

House Energy and Commerce

“Harming Patient Access to Care”

CHAIRMAN: I call this hearing to order.

I'm advised that there probably will be a vote at 10:30 so we'll try to get to as many opening statements as we can. I'd like to thank our witnesses for appearing before the sub-committee today. The sub-committee certainly values your expertise and we're grateful for your cooperation and attendance. Today the House sub-committee is going to focus on how the current medical liability system is harming patient access to care. The United States is facing a crisis that, in the end is going to harm patients. One has to look no farther than my home state of Florida where some obstetricians/gynecologists are paying in excess of \$200,000 per year for their liability insurance. Or Mississippi where neurosurgeons have been leaving the state to practice in Louisiana, which has significantly lower insurance premiums. The most disturbing indication of the severity of this crisis, however, might be in Las Vegas, where the county operated trauma center was forced to close because the center's trauma surgeons could

no longer afford to risk their livelihood in this climate of runaway litigation. I am advised that the trauma center recently reopened, some sort of arrangements were made but hopefully that will spare the city from the dubious distinction of being the largest metropolitan area in the United States without a trauma center. Although it would be easy enough to gauge the severity of this crisis just by reading the newspapers, I decided to hold a field forum in my district to hear from providers about how this issue is affecting how they practice medicine. The event highlighted the scope of the problem and the urgent need for congressional action. As one solo practitioner remarked, "It is imperative that we act now to stem this crisis. If no action is taken soon and if the present trends are allowed to continue there will be no medical system left to save."

I am sure that everyone here believes that we are facing a crisis and that patients are going to find it increasingly difficult to find an OB/GYN, a neurosurgeon, or trauma surgeon, unless

the federal government intervenes. And I know that there are very different ideas about what format solutions should take and that's what this is all about.

While I have no doubt that many of my colleagues will use today's hearing to advocate for increased federal regulation of insurance companies, I would point out that this insurance is already regulated at the state level, in fact state insurance commissioners already approve each premium rate before it goes on the market. I will say, however, that that is a very legitimate and merited concern and topic and that's something that we certainly should focus on and this is the first of a series certainly of two or three hearings in any case, and we will be off emphasizing that aspect of the situation, more so in future hearings.

Instead of talking about increased regulation of an already regulated industry, however, having said that, I would prefer that we looked at models that we already know work. For

example, in 1975 California enacted the Medical Injury Compensation Reform Act, or MICRA. That's in 1975. The defining feature of MICRA is the limits it places on non-economic damages, on non-economic damages. This reasonable law has done a commendable job of protecting patients' rights, while also keeping insurance premiums at a relatively low level.

The United States has seen steady increases over the past several years in both jury awards and malpractices and the average amount paid by insurance companies for claims merely alleging malpractice. However, California has remained relatively immune to the pressures brought about by these trends thanks, largely thanks to MICRA. It is a time-tested system that certainly seems to work and we should not be discarding any consideration of that type of a process.

I'm a co-sponsor of legislation HR4600 that closely mirrors this groundbreaking law. Without delving into the specifics of this

particular bill, I do believe that it represents a common sense solution to this problem and respects a state's traditional roles, regulators of the insurance industry.

Although I am aware that many members of sub-committee have some strongly held views in this issue, I would hope to use this hearing to take advantage of our witnesses' expertise and explore this issue in depth. Hopefully we will leave with a better understanding of why this problem exists and what our role is in identifying and implementing a solution.

While I often say that not every problem requires action by the federal government, this one apparently does. And I believe we can stabilize our out of control medical liability system without harming the ability of patients to recover adequate compensation when they have been harmed and I now yield to the ranking member, Mr. Brown for his opening statement.

MR. BROWN: I thank the Chairman. I'd just like to thank all of our witnesses for joining

this morning. I share your interest, Mr. Chairman, in this issue. Actually, a friend of mine in Ohio was recently informed that his medical malpractice carrier is leaving our state. He tells me many carriers have either limited their coverage or left the state. The least expensive premium he has been quoted represents a 300% increase over his current year premium. There's something wrong with this picture and I'm pleased that the sub-committee is looking into it.

I assume Mr. Chairman that the purpose of this hearing is to take an objective look at the diversity of factors that could be contributing to the spike in medical malpractice insurance premiums and the gaps in access to this type of coverage. I'm assuming the underlying goal is to make informed decisions about how best to remedy these problems and to do that we must take into account the full range of factors contributing to the current situation. Not only do we have a responsibility to the doctors who are reeling at the size of medical malpractice premiums in some

cases. I am inclined to react to the unavailability of coverage. We also have a responsibility to patients who expect and deserve access to high quality healthcare. Malpractice insurance shouldn't hinder access to high quality care; it should help insure access to high quality care. Harming patient access to care, the impact of excessive litigation, the title of this hearing, implies that this hearing is perfunctory. That we've already drawn a conclusion about what is causing the spike in medical malpractice insurance premiums. Doctors in my district can justifiably wonder where their, whether the recent premium increases in any case they justifiably wonder whether the recent premium increases are actually the insurance industry's attempt to recoup stock market losses or perhaps bad management decisions by the insurance company. Perhaps instead of calling this hearing "Harming Patient Access to Care: the Impact of Excessive Litigation" we should title the hearing "Harming Patient Access to Care: the Impact of Corporate

Abuse on Stock Market Volatility and Insurance Profit Objectives." Or maybe we should call the hearing "Harming Patient Access to Care: the Impact of Huge Insurance Company CEO salaries." Or perhaps we should call the hearing "Harming Patient Access to Care: the Impact of the Insurance Underwriting Cycle."

The point of this, Mr. Chairman, is that doctors have raised valid concerns about medical malpractice insurance premiums, about access to medical malpractice coverage, about the nature of medical malpractice litigation itself, but the current medical malpractice crisis, it is undoubtedly a crisis because of its effect on patients, first and foremost, and on physicians, importantly, the current crisis should not be used as an excuse to decimate a system that affects patients and doctors. We shouldn't use this hearing as an excuse to beat up on the insurance industry or to demonize lawyers or to trivialize the concerns of providers, or to dismiss the legitimate rights of patients. The doctors in my

district and others around country whom I know and whom I respect have no problem with being held accountable as long as the system is fair.

That brings me back to my doctor friend in Northeast Ohio. I wouldn't call a 300% premium increase fair. I would call it an outrage. I hope and expect that today's witnesses can help us build factual basis for doing something about it, not simply to exploit preconceived notions. Thank you, Mr. Chairman.

CHAIRMAN: I thank this gentleman and I would say to this gentleman that there is merit in everything that he just said and as I've indicated this is the first of a series of hearings and I can't tell you how many we will have but certainly we will look at some of the areas that we're not looking into today. Mr. Greenwood

MR. GREENWOOD: Thank you Mr. Chairman. I thank you for holding a hearing on access to care for patients and the need for medical liability reform. As you know, I am deeply committed to solving this problem affecting both of our states,

affecting healthcare across the nation. A few weeks ago at the committee field event in your district we heard about the dire circumstances your constituents find themselves in throughout Florida. Let me tell you about how this is impacting care in Bucks County in Southeastern Pennsylvania. Philadelphia and the surrounding five county area with its world-class hospitals, medical schools, doctors, and other institutions, is one of the nation's and I daresay the world's, crown jewels of healthcare. However, the fabric that holds together these doctors, patients, and institutions has become more than frayed. It has begun to tear and disintegrate before our eyes.

The long-term damage caused by the exorbitant costs and concomitant lack of medical of medical liability insurance in Pennsylvania has become incalculable. To give you an example, recently Methodist Hospital, South Philadelphia, was forced to close down its obstetrics practice, which has been present in the hospital since 1892.

Chairman, let me read for you from several

letters I've received from constituents who describe this crisis most poignantly. This came from a woman in the Philadelphia area of my district.

"I was born and raised in the Philadelphia area, an area that used to be known for excellent medical care. Eight months ago I again found a wonderful OB/GYN office. The doctors are wonderful, respectful, well educated, and overall just great. They delivered my beautiful baby girl for me. I could not have been happier with their care. I referred my sister, who is currently pregnant and due in a few short weeks, to them. She too was satisfied with them. Two weeks ago we were outraged to discover that they were closing their doors at the end of May 2002. My sister, who has been going to their office for all of her prenatal care visits, cannot even have her after delivery exam by the doctor who delivers her first child. I will not be able to return to them for subsequent prenatal care, or even normal GYN care. This is an outrage. It is also the second

physician's office I have been to in the last couple of years that has been forced to close due to medical liability costs. Another office that I was aware of closed as well for the same reason. I can't even switch to see them because they no longer exist within our state. I don't know who I can even go to now. No other OB/GYN physicians practice in my area any more.

I plan to be in Doylestown area for quite a while and it would be a disaster to have families leaving the state so that they know they will be cared for properly in the event of an emergency medical situation."

Here's another letter. This is from the husband of a physician.

"My family has a 200-year history in lower Bucks County and my wife and I decided to stay local. After my wife's residency at Penn and after four grueling years there and another at the MCP Hanneman Department of Neurology, she entered a group practice of neurology in the area. Her time there finished, she is trying to start her

own practice focusing on the under-served members of the Lower Bucks senior population: those in nursing homes, long-term care facilities, and homebound. Her desire to serve these patients was inspired, not by a business decision but for a true concern for those who find it difficult to get the quality of neurological care she is trained to provide.

Five months ago, after sending her first application for insurance, she is still not insured. The state-administered JUA (Joint Underwriting Association) is not an option for new physicians starting out and the cost is prohibitive."

Mr. Chairman, this crisis affects more than just patients and doctors. Recently the orthopedics practice that was to cover the Doylestown Hospital emergency room on the weekend found that its insurance coverage was lapsed. After months of searching the hospital then had to find other practices to cover the ER. Other orthopedics practices are also having trouble

finding insurance in the area. What happens when we can't find orthopedics to treat the broken bones and dislocated in ER on weekends?

Worse, St. Mary's Medical Center, the only trauma center in Bucks County faced closing its doors last fall since it could not find insurance. Luckily the state came through with emergency coverage, however, this is not sustainable in the long run. Las Vegas for the past few weeks, as we've seen in the news, has not been so lucky. This is about patients, doctors, and the healthcare institutions where care is delivered. Not merely a crisis. It is more than that. It is beyond a meltdown. It is a full-blown catastrophe that is having a damaging and detrimental impact on the healthcare of Pennsylvania and millions of Americans. Worse, this catastrophe will result in people dying as trauma centers will continue to close their doors, or emergency rooms will be unavailable to provide care, as doctors won't be available.

I am saddened and angered that this

catastrophe is having permanent and long-term effects, weakening hospitals, debilitating medical schools, reducing the number of doctors who practice, destabilizing healthcare institutions. The cause, Mr. Chairman, is clear, unfettered litigation. The median malpractice by jury awards rose from \$500,000 in 1995 to \$800,000 in 1999. You need reforms now. Chairman the reforms that I have proposed, along with you, Chris Cox, John Murtha and a number of other bipartisan co-sponsors, are common sense, time tested reforms. We followed the model used in California and a number of other states. This bill is fair and straightforward. This bill, HR4600, the Bipartisan Healthcare Act, includes reforms to make medical malpractice insurance affordable again and encourage healthcare practitioners to maintain their practices and continue to serve patients. Thank you, Mr. Chairman.

CHAIRMAN: I thank the gentle Mr. Pallone for an opening statement.

MR. PALLONE: Thank you, Mr. Chairman. We

can tell from the title of this hearing that the supporters of HR4600 believe that excessive litigation is the precise, direct reason for the current malpractice crisis and that by passing legislation that limits non-economic damages to \$250,000 the problem will be easily solved. But, Mr. Chairman I think this is far too simplistic. For example, you have the chart up there but in 1975 California enacted the Medical Injury Compensation Reform Act into law that has severely the rights of patients injured by medical malpractice. From what I understand California's medical malpractice liability premiums actually increased by 190% in the twelve following enactment of that law. I'd also like to add that medical malpractice insurance profits have been ten times greater than the profits of other lines of insurance in California.

Skyrocketing malpractice insurance premiums have been particularly acute in high-risk specialties. This is clearly because inherent in high-risk practices are bad outcomes that are

beyond the control of providers. Further this is compounded by the fact that medicine is changing in the direction of becoming more and more complex. For example, if a fifty-year-old woman goes to her OB/GYN and wants to have a baby, it makes a high risk specialist liable for an even higher risk pregnancy where the chances of a bad outcome are dramatically increased. The OB/GYN is not going to turn the patient away or tell her that it's not possible to have the baby, but my point is that although the face of medicine is changing, we have yet to examine how insurance needs to be changed in order to reflect the rapid advancements taking place in various fields of medicine.

Aside from this example, if we take a surface level look into other changes in healthcare, we see that HMO's for the last 15 to 20 years have entered the market. Doctors have been subject to certain limitations under HMO's that may prevent patients from receiving the best care possible from their doctors. Is there a

direct correlation between care under HMO's and bad patient outcomes? Well, it's something we have to look at.

I am also curious, given the atmosphere of corporate malfeasance, which we've seen so often in the last few weeks, whether bad accounting, or bad business judgment on the part of insurance companies, has anything to do with dramatic rises in medical malpractice premiums.

Mr. Chairman, I propose legislation of the Federal Medical Malpractice Insurance Stabilization Act of 2002 that would create a national reinsurance fund. This proposal mandates the Secretary of Health and Human Services to establish a program where insurance companies pay into a federal fund and in times of crisis those funds would be made available to those companies in an effort to provide stability in the market for medical malpractice insurance coverage. Some other ideas that my own state of New Jersey are examining are a deductible option of about \$10,000 that would lower premiums, a risk management

program for doctors that would correspond with a decrease in premiums, and allowing doctors to make installment payments for high premiums over time without a penalty.

I'm not suggesting that, you know, these are answers but I think that the title of this hearing once again shows that some on the committee just see the cap if you will on damages as something that's going to solve all the problems. And I don't think that's the case. There's no question that we have a crisis here. Certainly in my home state of New Jersey it is acute. We've had forums at my local hospitals with physicians to talk about this, we've had the state insurance commissioner, we had a rally on the steps of statehouse by physicians and other healthcare providers, basically begging that something be done. So I appreciate the fact, Mr. Chairman that we're having a hearing and that we will have others. I don't think there's any question that we need to address this. But I just hope that we can work together in this sub-

committee and come up with sensible legislation that will effectively address the current problems with medical malpractice insurance and not just assume that certain aspects of tort reform are going to solve all the problems. Thank you.

CHAIRMAN: I thank the gentleman. Mr. Cox.

MR. COX: Thank you, Mr. Chairman. The purpose of today's hearing is to learn how to put patients first. Our healthcare lawsuit system today is destroying hospitals. It's eliminating patient choice. It's driving specialists out of entire states and out of their practices. It's enriching an handful of amoral trial lawyers beyond any level previously imagined. In days gone by medicine and law were the professions. Both were respected. Both were considered outstanding members of the community. Both professions earned handsome compensation for their valued services. But neither doctors nor lawyers were paid extravagantly compared to say, investment bankers. Today in the early 21st century that has changed. Doctors' compensation by any standards is being

squeezed. Hospitals are having trouble staying in business. OB/GYN's face such financial risks that many now refuse to deliver babies. Meanwhile America is home to the only billionaire lawyers. Many of those billions have been taken from the healthcare system and directly from patient settlements. In a national poll taken this week lawyers rank at the bottom of the list, below politicians, below accountants, below CEO's, most of whom Americans can trust.

In California during the malpractice crisis of a generation ago, the democratic legislature and democratic governor, Jerry Brown, signed the law, MICRA, which regulates healthcare lawsuits for the benefit of all patients, not the lawyers. In California specialists are not leaving our state. The malpractice insurance crisis so acute in other states has not struck California. There's a simple way to test this fact. Ask the doctors. America, it's high time we trusted our physicians, not our lawyers with our nation's healthcare. Thank you, Mr. Chairman.

CHAIRMAN: [Unintelligible] Ms. Eshoo for your opening statement.

MS. ESHOO: Thank you, Mr. Chairman and good morning to all my colleagues and to our distinguished witnesses. Thank you for holding this hearing. I think it's important to hear from a variety of witnesses, people that are steeped in the background that certainly Members of Congress need to hear and be made aware of.

I agree with many of my colleagues that we have a problem and that it needs to be addressed. Physicians across the country are having trouble meeting the skyrocketing cost of malpractice insurance. We know that and that is cause for alarm. To have a stable healthcare system we have to have a stable malpractice system. My father used to say, "At the end of the day you want the best doctors standing on one side of you and a great lawyer on the other side." So I don't think that we should fall into the trap of either defending one side and damning the other or vice-versa. We have to have strength on both sides and

you have to have clearly a balance between the two. Just as patients need to have access to medical care, and that we need top physicians that are going to provide the care that only they can, as well as their corollaries in the system, when something goes wrong that has to be spoken to in our system as well. It hurts the medical practitioner in this country if there is a bad apple in the barrel just as it hurts members of Congress when we have bad apples in the political process as well. So where I disagree with some of my colleagues is in the total presumption, in the total presumption that the rising costs of malpractice premiums are solely due to patient litigation. We have to restrain ourselves a little here and we need to get more information. Is there something wrong? Yes. But I don't think we can afford to just leapfrog today. That's why the hearing and hearings, subsequent hearings are very important. In reality there are a whole host of factors in my view that have lead to the increases and that the Congress has the duty to examine each

and every one of the factors before we act. As a Californian, my state created MICRA and its been referenced in 1975. I'm pleased with how that law has helped to moderate malpractice premiums in our state and I know that Representative Greenwood has introduced legislation that's based on the MICRA law.

I'm concerned that there's an urgency to act before understanding. We have to understand things before we can accept or reject so developing, Mr. Chairman, and you're doing that by having a hearing, is really important and I can't state that enough. I also understand that there's a GAO report that's been requested on the role of market conditions and insurance company practices and I look forward to the results of that report and I think we all should. That needs to be taken into consideration as well. So the testimony of today's excellent witnesses, amongst them I think one of the real greats on behalf of women and the issues of breast cancer in our country, Fran Visco, with the GAO report and the data we already

have on the effects of litigation on the malpractice system, should really allow us to more ably and responsibly address this serious problem. So thanks again, Mr. Chairman and certainly to Mr. Greenwood whom I admire as a legislator. He's serious, he's always worked to be fair, and as a complete disclosure, he's been, I am proud to have been, still am, a partner with him on many pieces of legislation.

CHAIRMAN: Thank you. I thank the gentle lady.

MS. ISSUE [Misspelled?]: I yield back. Thank you.

UNKNOWN: Chairman, I would ask the gentle lady [Unintelligible] we have three minutes to make this vote.

UNKNOWN: Yes, don't step on that, Mr. Chairman.

CHAIRMAN: We have three minutes to make this vote so we're going to run over and make this vote. That's in fifteen to twenty minutes of delays we should get started again. When I get

back into this chair we're going to get started.

CHAIRMAN: The gentleman from Kentucky, Mr. Whitfield to give his opening statement.

MR. WHITFIELD: Thank you very much Mr. Chairman and of course I'm also delighted that we're having these hearings on this particularly important subject. There's been a lot of comments made about the possibility that insurance companies are doing some gauging and so forth but I find it interesting that last year the nation's second largest malpractice insurer had underwriting losses of \$940,000,000, the St. Paul Companies, and they announced that they were getting out of the insurance business, the malpractice insurance business. Well, if they're making so much money then why are they getting out of the business?

An article in the Wall Street Journal indicated that the consequences of actions like that because other malpractice carriers were getting out of the business, the consequences are being felt by patients all around the US. Last

year, Bolivar County in Western Mississippi had six doctors 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. In neighboring Sunflower County all four doctors who delivered babies have quit private practice. In the northern half of the state last year there were nine practicing neurosurgeons. Today there are three on emergency call.

And I could go on and on. There was an article just a few days ago in my home state of Kentucky: "State Losing Doctors To Insurance Hikes. Coverage For Malpractice Jumps As Much As 204%." And the doctors are blaming jury verdicts for this increase.

And then there's another part of this article indicates that, for example, in Corbin, Kentucky, the Corbin Family Health Center lost malpractice coverage and closed down. We have doctors leaving Kentucky, going to Indiana, because the Indiana insurance rates are much lower

for malpractice insurance than in Kentucky. And one reason that they're lower is that Indiana adopted meaningful tort reform legislation some time ago. And so there is a real difference in the insurance rates because those areas where tort reform has been adopted and where it has not been adopted. So I'm delighted with hearing. I look forward to the testimony and give back the balance of my time.

CHAIRMAN: I thank the gentleman.

[Unintelligible] Mr. Waxman.

MR. WAXMAN: Thank you very much, Mr. Chairman. I welcome this hearing on the crisis behind medical liability insurance and its impact on doctors and patients around the country. The title of the hearing, which focuses on the impact of litigation, is unfortunate. It's unfortunate because it assumes that increases in malpractice premiums are simply the result of a legal system out of control. That conclusion, which we heard during the insurance crisis of the mid 1980's and many times since, is far from clear. We don't

know, for instance, to what extent the business cycle and the business practices of insurance companies have contributed to these increases. There is substantial evidence to suggest that rates are more closely related to these factors than the lawsuits and large jury verdicts. These are fundamental questions that need to be answered before we attempt any legislative fix for the problem and before we enact what is essentially a bill that maybe considered a bailout for the insurance industry.

In 1975 California adopted MICRA, which stands for the Medical Injury Compensation Act. It imposed significant limitations on the rights of injured patients to sue and recover from malpractice related injuries. For example, MICRA imposed a \$250,000 cap on non-economic damages and eliminated joint liability. Some of the witnesses appearing before us today are going to tell us that MICRA has worked well in California and because of that we should adopt legislation even more restrictive on the national level. HR4600,

for example, adopts many of MICRA's major provisions and goes further. It extends limitations to product liability cases for defective drugs and it imposes caps and other significant limitations on punitive damages. I have serious reservations about moving quickly to adopt limitations along these lines. Insurance regulation is an area that Congress has traditionally left to the states and for good reasons. It's a complex business. It [Unintelligible] market-by-market and community-by-community. We do not license medical doctors and other health professions. That's done at the state level. One size does not fit all. We will hear testimony that raises serious questions about the California experience from Jamie Court, the Executive Director of the Foundation for Taxpayer and Consumer Rights, who will testify that MICRA has prevented the courts from awarding adequate compensation for many deserving victims. He's also expected to testify that MICRA has given a windfall to insurance companies in California. It

has not delivered the reductions it promised for medical malpractice insurance. He will contend that the malpractice premiums stayed close to premium trends around the country and in fact between 91 and 2002 premiums grew at a rate of 3.5%, which is higher than the national average of 1.9%.

According to Robert Hunter, who is an actuary from the state of Texas and a former Texas Insurance Commissioner, in the years since MICRA was enacted medical malpractice insurers have profited more from their business in California than in any other state. Since 1989 California medical malpractice insurers paid out less than 50 cents in claims for every premium dollar they took in. In other parts of the country he contends malpractice insurers typically paid out more than two thirds of every dollar taken in through premiums. In addition, California medical malpractice insurers earn higher operating profits, that is profits earned as a percentage of premiums, than do medical malpractice insurers

outside the state.

In short, there are a number of serious questions to sort through. We should be careful before we rush and use any one model for the entire country. I look forward to the testimony that we're going to receive from witnesses today and to work with my colleagues on this very difficult issue.

CHAIRMAN: I thank the gentleman. Dr. Ganske.

DR. GANSKE: Thank you, Mr. Chairman for holding this hearing. I think this is a very important issue. In my home state of Iowa we are not in a crisis yet. We are probably about twelve to eighteen months from that. Let me give you a real life example. A woman family practitioner in Iowa is called to the emergency room because a Hispanic woman, who has received no prenatal care has shown up in labor. Out of the goodness of her heart and her professional ethics this woman physician goes to the hospital, delivers a baby, no problems during the delivery, baby is handed

over to the neonatal unit, subsequently becomes septic, and dies.

Needless to say, very shortly afterwards, this woman family physician is named in the lawsuit for basically pro bono work. Mr. Chairman I will tell you we have worked on this issue. How many times have we voted on this now in the House in the last eight years? At least, I think we've passed this at least twice, medical mal tort reform, if not three times, and will do that again. The real problem has been the holdup in the US Senate in terms of getting something done on this. Now I don't know whether insurance companies' investments in the [Unintelligible] have some effect on their ability to, cap their reserves. That's something we can find out easily. But I do know this. I know that the incidence of the types of lawsuits that this woman physician experienced recently in Iowa are driving insurance rates and it is something that we need to do something about or I tell you, you know, if you're looking at going to Las Vegas these days, you may

be gambling a little bit more than your money if you have an accident. And this is happening all over the country so thank you Mr. Chairman for holding this hearing. I look forward to learning from it.

CHAIRMAN: Thank you, Dr. Ganske. Mr. Tippett [Misspelled?].

MR. TIPPETT [Misspelled?]: Thank you, Mr. Chairman and thank you for holding this hearing today on the impact of litigation on medical malpractice insurance premiums. No doubt about it this is an issue that merits our attention. We need today to sort out the fact from faction and to help us understand the real underlying reasons for those steep premium hikes.

I'm concerned all over that some of us here have already made up our minds as to the reason for these hikes. Has blame already been placed? Let's look no further than the topic and title of today's hearing: "Harming Patient Access: the Impact of Excessive Litigation."

In this area, as in so many other areas,

the right to sue is being attacked as the root of all evils. And stopping Americans from suing is being proposed as the magic cure-all. In fact, when you take away the incentive to behave or to be sued, you eliminate deterrents. This is a proven fact. I recommend to this committee, in light of what the last couple of speakers on the other side of the aisle have said, look at two Wall Street Journal articles written less than a month ago, the first one on June 24. It says: "Wall Street Journal, June 24th, insurers' price wars contributed to doctors facing soaring costs. Lawsuits alone didn't inflate malpractice premiums. Reserves at St. Paul distorted pricing picture in the 1990's."

