably and rapidly compensates patients who have received substandard care, but which at the same time limits frivolous lawsuits and increases access to health care.

Background

Despite stunning advances in scientific knowledge, medicine remains more art than science, because human beings are not machines. Sadly, however, the tide of litigation against America's doctors rises ever faster. Approximately one of every six practicing physicians faces a malpractice claim every year. In high-risk specialties such as obstetrics, orthopedics, trauma surgery, and neurosurgery, there is one claim for each doctor every two and one-half years. Fully 70 percent of these tens of thousands of cases are found to be without merit. Nonetheless, each one requires a costly legal defense. Nationally, as the chart below shows, these loss adjustment expenses average $22,967 per defendant. Cases that go all the way through trial before a vindicating defense verdict average $85,718 per defendant.[1] [See chart below] The Doctors Company alone has spent more than $400 million defending claims that ultimately were shown to be without merit.



Roots of the Current Environment

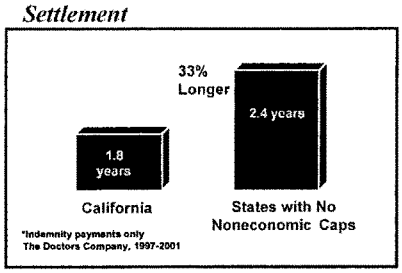
Medical liability claims were fairly uncommon until the 1970s. Nearly 80 percent of the malpractice claims in the 20th century to date were filed between 1970 and 1975.[2] Massive losses forced many commercial insurers to conclude that the practice of medicine was an uninsurable risk, and they simply refused to provide malpractice insurance at any price. This resulted in a "crisis of availability" to which providers responded emergently. Doctors contributed their own funds as capital to support the efforts of their state medical and hospital associations, among others, to start as many as 100 provider-owned specialty carriers across the country. Dubbed "bed pan mutuals" by their commercial competitors (many of whom had fled the market), these upstarts were not expected to succeed where the giant commercials could not find success. Because their primary mission is to provide a service, and because they were entirely committed to remaining present even in the most difficult markets, these companies have succeeded and are the basis of the PIAA. As one example, The Doctors Company was formed by doctors, for doctors, in 1976 and today insures more than 25,000 doctors throughout the nation.

A Litigious Society Grows

A second crisis emerged in the early 1980s, known as a "crisis of affordability." Insurers faced ever-mounting losses, with rampant increases in paid claim frequency (number of paid claims) and severity (amount of indemnity payment). PIAA data shows that, on average, it takes five and one-half years for an insurer to close a malpractice

claim after the date of the incident.[3] There is often a long lag before the claim is reported. The majority of the delay, however, comes because of the inefficiencies of the tort system. In contrast, California's Medical Injury Compensation Reform Act of 1975 (MICRA) largely eliminates the lottery aspect of malpractice litigation, and The Doctors Company data reveals that claims are settled in one-third less time than the national average. This not only decreases the cost of litigation, but it means injured patients are indemnified faster in California.

MICRA Reduces Average Time to Settlement

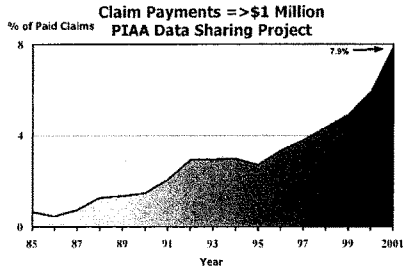


During much of the 1990s, PIAA companies exercised appropriate fiduciary responsibility and wisely invested the premium deposits of their policyholders. The significant returns were used, not to line the pockets of the companies, but to *subsidize* premium rates being charged to policyholders. This allowed them to remain affordable even as claims costs were increasing. It was the policyholders (health care providers) who reaped the financial benefits.

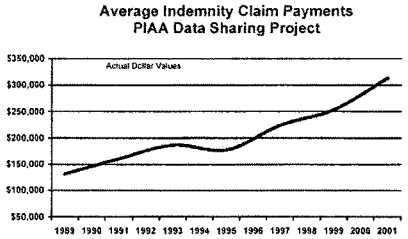
It must be noted that insurance is a highly regulated industry. Every state department of insurance, as well as the national rating agencies, closely monitors both the kinds and qualities of investments. Virtually no medical liability insurance company has experienced capital losses in excess of investment income. In fact, 80 percent of investments by PIAA companies are in high-grade bonds. What has happened is that investment yields have declined as interest rates have fallen and can no longer subsidize premium rates to the extent they once did. In other words, premium rates must now more closely match the actual cost of losses. The combination of these factors created "the perfect storm" for medical liability insurers.

