

**ADDRESSING THE NEW HEALTH CARE CRISIS:
REFORMING THE MEDICAL LITIGATION SYSTEM
TO IMPROVE THE QUALITY OF HEALTH CARE**

HEARING

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

SPECIAL HEARING

MARCH 13, 2003—WASHINGTON, DC

Printed for the use of the Committee on Appropriations



Available via the World Wide Web: <http://www.access.gpo.gov/congress/senate>

U.S. GOVERNMENT PRINTING OFFICE

85-833 PDF

WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
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THURSDAY, MARCH 13, 2003

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:34 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.
Present: Senator Specter.

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Good morning, ladies and gentlemen, the Appropriations Subcommittee on Labor, Health and Human Services, and Education will now proceed with this hearing to consider issues on medical legal liability.

There are problems in many States, including my home State of Pennsylvania. My travels around the State in covering Pennsylvania's 67 counties have led me to situations where there are areas where obstetricians are unavailable, requiring women to travel long distances. I talked to one orthopedic surgeon who told me that he was the last specialist in town, and raised the issue as to what would happen if he broke his leg, and there are problems in other States. Some States do not have the intensity of the problems which the State of Pennsylvania and some other States do.

There are a variety of factors which are cited, depending on the source, as the cause or causes of the issue. One is the litigation system, a second is the rising cost for delivery of health care and declining income, a third factor is cited as errors by the deliverers of health care, and a fourth factor is cited as the insurance company investments, or insurance company management.

With respect to the litigation issue, there is no doubt that there is a significant problem caused by so-called frivolous lawsuits. Last month, there was a joint hearing held by the Judiciary Committee and the Committee on Health, Employment, Labor, and Pensions, and that February 11 hearing had a good bit of important testimony, one aspect of which was the citation that while 70 percent of the claims are dismissed or lost, that the litigation costs were an enormous factor in driving up health care costs.

There have been a number of ideas advanced on that issue. One is to require a statement by a certified doctor in advance or near the start of a lawsuit specifying that there is a valid claim. Another remedy has been cited as sanctions to be imposed by the court for frivolous lawsuits. Federal courts have substantial authority under Federal Rule 11 to impose such sanctions.

There has been concern expressed about medical caps and a counterconcern about limitation of the traditional role of the jury, especially where there are what Senator Hatch described in a quotation on the front page of the New York Times on February 26. He said that any legislation to cap malpractice awards would have to have an exception for egregious cases, close quote.

Concern has been expressed as to what egregious means, and there would have to be a definition which is based upon some experience, and there are some State statutes which deal with this problem generally. Pennsylvania has two statutes, 42 P.A. section 8553(c), in the limited tort context, and 75 P.A. 1705(d), which deals with suits against governmental agencies. Michigan has a statute which provides a definition for a category of cases which Senator Hatch and others have referred to as: "a category of death, serious impairment of bodily function, or permanent serious disfigurement."

The rising costs of medical practice and declining physician income have been a factor. Doctors have complained that Medicare was about to put a 4.4 percent cut effective March 1, and in light of some other reductions from the Balanced Budget Act of 1997 there was a real problem there, and in the omnibus bill which was signed into law last month, Senator Stevens, Senator Cochran and I and others took the lead in freezing that cut.

Doctors have also complained that Medicare has not kept up in the allocation of costs of malpractice insurance. They are several years behind, and malpractice rates have gone up very considerably in the immediate past. We had the Administrator of CMS, the Centers for Medicare and Medicaid Services in a hearing here not too long ago. Mr. Scully said he had no intention of making a modification, and the omnibus bill directed Mr. Scully and CMS to make that modification. When he was in here the day before yesterday for a hearing on outlier payments he said they would be making that change, so we have moved in a couple of directions to give relief to physicians on that crunch between declining income and rising expenses.

The issue of the insurance investments is one which we will take up. The New York Times ran an extensive article several weeks ago about the inability of homeowners to get insurance in Texas because there have been so many hurricanes, the insurance companies have pegged their premiums low, and the investments had gone down, so that there is an issue as to what extent those factors on insurance premiums are in play.

Doctors' errors are another factor. This subcommittee has done extensive work in this area, following a report by the Institute of Medicine attributing almost 100,000 deaths a year to those medical errors, and in fiscal year 2001, we started off with a \$50 million appropriation, and it has increased each year, and this year the budget request is for \$84 million to find ways to reduce medical er-

rors and trying to limit the scope of lawsuits which are filed against doctors.

This specific hearing was prompted by a report which just came out on March 3 from the Department of Health and Human Services entitled, Addressing the New Health Care Crisis, Reforming the Medical Litigation System to Improve the Quality of Health Care.

STATEMENT OF CLAUDE A. ALLEN, DEPUTY SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator SPECTER. Our first witness is the Deputy Secretary for the Department of Health and Human Services, who also serves as the Department's chief operating officer, Mr. Claude A. Allen, who holds a jurisdoctorate and master of laws from Duke University Law School, did his undergraduate education at the University of North Carolina at Chapel Hill. Welcome, Mr. Allen. The floor is yours, and we look forward to your testimony.

Mr. ALLEN. Thank you, Mr. Chairman. It is a privilege to be here with you today. We appreciate your inviting the Department to appear before the committee today to strongly support legislation that will increase access to quality health care for Americans by fixing what we see as a broken medical litigation system.

We are facing a threat to health care today, trapped in a medical litigation system that does more to reward trial lawyers than to help injured patients. The administration believes strongly that medical professionals, not lawyers, are the key to providing quality health care, and our reform package demonstrates this belief.

When we talk about the medical litigation crisis today, however, we should not focus on doctors or hospitals, or insurance companies, or even lawyers. We need to be focused on patients and what is best for them in terms of their care, and that is why the President and Secretary Thompson are calling upon the Senate to enact legislation this session that will reform the medical litigation system and improve patient quality of care.

The President likes to illustrate how destructive our current system is by talking about a fellow named Kurt Kooyer in Mississippi. Dr. Kooyer went to Rolling Fork, Mississippi to serve as a pediatrician. Unfortunately, because of frivolous lawsuits and his rising liability insurance premiums, Dr. Kooyer left Mississippi, which means there will no longer be a pediatrician in that county.

Dr. Kooyer's story is not unique. Mr. Chairman, you have already pointed out some cases in Pennsylvania, even, and it is being repeated all too frequently across the country. Three OB-GYNs who staffed a practice responsible for delivering half of the babies in Fayette County, Pennsylvania, stopped delivering babies to reduce their malpractice premium expense. Without the OB services, their premiums went down from \$400,000 to under \$100,000 a year.

Pregnant women in States like Nevada, Mississippi, Pennsylvania, West Virginia, and Florida now have to drive hours to find an obstetrician who can care for them. Several States like Vermont, Mississippi, Nevada, and Massachusetts have witnessed an exodus of obstetricians who simply cannot afford to practice in those States any longer.

Trauma centers in several States have had to close because insurance carriers were not willing to offer malpractice liability insurance to their doctors, or surgeons could no longer afford malpractice insurance. Some doctors' premiums have increased from \$37,000 to \$150,000 in 1 year, such as an OB-GYN in Nevada who had to move her practice from that State to California.

Six of the largest nursing home companies have filed for bankruptcy in the past 2 years, largely because of the uncontrollable costs of medical liability premiums and tort-related expenses. One-third of hospitals saw an increase of 100 percent or more in liability premiums in 2002, and over one-fourth of all hospitals have reported either curtailment or complete discontinuation of services as a result of growing liability premium expenses.

Physicians are reacting to the threat of litigation by avoiding the specialties that present the greatest risk of a lawsuit, such as general surgery and obstetrics. A recent survey of physicians revealed that one-third shied away from going into a particular specialty because they fear the liability exposure.

This litigation system attacks the wallets of every American, and we have calculated, the Department, that each American household is taxed over \$1,200 to pay the costs associated in defensive—defending frivolous lawsuits, exorbitant jury awards, and the costs associated with defensive medicine.

The saddest part is that our medical liability system does not serve the interests of the patients it is designed to. Up to 70 percent of medical liability claims result in no payments to the patient, but it costs an average of over \$40,000 to defend each claim, and less than 2 percent of the cases result in trial victories for plaintiffs.

A plaintiff who wins a judgment must pay the lawyer 30 or 40 percent of that judgment, and sometimes even more. Successful plaintiffs do not recover anything, on average, until 5 years after the injury, and even longer if the case goes to trial, and for most injured patients the litigation process offers a remote chance of a large judgment or provides very real, little benefit.

The President believes all of those who are truly injured by negligent medical care should receive swift, certain recovery of their economic injuries. They should be made whole financially, but we need reasonable limits on noneconomic damages, such as pain and suffering, and reasonable caps on noneconomic damages to result in lower health care costs and reductions in premium increases and, thus, greater access to care.

Estimates show that if this reform were adopted nationally, it would save at least \$70 billion a year in health care costs, of that amount, over \$28 billion in taxpayer money that the Federal Government spends through our programs.

Over the last 2 years, States with reasonable limits of \$250,000, or \$350,000 on noneconomic damages have seen increases in premium quotes for specialists, increases in terms of their premium quotes increase only 18 percent, but States without reasonable limits on economic damages, which represent almost half of the entire U.S. population, have seen increases of 45 percent, and this is why the President wants to ensure that recoveries for noneconomic damages do not exceed a reasonable amount.

The President has also called for reserving punitive damages in health care cases that justify them, such as instances where there is clear and convincing proof that the defendant acted with malicious intent, or failed deliberately to avoid unnecessary injury to the patient, and we are encouraged that today the full House will vote on needed malpractice reforms, and yesterday passed legislation to improve patient safety. These reforms will not only bring the cost of practicing and providing medical care down, but it will also improve the quality of health care and access to health care throughout the country.

Studies have established that one of the best ways to improve health care quality is to provide better opportunities for health care professionals to work together to identify errors, or practices that may lead to errors, and then correct them. Doctors, nurses, hospitals, all who participate in good faith peer review efforts and research activities should not be afraid that their quality efforts would get them caught up in a lawsuit.

As well as increasing quality, our reform package helps provide greater access to health care in areas where it is needed desperately. Our rural areas pay the greatest price, with no health care in their communities, and I have traveled throughout some of the poorest counties in America, including some with Senator Sessions in Alabama when I first came to the Department, and as physicians and health care providers left communities, patients were faced with long drives and long waits for health care.

There are many doctors like Dr. Kooyer in Mississippi who want to serve people in rural areas like this but cannot afford to do so, and we have to make it easier for physicians and health care professionals like them to do what they love to do for the people who need their care the most.

PREPARED STATEMENT

I want to thank you for the opportunity to represent the administration here today, Mr. Chairman, and I look forward to working with you in this committee and Members of Congress to help fix the medical liability system and improve access to care for all Americans. I want to thank you again, members of the committee, for your commitment to this issue, and look forward to answering any questions you may have.

[The statement follows:]

PREPARED STATEMENT OF HON. CLAUDE A. ALLEN

Thank you very much, Chairman Specter, Senator Harkin, distinguished committee members, for calling this very important hearing, and for inviting me here to discuss the Bush Administration and Department of Health and Human Services' strong support for legislation that increases access to care for Americans by fixing the broken litigation system.

Before I begin, let me start out by thanking this committee for its leadership and vision on this important issue. Last year, the House passed its medical liability reform bill, however the Senate did not act. Mr. Chairman, the Administration looks forward to working with this Committee and other Senators to move a bill through the Senate this year.

On behalf of our President, I must report that there is today a threat to health care quality and access because of our badly broken litigation system that does more to reward trial lawyers than to help injured patients. This system is impairing access to care for all Americans.

The medical liability crisis is not about doctors or hospitals or insurance companies or even lawyers; it is about patients. This crisis is threatening quality of care; it is threatening access to care for all Americans. Last week our Department issued a report entitled: "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care," which shows how problems associated with medical litigation have worsened significantly in this past year. Premiums charged to specialists in 18 states without reasonable limits on non-economic damages increased by 39 percent between 2000 and 2001. Premiums in these states have since gone up an additional 51 percent. In other words, they have almost doubled in two years. The report documents the spiraling cost of insurance for health care providers, which is impairing patients' access to care, as well as the cost and quality of care.

In states without reforms, physicians are leaving their practices for states with lower premiums, reducing their care for high-risk patients, or leaving the practice of medicine altogether. Hospitals and nursing homes also are finding it increasingly difficult to obtain insurance against lawsuits. As a result, patients in more states are facing greater difficulty in obtaining access to quality care and physicians.

Pregnant women in states like Nevada, Mississippi, Pennsylvania, West Virginia, and Florida have to drive hours to find an obstetrician who can care for them. Several states, like Vermont, Mississippi, Nevada, and Massachusetts have experienced an exodus of obstetricians from their state.

Trauma centers in several states have had to close because insurance carriers were not willing to offer malpractice liability insurance to doctors staffing it, or surgeons who were called in for cases could no longer afford to pay their malpractice insurance. Some of these doctors' premiums have increased from \$40,000 to \$200,000.

In Mississippi, doctors have moved across the river to Louisiana to serve the same Mississippi patients because they can no longer afford to practice there. Washington State has reported a thirty-one percent (31 percent) increase in the number of physicians moving out of state since 1998. The Massachusetts Medical Society reported that rising premiums in their state have forced many obstetricians to give up delivering babies. The Florida Medical Directors Association has reported that attending physicians have stopped seeing their patients in nursing homes in the last 12 months because of difficulty obtaining liability coverage.

Six of the largest nursing home companies have filed for bankruptcy in the past two years, largely because of the uncontrolled costs of medical liability premiums and tort related expenses. One-third of the nation's hospitals saw an increase of 100 percent or more in liability premiums in 2002, and over one-fourth of all hospitals have reported either a curtailment or complete discontinuation of some services as a result of growing liability premium expenses.

Physicians also are reacting to the threat of litigation by avoiding the specialties that present the greatest risk of a lawsuit. A recent survey of physicians revealed that one-third shied away from going into a particular specialty because they feared the liability exposure. Fear of liability forces physicians to engage in the practice of defensive medicine. The practice of defensive medicine, performing tests and providing treatments to protect themselves from the risk of possible litigation, is astounding. Seventy-nine percent (79 percent) of physicians admit that fear of litigation caused them to order more tests; Seventy-four percent (74 percent) refer more patients to specialists than they otherwise would. Fifty percent (50 percent) have recommended what they consider to be not-medically necessary procedures to confirm diagnoses because of litigation fears.

The litigation system attacks the wallets of every American. We have calculated that each American household is taxed over \$1,200 to pay the costs of associated with defending frivolous lawsuits, jackpot jury awards, and the costs associated with defensive medicine.

At the same time, this crisis is being caused by a medical liability system that does not serve the interests of patients. Too many lawsuits that have no merit are filed against doctors. The unpredictability of our liability system encourages plaintiffs' attorneys to file frivolous cases, in the hope of receiving a very large verdict—a verdict that means a very large payday for the lawyer. Mega-million dollar "jackpot" jury awards for non-economic damages are a very real problem to our health care system. The health care system suffers because the awards siphon money out of the system. Future settlements are influenced because the "jackpot" awards create a benchmark for them. Between 1991 and 2001, the maximum payment reported to the National Practitioner Data Bank escalated from \$5,300,000 to \$20,700,000. The number of payments of \$1 million or more reported to the National Practitioner Data Bank exploded in the past 7 years nationwide, from 298 in 1991 to 806 in 2002.

This crisis has also not been caused by losses from investment income. In fact, investments by medical malpractice companies have been conservative. Most states have laws that specifically limit the percentage of assets an insurance company can put in stocks. Over the last five years, the industry wide allocation of assets into equities has been relatively constant. Medical malpractice insurers' investments in equities as a percentage of total assets, as shown below, has been 11 percent or less. Neither asset allocation nor investment income correlates to, much less causes, the current medical malpractice crisis. Brown Brothers Harriman & Company analyzed the relationship between premiums and the change in investment yields among malpractice insurers. The results showed that the performance of the economy and interest rates do not determine medical malpractice premiums.

There is another attempt to shift the blame to insurers by asserting that they have engaged in anti-competitive practices. The National Association of Insurance Commissioners has reviewed this assertion and reported that "insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation." Rather, the NAIC also says, "the preliminary evidences points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice [insurance] prices."