I also recommend another article, again on June 24th. "Wall Street examines medical malpractice liability crisis. Finds its insurance industry generated. Insurance company executive admits the crisis is self-inflicted." It goes on to say, "the insurance industry's questionable accounting exposed." It sounds like Enron and

Worldcom to me all over again so we're going the victims of malpractice.

We've seen this happen with disastrous results with securities litigation that we passed - the Private Securities Litigation Reform Act of 1995. Accountants and executives had no incentive to be good corporate citizens and look what's happened since then, the largest corporate bankruptcies in American history. And it's not the fat cats that are paying, Mr. Chairman. The people who are paying are our constituents and now we have a proposal to do the same for those harmed by medical mistakes. HR4600 introduced by the distinguished from Pennsylvania, Mr. Greenwood, I believe would do a similar injustice to medical consumers as the Private Securities Litigation Reform Act did to shareholders and investors. As we've done for shareholders, we are now proposing to do for patients. I commend Mr. Greenwood for attempting to find a solution but this bill's not the answer. This bill's a one-size fits all approach to a complex issue. Experts on

this issue in front of us today will testify that stopping lawsuits and capping damages is not the magic bullet. In fact, the insurance companies themselves have stated unequivocally that tort reform will not reduce premiums and will not fix the medical malpractice liability system. In my home state of Michigan many of these reforms have been listed as listed in this bill before us have been done in Michigan. And yet Michigan is listed as one of these critical crisis states for malpractice reform.

I understand I sympathize with the doctors facing huge premiums but this bill's not the answer they're seeking. Careful, thoughtful consideration of all factors contributing to this dilemma is what we're here to do today. I'm particularly bothered by Section 7C in this bill, found on Page 10 and it states under Section, Line 17, Sub-Section C, "No civil monetary penalties for products that comply with FDA standards."

We've seen this over and over again, much like the PLSRA. Again, go back to Los Angeles

Times, December 20, 2000, headline, "How a New Policy Lead to Seven Deadly Drugs: Medicine, Once a Wary Watchdog, the US FDA Administration Set Out To Become a Partner of the Pharmaceutical Industries. Since 1997 these drugs have been approved with an expedited process, only to find they have to be certainly then withdrawn.

According to the Adverse Events Reports filed with the FDA, the seven drugs were cited as suspects in 1,002 deaths." It goes on to say that "a total of ten drugs have been pulled from the market in just the past three years for safety reasons, including three pills that were approved before the shift that took hold in 1993. That was [PUDUFA] [Misspelled?]. Never before has the FDA overseen the withdrawals of so many drugs in such a short period of time. More than 22 million Americans, about 10% of the nation's population, took these drugs. And the drug companies themselves benefited to the tune of over \$5 billion before they were withdrawn." So the answer is not to restrict the FDA, or say because the FDA approved a drug it is

suddenly immune from any kind of tort liability or certainly restrict the rights of patients to bring lawsuits.

Look, we need to look at our past mistakes on tort reform, PLSRA, and some of these other bills that have passed through this committee and learn from them. So, Mr. Chairman, I look forward to hearing from our witnesses today. Looking forward to working with you and the gentleman from Pennsylvania, Mr. Greenwood, and let's really look at the real cause of the problem, and not just artificially go after medical malpractice as the answer.

CHAIRMAN: The gentleman's time has expired. Dr. [Unintelligible]

UNKNOWN: Thank you very much, Mr. Chairman. As we all know, all of us, both sides, we are in the midst of a full-blown healthcare crisis. I like to liken it to a perfect storm where many storms are coming together. One of those storms could very well be the insurance industry and I want to know more about that than

this committee is going to find out.

But one of the storms we do know a lot about and are for certain of is the liability crisis. And it would be of help if everybody on this committee would recognize that that is part of the problem, it may not be the entire part of the problem, but it is one that we do have a lot of information on. I don't know any physician or healthcare provider who has not witnessed drastic increases in the insurance premiums over the past year. Whether these rate increases are 30% or 300%, the bottom line is that these premium increases threaten the physician's ability to continue to practice, especially specialty physicians such as OB/GYN's. But while the financial burden for [Unintelligible] of physicians is the most obvious symptom of this crisis, the greatest harm that is occurring is patient access and patient care.

On July 3 the trauma center of the University Medical Center in Las Vegas closed its doors, as Dr. [Ganci] [Misspelled?] alluded to.

Facing a 93% premium hike, what are the surgeons going to do? They had to walk out, obviously. This ain't no [Unintelligible] but it has become the closest thing to emergency care as a 10,000 square mile area was left without a trauma center.

We have an opportunity here before to defend patient's access to healthcare and shore up the sovereignty of the healthcare industry. I realize the complexity and the multitude impacting this medical liability crisis, regardless of what anybody on this committee says. And the surplus of editorial page banter that's going on but the issue of tort reform is front and center. We know a lot about that. [Unintelligible] unlimited liability is part of the problem and it deserves all of our attention. We have clear and convincing evidence of the overwhelmingly positive results of medical liability reform for 25 years worth of data under California's MICRA. This reform measure is centered on limiting non-economic damages and restricting abusive lawyer contingency fees. Let's be clear. Non-economic damages are rewarded to

compensate for pain and suffering or other non-tangible, unquantifiable, non-monetary losses. Under the proposed legislation economic damages would receive no cap and punitive damages are left to a sliding scale. I strongly believe in fair compensation injured by healthcare provider negligence, but not in excess of these great jury verdicts. But of course when we talk about limiting runaway jury awards, we're also talking about limiting runaway fees to lawyers, which form the only true opposition to this legislation, the only opposition to this legislation. The medical liability industry started a vicious cycle that hurts patients any way you cut it. Let's fight for patients' access to care and patient care. Mr. Chairman I look forward to the testimony of our witnesses today. I look forward to other hearings as we look at different parts of this storm and hopefully we can come together to improve the healthcare in this country. Thank you.

CHAIRMAN: I thank you doctor. Mr. Strickland.

MR. STRICKLAND: Thank you, Mr. Chairman.

There is trouble in the medical malpractice insurance industry. That much is clear. I have heard from doctors in my district since early this year about spikes in costs and fears that more serious problems in the neighboring states of Pennsylvania and West Virginia will be replicated in Ohio. As a representative of a rural area, I am particularly concerned about this issue. My district already suffers from chronic access problems and I am very worried that a malpractice crisis, which doctors simply cannot buy insurance that exacerbates this problem to the point of emergency. I received a letter last week from a physician in my district who told me that his malpractice insurance has gone from \$12,000 last year to over \$45,000 this year. This obviously is not sustainable. But the question we must ask and answer is why. As many of the witnesses before us today will confirm and discuss, a variety of factors have contributed to the current crisis. Certainly we should consider what tort reforms may

be needed. But as has been mentioned, the recent Wall Street Journal article illustrates other problems that may be serious factors in this escalating problem. Many of my colleagues are championing this HR4600 bill, a bill that seeks to address the problem in medical malpractice using just one approach, tort reform. A look at research from across the country though, finds that states have dramatically different situations with respect to medical malpractice systems demonstrating how complicated this industry. It is wrong to think that we can assign only one size fits all solutions that will adequately address this crisis. In fact, I fear that HR4600 will not fix the problems. I worry that the bill may, though, hurt patients. Specifically, I fear that this bill could:

- 1) Violate states' right by stripping away state law and federalizing a new body of law and procedure.

- 2) Set a very short and unfair statute of limitations that could actually increase the

number of lawsuits that are filed because people may rush to file before their window of opportunity expires, and

3) I fear that HR4600 would create laws that have already been found unconstitutional such as the limit on non-economic damages.

Even more importantly though, HR4600 does absolutely nothing, nothing to address the reforms that are needed in the insurance industry to repair the current crisis and ensure that it doesn't happen again.

I am particularly concerned about the cap on non-economic damages. I find this cap egregious because it limits access to our legal system. It disproportionately caps damage awards for women and others who earn low incomes. In addition, there is no evidence that these caps will actually reduce malpractice rates. The California situation has been alluded to. A \$250,000 cap on economic damages has been in place since 1975 and still the state of California has premiums that are 56% higher than in my state of Ohio, which doesn't

currently have caps. Limiting access to our legal system and placing the burden of this limited access disproportionately on the most vulnerable in our society won't insure that malpractice rates stop rising.

All of these reasons are why I am working with some of my colleagues, including Representative Sandlin, to draft a thoughtful legislative response to malpractice crisis that takes all dimensions of the crisis into account including tort reform and insurance industry reform. We must look critically at all of these systems and the problems that are plaguing them, instead of believing that a single issue as addressed in HR4600 will do the job. The problem is far too serious for us to do that. The health of all Americans depends upon the actions that we are likely to take in this committee. Thank you, Mr. Chairman for this hearing and I yield back whatever time I have.

UNKNOWN: Mr. Chairman, will the gentleman yield [Unintelligible] for this time just for one

quick correction.

MR. STRICKLAND: Yes, I would.

UNKNOWN: The gentleman from Ohio, I think misspoke when he said that California caps economic.

MR. STRICKLAND: Non-economic damages.

UNKNOWN: Yes, that's ...

MR. STRICKLAND: If I misspoke, thank you for correcting that.

CHAIRMAN: Dr. [Fletcher] [Misspelled?].

DR. FLETCHER: Thank you, Mr. Chairman. And I appreciate you allowing me to stand on this hearing. I want to thank Mr. Greenwood for his work on HR4600. I don't think there's any question that runaway lawsuits have contributed to the increased cost of healthcare. There may be other problems that additionally have increased the cost of healthcare but I don't think there's any question it's had an impact on both increased cost in healthcare as well as access to healthcare. And let me say that I don't believe any of us want to take away the appropriate redress to patients

who've been injured by negligence have in this nation. I don't think there's any question that we all believe that we need to certainly rid our communities of those that would practice negligently and that if physicians or other healthcare providers do such, that they need to be held accountable and their patients need to be compensated for that injury.

But let me say what the runaway costs have done. They have increased the cost of healthcare. They siphoned money from healthcare and from patient care and they've gone into the pockets to make personal injury lawyers very, very wealthy. I don't have any problem with people being successful in life but we've got to realize that the money comes out of healthcare and it goes, a large portion, the lion's share, goes into personal injury lawyers' pockets. Second, you look at the [IOM] [Misspelled?] report and you look at other studies. There's a physician/attorney at Harvard named [Floyd Brennan] [Misspelled?] who's done studies that

show that the runaway liability we have does not improve the quality of healthcare. The system does not help us improve the quality. And, in fact, promoting defensive medicine may actually have a deleterious effect on the quality of healthcare it may worsen the quality of healthcare in fact.

Third, California rates, people have talked about California, actually there's been 125% increased malpractice cost in California versus 425% across the US in the same time period. There may be aberrations of that within certain states, as the gentleman mentioned Ohio, but in fact the procedures or the policies that are in place in California have reduced the increase in escalation costs of premiums. I don't question that there are probably not some concerns with insurance companies. The gentleman mentioned the New England Journal of Medicine. I read that article, and from my recollection of that article, when you look at St. Paul, the problem with health insurance rates, or question, malpractice premium insurance rates, are much higher now because they were

undercharging in the nineties. They were charging less than actuarially the responsibilities that were laid upon them which meant the increased cost of the liability and all the lawsuits exceeded the premiums in the nineties, so because of that they have to compensate, make up for that with increased cost. It is about patient access and I reference an article out of our local newspaper, "Doctors seek care for skyrocketing insurance. Malpractice rates take toll on medical care." Here's an OB/GYN that's leaving rural Kentucky where he delivers a large portion of Medicaid patients, delivers babies there, his insurance rates went from \$65,000 to \$185,000 a year. Now he's leaving Kentucky because he can't make a living there. We have a crisis, a malpractice crisis in this country. It affects some states more than others and I want to commend Dr. Greenwood, or Mr. Greenwood, excuse me there Jim, Mr. Greenwood for his effort on his bill. I think you've put together, contrary to what's been said, a very thoughtful piece of legislation. It's not

the full answer of rising healthcare costs but it's a very thoughtful piece of legislation to address this problem. Thank you, Mr. Chairman. I yield back the remainder of my time.

CHAIRMAN: Ms. Capps.

MS. CAPPS: Mr. Chairman, I am pleased we are considering recent increases in professional liability insurance premiums. These increases may in fact be barriers to access for our constituents but I have to say that I think we are putting the cart before the horse with this hearing. Even its title is prejudicial. It assumes that so-called excessive litigation is the cause of premium increases and that it does reduce access to care. But I am not sure that that's been established yet. There is serious debate about why premiums are rising and what should be done to stem that growth. But until we resolve that debate it seems unwise to determine solutions. The wrong solution could be harmful to many people and not prevent an increase in premiums.

Someone suggested that the malpractice

insurance companies are trying to make up for money they have lost playing the stock market. If that is true we need to look at regulating the insurance industry. Others think that frivolous lawsuits and exorbitant awards for damages are driving them up. These people argue we need legislation to cap non-economic damages to patients who have been harmed by doctors and [Unintelligible] negligence. The problem with this argument is that these lawsuits are not by definition frivolous. In cases where large damages are awarded a jury has found that the patient has been severely damaged, harmed and I have to say that I'm very skeptical of putting caps on the damage awards that a severely injured patient receives. This puts the burden onto someone who is rightfully seeking redress and it will unfairly penalize people who do not work or who are paid little such as senior citizens, stay at home Moms, people with disability. They would have their damage payments limited while corporate CEO's will see massive payments. It is non-economic damages

that make sure everyone gets the redress they deserve. I cannot support measures to cap damages in a way that will harm the neediest in society. Particularly not when it has not been demonstrated that capping them will have a positive result on premiums. California has capped, it has been pointed out and we in my area of California are still suffering great shortages of doctors. With our caps in place, and even though they are in place, doctors are still leaving their practices in droves. So I hope that, as this committee moves forward on this issue, Mr. Chairman, that we will carefully consider all the factors and not jump to conclusions about the remedies and I yield back the balance of my time.

CHAIRMAN: California does have "caps" in more ways than one.

MS. CAPPS: More than one kind. Yes, thank you.

CHAIRMAN: Is this [Unintelligible].

UNKNOWN: Thank you. I've sat on Quality Assurance and Risk Management meetings of

hospitals, I've litigated medical malpractice, I've done personal injury and I'm gonna tell you I'm stunned when I hear individuals willing to defend the lawyers here and blame insurance companies, blame hospitals, blame medical providers. I look at my own bar. My own bar has lawyers in there, some of whom are very responsible, and as an individual whom has been harmed by someone's negligence, and we also had individuals in that bar who will take any case imaginable and really disgust me in what they do to my profession. And we have become too litigious of a society and I'm not surprised at all that you can even break this down. I mean we went through this whole Medicare thing and others had a lot of fun saying Republicans are in the pockets of so and so. It's not even debated in this country that the Democrats are in the pockets of the trial lawyers. That's not even debated. So we're not even surprised at all that we would hear that the day that [Unintelligible]

MS. CAPPS: Would the gentleman yield?

Would the gentleman yield?

UNKNOWN: No, I'm having fun. And so I'm not surprised at all that we would hear that. Now let me share something. It's not, Ms. Capps is correct, when she says it's not just the lawyers. You see the fear of lawsuits, not medical necessity drives the ordering of many tests even. Doctors go to extensive lengths and expensive lengths to protect themselves from lawsuits and that ends up becoming a driver of medical costs. There is a better way. Now I have something that's really interesting here. You want to say, "Well in California we have caps and we have all these expenses." Let me share a perspective with my colleagues. Indiana - twenty years ago Dr. Otis Bowen, the former, not only Governor of Indiana, but he also went on to serve as the Secretary of Health and Human Services under President Reagan [Unintelligible] since armed by the healthcare system to seek redress and the need to insure continued access to healthcare by all Hoosiers. Indiana was one of the first states to pass a

comprehensive medical malpractice reform and the Indiana model has now been used by other states in reforming medical tort law so it's workable for both injured patients and healthcare providers. Briefly, Indiana law places limits on the liability of healthcare providers. Any recovery over this limit is provided by a patient compensation fund. It's managed by the State of Indiana and is funded through insurance surcharges. The total recovery is capped, attorney fees are capped, attorney fees are capped, and importantly a medical review panel is convened for each case to review the validity of medical claims and must make its findings before a party can go to court. The findings of the medical review panel are admissible in court and there are time constraints on convening the panel and the panel making its finding so the case is not drawn out indefinitely. Injured patients receive compensation in a timely fashion. As I listen to some of my colleagues, let me do a little quick comparison. I have a medical liability rate survey

here and in Indiana, [Unintelligible] OB/GYN, in Indiana the insurance board average for the State of Indiana is \$13,800. I heard testimony from my colleagues in Kentucky. In Kentucky the average is \$57,000. Let me go to Ohio since I heard some of my colleagues talk about Ohio's problems in light of doctors who [Unintelligible] Indiana. Ohio, for OB/GYN the average is around \$57,000-58,000. I can go to New Jersey. New Jersey is around \$72,000 so you can defend the lawyers all you like, you can do rallies on whatever steps you choose, but don't stick your head in the sand and defend the lawyers and ignore the problems. It's happening throughout the country and it's a driver of cost. And if you wanna say we're not too litigious of a society you're having a huge impact on individual's responsibility and I just, as a member of the bar, I'm disgusted by the conduct of some of my colleagues. I yield back.

CHAIRMAN: The gentleman's time is expired.

Mr. Wynn.

MR. WYNN: Thank you, Mr. Chairman. Thank

you for calling this hearing. I just wanted to make a couple of observations that kind of struck me in the course of this discussion.

First of all, we've heard about California, now we've heard about Indiana and I can reflect on the experience of my own state of Maryland, which also is capped and it says one thing. States are competent to make this decision and the federal role or the federal intrusion in this area is not necessary. There's no real pressing issue here. If he cites a good example in Indiana, perhaps other states will follow as they see fit.

The second observation that I want to make is this notion of so-called runaway lawsuits. Lawsuits in medical malpractice cases reflect the decisions of a jury, a jury of peers. They reflect what the citizens of that community believe is fair in light of the injuries have suffered. So the suggestion that somehow it's the malpractice lawyers that are the villains in this scenario is just not accurate. You would think, hearing the

rhetoric that the other side doesn't have lawyers, that there's no standard of medical care to which practitioners can be held or critiqued on. That's the reality of malpractice law, that there's two sides in a courtroom, very competent lawyers representing doctors and most lawsuits are not runaway lawsuits, most awards are not astronomical, and most of the people that receive these awards are just average citizens, most of them women in fact, who get awards that their community feels are fair. So I think that has to be considered, taken into consideration.

Third, you hear about runaway lawsuits driving healthcare costs. But I would really hope that this panel would share with us some concrete data and the analysis supporting it to show that that is in fact the case.

And finally, I think we have to look at the business practices of the insurance companies. They made decisions during the nineties regarding setting premiums. In many cases they made some decisions, under priced their premiums in relation

to their true cost, used profits in the booming nineties to patch over these bad decisions, and now are reaping the consequences of those business decisions. So I don't see that we can portray as the poor victims of the malpractice system because they made bad decisions. I think this is a good hearing to have. I am looking forward to hearing the witnesses but I hope it will be a balanced hearing and not one that just attempts to characterize the malpractice attorneys as somehow the villains in what we all recognize to be a very balanced judicial system which the forefathers conceptualized as a means to which citizens could have their grievances addressed. I hope we'll have good testimony on all of these issues and I look forward to hearing the witnesses. I would like to yield the balance of my time to my colleague, Ms. Eshoo.

MS. ESHOO: I thank the gentleman. I'd like to jump in and say something here and that is that, if any of us went to a doctor and said we weren't feeling well and the doctor said, "I'm

only going to examine one part of your body." You'd move on to someone else. I think that this committee, with all due respects to my colleague from Indiana who said, "I'm just having fun", this is not meant for fun. There are problems each person here whether I agree 100% with them or not, has pointed out something that we need to pursue. To come here and to pretend that we have the entire answer simply because we showed up this morning and think we're having fun, I think that's a disservice to the people that we represent. So let's listen to our witnesses and let's see what we can [Unintelligible]. I think that we should stay away from the bluster. It doesn't do anything for me and most frankly for anyone that's listening because this is being carried. I think it's going to turn them off instead of being constructive, sensitive, and see what we can come up with to resolve the problems that are being pointed out. I thank the gentleman for yielding time..

CHAIRMAN: Mr. [Unintelligible], would you

yield for just a second?

MS. ESHOO: Have any time, if there's any time?

UNKNOWN: Yes, I'm out of time.

UNKNOWN: I don't think anybody here has said in any way that this is the only part of the problem. Nobody's saying that.

MR. WYNN: If I could just reclaim my time.

CHAIRMAN: We're not going to get into a debate here. These are opening statements only.

MR. WYNN: Mr. Chairman, I yielded to my colleague. I just wanted to respond to a statement merely to say that I would like to know the facts on that question because it's being characterized that this is the driving force behind the increase in health insurance rates and access to care and if there are facts to support that, I think we'd certainly like to hear them but just to keep saying this and making this allegation without evidence I don't think is very helpful. I yield back the balance of my time.

CHAIRMAN: The intent of the chair is that

we will get into those facts regarding the impact of litigation, regarding the, what might be the impact of insurance regulation or lack of it or whatever the case may be.

UNKNOWN: Mr. Chairman, Mr. Chairman. I think that [Unintelligible] for a moment.

MR. BROWN: I just asked for thirty seconds. Our side is not real happy with the title of the hearing. Just that it appears that all of the problem, in the title of the hearing, all of the problem is one thing and I think all of us when we're more introspective about it understand the problem is much more complicated than that. Whether it's physicians I know in Ohio or Mr. Wynn knows in Maryland or whether it's our own judgment, we all know that it's more complicated and [Unintelligible] and we just wanted to express some unhappiness with the title and the direction it...

CHAIRMAN: If the gentleman will yield, the title is "Harming Patient Access to Care: the Impact of Excessive Litigation", whatever that

impact might be. And it's only one of the impacts. Maybe there are other impacts. Alright? So there's nothing wrong with the title it's the way I think that you're ...

UNKNOWN: Mr. Chairman, Mr. Chairman, would you yield for just a...

CHAIRMAN: I'll be glad to yield. You have the time.

UNKNOWN: I wanted to say that perhaps it's the use of the term "excessive" that creates this impression that there may be somewhat of a predetermined...

CHAIRMAN: Ah, come on, this is about.

UNKNOWN: I yield back.

CHAIRMAN: Let's get to the problem here for crying out loud. Let's quit quibbling about the wordage and that sort of thing. That's we quite often get things done the way we should around here. Mr. Deal for his opening statement.

MR. DEAL: I thank the chairman. Mr. Chairman, quite frankly, I've enjoyed these opening statements better than any series of

opening statements I've heard in a long time. I do think that this hearing is appropriate and I think the comments of all of our colleagues have likewise been appropriate. I think the reason this issue has been surrounded with so much intensity is that it literally involves life and death issues. It likewise involves two of the great professions that are the hallmark of our nation, the medical profession and the legal profession.

It is not a solution that is easy to come by as we have seen from experiments in our various states. Now I know that we're gonna hear from various points of view but I'm hear to say there's plenty of blame to go around in every way and direction you wish to point your finger. Let me give just a few examples.

With regard to the insurance industry, for years as a member of the State legislature in Georgia I continually asked the question why are you charging the same premiums for the same specialties in the metropolitan city of Atlanta as you're charging in rural North Georgia. I never

got a satisfactory answer. The reason was simply they're in the same specialty. When you compare that to what most insurance premiums are dictated upon and that is a loss ratio. There was no correlation in most instances to loss ratios nor any adjustment for geographical areas in which the practice is being maintained. I think they have done better in recent years to make those adjustments, but still I think they have a long way to go in that direction.

With regard to my own profession, and I was as Mr. Bulyar [Misspelled?] previously a trial lawyer, I am totally disgusted by the fact of the advertisements on television by members of our profession who say, "Come down to see me, I can get you thousands or millions of dollars for your claim" with no understanding of whether there was a meritorious claim or not. That to me is taking, and I regret that the Supreme Court has gone so far to extend the First Amendment to that kind of advertising, but unfortunately we live in that area.

With regard to the medical profession, certainly there are innocent medical providers who have been harmed and who are fearful of the effects of potential malpractice judgments where they think they may be blameless. I know that there are some things in the medical community that need to be looked at. For example, they have constantly shielded their own members from their own malpractice as far as the public is concerned. It is a known fact that it is almost impossible in many instances to find out where the bad doctors are and many times the way to discipline a bad doctor is simply to ship him to another community where they are unsuspecting and have no knowledge of his negligence and his background. That is something the medical community in my opinion has not come face to face with and until they do they're gonna to continue to have, as Mr. Wynn says, the peers in their community who are suspect of what they're doing and they are the ones delivering the verdicts. So maybe the bedside manner does translate into jury verdicts or

perhaps in some cases the lack thereof. My point is this. There's a lot of blame to go around. I think the purpose of this hearing is to look at all of the facets that surround this very emotionally charged issue. But the fact and reality is it is having an effect on the availability of healthcare in many parts of the country. My district, like many of your districts, are seeing premium increases of 1,000% or more in a one year period of premium jumps. And that cannot be justified in most instances based on loss claims that have been paid. They have no relationship in most instances. So I think the question is, why are these premiums so high, what are the justifications for them, and what can we do in a reasonable, considered fashion, not to do unjust damage to our judicial which is the foundation for resolving all civil disputes in our country. I yield back, Mr. Chairman.

CHAIRMAN: The voice of reason yields back.
Mr. Pickering.

MR. PICKERING: Mr. Chairman, I would yield

to my senior member.

CHAIRMAN: Yes, he was hiding in back there behind Mr. Cox and I didn't see he was there. All right, you will not accept the yield from Mr. Pickering.