The Perfect Storm

During this same time period, claim frequency and severity continued to increase. In addition, reinsurance costs rose significantly in relation to the increase in loss costs. The insurance system was able to accommodate even this inexcusable volume of litigation as long as the size of the few valid claims was predictable. Unfortunately, in the past few years, there has been an explosion in the cost of individual claims. Texas has seen a $268 million verdict. A number of states have witnessed verdicts in excess of $100 million. The city of Philadelphia alone has recorded multiple verdicts in excess of $50 million in just the past two years. Four claims in Arkansas totaled $98 million in just the past year. According to PIAA data [shown on next chart], during the period 1991 to 2001, the percentage of claims costing in excess of $1 million dollars increased nearly four-fold. *Insurance is not magic.* If society expects insurers to pay unlimited awards, it should expect unlimited premiums. As premiums increase, so must the cost of health care. Since health care today is a zero-sum game, these cost increases mean corresponding decreases in ***access*** to health care.



Those are the largest claims. What about the size of the average claim? PIAA data shows that the average indemnity payment in 2001 was more than $310,000, a 60 percent increase in the last five years. As the next chart shows, the cost of the average malpractice payment is rising precipitously. In New York and Pennsylvania alone, nearly $1 billion was paid in 2000.



*Per defendant - many claims have more than one defendant

**Data reported for year 2000 incomplete at time of analysis.

The Current Situation

As the new millennium began, insurers who were not able to weather the storm experienced rapidly deteriorating financial results. Expressed differently, a number of companies that believed they could provide insurance for less than its true cost learned the inevitable lesson. Several, such as PHICO, PIE, and Reliance, have ceased all underwriting operations. In December of last year, long-time industry leader St. Paul announced that due to unsustainable losses and the "unfavorable tort environment," the company would no longer write new medical liability coverage, and that it would not renew the policies of its 42,000 physicians, 750 hospitals, and 73,000 other health care providers. Though St. Paul is a commercial carrier and not a member of PIAA, it is telling that the largest company in the industry for the better part of two decades feels that it can no longer afford the risk of insuring the practice of medicine. Companies remaining in the market have had no choice but to take the rate increases necessary to insure survival. Conning & Co. estimates that malpractice insurers will pay out approximately $1.40 for every premium dollar collected in 2001 and 2002. Even with the projected rate increases, Conning & Co. still projects insurers will pay out $1.35 for each dollar collected in 2003 (Conning Report on Medical Malpractice Insurance, April 2002). PIAA data reveals that since 1990, claims costs have increased by 6.9 percent annually, nearly three times the rate of inflation.

False Allegations

The average claim payment has increased by 60 percent over the past five years. The cost of the most expensive claims has exploded in a manner that is absolutely unprecedented. If judgments are to be unlimited, the premiums needed to pay for those judgments must increase accordingly. With absolute certainty, this money will be taken out of our health care system and compound the severe access to care issues that we face today.

Several spurious arguments have been put forth by those with an interest in continuing the tsunami of medical malpractice litigation. First, it has been deceptively argued that stock market losses are the real driver of price

increases. In fact, investments by insurance companies are highly regulated and controlled by each state department of insurance and closely monitored by the rating agencies. Insurance companies continue to gain funds from their investments and use those funds to offset higher malpractice premium rates. As income from investments decreases, however, premiums must more closely match losses.

Second, it is argued that insurance companies should have raised rates sooner. There may be some truth to this. However, *it is difficult to understand how having today's sky-high rates earlier would make them more palatable.*

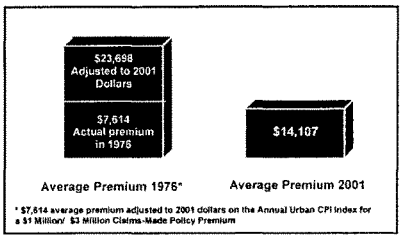
Third, it is argued that insurance companies fail to settle claims when they should and are, therefore, exposed to astronomic jury verdicts. This is a particularly empty argument. In most cases, it is the physician, not the company, who must make any settlement decision. Doctors are found to be without fault in approximately eight out of 10 malpractice trials. Should these cases have been settled? Moreover, it is difficult to accept the notion that the price for demanding one's day in court should be an unreasonable jury verdict.

Finally, there are those who argue for a state-run medical liability system. Allow me to point out that the majority of state-run malpractice programs have gone bankrupt or charge premiums that are much higher than those charged by PIAA companies. In New York, premiums are actually set by the Department of Insurance, not by individual companies, and New York rates are among the highest in the nation.