President Bush outlined a framework for addressing this national crisis. First, the President believes all those who are truly injured by medical care should receive swift, certain recovery of their full economic injuries. But for the sake of affordability and access, we need reasonable limits on non-economic damages, such as pain and suffering. While we grieve for the individuals who were injured, we also recognize that money obtained years later will do little or nothing to relieve the pain. The House of Representatives passed these reforms last September. We believe that was an important step in the right direction—and are encouraged that the Judiciary and Energy and Commerce Committees have forwarded H.R. 5 for a full vote in the House. I understand that the House is scheduled to vote on this important legislation this afternoon. We are committed to working with this committee, and other members of the Senate to bring these common sense reforms to all Americans.

Reasonable caps on non-economic damages result in lower medical liability costs and lower insurance premiums—increasing doctors', hospitals', and nursing homes' ability to stay in business, which leads to greater access to care. Everyone wins, except trial lawyers. We have estimated that if this reform were adopted nationally, it would save as much as \$126 billion in health care costs this year. Of that amount, over \$28 billion is taxpayers' money the Federal Government spends in Federal health care programs. The research is compelling that this type of reform works. Over the last two years, states with limits of \$250,000 or \$350,000 on non-economic damages have seen increases in premium quotes for specialists increase only 18 percent, but states without reasonable limits on non-economic damages, in states representing almost half of the entire United States population, have seen average increases of 45 percent. Since California instituted a reasonable cap on non-economic damages and other critical procedural reforms 25 years ago, liability premiums have increased by less than one-third as much as in the rest of the country.

The President has also called for reserving punitive damages in health care cases where there has been egregious misconduct. And he has called for several other key procedural reforms that would ensure that defendants pay their fair share—ensuring that cases are brought before they become stale and taking steps to make future payments are available when patients need them.

We are also encouraging states to consider other innovative ways to deal with the broken medical liability system. The Department of Health and Human Services is implementing a demonstration program, an "Early Offer Program," for rapid and fair settlement of claims made against the Department for claims of negligence by Indian Health Service and Health Center patients.

Our judicial system must also address medical errors. If we truly want a healthcare system where quality is valued, we should seek to change health care systems to reduce or avoid real medical errors before problems become injuries. Seminal studies have established that one of the best ways to improve health care quality is to provide better opportunities for health professionals to work together to identify errors, or practices that may lead to errors, and correct them. Many preventable errors and complications arise not from failures by individual doctors, but from systemic problems in our increasingly complex medical delivery system. In its report, *To Err is Human*, The Institute of Medicine acknowledged, "the common initial reaction when an error occurs is to find and blame someone . . . Preventing errors and improving safety for patients require a systems approach in order to

modify the conditions that contribute to errors. The problem is not bad people; the problem is that the system needs to be made safer.”

Providers need to be able to study how mistakes occur and how to prevent them. When they do, the results can be incredible. The doctors and hospitals of the Pittsburgh Regional Healthcare Initiative reduced blood infections in ICUs by 20 percent through collaborative work to identify safer ways to treat ICU patients. Anesthesiologists reduced dramatically the patient death rate from anesthesia administered during surgery, from two deaths per 10,000 anesthetics in the mid-1980s to about one death for every 200,000–300,000 anesthetics administered today.

How did the anesthesiologists do it? First, they acknowledged that a problem existed, and they shared information. They standardized anesthesia machines to ensure consistency in the delivery of drugs and also addressed issues of fatigue and sleep deprivation and changes in training. To give one example: an engineering researcher observed a number of anesthesiologists in operating rooms. The researcher noted that anesthesia machines were not standardized: Turning a dial clockwise on one machine decreased the concentration of anesthesia in some machines. In others, turning the dial clockwise increased the concentration of anesthesia. The research was publicized and manufacturers standardized anesthesia machines so that dials turned in a uniform direction.

Unfortunately, our tort system has set up roadblocks that discourage health care providers from participating in quality improvement efforts. Providers are reluctant to report information about adverse events or near misses out of fear that it will be used against them in a tort action and are reluctant to collaborate on solutions for fear of drawing up a road map for lawsuits.

Legislation in the last Congress would have given health professionals the ability to engage in quality and safety evaluation without fear of having the process or information used against them in court. The Administration supported these efforts, and has encouraged quick action this year. Just yesterday, the House passed H.R. 663, the Patient Safety and Quality Improvement Act. I would like to take this opportunity to applaud the House’s quick action on this important issue. We look forward to working with this Committee and members of the Senate to secure passage of a similar bill and other proposals to help fix the medical liability system and improve access to care for all Americans.

Additionally, today Secretary Thompson is making a major patient safety announcement. FDA is proposing a new regulation that would require “bar codes” on all prescription and some over-the-counter drugs. Bar codes are symbols consisting of horizontal lines and spaces and are commonly seen on most consumer goods. In retail settings, bar codes identify the specific product and allow software to link the product to price and other sales- and inventory-related information. FDA’s bar code rule would use bar codes to address an important public health concern—medication errors associated with drug products. FDA’s regulation proposes to require bar codes on prescription drugs, over-the-counter drugs packaged for hospital use, and vaccines. The bar code would, at a minimum, contain the drug’s National Drug Code number, which uniquely identifies the drug, its strength, and its dosage form.

The Institute of Medicine and other expert bodies have concluded that medical errors have substantial costs in lives, injuries, and wasted health care resources, and that misuse of drugs is a major component of those errors. FDA estimates that the bar code rule, once implemented, will result in a 50 percent increase in the interception of medication errors at the dispensing and administration stages. This will result in 413,000 fewer adverse events over the next 20 years. Some hospitals that currently have bar code systems in place report a substantially higher reduction in errors from bar code usage. This initiative is another example of the Administration’s commitment to doing everything in our power to increase access to health care and enhance patient safety, both of which are among the President’s and the Secretary’s top priorities.

Thank you for giving me the opportunity to represent the Administration here today. In closing, let me stress that the Administration believes that doctors who practice bad medicine ought to be held accountable for their actions. But, a system that puts good doctors out of business is a broken system; a system that restricts patient access to physicians is a broken system; a system that encourages physicians to order excessive tests and procedures that places patients at great risk is a broken system. Needless litigation does incredible harm to our health care system. Our goal is to improve the quality of care, increase access to care, and reduce the costs. The litigation system is imperiling this effort. We should rely on doctors, not lawyers to improve our health care system. We need to fix this broken medical liability system now, and the reforms I just discussed are the first step. With good ideas, strong leadership through this committee, and much-needed reform, we can truly restore common sense to medical liability in America.

Thank you, Mr. Chairman, and Members of the Committee, for your commitment to this issue.

Senator SPECTER. Thank you, Mr. Allen. Let me begin with the issue of doctors' compensation, which your Department has some direct control over. What can HHS do to stop the periodic reductions in payments of physicians under Medicare?

There is a terrible squeeze on the doctors. They were supposed to have a 4.4 percent cut on March 1. There was a national outcry about the matter, but we did not see the Department of HHS doing anything about it, or coming forward with any recommendations. It was left to the Appropriations Committee to freeze that. What can HHS do to stop these reductions in payments to doctors and hospitals which are just so debilitating to the medical system?

Mr. ALLEN. Senator, first of all, I would suggest that it is not just HHS's responsibility. It has to be in concert with Congress, and Tom Scully was here the day before yesterday to testify, and I think he has been on the Hill numerous times working with Members of Congress to consider and try to address this issue.

Senator SPECTER. But we look to HHS for leadership. The executive branch has the expertise. We deal with all of the problems that the Government has. We had to reach out to Mr. Scully the day before yesterday on outlier costs which HHS planned to put into effect without any notice to hospitals, drastic curtailment, and it was only through action of this subcommittee that they allowed a comment period—a little unheard of, not to have a comment period—until April 4, and to allow hospitals some opportunity to figure it out.

Why does that initiative have to come from this subcommittee, as opposed to HHS taking that kind of step without an opportunity for hospitals to be heard, or without any transition period?

Mr. ALLEN. Certainly Senator, in terms of a comment period, that certainly is something that is within our control, and we were remiss if we did not allow for a comment period to occur in that situation, but let me make it very clear that we are limited by the legislation that Congress enacts, and our hands are tied in terms of the formulas that we are allowed to use when it comes to addressing physician payments, fee schedules, so we have parameters that are set by Congress within which we are required to work.

Senator SPECTER. I understand that Congress passes the laws, but where you have the expertise at HHS it would be enormously helpful to the Congress if you would come forward and take the initiative and say what ought to be done.

Now, take the issue of malpractice rates. I have heard all over my State about malpractice insurance rates going up. It is a big point you were making, and yet HHS was using old statistics. The rates have gone up enormously since HHS made an allocation to doctors for malpractice insurance, and we issued a directive, an order from the Congress, signed by the President, that you had to update those statistics. Why doesn't HHS take it upon itself to give relief to the doctors by doing what the law mandates, and that is to use current statistics for calculating malpractice insurance reimbursement?

Mr. ALLEN. Senator, that is a great question, and I think we are doing a lot to try to address it, and I will give you a good example

of that. We have come to Congress and we are requesting Medicare reform. We know that the Centers for Medicare and Medicaid Services is using 40-year-old technology to try to address this very issue.

Senator SPECTER. You are off the point, Mr. Allen. I do not want to talk about the generalizations of Medicare reform. We only have a few minutes here.

Mr. ALLEN. Sir, you asked me a very specific question. If I am permitted to answer it, I will attempt to do so—

Senator SPECTER. Please do.

Mr. ALLEN [continuing]. But if I am not permitted to do so I cannot help you with trying to get to the answer that you are seeking.

Senator SPECTER. I would like an answer to the question as to why HHS did not use up-to-date statistics on calculating reimbursement to doctors for malpractice insurance payments.

Mr. ALLEN. Senator, we are using the most recent statistics that we are able to get, and utilizing the systems that we have at Medicare—Medicaid—the Centers for Medicare and Medicaid Services. We attempt to do that. It is not something that happens overnight.

Senator SPECTER. You are not right on the facts, Mr. Allen.

Mr. ALLEN. Sir, if you have additional facts that you would like me to take into consideration I would be glad to do that, but I sit and work with Mr. Scully regularly. We address these issues, and try to address them, and we have tried to work with Congress to bring reasonable solutions to look at how do we resolve issues in terms of payments to physicians but at the same time how do we do it consistent with the law that we are required to operate within.

Senator SPECTER. Well, the narrow question which I am pursuing is the one of calculating payments to physicians to take into account their costs for malpractice insurance, and the facts are that you are 3 years out of date, and Mr. Scully testified here at a hearing last month that there was no intention by HHS to update those statistics, and then there is a specific requirement in the omnibus bill directing HHS to use up-to-date statistics, and on Tuesday Mr. Scully said that HHS would follow the mandate of the Congress which, of course, HHS has to do.

But my question to you is, why was there a significant delay period before this issue was taken up? Why does Congress have to tell HHS to use up-to-date statistics?

Mr. ALLEN. Because the physician payment schedule, those numbers are set in statute. That is not set by the Department. We have formulas that we have to follow and we do that to the best of our ability.

In the specific case that you are raising in terms of outlier payments—physician payments, I am sorry, we were bound by what was required in statute and the interpreting the regulation that we were required to follow, and that is not something that we can change overnight. That is something that we try to exercise the amount of flexibility that we are provided in statutes, and that is what the Department consistently tries to do.

Senator SPECTER. Well, the statute says you compensate the physicians in part based on their malpractice insurance rates, and that up-to-date statistics be used. Will you go back to those statutory

provisions and review them? We have gone over this with Mr. Scully in detail, and the response that HHS has made is not really timely on using the statutory authority which you have to compensate the doctors for that very important part of their expenses.

Mr. ALLEN. Mr. Chairman, I will be glad to go back and look at that and work with the Congress to address what we think is limiting on our flexibility to do exactly what you are talking about us doing.

Senator SPECTER. Moving to the subject of physicians' errors, when the Institute of Medicine came out with its report that almost 100,000—the figure was set at 98,000 deaths due to physicians' errors, this subcommittee took the lead in providing \$50 million on a statute which was promulgated on May 12 of the year 2000, giving HHS 2 years to come up with recommendations to deal with physicians' errors, and as yet we have had no response. That provision was contained on a directive to the Agency for Health Care Research and Quality which, of course, is a part of Health and Human Services.

The report noted that the committee is troubled by these statistics on the Institute of Medicine report. Responsible for as many as 98,000 deaths per year, medical errors have a substantial economic cost, with estimates ranking as high as \$29 billion annually, and we directed the Agency for Health Care Research and Quality to devote \$50 million to determine the ways to reduce medical errors, with a report, but so far we have had no response, and it is almost 3 years. What is happening on that, Mr. Allen?

Mr. ALLEN. Mr. Chairman, if that is a report—I am assuming you are referring to a report that the Agency for Health Care Research Quality was asked to review on patient safety, and I understand from the Department that we have provided the subcommittee staff with an oral interim report of what the findings have been. The final report will be completed in September of this year, coming out of the Department. We will move to get that out as soon as we can, but it looks like September 2003 is when the report is due out.

Senator SPECTER. I am advised by my chief of staff here that about a year ago—precisely what happened, Bettilou?

Ms. TAYLOR. You had met with us regarding what your plans were for it, but I have not gotten anything back as far as what the report will contain.

Mr. ALLEN. I would be more than happy, Mr. Chairman, to schedule another interim review pending the final report coming out, and will be glad to have our staff discuss that with you.

Senator SPECTER. Well, we would like to have the report, Mr. Allen.

Mr. ALLEN. And I gave you the date for when the report is supposed to be ready, as I understand it will be completed.

Senator SPECTER. Well, could you expedite that?

Mr. ALLEN. I will certainly see about—

Senator SPECTER. We are really working on legislation in the field, and we would like to have a better handle on what the medical errors are as a part of this problem. Your report published on March 3, addressing the new health care crisis, does not take up that issue at all, does it?

Mr. ALLEN. Of patient quality or patient safety?

Senator SPECTER. Medical errors.

Mr. ALLEN. As I recall, we do discuss the role of medical errors in terms of solutions. We recognize that medical errors are a tremendous part of the burden that we bear in terms of health care expenses, and so we do address that. I will do all that I can to try to expedite getting the patient safety report out.

Senator SPECTER. Well, aside from recognizing that medical errors are a factor, which you do not need a report to say, my question is, when you have been working on this for almost 3 years, is there something from all that study that you could have incorporated into this report to give us some understanding as to how medical errors play into this equation so that when we legislate we know what that factor involves?

Mr. ALLEN. Mr. Chairman, with regard to the specific of the report, again, it is in process. The reason it was not incorporated in the study is because it is not finished. But, we did incorporate other reports that do have finished products that address patient safety, medical errors, and that would include the IOM study that you referenced earlier. We work very closely with the Institute of Medicine.

Senator SPECTER. Well, Mr. Allen, could you supplement this report, which you published on March 3, with at least a synopsis of what your study on medical errors shows so that the subcommittee and the Congress can have an idea as to how that factor bears on legislation which we are considering right now?

Mr. ALLEN. We would be more than happy to go back and look at it and provide additional information. In addition, I can update you on what the Department is doing in terms of looking at medical errors and the roles that they play, apart from the report that is due, September 2003.

Senator SPECTER. My request to you is, if you are going to have the report in September of this year, and it has been in process for several years, would you review that as to whether there is any information that you have already gleaned which would bear upon the topic of this report, which is addressing the health care crisis?

Mr. ALLEN. Well, certainly we will go back and review that and we'll be glad to work with you to find out if there is something that will be helpful. That is not a problem.

[The information follows:]

Question. (a) What has AHRQ discovered so far from patient safety research (essentially a preview of substance of findings that will be in the September Report to Senate Appropriations' Committee on Patient Safety)?

(b) Can AHRQ commit to doing a briefing soon, and if so, when?

Answer. (a) The projects from which this information is being gathered are still quite early in their life cycle. However, we have gathered some preliminary information that you may find useful. Early investigation suggests some common causes for medical errors irrespective of condition or specific circumstances: communication; health care professional staffing patterns or skill mix; devices and equipment failure; inadequate patient education; incomplete assessment of the patient; lack of adherence to protocols and poor or incomplete documentation in medical records. Additional issues include improper identification of patients, training or orientation deficiencies, staff overload, lack of supervision, lack of coordination at transfer, failure to get patient consent, poor specimen labeling, and inadequate procedures as the source of medical errors.

AHRQ grantees confirm what we frequently hear from health care leaders: the definition of medical errors is variable and often unclear to those who report them.

Trust, team building, and partnering is an important factor in developing and implementing successful reporting systems but presents a real challenge because of different institutional cultures and perceived or real legal protections. Furthermore, legal protection of reporters and reported data is critical for success of a reporting system. Reporters must feel comfortable that they will not be at increased risk of punitive or malpractice actions. Grantees noted that organizational culture varies considerably and directly impacts institutions' and leaders' willingness to embrace changes necessary to improve patient safety.