UNKNOWN: I always try to follow my good sub-committee chairman on Energy [Unintelligible]. But Mr. Chairman, I want to thank you for having this hearing. I want to thank Mr. Deal for his comments, his attitude, and I wanted to talk about the issues before us today. I come from a family, my father was a trial lawyer, today he is a judge. I can remember going to the courtroom as a boy where he tried his cases and I was always proud that I thought that he was trying to bring justice to somebody who may have been harmed [Unintelligible]. But I look today at my home state, the situation that we face, and I try to make decisions, how do we balance, how do we maintain the principles, making sure that we have a jury system, how do we deter, when there are wrongful acts, our negligence, but how do we also

protect healthcare in my home state where we're seeing some terrible lawsuits. We're seeing 400 doctors leave our state. For the first time in the history of the University of Mississippi Medical Center in the OB/GYN specialty, not one, not one OB/GYN medical student is staying in the state of Mississippi. We're seeing clinics close. The state hospitals talk about moving away from Mississippi across the river into Louisiana. We are seeing from Jackson, Mississippi to Memphis, Tennessee, because if you know anything about geography [Unintelligible] a lot of territory, a lot of communities, a lot of folks, and we'll over have about two [Unintelligible]. We're seeing OB/GYN an acute crisis of choice. We're seeing in rural hospitals that cannot afford healthcare, medical malpractice insurance premiums for their hospitals, or for example, in Franklin County, which is a community or county of about 8,000 people their insurance premiums have increased over the past year from \$54,000 to \$265,000. Now that healthcare [Unintelligible] hospital, if you

went to it, you would see that it is in terrible need of capital investment to improve their facilities and they're struggling to pay that bill so that they can give quality healthcare and then having a five fold increase. There has to be balance here that I hope that we can strike. I do believe that some cap, some limit, so that we do not have the excessive, that it would not drive hospitals, it would not drive doctors, it would not drive specialties, it would not close [Unintelligible] as a result of excessive verdicts.

In my home state of Mississippi, the average malpractice case across the nation is \$3.5 million, but in Mississippi it's \$8.2 million. But the rate, the number of claims for medical negligence, those cases have brought is 55% greater than the combined averages of all states.

So you see a terrible crisis in a state that is rural, that is low income, many of the citizens on fixed income and you're creating a crisis because of the excessive. We've got to

maintain the principles of our judicial system so we have to find a way to have balance so we do not harm... OK, I believe in the right to a jury but I also believe in the right to good healthcare. Our mothers have a right to see an OB/GYN when they need to deliver a child. That if we have a tragedy, a trauma, car wreck, and you have minutes, that window of opportunity, that window of life to get care, that we'll have a neurosurgeon that will treat our sons and daughters, our husbands and wives, if that tragedy occurs.

So we've got to find a way that Mr. Deal was talking about to find a way to address all the issues and to find a way to bring justice, but also protect affordable, [Unintelligible] healthcare.

UNKNOWN: The gentleman yield?

MR. PICKERING: Yes.

UNKNOWN: I really appreciate the statement you made. I know it's made out of a great deal of sincerity but I have to ask the question, why

can't the State of Mississippi address this problem in a way that it sees fit just as other states have done, including my own and others that have been referred to here. I feel kind of awkward on the Democratic side arguing state's rights but...

CHAIRMAN: These are opening statements for crying out loud, now let's not get into debating. If you chose to respond to that Chip, please do so very briefly but come on now, let's not take advantage.

MR. PICKERING: Like I was saying, I do believe in state's rights but we have a situation in my home state, the states that are around us that have implemented reforms have seen 30% reductions in medical malpractice insurance premiums and the question is, what we're saying is that any state that adopts reforms, this legislation will not apply. But we are giving incentives for states to take care of this problem themselves but if they don't, my fundamental responsibility, and I think a fundamental responsibility of all members is to make sure that

our mothers have healthcare, our families have healthcare, and we've got to protect that right. Thank you.

CHAIRMAN: The gentleman's time has expired. Mr. Barton.

MR. BARTON: Thank you, Mr. Chairman and a public happy birthday plus one.

CHAIRMAN: Thank you.

MR. BARTON: Yesterday was Chairman [Unintelligible] birthday. He's now old enough to buy alcohol legally in his state. I want to compliment you and Chairman Greenwood for, there you go, see, holding this hearing. I wish that my sub-committee members paid as much attention to the titles of the hearings that I do as they do to yours and I have waited to give my opening statement, Mr. Chairman, because my staff put together a really good statement. In fact, it's so good that Congressman Norwood told me that his staff helped my staff put it together so I felt like I needed to be here to do it.

This is a good bill that we're going to

hold a hearing on, HR4600 that you and Chairman Greenwood have produced. We do have a crisis in my opinion in our medical liability system. I've heard from many of the doctors in my district down in Texas, they're facing astronomical increases in their medical malpractice premiums. They have had their premiums doubled, and in some cases tripled. Because of that they've stopped performing certain procedures. Some have even retired from medicine altogether. I believe that it is a crisis in medical liability and that this crisis is creating a barrier to obtaining quality healthcare. For example, women in South Texas are now finding it difficult to find an OB/GYN to help deliver their expected child. I'm told that out in Nevada, in Clark County, one of their emergency rooms, the trauma centers just shut down, just closed the doors because of the rise in medical liability premiums so I think the crisis is real. We all agree that if a patient's injured through malpractice or negligence that patient should be compensated for their injuries and that

compensation should not be abridged. The Health Act contains no cap on economic and medical damages. If a patient's injured he or she will rightly have the ability to be made whole through the judicial system. The Health Act allows unlimited recovery of economic damages. A person will be able to recover all past, present, and future economic losses. There is a cap on non-economic damages of \$250,000. Punitive damages are still allowed and can be levied against those who demonstrate malice or gross negligence.

Our courts have become a system or form of legal lotto. The purpose of lawsuits is not to compensate injured victims so much as it is to enrich the plaintiff lawyers that bring the lawsuits. They work on contingency fees. They're looking and hoping that their winning ticket will turn them into instant millionaires. This system has clogged up the courts with frivolous lawsuits and has delayed the judiciary from processing more meritorious claims. One of the most important reforms in the Act before us is the elimination of

joint and several liability. Joint and several liability encourages trial lawyers to search for deep pockets regardless of the culpability.

This country was founded on the ideal of personal responsibility, the idea that a person should be responsible for his or her actions. Joint and several liability is the antithesis of this idea.

Mr. Chairman, I want to thank Mr. Cox for helping me to pronounce antithesis and for my staff for putting in a big word so that I can learn a new word today. Was that your staff that did that?

Under the concept of joint and several liability a party could be found to be 1% at fault for a particular injury, yet could be responsible for paying 100% of the damage award. This encourages trial lawyers to file a claim, throw everything up against the wall and hope that something sticks.

Our current medical liability system in my opinion creates one group of winners and that's

the plaintiff lawyers. However, there are numerous losers: the injured patients whose lawsuits linger in the judicial system because they are overwhelmed by other frivolous lawsuits. Patients who can't get care period because their providers no longer provide that care. I come to this hearing with an open mind. I want to thank you and Chairman Greenwood for putting in the bill and I hope that after the hearing we can work in a partisan basis to move the bill.

CHAIRMAN: I thank the gentleman. I believe that completes finally the opening statements to the relief of all of us.

The first panel... oh, yes, by all means, unanimous consent requested.

UNKNOWN: All members have the opportunity to [Unintelligible]

CHAIRMAN: Yes, without objection. That would be the case. I thank the gentleman.

Dr. Lisa Hollier is with the LBJ General Hospital, Department of OB/GYN in Houston and she is here on behalf of the American College of

Obstetricians and Gynecologists. Ms. Fran Visco, National Breast Cancer Coalition, Mr. Visco's been with us before. Welcome. Dr. Sam Roberts is from Elkins, West Virginia. Ms. Lauren Townsend, Coalition for Consumer Justice from Philadelphia. Mr. Stuart Fine is Chief Executive Officer of Grand View Hospital, Sellersville, Pennsylvania, here on behalf of the American Hospital Association.

I don't know whether Mr. Greenwood wanted to introduce Mr. Fine and supplement my introduction about Mr. Fine.

MR. GREENWOOD: I would be delighted to Mr. Chairman. Stuart Fine is the Director of the Grand View Hospital, one of the finer hospitals in our region. He's a good, long time friend and has really been a leader in trying to change the medical system, the healthcare system, a fighter against abuses in a variety of [Unintelligible]. I'm delighted to have him here. I understand why we call this a hearing because you come and you hear us for two hours.

CHAIRMAN: Huh, true. Anyhow, you've written, you've sent in written statements, those will be matter of record. I would hope that what you would do is complement, if you will, or supplement your statements. I will set the clock at five minutes. Hopefully you will bide by it as well as you can. Dr. Hollier, please proceed ... your mike, your mike, please.

DR. HOLLIER: Thank you, Mr. Chairman. As an obstetrician/gynecologist I welcome the opportunity to speak with you this morning on behalf of the American College of Obstetricians and Gynecologists' 44,000 partners in women's healthcare.

I am here today because excess litigation has left American women asking, "Who will delivery my baby?" An ailing civil justice system is severely jeopardizing patient care for women and their newborns forcing one out of ten obstetricians to stop delivering babies and countless more physicians to contemplate the same.

After a brief overview, today I will

delineate the inevitable health consequences for women if we allow excessive litigation to persist. In my home state of Texas, and across the country, liability insurance for obstetrician/gynecologists has become prohibitively expensive. Premiums have tripled and quadrupled practically overnight. In some areas OB/GYN's can no longer obtain liability insurance at all as insurance companies fold or abruptly stop insuring doctors. When OB/GYN's cannot find or afford liability insurance they are forced to stop delivering babies, curtail surgical services, or close their doors. This shortage of care affects hospitals, public health clinics, and medical facilities in rural areas and inner cities. Now women's healthcare is in jeopardy and this crisis will only end soon with legislative intervention. This crisis involves more than just the decisions of individual insurance companies. The manner in which our antiquated tort system resolves medical liability claims is at the root of the problem.

A liability system should aggregatively

spread the insurance risk of providing affordable healthcare for our society. It should fairly compensate patients harmed by negligent medical care. It should provide compensation to patients with devastating outcomes unrelated to negligence, like newborns born with cerebral palsy.

Our current system fails on all counts. It's punitive, expensive, and inequitable for all, jeopardizing the availability of care.

Although the number of claims filed against all physicians claimed in recent decades, the phenomenon does not reflect an increased rate of medical negligence. In fact, OB/GYN's win the vast majority of the claims filed against them. One half of claims against OB/GYN's are simply dropped by plaintiff's attorneys, dismissed or settled without a payment, of cases that did proceed to court, OB/GYN's won seven out of ten cases closed by a jury or court verdict.

What should not be overlooked here are the ripple effects that excessive litigation is directly having on the delivery of women's

healthcare. Today the liability crisis is causing women and their newborns to suffer in the following six ways.

Number one - less prenatal care: with fewer obstetricians it's harder for women to get prenatal care, a significant factor in the delivery of a healthy baby. A greater availability of this care over the last several decades has resulted in the country's lowest infant mortality rate. Now, our ability to maintain that standard is threatened.

Number two - shorter visits and longer waits: doctors' shortages mean women have to travel longer distances for prenatal appointments and to deliver their babies, especially in rural areas. Wait times for appointments increase, while quality time with doctors inevitably decreases.

Number three - needing gynecologic surgery: as doctors stop performing gynecologic surgery women can lose access to care that helps protect fertility, ends pelvic pain, or treats precancerous conditions early.

Number four - less preventative healthcare: fewer doctors offering fewer services means less regular screenings for reproductive cancers, infections, and other health risks for women.

Number five - less for the underserved: clinics that provide prenatal and delivery care to underserved and high risk populations including rural, inner city, and teaching hospitals will have trouble recruiting and affording physicians.

And finally, number six - less training in women's health: hospitals may drop their residency training programs in obstetrics and gynecology when they can no longer afford to insure OB/GYN residents in future. The result, fewer new doctors trained to treat women, particularly pregnant women.

As a physician I strive to provide every woman in my practice with affordable healthcare of the highest quality. And, without question, I believe that patients who have been harmed by professional negligence should have the

opportunity to be adequately compensated for their injuries. But today the scales of justice are out of balance and until this nation enacts common sense medical liability reform, America's women and mothers will continue to suffer.

Thank you, Mr. Chairman, for your leadership on this important issue and for the sub-committee's attention to this crisis. I appreciate the opportunity to present our concerns for the panel's consideration and look forward to working with you to protect women's access to healthcare.

CHAIRMAN: Thank you very much, Doctor. Ms. Visco.

MS. VISCO: Thank you very much, Mr. Chairman. As you know, I'm the President of the National Breast Cancer Coalition and a fifteen-year breast cancer survivor. The National Breast Cancer Coalition is a group of more than 600 organizations from across the country. We are dedicated to eradicating breast cancer through action and advocacy and we focus on increasing

federal funding for breast cancer research and collaborating with the scientific community to make certain that research is well done, to increasing access to healthcare for all women, and [Unintelligible] quality clinical trials, and to increasing the influence of women with breast cancer and other breast cancer advocates in all decision making around breast cancer.

We've been fighting as an organization for access to high quality healthcare since our inception in 1991. And much of the debate over the past decade has focused how to finance and deliver healthcare but we believe an equally, if not more important question is, how do we define quality care. What is it? How does it compare to the kind of care the patients usually and currently receive?

You were talking today about whether excessive limit litigation is harming patients' access to care and I have to say in listening to a number of the opening statements I was questioning whether I am in the right room. Because really

what I'm focusing on is, and what the National Breast Cancer Coalition is focused on, what our goals are, to make certain that patients have access to quality healthcare and there are many barriers standing in the way of access to quality healthcare. You're dealing today with whether excessive litigation is one of those barriers. There's an assumption that excessive litigation is increasing medical malpractice rates and increasing medical malpractice rates have resulted in a barrier to access to healthcare. Those are all assumptions that you're going to have to test and put into the context of all the other barriers and prioritize what is the most important and how can we achieve as quickly access to quality care for all Americans.

The National Breast Cancer Coalition is one of a number of organizations that have supported very strong enforcement mechanisms in all litigation. We have approved caps on liability damages. We are one of a number of organizations that take and continue to take that position.

We're asking today again whether the prevalence and amount of jury awards has been the cause of skyrocketing insurance fees, and if that is the case we are asking, well, would limiting lawsuits be the solution. Perhaps a better solution, one of a number of better solutions, would be to limit the need for lawsuits. For there's an atmosphere in this country now among the public and the patient community of mistrust, mistrust certainly for corporations, for institutions, and the medical community. We're looking at where the barrier is in the way. What is it that we need to work on and focus on? The Institute of Medicine has issued a number of reports that have identified so many problems in the healthcare system in this country: the Quality Chasm Report, Medical Errors Report, the Data Report, there is much dialog and much research going into looking at the barriers to healthcare. There are the issues of corporate, individual, and institutional actions. We are looking at issues like ImClone, not just the insider trading issues,

but the issue of conflict of interest in institutions and clinicians who are involved in research. How does that impact access to quality care? What effect does that have on individuals? Those conflicts are serious and they're real and they're undermining the trust in this country for the medical community.

They're looking at, recently there were a number of [Unintelligible] but there was also a recent article in the paper about a large pharmaceutical company hiding toxicity data when it presented data to the FDA for drug approval. That drug then was approved, out in a public, and a number of deaths occurred.

We're looking at a lack of evidence-based medicine in this country. You've seen the recent report on arthroscopic surgery. You're looking at the hormone replacement - critical trial recently, breast cancer, breast self-exam, mammography screening. You're looking at a system that needs serious attention and fixing in order to give access to quality care. You're looking at tens of

millions of Americans who lack health insurance. You're looking at millions and millions of Americans whose health insurance premiums are increasing. There are barriers to doctors and institutions to providing care. There may be an overuse of technology. There's saturated markets of competition. There's lack of a focus on evidence based medicine and we're dealing with the necessary shift to evidence based medicine from a fee for service system.

Malpractice premiums are too high but what caused that? Was it corporate mismanagement? Was it excessive litigation? The resources of the grassroots of the patients across this country that are part of the National Breast Cancer Coalition are precious. We're very careful how we utilize them. We're very careful when we ask them to get behind a particular issue and the resources of the United States Congress are equally precious. We look to you for leadership. We look to you for focusing on the right priorities on what we really need to accomplish to get all

Americans access to quality healthcare.

If extensive litigation turns out to be the case, then that is something that I hope you will look at extremely carefully and we can work on together. But we need to work together to fixing the healthcare system and as an organization, along with a number of other organizations to date, we do not believe that putting hats on what a patient is going to receive as a result of malpractice is an answer to this problem. Thank you very much.

CHAIRMAN: Thank you, Ms. Visco. Before I introduce Dr. Roberts, I would like to announce that Ms. Capito, Congresswoman from West Virginia, who is not a member of this sub-committee but is, of course, greatly interested in this issue because of the problems in West Virginia particularly, has joined us. [Unintelligible] Thank for being here. Mr. Roberts. Your mike, sir, I don't think it's... it's either not on or...

MR. ROBERTS: I'm Dr. Samuel Roberts of Elkins, West Virginia. I live in a town of about

10,000 people, in a county of approximately 30,000 people, and we take care of seven counties, approximately 100,000 patient population. We have one hospital there. When I first went into practice in Elkins in 1978 there were six hospitals providing full service obstetrics, surgery, and emergency room intensive care work. There's now one hospital in that area. We serve 100,000 people. We are losing physicians by the day. We have four OB/GYN's and myself delivering babies in that community. One of our OB/GYN's went to Canada last week to interview for a job because he could not find malpractice insurance in West Virginia. The three other OB/GYN's went to work for the hospital. I am presently in private practice. My partner, who is also a family physician, stopped doing obstetrics two years ago because he could not afford the malpractice cost.

I'm a second-generation family physician. My father and I have delivered over 9,000 babies in Elkins, a town of 10,000. In the last 63 years, there's been a Dr. Roberts practicing medicine,

other than the five years that my father was gone during World War II as a medical officer in the European theater [Unintelligible] and I'm very proud of that. But he and I practiced together for approximately six years and I have tried to continue that, that heritage. I have a daughter named Leah Roberts, who is a second year medical student at West Virginia University. Leah had hoped to come back to practice with me as I did with my father, carrying on the tradition of caring for people in our community. Leah and many of her classmates do not feel they can come back to West Virginia because they cannot afford to pay the malpractice premiums. I have four children in college and graduate school. I'm having difficulty paying their tuition and continuing to keep my practice.

My practice is partially 90% welfare, Medicaid and Medicare and my obstetrical practice is 90% Medicaid. We provide services, I have two physician's assistants, a nurse practitioner, I have ten employees total and we try to take care

of as many people as we can. We're not in it for the money. We're there to try to help people. And honestly this is not a, it's not an issue of money, this is an issue of access to care. And the people really have a chance to see their family doctor, have a chance to do something to help themselves provide their family with the best care possible.

The number of OB providers in West Virginia in 1978 was approximately 200. That included 140 family physicians and approximately 65 OB/GYN's. Now there are approximately 100 providers. In the last 23 years the numbers of providers has dropped, 24 years, has dropped from approximately 200 to less than 100. But access to prenatal care and delivery services has diminished. For every dollar spent for prenatal care, you save \$4 on the care of a pre-term infant. As the gentleman mentioned earlier, a woman comes into the emergency department at 26 or 28 weeks. If that woman had had good care, anticipatory prenatal care, she could have been

prevented possibly from being brought in in an emergency situation to deliver in the emergency situation to deliver in an emergency department. That child, that family, and the society will pay the bill the rest of their life. When that child is born at 26 weeks, it's going to have respiratory problems, many times cerebral problems, blindness, many complications that can occur from excessive prematurity. We need to be aware that this has long-term impact on the people of America. And the access to care is not there. In West Virginia it is critical. We are losing people by the day. We have two surgeons, we have four surgeons in Elkins, two of them are going to retire this year. Because they had to change companies they cannot afford to pay their [Unintelligible]. If they switch to a new company, they have to buy a [Unintelligible] with that company. I had to switch to BRIM, which is the Bureau of Risk and Insurance Management, which is run by the state of West Virginia. It was initially brought about in order to provide

services for professors at the University and [Unintelligible]. What has happened is BRIM has had an emergency situation to accommodate physicians such as myself that could not find other malpractice insurance. I have never had a malpractice claim in 24 years. My rates doubled last year from \$17,000 to \$35,800. I can't afford that next year because they tell me it's going to double again. I cannot afford to continue to provide obstetrical services in Elkins, West Virginia. I have families that I have delivered eight, nine children for. It makes me very sad to know that I'm not going to be able to be there for these families. I'm delivering babies of women that I delivered. That's a very wonderful feeling, to live in a small community in West Virginia. I realize that we're going to lose that special touch. It makes me very sad to know that my daughter doesn't feel that she can back and practice with me. I think it's a loss to West Virginia. It's a loss to the United States. We don't have a sense of what's right here. We're

making, the lawyers are pointing at the insurance companies. The insurance companies are pointing at the lawyers. The doctors are pointing at the insurance companies and the lawyers. We need to sit down and work out something we can all live with that allows our people to have the right to healthcare. We need to use common sense. We need not to make this a political issue.

I'm a Democrat. My grandfather was Governor of West Virginia in the 1930's. He brought West Virginia through some hard times. And I hope that we can come through this hard time. I hope that medically we can make a difference. That we can stabilize this situation but it takes people sitting down and working together and that's the reason I'm here today. I appreciate you listening. Thank you.

CHAIRMAN: I thank you very much, Doctor, for your excellent testimony. Ms. Townsend.

MS. TOWNSEND: For the committee, that's better, um, and for the civics lesson where my son has been listening to all the back and forth about

today.

Um, I'm the Director of Citizens for Consumer Justice for Pennsylvania's largest consumer coalition and organization. I'm also representing US Action. I'm on the Board of US Action nationally. We applaud you for addressing this very, very important issue. However, with all due respect to our own Representative Greenwood, we vehemently oppose the contents of HR4600 because we know that it will hurt victims of medical malpractice, it will immunize wrongdoers and be a boon for the insurance company.

We as patients, I know you've heard this over and over again, are regularly subjected to the hassle factor when we seek healthcare. Because of HMO's, because of these corner of the market hospital system giants, our relationship with many doctors, unlike Dr. Roberts, is tenuous at best. Our hands, patients and doctors, are tied because of bureaucrats calling the shots and deciding how healthcare should be delivered. The result is healthcare cost containment and that means

frequently blowing through patients, avoiding costly referrals to specialists, making nurses work overtime, and not modernizing or streamlining systems and processes and procedures to avoid mistakes. Doctors are finding themselves in a terrible, terrible predicament. They're told how to practice medicine by administrators, all the while finding the environment for practicing more difficult because of the skyrocketing insurance rates you've been talking about all day.

But another issue that's really important. The AMA itself has said that medical errors, medical mistakes, account for the fifth leading cause of death in this country. At a rally Pennsylvania victims spoke of malpractice and their own personal horror stories. Donald Davis used to work at a Home Depot. In September 2000 he went to a doctor to have a bone spur removed from his right baby toe. It shouldn't have been a big surgery and he was expected back to work within a few weeks. Because of a mistake on the part of the doctor, the surgery incision didn't heal properly

and became gangrenous. Ultimately the infection ensued and he had to have the toe amputated and [Unintelligible] bypass in his leg. By January of that year he developed a massive blood infection and, in his own words, he said, "if I hadn't ended up finding a new doctor, I would have died because of the blood infection. But unfortunately the only way to save my life was to have both my legs amputated. What happened to me was the result of two doctor's errors and it was preventable. Because of my amputation I've had to leave my job and my life will never be the same. I went in for a problem with one toe and came out without my legs."

HR 4600 is not the answer. It'll further hurt injured victims and do nothing to foster patient safety or lower insurance premiums. It tells a woman whose doctor's negligence cost the life of her child that the child's life was worth only \$250,000. It tells Donald Davis that having no legs for the rest of his life, because of malpractice is worth the same. Through caps on

non-economic damages you place an arbitrary price tag on the most horrendous of injuries. Should legislation decide the value of your baby's life or your eyesight when taken from you by a negligent doctor? Wouldn't we prefer to have that decision in the hands of twelve of your constituents on a jury that has heard all the facts? Last summer at Philadelphia's St. Agnes Hospital a number of people died because of mistaken lab tests that went on for weeks without detection and affected hundreds of patients.

This bill does nothing to update technology and processes and procedures at our nation's hospitals. Instead, it eliminates joint and several liability, which just further immunizes hospitals and HMO's. It also does nothing to deal with the issue of fatigue on the job. Healthcare workers have to work brutal schedules without adequate rest. The government doesn't allow truck drivers or airline pilots to work for such long hours. Why should we let our healthcare providers?

Throughout our nation most doctors do wonderful things for people and it's just a small percentage that repeatedly make errors. This bill does nothing to weed out the regular offenders or the ones who regularly malpractice. In fact it's a double whammy for victims because it caps damages against the repeat offenders and then compensates victims through periodic payments that many victims, particularly women and the disabled, need sooner rather than later.

Americans need insurance reform. We need it desperately. In Pennsylvania we've gone from eight malpractice insurance providers, it's a big one, to four in a very short period of time. Industry experts like Charles [Kolodna] [Misspelled?] of Gallagher Healthcare Insurance Services tell us that a quick examination of the medical malpractice insurance marketplace might lead a dispassionate observer to conclude that that segment of the insurance industry is confused, in disarray, and generally in a state of disorder. Premiums are doubling, hospitals

deductibles are tripling, claims [Unintelligible] are being non-renewed, and insurers are leaving territory unmapped. We've seen St. Paul drop its malpractice branch. We've seen two notorious medical malpractice insurers, PIE and [Pick] [Misspelled?] that are no longer in business. In fact, the President of PIE Insurance Company admitted that he stole more than \$6.8 million from the company to buy a pig farm in Tennessee to pay off gambling debts. He pleaded guilty in federal court to charges of conspiracy, insurance fraud, and tax evasion.