There Is a Proven Solution

California has 27 years' of experience with the MICRA statutes. We know, we do not have to speculate, that tort reform works. Since 1975, The Doctors Company malpractice premium rates in California have decreased by 40 percent in constant dollars. [See chart below] This is true despite the fact that there has not been, and is not today, any limit on actual damages awarded.

MICRA Helps Reduce California Medical Liability Premium Rates by 40%



We know, we do not speculate, that claims settle about 33 percent faster in California than the rest of the nation because the lottery aspect of noneconomic damages has been controlled. We know, we do not speculate, that even very large judgments can be accommodated by the insurance system because they can be paid on an annual basis over the intended period of compensation, not as a single jackpot.

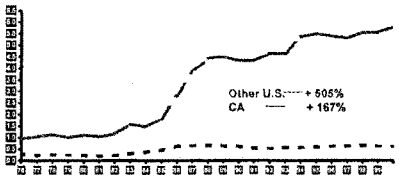
We know, we do not speculate, that injured patients actually take home a significantly higher percentage of awards in California because there is an upper limit on attorney contingency fees. In many areas, more than 40 percent of a malpractice award goes directly into the pocket of the plaintiff's attorney. In California, MICRA contains a limitation on this fee. An attorney winning a $1 million claim must be satisfied with a legal fee of $221,000.

We know, we do not speculate, that MICRA has *not* limited access to attorneys. California remains a litigious state, and The Doctors Company data shows the frequency of malpractice cases in the state is 50 percent higher than the national average.

California has passed effective tort reforms, and its providers have been able to weather this liability crisis very well. These same reforms are found in H.R. 4600, the Help Efficient, Accessible, Low-Cost, and Timely Healthcare Act of 2002 (the HEALTH Act). The PIAA and The Doctors Company fully support the provisions of this act, which when signed into law, will provide the same protections to patients across the United States as found in California

for over a quarter century. The next chart, which was compiled from data reported to the National Association of Insurance Commissioners, clearly demonstrates the effectiveness of MICRA.

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



We thank members of the Committee and their staff for holding this important hearing and inviting us to testify. We look forward to working with you to make the health care liability system fairer for everyone. I will be happy to answer any questions.

[1]PIAA Data Sharing Project, May 2002.
[2]Professional Liability in the '80s, Report 1, American Medical Association, 10, 84, p4.
[3]PIAA Data Sharing Project, December, 2001.

The Medical Liability Reform Solution is a State's Rights Issue

- Myth #1. Once the Federal Government enacts medical liability reform that includes a monetary cap on noneconomic damage awards, states will be powerless to change or write a law for their noneconomic damage award cap or any other medical liability reform ingredient.
  - EXPLODING THE MYTH
    - Under the federal legislative proposal, known as HR 5, state laws that set limits or other restrictions more comprehensive that HR 5 will remain in effect.
    - Under HR 5, states are allowed the flexibility to establish or maintain their own laws on damage awards whether they are higher or lower than the federal standard.

The Medical Liability Reform Solution is a State's Rights Issue

- Myth #2. The Medical Malpractice Crisis is a state issue that should be left to the states to solve and not the federal government.
  - EXPLODING THE MYTH
    - It is a national problem. Over 18 states are experiencing a medical malpractice crisis. Another dozen or more states have a looming crisis.
    - Access to health care is threatened as physicians retire or leave one state to practice in another state.
    - Estimated savings from federal medical liability reform could provide health care coverage to almost all of the uninsured in the states.
    - Over half of the states have monetary caps. West Virginia just enacted a $250,000 non-economic damage cap. Florida and Texas are considering the same cap. States will determine whether their current caps are effective medical liability reform or whether the federal cap is more effective.
    - National and state public opinion surveys demonstrate Americans are concerned about access to health care and soaring health coverage costs. They overwhelmingly agree that medical liability laws suits are one of the main factors driving the costs and crisis.
    - The cost of medical liability coverage is included in the federal government's funding of Medicare, Medicaid, and other programs. Medical liability reforms can produce significant savings in these programs. The Congressional Budget Office estimates that the Medicare Program could save $10.8 billion over ten years.
    - As to the annual cost of defensive medicine, the U.S. Department of Health and Human Services estimates that the costs could be as large as $25.3 to $44.3 billion annually. The U.S. House of Representatives Ways and Means Committee has requested the U.S. General Accounting Office to study and report to the Congress on the total cost savings to the Medicare Program, its beneficiaries, and the U.S. taxpayers from federal medical liability reforms.