Technology is both a solution for some medical errors and a direct contributor to others. The latter point is that human factors (i.e., the machine/user interface) must be addressed for each technological solution developed and implemented. Information on "near misses" (i.e., errors that occur but are intercepted before they reach the patient) can contribute substantially to our understanding of errors and the interventions necessary to prevent or mitigate their injurious impact on patients. However, the sheer magnitude of medical errors may be overwhelming making them both difficult to capture and analyze. Reporting systems that provide easy-to-use, actionable information may be more readily accepted compared to systems that are time consuming, awkward to use, redundant, and lack adequate value-added factors and feedback mechanisms to reporters. Furthermore, physicians and patients have different perspectives on how they want medical errors disclosed.

Research that AHRQ supported showed that both patients and physicians had unmet needs following errors. Patients wanted disclosure of all harmful errors and sought information about what happened, why the error happened, how the error's consequences will be mitigated, and how recurrences will be prevented. Physicians agreed that harmful errors should be disclosed but choose their words carefully when telling patients about errors. Although physicians disclosed the adverse event, they often avoided stating that an error occurred, why the error happened, or how recurrences would be prevented. Patients also desired emotional support from physicians following errors, including an apology. However, physicians worried that an apology might create legal liability. Physicians were also upset when errors happen but were unsure where to seek emotional support. (Gallagher et al, JAMA, Vol. 289 No. 8, Feb. 26, 2003)

(b) The AHRQ staff is available to do a briefing at the convenience of the Committee.

The Agency's Interim Report to the Senate Appropriations' Committee, which is coming in September 2003, will detail, to date, the results of the Agency's efforts to reduce medical errors and will provide information specifically about:

- How hospitals and other health care facilities are reducing medical error
- How these strategies are being shared among health care professionals
- How many hospitals and other health care facilities record and track medical errors
- How medical error information is used to improve patient safety
- What types of incentives and/or disincentives have helped health care professionals reduce medical error
- Most common root causes of medical errors
- Data showing the effectiveness of State requirements in reducing medical errors

Senator SPECTER. We would appreciate it. I am going to have to excuse myself for a few minutes. We are in the middle of a vote, or at the end of a vote, and I will return very shortly.

Mr. Allen, there has been considerable criticism in the past of the fact that the same doctors appear many times with complaints against them, or litigation. Have your studies borne that out, that there is a pattern with some doctors coming up again and again with allegations of error?

Mr. ALLEN. Mr. Chairman, I am not familiar with any studies that we have pointed to that problem with a small class of doctors. We do have studies demonstrating that certain specialties are much more prone to litigation, obstetrics-gynecology, for example, and those that are involved with very invasive procedures, like neurological surgery.

Senator SPECTER. I am on a different point. I am on the point whether there is a recurrent pattern of the same doctor having complaints filed against him.

Mr. ALLEN. Again, answering your question, I do not know that we have studies that we have looked at that demonstrate that. I do know that the Institute of Medicine's report looked at some of these issues, and what they pointed out is that the issue is not so much individual doctors.

For example, we know that in the area of obstetrics, that the average OB-GYN has three malpractice cases filed against him or her during the course of their career. While we have statistics such as that, we do not have data that says that there is small percentage or a large percentage of the same doctors who are being sued over and over.

In fact, it is my belief, having just worked at the State level and overseen physician activities in the Commonwealth of Virginia, that we have systems in place that look at disciplinary actions and focus on malfeasant physicians. We do know that that happens, but I cannot tell you that we have studies that show more detail on a certain percentage of those—

Senator SPECTER. Well, the subcommittee would appreciate it if you would take a look at that, as to what patterns, if any, exist for the same doctors. You use the word, malfeasance. I would not go quite that far.

[The information follows:]

Question. To what extent do the data on medical errors confirm that the problem with medical errors is truly system-wide versus the problem of repeat offenders?

Answer. Medical errors are the result of multiple human and system failures stemming from the structure and process of health care. Reporting systems that capture and record root cause analysis almost universally find that events involve a combination of contributing factors leading to the event. While virtually all near-miss, no-harm (event occurred, reached the patient, but patient was not injured), and adverse events contain some element of human failure or error, these alone did not lead to the undesired outcome. Most often it is underlying risks and hazards within the structure and process of care that contributed the patient injury or harm. This finding has been reported repeatedly in the patient safety literature. The data supporting this observation comes from the United States, Australia, the UK, Denmark, and the Netherlands. Additionally, in a study of transfusion events, the researchers found that the greater the level of the severity of the event, the greater the contribution of organizational and technical failures that were involved. (Kaplan and Battles, 1999) It is only at the lowest levels of actual or potential errors where there were greater contributions of only human factors involved. This mix of human, organizational, and technical distribution of events seems to be matched outside of medicine as well. When events from a transfusion service in the United States were compared to a Dutch chemical process plant, the distribution of causes was virtually identical. (Kaplan, Battles, van der Schaaf, 1998)

Senator SPECTER. There is a Public Citizen's report on the situation in Pennsylvania which shows that repeat-offender physicians are responsible for the bulk of medical malpractice costs. I would appreciate it if your report, the Department's report on physician errors would look into this issue of repeat offender physicians and let the subcommittee know what is in place in the States, taking at least, say, a half-a-dozen State samples as to what action is taken on reviewing this matter by licensure boards, and also by hospitals.

We have had a number of reports that there is very little action taken by hospitals, disciplinary action, and that doctors move from one hospital to another when they are quietly let go, and no effort made to follow the doctors who do have these repeat errors. That is an area which is bubbling right below the surface, Mr. Allen, and

the subcommittee would appreciate it if your report would take into account that factor.

Mr. ALLEN. Mr. Chairman, we will be glad to look at that, but again I point your attention to the reports that are already out that do talk about a lot of these issues, for example, the IOM report. The title is: "To Err is Human", and one of the things that they say in the report is that preventing errors and improving safety for patients requires a systems approach.

[The information follows:]

Question. To what extent do hospitals address problems of medical errors and medical malpractice? To what extent do "bad actors" simply move on to other institutions or jurisdictions?

Answer. Virtually every hospital in the country has in place some type of an event reporting system. However the extent to which hospitals actually use reporting systems to make patient safety improvements is variable. Some institutions have done and continue to do an outstanding job in using the data. Others do not fully utilize the available data that they already collect as an optimal patient safety management tool. What we do know is that hospitals which are committed to patient safety improvement tend to encourage reporting of patient safety events, and move to align their internal policies (and thereby culture) to encourage reporting by adoption of a just culture. When this happens, institutions may experience a large increase in reporting. AHRQ has developed a survey to determine the extent to which hospitals collect patient safety data and how those data are used, and a pilot study of the instrument is currently being conducted.

For the most part, the type of information on problem physicians moving to other institutions or jurisdictions is anecdotal, and without strong linkages between state licensing boards, these issues cannot be fully tracked. However, in a study completed a few years ago that focused on risk-adjusted mortality for cardiac by-pass graft (CABG) surgery in New York State, the researchers found that some of the surgeons with high mortality rates left the state while some continued to practice within New York State but ceased performing the CABG surgery. (Chassin, Health Affairs, July/August, 2002, Vol. 21, No. 4, pp. 40-51). Some information on migration of individual practitioners may also be available through the Health Resources and Services Administration's National Practitioner Databank. We would like to emphasize, however, that the majority of injuries resulting from the delivery of health care are not attributable to individuals, but rather to systems-related issues.

Mr. ALLEN. We can spend a lot of attention focusing on the doctors who are responsible for committing the errors. That is only one aspect focused on the individual. What we at the Department believe, and the reason we think it is so important that we look at this broadly, we look at the medical liability system. We look at the impact that it has on health care in general. That impact is evident in several ways. We spend between \$70 and \$126 billion a year in terms of what we call defensive medical practices, where doctors are ordering more tests, where doctors are prescribing more medication, where doctors are taking steps because of the fear of litigation.

What we want to focus a lot of attention on, is how do we work with medical systems. So, you can deal with the individual physician whether there are many or few, but the key is to take a system approach to catch those situations before a mistake is made that damages a person's life.

Senator SPECTER. Well, Mr. Allen, that is very interesting, but that does not respond to the specific point that I am making. When you talk about defensive medicine, I understand that. That is a factor. When you talk about before a mistake is made, I understand that. I am having a very focused question about doctors who make repeat mistakes, are sued, or are up for disciplinary action.

Mr. ALLEN. And Mr. Chairman, I responded to that.

Senator SPECTER. And if I can finish my question, and we are putting up \$84 million, and the subcommittee would like to have you take a look at that.

Mr. ALLEN. Mr. Chairman, I have already answered that and said we would look at that. I said we would certainly be glad to go back and look at it. The specific question you asked me was whether we had studies that showed that, and I answered that and said no, and you asked us to look at that, and I said yes, we would go back and attempt to look at that.

Senator SPECTER. With respect to the insurance factor, Mr. Allen, are you familiar with the situation in Texas where people cannot buy homeowners' insurance because the insurance companies have stopped writing it because the losses were so extensive from hurricanes, and the reserves of the companies have gone down so much?

Mr. ALLEN. I heard you reference that earlier, Mr. Chairman. I am not personally familiar with it. I do not follow the homeowner insurance areas, but I do follow what is happening in the medical area.

Senator SPECTER. Well, I would appreciate it if you would take a look at this extensive report in the New York Times on December 1, and one extract, the price and availability of homeowners' insurance has become a political issue in Texas. Texans pay the highest premiums for homeowners insurance in the Nation, while the insurance companies say they lost billions of dollars because of the State's run of natural disasters like tropical storm Alison, and then the study goes into the issue of the insurance companies having lost a lot of money on their investments.

What are the best statistical studies you know of which bear upon the question as to how much of the increase in premiums has been caused by the investments of the insurance companies?

[The information follows:]

HHS has not conducted such statistical studies and our researchers have not conducted a literature search on this topic.

Mr. ALLEN. The two areas I can point to are in the report itself. There is a table, Table A, that talks about the 5-year historical asset allocations for medical malpractice carriers, and it lays out for the asset classes and lays out for the years 1997 to 2001 information regarding their asset allocations. It points out what we think is the case that this crisis has not been caused by poor management practices by insurers in terms of their investments.

In fact, there is a letter of February 7 that was sent to Senator Gregg from the National Association of Insurance Commissioners, and I will make sure you have a copy of it, where they look at this issue. They are charged with overseeing the insurance industry in terms of their portfolio investments. Insurance carriers are very conservative in terms of their portfolio investments. What they point out is that the issue is not the investments of the portfolios, but rather they believe the issue is the high loss ratios in many States. Regulator concerns have been with rate inadequacy in those regards, and so those would be the two areas that I would point you to that address insurance company investments.

Senator SPECTER. Well, we are going to have other witnesses testify to this. I am sorry that you will not be here to listen to their testimony, because what the subcommittee customarily does is to

have witnesses interact, and we have put you on a separate panel out of deference to your standing as Deputy to the Department, but I wish you would convey to Secretary Thompson the subcommittee's request that when witnesses come here they are prepared to spend the time of the hearing. If the Senators can spend the time, we would ask the Department to spend the time, and you have told me in advance that you have other commitments, so would you please convey to the Secretary my request that when he or witnesses from your Department come, you are prepared to stay for the hearing?

Mr. ALLEN. Mr. Chairman, I will be glad to do that, and as I shared with you, because of the situation that we are dealing with in terms of homeland security, I am required to be back at the Department to deal with some issues there. Otherwise, I would have intended to stay here. That was my intention, but unfortunately, because of the press of other business, I do need to return.

Senator SPECTER. I am doing a lot of work on homeland security myself—

Mr. ALLEN. And we greatly appreciate that.

Senator SPECTER [continuing]. On the Appropriations subcommittee and on the Government Affairs Committee, and on the terrorism issue with Judiciary. We are all very, very busy, but when the subcommittee schedules a hearing—just tell the Secretary we would like his witnesses to stay, okay.

Mr. ALLEN. We will pass that on for you.

Senator SPECTER. Thank you.

Mr. ALLEN. Thank you.

Senator SPECTER. I am not finished, Mr. Allen.

Mr. ALLEN. Okay.

Senator SPECTER. Going on to the issue of the lawyers, the frivolous lawsuits are a real problem, beyond any question, and on the hearing we had last month with the Judiciary Committee and the Committee on Health, Education, Labor, and Pensions, the testimony was given that although 70 percent of the lawsuits are won, the litigation costs are very high.

A couple of ideas which have been advanced are to require, as Pennsylvania has done, a certificate be filed at the time the lawsuit is instituted, or within 60 days, from a recognized expert that there is a bona fide claim, and another line has been the imposition of sanctions on the lawyers who bring frivolous lawsuits, giving the judge discretion to identify a frivolous lawsuit, and to have that as a deterrent effect.

Do you think that those measures would be effective in eliminating frivolous lawsuits?

Mr. ALLEN. I think Rule 11 has been in place for a long time as a deterrent on attorneys bringing frivolous claims, and so the States enforce that in terms of lawyers bringing frivolous claims.

Our concern is the patients, and in many of these situations very few patients file claims. In those cases where they do, it is usually 5 or more years before they see anything in terms of recovery. We think the approach that we are recommending in terms of malpractice litigation reform is an important step overall, in terms of the principle, but the examples that you cite certainly are tools that can be utilized.

We are focusing on how to get a quicker judgment, or quicker decision that serves the patient who has been injured, but at the same time how do we focus on the system changes that can contribute to improving the quality of health. That is what we are going to focus on, and that is what we think is a very key piece of the puzzle.

Senator SPECTER. Well, there is no doubt that we want to take care of the patients and have the matter resolved as promptly as we can, but when your report deals with reform of the system, my question to you is, how big a part of the problem is the frivolous lawsuit, and how effective will these two measures be on that point? I do not think your last answer was responsive at all to that question, Mr. Allen.

Mr. ALLEN. Let me try again, Mr. Chairman.

Senator SPECTER. Thank you.

Mr. ALLEN. With respect to frivolous lawsuits, we already have laws on the books that address frivolous lawsuits.

Senator SPECTER. You cite Rule 11. That is the Federal court. Relatively small numbers of malpractice cases are brought in Federal courts. You do not have sanctions imposed in the State courts to any substantial extent, or is your information different?

Mr. ALLEN. I think you can qualify the issue by saying to a substantial extent, there are States that do have sanctions, and that have attempted to impose sanctions.

Senator SPECTER. Are the States imposing sanctions on frivolous suits, Mr. Allen?

Mr. ALLEN. Some States do.

Senator SPECTER. Do you have any evidence to back that statement up?

Mr. ALLEN. I can certainly provide those for you for the record to give you what we have looked at in terms of efforts States have undertaken to try to address that issue.

Senator SPECTER. The complaints that I have heard from the medical profession is that frivolous lawsuits are filed and the insurance companies complain they eat up a lot of time and cost, and there is no remedy at all in existing State court practices.

Mr. ALLEN. Mr. Chairman, you are not getting an argument from me saying that is not the case. We would agree that frivolous lawsuits are taking place. Steps, as you suggest, can go a long way to addressing those issues in terms of slowing the litigation process, those that are frivolous.

Senator SPECTER. Mr. Allen, what I want to focus on, I want to focus on the issue of frivolous lawsuits, and your judgment as to how they would be affected by these two remedies. That is what I want to focus on.

We are trying to get a handle on what we ought to do legislatively, and your Department has published this report on addressing the health care crisis, and we want to make a determination as to whether we ought to legislate on this subject. That is the thrust of the question. We would like to know if your Department has any evidence as to whether States are now adequately handling frivolous lawsuits, or the Federal Government adequately handling frivolous lawsuits, and what ought to be done about it.

Mr. ALLEN. Mr. Chairman, I think again the goal seems to be moving. I think I addressed your concern in saying that we agree that frivolous lawsuits are taking place, that they are casting a chill on the practice of medicine, and we should do something to address frivolous lawsuits. So, I am not sure where the argument is—I said I agreed with you in what you are saying.

Senator SPECTER. There is no argument. You have not yet addressed the question as to whether these two reforms would take care of frivolous lawsuits.

Mr. ALLEN. Mr. Chairman, I am not in a position, nor do I think the Department is in a position to say across the board whether these will take care of all the issues. In fact, what I would say is, given what we have looked at in terms of the impact that it has on health care in general, they would be two steps that could be addressed, but they are not the only issues. It is not just the cases that are frivolous that are impacting the system.

They have a major impact. As I cited already, we find that defensive—defending claims cost on average about \$40,000 per claim. The numbers would suggest that the more claims that we could deal with, whether they were frivolous or not, they should be dealt with on the front end of the system.