CHAIRMAN: Please summarize, Ms. Townsend.

MS. TOWNSEND: The bottom line is that we should not allow that insurance and health industries to play divide and conquer politics. We applaud you for calling members of this committee and members of Congress for calling on the GAO to investigate the insurance industry's role in creating this havoc. You need to be asking questions and demanding answers. Aren't the regulators of the insurance industry supposed to

head off problems before they become disasters?
Whose rates are too high? Whose rates are too low?
What is responsible pricing? When we're confronted
with a [Pick] [Misspelled?] or a [FICO]
[Misspelled?] or a St. Paul, how do we get to the
root cause of why the insurer got itself into
trouble? And then why aren't reviewing other
insurance providers to find out whether they're
engaged in the same bad practices?

The culprit is the insurance crisis, is
the insurance industry for this insurance crisis
and the system is rigged. This kind of
legislation, this further sabotages an already
damaged system and we know that passage of tort
reforms do nothing to really eliminate the
mistakes from happening.

CHAIRMAN: Your time, your testimony is
very excellent but your time is long expired.
You're two minutes over.

MS. TOWNSEND: Oh, forgive me.

CHAIRMAN: I will forgive you. But we do
have to move on.

MS. TOWNSEND: I will just say one final thing. Study after study has shown that tort reform measures across the country have not lowered insurance rates. There's no evidence to prove that and members of the Insurance Association of America have said so as well. Thank you.

CHAIRMAN: Mr. Fine. Please use a mike.

MR. FINE: [Unintelligible] Thank you very much. I am Stuart Fine, Chief Executive Officer of Grand View Hospital in Bucks County, Pennsylvania. I also chair the [Cassette] [Misspelled?] Insurance Group of twelve healthcare organizations of Eastern Pennsylvania that work together to improve patient safety and patient care quality and to share and insure risk on a group basis. I am here today on behalf of the American Hospital Association.

We're pleased to testify before you about the harmful effects that excessive litigation is having on patient access to care. In my testimony this morning I hope to make three points. First

the cost of medical liability insurance is spiraling out of control. Next, the lack of affordable medical liability insurance is having a severe impact on patients' access to care, and finally, there is an outstanding national problem that requires a timely [Unintelligible].

Grand View is our region's largest employer provides jobs to more than fifteen [Unintelligible] with an annual payroll that exceeds \$55 million. These figures do not include the more than 250 physicians [Unintelligible] or the hundreds of employees who are employed by those physicians. It's often been said that, as goes our hospital so goes the [Unintelligible] of our community. It's important to remember that during Grand View's 89 years of operation our hospital has never had a court judgment against it for a professional liability claim. I'll repeat that. We've never had a court judgment against us for a professional liability claim. The experience of Grand View Hospital on our [Cassette] [Misspelled?] [Unintelligible] is quite telling.

[Unintelligible] certain professional and general liability exposures for more than ten years. Until [Unintelligible] we could secure reinsurance for our group, affordable rates due to competition among commercial failures. However, because of the frequency of lawsuits and the size of jury awards that has recently [Unintelligible] Grand View's cost for insurance increased last year by about one third. [Unintelligible] the group up to \$5 million [Unintelligible] on an each and every reinsured claim basis. This year our cost increased by almost 50% and the deductible both increased \$7.5 million and involves a 50% per claim co-payment. This year Grand View will [Unintelligible] in excess of [Unintelligible] every day, 365 days a year for professional liability insurance coverage. That's nearly as much as we'll spend on medications for our patients. The [Cassette] [Misspelled?] Group as whole will spend in excess of \$60 million to insure itself. [Unintelligible]

If hearing this reduced level of coverage

[Unintelligible] cost would not easily accomplished. Earlier this year I traveled with colleagues to London for two days of meetings with seven different reinsurers from Switzerland, Germany, and Lloyds of London. We were told on three different occasions that, along with Australia and Czechoslovakia, our region is viewed as being among the least attractive in the world within which to write insurance quotes. Because reasonably priced insurance coverage is not available for practitioners in many specialties, many of our region's physicians have retired or are relocating. It's become much more difficult to recruit new doctors and to secure insurance for practicing physicians. If this situation continues, we'll be forced [Unintelligible] patient services leaving our community with little or no access to needed healthcare. For example, if Grand View hadn't been able to secure insurance coverage for our largest OB/GYN group at a cost of approximately \$1,000 per delivery, Grand View would have lost five of our nine practicing

obstetricians from practice three months ago. This would probably have resulted in the closure of our OB service. Something that's already occurred at three other Philadelphia area hospitals.

That's why Congress must help hospitals and physicians to find a solution to skyrocketing medical liability [Unintelligible] so we can continue to provide right care, at the right time, at the right place, twenty four hours a day, seven days a week. We must reform this system as [Unintelligible].

It's well documented that the United States has the world's most expensive tort system. Court costs over the past fifty years have outpaced growth of the United States economy by a factor of four. According to the GAO, 43% of insurance defense costs are spent on claims that have no merit, while other studies show that many claims with merit are never even filed.

A federal solution is warranted here. That's why AHA strongly supports HR4600, the Health Act of 2002, sponsored by my Congressman

Jim Greenwood. The AHA believes that the California style reforms reflected in HR4600 should be adopted at the federal level. For more than 25 years the reforms known as MICRA have demonstrated that patients' rights can be protected while reducing medical liability costs. The MICRA law has proven to be equitable, while the number of health care liability claims in California has remained steady on a per capita basis. Compensation actually paid to those medically injured in California has been higher after MICRA than before. It's not an issue to just Pennsylvania and California. The medical liability insurance crisis affects hospitals and physicians nationally.

Mr. Chairman, you already mentioned the reprieve recently realized by the University Medical Center and Trauma Center in Las Vegas. Other members of the committee have discussed the situation that exists within their home states. In conclusion, hospitals and physicians need Congress to enact House of Representatives Bill 4600 to

prevent even more hospitals from shutting down needed services and closing their doors. We have a mission of providing healthcare services that save lives, improve the quality of lives of our patients, but hospitals can't fulfill that mission without your timely help. We look forward to working with you to enact House of Representatives Bill 4600 [Unintelligible].

CHAIRMAN: Thank you very much, Mr. Fine. Dr. Roberts, you've testified that just a few years ago you had six hospitals in your immediate area. What is that, a number of counties?

DR. ROBERTS: Yes, there are seven counties.

CHAIRMAN: And now it's down to one.

DR. ROBERTS: There's one. The other hospitals have either completely closed or they became emergency rooms or they have a two day holding bed possibility, but they do not do obstetrical care, surgery, or intensive care work.

CHARIMAN: And to what do you attribute these other five hospitals not being available?

DR. ROBERTS: Largely it was by federal mandate. When they wanted to regionalize healthcare and that has happened for a question of cost efficiency. The problem is that bad things happen to good people and sometimes malpractice situations occur because people are blaming someone, they are upset, they have to understand what happened, and the most proximate person is the healthcare provider. So many times we get caught in that phase of resolution that people are going through. In our community we have a very good feeling between our patients, I believe. But what's happening is physicians are becoming afraid of their patients. Who's going to turn around and be the next, you know. So it creates a barrier, as was mentioned earlier. It's a barrier between the physician and the patient. And I think it's critical that we address this and we look at access and the ability to find their healthcare provider and chose the person that will provide their family with family-oriented care.

CHAIRMAN: Doctor, you indicated your rates

have already doubled and you've received word they're going to plan to double next year.

DR. ROBERTS: They have not given me a firm quote. My insurance is up to the end of November...

CHAIRMAN: They being your insurance company?

DR. ROBERTS: ...and they told me it would probably double again next year.

CHAIRMAN: All right, have you...

DR. ROBERTS: I was with [FICO] [Misspelled?] and [FICO] [Misspelled?] went under and then I was picked up by BRIM, and they doubled the rate.

CHAIRMAN: Have you enquired as to why this is taking place, the insurance commissioner of your state?

DR. ROBERTS: Yes, I have.

CHAIRMAN: And what's the [Unintelligible] his or her response?

DR. ROBERTS: Well, because BRIM is the insurance of last resort, they created a premium on all BRIM rates to make us try to find other

insurance companies. The problem is the insurance companies are leaving the state. We just had physicians last week be notified that they would not be renewed by medical insurance and St. Paul has already pulled out, so we are in a critical situation. We have physicians on our staff that will not have insurance as of October 1 or November 1, the end of this year. And they're going to have to leave the area. We are losing people from early retirement. We are losing people because we can't recruit new physicians into the community. Private practice physicians such as myself will have to, I may have to go back to West Virginia University. I am a professor there. I may have to go there and teach and stop my private practice.

CHAIRMAN: You've already told us that you haven't had any claims against you, what you have never had any claims against you?

DR. ROBERTS: No, sir.

CHAIRMAN: OK. How do the claims filed against members of the medical profession in West

Virginia compare to other states?

DR. ROBERTS: West Virginia

[Unintelligible]

UNKNOWN: ...have been placed on mute to...

DR. ROBERTS: and claims there were a lot filed last fall. The state legislature spent sixty days in session at \$35,000 a day trying to deal with this problem. And there was some cursory changes that were made but I don't feel that they really made any significant change in the threat of major lawsuits.

CHAIRMAN: So you attribute the doubling of the rates to the total number of claims that ...

DR. ROBERTS: Absolutely.

CHAIRMAN: ...are taking place in...

DR. ROBERTS: Absolutely.

CHAIRMAN: ...West Virginia.

DR. ROBERTS: In many of my colleagues the rates have tripled. I was really quite fortunate it wasn't higher. But next year it will be and I'm going to have to stop delivering babies.

CHAIRMAN: All right, I have one minute

left and I'm going to yield it to Ms. Capito if she would like to enquire of either Dr. Roberts or anyone else.

MS. CAPITO: Thank you, Mr. Chairman.

Welcome, Dr. Roberts from West Virginia.

DR. ROBERTS: Thank you.

MS. CAPITO: ...in my district. I am pleased to be here. I know that we have the, what you're saying is absolutely true and one of the hospitals where I live in Charleston is actually paying for the neurosurgeons to cover them, \$1,000 a day for each of the two neurosurgeons in the Charleston Area Medical Center to cover their insurance. Doctors are leaving West Virginia for early retirement and, but you know they're going to other states. They'll go to Ohio. I hear stories of them going to Ohio, Virginia - what do you attribute that to? Is it the number of lawsuits filed in West Virginia?

DR. ROBERTS: The rates presently in those states are approximately half or less than what they are in West Virginia. So physicians in

Blufield, West Virginia move across the street to Blufield, Virginia and their rates drop. I understand though that some of the insurance companies have gotten wise to that and they are now looking for the zip codes of the patients on the other side of the border.

MS. CAPITO: Is it so easy for a doctor to go ...

DR. ROBERTS: Yes, people are moving from Wheeling over into Ohio. I can't do that. I'm in the center of the state.

MS. CAPITO: Right.

DR. ROBERTS: I either stay there or I leave.

MS. CAPITO: I want to thank you for your years of service and, your generational years of service and this is a crisis in West Virginia, no question about it. And, not only does it affect our healthcare, but it goes into effecting the economic fabric of our state because who's going to bring a company in if you can't get good healthcare? So I applaud your efforts in this and

I look forward to working with you

[Unintelligible]

CHAIRMAN: The chair ...

DR. ROBERTS: I'm a physician that feels fortunate to have a chance to help people make a living doing that.

CHAIRMAN: It sounds like that..

DR. ROBERTS: And I really feel that we need to look at that aspect of this and how we serve our patients.

CHAIRMAN: If we are really, if there's less rhetoric and a real interest on the part of all of us to solve this problem, you know in an objective, open minded manner, we're going to get it done and hopefully we will. The chair recognizes Mr. Brown [Unintelligible].

MR. BROWN: I thank the chairman. Dr. Roberts, my father practiced medicine as his father did in a town a little bit bigger than Elkins but in Mansfield, Ohio he practiced some fifty years general practice, and never had a claim against him. [Unintelligible] practice.

Unfortunately not able to practice with his father too. [Unintelligible] I empathize with you and thank you for doing the same kind of work that I believe [Unintelligible]. I'm not a lawyer so I don't have a dog in this hunt but I hear my friend, Mr. Norwood say that it's only the lawyers who have concerns or are opposed to or whether exact term he used about the Greenwood bill and I just want to enter into the record in essence a request to enter into the record the National Partnership for Women and Families letter. I am expressing their concerns and if I understand this as a non-lawyer, it, I'm a little confused about the non-economic caps. I mean, I understand that the Norwood bill does not limit the [Unintelligible] damages done and does not limit economic damages but what that tells me is that if you limit non-economic caps, it's a little bit like the Republican tax cut. In that it helps those people that are already wealthiest and penalizes those that aren't.

I wish Ms. Visco were still here because

she talks very passionately and convincingly about how this hurts women, especially a 58 year old woman who is working as a hotel maid or is a clerk at Walmart and has very earning power in her future and so the non-economic damages are, the economic damages are pretty minimal for her compared to a 32 year old investment banker who has got millions of dollars [Unintelligible] the 58 year old woman who worked as a clerk has, is close to retirement. She never could retire on the little bit of money she earns, and has very little potential economic, economic potential, earning potential in her life so to limit the economic, the non-economic damages, you know I'm not a lawyer and I don't totally get this, but to limit the non-economic damages is sort of like tax cuts for rich people. We give tax breaks so yeah, we're cutting taxes for everybody. Well, yeah, if you're making \$1 million a year you get tens of thousands, if you're making \$30,000 a year you get \$12. There's a little bit of that in this and it's just this sort of continued class warfare that my

friends on that side of the aisle commit against working people in this country working. I'm frankly sick of it. I'm sorry that this hearing was used to continue that sort of assault.

I would like to move on and ask Ms. Townsend a couple of questions and I appreciate the testimony of all four of you. I think it was helpful and enlightening and [Unintelligible] was too. I agree with, first of all, Ms. Townsend, I agree with Mr. Fine's assessment that Congress must help hospitals and physicians find a solution to this very real crisis. I hear Dr. Roberts. I hear my Dad talking about it in a lesser way. The problems weren't half as great twenty years ago when he retired. But, fifteen years ago, but Mr. Fine mentioned three factors that contributed to increases in Pennsylvania: one - declining returns on investment for insurance companies, second, that the three largest insurers are vacating the market and third, large jury awards. Based on your experiences in Eastern Pennsylvania, what contributed most to these increases in premiums?

Can you help us understand that?

MS. TOWNSEND: I think that the biggest culprit was the insurance industry's boom during the nineties and the way it was investing and then spending the money that it brought in and then not having enough money in reserve. And there were a lot of improprieties that are now coming out in the newspapers that there's litigation going on, the insurance commission is actually looking into [FICO] [Misspelled?] and there's litigation going on about [Pick] [Misspelled?] and PIE right now too. I would say that is the biggest culprit and I think it's critical. I mean there was, it's been mentioned a number of times the comment from an insurance executive in the Wall Street Journal saying, you know we have to look inwards. We made the mess and I think that we really need to investigate the insurance industry as we are Enron, Global Crossing, and look for ways of making the system work better.

MR. BROWN: ...ask you about, you call it PIE, we in Ohio who are not as literate call PIE

(letters spelled out) where, I believe it is headquartered in Cleveland. What caused PIE to leave Pennsylvania medical malpractice insurance market? Maybe you can talk more informatively about [Pick] [Misspelled?] or about [FICO] [Misspelled?] [Unintelligible] What can you tell us about that?

MS. TOWNSEND: To the best of my knowledge, I think it was because they ran out of money and they just could not, they could not continue the business.

MR. BROWN: They ran out of money because?

MS. TOWNSEND: Because they'd it all on poor investments and, and they invested unwisely and didn't have enough in reserve to be able to pay out when losses happened.

MR. BROWN: With PIE, it was also obviously that you, you cited the case of, I believe...

MS. TOWNSEND: There was impropriety on the part of the President there.

MR. BROWN: In these other cases was it, is it mostly mismanagement or is it fraud or is it

some sort of uh... I mean one of the interesting things, I will wrap up, Mr. Chairman, one of the interesting things about all this corporate abuse as the President points out, it's not just the illegal abuses that we should be concerned about, it's also the corporate CEO's sitting on each other's boards and paying huge amounts of money in salaries, not illegal, bonuses but that ultimately cause layoffs in the companies. Is it some of that too in your mind?

MS. TOWNSEND: Something that remains a mystery to me, if I can answer your question in a different kind of way, is um, we've had a catastrophic loss fund in Pennsylvania and over time it is now going to be phased out as a result of recent legislation. The cap fund, as opposed to these private insurers about which we're speaking with huge CEO salaries, runs in a very lean kind of way, the amount of money per claim, claims management they call it, per claim is about \$500 on per claim to manage it from start to finish, as opposed to what they're going to do

now, which is phase it out and then shop it out to the for profit entities that will cost between \$4,000 and \$5,000 per claim, with less experienced people managing them. I guess that's my way of saying that, because of the obscene amount of money that's made by the insurance industry, which is one of the richest industries in America today, consumers and patients are losing. And a suggestion that we had made that a number of people...

CHAIRMAN: Please wrap it up, Ms. Townsend. Time is expired for Mr. Brown and everybody gets their...

MS. TOWNSEND: Oh OK. Um, you want me to tell you.

CHAIRMAN: No, I don't.

MR. BROWN: That's fine.

UNKNOWN: I would like her to finish her thought. Yes, Mr. Chairman.

MS. TOWNSEND: Un, we have been talking about making a single payer malpractice insurance system in Pennsylvania. JUA's don't have to charge

such excruciatingly high rates. If we had one payer per state, or one payer nationwide, the administrative costs would go down, premiums would go down, and we'd have a centralized place to monitor mistakes where and when they happen and why they happen and get to the root cause.

CHAIRMAN: Thank you, Ms. Townsend. Mr. Brown, the prerogative of the chair, I wanted to point out that this is not the Norwood bill. It is the Greenwood bill, for which I support the basic premise of which, if you don't have some limits on liability, we are never going to solve the problem of access but Mr. Greenwood certainly is on the right track. I would like to recognize Mr. [Unintelligible].

UNKNOWN: I thank you Mr. Chairman. I think it's important to point out as the dialogue is taking place, that the experience in California is that there are no real limits in MICRA, that is to say, there is no limit on the amount that a [Unintelligible] lawsuit can recover. It's unlimited. [Unintelligible]. Wrong, punitive

damages are routinely recorded and the amount is unlimited. Likewise, after all medical expenses are paid, not just to remedy whatever went wrong, but also to take into account all future medical expenses for one's lifetime, if that's is caused by injury. That of course is [Unintelligible]. Also, all manner of conceivable second order of facts from an injury such as, "I can't work in exactly the same line of work that I used to [Unintelligible]. Now that's unlimited. There are no limits overall in California as to what can be recovered. The limit is effectively infinity. The only thing that MICRA limits in California is non-economic damages by which [Unintelligible] so-called injured feelings damages. It is currently non-qualified damages that juries assess based on hurt feelings. That thought a quarter of a century ago was the main contributor to the [Unintelligible] nature of some verdicts or more specifically the lack of horizontal equity and the lack of visibility and the faction of significant amounts of money from the healthcare system. We

now have some experience with California versus the rest of the United States and because some people in their opening statements suggested that premiums might have gone up unduly in California, notwithstanding MICRA, I think it's pointed out that, since 1976, up until the turn of the 21st century, US malpractice premiums over that period went up 420%. In California the premiums went up 168%. That's a rather significant difference in the biggest populous state [Unintelligible]. And yet, and yet we hear that we have these horrible problems in West Virginia and we hear that we have these terrible problems in Nevada, horrible problems in Mississippi [Unintelligible] look around this country and sadly, tragically, some of this relates to OB/GYN's.

I want to ask Dr. Hollier, because she's here in that capacity. Laura you're an OB/GYN yourself, is that right?

DR. HOLLIER: Yes, sir.

UNKNOWN: Why do you think it is that doctors that deliver babies especially

[Unintelligible].

DR. HOLLIER: Doctors who deliver babies are considered high risk practitioners because babies can be born with problems. And very often babies who are born with problems are associated with lawsuits against physicians. I think it's important to remember that the claims that are brought against these physicians are not necessarily truly medical negligence.

UNKNOWN: Another specialty that is deemed high risk is neurosurgery.

DR. HOLLIER: Yes, sir.

UNKNOWN: On the one hand I can understand actions that are taken [Unintelligible] and the insurance risk [Unintelligible] paralyzed [Unintelligible] and on the other hand it strikes me as a lawyer, not a doctor, that delivering babies in a prudent sense is the most basic function of the healthcare system.

[Unintelligible] when people are run out of town and can't deliver babies any more and Dr. Roberts has [Unintelligible] on that regard, are we

mischaracterizing that profession, that specialty, calling it especially hazard, especially high risk, because of the [Unintelligible] propagate itself for a long time. [Unintelligible] how does this characterization of your specialty, how is it justified?

DR. HOLLIER: I think that obstetrician/gynecologists clearly provide an incredibly important service for women and the four million women who are going to deliver their children are relying on us to provide them with the highest quality of medical care. Perhaps my colleagues in the insurance industry can better explain why obstetricians and gynecologists pay such dramatically higher premiums than in other types of physicians. We certainly work very hard to provide the best quality care that we can every day.

UNKNOWN: I am wondering whether or not there might be more jury appeal when we, when we [Unintelligible]. Whether it's the fact that there's a whole lifetime ahead for these

[Unintelligible] but when I look at the Nevada situation and West Virginia, the panel here didn't quote Mississippi but [Unintelligible] also an extreme case. [Unintelligible] Medical School tells us that [Unintelligible] 32% of obstetricians are making plans to move their practices out of Southern Nevada. And if that happens, only 78 obstetricians are going to be left in Las Vegas, a city of one and half million people, with 23,000 births every year. 76% of the obstetricians in Las Vegas have been [Unintelligible]. Now it's inconceivable in America that there is a city of substantial where three quarters of the doctors are crooks or frauds or charlatans or quacks. Dr. Roberts [Unintelligible].

DR. ROBERTS: I think the problem is that everyone expects a perfect baby every time. When my father began practice in the thirties, they didn't have the antibiotics that we have today. They didn't have the procedures that we have today. So they expected to lose some children and

not always have a perfect outcome. Unfortunately, today people in America expect a perfect baby every time. It's not always someone's fault. Many times it's an act of God. It's something that was going to happen no matter what the individual physician did, or the nurse, or whomever is held accountable for the problem. So I think we need to have a more realistic expectation. We all pay for lawsuit abuse. We pay the bill one way or another. It plays into the inflationary spiral. It costs us all more money every day. You can't put a price on non-economic damages. You can't put a price on a human life. You cannot give somebody a million dollars and tell them they feel better because they lost their loved one. Unfortunately, our society has gotten to that point. We believe money is more important than feelings. Many times physicians need to communicate better and this is a problem I see in many physicians as I teach students. I tell them to talk to people. Treat people the way you would like to be treated if you were that person and that was your wife, or your

child, or your parent. If we all did that, we'd have a much better communication system. We wouldn't be afraid of each other. We'd be treating each other with respect.

CHAIRMAN: Thank you, Dr. Roberts.

DR. ROBERTS: Thank you, Mr. Chairman.

CHAIRMAN: Ms. Eshoo you're now recognized for five minutes.

MS. ESHOO: I want to thank all of the witnesses that are part of this first panel. While you have some differing views, I think that you have yours very, very well and with a great deal of sincerity and professionalism. Doctor, I think that, that you have, with your war testimony, with your words, really etched into single member's mind that we really do a problem. Here you are, someone that has a continued tradition in your community. You have never had a suit against you and yet what did you say the cost of your premium this year?

DR. ROBERTS: \$35,800.

MS. ESHOO: Who is the carrier that you pay

your premiums to?

DR. ROBERTS: The Bureau of Risk and Insurance Management of the State of West Virginia.

MS. ESHOO: And it was how much last year?

DR. ROBERTS: \$17,000, that was with, that with [FICO] [Misspelled?] and then [FICO] [Misspelled?] of course went into receivership so they essentially doubled, they did double the premium and I've understood, I tried to get hard figures before I came down, they have said it may be as much as twice that next year. And I obviously will not be able to afford that.

MS. ESHOO: And approximately what's the gross of your practice? What does this represent?

DR. FOREST: I can't tell you that. I mean there's two physicians, two nurse practitioners, and...

MS. ESHOO: What does this represent in terms of overhead for you.

DR. FOREST: It represents, I'm going to say 10% of my income, OK, and then there are

expenses that come out of that.

MS. ESHOO: Is this the, I'm sure you've shopped for insurance?

DR. FOREST: I can't get any other insurance in the state of West Virginia. All the other providers have pulled out. They will not insure family physicians that do obstetrics. If I did not do obstetrics my rate would be approximately half what it is. The risk, what happens is people drop procedures. They stop delivering babies. So women don't get prenatal care. Babies end up being born at 28 or 30 weeks, you know, in an emergency situation. They have to get in a helicopter and go to Morgantown. Those babies cost approximately \$1500 a day, besides the human cost to that family and that child, the state pays the bill. Eventually we all pay. Providing prenatal care is one of the most important things we can do as a society.

MS. ESHOO: You're a good man. You really have touched me. It's, how you've conducted yourself [Unintelligible]. I'll tell you one

thing, I [Unintelligible] for a woman to, the relationship of women with their physician, their OB/GYN is something is that no one can ever drive a wedge through. We have very, very complicated bodies and we're reliant upon you so I'd like to ask the person setting next to you. Yes, how do you respond to the doctor? I mean, here he is, just a little cross rough, I'm not looking to make mischief. We have, you know, each one comes in with their 100% clear cut view and yet, this is a pretty, this is not I don't think a stand alone case. It speaks to the problem that we have in our system. He has never been sued. What do you have to say about the problem and also, I mean I appreciate your testimony. You point out some very important things. How would you respond...