Malpractice Victims, Who are Young, a Homemaker, or a Senior, have no Economic Loss

- Myth #1. A 17-year old, who will never work again, receives no economic benefits under California's MICRA's law or federal medical liability reform proposals.
  - EXPLODING THE MYTH
    - Both the plaintiff and defense attorneys can use economic data from the U.S. Bureau of Census to establish the earning capacity of this victim.
    - The economic loss for this 17-year old male, whose date of injury was January 1, 2002 and who will never work again and obtains his High School Diploma, is $857,149. With an AA Degree, his economic future earnings damage award is $1,108,774. If he were to graduate college and obtain his Bachelor of Arts Degree, his economic award would be $1,520,291.

Malpractice Victims, Who are Young, a Homemaker, or a Senior, have no Economic Loss

- Myth #2. A 35-year old homemaker, who dies as a result of medical malpractice, receives neither past nor future economic benefits under MICRA or federal medical liability reform proposals.
  - EXPLODING THE MYTH
    - Once again attorneys for both sides in the medical malpractice lawsuit use economic data to establish and receive compensation for economic loss.
    - The past loss of economic household services for the 35-year old woman is $55,215.
    - The future loss of economic household services for the victim is $347,218.
    - The total past and future economic damage award is $402,433.

Malpractice Victims, Who are Young, a Homemaker, or a Senior, have no Economic Loss

- Myth #3. Grandpa dies on January 1, 2002 at age 62 as a result of medical malpractice. Under MICRA or federal medical liability reform proposals he and his family receive no compensation for economic loss.
  - EXPLODING THE MYTH
    - Attorneys using government data can obtain past and future economic loss data. This takes into account that the male can continue his earning capacity until a retirement age of 75.
    - The past loss of economic household services for the senior is $28,475.
    - The future economic loss of household services is $103,074.
    - The total past and future economic damage award is $131,549.

Medical Malpractice Premium Increases are the Result of Insurance Company Bad Investments, Stock Market Losses and not the Result of Paid Losses

- Myth #1. Medical malpractice premiums are exploding because they are tied to insurance company stock market losses, especially Enron and WorldCom.
  - EXPLODING THE MYTH
    - There is no possible way to legally raise rates to cover losses whether insurance company losses come from stock market investments or from any other investment source.
    - State insurance commissioners and insurance laws in all states require that medical malpractice insurance liability rates be based on estimates of future losses and future investment income.

Medical Malpractice Premium Increases are the Result of Insurance Company Bad Investments, Stock Market Losses and not the Result of Paid Losses

- Myth #2. Medical malpractice insurance companies have significant investments in the stock market.
  - EXPLODING THE MYTH
    - In 2001, stock market investments comprised only 9% of the investment portfolios of the entire medical liability insurance industry.
    - Over 85% of the medical liability insurance companies are invested in bonds, which include risk-free Treasury bonds.
    - Medical Malpractice insurance companies are required to follow a formula in state laws that matches bond maturities to written policies.
    - An insurer's investment income is affected more by changes in interest rates and the market value of bonds, than changes in the stock market.

Medical Malpractice Premium Increases are the Result of Insurance Company Bad Investments, Stock Market Losses and not the Result of Paid Losses

- Myth #3. The paid losses that medical malpractice insurance companies pay out are minor, especially for non-economic damage awards, and have nothing to due with premium increases.
  - EXPLODING THE MYTH
    - The losses that medical malpractice insurance companies are paying out are not only increasing rapidly, but are the direct result of frivolous lawsuits and jackpot justice where jury awards have no limits.
    - Medical malpractice premiums must cover present and future losses.
    - For the first time ever in 2000, there was a medical malpractice claim among the ten largest awards in the country. In 2001, there were two malpractice claims and two health care claims on behalf of individual patients among the ten largest awards in the country.
    - One in six physicians face a medical malpractice claim annually.
    - More than 125,000 lawsuits are pending against the country's physicians on any given day.

Insurance Reform, known in California as Prop. 103, is the Solution

- Myth # 1. California's Prop. 103 of 1988 (known by its supporters as insurance reform) and not MICRA is responsible for California's lower medical malpractice premiums.
  - EXPLODING THE MYTH
    - As to medical malpractice coverage, only 50% of California's medical providers were insured by entities subject to Prop. 103's provisions.
    - The remaining 50%, including public and private education and medical institutions, were not subject to Prop. 103 nor they receive any benefits.
    - Prop. 103 was adopted by the voters in 1989, 13 years after MICRA became law and 4 years after MICRA was declared constitutional.