So I am saying that we agree with what you are suggesting as a potential one step in the situation, but that does not cover the vast majority of issues which we are talking about in terms of the cost that huge awards for noneconomic damages are having on the medical industry. That is what we are talking about in terms of patient care.

Senator SPECTER. Mr. Allen, I am about to come to the non-economic issues, but the questions which I have addressed to you are these: To what extent is your Department in a position to comment about the seriousness of frivolous lawsuits, number 1. Number 2, what is your evaluation of the two reforms which I have suggested?

What I would like you to do is get the transcript and see if your answers have been responsive, and if you think they have been responsive, forget it. If they have not been responsive, give me responsive answers.

Mr. ALLEN. I will be glad to.

Senator SPECTER. On the issue of caps, do you agree with Senator Hatch's statement that there ought to be an exception for what he classified as egregious cases?

Mr. ALLEN. The President's proposal does consider what we call the egregious cases, those cases where it has been demonstrated clearly and convincingly that there has been a malicious intent, or willful knowledge of the wrong that has been done. There should be reasonable caps on it, but certainly exceptions exist for egregious cases within a reasonable cap limitation. The President's proposal does envision allowing for those situations where there has been an egregious case to allow for increased recovery through punitive damages.

Senator SPECTER. Well, Mr. Allen, there are two concepts involved here. One is the point of the nature of the wrongdoing, if it is negligence or if it is willful or malicious. There is another

issue, which is totally separate, and that is the question of damages.

Now, if you leave out the punitive damage question for just a minute, because we will come to that, the issue is whether there should be a category—let me back up just a minute. Are you saying that the President's plan allows for more than a \$250,000 cap on noneconomic damages, aside from punitive damages?

Mr. ALLEN. We would separate out punitive damages from noneconomic damages.

Senator SPECTER. Just focus on noneconomic damages. Are you saying that there is some category of cases in the President's plan where the cap of \$250,000 would not apply?

Mr. ALLEN. We would say that the President's plan calls for ensuring that for noneconomic damages, that they would not exceed a reasonable amount, and we have stated \$250,000 based upon what we have seen in States where the cap is between \$250,000 and \$350,000. I do not want to settle on a hard and fast number, because it is that range between \$250,000 and \$350,000 where we have seen States' experience has demonstrated a benefit from that, and putting a cap on.

Senator SPECTER. All right. Whether the figure is \$250,000 or \$350,000, are you saying that the President's plan would allow an exception above whatever figure is set for egregious cases?

Mr. ALLEN. We would say that again, in this situation that we are looking at for noneconomic damages, egregious cases in terms of—you are focused on noneconomic, not punitive damages, is that—am I understanding you correctly?

Senator SPECTER. I am focused again—to repeat for the fourth time, I am talking about noneconomic damages, not punitive damages, and not where the quality of the act is involved, like malicious or gross, to warrant punitive damages. I am talking about the injuries, the damages. Are you saying that the President would allow more than whatever figure is set, \$250,000 or \$350,000, for egregious cases?

Mr. ALLEN. No, that is not what I am saying. What I am saying is that the President's proposal would put a reasonable limit of between \$250,000 to \$350,000 on noneconomic damages.

Senator SPECTER. Well, take a look at your earlier testimony. I think you have shifted a bit here, but so be it. So essentially you disagree with Senator Hatch on having a category of egregious cases which would not be limited by whatever cap is set?

Mr. ALLEN. I would—again, not knowing specifically Senator Hatch's statement, whether he was referring to noneconomic damages. We would suggest that in the area of punitive damages—not noneconomic damages—that is where you deal with egregious cases—if there is an egregious case, we believe punitive damages are appropriate in those circumstances, but not in the area of noneconomic damages.

Senator SPECTER. Mr. Allen, if you had a situation like the young woman in North Carolina, where they made the wrong transplant, would you say that the noneconomic damages ought to be limited to \$250,000 or \$350,000, whatever the cap is set?

Mr. ALLEN. In the case of the North Carolina case which was cited—I am assuming it is the one at Duke Hospital you are talk-

ing about, the double transplant case—we would say, again, first and foremost, the loss that that family experienced is tragic, and we recognize the tragedy, and we believe in those circumstances that, compensatory damages, those are the economic damages should be recovered, and we believe a reasonable recovery for noneconomic damages should take place.

The issue there that we focus on, however—and if there is evidence that the physician involved, or those involved had malpracticed, then there would be an appropriate place for punitive damages that would be consistent with the injury. However, we would also say in that case, and this is what the Department feels very strongly about, that this is the classic example where system reforms would minimize the risk associated with that practice. In this case, it would have helped if there were duplicate checks in place that would look at the blood type, look at the errors where errors are made, and that is where we focus much of our attention.

Because even awarding those individuals large awards, if that is what they recover, does nothing to mitigate the problem in the vast majority of the system where access is an issue, where physicians are leaving practices. So we think that yes, you can deal with that individually in that regard. That would be consistent with reasonable recovery, but we believe there is a broader concern, and that is why the President stepped in to suggest system reforms.

Senator SPECTER. Mr. Allen, I would invite you to take a look at the transcript and your response to my last question, and if you think it is responsive, just forget it. If you do not, I am interested to know the position of your Department on whether noneconomic damages for the transplant victim should be capped at \$250,000 or \$350,000. You take a look at your answer, and if you think it is responsive, then forget it, and if you do not, I would be very much interested in an answer to my question.

Let me move on to another example of the wrongful mastectomy on the wrong woman, where there are hardly any economic damages. Is the position of your Department, the administration, that the noneconomic damages ought to be limited to \$250,000 or \$350,000?

Mr. ALLEN. Once again, in terms of the recovery for noneconomic damages, the President's proposal is focused on noneconomic damages that would be reasonable between \$250,000 and \$350,000. In that situation, if there was evidence, again, that demonstrated that there was clear and convincing evidence of wrongdoing—

Senator SPECTER. No, we are not talking about punitive damages. I am just talking about ordinary negligence.

Mr. ALLEN. The answer would be yes, we believe that in the proposal, in the circumstances where that is happening, we believe that a reasonable noneconomic recovery would be appropriate because (1) you cannot replace what has been taken from someone. You cannot replace a child that has been lost to a family, or someone who has been injured in that regard, but what we can do is, we can ensure that we have systems in place and processes in place that try to minimize the error.

Senator SPECTER. Mr. Allen, no one would deny that you cannot make people whole and put them back in the position they would have been had the act not occurred. The whole purpose of damages

is to compensate as best you can, so that presentation is really aside from the point, but if you think that wrongful mastectomy should be limited on noneconomic damages, I understand your position.

Mr. ALLEN. Mr. Chairman, my position is, and the administration's position focuses not just on individuals. We believe that there are systems in place to address individual wrong and harm, but we need to look at the impact on the system of an award to an individual. As we have seen in many States, Mississippi being a good example, where they have had nine awards in excess of \$9 million, where we see large awards there is an impact on health care throughout the system. That is what we focus on.

We do not seek to minimize the harm that has been done to individuals, nor do I suggest that you or Congress or anyone is suggesting to do that. But, we do believe that we need to look at what is happening to a system that is driving doctors out of the system, and a system that is not contributing to patient safety and quality improvements. We are looking at that the medical liability situation in this country today is doing just that, in order to stimulate such system changes.

Senator SPECTER. Mr. Allen, it is a given that there is concern by the legislative as well as the executive branch on the delivery of health care to Americans. It is something I have been working on now for 23 years on this subcommittee in many, many directions, and it is a given that there are problems in many States. It is a legislative job to analyze and see where the sources of the problems are, and it is a complex matter on many, many lines which I have already identified, and we are trying to figure out where an appropriate line for compensation is.

Thank you very much, Mr. Allen.

I would like to call our second panel now, Dr. Peter McCombs, Dr. Donald Berwick, Mr. Jay Angoff, Mr. James Hurley, Dr. Brian Holmes, Ms. Linda McDougal, and Ms. Leanne Dyess.

STATEMENT OF PETER McCOMBS, M.D., CHAIR, DEPARTMENT OF SURGERY, PENNSYLVANIA HOSPITAL

Senator SPECTER. Our first witness, Dr. McCombs, is the chair of the Department of Surgery at Pennsylvania Hospital. He is also the clinical associate professor of surgery at the University of Pennsylvania School of Medicine, received his bachelor of science degree in American studies from Yale and his medical degree from Tufts.

Dr. McCombs, thank you very much for joining us, and we look forward to your testimony. Our subcommittee rule, which is general in the Congress, is to limit testimony to 5 minutes. You have been advised of that.

I more recently have been adding an addendum to the time limit. We had a memorial service for Ambassador Annenberg and the limit was 3 minutes for speeches, and that applied to former President Ford and Secretary of State Powell and me, and many, many others, so I want you to know that by those standards 5 minutes is generous. It does not sound like it when you have the kind of expertise and study you experts have put into this subject, but if

you can limit your testimony to 5 minutes, it gives us the maximum time for discussion.

Thank you for joining us, Dr. McCombs, and we look forward to your testimony.

Dr. McCOMBS. Thank you, Mr. Chairman. It is a privilege for me to be here.

Senator SPECTER. There is a button on your microphone.

Dr. McCOMBS. Okay, I have it now.

Mr. Chairman, Pennsylvania Hospital is a teaching hospital located in the center of the City of Philadelphia. It happens to be the Nation's first hospital, and it has a long tradition of medical education dating back to 1773. It is one of four institutions that comprise the University of Pennsylvania Health System.

Senator, you are well aware of the gravity of this problem, and I do not intend to reiterate any inflammatory rhetoric. I will simply state that we need Federal action now to address a serious problem jeopardizing health care both nationally and in our Commonwealth. H.R. 5, the HEALTH act, sponsored by Congressman Jim Greenwood of Pennsylvania, provides the critical elements of such an initiative.

As chairman of an academic department of surgery, I have ultimate responsibility for the quality of care across the entire array of surgical services. I take pride in our many surgical triumphs. Regrettably, I also know about our complications and deaths, our mistakes and near misses, and the occasional cases that suffer potentially preventable disabilities. I live with surgeons every day, and I am actively engaged in training the young surgeons who will become their successors. It is my job to adjudicate, to teach, and to listen, to perpetuate an environment that is founded on ethical standards and open inquiry that effectively balances risk and benefit, and that above all never loses its focus on the needs of patients.

The majority of our staff is engaged in private practice. Management of overhead is a way of life, and overhead includes payment of malpractice premiums. These have recently become so expensive that many surgeons have reconsidered their options in order to remain even marginally profitable. A significant number have been faced with the drastic decision to change the scope of their practice, to retire early, to temporarily suspend performing surgery, or to leave Pennsylvania in search of a better environment.

I am personally familiar with three vascular surgeons, three neurosurgeons, one orthopedic surgeon, two plastic and reconstructive surgeons, three general surgeons, and one interventional radiologist who have retired prematurely or relocated their practices and their families outside of Pennsylvania.

We have the busiest obstetric service in Philadelphia, but our department of obstetrics has been reduced from 50 to 29 obstetricians over the past 3 years on account of this problem. In addition, 11 orthopedists, 2 neurosurgeons, 7 general surgeons, 8 urologists, and 3 surgical oncologists suspended their surgical practices for a period of days to weeks late last year and early this year.

Finally, I have five general surgeons on my staff whose malpractice policies expire on June 30. They face the future with great uncertainty. These surgeons have placed their faith in Governor

Rendell's commitment to deliver relief for this crisis in Pennsylvania. All are considering relocation of their practices if no significant relief is forthcoming.

In addition, according to the Pennsylvania Hospital Association the total cost of medical liability insurance coverage for Pennsylvania's hospitals has increased by 86 percent over the past 12 months, and 23 percent of hospitals reported premium increases that exceeded 200 percent.

One has to look carefully at the implications of this crisis on patient care. While very few individuals have been denied needed surgical treatment in the Philadelphia area, this is not the case in other parts of Pennsylvania. The departure of high risk specialties from Berks, Fayette, and Lackawanna Counties has forced patients to travel to find replacement specialists.

In the Philadelphia area, many patients have voiced complaints to me about excessive delays in obtaining surgical consultation, and about receiving treatment from younger and less experienced surgeons than they had expected or preferred, or from surgeons who are clearly overworked and overstressed, and going forward, it appears that a significant number of our most respected surgeons are destined to be replaced in the prime of their careers.

One additional byproduct of this crisis in Pennsylvania has been that recruitment of new surgeons has been very difficult. Philadelphia is fortunate enough to have five medical schools and a much larger number of excellent training programs in all of the surgical disciplines, yet the number of graduates remaining in the Philadelphia area to practice is almost negligible. Groups attempting to recruit a young surgeon almost invariably need to go to the Joint Underwriters Association, the last available resort, in order to obtain coverage.

In fact, many doubt that the private practice model, as our patients and we have known it over the years, is sustainable. As damage to our system continues, the feasibility and costs associated with rebuilding it are virtually impossible to fathom.

Quality assurance is an integral part of the surgical culture. We have an active safety initiative that is built on the foundation of a systems-oriented, nonaccusatory, root cause analysis process. Our weekly morbidity and mortality conference is the backbone of our educational program. Discussions are structured and explicit, and sometimes are emotional and brutally candid, but it is through these dialogues that we all learn and grow. They remind us about our standards. They help us to make the right choices. They establish role models for younger surgeons to follow.

Senator, there are warning signs that our system is collapsing. We are not only failing to attract the best candidates into surgery, but are also losing some of our bright young residents to fields outside of medicine altogether. A shocking number of graduating medical school seniors is choosing to pursue a second degree, or to enter industry rather than to begin a residency. I have serious concerns about who may be doing your, and when I say your, I am referring collectively to everyone in this room—

Senator SPECTER. Dr. McCombs, you are over time. Could you summarize, please?

Dr. Mccombs. Yes, sir—or mine when the time comes, or who may be delivering your grandchildren or mine in the years ahead.

PREPARED STATEMENT

It is not appropriate for individual States to compete for surgeons and obstetricians based on the cost of liability insurance. In order to preserve access to good health care for everyone, the playing field must be leveled.

Thank you, Mr. Chairman.
[The statement follows:]

PREPARED STATEMENT OF DR. PETER R. MCCOMBS

Chairman Specter and members of the Committee, good morning. I am Dr. Peter McCombs, Chairman of the Surgery Department at Pennsylvania Hospital, a teaching hospital located in Center City Philadelphia. It happens to be the nation's first hospital and has a long tradition for medical education, dating back to 1773. It is one of four hospitals that comprise the University of Pennsylvania Health System. The Penn Health System is an integrated, academic health system that also comprises associated medical staffs, three multi-specialty out-patient facilities, a faculty practice plan, a primary care physician network, a significant number of clinicians in private practice, and numerous other sub-acute providers.

I am a practicing surgeon, board certified in general surgery and vascular surgery. I came into my present position following a twenty-three year career as a community-based clinician and dedicated educator. From this perspective, I would like to present my views on the medical liability crisis as it currently impacts patients, physicians and the health care institutions on which we all depend in Pennsylvania. I am very grateful for this opportunity.

Senators, I know that you are well aware of the gravity of this problem in Pennsylvania and elsewhere around the nation. I am confident that many of the hardships experienced by patients and physicians are well known to you. I know that you understand and have sensitivity for the impact that the changing climate has had on such vital and customary services as prenatal and obstetrical care, trauma care, surgical care across a wide spectrum, and now even primary care. I do not intend to take your time by reiterating the inflammatory rhetoric that has become so ubiquitous in the media as well as throughout our hospital cafeterias, hallways and waiting rooms.

I will simply state that we need federal action now to address a serious problem that jeopardizes the way we provide health care both nationally and in our Commonwealth. We need your leadership to move a comprehensive medical liability reform initiative forward, and I propose that H.R. 5, the HEALTH Act sponsored by Congressman Jim Greenwood of Pennsylvania, provides the critical elements of such an initiative.

Let me now take a moment to set before you a representation of the issues as I see them. As Chairman of an academic department of surgery, I have ultimate responsibility for the quality of care rendered to our patients across the entire array of surgical services at Pennsylvania Hospital. In addition to general surgery, these include vascular and thoracic surgery, cardiac surgery, urology, ophthalmology, otolaryngology, orthopedics and neurosurgery. I know about our many surgical triumphs and, like my colleagues, I take a lot of pride in those cases. Regrettably I also know about our complications and deaths, our mistakes and near misses, and the occasional cases that suffer potentially preventable disabilities. I live with surgeons every day, and I am actively engaged in training the young surgeons who will one day become their partners and their successors. It is my job to adjudicate, to teach and to listen, to perpetuate an environment that is founded on proper ethical standards and open inquiry, effectively balances risk and benefit, and above all never loses its focus as a resource for the needs of patients. For many years, Pennsylvania Hospital has been a wonderful place to practice surgery.