DR. TOWNSEND: I have been equally moved by Dr. Roberts. I mean it's unbelievable...

MS. ESHOO: He's not a single, he's not just a smokestack, a single smokestack here.

DR. TOWNSEND: Oh no he's not...

MS. ESHOO: It underscores the problem that

we have. Now, I understand when the room that there is in the system for medical malpractice, but if the insurance rates are what they are, and he has never done anything that's wrong, what, what does that say to you? Maybe that's the fairest way to ask a question.

DR. TOWNSEND: That tells me that Dr. Roberts, I believe is being price-gouged by the insurance industry and that tells me, and maybe this is a crazy idea, I don't know whether this happens elsewhere, but is there such a thing as experience based insurance for, for medical professionals. I mean, it makes me think about that.

MS. ESHOO: But we have, I know on our next panel, and I hope I'm going to be able to be here for it, because we've already been in for about three hours here but that's not enough from [Unintelligible]. There's a lot of discussion and debate. As long as it takes, we should do it. But do the other two panelists, would you like to lean in on this and say a few words. I give you the

opportunity to.

MR. FINE: Well, if I may add...

MS. ESHOO: Not very long so that everybody has a chance, but go ahead.

MR. FINE: Physicians and rightly so take care of patients one at a time. Hospitals have to bridge taking care of patients one at a time, while at the same time [Unintelligible] to play a public health role, preparing and addressing the healthcare needs of their community. So we're caught in the catch-22 of trying to address the individual situations, such those that are discussed by Dr. Roberts and by Ms. Townsend, and the need for us to be prepared to take care of the people in our community. Without resolving this problem, we will lose the capability to ...

MS. ESHOO: It becomes gum stuck to your shoe as well. Doctor, would you like to say something before my time expires?

DR. HOLLIER: Thank you very much for giving me the opportunity. We certainly appreciate your attention to this issue today and we appreciate

the recognition of this committee that this truly is a crisis. The residents who I train who have debt from medical school, who have debt from brand new processes...

MS. ESHOO: It's another huge problem we should be addressing...

DR. HOLLIER: They are going to be unable to continue to practice obstetrics next year if premiums increase again. We desperately need a solution and the American College of Obstetricians and Gynecologists strongly supports the...

MS. ESHOO: Have the Academy looked at the whole issue looked at, what is it called, experience pricing, what is it?

CHAIRMAN: Your time is up.

MS. ESHOO: If she could answer that, Mr. Chairman. Has the Academy looked at that, Doctor?

DR. HOLLIER: I am not aware at that.

MS. ESHOO: Thank you, Mr. Chairman.

CHAIRMAN: Yes, ma'am. I now recognize myself for a couple of brief questions. Dr. Roberts, your malpractice insurance company is

whom?

DR. ROBERTS: BRIM, B R I M, the Bureau of Risk and Insurance Management of the State of the West Virginia.

CHAIRMAN: So Ms. Townsend is implying that the State of West Virginia is gouging you with that high premium?

DR. ROBERTS: I'll leave that question alone.

CHAIRMAN: Is that what you were implying, Ms. Townsend?

MS. TOWNSEND: I think he's being charged too much money.

CHAIRMAN: So the State of West Virginia is charging you too much money but nobody else will insure you?

DR. ROBERTS: That sort of leads me to the question, Dr. Hollier, about what happens if we have choices here? Would pregnant patients around the nation rather have access to windfall jury awards because we refuse to admit there needs to be some limit on liability. I'm not wishing to

debate what that limit is. The fact that there needs to be some number out there in malpractice lawsuits or would the women of the country rather be ensured that they will have access to help ensure a safe pregnancy and a healthy child by having people stay in business. What would be your feeling about that?

DR. HOLLIER: Thank you very much for asking that question. My feeling is that the women of this country, just as I did, would recognize that prenatal care is extremely important into the delivery of a healthy child and would advocate for access to care. I think this legislation is important because we need to balance a few women who recover unquantifiable damages against the ability of all women in this country to receive the preventative and the diagnostic care that they need.

CHAIRMAN: So the American College supports HR4600?

DR. HOLLIER: The American College of Obstetricians and Gynecologists strongly supports

HR4600.

CHAIRMAN: And, do you agree with what many members have said, and panelists that actually physicians at a rapid rate are leaving medicine, and in particular OB/GYN?

DR. HOLLIER: Yes, sir. I absolutely agree with that. One of my colleagues in [Cadia] [Misspelled?], Texas just recently found out that his liability insurance was going to cost him \$70,000 for the practice of both obstetrics and gynecology. If he drops obstetrics it's only \$20,000. So he's dropped obstetrics.

CHAIRMAN: And Dr. Roberts, you agree that physicians in the country, particularly those around mine and your age that may have had some experience are rapidly getting out of it?

MR. ROBERTS: Yes, sir.

CHAIRMAN: Out of the practice of medicine and in particular OB/GYN? Then it's logical to conclude that women in this country do not have access. Now what we're discussing today is why are those premiums as high as they are?

MR. ROBERTS: What is happening in the State of West Virginia, the Bureau of Risk and Insurance Management is dependent upon the State Treasury of West Virginia. They do not want physicians to be on the BRIM program. The BRIM program was initially begun so that the professors at Western University and [Washington] [Misspelled?] University would have coverage. What's happened is, by default, they had to provide the availability of insurance to us. The other insurance companies have left. BRIM does not want us to continue. They are trying to get the state medical society to create a physician's mutual, which has in the past not done well. Look at PIE and [FICO] [Misspelled?] and there are other examples across the country. So the State Medical Society has been very reticent to produce an insurance alternative because it's just a stopgap measure. Until we address the real issue, which is the excessive awards and the fact that people have developed this lottery system, then we are never going to have anything that's going to

have a significant meaning. The State Treasury does not want to be at risk. That's why they have made BRIM the highest price. There's a 10% premium, whatever rate you can get in the State of West Virginia, they add 10% to it, and that's your BRIM rate.

CHAIRMAN: We all can then agree that part of the problem for the premium enquiries has got to be part of it. The enquiries, awards that are going on and in many cases, not even an award. Dr. Hollier you said in your opening, in your statement that out of ten cases taken to court of OB/GYN, seven were found for the defendant, meaning were found to have done something wrong and there was then an award, but the other seven, having spent time, dollars, etc. were found not guilty.

DR. HOLLIER: Yes, sir that is absolutely correct. In addition, in Texas, in fact one study has shown that 86% of claims against physicians are ultimately dropped by plaintiff's attorneys, thus these claims are non-meritorious.

CHAIRMAN: Well, why would these attorneys spend so much money taking a claim like that to court and lose so many of them?

DR. HOLLIER: I think that's a very difficult question but that's certainly brings to address one of the important legislative components of HR4600, which is a unit on the contingency piece that lawyers can charge in litigation involving professional liability.

CHAIRMAN: Well, does that mean that maybe 60% of an award that's supposed to go to a patient actually goes to the plaintiff attorney in court costs, therefore windfalls are potential here, therefore it's OK to lose seven out of ten because all you have to do is win one, and you don't even have to be right to win one in this system. You just have to be able to hire the most expert witness. So, surely we can come to some agreement in this committee that there is a problem with the system that is contributing to the fact that women in this country are losing access to care, no matter which side of this you're on, Mr. Brown. We

ought to be able to sit down as grownups and discuss this and recognize there's got to be some limit somewhere. My time is up I'm sorry to say. Mr. Prupeck [Misspelled?], you're now recognized for five minutes.

MR. PRUPECK [Misspelled?]: Thank you Mr. Chairman. In your comments to Mr. Brown I think we probably could sit down and talk about this if we were going to step right back from fiction. I don't know of any state that allows a 60% recovery for attorney fees in malpractice cases as you claim. With this big windfall for attorneys I just think...

CHAIRMAN: Would you yield just a second? I include...

MR. PRUPECK [Misspelled?]: As long as I get my time I will.

CHAIRMAN: I included court costs in that too, attorney's fees and court costs.

MR. PRUPECK [Misspelled?]: All right. I'll let it go. I don't tell you how to practice dentistry, don't tell us how to [Unintelligible].

All right. Dr. Roberts, you said that the West Virginia legislature had tried to address this malpractice situation?

DR. ROBERTS: Yes, sir.

MR. PRUPECK [Misspelled?]: What did they determine?

DR. ROBERTS: Well, they spent 60 days in session and I can give this off the top of my head, but don't quote me exactly. But they raised the fee to file a malpractice claim from \$85 to \$250. They increased the jury from six people to twelve. Nine of the twelve have to be, agree that there is malpractice. They created a tax credit. We have a provider tax. We pay 2% of our gross before we pay any bills for the right to practice medicine in West Virginia. They gave us a partial tax credit. You deduct \$10,000 from your malpractice fee, premium, and you take 10% of that amount off of your provider tax. So those are the things that were primarily done in the State of West Virginia, which again I feel are relatively minimal in having impact on the situation.

MR. PRUPECK [Misspelled?]: Well, let's back up here. You said your total income, your malpractice is about 10% of your total income and it's probably going to be, let's see it's \$35,800. So if that's 10%, your income's about \$300,000 and if West Virginia taxes you what 2%?

DR. ROBERTS: 2%.

MR. PRUPECK [Misspelled?]: So how much is it? 2% of your gross income that you pay to West Virginia?

DR. ROBERTS: \$6,000, something like that.

MR. PRUPECK [Misspelled?]: Yes, so they gave you a rebate on that?

DR. ROBERTS: 10% of [Unintelligible] credited towards that amount.

MR. PRUPECK [Misspelled?]: \$600 then. OK. They didn't go to caps and all this other stuff, right? West Virginia?

DR. ROBERTS: No. There is a cap at a million dollars on non-economic damages now in West Virginia, already in place.

MR. PRUPECK [Misspelled?]: If your

legislature, you say your state's in crisis, if your legislature won't take the steps that you want them to do that are found in this bill, why then should the federal Congress pass a law that affects all the states?

DR. ROBERTS: This is a very political issue. In the State of West Virginia I don't believe that any tort reform will be passed unless the State Bureau of Risk and Insurance Management is the only provider in the state, and the State Treasury becomes at risk, then the legislature will have to do something to limit the awards. The other thing that could happen is that a federal mandate such as HR4600 would come down to the State of West Virginia. They would have to comply with that.

MR. PRUPECK [Misspelled?]: Well we always hear that the state legislatures are so much closer to the people and they know better than we do so why would be federalizing the system that the state won't do.

DR. ROBERTS: State legislatures are just

as prone to politics as they are at a national level.

MR. PRUPECK [Misspelled?]: Sure. Doctor, can you tell me then Dr. Roberts, you indicate you never had any claims or anything like that against you, right? You didn't get any credit for that from the insurance carriers?

DR. ROBERTS: None.

MR. PRUPECK [Misspelled?]: Never eh? No claims your policies keep going up, the premium keeps going up?

DR. ROBERTS: Yes, sir.

MR. PRUPECK [Misspelled?]: OK. And your license has never been suspended for anything though?

DR. ROBERTS: I had a situation about 15 years ago. Yes, sir. It's a personal matter that really is not germane to this issue.

MR. PRUPECK [Misspelled?]: OK.

DR. ROBERTS: And it did not affect my malpractice claims if that's your question.

MR. PRUPECK [Misspelled?]: No, no, I was

just trying to figure out why it always goes up, you don't get a rebate if you never had a claim, but if your license is suspended, that's by the State of West Virginia, then, right?

DR. ROBERTS: Yes, sir.

MR. PRUPECK [Misspelled?]: OK. So there's something else there other than a malpractice claim?

DR. ROBERTS: Yes, sir. It had nothing to do with malpractice; it did not affect my rates in any way.

MR. PRUPECK [Misspelled?]: Your carrier told you that?

DR. ROBERTS: Yes, sir.

MR. PRUPECK [Misspelled?]: OK. I would just think that if the state would take a drastic action like taking away a license of a physician, that's a right that you have, a property right and your income right, that there has to be...

DR. ROBERTS: Sir, I addressed this with the Board of Medicine of West Virginia in 1987, fifteen years ago. It was addressed correctly, it

was resolved, I pulled licensure with the federal government and with the state government of West Virginia. This is not an issue. Obviously, you are trying to turn this into a political process. I'm a Democrat too. Why are you attacking me?

MR. PRUPECK [Misspelled?]: Now wait a minute, I asked an innocent question. You said you never had a, had had a license suspended or anything like that, no malpractice claims, so I asked a question. There's [Unintelligible] part of licensing, or malpractice, called licensing. Did you have your license suspended? Innocent question. I'm not trying to get into your personal life. What I'm trying to say, does it have influence on these malpractice premiums? There's a lot of factors that go into it. It's not just lawsuits. So answer this if you can, Doctor. What is it that states with caps on damages, why those with damages caps, why isn't the premium higher than those without the caps?

DR. ROBERTS: I don't have an answer to that question. I don't know.

MR. PRUPECK [Misspelled?]: And was West Virginia then, go to caps, was that an option they had in the legislature, to go to caps? Or was that an option that they presented, West Virginia, go to caps? On malpractice awards for non-economic losses, for punitive damages, did they propose caps in West Virginia?

DR. ROBERTS: They proposed a cap of \$1 million on non-economic damages. Yes. And there is no price on human suffering. I don't care if you call it a million dollars or \$250,000, you cannot replace human suffering with money.

MR. PRUPECK [Misspelled?]: Then why would you put a cap on it then? Shouldn't you let the jury make the, determine then what that suffering was?

DR. ROBERTS: Because we all pay that price. Can you reward pain and suffering? Can you replace that individual? I don't think so.

MR. PRUPECK [Misspelled?]: But, but you said you can't put a price on it but yet you want to put a cap on it. Correct?

DR. ROBERTS: I think it's a matter of economics. The United States cannot afford to continue to pay the prices that we are paying.

MR. PRUPECK [Misspelled?]: So life is just a matter of economics then?

DR. ROBERTS: It's economics if people can't find a doctor. It's economics if a baby is born weighing 1_ lb. at 26 weeks and has to go in a ventilator. That child becomes blind because of oxygen toxicity or has a intra-ventricular bleed because they could not find a doctor. They had no prenatal care.

CHAIRMAN: Thank you very much.

MR. PRUPECK [Misspelled?]: Sure. It's also economics if you have to take care of that injured person for the rest of your life. That family then has some economic factors that have to be considered.

DR. ROBERTS: It wasn't my fault if I wasn't able to be able to take care of the mother or baby.

MR. PRUPECK [Misspelled?]: I didn't say it

was your fault.

DR. ROBERTS: She couldn't get care because there was no access.

CHAIRMAN: Thank you, gentlemen.

MR. PRUPECK [Misspelled?]: I didn't say it was your fault. I said if you're talking about economics it applies both ways, it just can't be one side.

CHAIRMAN: Thank you very much MR. PRUPECK [Misspelled?].

MR. PRUPECK [Misspelled?]: Thank you, Mr. Chairman.

CHAIRMAN: And I want to apologize to you. I misspoke and I want to correct that. It's not 60% that goes in to the administration and defense costs and attorney fees, it's actually 58% and I'd like to submit for the record the report on the Council of Economic Advisors and put that in the record [Unintelligible]. The problem is the patient doesn't receive as much as you think they do. Now I'd like to recognize Mr. Bulyar [Misspelled?] for five minutes.

MR. BULYAR [Misspelled?]: Thank you. I have some questions about the culture of greed here. I sort of touched on it in my opening remarks about, but I guess it can also be called practicing defensive medicine. And, so I would like Dr. Roberts and actually [Unintelligible], I'm getting on the jukebox here. Help me out here. You're practicing medicine, you're doing the best you can but you also know that there are, the lawyers are out there and if a lot of these claims are being filed also are being classified then as frivolous suits, non-actionable, or whatever, however you want to title them, tell me about the inside [Unintelligible] sit down with your colleagues. Tell us about the inside, about the practice of defensive medicine. Is it happening? Is it not? [Unintelligible]

DR. HOLLIER: Thank you [Unintelligible] my problems today are technical. The, we have quantifiable data that talks about the practice of defensive medicine and it appears that more than three fourths of physicians feel, um, concerned

about malpractice litigation, in fact 76%. This concern has hurt their ability to provide quality care in recent years. Physicians also report that the fear of malpractice claims causes themselves and/or other physicians to order more tests than they would need based on professional judgment of what's truly medically needed. 91% have noticed other physicians do this and 79% report that they do this themselves due to concerns about professional liability. Physicians may prescribe more medications, such as antibiotics and only a scant 5% of physicians think that their colleagues are very comfortable discussing medical errors with them.

I think the medical community is working very hard to limit medical errors. We are actively involved in research to limit medical errors. Hospitals, as I believe you addressed earlier in your opening remarks have quality assurance committees, risk assessment committees and physicians are working very hard to improve patient safety.

DR. ROBERTS: I think one thing has happened. In some states there are certain practice guidelines that have been established and what they've done there is try to determine a standard of care in the community. And if you have met that standard of care, then you can be held non-responsible. But sometimes this leads to unnecessary x-rays, scans, and lab procedures that are done purely because we are afraid. If you are afraid that you are going to be sued you order the extra CAT scan, whether you really feel it's necessary. If a child falls, and the child's fine and you've done a complete neurological exam, you've looked in their eyes, you've done all the screening tests. You go ahead and order the CAT scan in an emergency room because you're afraid that if it ever is that one a million case, that that's going to be the thing that's brought into court.

MR. BULYAR [Misspelled?]: Is it, now I, answer this. [Unintelligible] but if you have a doctor doing his diagnostic analysis and he thinks

it's 'A', it could be 'B', but I really think it's 'A', um, but you know what, I know that this individual's insurance covers an MRI, I just want to be 100%. Is it happening that they go ahead and go, yes, let's just go ahead and get that MRI done. Let's go ahead and that other procedure. Is that happening out there?

DR. ROBERTS: Absolutely. Every day. In every emergency room across the country and every doctor's office.

MR. BULYAR [Misspelled?]: So it wouldn't be just for an MRI, it could be for laboratory tests, for blood, use some examples. Then Mr. Fine I'd like to hear [Unintelligible].

DR. ROBERTS: What happens is the individual physician is put in a position of realizing that this case could be brought into court and he could be held accountable. Whether it's their fault or no. You know, did you do the proper procedure? Did you order the proper tests? And subsequently the individual physician orders the test just because they know that, not because

they feel it's necessary for the patient. And the problem is maybe these people don't have insurance.

MR. BULYAR [Misspelled?]: So it exceeds the boundary of the community standard of quality of medicine..

DR. ROBERTS: Absolutely.

MR. BULYAR [Misspelled?]: And then becomes defined as defensive medicine.

DR. ROBERTS: I agree.

MR. BULYAR [Misspelled?]: Thank you. Mr. Fine.

MR. FINE: Yes, the feedback on that, it certainly occurs in every emergency room across the nation, regardless of whether the person has insurance or not for their own coverage. If someone comes in as the doctor described, they've fallen and cut their head, a CAT scan or an MRI becomes the standard of care, whether or not it's necessary in that instance. That occurs in the Philadelphia area, whether or not the hospital is paid for the case. Most of us are paid a flat rate

for an emergency room case, actually less than \$100 per case, and that person who comes in who has lost consciousness or had a minor head injury, can end up with \$1,000 CAT scan or MRI. But the emergency room cannot afford, the emergency room physician cannot afford the exposure that's associated with not doing that test.

MR. BULYAR [Misspelled?]: Thank you. Mr. Chairman. I yield back.

CHAIRMAN: Thank you. Mr. Strickland you're now recognized for five minutes.

MR. STRICKLAND: Thank you, Mr. Chairman and I'd like to say to my friend, Representative Deal, that I wish I had been wise enough to make your opening statement. I listened to all the opening statements, and I very much appreciated the balance and the passion with which you spoke. Thank you.

Um, Dr. Hollier. I'm not sure I'm pronouncing it correctly. Do you believe that caps, if they are or were in place, would reduce malpractice premiums?

DR. HOLLIER: Well, sir, I believe that they would. I think that the micro reforms that we've been talking about today really have stood the test of time in California. We've talked a lot about how the absolute number of the premium paid by physicians in California is relatively similar to numbers physicians pay in other states and I think it's important for us to remember that we may very be comparing apples and oranges.

MR. STRICKLAND: Can I ask you to respond to this then. I have data here from the Medical Liability Monitor. And it presents the average liability premium for OB/GYN physicians for 2001 and then states, without caps, the average premium is \$44,485 and in the states with caps, the average premium is \$43,010. How do you explain that data from what I believe is a credible source, um, because it seems as if there is a very insignificant difference, if any at all?

DR. HOLLIER: Well, I have not had the opportunity to specifically review that data. I would like to say that it's important to remember

that we need to compare rates for the same amount of coverage. For example, my physicians in the State of Texas can't obtain one million, three million coverage. In fact, what we're obtaining for our \$37,000 a year may in fact be five thousand, one million, or what is most common now in the state of Texas is two hundred thousand, six hundred thousand.

MR. STRICKLAND: You see the problem that we face up here is that we hear all of these claims and accusations. At some point there needs to be some coming together, some reasoning together, to find out that we're looking at the same data, providing the same coverage, and I don't think we're yet. Um, I have a second question if you would be so kind. Many of us are interested in exploring, not only the solutions that have been suggested by many of you, but also exploring reforms in the insurance industry as a part of the solution to the current problem. Now I have here information regarding several states that have already enacted caps. Florida caps both

punitive and non-economic damages. Nevada caps punitive damages. New Jersey caps punitive damages and in wrongful death cases, non-economic damages are not available. Michigan caps punitive damages and non-economic. Texas caps non-economic and punitive damages. Washington has abolished punitive damage.

Why is it that states with caps on damages are still facing this same crisis that we are describing if caps are going to provide the kind of premium relief that many of you seem to believe they will provide?

DR. HOLLIER: I think that's a very good question. Clearly the problem is multi-faceted and we are interested in investigating multiple measures to reduce this crisis and ensure access. As our patients [Unintelligible]. We do however strongly support tort reform.

MR. STRICKLAND: Well, it seems to me that your answer, and I think it's an accurate one. It's a multifaceted problem and calls for a multifaceted solution and my problem with what we

are attempting to do here is that we seem to have a single shot solution to a problem that is multifaceted in nature. I'm very close to the hospitals in my district, Mr. Fine. I value what you and your association does. And I'm wondering if you would just speak to that same series of, or couple of questions that I've addressed to the good doctor here in regard to why are states which have these caps in place, still experiencing the kind of crisis that we're recognizing as a reality?

MR. FINE: Two points there. First of all within states there are significant differences by region. Pennsylvania, the Southeastern Pennsylvania region's rates for professional liability coverage are substantially higher than the more rural central part of the state. So part of this has to do with the venueing of cases and the way in which cases are reviewed by local juries. The listing that you had offered relative to the states in which limits have been already implemented, as I understood the list, most of

those limitations applied, not to non-economic damages, but mostly to punitive damages. And in HR4600 those two things are very, very different.

MR. STRICKLAND: But it's just, if I could just make one concluding statement, Mr. Chairman. I am conflicted because we trust the jury system to make life and death decisions regarding whether or not a person should be put to death, for example. It troubles me that we would trust the jury system to make decisions about life and not trust the jury system to make decisions about money. That is so fundamental to the conflict that I am feeling, while recognizing that the problems that you described here are very real ones and that we need to address them. Mr. Chairman, I think my time is up, as a matter of fact. Thank you.

[BEGIN 3:00]

MR. DEAL: Mr. Fine is a hospital administrator and CEO of a large hospital. I presume that your, one of your requirements for granting hospital privileges for positions is that

they must have liability insurance in their own right, is that correct?

MR. FINE: Not only a requirement but [Unintelligible]

MR. DEAL: So there's no, in that case there's no option about having to have liability insurance? You can't, you can't just electively self-insure it, in other words.

MR. FINE: Correct.

MR. DEAL: And especially in situations where there is no separate liability allowed but joint and several liabilities in place, obviously the hospital is almost invariably a co-defendant in cases of alleged malpractice that occurred within the confines of the hospital. Is that correct?

MR. FINE: Yes.

MR. DEAL: With regard to the insurance coverage of the hospital itself, would you repeat what your percentage of increases has been?

MR. FINE: Sure. Landview Hospital specifically, two years ago was \$1.5 million.

That went up to about \$3 million last year
[Unintelligible] \$7.5 million deductible.
[Unintelligible]

MR. DEAL: I understand that that's a similar pattern that hospitals in my state and other states are experiencing, the larger upfront deductibles and the larger percentage of co-pays. I don't think your situation is unique in that regard. Is that your general understanding?

MR. FINE: That is my understanding.

MR. DEAL: I think all of us - my time up, Mr. Chairman? I'm sorry. I would not dare infringe on that. Thank you.

CHAIRMAN: Thank you Mr. Deal. I sure didn't want to call you down on it either. Mr. Deutsch is now recognized for five minutes.

MR. DEUTSCH: Thank you, Mr. Chairman. I would throw this out. I mean, I know all of you in good faith answered [Blank on tape] ... other states besides Florida and I'd be curious.

FV1: I have examples of three states. One is according to the New York Public Institute

[Unintelligible]. The state of California was ranked 27th and when compared to Connecticut ranked second ahead of New York state in the number of [Unintelligible] per capita. Once more, the number of physicians practicing versus [Unintelligible] gone up significantly [Unintelligible].

MR. DEUTSCH: You know what. I tell you, I get the gist of what you're saying to be able to provide ...

FV1: And also, this is the Center for Justice and Democracy, the results of a study done on the price of practice [Unintelligible] in Virginia that was done by two reporters [Unintelligible]

MR. DEUTSCH: Mr. Chairman. Mr. Chairman, I want to take my time ...

CHAIRMAN: Would you find out what study that was?

MR. DEUTSCH: I'd be happy to yield.