Insurance Reform, known in California as Prop. 103, is the Solution

- Myth #2. Prop. 103 was implemented immediately in California and began impacting the cost of medical malpractice premiums.
  - EXPLODING THE MYTH
    - There was no immediate impact at all. Prop. 103 was challenged in the courts and was caught in the regulatory process until the 1993.
    - Prop. 103 only prohibits premium rates, including medical malpractice, from being "unfair and excessive".
    - Prop. 103 does not require that premium rate filings be justified regardless of the amount of the proposed increase.
    - Under Prop. 103, no California medical malpractice insurance company has ever been denied a premium rate increase.

Insurance Reform, known in California as Prop. 103, is the Solution

- Myth #3. Prop. 103 reduced medical malpractice insurance rates by requiring a 20% rollback and refunds to physicians.
  - EXPLODING THE MYTH
    - California medical malpractice insurers, including physician-owned companies like The Doctors Company, were already paying annual dividends. There was no premium rollback.
    - In every agreement with the California Department of Insurance, the medical malpractice insurers were exempted from rate rollbacks because their annual dividend exceeded any rollback obligation.
    - The Doctors Company had been paying annual dividends for 11 years prior to Prop. 103.
    - The Doctors Company paid out higher dividends in the five years preceding Prop. 103 than in the five years after its enactment.

Medical Malpractice Liability Reform will not address policing bad doctors, increasing patient safety or providing access to the courts or access to health care.

- Myth #1. Medical Liability Reform prevents quick and easy access to the courts.
  - EXPLODING THE MYTH
    - The average time to settle a claim is 33% longer (2.4 years) in a state without a monetary cap on non-economic damages than in California where the average is 1.8 years. Meritless lawsuits do not clog the courts.
    - 76% of 1,000 American adults in a national survey favor laws that guarantee injured patients full payment for past and future lost economic wages and medical costs with a reasonable limit on noneconomic damages. They are the essential components of effective medical liability reform.
    - Even after the passage of effective medical liability reform in California, there has been no measurable decrease in the number of medical malpractice lawsuits filed. By state law, only the health care provider can agree to settle, not the insurer. 80% of the cases are determined to be without merit.

Medical Malpractice Liability Reform will not address policing bad doctors, increasing patient safety or providing access to the courts or access to health care.

- Myth #2. Medical Liability Reform Has No Impact on Access to Health Care.
  - EXPLODING THE MYTH
    - 84% of 1,000 American adults in a recent national survey believe that availability and quality health care is threatened directly by exploding medical liability costs that are forcing physicians to retire or move their practice to another state where effective medical liability reform laws are in place. 71% of these same Americans believe that one of the primary factors driving up health care expenses is the rising cost of medical liability lawsuits.
    - California with its effective medical liability reform in law lowers the state's annual health care costs by 6% and allows an additional $6 billion to be spent.
    - According to two recent national studies, medical liability reforms would reduce annual health care costs by at least $100 billion so that it can be spent directly in providing access to quality medical care to the young and the old.

Medical Malpractice Liability Reform will not address policing bad doctors, increasing patient safety or providing access to the courts or access to health care.

- Myth #3. Failing to police bad doctors is the cause of exploding malpractice rates.
  - EXPLODING THE MYTH
    - According to the Harvard Study, the degree of injury, not medical negligence, predicts the medical care outcome.
    - When California enacted its medical liability reforms, it created the state medical board with the authority to license and the power to police doctors.
    - Physician owned medical liability companies developed and implement loss prevention programs that continue to improve the quality of care and reduce losses.
    - Doctors most often sued are those of high skill level who perform the most complex and high-risk procedures.
    - According to two recent national studies of the medical liability system, from 1990 to 2002, just 5% of physicians were involved in 54% of the payouts that included both jury awards and out-of-court settlements.
    - A marker of physician competence should not be based on whether a lawsuit or claim has been filed.

Medical Malpractice Liability Reform will not address policing bad doctors, increasing patient safety or providing access to the courts or access to health care.

- Myth # 4. Providing patient safety is the solution to exploding medical malpractice rates.
  - EXPLODING THE MYTH
    - Physician owned medical liability insurance companies, such as The Doctors Company, support confidential reporting systems as suggested by the Institute of Medicine and the Patient Safety Foundation.
    - According to the Stanford Study, reducing the costs of defensive medicine in states with effective medical liability reform laws lower health care costs by 5-9% annually. This translates into at least an annual savings of $60 billion. Today, the US Department of Health and Human Services estimates this cost at over $100 billion.
    - The US Department of Health and Human Services reports that 4 out of 5 physicians order more tests than medically necessary due to the fear of litigation.
    - Utilization of medical guidelines as risk management protocols are currently offered to the health care providers insured by physician owned medical malpractice insurance companies.