As in many community-based hospitals, the majority of our staff is engaged in private practice. These physicians are fully responsible for managing the business aspects of their practices. Recruitment and retention of staff, billing and collection of revenue, management of pension and retirement plans for partners and employees, and management of overhead are all a way of life for physicians in private practice, and overhead includes payment of malpractice premiums. Always a major line item in the practice overhead, these premiums have recently become so expensive that

many surgeons have had to reconsider their options in order to remain even marginally profitable. A significant number have been faced with the drastic and unexpected decision to change the scope of their practice, to retire early, to temporarily suspend performing surgery, or to leave the state of Pennsylvania in search of an environment in which they can practice and raise their families with greater stability and less uncertainty.

As examples, I am personally familiar with three vascular surgeons, three neurosurgeons, one orthopedic surgeon, two plastic and reconstructive surgeons, three general surgeons and one interventional radiologist who have retired prematurely or relocated their practices and their families outside of Pennsylvania. In addition, I personally know eleven orthopedists, two neurosurgeons, seven general surgeons, eight urologists and three surgical oncologists who were forced to suspend their surgical practices for a period of days to weeks during lapses in coverage brought about by skyrocketing premiums late last year and early this year. I know two neurosurgeons and three general surgeons who have changed their employment model, becoming full-time health system employees as an alternative to leaving the state. Finally, I have five general surgeons on my staff whose malpractice policies expire on June 30. They face the future with great uncertainty. These surgeons have placed their faith in Governor Rendell's stated commitment to deliver short and long-term relief for this crisis in Pennsylvania this year. All are considering relocation of their practices if no relief is forthcoming.

In addition, according to the Pennsylvania Hospital Association, the total cost of medical liability insurance coverage for Pennsylvania's hospitals has increased 86 percent over the past 12 months, and 23 percent of hospitals reported premium increases exceeded 200 percent. These premium increases have occurred even as coverage has decreased, either in the form of deductibles or higher retention levels.

One has to look carefully at the implications of this crisis on patient care. While I am aware of very few, if any, individuals who have been denied needed surgical treatment in the Philadelphia area, this is not the case in other parts of Pennsylvania. When high-risk specialists leave Berks, Fayette, or Lackawanna Counties, Pennsylvania residents in those areas have to travel to find replacement providers. In the Philadelphia area, many patients have voiced complaints to me and to others like me about excessive delays in obtaining surgical consultation, and about eventually receiving treatment from younger and less experienced surgeons than they had expected or preferred, or from surgeons who were clearly overworked or overstressed. And going forward, it appears that a significant number of our most respected surgeons are destined to be replaced in the prime of their careers by less experienced colleagues.

One additional byproduct of this crisis in Pennsylvania has been that many surgical practices have found it very difficult to recruit new surgeons. Philadelphia is fortunate enough to have five schools of medicine or osteopathy and a much larger number of excellent training programs in all of the surgical disciplines. And yet, the number of graduates of those programs who have demonstrated an interest in entering the practice of surgery or a surgical subspecialty, particularly in the private practice arena in the Philadelphia area, is almost negligible. Practices interested in attempting to recruit a talented young surgeon almost invariably need to go to the Joint Underwriters Association, the last available resort, to obtain coverage for new surgeons entering the area. In fact, a number of my colleagues are seriously wondering if the private practice model as we and our patients have known it over the years is sustainable on account of the malpractice crisis. Also, as the damage to the system continues, it is unclear if we will ever be able to return to that system as we knew it, and what the costs incurred will be to try to rebuild it.

Quality assurance is an integral part of the surgical culture. We participate actively with numerous advocacy groups and task forces. We have an active safety initiative that is built on the foundation of a systems-oriented, non-accusatory root cause analysis process. We are doing our best to police ourselves and to create a safer environment for our patients. The morbidity and mortality conference that I moderate weekly is the backbone of our educational program for medical students, residents, fellows, and surgical faculty. Our discussions are structured and explicit, and are sometimes emotional and brutally candid. But it is through these dialogues that we all learn and grow. They remind us about our standards. They help us to make the right choices. They establish role models for younger surgeons to follow.

From a broader statewide perspective, according to the American Medical Association, Pennsylvania is one of 12 states nationwide in the midst of a liability crisis. Only six states are considered stable, one of which is California, which passed significant liability reforms in 1975. The additional 32 states and the District of Columbia are considered states that are beginning to show problem signs. In 2000, Pennsylvania's medical liability payments per capita—the amount of money spent

per resident—was the highest state in the nation. The amount for Pennsylvania was \$40.23 per person compared to California's \$5.98 per person in 2000.

Only a few short years ago there were more than 30 insurance companies active in the Pennsylvania market. Today, there are only two major insurance companies left. The Pennsylvania Insurance Department has approved several new medical liability insurance companies during the past year, but the market still lacks sufficient capacity and competition.

The Secretary of the Pennsylvania Insurance Department recently testified before a State senate committee on the status of the Pennsylvania medical liability insurance market. Among the key points that she shared:

- Total medical liability coverage payments (primary and the state Mcare Fund) have doubled in the last decade from \$363 million in 1991 to \$730 million in 2001. Actuarial estimates for 2002 and 2003 are \$893 million and \$1.2 billion, respectively;
- Pennsylvania healthcare providers have had to seek alternative risk arrangements, such as self-insurance or risk retention groups, or turn to the Pennsylvania Joint Underwriting Association (JUA), the insurer of last resort;
- Loss experience data from the Pennsylvania Insurance Department indicates a tenuous financial situation for medical liability insurers. Direct losses incurred exceeded direct premiums written in 2001 by \$102 million. The loss ratio for all Pennsylvania medical liability insurance companies has increased from 67 percent in 1996 to 127 percent in 2001;
- Investment asset distribution of medical liability insurance companies demonstrates that medical liability insurance companies have less than 9 percent of their investment portfolio in common stocks and they have not lost significant investments as a result of the downturn in the financial markets;
- Mcare Fund payments have doubled since 1994. About \$175 million was paid in 1994 and about \$350 million was paid in 2002; and
- Medical liability insurers indicate that the two most important barriers for entry and expansion in Pennsylvania are no caps on non-economic damages and the existence of the Mcare Fund.

It is significant that insurers are not leaving other property/casualty markets. If the crisis were solely caused by lower investment income, as some groups have asserted, these companies would be leaving other insurance markets. But they are not. They are leaving the medical liability market because of the instability and lack of predictability of the risk. According to the Pennsylvania Insurance Department, liability insurance carriers had combined underwriting losses of \$102 million in 2001.

Until insurers feel that they can make money writing medical liability policies in Pennsylvania, they will either dramatically increase their rates to ensure that they are more than adequately covered or discontinue writing any policies in Pennsylvania.

As the medical liability insurance market continues to deteriorate, some commercial carriers have had to exit markets and others have had to dramatically increase premiums to stabilize their financial conditions. As a result, many companies have seen their ratings downgraded and the number of plans in rehabilitation or liquidation has grown, which increases the coverage gaps.

With the crisis only growing worse, Pennsylvania enacted three liability reform bills in 2002: the "Medical Care Availability and Reduction of Error (Mcare) Act," the "Fair Share Act" that changes the joint and several liability rule, and a new law to end venue shopping. In addition, the Supreme Court has issued new rules designed to alleviate the problem. Combined, these new laws and rules should result in long-term premium savings.

It will take several years to realize the full benefit of these reforms since they apply only to incidents on or after the effective date of the acts and are spread over a multi-year period before the full financial benefits are realized. In addition, insurers are likely to wait for actual claims experience and the results of anticipated court challenges before modifying premiums.

Meanwhile, hospitals and physicians continue to feel the effects of a shrinking income base and dramatic expense increase, and patients pay the ultimate price.

To help address this crisis, hospitals and physicians need reasonable limits on non-economic damages. To help lower settlements and awards and for insurance companies to be able to better predict awards for liability cases, we must address non-economic damages. Today's system for assessing non-economic damages in medical liability cases is lacking in standards and thus is prone to variable results in similar cases. The resulting unpredictability encourages divergences in valuation of cases, thus undercutting the ability of parties to reach voluntary settlement without

expensive trials. It also adversely affects the availability and cost of medical liability insurance.

Non-economic damages are separate from, and do not include, compensation for medical costs, lost wages, or other out-of-pocket expenses, and they do not include punitive damages.

Two principles must guide our debate on this issue. Injured patients are entitled to full compensation for all economic losses. Every person is entitled to receive health care services from a physician or other provider that are at least equal to the "community standard of care." If the patient is injured by substandard care and suffers economic losses, the patient is entitled to recover those losses completely.

Second, non-economic damages should be fair, equitable, stable and predictable. Almost everyone in society—physicians, patients, lawyers, and judges—agrees that losses due to substandard care should be compensated, but not excessively. Medical liability claims are complex. Seventy percent of such claims are won by the defendant, dismissed or dropped because they have no merit, but when juries do award damages they give health care injury claimants significantly more for their "pain and suffering" than persons who have incurred the same kinds of injuries in car accidents or other settings. The median jury award has increased to \$1 million a doubling of the amount since 1995.

In closing, I would stress that the medical liability crisis is very real. Each day that passes without additional reform further batters a health care system already under siege. Policymakers must be prepared for the consequences of non-action—continued erosion of access to care, the unraveling of an exceptional system of care that may never be truly salvaged, and the clear cut costs that will come with rebuilding that system.

Senators, there are warning signs that our system is collapsing. We are not only failing to attract the best candidates into surgery, but are also losing some of our bright young residents to fields outside of medicine altogether. A shocking number of graduating medical school seniors is choosing to pursue a second degree or to enter industry rather than to begin a residency. I have serious concerns about who may be doing your surgery or mine when the time comes, or who may be delivering your grandchildren or mine in the years ahead. It is not appropriate for individual states to compete for surgeons and obstetricians based on the cost of liability insurance. In order to preserve access to good care for everyone, the playing field must be level. For those reasons I respectfully urge you to urge you to support H.R. 5, the HEALTH Act, and to move as expeditiously as possible to deliver it to President's Bush's desk for signature.

I thank the Chairman and this subcommittee for this opportunity and welcome questions at the appropriate time.

Senator SPECTER. Thank you very much, Dr. McCombs.

STATEMENT OF DONALD M. BERWICK, M.D., M.P.P., PRESIDENT AND CEO, INSTITUTE FOR HEALTHCARE IMPROVEMENT; MEMBER, QUALITY OF HEALTH CARE IN AMERICA COMMITTEE, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES

Senator SPECTER. We turn now to Dr. Donald Berwick, president and CEO of the Institute for Healthcare Improvement, a member of the Institute of Medicine of the National Academy of Sciences, a graduate of Harvard, master's in public policy from the JFK School of Government, and an M.D. from the Harvard Medical School. Thank you for joining us, Dr. Berwick, and we look forward to your testimony.

Dr. BERWICK. Thank you, Mr. Chairman. My full remarks are here for the record.

Senator SPECTER. Your full statement will be made a part of the record, without objection.

Dr. BERWICK. Thank you so much.

I am here as a representative of the IOM. I served on the committees that wrote the reports that you have referenced, and I serve on their governing council. Their reports are familiar to you.

The To Err is Human report on which I focus says that tens of thousands of Americans are injured by their care, and many die as

a result of their care instead of their diseases. Only a tiny fraction of these injuries are due to incompetence, or carelessness, or sabotage, or even gross negligence on the part of individuals. Most are wired into the system. Any human being in a similar situation runs the same risk of causing that injury, so in some sense they are due to errors, but that is a misleading idea, because they are caused by the design of the system.

A way to think about that is, if today we fired every doctor and nurse that made a mistake in care, even multiple mistakes, tomorrow the injury rate would remain the same, because new human beings would be subject to the same frail systems in which they are embedded.

The third finding, though is, that is not a prescription for hopelessness. Other industries have gotten safe. They have done it by engineering safety into the design of the system of work. We can do the same in health care, but we have not yet. In order to get safer, health care has to change. If it is to get much safer, it is going to have to change a lot.

The two changes that our committee has recommended are in the arena of technology and in the arena of culture. Technologically, we are a backward industry. We lack modern information systems, we lack an electronic medical record, we have complex procedures and steps that vary senselessly from place to place, we build complexity into systems, and complexity invites failure.

Culturally, we are even in worse shape at the moment. There are safe cultures and there are unsafe cultures. We are an unsafe culture in health care, despite the best intentions of the professionals who are in that system. A safe culture has four attributes. Safety is a priority. People can be open and talk about hazards and injuries in their own areas, in the areas of others. It can be discussed. Communication and coordination are high priorities, and innovation is constant.

Today, health care organizations do not exhibit a culture of safety. Safety is not a top priority for top leaders. Their attention is focused on other imperatives for their organizations, and safety does not really pay off now in the health care system, and we do not talk about it very much. As the prior witness said, physicians and others are frightened to talk about injuries to patients and things that they are involved in, despite their wish to do well.

I am an optimist. Today, I am speaking at noon to 1,000 people at the National Patient Safety Foundation meeting here in Washington, which is making tremendous progress, as are many Federal agencies, including the Veterans Health Administration, DOD, Bureau of Primary Care, and HRSA. We have progress underway, but it is nowhere near enough.

Congress has helped a lot. I have five recommendations for more help from Congress. The first is, I would like to suggest that you continue to review and support and encourage the really path-finding work going on in Federal agencies that give and fund care, the Veterans Health Administration, the Military Health Command, the Indian Health Service—these are gems, and they are making progress which could become national benchmarks.

Second, please keep the spotlight on safety. Keep the heat on with hearings like this. We need to grow will in the public and the professions and in the leadership to make safety a priority.

Third, the attention of your particular subcommittee on malpractice reform is important. The malpractice system impedes work on safety today. It enforces a culture of secrecy and fear which no successful safety agenda can really tolerate.

I do not have a simple answer. The Institute of Medicine has recommended tort reform demonstration trials. I think the recommendation is correct. I see recently a report in the State of Florida just a few weeks ago for a statewide change that I think would be great.

My personal recommendation—I am departing a bit from the Institute of Medicine here, because I am getting into details that are not in our report, but it would be for demonstrations that have five properties at the State level.

The first property is that at the demonstration there should be immediate disclosure of any injury to any injured patient and family. It must be a requirement that disclosure occurs.

Second, there should be apology. Injured patients want someone to say they are sorry. Our current system does not do that.

Third, there should be fair and reasonable compensation to injured families and patients. I think the analogy to a workers' compensation system is correct.

Fourth, there must be learning from these injuries so the rates go down.

And fifth, the proper locus of responsibility is with the executives, boards, and leaders of health care systems, not with individual physicians. In general, when there is egregious misconduct or bad intention, that person should be rapidly disciplined, but that will only cover 2 or 3 percent of the injuries that patients get subjected to.

I recommend that such tests be time-limited, and that the health care system be mandated to deliver. If the system does not get safer under the conditions of such a test, the test should end and we should return to the status quo.

My fourth recommendation is that Congress should mandate the development of a national patient electronic medical record that should be available to any physician, office, practice in the United States at no cost or low cost. It should become a Federal standard, and should be used throughout the country, compatible with legacy systems.

PREPARED STATEMENT

My final recommendation is that you continue to support, as you have, Senator, ambitious, path-finding research on patient safety through ARC and others. We are making progress intellectually. It needs to continue. Please be the voice of the American people on this. We need you to speak out about your concern about safety levels and demand that the system become safer.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF DR. DONALD M. BERWICK

Thank you for the opportunity to testify here. I am President and CEO of a non-profit organization, the Institute for Healthcare Improvement, whose mission is to accelerate improvement of health care systems. I am also Clinical Professor of Pediatrics and Health Care Policy at Harvard Medical School.

I am here today as a representative of the Institute of Medicine of The National Academies. I serve on the IOM's governing Council, and I was a member of the IOM's Committee on Quality of Healthcare in America, which wrote the two landmark reports on quality, *To Err Is Human* and *Crossing the Quality Chasm*. I believe that these and subsequent IOM reports on quality offer this nation, and this Congress, a superb blueprint for the redesign and improvement of our American health care system.

I am going to focus on the *To Err Is Human* report mainly: What does it say? What should we do? And, how can Congress help?

That report has three major findings:

—*First.*—Many Americans are injured by the health care that is supposed to help them. Tens of thousands, in fact, die from injuries caused by their care and treatment, rather than from their diseases. The IOM's estimate is between 44,000 and 98,000 such deaths per year in hospitals, alone.