FV1: It's called, it's a series that appeared in the [Unintelligible], it's called "The

Price of Practice" and the reporters

[Unintelligible]

CHAIRMAN: Thank you very much.

MR. DEUTSCH: Thank you. Reclaiming my time. You know, we've had a lot of testimony this morning and I guess the question that I would raise and give you the opportunity, as far as I'm aware it really hasn't been discussed - why are we here? Why are we talking about this as one of the unique things that the Federal Government needs to be involved in. Many of us on this panel have served as state legislators and actually dealt with malpractice issues in legislatures. This has traditionally been a legislative issue, state legislative issue. Why all of sudden is this an issue that has to be federalized? I'd like to thank my colleagues on the other side of the aisle who continuously always say, you know, local government does better, state does better. Why are we choosing to have this hearing? Why are we choosing to federalize what has historically, traditionally been considered [Unintelligible].

Any reason for it?

MV1: I'll offer the comment that some states [Unintelligible]

Mr. Deutsch: What is it - but again, I guess I would ask you, why can't you go to your legislature? I mean, there's a reason why we have not federalized insurance. And again, my question would be, if the crisis is so dramatic as you're describing, and the numbers you've presented, I think, would absolutely point to that. Why isn't your legislature responding? And let me just follow up on that, that if they're not responding, and the crisis is as bad as you're describing, you know, you have the ability in a political process to elect new legislators. I mean, this is, again, this is historically not a federal issue for some very good reasons, you know. And it seems very selective that we're even here today, all of a sudden federalizing this particular issue. I mean, I ...

MV1: May I respond?

MR. DEUTSCH: Yeah, go ahead.

MV1: In Pennsylvania I would ask some [Unintelligible] members of the state legislature. In Pennsylvania we have certain constitutional provisions that, according to the Pennsylvania Supreme Court, have concluded that the establishment of such things as caps on non-economic damages, members of the Pennsylvania house with whom we worked closely on this, have worked to pass legislation that was then overturned by the State Supreme Court. This occurred in [Unintelligible] when Congressman Greenwood was sitting ...

MR. DEUTSCH: Let me just, you know, let me just mention because I see I'm wrapping up on time. I mean, in Florida, again, I have a fair amount of experience in Florida. Both sides of this issue, or three sides of this issue, four sides of this issue, on more than one occasion - I don't know Pennsylvania's ability to do initiatives in terms of constitutional amendments, but in Florida we've had some very aggressive constitutional amendments because of similar

issues related to, as you said in Pennsylvania. The last thing I would mention, and really give people an opportunity and maybe Mr. Fine, you in particular, which always sort of - I have questions of this in terms of the whole malpractice issue. You mentioned a specific thing in terms of someone coming into an emergency room and getting a CAT scan. And I guess the perspective I have is, you know, in terms of you either practice parameters or in terms of, you know, what is appropriate medical care. If it's not appropriate, all right, even if it's one in one thousand times that, you know, the case that looks like it's [Unintelligible] a severe concussion that only a CAT scan could pick up, then in any type of factual setting, why would someone, you know, what - it doesn't make sense that they would not do a CAT scan. It might not be, you know - in other words, what I'm saying is you have to have evidence of the factual issues. There has to be a factual basis at some point in a setting that that was an appropriate procedure to

do, an appropriate test to do. You're not doing, you know, CAT scans on fingers, you know, or broken arms because you're not. And again, it might not be likely. It might not be that often. If you were paying out of pocket maybe you wouldn't want to do it. Or maybe the patient might not want to do it. But I guess what I'm saying is that if a test is actually showing something, even if its unlikely, in a sense it has to be showing something that very well might save the person's life. So I guess my question is that ...

CHAIRMAN: Mr. Deutsch, stick with the protocol and your time has expired.

MR. DEUTSCH: Well, Mr. Chairman, I would ask to give the gentleman an opportunity to follow up and see if he can answer.

CHAIRMAN: Well, there wasn't a question, was there?

MR. DEUTSCH: Well, it really was.

CHAIRMAN: You want to answer, Mr. Fine.

MR. FINE: If I understood the gist of the

statement, the issue becomes in retrospect, any test that is found positive is determined to have been a necessary test and any test that is negative is generally viewed as having been unnecessary. And that can only be determined after the fact, in retrospect, until such time as we have either reforms such as those that are being discussed today, or we have practice parameters that are established and protection for practitioners so that they will not be found retrospectively to be responsible for having made what was very well informed at the time, we will continue to have the problem that I see

[Unintelligible]

CHAIRMAN: Thank you very much Mr. Fine. Mr. Fletcher, Dr. Fletcher you're now recognized for five.

DR. FLETCHER: Thank you Mr. Chairman. Let me say I agree with some of the comments about Mr. Deal's opening statement. I think it was very thoughtful and I concur within the profession of medicine we need to do a lot more on policing our

own members and I'll ask you a question about that, just briefly, regarding transparency, which I think the run-away lawsuit decreases, which makes it more difficult for peer review.

Additionally, let me make a statement regarding also the Chairman's, or Dr. Norwood's questioning regarding lawsuits. Only 70 percent, or 70 percent of all liability claims that result in no payment to the plaintiffs, and this is one of the problems of having this possibility of getting this large settlement, is the fact that it attracts trial lawyers and we see a lot of their ads on television, as I believe Mr. Gill had mentioned. They go after cases which don't have the facts with them simply because it's kind of a roll of the dice. And not only that, but the median cost of defending such a case, one where the jury rules that the defendant is not guilty, is \$66,767, and that was in 2001. So you see, there's a lot of money that changes hand, a lot of money to be made, even in these lawsuits that have no credibility and that are lost. And that's part

of the problem, that's what makes it, it broken. Let me make a comment additionally on the quote about the poor, and I want to quote from Cruz Reynoso, a Democratic Vice Chairman of the U.S. Commission of Civil Rights, Professor of Law at UCLA and a former justice of the California Supreme Court. He stated, "The publicly funded medical centers are supportive and MICRA [Misspelled?] because in their own insurance rate they found they would go up much more without MICRA, which would decrease their ability to serve the poor." And I think that's true for institutions all across this country. I don't think as some have tried to purport here, that having unlimited liability somehow protects the poor disproportionately. I think it's just the opposite. We've heard where rural physicians have had to stop practicing and move to other states or out of the rural area. Dr. Roberts, you talked about that. You and your father delivering 9,000 out of 10,000 people - I don't know how that happened, but - in your community, but obviously

your departure of doing obstetrics there is going to have a tremendous impact on that community. Young women are going to have to travel. Let me ask you, what percentage of the physicians here, Dr. Hoyea [Misspelled?] and Dr. Roberts, do you all deal with Medicaid patients or patients that you don't end up getting paid from? What do you all do with those patients?

DR. HOYEA: I practice at LBJ General Hospital in northeast Houston and the vast, vast majority, more than 90 percent of my patients, are uninsured or Medicaid patients.

DR. FLETCHER: And so if you left practice because you can't afford the escalating premium costs of malpractice insurance, you would leave those people trying to find someplace to go. Is that right? Dr. Roberts?

DR. ROBERTS: It's the same situation with Virginia. We have a very high percentage of Medicaid and uninsured patients. They have expanded the Federal guidelines so more people can be guaranteed by Medicaid, but the majority of my

patients, probably 90 percent of my obstetrical patients, are Medicaid patients.

DR. FLETCHER: I think the point is well taken. Here's an individual who took care of a number, majority of poor individuals, women particularly, and his service is no longer available because of this crisis, so I - this bill certainly is not a perfect solution but it is part of the solution. I think a very important part of the solution. If I can ask my assistant to put a chart here, there's a study done at Stanford on defensive medicine that shows the five to nine percent increase in medical costs due to unlimited liability and effective tort reform would lower the cost five to nine percent. Savings nationally would be \$50 billion. Do you know how many prescription drugs we could provide for our seniors, low-income seniors, if we could spend that \$50 billion on prescription drugs? Or what about on caring for the poor, those that have no insurance? Almost 40 million people in this country. I want - the physicians, I think

mentioned or spoke to this, does defensive medicine affect your practice? Is there - do you feel that sometimes there's a sense of fear of liability in the practice that sometimes affects your judgment? Dr Hoyea? I know it's a difficult question, but I've been there and I - let me say I've felt it personally.

DR. HOYEA: I think there's definitely a climate of fear in the [Unintelligible] practice.

DR. FLETCHER: Dr. Roberts?

DR. ROBERTS: I think it absolutely affects the decisions that every physician makes every day. I don't think you can decide if someone has insurance or doesn't have insurance, whether they need a test. You need to order the test anyway. And I think we need to be very careful that we don't become afraid to deal with people honestly and straightforwardly, that we continue to communicate with them in the way we would as if they were our own families.

DR. FLETCHER: Thank you. Let me ask you a question. Ms. Townsend, I certainly appreciate

your testimony. I'm sorry wasn't ...

CHAIRMAN: Your time is up. Without objection you can have an additional minute.

DR. FLETCHER: Thank you Mr. Chairman. The IOM Report, "To Err Is Human," notes over and over again that health care professionals are threatened from sharing information on medical errors because of peer retaliation. The IOM report states, "Fears about the legal discoverability of information may undercut motivations to detect and analyze errors. Unless such data are assured protection, information about errors will continue to be hidden and errors will be repeated. A more conducive environment is needed to encourage healthcare professionals and organizations to identify, analyze and report errors without the threat of litigation, without compromising patients' rights. Let me ask you, does your organization support legislation to grant peer review protections for data related to patients' safety and quality improvement?"

MS. TOWNSEND: Could you define "peer

review?"

DR. FLETCHER: Does your organization support legislation to grant peer review protection, if you have a peer review program in a hospital that tries to identify any concerns or problems going on with a colleague physician, of protecting that peer review so that you can identify problems and correct them, to protect that data for patients' safety and quality? Because if the Institute of Medicine, I think they're a pretty good organization, has stated that this impairs the ability to improve the quality of medicine. And to do what Mr. Deal was talking about, to identify bad practitioners.

MS. TOWNSEND: That's a very interesting idea. My organization has not looked at that particular recommendation. I ...

DR. FLETCHER: So you have no stand on that?

MS. TOWNSEND: I think we need to do something about making it more commonplace for doctors and healthcare workers to come forward and

talk about what goes wrong in the hospital. It was interesting, when I spoke with John Reid [Misspelled?] of the Cap Fund in Pennsylvania. He was a wealth of information. He could tell me which corner of the hospitals mistakes happen more often. He could tell me which day of the week was the, you know, least desirable day to go to a hospital to get a procedure.

DR. FLETCHER: Will you share all that with us?

MS. TOWNSEND: Well, if we had a centralized location, if we had a single payer system, perhaps, we would have that information then you could, you know, fix the problem.

CHAIRMAN: Gentleman, your time has expired. Mr. Greenwood [Unintelligible].

MR. GREENWOOD: First up, if I could, Mr. Chairman, I'd like to enter into the record a series of letters that I've received from physicians. [Tape problems] In your testimony you say that H.R. 46, that "we vehemently oppose H.R. 4600 which we know will hurt victims of medical

malpractice, immunize wrongdoers and be a boon for the monolithic giant that should be the target of every [Tape problem] in the insurance industry." Tell me how you know that victims of medical malpractice will be hurt by this.

MS. TOWNSEND: Well, in the case of, in the case of somebody who's a low income person, in the case of a woman, women, women traditionally today make less money than men do, a senior citizen, a person with a disability ...

REP. GREENWOOD: How does that - let's take a woman who is low income and she's injured as a result of malpractice. How does ...

MS. TOWNSEND: If she is injured as the result of malpractice and it's severe malpractice and the jury decides that in addition to non-, in addition to economic damages, non-economic damages, to cap non-economic damages at \$250,000 is hurtful to that person who might need additional money ...

REP. GREENWOOD: For what?

MS. TOWNSEND: To take care of her life

for the rest of her life, because she wasn't making a lot of money and economic damages are ...

REP. GREENWOOD: But she is entitled, say, "I lost my right arm due to the error of my physician and this will be the limitations on my economic ability." She would be able to - you would agree that she can recover all of her medical costs, all the medications costs, all of the therapy costs, psychotherapy costs, whatever inability she has to achieve an income, she'll be able to recover that, right?

MS. TOWNSEND: My question, you would be - what would be the difference between that woman's economic damages versus a CEO of a company who had the same thing happen to him?

REP. GREENWOOD: She would recover everything that she might have otherwise had, that would [Tape skip]

MS. TOWNSEND: The CEO would receive a significant sum more ...

REP. GREENWOOD: He was going to - he or she was going to get that anyway. In other words,

she's going to recover, she's going to be - she's not going to be held, she's going to be held whole.

MS. TOWNSEND: But he's going to be given money to give him the style to which he has grown accustomed and the woman who was struggling, who perhaps will not be able to work again for the rest of her life or has been severely altered what she can do, will never be able to, will never be able to factor in the fact that maybe that woman would be the American dream and was going to be a manager in a store one day and own the company the next day and ultimately be that CEO.

REP. GREENWOOD: Well, she's of course able to get punitive damages as well, correct?

MS. TOWNSEND: Well, there's in this legislation, is there not caps on punitive damages?

REP. GREENWOOD: No. There are no caps.

MS. TOWNSEND: There are no caps? Is there a formula?

REP. GREENWOOD: The cap is, the cap is - excuse me. The cap is, do you not know how we

treat punitive damages?

MS. TOWNSEND: If you could tell me again, I know that there's a formula to it and I don't have a cumulative memory.

REP. GREENWOOD: I don't mean to be insulting but if come and testify about a bill it helps if you've read it.

MS. TOWNSEND: I'm honestly ...

MV1: Now wait a second.

CHAIRMAN: Gentlemen, I ...

REP. GREENWOOD: I have not yielded any time.

MV1: First of all, she's not testifying on the bill. She's testifying on the issue.

CHAIRMAN: Did you yield ...

REP. GREENWOOD: No, I did not yield the floor.

CHAIRMAN: Okay, let's go on.

REP. GREENWOOD: Ms. Townsend, the individual in this case can indeed recover all of her economic damages. She can receive \$250,000 in non-economic damages. She can receive punitive

damages twice her economic damages.

MS. TOWNSEND: I understand that now, thank you. What I do know about punitive damages, if this woman has had something so egregious happen to her that the jury decides that she should receive punitive damages, I believe one, that it should be up to the jury to decide what that amount is, an amount that is oftentimes ratcheted down ultimately, because it's aimed at sending a message to the wrongdoer that they should never do that again.

REP. GREENWOOD: That's what punitive damages are for.

MS. TOWNSEND: They happen also very, very rarely. So we can't, unless we know the circumstances of that woman, count on punitive damages because they happen seldom.

REP. GREENWOOD: Let me ask this question. Where does your organization [Skip in tape]

MS. TOWNSEND: We receive funding from a variety of individuals and organizations from around the country and the state.

REP. GREENWOOD: To what degree would you say that the trial bar constitutes [Unintelligible] your organization?

MS. TOWNSEND: I would say that attorneys and the Association gives a very little bit, probably figure some 25 to 30 percent of the organization. And like you, I'm sure you know that you need to raise money to run for office like we need to raise money in order to exist as an organization. And we work to bring in funding from individuals who agree with our organization on the issues rather than adapting to the ...

REP. GREENWOOD: That question has been answered by this point in the record. Thank you Mr. Chairman.

CHAIRMAN: All right. I think [Tape problems] Would you like a minute? Two minutes?

MV1: Sure, two minutes.

CHAIRMAN: You're next, without a pitch.

MV1: First I heard Mr. Greenwood say that punitive damages aren't limited, and I think that [Tape problem]

MR. GREENWOOD: That they're not capped. They are permitted to - punitive damages are limited to the result twice the economic damages.

MV1: [Unintelligible] The interesting thing here, and I go back to this Congress, the majority in this Congress, continuing to go after working families and rewarding the wealthiest in society. Think about this. The cap on punitive damages is based - it's two times the amount of the economic damages. That means if a doctor injures a CEO, the CEO can get more punitive damages than if a doctor injures - or the hospital, or the nurse, or whatever - injures a woman who works in a hotel. So, that's just sort of inexplicable. I'll just leave it at that. I don't get that, why what should be the case. In addition to the earning power in the future and all that we're doing on economic damages, that, that sort of, to me, makes me wonder about the whole intent of this legislation.

REP. GREENWOOD: Mr. Chairman I want to ...

CHAIRMAN: All right. I guess we ...

MV2: Mr. Chairman, could I have two minutes too, please?

CHAIRMAN: If there's no objection but I don't any more of that [Tape skip] This panel's been here for four hours ...

MV2: Just a quick [Unintelligible]

CHAIRMAN: Without objection, go ahead.

MV2: The purpose of economic damages is if a person is harmed economically, they are made whole. And the person who is harmed economically as a CEO ...

MV1: These were punitive damages.

MV2: Don't interrupt now. We're all sticklers for that. The other thing I wanted to quickly ask Dr. Roberts is, I heard you say that defensive medicine is practiced - Mr. Fine says it's also in emergency rooms - is practiced all the time because you are afraid. And what I think you're afraid of is that juries today, with so many plaintiff lawyers trying to take you to court, that you can lose everything, all your life's work, all at one leap because there is

absolutely no limit as to what they can do and the trial attorney has great interest in driving that number up as high as possible. Would you be less afraid if there were terms, reasonable limitations, so that you could then protect yourself through reinsurance and be able once again to practice medicine rather than having the practice of law defend you.

DR. ROBERTS: Absolutely. I think that would be an ideal solution.

MV2: Thank you.

MV3: [Unintelligible] Thanks so very much. I apologize that it's this long, but [Tape skip] was gained by all of us, knowledge. We customarily have written questions [Tape skip] witnesses and panelists, if you will, and ask for a response in a timely fashion. If you all are willing to [Long Tape skip]

... nation, The Taxpayer Consumer Rights here from Panama. Your written statement is, of course, a part of the record and we would hope that you would compliment it, if you will, orally.

Set the clock at five minutes and hopefully stay within that period of time, or shortly thereafter.

Mr., Dr. Anderson, if you would pull that mike closer so we can hear you. Please proceed sir.

The mike. The mike in front of him is not on.

DR. ANDERSON: Chairman Bilirakis, Representative Brown and members of the Subcommittee, thank you for this opportunity to present our views on the implications of the excessive malpractice litigation on our health care system and the need for Federal reform. I am Chairman of the Board of The Doctors Company, one of the 45 doctor-owned and/or operated medical liability insurers that comprise the [Tape Skip] Association of American, the EIAA. EIAA members insure more than 277,000 physicians and 1100 hospitals against the accusation of malpractice. Personally, as an oncologist, I must bear the knowledge that each and every cancer patient whose life I try to save could be turned into a potential adversary in our current medical/legal system by the effects of the terrible fees

[Unintelligible] plaintiff's attorney.

In my testimony I would like to discuss with you proven solutions to some of the most serious problems affecting our healthcare. Today's crisis in medical access is well known to you. What must be understood is that states like California have previously experienced very similar crises and have successfully adopted medical liability reform and have no such crises [Unintelligible].

Despite stunning advances in scientific knowledge, medicine remains more art than science because human beings are not machines. Medicine's achievements today and promise tomorrow, as remarkable as they are, cannot be guaranteed. It is a sad commentary on our society that approximately one of every six practicing physicians faces a malpractice claim every year. In high-risk specialties such as obstetrics, orthopedics, abdominal surgery and neuro-surgery, there is one claim for every doctor. [Tape skip] It is critical to understand that seven or more

out of ten claims are found to be without merit. Nonetheless, each of these meritless cases requires costly legal defense averaging approximately \$23,000. Doctors Company alone has spend more than \$400 million on pending claims [Unintelligible]

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. Excess seen in \$268 million verdicts. A number of states have witnessed verdicts in excess of \$100 million. The City of Philadelphia alone has reported multiple verdicts in excess of \$50 million just in the past year.

Mr. Chairman, insurance is not magic. Society expects insurers to pay unlimited awards. It should expect that those who are insured can pay corresponding premiums. As premiums rise, so must the cost of health care. Healthcare today is

a zero sum game. These cost increases mean corresponding decreases in access to necessary medical services.

Those are the largest claims. What about the size of the average claim? EIAA data shows that the average indemnity claim payment in 2001 was more than \$310,000, a sixty percent increase in just the past five years. The figure continues to be affected by the tens of thousands of malpractice claims posed every year. Whatever the number, beyond dispute is that the cost of these claims is rising precipitously. Some of the malpractice indemnity [Unintelligible], New York and Pennsylvania alone, nearly \$1 billion.

Those who would come to obfuscate the truth will argue that the numbers are much smaller. The Center for Justice and Democracy and A. Robert Hunter actually state that the average claim payment in 2002 was \$8,056. They got this number by adding all the claims that were disposed without any payment whatsoever, in other words, zero dollar claims, to the number of paid claims.

But differently, Hunter would argue that the solution to today's malpractice crisis is more frivolous litigation because that brings down the average cost per claim. Such arguments are as without merit as the frivolous claims themselves.

Mr. Hunter also claims that the cost of malpractice premiums had risen no more in California, which has tort reform, than in the rest of the country. In fact, since the MICRA statutes of 1975 were enacted, rates in California have increased at rate only one-third that of the rest of the country. You don't need to take my word for this, this is data confirmed by the National Association of Insurance Companies. Moreover, those who would obfuscate the truth argue that stock market losses by insurance companies are the real driver of price increase. The truth is once again quite different. I know of no insurance companies that have experienced net losses greater than their investment income. Not only do state insurance commissioners closely regulate such investments, but the rating agencies

also monitor them closely. What has happened is that less investment income is available to subsidize premium levels. Therefore, today premium levels must more closely approximate the claim losses.

California has 27 years experience with MICRA. This is not an experiment. We know, do not speculate, that genuine liability reform works. Since 1975 Doctors Company malpractice premiums in California have decreased by 40 percent, constant dollars. This is true despite the fact that there has not been, and is not today any limit whatsoever on actual damages awarded.

We know, we do not speculate, that claims settle about 33 percent faster in California than the rest of the nation, as the lottery aspect of non-economic damages has been controlled.

We know, 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, do not speculate, that injured patients take home a significantly higher percentage of awards in California because there is an upper limit on attorney contingency fees.

CHAIRMAN: If you could summarize, Dr. Anderson.

DR. ANDERSON: Yes sir. We know, we do not speculate, that MICRA has not limited access to attorneys. California is a litigious state and the frequency of suits in California is 50 percent higher than the national average. But still, eight out ten claims in California are found to be without merit.

Finally, we know that not only does MICRA not limit total awards, but also that malpractice awards still rise faster than inflation in California. These same reforms are found in H.R. 4600. The EIAA and The Doctors Company fully support the provisions of this Act. If it's signed into, when it's signed into law, it will provide the same protection to patients across the United States as found in California for over a

quarter century. I thank the members of the Committee and staff for pursuing it and inviting us to testify. We look forward to working with you to make the healthcare liability system fair for everyone.

MR. CORT: I'm Jamey Cort [Misspelled?] and I have a few slides. Hopefully we can put the first one up. I'm Executive Director of the Foundation for Taxpayer and Consumer Rights and I deal with patients. I've dealt with probably a couple hundred patients over the years who have been victims of MICRA, the medical malpractice restrictions you're debating for the nation. This is one of them, and he's the reason I actually came 3,000 miles here today. His name's Steven Olson. He's 12 and this picture was taken last week. He's blind, he's brain damaged. When he was two he fell on a stick in the woods. He tripped, the stick impaled him. He went to a hospital, they took the stick out. His parents felt he was acting a little weird, rubbing his head, asked for a CAT scan because his mother had

a tumor, she had had a brain tumor before, thought something was up. They didn't give him the CAT scan, they sent him away. He came back, same situation. They wanted the CAT scan. Again, these are doctors driven in an HMO system to do less for the patient, not exhibit enough caution. Sent him away. He came back, finally, blind, comatose and as he is today. A jury awarded \$7.1 million after hearing these facts in non-economic damages for his lifetime of pain and suffering, for his lifetime of darkness, for not knowing, as a child, whether he would become an executive, or a millionaire, or a doctor. He'll never have that chance. That's what that compensated him for. And today, after that \$7.1 million verdict, it was reduced by a judge unbeknownst to the jury, to \$250,000 for pain and suffering. The jury foreman found out about it in the newspaper and wrote a letter that's in my testimony that you can read, shocked that in America a jury could be overturned and not know about it. This child today has lots of problems. His mother had to quit her job.

They've had to take him to over 100 medical and therapy appointments last year. His life and his family's life is forever altered and he is a victim of MICRA. He is a kid who will never see, and because of a one size fits all cap on compensation his pain and suffering is valued as the same as anyone else in California. And it was determined by an arbitrary limit set by the legislature. MICRA has denied victims not just adequate compensation but also legal representation. If you are a patient with only non-economic damages you will not find a lawyer in California and I urge you to read the patients' stories I've put together. There are a lot of patients who don't find attorneys and what happens to them? They go on public assistance and the taxpayer pays for them when they can't get their injuries compensated. That's what's happened to patients. The other aspect of MICRA that I'd like you to consider today is that does have an affect on HMOs. The nation's larges HMO, which is also Kaiser, which is Kaiser, and the state's largest

HMO, is protected in about 400 lawsuits every year by the MICRA cap. And in my testimony I've shown some evidence that's come out in newspapers. It's systemic problems in Kaiser that were never fixed because of the price of those injuries to Kaiser was limited in non-economic damages to \$250,000. There was no incentive for this system to change and Kaiser operates nationally. It covers six million California patients, over six million of our 24 million insured. Those patients don't have redress. The final question that I'd like to bring to your attention is, for what? And if we can move to the next slide, why, what has been the impact overall of MICRA and what I've put together is NAIC data showing medical loss, these are insurers loss ratios which go across all lines of insurance and if you can see, in California, ever since 1986, was when the Supreme Court said the MICRA cap was legal, you have seen that malpractice insurers consistently have paid out less than \$0.50 of every dollar they have taken in in premiums and claims. So less than \$0.50 of

every premium dollar goes out in claims in California.