—*Second.*—Only a tiny fraction—perhaps two or three percent—of these injuries are due to incompetence, carelessness, sabotage, or gross negligence on the part of individuals. They tend, instead, to come from latent hazards built right into the systems of care. The more complex the systems, the bigger the hazards. Put otherwise, the IOM finds that most patient injuries, if they are due to human errors, are due to those kinds of errors that are part of daily life—human factors—and therefore those errors are in some sense, inevitable. If we fired every single doctor and nurse who made a mistake today, the error rate in America health care would be the same tomorrow. Mostly, the people are good, but they work in flawed systems.

—*Third.*—Errors can be reduced, but not eliminated. Injuries are different; they can be eliminated, or nearly so. From other industries and from good theories, we know that it is possible for very complicated systems to be very safe—much safer than health care—by providing technological and cultural supports that make human error less likely to do harm. The problem is that health care has not yet invested anywhere near enough time, talent, and money in trying to become much safer. We lack both the technologies and the culture that could make us safe.

To get safer, health care has to change. To get much safer, it has to change a lot.

On the technology front, we must modernize our information systems, make the electronic medical record a routine feature of all health care, and simplify our procedures and practices by removing unnecessary steps, unnecessarily complicated equipment, and senseless variations in practice from place to place. We need to integrate information across boundaries, so that we do not drop the ball when the patient moves from one hospital to another, or from the office to the hospital to the nursing home and back home. We need to develop registries and systems for remembering patients' drugs, diagnoses, and preferences. We—both the care providers and the public—need to understand that in health care, more is not always better—in fact, it is very often worse. And that even in this wonderful age of biomedicine, simpler care is often safer care.

As tough as the technologic challenges are, the cultural changes we need may be even tougher. There are safe cultures, and there are unsafe cultures. The properties of a safe culture include the following:

—Safety is a top priority, from the top, all the time; no injury—none—is regarded as inevitable;

—People talk openly about hazards, errors, injuries, and other threats to safety. A fearful organization—where people feel that they have to hide their own mistakes—cannot be a safe organization;

—Communication and coordination are high priorities; people value teamwork above all;

—Innovation is constant, and new ways to make things safer are rapidly incorporated into practice.

From this cultural viewpoint, most health care organizations do not exhibit a culture of safety. Becoming much safer is not yet a top priority for clinical leaders, executives, and Boards. Other, apparently more pressing, issues of organizational finance and survival occupy their attention. Few seem to believe that major improve-

ments in patient safety will help them become more vital, resilient players in their markets. Financially, safety in health care does not yet pay off.

In fact, we still do not even talk about it much. People in health care are fearful about discussing injuries to patients, near misses, and errors. They are afraid of lawsuits, embarrassment, and mistrust from colleagues. Most injured patients never know that it happened to them. Communication and coordination are not taught as skills in professional training, nor are they well-supported by proper investments of time and leadership attention. Nor have we yet invested enough in innovations to modernize our safety systems, especially innovations related to electronic patient records and prescribing systems. Health care systems are complaining about the costs of modernizing their patient record and drug order systems. In short, with respect to the needed cultural changes, we are stuck in “neutral” too often and in too many places.

Since the IOM reports, awareness has grown that health care safety ought to be a top priority. But, actions have lagged well behind awareness.

And yet, I am an optimist. People are waking up. Today and tomorrow, the National Patient Safety Foundation is holding a conference here in Washington with hundreds of clinicians and health care leaders attending to learn about how to improve from some of the greatest experts in the world. Federal systems, like the Veterans Health Administration, the Department of Defense’s medical care system, and the Bureau of Primary Care in the Health Resources and Services Administration, are making widespread progress in improvement. My organization—the IHI—is announcing this afternoon the launch of a free, open, web-based support system—“QualityHealthCare.org”—to help anyone, anywhere, who wants to improve care, and we are beginning with patient safety as the prime focus.

Congress has helped, but you can help even more. Here is how.

- Continue your review, support, and encouragement of leading work on patient safety in Federal agencies that give or fund care, including the Veterans Health Administration, the Military Health Care System, HRSA, the Indian Health Service, and CMS. Urge—insist—that these systems become benchmarks of safety for the nation.

- Keep the spotlight on safety with hearings such as this, and in your own individual work, so that the public will for change grows.

- Help us reduce the toxicity of our current unfair, inefficient, and illogical malpractice liability system, which today produces too much fear and waste, and which fails to compensate most injured patients at all. The IOM has called for one or more statewide demonstration projects on medical tort reform, and Congress should do what it can to make sure these actually take shape. (A recent report from the Florida Governor’s Select Task Force on Health Professional Liability Insurance includes some creative ideas for one such demonstration.) A tort reform demonstration trial should have, in my personal opinion, the following five elements: (a) immediate disclosure of injuries to patients and families; (b) apology; (c) fair and reliable compensation to injured patients and families (analogous to a workers’ compensation system); (d) learning from injuries and near misses so that hazards are continually reduced; and (e) fixing the locus of responsibility for all of this at the enterprise level—holding executives, Boards, and leaders accountable for improving safety, rather than generally blaming individual clinicians. (Of course, in the very rare instances when the injury is the result of bad intention or clear and gross individual incompetence or negligence, action to correct individuals should be prompt and precise. We must keep in mind, however, that the vast majority of injuries do not have this property.) Finally, tort reform experiments should be time-limited tests—at first perhaps three or four years long. The changes should become permanent only if the new system achieves measurably higher levels of fairness, compensation, and safety than the current one.

- To help bring health care into the modern electronic era, please establish a national program to produce, within the next two years, a simple, public-domain electronic medical record that any hospital or physician’s office in the nation can get and use. Such a record should have a problem list, a medication list, registry functions, and the ability to interface and exchange information helpful to individual patient care.

- Continue to fund ambitious, path-finding patient safety research through the Agency for Healthcare Research and Quality and other related research programs.

Above all, please continue to be the voice of the American people, expressing our shared concern about the current, unacceptable levels of injuries to patients. Insist that the health care system become safer, and create rewards for those systems that invest authentically in that goal, and consequences for those that do not.

Senator SPECTER. Thank you very much, Dr. Berwick. We will be coming back with questions a little later.

STATEMENT OF JAY ANGOFF, COUNSEL, ROGER C. BROWN & ASSOCIATES

Senator SPECTER. I would like now to call on Mr. Jay Angoff, Of Counsel to Roger Brown & Associates, Jefferson City, Missouri. He has served as Missouri's Insurance Director and as New Jersey's Deputy Insurance Commissioner, and is a graduate of Oberlin and Vanderbilt Law School. Thank you for joining us.

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

In Missouri, Mr. Chairman, we have got a law which requires the Insurance Department to collect data directly from the medical malpractice insurers on claims filed each year, claims closed each year, both paid and unpaid, and payment per claim. We actually collect data on each payment, each medical malpractice payment that occurs.

What we have found is that there is a general downward trend. In the 6 years I was a commissioner, between 1993 and 1998, the number of malpractice claims filed went down, the number of malpractice claims paid went down, and not surprisingly, medical malpractice rates went down.

After I left the Department, claims filed continued to go down, claims paid continued to go down, and in particular the average payment per claim, particularly between 2000 and 2001, went down substantially, so what happened to medical malpractice insurance rates in Missouri? They went up. They went way up. That does not seem to make sense, but it really does make sense when you understand the underlying characteristics of the medical malpractice insurance industry, and I would like to talk about four.

First, malpractice carriers make their money on investment income, not on paying out less than they take in. The reason is that malpractice carriers hold their premium income for an average of about 6 years before they pay out the claim associated with that premium, so when investment income is high, malpractice carriers do great. When investment income is low, they do not do very well and obviously, Mr. Chairman, they are not doing very well now. Regardless of whether they have their money in stocks or in bonds, they are not making very much money.

Today, they have an unprecedented amount in cash, because there is no place today malpractice insurers can put their money where they are going to make any money, so that is number 1, the first explanation of the underlying cause of the insurance cycle which causes rates to go up even though claims might be going down.

A second reason is the cost of reinsurance. Just as we buy insurance to pay claims we cannot afford, insurers buy insurance called reinsurance to pay the very high claims they cannot afford to pay. The cost of reinsurance, Mr. Chairman, was going up before September 11. After September 11, obviously, as you know, it went up even more, for reasons that have nothing to do with malpractice or the medical system.

Cause number 3, and this is fairly technical but it is very important, when insurance companies say they have a loss, what they

mean is, not—when they talk about their losses, they do not mean the amount they actually pay out in a given year. They talk about the amount that they project that they ultimately will pay out on premiums collected in that year.

So for example, let us go back to the last insurance crisis, which you remember, in the mideighties, the same thing was happening then as is happening now, and there was the same rhetoric on both sides, as we hear today. At that time, insurance companies said they had a very high loss ratio, that they were paying out more than a dollar in losses for each dollar they took in in premiums, but what they meant was—and there is nothing insidious about this—this is just the way that insurance accounting is done.

What they meant was, they projected that they were going to pay out more than a dollar ultimately on the premiums that they took in, let us say in 1986. Well, what it turned out was, when it came time to pay those premiums they actually paid out a lot less than they projected that they would pay out. That is why insurers were able to cut their rates in the nineties. The same thing is happening now. Insurers are projecting that they are going to pay out a great deal. In fact, ultimately they will not pay out that much.

And then finally, Mr. Chairman, the final cause which I think is very important in these periodic insurance crises, is the antitrust exemption for the insurance industry, the McCarran-Ferguson Act. That was an act enacted in 1945 which exempts insurers from the antitrust laws except for boycotts. Very importantly, though, even the boycott exception to McCarran has been narrowed.

After the last insurance crisis, the attorneys general of 19 States sued several insurers and reinsurers alleging that they had gotten together and restricted coverage. The Supreme Court ultimately said that the AGs could proceed with their case, and it was ultimately settled. It was ultimately settled because rates were going down by the time they got around to settling it, but very importantly, Justice Scalia wrote an opinion very narrowly construing the boycott exception.

PREPARED STATEMENT

So, Mr. Chairman, those four reasons are the underlying causes, the antitrust exemption, the high cost of reinsurance, the change in investment income, and the fact that insurers make rates based on incurred losses, not paid losses. These things occur regardless of the litigation system.

Thank you very much, Mr. Chairman.

[The statement follows:]

PREPARED STATEMENT OF JAY ANGOFF

Mr. Chairman and Members of the Committee: My name is Jay Angoff and I am a lawyer from Jefferson City, Missouri, and a former insurance commissioner of Missouri and deputy insurance commissioner of New Jersey. I appreciate the opportunity to testify here today.

BACKGROUND

During my 1993–98 tenure as insurance commissioner of Missouri, both the number of medical malpractice claims filed and the number of medical malpractice claims paid out decreased: according to the data the medical malpractice insurance companies filed with our department, the number of new medical malpractice claims

reported decreased from 2,037 in 1993 to 1,679 in 1998, and the number of medical malpractice claims paid out decreased from 559 in 1993 to 496 in 1998. See Exhibits 1 and 2. As might reasonably be expected, medical malpractice insurance rates in Missouri decreased during that time.

After I left the insurance department, the number of malpractice claims paid continued to decrease: from 496 in 1998 to 439 in 2001. And the number of malpractice claims filed decreased even more dramatically: from 1,679 in 1998 to 1,226 in 2001. Moreover, the average payment per claim rose by less than 5 percent—from \$161,038 to \$168,859—far less than either general or medical inflation.

Unexpectedly, however, malpractice insurance rates rose sharply last year in Missouri—by an average of almost 100 percent in little over a year, according to a Missouri State Medical Society survey—just as they did during the insurance crises of the mid-1970's and mid 1980's. Insurance rates going up while insurance claims are going down—and Missouri is just one of many states where this phenomenon is occurring—doesn't seem to make sense. But it does make sense, for four reasons.

CAUSES OF INSURANCE CRISES

First, malpractice insurers make money not by taking in more in premiums than they pay out in claims, but by investing the premiums they take in until they pay the claims covered by those premiums. Investment income is particularly important for malpractice insurers because they invest their premiums for about six years, since they don't pay malpractice claims until about six years after they have occurred; insurers pay other types of insurance claims much more quickly. When either interest rates are high or the stock market is rising, a malpractice insurer's investment income more than makes up for any difference between its premiums and its payouts. Today, on the other hand, stocks have crashed and interest rates are near 40-year lows. The drop in insurers' investment income today can therefore dwarf the decrease in their claims payments, and thus create pressure to raise rates even though claims are going down.

Second, just as people buy insurance to insure themselves against risks that they can't afford to pay for or choose not to pay for themselves, insurance companies buy insurance—called re-insurance—for the same reason. For example, an insurer might buy reinsurance to pay an individual claim to the extent it exceeds a certain amount, or to pay all the insurer's claims after its total claims exceed a certain amount. The re-insurance market is an international market, affected by international events, and the cost of re-insurance for commercial lines was already increasing prior to the terrorist attacks. After those attacks, not surprisingly, it increased far more, due to fears related to terrorism (and completely unrelated to medical malpractice).

Third, insurance companies use a unique accounting system—called statutory accounting principals, or SAP—rather than the generally accepted accounting principles (GAAP) used by most other companies. Under this system, insurers increase their rates based on what their “incurred losses” are. “Incurred losses” for a given year, however, are not the amount insurance companies have paid out in that year—although that would be its non-insurance, common-sense meaning—but rather are the amount the insurer projects it will pay out in the future on policies in effect in that year. These projections are, by definition, a guess, under the best of circumstances, i.e., under the assumption that an insurer has no business reason to either overstate or understate them.

Insurers do, however, have reasons for inflating or understating their estimates of “incurred losses.” Insurance companies who are thinly capitalized—who have very little cushion, called “surplus” in the insurance industry, beyond the amount they estimate they must pay out in claims—will often understate their “incurred losses” on the reports they file with insurance departments so that they can show a higher surplus on those reports. (It's the job of insurance department auditors to ferret out insurers who are doing this.)

At other times, however—like today—insurers overstate their incurred losses to justify a rate increase. In addition, because increasing their “incurred losses” lowers their income, they also have tax reasons for inflating those estimates. Today, insurers' incurred loss estimates have increased dramatically because they are seeking to recoup the money they have lost on investments—not because the amount they have actually paid out in the past has risen substantially (to the contrary, in Missouri it has actually decreased). When it becomes apparent that the insurers' current loss estimates are too high, insurers will be able to use the amount they estimated they would pay out but did not in fact pay out to reduce premiums or increase profits, or both. This is one reason premiums fell during the 1990's: the “incurred loss” estimates insurers made in the mid-1980's to justify their rate increases

during the 1985–86 insurance crisis turned out to be wildly inflated, enabling insurers to use the difference between what they estimated they would pay out and what they actually ended up paying out to both reduce premiums and increase their profits in the 1990's. These same phenomena will inevitably occur after this insurance crisis.

The final factor contributing to periodic spikes in insurance rates is the insurance industry's exemption from the antitrust laws under the McCarran-Ferguson Act. Unlike virtually all other major industries, insurance companies may agree among themselves to raise prices or restrict coverage, may collectively refuse to deal except on specified terms, and may engage in other anticompetitive activities. When times are good—i.e., when investment income is high—the industry's antitrust exemption would seem to be irrelevant. Far from raising prices in concert, insurance companies compete for market share by cutting price. When times are bad, however—and they could hardly be worse than they are today, when both the stock market and the bond market are producing low or negative returns—the antitrust exemption for the insurance industry allows insurers to collectively raise their prices without fear of prosecution. In other industries, fear of such prosecution prevents such collective increases.

There is a long and unfortunate history of classic boycotts collective refusals to deal in the property/casualty insurance industry. *See, e.g., U.S. v. South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944) (agreement by insurers not to deal with customers or agents of competitors who refused to join price-fixing conspiracy); *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978) (agreement among St. Paul and three other malpractice insurers not to write medical malpractice insurance for doctors insured by St. Paul); *Hartford Fire Ins. Co. v. California*, 509 U.S. 764 (1993) (agreement among insurers and reinsurers to refuse to do business using the traditional “occurrence” commercial general liability policy). At the same time, the Court has been careful to distinguish between classic collective refusals to deal, which under the boycott exception to the McCarran exemption are unlawful in the insurance industry as well as other industries, and other types of anti-competitive activities which are unlawful in general but lawful in the insurance industry. In *Hartford Fire*, for example, the Court emphasized that “concerted agreements on contract terms are as unlawful as boycotts” outside the insurance industry, 509 U.S. at 803, but that among insurers such agreements are lawful.

Under current law, therefore, anti-competitive activity among insurers is only actionable if it can reasonably be characterized as a complete refusal deal: McCarran-Ferguson immunizes not only price-fixing but also “concerted agreement[s] to terms,” which the Court in *Hartford Fire* characterized as “cartelization.” *Id.* at 802.

HOW TO PREVENT FUTURE INSURANCE CRISES

What, then, can be done to reduce medical malpractice insurance rates in the short run, and to prevent periodic medical malpractice insurance crises from occurring in the future just as they have occurred in the past? First, Congress should repeal the McCarran antitrust exemption, so that insurers could no longer act in concert to raise prices without fear. A second solution is to give doctors automatic standing to challenge rate increase proposals filed by medical malpractice insurers with state insurance departments. Some malpractice insurers are today owned by doctors, and many doctors have the quaint idea that those doctor-owned insurers are somehow different than other insurers. When doctors own insurance companies, however, they act like insurance executives, not doctors; and they are just as affected by poor investment performance and high reinsurance costs as are other insurers, and just as likely to inflate their incurred loss estimates and take advantage of their antitrust exemption as are other insurers. By hiring an independent actuary at a cost of a few thousand dollars to point out the unreasonableness or irrationality of an insurer's “incurred loss” estimate on which its rate increase request is based, a state medical association could save its members hundreds of thousands or even millions of dollars in the aggregate.

Third, the states could change their laws to make it easier for insurance commissioners to prevent excessive rate increases. In many states, for example, medical malpractice insurers can raise their rates at will, without getting approval of the insurance commissioner. In other states the insurance commissioner may disapprove a rate only if he first finds that the market is not competitive; by the time the commissioner makes such a finding, however, the damage has already been done.

Fourth, states can authorize and provide start-up loans for new malpractice insurers which would compete with the established insurers. In Missouri, the legislature created such a company to write workers compensation insurance in 1993, when

workers comp rates were increasing dramatically even though workers comp claims were not, and that company has been a success: it charged rates that were based on experience rather than inflated “incurred loss” estimates, which forced the other insurers to do the same; it paid back its loan from the state well ahead of schedule; and it now is a significant player in the workers comp market. The key to its success is the fact that it competed with the established insurers for all risks, including the most profitable; the established carriers had sought to limit its mission to insuring only the worst risks. If a state establishes a new medical malpractice carrier and authorizes it to compete with the established carriers for all doctors’ business then that insurer should help drive medical malpractice rates down just as the Missouri state-authorized workers comp insurer has helped drive workers comp rates down.

Finally, there is the California 20 percent solution. In 1988, California voters narrowly approved a ballot initiative, Proposition 103, which not only repealed California’s antitrust exemption for insurance companies and gave both doctors and consumers automatic standing to challenge insurers’ proposed rate increases, but also mandated that insurance companies roll back their rates. The California Supreme Court upheld substantially all of Proposition 103, including the rollback, modifying it only to the extent necessary to permit insurers to avoid the rollback if they could demonstrate that they would be unable to earn a fair rate of return if their rates were rolled back. Few insurers could prove this, and as a result medical malpractice premiums in California fell sharply in the years immediately after Prop 103 was enacted, and even today are lower than they were in the year before Prop 103 was enacted. While a mandatory rollback sounds—and is—extreme, what California tells us is both that it is constitutional and that it works. Some doctors argue that what has caused rates to fall in California is a law limiting the non-economic damages that injured people can recover that the California Supreme Court held constitutional in 1984. But in the first full year after the law was upheld, premiums rose by 35 percent. Premiums did not begin to fall until Prop 103 was enacted in 1988 and declared constitutional a year later. See Exhibit 3.

WHAT INSURERS THEMSELVES SAY ABOUT INSURANCE CRISES

To be sure, the current sharp and apparently irrational increases in insurance rates have created pressure to enact limitations on liability, based on the understandable rationale that if the amount injured people can recover from insurance companies is limited, insurance companies will pay out less money to such people, and they will pass at least some of those savings on to policyholders. I have explained that such limitations do not make sense because the other factors which cause insurance rates to fluctuate, such as investment income and the cost of reinsurance, have a much greater impact on the premium dollar than could any plausible limitation on the amount injured people could recover.

In addition, Missouri and many other states did enact such limitations after the insurance crisis of the mid-1980’s, or the insurance crisis of the mid-1970’s, yet rates are rising today in those states just as they are rising in states that did not enact such limitations—even if, as in Missouri, litigation is decreasing, not increasing.

But perhaps the best evidence that litigation does not cause insurance rates to rise—and conversely, that limiting litigation will not cause insurance rates to drop—is what two of the biggest medical malpractice insurance companies said themselves after the last insurance crisis. Florida reacted to that crisis by limiting non-economic damages for all injuries to \$450,000, and limiting liability in four other respects. After the law was passed, the insurance commissioner required all medical malpractice insurers to refile their rates to reflect the effect of the five major limitations on liability the state had just enacted. In response, Aetna Casualty and Surety conducted a study that concluded that none of those limitations would reduce insurance rates. See Exhibit 4. In particular, Aetna concluded that the \$450,000 cap on non-economic damages would have no impact on Aetna’s claims costs “due to the impact of degree of liability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff.”

The St. Paul Fire and Marine Insurance Company—which at the time was the largest malpractice insurer in the nation—conducted a similar study. That study analyzed 313 claims it had recently closed and found that 4 of those 313 claims would have been affected by the limitations enacted in Florida, “for a total effect of about 1 percent savings.” See Exhibit 5. The St. Paul further explained that the 1 percent savings estimate probably overstates the savings resulting from the new restrictions. And it specifically emphasized that “the conclusion of the study is that the noneconomic cap of \$450,000, joint and several liability on the noneconomic dam-

ages, and mandatory structured settlements on losses above \$250,000 will produce little or no savings to the tort system as it pertains to medical malpractice.”

What the Aetna and St. Paul studies may really be telling us—since they prepared those studies to justify their refusal to reduce their rates after limitations on liability were enacted—is that even if such limitations might reduce the amount insurers pay out, insurers don’t pass on any savings to policyholders. More important, however, even if they did pass on any such savings, they would be insignificant compared to the other factors affecting malpractice rates. Perhaps that is why after the last insurance crisis the chairman of the Great American West Insurance Company told an audience of insurance executives that tort reform “will not eliminate the market dynamics that lead to insurance cycles,” and warned them that “we must not over-promise—or even imply—that insurance cycles will end when civil justice reform begins.” See “Don’t Link Rates to Tort Reform, Insurance Executive Warns Peers,” *Liability Week*, Jan. 19, 1988, at 1.

CONCLUSION

In conclusion, over the long run the medical malpractice insurance industry is substantially more profitable than the insurance industry as a whole: during the 10-year period 1991–2000, according to the National Association of Insurance Commissioners, its return on net worth has been more than 40 percent greater than the industry average, and its loss ratio has been 6 percentage points lower than the industry average, i.e., it has paid out in losses six cents less on the premium dollar than have all property/casualty insurers. See Exhibit 7. Despite this long-run above-average profitability, however, medical malpractice insurance rates, for the reasons I have described, fluctuate substantially. The reforms I have outlined can both reduce those fluctuations and, particularly if the insurance industry’s antitrust exemption is repealed, reduce the level of malpractice rates over the long run.

I would be happy to answer any questions the committee may have.

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Exhibit 1

Source: 2001 Missouri Medical Malpractice Insurance Report, Missouri Dept. of Insurance, Statistics Section, Sept. 2002, at 14.

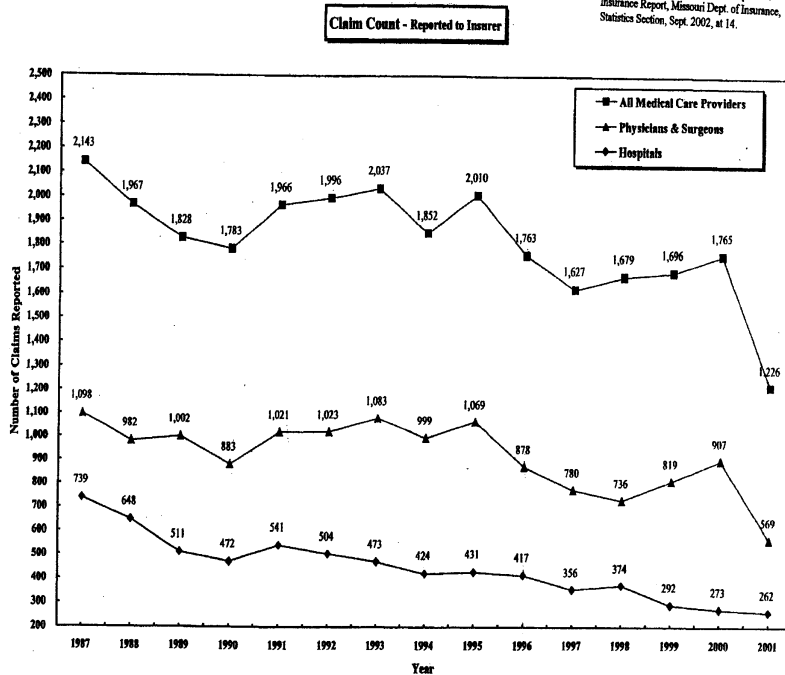
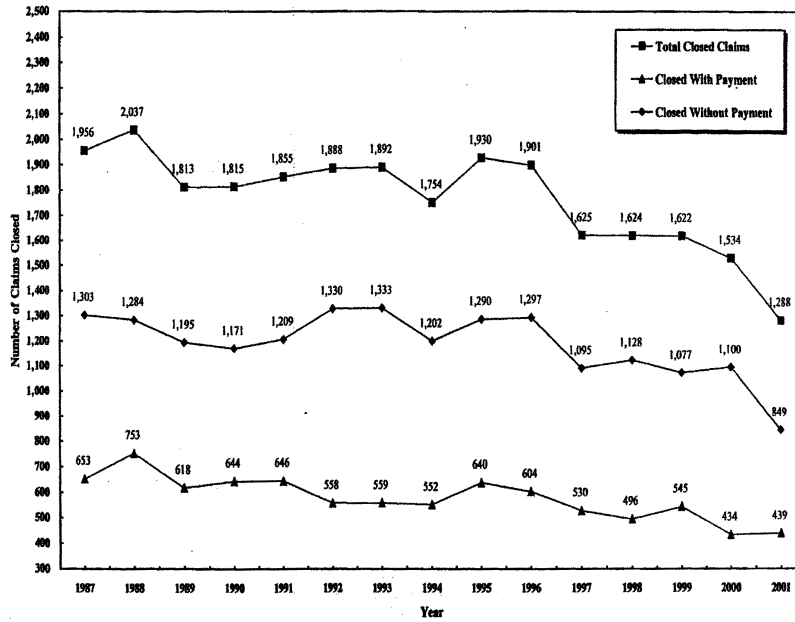


Exhibit 2

Closed Claim Count - All Medical Care Providers

Source: 2001 Missouri Medical Malpractice Insurance Report, Missouri Dept. of Insurance, Statistics Section, Sept. 2002, at 5.



In 1986, the reporting law was revised requiring self-insured hospitals to file their claim data.

CALIFORNIA MEDICAL MALPRACTICE PREMIUM VOLUME 1976 - 2000
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YEAR	PREMIUMS EARNED
	\$000
1976	228,451
1977	227,077
1978	248,724
1979	238,832
1980	230,230
1981	203,825
1982	210,652
1983	287,256
* 1984	374,661
**1985	449,727
1986	629,448
1987	633,903
***1988	663,155
1989	633,424
1990	605,782
1991	529,056
1992	526,496
1993	563,004
1994	576,771
1995	597,660
1996	610,003
1997	628,858
1998	652,601
1999	611,785
2000	609,712

* MICRA's collateral source and periodic payment provisions upheld by California Supreme Court

** MICRA's cap on damages and limits on plaintiff's attorney's fees upheld by California Supreme Court

*** 1988

SAVINGS FROM TORT REFORM ACCORDING TO AETNA:

"IMPACT OF TORT LAW CHANGES

<u>Tort Law Change</u>	<u>Line of Business</u>	
	<u>Products</u>	<u>All Other</u>
	<u>Bodily Injury</u>	<u>General Liability</u>
Collateral Source Offset	0	(0.4%)
Joint & Several	0	0
Limitation of Noneconomic		
Damages to \$450,000	0	0
Punitive Damages	0	0
Future Economic Damages over		
\$250,000 Paid at Present Value	0	0"

**SAVINGS FROM TORT REFORM
ACCORDING TO ST. PAUL:**

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

**MEDICAL MALPRACTICE v. ALL P/C LINES
1991 - 2000**

	<u>Loss Ratio</u>	<u>Return on Net Worth</u>
Medical Malpractice	60.1	12.1
All Lines	66.9	8.3

Senator SPECTER. Thank you, Mr. Angoff.

**STATEMENT OF JAMES D. HURLEY, CHAIR, MEDICAL MALPRACTICE
SUBCOMMITTEE, AMERICAN ACADEMY OF ACTUARIES**

Senator SPECTER. Our next witness is Mr. James Hurley, chairperson of the Casualty Practice Council Medical Malpractice Subcommittee of the American Academy of Actuaries, consulting actuary at Tillinghast-Towers Perrin, based in Atlanta, a B.S. from the College of Insurance in New York. Thank you for joining us, Mr. Hurley, and we look forward to your testimony.

Mr. HURLEY. Mr. Chairman, members of the subcommittee, thank you for inviting me to testify today on behalf of the American Academy of Actuaries.

The academy is the public policy and professionalism organization for actuaries practicing in all specialties within the United States. It is nonpartisan, and assists the public policy process through the presentation of clear and objective actuarial analysis. The academy also develops and upholds actuarial standards of conduct, qualification, and practice.

For those not familiar with actuaries, actuaries collect and evaluate loss and exposure data to advise about rates to be charged for prospective coverage and reserve liability to be carried related to the coverage already provided. The academy appreciates this oppor-

tunity to comment on issues related to the availability and pricing of malpractice insurance.

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

Recently, however, the cost of malpractice insurance has been rising. Rate increases have been precipitated in part by the growing size of claims, more frequent claims in some areas, and higher defense costs. The decline in expected future bond yields exacerbates the need for rate increases.

From a financial standpoint, medical malpractice results deteriorated for the 3 years ending 2001. 2002 data is not yet available, but it is projected to reflect similar results. Two indicators of the financial results are the combined ratio and the operating ratio. We can obtain these indicators for reporting companies from A. M. Best data. A. M. Best is a company that offers comprehensive data to insurance professionals and tracks these results. The combined ratio is an indication of how the company is doing in its insurance underwriting.

For all companies reporting to A. M. Best, the combined ratio of 130 percent and 134 percent for 1999 and 2000 respectively deteriorated to 153 percent in 2001. For underwriting, this represents an expected loss of 53 cents on each dollar of premium written in 2001. Preliminary projections for 2002 are for a combined ratio just under 140 percent.

A measure of the overall profitability of companies is the operating ratio. The A. M. Best operating ratio adjusts for the combined ratio for other expense items and primarily investment income as well. It does not include Federal income tax.

The operating ratio for 1999 and 2000 was approximately 106 percent, indicating a net loss of 6 cents on every dollar of premium. This deteriorated to 134 percent in 2001, indicating a loss of 34 cents per dollar of premium. Given lower investment income, the 2002 operating ratio will probably not improve as much as the projected improvement in the combined ratio. At these levels, 2001 and 2002 results are the worst they have been in 15 years or more, certainly approximating levels of the 1980s.

The data is clear. Today, the loss and operating environment has deteriorated. Benefits of favorable reserve development appear to be gone, and the available investment income offset has declined. In fact, some say that reserve liabilities may require increases to cover current ultimate loss obligations. As a result, rates for both insurers and reinsurers need to increase to properly align with current loss and investment income levels. Companies failing to do this jeopardize their surplus base and their financial health.

My written statement summarizes the two key drivers of financial results and their effects on operating results and surplus for some 30 companies that specialize in this coverage. These compa-

nies represent about one-third of the companies reporting to Best. The results for these companies are more favorable than the industry, but reflect similar deterioration.

In chart B at page 6 of my testimony, the total after tax operating income for these companies is shown. The favorable operating income of the earlier years in the 20 percent neighborhood has declined to a slight profit in 2000 and a 10 percent loss in 2001.

Likewise, on chart E on page 8 of my testimony, the surplus declines in the most recent couple of years. This is important, because surplus represents the capital base for these insurers. Its decline reduces capacity to write new or renewing business prospectively, and lessens insurers' ability to absorb any adverse development on business written in prior years.