Next slide please. You can also see from this slide that insurer profits - and it's all in the testimony as well - have been higher than the national average every year since 1986.

Next slide please. This all attributable to the fact that was described in The Wall Street Journal article, "The Insurance Cycle." This is happening against all lines of insurance, not just medical malpractice insurance. I deal with HMOs - premiums are going up in California, by the way, to almost 30 percent for small businesses. It's happening on homeowners, it's happening on other lines of malpractice and it's because when investments are good, when they're rich, insurers cut their premiums to attract people so they have more capital to make money on the investment markets. And when Wall Street's bad, what happens? They raise their rates to make up for their losses. This is the problem that needs to be addressed, the passing through of investment

losses, and that happens in all lines of insurance.

If you go to the next slide and the last slide, this is an article dealing with the malpractice crisis, but it's not for doctors. It's the California Bar Journal in this issue of July 2002. It's for lawyers whose premiums are now going up literally 200 and 300 percent. Why? Because investment losses are driving this crisis, and what I put to this panel is, I suspect from the discussion today you would not limit the rights of people who are represented by lawyers to sue them for malpractice as a way of solving this crisis. So if you're not going to do it for lawyers, I ask that you don't do it for medical providers. And there are some disputes in numbers. There is one statistic I would like to address before stopping. It is the statistic that's been thrown out a few times here about malpractice premiums. Bob Hunter did do a study that showed by looking at NAIC premium data, earned premiums, and dividing by the number of

doctors of California and then similarly by the number of doctors in the United States, and he found malpractice premiums pretty comparable. I mean, not enough to limit victims' rights, clearly. Not enough of a difference. The data that I've heard today talking about a 400 percent increase in premiums nationally versus 150 percent increase in premiums in California since '76, that deals with a very interesting little quirk that I found out when I was talking to a friend about Hunter's data. The friend's from the medical establishment and he told me, "Wait a second. California malpractice premiums you represent are way lower than we know them to be." And that's because a third of the physicians in California, those who are part of Kaiser Permanente, are self-insured and not counted in that premium data. And similarly, in this premium data from the NAIC that is being talked about today, a third of the premiums are not represented because a third of the doctors are self-insured. So thank you for the time.

CHAIRMAN: Mr. Hurley.

MR. HURLEY: Chairman Bilirakis. Thank you member Brown. Thanks for inviting me to testify today on behalf of the American Academy of Actuaries. My name is Jim Hurley and I am Chairperson of the Academy's Medical Malpractice Subcommittee. The Academy is the public policy and professional organization for actuaries practicing in all specialties in the United States. The Academy is nonpartisan and is the public policy process presentation of clear and objective actuarial analysis. The Academy also develops and upholds actuarial standards of conduct, qualifications and practices. For those of you who don't know, actuaries guide and evaluate loss statements and advise about rates and reserves of liabilities that companies carry. What I do is evaluate those loss data and make determinations about what rates they need to charge [Unintelligible]. I appreciate this opportunity to comment on issues related to the availability and pricing of medical malpractice

insurance. In the time available I would like to highlight a number of points from my written [Unintelligible]. It may be helpful to start by discussing recent experiences in medical malpractice in the line of business. During the 1990s the medical malpractice client experienced favorable operating results. Insurers competed aggressively. Healthcare providers shared in the benefit of improved loss experience, higher levels of investment income through lower charged premiums. Recently, however, the cost of medical malpractice insurance has been rising. Rate increases have been precipitated in part by the growing size of claims, more frequent claims in some areas, higher defense costs. The relation to increasing litigation and increased losses is clear. On the side of the medium jury award, the \$1 million and thousand jumped from roughly \$475,000 in 1996 according a July 2001 [Tape skip].

From a financial standpoint, medical malpractice [Unintelligible] deteriorated in 1999

and 2000 and they are expected to continue to deteriorate in 2001. These results can be looked at in two component parts, underwriting and investment. Combined ratio is an indication of how the company is doing in its insurance underwriting. Amvest Company offers comprehensive data to ensure professional [Unintelligible]. For all companies reported in Amvest, the combined ratio of 130 percent, 134 percent earlier two years, respectively, has deteriorated to 143 percent based on preliminary estimates in 2001. For underwriting this represents a loss of \$0.43 on each dollar of premium earned.

The operating ratio factors in investment income and other costs to reflect the company's bottom line. An operating ratio of 106 percent for the two earlier years, reflecting a loss of \$.06 on every dollar of premium earned, expected to deteriorate when 2001 results for the entire industry become available. At these levels 2001 will also be the worst they've been in ten years or more, approximating levels of the mid

[Unintelligible].

Today the loss environment has deteriorated. Benefits of favorable reserve development appear to be gone and the available investment income offset has declined. In fact, the overall liabilities may require increases over current ultimate loss obligation. All said, rates for both insurers and reinsured need to increase to properly align with current loss in investment income level. Companies failing to do this jeopardize their surplus base and financial health.

My written statement summarizes the two key drivers of financial results and their effects on operating results [Unintelligible]. The chart on display here is the Chart C in my testimony, demonstrates all and net operating income. This is for a subset of those companies reporting to Amvest because all of that data is not summarized yet, the summarization of a significant portion of the companies reporting data.

Strong operating results of the earlier

years, by the chart, in the neighborhood of 20, 25 percent, has climbed with a slight profit in 2000, to a ten percent loss in 2001.

The next chart, which appears as Chart D in my testimony, demonstrates the decline in surplus for these same companies. Surplus increased through 1999. It shows the rate of increase, you're looking at the percent of increase year over year. Surplus increased through 1999, decreased slightly in 2000 and decreased again more significantly in 2001. Surplus represents the capital base for these insurers and its decline reduces the capacity to write new or renewing business and/or absorb losses on business written in prior years. This includes their opportunity to write business that would become available to companies [Unintelligible].

I noted earlier the underwriting and investment components of financial [Unintelligible]. Most malpractice insurers anticipate losing money in their underwriting

operation and offsetting the loss with their investments. However, investment income is no longer shouldering the operating loss as reflected in the operating results of bottom line [Unintelligible].

Investment income plays an important role in overall financial results, particularly for insurers of medical professional liability because of the long delay when the payment of premium, payment of losses.

Insurers, for the record, have not suffered investment losses. They have experienced lower rates of return. In establishing rates insurers do not recoup investment loss, rather the general practice is to choose an expected prospective rate of return, for example five or six percent, calculate a discount factor, usually producing a credit to rates on the order of ten to 15 percent. Since interest yields drive this process, when interest yields decrease, rates increase.

In conclusion, I appreciate this

opportunity to provide an actuarial perspective on these important issues. I would be glad to answer any questions you may have, provide any additional information that would be helpful to the Subcommittee's deliberations. Thank you.

CHAIRMAN: Thank you very much. Mr. Klunkin. [Misspelled?]

MR. KLUNKIN: Thank you Mr. Chairman and thank you to the Chairman and Mr. Brown and the members of the Subcommittee for the opportunity to offer our comments on this very important issue. I'm Travis Klunkin. I'm the Legislative Director with the Consumer Federation of America. For the third time in less than 30 years, Congress and state legislators are grappling with the problem of fast-rising medical malpractice rates. As we just heard, insurers [Unintelligible] a sharp increase in large unwarranted jury verdicts to blame for the crisis. But research by our Director of Insurance, Robert Hunter, shows that insurers are pointing fingers when they should be looking in the mirror. The hard insurance market

and the insurance industry's own business practices are largely to blame for the rate shock that physicians have experienced in recent months.

Our research shows several trends that are relevant to the debate about malpractice rates. First, as we've already heard, these rate hikes aren't occurring in a vacuum. Commercial insurance rates are rising overall, depending on the size of the account and the type of insurance. The problem is caused by a classic turn in the economic cycle of the industry. I asked that the insurance cycle slide be put up. Sped up, but not caused by the terrorist attacks. There have been three malpractice crises since the early '70s, in the mid-70s, mid-80s and right now. As the graph shows, crises have coincided precisely with the bottom of the insurance cycle each time this has occurred, with the one exception in 1992, that would be [Unintelligible]. This appears to be so far, this crisis, the mildest of the three events in terms of price increases and coverage unavailability. Even with the withdrawal of the

largest malpractice insurer, [Unintelligible] from the market. According to the National Association of Insurance Commissioners, there are three major causes of this kind of steep underwriting cycle. First, a large loss or shock, second, changes in interest rates, third, under-pricing and soft markets. Lower interest rates and under-pricing have already been in place for quite some time. And September 11th provided the shock loss in an aching painful way. But the cycle had turned before the 11th, in late 200.

As I mentioned that a significant part of the problem is under-pricing. I'd like to turn now to Exhibit A. This shows that the average malpractice premium per doctor barely climbed from '91 to 2000, 1.9 percent, which is really a 32.5 percent drop if medical inflation is factored in. This means it would take a rate increase of 48 percent to bring premium rates [Unintelligible] back to the 1991 level.

Our research shows that medical malpractice as well, as a percentage of national

healthcare expenditures, is quite low, it's a fraction, about \$0.66 over the last decade for every \$100 of national healthcare costs. But, the maximum potential savings eliminated all rights for injured patients to seek legal redress it would be under \$0.60 on a \$100 medical bill. I say under \$0.60 because the year 2000 cost was about \$0.56.

Okay, regarding claims in the last decade, let us note that only one in four persons, as you've heard, get any payment at all. I'd like to turn to Exhibit C. Each closed claim in America, which includes all million-dollar verdicts, averaged 27,824 for the decade ending December 31st 2000. Notice I'm talking about the decade, not the most recent year where data on claims is clearly insufficient. This includes costs for insured defense and claims adjustment. The figures over the decade showed virtually no growth in closed claims. Now, why do we talk about closed claims? Because they include those costs you've heard so much about today. They include

the costs for the zero claims. They include the costs for paying out those claims and defending against those claims. It's important to note that. If you talk just about claims that are paid, and the number we have on our chart over a decade averaged \$112,000, this number doesn't include costs for defensive claims settled, adjudicated or otherwise closed with no payment. You have to look at both. You have to look at both the closed claims and those that are paid.

The conclusion we've drawn from this data is that the insurance cycle and the practices of the insurance industry themselves are the key culprit in the rate shock that physicians, hospitals, and patients are grappling with. Unfortunately, each time the cycle turns from soft to a hard market the response by insurers is extremely predictable. They shift from inadequate under-pricing to unconscionable over-pricing. They cut back on coverage and then they blame large jury verdicts for the problem. Insurers seem to expect Congress and the American public to

swallow the dubious line. Trial lawyers have managed to time their million dollar jury verdicts to coincide precisely with the bottom of the insurance cycle three times in the last 30 years. That just doesn't seem plausible. And as you've heard from others, the insurance cycle is quite complicated and you can't boil it down simply to a question of losses involving jury verdicts. A lot of this datum is debate. As you've already heard, the IOM Report demonstrates that far too many Americans face the serious possibility of an injury or even death due to medical mistakes in the hospital. Their range on medical errors was either eighth leading cause of death in the country, ahead of AIDS and breast cancer, or the fourth leading cause of death in the country, depending on how you calculate the numbers and what study you look at.

CHAIRMAN: It's summarized.

KLUNKIN: Absolutely. Some medical errors are directly attributable to physician negligence, some aren't, but the point is that there are

serious implications here if you roll back legal rights. The poor [Unintelligible] tort reform legislation. I urge you to look at these insurance issues very closely, get the facts and look at the role the insurance industry has played in this predicament that we all find ourselves in right now. Thank you.

CHAIRMAN: Your mike.

MV4: This is a live mike. Good. Thank you. That doesn't count against my time and I thank my friend from the CFA. Chairman Bilirakis, ranking member Mr. Brown, members of the Committee, I appreciate your inviting me here today to talk about the medical malpractice crisis. I've studied liability law as a law professor. I've practiced law for the plaintiff's side for 15 years. For the past 22 I've been on the defense side. I also chair the public policy group at Cicardi [Misspelled?] and Bacon and serve as general council to the American Tort Reform Association, but today my views my own, not that of the Association or any member.

One reason why the Committee thought it would be important for me to testify today is that some quotes of mine have been put before this Committee and the Judiciary that medical malpractice liability reform in your bill will do no good. Those quotes were taken from statements I've made about another bill which had no limits on damages. When I heard about this I felt actually good. In Washington first you're not quoted, then you're quoted, then you're misquoted, then you're quoted out of context. That's when you've made it, so I thought there was something satisfactory about that but I thought I should clear it up.

A bill that's going to limit damages to \$250,000 pain and suffering is going to ultimately have an affect on insurance. I don't think that bills should be passed simply to limit insurance costs. I don't think that's right. I think the first thing with tort reform is that it should be fair and it should be balanced. And second, if you have as a goal limiting insurance coverage or

limiting insurance, excuse me, costs, that can be done in a bill - are you going to take a break? Or, is there a roll call?

CHAIRMAN: I think we'll hear you first then we'll take a break.

MV4: Oh, okay. A bill such as H.R. 4600 can limit insurance costs because it limits the amount of payouts. Some members wanted this out. You don't need the study tort law for three decades to figure that out. Mr. Deutsch, other members raised the issue, why not let states do it? My view about medical malpractice has been that the states should do it.

SPEAKER: Law Professor I've practiced law on the plaintiff's side for 15 years, the past 22 I've been on the defense side. I also chair the public policy group at Chicardy and Bacon, served as general counsel for the American Tort Reform, an association but today in my view are my own, not that of the Association or any number.

One reason why the committee thought it would be important for me to testify today is that

some quotes of mine have been put before this commission and judiciary that "medical malpractice liability reform in your bill will do no good." Those quotes were taken from statements I've made about another bill which no limits on damages. When I heard about this I felt actually good in Washington. First you're not quoted, then you're quoted, then you're misquoted, then you're quoted out of context. That's when you've made it. I thought there was something satisfactory about that but I thought I should clear it up. A bill that's going to limit damages to \$250,000 pain and suffering, is going to ultimately have an effect on insurance. I don't think the bill should be passed simply to limit insurance costs. I don't think that's right. I think the first thing with tort reform is that it should be fair and it should be balanced and second, if you have as a goal limiting insurance costs, that can be done in a bill . . . are we going to take a break? Is there roll call?

CHAIR: I think we'll hear you first and

then take a break.

SPEAKER: A bill such as HR 4600 can limit insurance costs because it limits the amount of pay-outs. Some members pointed this out. You don't need to study tort law for three decades to figure that out. Mr. Deutch, other members raised the issue, why not let states do it? My view about medical malpractice has been that the states should do it. The problem is, and it was averted to by some of the witnesses, that state tort reform in key states that you're looking at, like Arizona, Nevada, Illinois, Ohio, has been decimated by states' Supreme Courts, holding these laws unconstitutional under state constitutions. When they do that, there is no way you can get a review of the decisions, because they use state constitutions and you cannot get to the Supreme Court. Even the Washington Post calls it Judicial Nullification. The Harvard Law Review has roundly criticized these decisions. We've got an article on it, and will be submitted to the Committee for the Record, but the answer to the question of why not

let the states do it, is that it's been shown that the states can't do it, and a handful of states can undermine the total national picture.

CHAIR: If you'll submit that article to the committee, it will be part of the record.

1st SPEAKER: Thank you. Another myth is somehow the insurers are all going to go to the bank and create a big raid once you pass this Bill. This Committee, back in 1981 and in 1986 passed the Federal Risk Retention Act. It was not mentioned by anybody today. I'll bring it to your attention because it's extremely relevant. If insurers do not really reflect the savings that would be brought about by your bill, doctors have a ready alternative. They can self insure, or they can be grouped together and purchase insurance on a group basis. The Doctor's Company which is a principal insurer, is a mutual, owned by the doctors so they're not there to keep cheat their members or not pass along savings brought by tort reform. The final thing and I've heard it many times, is that the tort reform won't be

effective and won't do any good. I heard the same thing about the General Aviation Recovery Act in 1994, which was signed by Bill Clinton, which limited the liability, in a constructive way of the general aviation industry. I was told in the Senate Room that it would be a paper mache airplane, fall out of the sky, that nothing would happen. Well let me share with you what happened, and we will submit an article which shows this. This Congress passed a tort reform, the only real federal tort reform that affects a substantial business in the United States. It bought back Piper, brought back Cessna, produced 25,000 jobs, and there's not been one member of Congress on either side of the aisle that sought to repeal that bill. they know if they did, they'd be in the paper for repealing a Bill that was effective. Civil liability reform, of this type, can be effective and achieve the goals you wish. I'd be happy to answer any questions you might have. I didn't realize the limited amount of time but I value answering questions, because there were a

lot of things said this morning that really deserve a clear concise answer.

CHAIR: Thank you.

[BREAK]

CHAIR: Mr. Hurley, you are the Chairperson of the Medical Malpractice Subcommittee, of which is the American Academy of Actuaries.

HURLEY: Yes sir.

CHAIR: You're not being paid for testifying here today. I mean is an actuary ordinarily hired by an association, a company or whatever the case may be to get answers.

HURLEY: Yes. [...Unintelligible ...] voluntary typically my job as an actuary. I do work for health insurers [...Unintelligible ...]

SPEAKER: Okay now you've submitted here a written statement, in regard to contributing factors [...Unintelligible ...] etc. all that was done by you, in conjunction with your testimony here today, is that right? You were not asked to do that by either the American Medical

Association, by the Insurance profession or the authority here.

HURLEY: No, I actually [...UNINTELLIGIBLE ...]

CHAIR: Okay. Sir, you were in the audience waiting and you heard Dr. Roberts testifying about rates having doubled and how he heard that [...Unintelligible ...] why aren't insurance commissioners [...Unintelligible ...]

HURLEY: As you know the regulators of the states have [Unintelligible] approved prior [...Unintelligible ...]

SPEAKER: In other words some states require approval before they go into effect and others after the fact

HURLEY: That's correct. In the case of West Virginia, prior approval actually retained by the state [...Unintelligible ...]

CHAIR: Alright well, uh, in your experience, how would you say the state insurance regulators function? Do they . . Do some function in your eyes better than others in terms of

allowing increases, in terms of decreases. I don't know whether it decreases at all due to the fact that there has been some documentation to show a loss. do some reduce.

HURLEY : The question is some state regulators reject to the rate increase to subsequent lower levels [Unintelligible] 25%. The state is looking at rate applications carefully. Some states are more aggressive.

CHAIR: Do any of them on their own volition, look at the rates, for instance, that only when an application is made by an insurance company, that they take a look at them or let's say for instance, do any of them take a look and say, 'well, claims have dropped' or whatever all that data is in the past year and therefor we are going to decrease rates. Has that happened at all?

HURLEY: Not so. As a practical matter, once rates are filed and approved, the rates stay in place until [...Unintelligible ...]

CHAIR: Alright, now the rates in West

Virginia that have doubled for Dr. Roberts, have you looked at those at all and come to any conclusion in that they were right in maybe doubling them again?

HURLEY: I can't speak for
[...UNINTELLIGIBLE ...] program works

SPEAKER : Well now many members of minority, Mr. Brown and others, and I'm not at all displeased, the intent here is to do what's right and I yes the original that sort of thing and it would be wrong not to look at the overall picture. But the insurer's statements, insurers are increasing rates, because of investment losses, particularly their losses in the stock market. State it very briefly, right, wrong, possible, impossible.

HURLEY: [UNINTELLIGIBLE] No From an actuarial standpoint

CHAIR: Alright you say they can't do that, violation of actuarial standards. Do any of them do that, might any of them done that?

HURLEY: Not to my knowledge.

SPEAKER: There are others, companies are operating irresponsibly. I don't disagree.

BROWN: Noted earlier, page 10 of HR 46, the language punitive awardees may be up to 2 times the amount of economic so I want to make sure I understand this. Someone so that if a doctor harms Ken Lay punitive damages are higher than if the doctor harms exactly the same way the woman that empties the wastebasket [Unintelligible] This is punish the provider of the negligent act. Is this something we see in tort law. I'm not a lawyer and hardly an expert in tort law. Is this common?

MR. GREENWOOD: Not this is not common. The states don't have caps or limits on punitive damages, some do and there's a variety of ways to treat them. The supreme court has said one opinion and at some point, the ratio of punitive and compensatory so extreme that it's so close to the line of constitutional but there's the court was talking about compensatory damages, which include both economic damages.

BROWN: Do you support that Bill?

MR. GREENWOOD: Do I personally support it?

Brown: I think one has to make sure that punishment is adequate for defendant. I would want to give some thought. I wasn't really asked to comment on the [Unintelligible] of the Bill and I have not supported ratios in the past based upon punitive really economic losses so the answer would be is that that's not something I've supported.

BROWN: [UNINTELLIGIBLE]

MR. GREENWOOD: I want to mention thing because you asked a lot of questions about it, and that is economic losses vs. non-economic losses. Believe me it's a complex thing.

There are a lot of things in the law that are economic losses. Somebody who's not a lawyer wouldn't think of as economic losses. For example somebody who's at home, a housewife or house husband, they're not earning anything but one might think they have no economic losses but

that's not the way it is if you're a plaintiff's lawyer. I used to jack those things up to \$60, 70, 80,000 a year, I'd break down on a charge, everything a woman did so I can build their economics up very very high. With a child, child growth, you can take a child and bring in neighbors or new hear, show his promise of economic losses in the future and build them up very very substantially. So some of the remarks on the focus on economics are probably misplaced for those who haven't tried cases, so that the distinction that's made in the bill is an honest distinction. You're not leaving someone high and dry simply because at that point in time, not have a job.

The final point on this, is that California statute is not going to work miracles once the plaintiff's lawyer, and I was one, they're smart, they readjust, figure it out what the situation was, moved a lot of [Unintelligible] pain and suffering into economic losses so [Unintelligible] saved money, but not a huge ton

because things that had previously been regarded as pain and suffering damages were put into economic losses, and I think the record should reflect that.

BROWNI have one question, one of the witnesses' reference to the departure of St. Paul, from the malpractice market. Are there other reasons why St. Paul left.

HURLEY: I don't know. I know that they were the largest provider of malpractice insurance. I actually don't know much about their departure.

SPEAKER: St. Paul's losses were a billion dollars. [Unintelligible] despite the fact that [Unintelligible] I don't know what the lawsuit with Enron played a role [Unintelligible]

MR. GREENWOOD 2: Mr. Brown since the subject's been brought up, let me mention that. There were concerns that St. Paul moved too fast to expand in too many states, to take advantage of the positive environment of the 90s for medical malpractice insurance and they over reached and in

particular that they underpriced premium and then losses started increases moderately and weren't in a position to deal with that financially.

MR. GREENWOOD: There's been an awful lot of talk about blaming the insurance and the real reason we have these outrageous rates is because the insurance industry lost so much money in the stock market, it had to make it up. Now, is there a grain of truth to that.

ACTUARY: Barely, actually probably less. Insurance is a highly regulated Most companies .

MR. GREENWOOD: Less than a half a grain. Mr. Hurley you said that they can't recoup. Insurance officials do not allow insurance companies to put into their rates, past losses, right, but wouldn't make it a jot of difference if St. Paul or anybody else lost a hundred million and two hundred million in Enron or anywhere else in terms of where they set their rates. is that you testified? SCHWARTS: Is anything built into the rate, has anything in your opinion have to do with past losses.

SCHARTZ: If the insurance commissioners are doing their job, no.

MR. GREENWOOD: Mr. Plunckett do you disagree with these other two gentlemen

PLUNKETT: Yes. Income affects reserve. Reserves affects operating income. The combination there is especially potent for medical malpractice because you have longer lag time for medical malpractice so it actually does have an impact.

MR. GREENWOOD: Mr. Anderson would you agree

ANDERSON: [Unintelligible].

MR. GREENWOOD: Mr. Hurley is Mr. Plunkett [Unintelligible]

HURLEY: [UNINTELLIGIBLE]

MODERATOR: Mr. Hurley what are the components of a rate that accompanies premiums. Mr. Hurley In that premium is less than they expect to pay in payoffs, right. So, that premium, so then out of their future investments, they have to get all their operating costs, and

then profit

HURLEY: Not always [Unintelligible] costs and operating rate. [Unintelligible]

MR. GREENWOOD: There's a draft Democratic Bill for medical liability in terms of [Unintelligible] alternative one of the things that they propose to do is freeze medical malpractice insurance especially when the data, rates would be frozen at the level of January 1, 2002, 6 months after the filing of the judicial report. What would a 6-month freeze on insurance.

HURLEY: I think it would be devastating. You've heard allegations [Unintelligible] a nothing that I find very difficult.

MR. GREENWOOD: If the bill also proposes, says advancing medical malpractice insurers exiting the market, any insurer who exits the medical malpractice market must also stop offering all types of insurance.

HURLEY: [Unintelligible] not a lawyer

MR. GREENWOOD: Mr. Plunkett, you don't support tort reform approach, do you concede that

the rates are outrageously high, you agree with that, don't you.

PLUNKETT: We have a rate problem.

MR. GREENWOOD : You don't think that tort reform is the way of solving the difficulty. Can you outline for what insurance reforms would solve this problem.

PLUNKETT: Absolutely: We proposed to cut a number of items at the state and federal level and some of them are unique in recognizing the problems that the high risk specialties you've heard so much today, the obstetrician, neurologist, some of the specific problems that they face. For example, in the written testimony, we suggest that the states consider a fee based on risk that would be adjusted . . . it would be a fee that insurance companies would assess it on all physicians. It would be based on the risk of the specialty, so a higher fee for a higher risk.

MR. GREENWOOD: What about a higher fee for a higher premium.

PLUNKETT: It could possibly mean that for

general practitioners and internists and those who are paying much lower malpractice rates at this current time but are doing what we call as referring up. The problem with some of these specialists is they're seeing patients who are at the highest risk. Neurologist and neurosurgeons are having referred up to them from other practitioners for patients.

MR. GREENWOOD: The family doctor pay higher insurance rates

PLUNKETT: The family doctor, Mr. Greenwood is actually benefiting from the medical malpractice structure so I'd have them pay a little bit absolutely and that would actually deal with some of the problems that we've heard today where we have obstetricians leaving practice where we have neurologists who are facing medical malpractice insurance premiums are extremely high, a slight subsidy for those high risk specialties recognizing that all physicians are part of the care that these patient's get but only some of them are taking the risk.

MR. GREENWOOD: Pennsylvania you find out there are no physician medially that aren't gouged, no room to simply transfer the premiums down [Unintelligible]

VOICE2: Dr. Anderson, you talked a lot of about St. Paul, you said St. Paul medical malpractice and [Unintelligible] 10%, 90% lost some [Unintelligible] in Enron, lose money [Unintelligible]

Dr. Anderson: [Unintelligible]

VOICE 1: St. Paul 1991 and 1997 released \$1 billion from reserves, reserves that were set aside certainly encouraged the malpractice business and made their bottom line and pocketbook [Unintelligible] a run of claims that's going to hurt you.

[UNINTELLIGIBLE]

HURLEY: Last year they had \$1.8 billion 10% malpractice anyways

GREENWOOD: Mr. Schwartz do you know about the medical liability [Unintelligible]

SCHWARTZ: I've heard of it.

GREENWOOD: Is it a credible report?

SCHWARTZ: I have no idea, it's not something that [Unintelligible]

GREENWOOD: You've never relied on it.

SCHWARTZ: No I have not, sir.

[Unintelligible]

VOICE: States without caps on damages, with caps on damages, the premiums are actually the same, the caps how's that going to reduce malpractice [Unintelligible]

SCHWARTZ: I can't evaluate a source that I don't know anything about. I've been working in tort law for 30 years and have never heard of that so well I just would say that where you have a certain common sense approach to all of this, if you limit damages, in tort law to \$250,000 there are a number of things that are going to reduce costs. No. 1. Before the thing is law, a jury can come back with a million dollars pain and suffering. After it can only come out with \$250,000. Ninety-seven percent cases are settled. I've been in a lot of settlement negotiation. If

there is a cap in a state, whether I'm on the plaintiff side or the defense side, the perimeters of the settlement are going to be narrowed, they just are, so I don't know what this periodical showed but it's a matter of common sense, it should reduce costs.

VOICE 2: Common sense is based on assumption based upon your experience

SCHWARTZ: That's all I have, sir.

VOICE2: Michigan did pass medical malpractice, pass very similar to 4-600, but yet AMA still lists them as a medical malpractice crisis, if caps work so wonderful, verdicts would be through the system, why is Michigan still a crisis state?

SCHWARTS: Well, it could be one has to look at the Michigan verdicts and Michigan experience that after a period of time, plaintiff's lawyers were able to shift enough costs into economic losses so that it wouldn't make any different. I haven't studied it, but I'd say that would be, and I haven't labeled Michigan

as a crisis state. Michigan law, overall, is pretty fair. It's a good court and isn't a state that comes to my mind as being a crisis-state.

HURLEY: Based upon national practitioner's data base, medical malpractice [Unintelligible] 85,000 where the rest of the nation is 125,000 almost a third less but still considered a crisis but less pay-outs

SCHWARTS: I wouldn't want to see the criteria for crisis.

VOICE: Thank you very much. I now recognize Mr. Cox for five minutes.

MR. COX: Thank you Mr. Chairman. Mr. Plunkett [Unintelligible] California trial lawyers

MR. PLUNKETT: I can't tell you, I don't know.

MR. COX: How can we find out the answer to that question. I only ask this under Full Disclosure, obviously we have

PLUNKETT: Here's what I can tell you, we have an annual awards dinner every year, I'm a regular attendee, I think that on occasion . . . no

not that I know of.

MR. COX: Do you disclose your finances publicly? Is there a way to find out who funds Consumer Federation of America?

PLUNKETT: We can give you our annual report

MR. COX: Does that include an information of where the money comes from.

PLUNKETT: I don't know I haven't looked at it recently. To tell you the truth, the truth is less than 1/2 of a percent. There's your answer.

MR. COX: Actually that's a very direct answer.

PLUNKETT: Well, what I tried to say Mr. Cox. We have an annual worth the only time that we accept outside contribution so if there's a percentage, it's teeny teeny teeny probably only equivalent to . . . Mr. Schwartz here .

MR. COX: Outside contributions. What are other things.

PLUNKETT: Foundation Grants and

Contributions from our members.

MR. COX: Might those members include
[Unintelligible]

PLUNKETT No. no. Members of the
consumer group include the legitimate] consumer
group. They include other members such as credit
unions and public power entities, and our
association. They don't include trial layers.

COX: I'm trying to figure out where all
that comes from but I appreciate that. The
Doctor's Company has been in the market throughout
the malpractice crisis, Jerry Brown was governor
when Democratic legislation enacted and you're
still around. Correct me if I'm wrong, 1976
malpractice n California was \$23,000 and today,
the average is \$14,00. So in other words, the
premium is less now than it was then.

VOICE: [Unintelligible]]

ACTUARY: [Unintelligible]

MR COX: Dr. Anderson What is the nature
of the law in California. ANDERSON: Did I say
California, I meant to say Colorado:

DR. ANDERSON: Colorado has very similar
[Unintelligible]

MR. COX: Colorado \$30,000 back in 1986,
\$11,000 So over a period of time [Unintelligible]

MR. STRICKLAND: Thank you Mr. Chairman, I think we have had witnesses before these committees to pick your brains. We've heard here today something that really bothers me, that has to be not but not with the economic damage or non-economic move but the punitive damage, damage where the sole purpose of punishing or deterring inappropriate behavior. We've been told that this bill allows in the area of punitive damage an amount two times the amount of the economic damages up to \$250,000 whichever is greater. Now I think that means if you were a relatively poor person and you have been subject to bad behavior so that punitive damage is called for and you have the possibility of getting a little bit of money. But if you were a successful for high income individual and you qualify for possibility of punitive damages and getting a whole lot of money.

So I'm just interested in your opinion, how likely tell me if you would as you got down, the table there. Do you think this is fair, Dr. Anderson?

DR. ANDERSON: Punitive damages are rarely paid adequately.

MR. STRICKLAND: When they are? When they are? This is a theoretical question but I'm trying to get at your best judgement and perhaps your values, I don't know, but

DR. ANDERSON: This would apply
[Unintelligible]

MR. STRICKLAND: But it's based on economic damage, it's not based on the severity of the injury as such.

DR. ANDERSON: Makes a difference. There is one limitation [Unintelligible]

MR. STRICKLAND: But this is based not on economic damages but on economic damages which means has a person of low income is going to receive less, in terms of punitive awards than the person of high income, is that fair when the purpose of punitive damages is to deter bed

behavior. Isn't it appropriate that we have at least an equal punishment for bad behavior directed toward a poor person as we would have directed toward a wealthy individual.

DR. ANDERSON: The whole purpose of punitive damages is to punish people.

MR. STRICKLAND: But the amount would, would it not? The amount would have a deterrent effect.

MR. SCHWARTZ: Would the gentleman yield? Does this mean a physician or physical therapist working on a wealthy person, providing some service, they're going to be a lot more careful because punitive damage will be higher or working on a wealthy person's maid or they do injury to that person, the damage is very little.

VOICE: I hope that's not the answer. Dr. Anderson, can I get a yes or no, or 'i don't know' answer from you, that question, give you 3 choices, yes, no or I choose not to say.

DR. ANDERSON: I'm sorry I don't find the question

MODERATOR: Do you not understand the question, sir, I'll explain it again.

If you are a poor person, you are injured and the jury awards punitive damages, you're going to get less if you are a poor person than if you are a wealthy person, can you understand that?

DR. ANDERSON: I understand your words.

MODERATOR: Let's assume it is the case

DR. ANDERSON: That's your answer

MODERATOR: I don't think you want to answer me, sir, so we're going to move on. Next.

AMERICAN ACADEMY REP: As a representative of the American Academy, I'm not speaking for the Academy

MODERATOR: Sure, I understand that,

AMERICAN ACADEMY REP: Sir but it seems that punitive damages don't tend to be dealt with in medical malpractice insurance, in a lot of cases [Unintelligible]

MODERATOR: But when they are, when they are should a poor person get less than a wealthy person, I'm just asking for your judgement.

AMERICAN ACADEMY REP: My personal judgement is not litigated by [Unintelligible]

MODERATOR: Thank you sir, Hurley, I'm sorry, Mr. Plunkett

PLUNKETT: Well as with Mr. Brown, I'm a lot of not an attorney and we have not taken a position on the Greenwood bill because we're still looking at it but in general we are wary of this kind of tort reform, so here's your general answer. It doesn't make much sense to me to base punitive damages on the income of the person who's suing. The punitive damage should be based on the current value.

VOICE: I was asked that question by Mr. [Unintelligible] when you were out of the room. That's not an approach I would advocate. I think there should be reasonable limits on punitive damages. I hate to see this bill sidetracked on what as a practical matter is a non-issue because some of the witnesses testified that punitive damages rarely come in med now.

MODERATOR: I know but I want to tell you,

this single issue . . .

VOICE: I can understand that, and hopefully when . . . it's really confusing but having the five hours there allows me to stop and think, once in a while I do. I had a good day, so, there's three things going on here, and everybody keeps mixing them up. One, is there a problem, and there seems to be at least some consensus that there is a problem for some of the doctors. No. 2, whether this particular bill, would be effective in addressing that problem and there is considerable debate among the members as whether it would or not, whether in California, has worked or has not worked. I think it's worked, that's my view, and the third which goes to your questions, and that is whether the contents of this bill are fair and I think that it might be helpful over time as you talk among yourselves, to keep those things separate because I would say, 'that's not an approach I would advocate on punitive damage reform which I believe that goes to the Part Three.

MODERATOR: Mr. Bowie you're recognized for five minutes:

MR. BOWIE: I want to thank you for [Unintelligible] There are more thoughts that we have. Immediately towards you are thoughts when you spoke about states' rights so here I am and I am concerned about commerce and laws, Reality appears depending upon whatever party is in control. Pick an issue. Pick and choose when we should intervene. All politician is justified as [Unintelligible] so I'm interested in the constitutional question. The other is in regard to punitive, lawyer's caps. These are just really my opinion about the punishment, that has no idea about [Unintelligible] justice blind they have no idea about the case, or care about the rest of the economic standards. I would just say I don't get as emotional as [Unintelligible] did, I agree with him.

Anyway, that's just the way it works out there, as I know it, so this is an issue about the constitutional question, in regard to Mr. Anderson

and Mr. Hurley, the question for you is, this idea on . . . I have looked at [Unintelligible] 2001 rates for the medical profession and liability and looking at all these increasing rates, all the jurisdiction and those of whom have some type of cap, they all got a hybrid out there. The doctor company you're dealing with a lot of different [Unintelligible] but my question is, those states that have some form of has there not been

MR. BOWIE: [Unintelligible]
astronomically high rates, point out
[Unintelligible] I was in Pennsylvania when the legislature primary [Unintelligible]

VOICE: In Pennsylvania, this is when the legislature increased primary limits up to \$500,000/ 1.5 million on surcharge of and also skyrocketed absent.

VOICE: City of Philadelphia . . . , went bankrupt had a mechanism. First it's not measured, insurance companies, jeer

[Unintelligible]

MVOICE: As far as tort reform, one of the

clearest examples, and figure out measurement the companies did decline, now reduced rates in 30 sates, largely due to the impact of [Unintelligible] companies will respond.

VOICE: I agree with Dr. Anderson,
[Unintelligible]

Any person aware what efforts are being elicited, the alternative to point out that most of the companies went bankrupt during a time when financial returns of investment were highest. [Unintelligible] went bankrupt, but you'd thought they had a mechanism of pricing their insurance less than the cost. First, it's not measured in terms of [Unintelligible] cost of the judgement where they won't [Unintelligible] patient's have their indemnity

MODERATOR: I see the lights come on. I'd appreciate it if [Unintelligible] this report.

VOICD: As far as the tort reform, one of the clearest examples we have of [Unintelligible] and figure out measurement, companies did [Unintelligible] now, largely due to the impact of

[Unintelligible] and tort reform, have an impact on lawsuits, the companies will respond. I agree with Dr. _____- with Tyson. One thing about increase the limit of the coverage, [Unintelligible] the state of Pennsylvania \$590. Rating, that's [Unintelligible]

MODERATOR: Mr. Byer, there's an article written by former Judge Bork, actually a young man at the American Enterprise Institute, his liberal impact showing that the commerce causes a [Unintelligible] tort law and it's a good study and it's Harvard Journal of Law and Public Policy and Judge Bork and his colleague show how the commerce clause today would be impacted by the things that were discussed this morning, that medical malpractice crisis is not really isolated to the one state. The [Unintelligible] also that are born by this are born by thus government and laws passed by this congress, so they make the argument that this is an area where the Congress of the United States can act.

Now I agree with you, around this great

institution, states' rights often is the eyes of the beholder so merely because the commerce clause allows this, that doesn't mean that it should be done. The reason I think it should be considered very very seriously is state tort reform, right now is Russian Roulette, you never know whether a particular act is or is not going to be held constitution because it really depends on the vagaries, who's sitting on a state court. In Ohio, they nullified a tort reform, in California they didn't, in Florida a lower court, they did, so how can one operate in something as serious as medical mal with that going on. Moreover, if I were running an insurance company and the state passed a medical mal cap, I would not touch my reserves or my rates and premiums until I knew whether or not the issue would be how constitutional or not and that can take 4 to 5 years.

MR. GREENWOOD: Mr. Schwartz you're referring to you've found then states unconstitutional according to the state

constitution.

MR. SCHWARTZ: That's correct sir, in state constitutions, and we'll submit this article to you. I just started to read them the years ago, I didn't read them in law school, they can be two or three hundred pages in length and they have clauses in them that are extremely malleable, something like open courts and an open courts provision to a judge could say the courts could be open 24 hours a day or if you touch one dollar of compensatory damages it's unconstitutional and unfortunately for both sides these decisions seem to be reflected the elected judge constituency who elected them. So if he or she were elected by a business community, they're held as constitutional as he or she were elected by our friends in the plaintiff's bar, it's held unconstitutional and that's where state tort reform is left right now and it is not a pretty picture.

MR. GREENWOOD: First of all, let me go back to the Punitive damages issue

Mr. Strickland addressed and perhaps

another point of view. In my state, and although I've been out of the practice of law now for ten years by virtue of my position here. My state passed an unusual provision. I say unusual, perhaps it's affected other states, and that is because punitive damages are, by their very nature, not really intended to compensate the victim, but rather to punish and therefore take on more a criminal type fine approach rather than reimbursement or restitution. In products liability cases, our state, I believe now requires that either 2/3 or 3/4 of that will be paid to the state and as I recall, the challenge to this constitutionality has been upheld. So, Mr. Greenwood, I might suggest we might think about in terms of punitive having a portion of punitive damages escheat to the state to be used to help the state pay the cost of their Medicaid program.

MR. GREENWOOD: Would my friend yield?

STRICKLAND: Sure.

MR. GREENWOOD: You know, that seems fair to me, if the amount was the same regardless of

the income of the individual. That's discrimination.

STRICKLAND: Well, reclaiming my time, I understand the point that you're trying to make. The point also is that sometimes the amount of compensatory damages is not always based on the financial status of the alleged victim at most times is based primarily on the extent of the individual injury not the financial condition of the individual. Financial condition would primarily be an ingredient only when you're trying to calculate lost earnings or lost wages and that, of course has to have an actual factual basis before making that calculation.

Going back to something else. I would like Mr. Schwartz, and I thank you for being here today. I think all of us would like to know what effect these state statutes fixing caps have actually had, in real terms, on reducing the cost of mal practice insurance. One of the procedural things that I have run across is, that in most instances, the jury is not advised of the

existence of caps before they make their award, is that generally true.

SCHWARTZ: That's generally true and the reason that's done is there's a belief that if they knew what the cap was, that they would always award the cap. Now that belief may not be true but if these issues or lobby one reasons they're not told about it is that they would always move to the top of the ladder, again, I'm saying they would do it but that's the reason it's put in the law [Unintelligible].

STRICKLAND: Does anybody have anything that indicates how much jury verdicts have been written as a result of the caps in other words, they return verdicts in excess of the caps but because they did not know the caps and the judge was required to write off those verdicts. Does anybody have any information as to how much those amounts might be and if they're known, what effect would the write-offs have on premiums had they not had the caps.

[UNINTELLIGIBLE] I recognize some things

are based on what is your achievable end in the long run. Mr. Schwartz if you would walk us THROUGH some other things, too. These are procedural issues, just as you don't tell the jury about the statutory caps, the debate is on-going about collateral sources, as to whether or not an injured plaintiff would have disclosed to the jury, of course, what other collateral sources had paid for medical expenses, etc, and whether or not mandatory offsets should take place. The argument on the other side is if you're going to do that, then why not disclose to that same jury what the limits of liability of the insurance policy that the defendant is carrying also has so that they can take all of these outside sources into account. Would you sort of walk us through the debates that have surrounded all of that.

MR. SCHWARTZ: It's sort of complicated but in some states they do let the jury know about the collateral sources and then let them make the judgement as to whether to not the plaintiff, and it's really a false thing, it's double recovery or

not, whether they should know about it. I agree with that, actually. I think that the jury's otherwise are left to speculate about it and they already know that a lot of people have insurance so they might as well be informed and I'll conclude with this, the reason for each rule. I gave you the reason for the rule on the \$250,000. The reason for the collateral source rule is that a wrong-doer is not supposed to benefit from the fact that the Plaintiff has been proven or has been paid by a source other than the defendant. That's the reason for the rule. Now, wrong doing varies. Some people are more heinous than others, so my feeling on that issues is let them make the decision as to whether or not the defendant's conduct is to bad that the collateral source should be considered, that's my position on that.

CHAIR: Do you know of any states that have allowed indicates being made known to the jury as to the liability coverage of the defendant through his insurance policy.

MR. SCHSWARTZ: No I do not.

CHAIR: Now I'll recognize myself for 5 minutes. (laughter) Let me . . . Mr. Schwartz first let me say I've liked a lot of words fair and balanced, common sense, and with that in mind, let me ask all of the panel. Were any of you out there would believe in your heart that not having some limit or economic damages would not improve the health care system and lower premiums, many of you thin that's wrong.

VOICE: I agree.

MR. HURLEY: Once again, our expertise is on the insurance side but for all those out there who aren't here, if you are going to improve the health care system for those who are not able to live their lives.

MR. GREENWOOD, Yes or no would have been find. Your answer's no.

HURLEY: You have my answer.

CHAIR: Is there any limit on non-economic damages that you would settle or live with.

VOICE: I think there might be, Mr. Chairman, but I think that it has to be based on a

real sense of what's happening. If you think that jury verdicts are explosion or out of control, if you rely only on jury verdicts research, the firm that is source for much of this information and as described in that Wall Street Journal story, acknowledges huge gaps in their information, if you don't understand the insurance cycle, then you're going to come to . . .

CHAIR: The stories I've heard today, the comments, the opinion it is all over the board. I don't know who got what study right any more but to me it is alright for me to say there is perhaps somewhere a limit that you could agree to that might help reduce premium costs.

HURLEY: If it's based on a real sense of what's happening and not based on a kind of warfare that goes on at the state level and Congressional level, it looks at the insurance industry and jury verdicts, claims that are paid, [Unintelligible] that I mentioned, we haven't rolled it out, no.

CHAIR: Are you a lawyer?

HURLEY: No I'm not.

CHAIR: I want you, if you would, take a minute and explain to me something that I have been told by a lot of people around this town for at least the last year and that's about economic damage. Are the courts just wrong in their awards on economic damages or does that actually work, nobody has ever suggested anywhere that the unified caps on economic data. Do patients actually receive economic damages or do they need this other amount of money called pain and suffering.

MR. SCHWARTZ: That's a question that has been debated for the ages. In terms of needs, okay, you used an interesting word there, need. When it comes to worker compensation, if somebody's hurt in a workplace, they don't get any pain and suffering, they get their needs. They get their medical costs and a percentage of the loss of wages. Under our social security system of disability, they do not get pain and suffering, under our no fault, they don't, so if we're

focussing on need, in a sense of what do I really need to survive, pain and suffering is not needed. However, you're in the middle of this crazy tort system and a profession back in 1914 wrote an article that probably told the truth as much as anything else. One third of the costs are going to lawyers when you recover. So, the person doesn't get 100% of their need, so some damage for pain and suffering, he said, for the record the man's name is Terry Onigent [Misspelled?] but hopefully I understand what a new idea is vs. an old idea. The pain and suffering damages actually make up for the amount that the person is having to pay to his or her lawyer which is about one-third and I think that sort of underground explanation for pain and suffering is that. There was an article written by the Dean of Washington LW School, a very brilliant man named Cornelius Peck, how studied whether pain and suffering damages do any good. I give this gentleman \$one million in pain and suffering. Does he feel any better? Does he have any less pain? When he wakes in the morning,

is the fact that his arm is not there, does he feel better about it because he has the money. Well, Professor Peck concluded 'no, he doesn't' and there really is not relationship between the amount of money and how people feel. So, that's as best as I can do with respect to that question.

CHAIR: On a \$50 million verdict. Surely, that can't then be just pain and suffering, just to pay for lawyers, there's a lot of other money.

MR. SCHWARTZ: That's right, you're getting up in the \$50 million range but an economic loss can possibly get up there. It's difficult but you can get there. Remember with economics, and I think that one thing that I can say from listening this morning, I felt the economic question to the verdict was downplayed too much. Economic losses today, with a good Plaintiff's lawyer. They vary, sir. You got a good one helping you, he or she is going to get those economics up because many many things can translate into market values and every piece of medical equipment, every aide, everything that you

could have done before that you can't do now when you measure it in terms of economic losses and I think that the definitions in your Bill has been criticized. I think that the Bill does a very nice job, a good job of defining what is economic and what is non-economic so it has guidelines to course as to dividing these two areas because believe me, if this were to become law, what I would be doing and all the lawyers would be doing, is arguing what's on which side of the line. That may seem a little bit abstract but that's what would occur every day. The Bill does a very good job on that. I'm just saying in summary, the economic portion of this Bill should not be downplayed. It is a significant component of awards.

CHAIR: What if we just had unlimited economic damages. No, not economic damages but just cook the law.

MR. SCHWARTZ: Well that would be a very intriguing thing and Terry's spirit is up in the sky somewhere. I don't think any tort person gets into heaven but there may be another place where

they go, sort of a special tort place that he would be very pleased because that's what he recommended in 1914.

CHAIR: Well how do you feel about that.

MR. SCHWARTZ: I don't think that's a bad idea. I think it's very intriguing.

VOICE: Will chair yield. If I may follow-up on that we have federal statutes whereby we allow the judge to fix compensation for the attorneys. The one that comes to my mind is the wage discrimination cases which the plaintiff is successful then the trial judge has the ability to consider what the records are, the costs and fixed compensation for the attorney. It would be interesting to see whether or not the insurance companies would like that one.

SCHWARTZ: Well, that is a very ingraining thing. I have the feeling that while my friends don't like this Bill. If you did that, I'd be running out of the building into the hearing.

CHAIR: Just quickly. You do believe that patient's are compensated for medical damages

SCHWARTZ: Absolutely.

CHAIR: Very well in most cases.

SCHWARTZ: Yes. The lawyers that you've met now, plaintiff's lawyers, first, you'd be surprised, there's not that many of them. This is not automobile fender bender stuff. This is hard stuff on either side. The cases are hard to win and you have to be very talented and I'm thinking of a man in this jurisdiction, a former Outlook president, Barry Nasis, a superb last year, whom I've heard many cases and he will make sure that any medical costs, to the nearest dime to now to the projected life of that individual is recovered by that individual and every possible loss of wages is covered by that individual. And any other economic loss is compensated to that individual so that answer is yes, they are fully compensated under our tort system, if they have the benefit of having a good lawyer and in medical malpractice, most of the plaintiff's lawyers know what they're doing because it's both an art and a science.

CHAIR: I'd like to thank all of you.

[idle banter]

SCHWARTZ: I appreciate that. I was for many years. I was told not to mention this but I do have this book called Schwartz on Schwartz. I will give a discount to any member who is here.

(laughter)

VOICE: If Mr. Brown would agree to go to law school, I believe we can take up a collection for tuition.

CHAIR: I appreciate all of you coming in. I'm going to ask Mr. Greenwood since it is his Bill, to close our hearing.

CHAIR: Thank you, Mr. Chairman. I think Mr. Schwartz put it very well when he said there were things we had to consider and that is, "is there a problem?" Tort reform and provisions of HR 4600 is a way to solve the problem. Is it just? It think you're correct that this hearing that any reasonable observation, has a huge problem and Pennsylvania, it is unimaginable I do not know what will [Unintelligible] in the very

near future. It's beyond the reach of the present legislature that we have a constitutional prohibition against caps so that is a crisis. Caps in tort reform reduce premium significantly and I think frankly beyond dispute. All you have to look at in California, Indiana and other states, put caps on it because you [Unintelligible] you will reduce costs of premium to solve the problem. The only question is the fairness question. Is it fair? Do we treat plaintiff's fairly enough with this legislation and for instance, deriving punitive damages as a function of economic [Unintelligible] is that fair? I think we ought to work on that. I look forward to working with Democrats on this committee who want to get bipartisan and I think that it's possible. I am open to adding insurance reforms if they're real but frankly I haven't seen any evidence from our hearing today. I think fundamentally we need to find out if [Unintelligible] fair from one side of the aisle

VOICE: I've never seen this kind of

[Unintelligible]

VOICE: To start out this hearing with the assumption that all of the problems rest with trial lawyers and not questions of fairness, no representation I'm just a little bit surprised that . . .

CHAIR: Hearing admourned!