This, coupled with voluntary and involuntary withdrawals—for example, St. Paul, MIIX, Reciprocal of America—contributed to availability problems, in addition to affordability problems.

Companies continuing to write malpractice insurance must interpret current experience and determine what rates to charge for prospective coverage. The term ratemaking is used to describe this process. In ratemaking, the company must estimate the cost of the coverage, set a price for it, and assume the risk that the cost may differ, perhaps substantially, from those estimates.

The ratemaking process is forward-looking. It does not reflect loadings for past pricing inadequacy or past investment losses. In short, ratemaking reflects future costs and expectations.

PREPARED STATEMENT

My written testimony provides a bit more detailed discussion of this process. However, three additional observations. It should be noted that rates are generally subject to regulatory oversight in most jurisdictions. Second, investment portfolios are subject to regulatory constraints, so companies are limited in how much they can invest in equities, and third, because rates are generally reduced based on prospective bond yields, when yields decrease, rates need to increase.

The academy appreciates the opportunity to provide an actuarial perspective for these important issues, and will be glad to answer any questions the subcommittee has. Thank you.

[The statement follows:]

PREPARED STATEMENT OF JAMES D. HURLEY

INTRODUCTION

The American Academy of Actuaries appreciates the opportunity to provide comments on issues related to patient access to health care and, in particular, the availability and pricing of medical malpractice insurance. The Academy hopes these comments will be helpful as Congress considers related proposals. This testimony discusses what has happened to medical malpractice financial results and likely effect on rates, the ratemaking process, and some discussion of frequent misconceptions.

MEDICAL MALPRACTICE—WHAT HAS HAPPENED?

The medical malpractice insurance marketplace is in serious turmoil after an extended period of reported high profitability and competitiveness during the 1990s. This turmoil began with serious deterioration in financial results, continued with some consequences of these results and, at least at this point, gives rise to an uncertain future. Industry-wide financial results reflect a 2001 combined ratio (the measure of how much of a premium dollar is dedicated to paying insurance costs of the

company in a calendar year) that reached 153 percent and an operating ratio (reducing the combined ratio for investment income) of about 135 percent; the worst results since separate tracking of this line of business began in 1976. Projections for 2002 are for a lower combined ratio of approximately 140 percent and probable lesser improvement in the operating ratio. This follows 1999 and 2000 operating ratios of 106 percent.

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

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

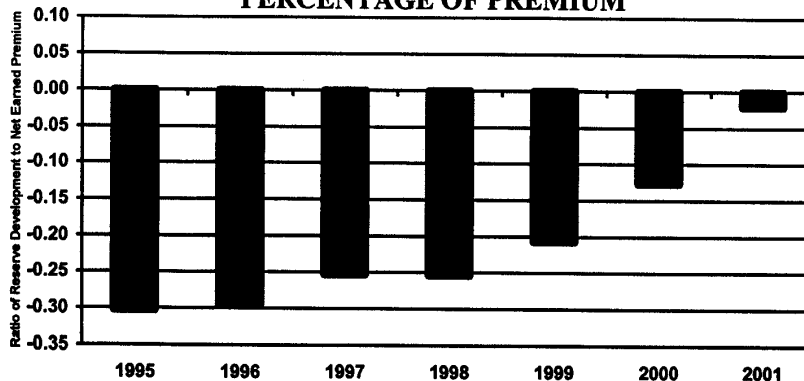
The future outlook is not positive, at least in the short term. Claim costs are increasing more rapidly now than they were previously. Further, the lower interest rate environment would require higher premium rates, even if losses were not increasing. The combined effect is that there are likely to be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

Background

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

—*Favorable Reserve Development.*—Ultimate losses for coverage years in the late 1980s and early 1990s have developed more favorably than originally projected. Evidence of this emerged gradually over a period of years as claims settled. When loss reserves for prior years were reduced, income was contributed to the current calendar years, improving financial results (i.e., the combined and operating ratios). That was the pattern during the middle to late 1990s for 30 provider-owned medical malpractice insurers whose results are shown in Chart A. What is evident from that chart is that favorable reserve development (shown as a percentage of premium) was no longer a significant factor in 2001 for these insurers as the effect approached zero. In contrast to the experience of these provider-owned insurers, the prior-year reserves for the total medical malpractice line of business actually deteriorated in 2000 and in 2001.

CHART A: LOSS RESERVE DEVELOPMENT AS PERCENTAGE OF PREMIUM



—*Low Level of Loss Trend.*—The annual change in the cost of claims (frequency and severity) through most of the 1990s was lower than expected by insurers, varying from state to state and by provider type. This coincided with historically low medical inflation and may have benefited from the effect of tort re-

forms of the 1980s. Rates established earlier anticipated higher loss trends and were able to cover these lower loss trends to a point. As a result, rate increases were uncommon and there were reductions in several states. This was justified in part because the rates established at the beginning of the last decade proved too high, inasmuch as carriers had assumed higher loss trends.

Insurers responded to the emerging favorable loss trend in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others increased rates modestly and tried to refine pricing models to improve overall program equity. In general, however, premium adequacy declined in this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower, particularly in some jurisdictions.

—*High Investment Yields.*—During the 1990s, investment returns produced a real spread between fixed income rates of return and economic inflation. Counter to what some may believe, medical malpractice investment results are based on a portfolio that is dominated by bonds with stock investments representing a minority of the portfolio. Although medical malpractice insurers had only a modest holding of stocks, capital gains on stocks also helped improve overall financial results. These gains improved both the investment income ratio and the operating ratio.

—*Reinsurers Helped.*—Many medical malpractice insurers are not large enough to take on the risks inherent in this line of insurance on their own. The additional capacity provided by reinsurers allows for greater availability of medical malpractice. Similar to what was happening in the primary market, reinsurers reduced rates and covered more exposure, making the net results even better.

—*Insurers Expanded Into New Markets.*—Given the financial results of the early-to-mid-1990s, some insurers expanded into new markets (often with limited information to develop rates). They also became more competitive in existing markets, offering more generous premium discounts. Both actions tended to push rates down.

What Has Changed?

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

—*Loss Trend Began to Worsen.*—Loss cost trends, particularly claim severity, started to increase toward the latter part of the 1990s. The number of large claims increased, but even losses adjusted to eliminate the distortions of very large claims began to deteriorate. This contributed to indicated rate increases in many states.

—*Loss Reserves Became Suspect.*—As of year-end 2001, aggregate loss reserve levels for the industry are considered suspect. Reserve reductions seem to have run their course. As mentioned earlier, the total medical malpractice insurance industry increased reserves for prior coverage year losses in 2000 and 2001, although results vary on a company-by-company basis. Some observers suggest that aggregate reserves will require further increases, particularly if severity trends continue or intensify.

—*Investment Results Have Worsened.*—Bond yields have declined and stock values are down from 1990s highs. The lower bond yields reduce the amount of expected investment earnings on a future policy that can be used to reduce prospective rates. A one percent drop in interest rates can be translated to a premium rate increase of two to four percent (assuming no changes in other rate components) due to the several year delay in paying losses on average. A 2.5 percent drop in interest rates, which has occurred since 2000, can translate into rate increases of between 5 percent and 10 percent. Note that this factor may discourage an insurer from maintaining market presence and also may discourage new entrants.

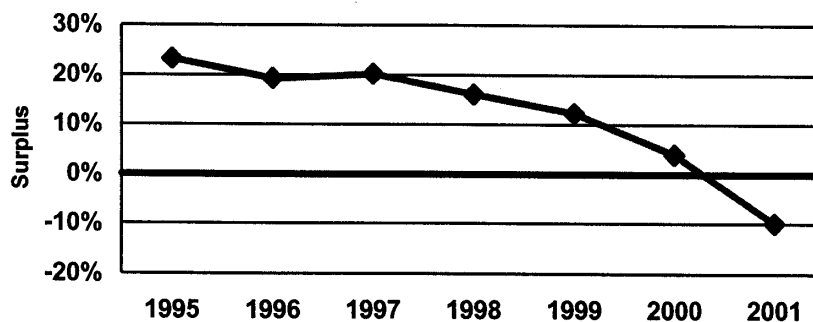
—*The Reinsurance Market Has Hardened.*—Reinsurers' experience deteriorated as their results were affected by increased claim severity and pricing changes earlier in the decade. Because reinsurers generally cover the higher layers of losses, their results are disproportionately influenced by increases in claim severity. This, coupled with the broadly tightened reinsurance market after Sept. 11, has caused reinsurers to raise rates substantially and tighten reinsurance terms for medical malpractice.

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

The Results

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

**CHART B: CALENDAR YEAR OPERATING RESULTS
TURN NEGATIVE**

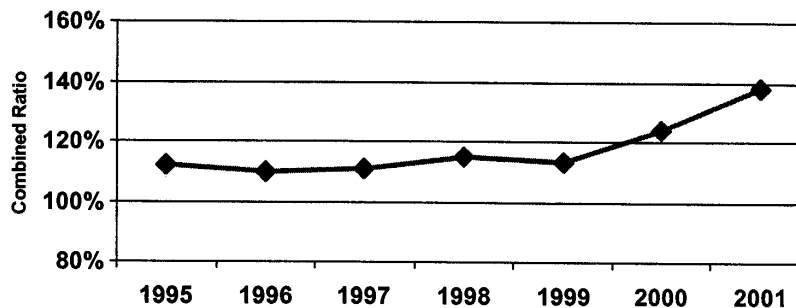


These insurers, achieving more favorable financial results than those of the total industry, showed a slight operating profit (four percent of premiums) in 2000. This deteriorated to a 10-percent operating loss in 2001 (see Chart B).

There are two key drivers of these financial results:

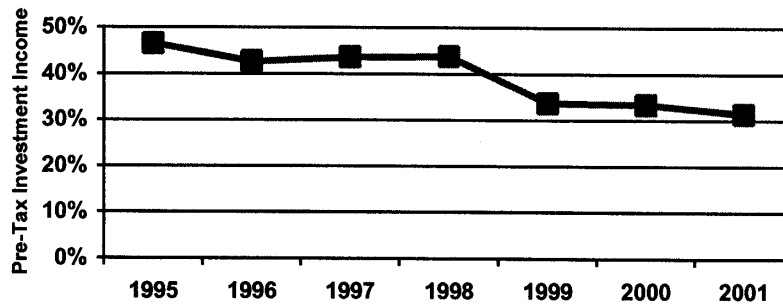
—*Insurance Underwriting.*—For these companies, a simplified combined ratio was calculated by dividing calendar year loss and loss adjustment and underwriting expenses by premium. The combined ratios were 124 percent and 138 percent in 2000 and 2001, respectively. That means in 2001, these insurers incurred \$1.38 in losses and expenses for each \$1.00 of premium. The preceding five years were fairly stable, from 110 percent to 115 percent. Deterioration of the loss and loss adjustment expense ratio drove these results; the underwriting expense ratio remained relatively constant (see Chart C).

CHART C: COMBINED RATIO



—*Investment Income.*—Pre-tax investment income (including realized capital gains and losses) derives from policyholder-supplied funds invested until losses are paid as well as from the company capital (“surplus”). The ability of investment income to offset some of the underwriting loss is measured as a percentage of earned premiums. This statistic declined during the measurement period from the mid-40 percent to the mid-30 percent level and, in 2001, to 31 percent (see Chart D).

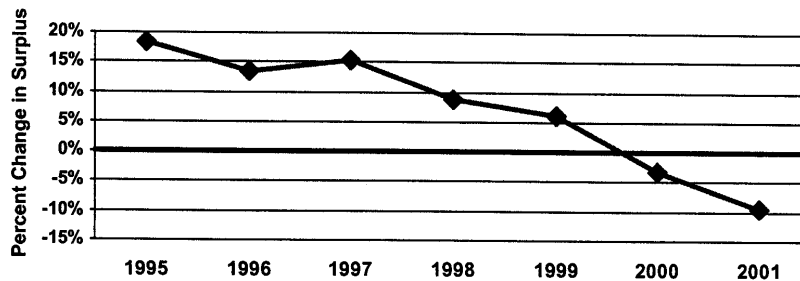
CHART D: INVESTMENT INCOME AS A PERCENTAGE OF PREMIUM DECLINES



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

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

CHART E: SURPLUS CHANGE TURNS NEGATIVE



THE RATEMAKING PROCESS

Ratemaking is the term used to describe the process by which companies determine what premium is indicated for a coverage. In the insurance transaction, the company assumes the financial risk associated with a future, contingent event in exchange for a fixed premium before it knows what the true cost of the event is, if any. The company must estimate those costs, determine a price for it and be willing to assume the risk that the costs may differ, perhaps substantially, from those estimates. A general principle of ratemaking is that the rate charged reflects the costs resulting from the policy and the income resulting from the anticipated policy covered losses, not what is actually paid or is going to be paid on past policies. It does not reflect money lost on old investments. In short, a rate is a reflection of future costs.

In general, the actuarial process used in making these estimations for medical malpractice insurance starts with historical loss experience for the specific coverage and, usually, for a specific jurisdiction. Rates are determined for this coverage, jurisdiction, and a fixed time period. To the appropriately projected loss experience, a company must incorporate consideration of all expenses, the time value of money

and an appropriate provision for risk and profit associated with the insurance transaction.

For a company already writing a credible volume of the coverage in a state, the indications of the adjusted ultimate loss experience can be compared to its current premiums to determine a change. For a company entering the line or state for the first time, obtaining credible data to determine a proper premium is often difficult and, sometimes, not possible. In the latter situation, the risk of being wrong is increased significantly.

Additionally, some lines of insurance coverage are more predictable than other lines. The unpredictability of coverage reflects its inherent risk characteristics. Most companies would agree that costs and, therefore, rates for automobile physical damage coverage, for example, are more predictable than for medical malpractice insurance because automobile insurance is relatively high frequency/low severity coverage compared to medical malpractice insurance. In the case of auto physical damage, one has a large number of similar claims for relatively small amounts that fall in a fairly narrow range. In medical malpractice insurance, one has a small number of unique claims that have a much higher average value and a significantly wider range of possible outcomes. There also is significantly longer delay for medical malpractice insurance between the occurrence of an event giving rise to a claim, the reporting of the claim, and the final disposition of the claim. This longer delay adds to the uncertainty inherent in projecting the ultimate value of losses, and consequently premiums.

The following guidelines explain the ratemaking process:

1. Historical loss experience is collected in coverage year detail for the last several years. This usually will include paid and outstanding losses and counts. The data is reviewed for reasonableness and consistency, and estimates of the ultimate value of the coverage-year loss are developed using actuarial techniques.

2. Ultimate losses are adjusted to the prospective level (i.e., the period for which rates are being made). This involves an appropriate adjustment for changes in average costs and claim frequencies (called trend). Adjustments also would be made for any changes in circumstances that may affect costs (e.g., if a coverage provision has been altered).

3. Adjusted ultimate losses are compared to premium (or doctor counts) to determine a loss ratio (or loss cost per doctor) for the prospective period.

4. Expenses associated with the business must be included. These are underwriting and general expenses (review of application, policy issuance, accounting, agent commission, premium tax, etc.) Other items to consider are the profit and contingency provision, reinsurance impact, and federal income tax.

5. A final major component of the ratemaking process is consideration of investment income. Typically for medical malpractice insurance, a payment pattern and anticipated prospective rate of return are used to estimate a credit against the otherwise indicated rate.

These five steps, applied in a detailed manner and supplemented by experienced judgment, are the standard roadmap followed in developing indicated rates. There are a number of other issues to address in establishing the final rates to charge. These include recognizing differences among territories within a state, limits of coverage, physician specialty, and others. The final rates will reflect supplemental studies of these various other aspects of the rate structure.

Many states have laws and regulations that govern how premium rates can be set and what elements can or must be included. The state regulators usually have the authority to regulate that insurance premium rates are not excessive, inadequate, or unfairly discriminatory. It is not uncommon for state insurance regulators to review the justification for premium rates in great detail and, if deemed necessary, to hold public hearings with expert testimony to examine the basis for the premium rates. In many states, the insurance regulator has some authority to restrict the premium rates that insurance companies can charge.

FREQUENT MISCONCEPTIONS

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

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

As we have pointed out, investment income plays an important role in the overall financial results of insurers, particularly for insurers of medical professional liability, because of the long delay between payment of premium and payment of losses. The vast majority of invested assets are fixed-income instruments. Generally, these are purchased in maturities that are reasonably consistent with the anticipated fu-

ture payment of claims. Losses from this portion of the invested asset base have been minimal, although the rate of return available has declined.

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

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

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

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

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

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

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

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

Senator SPECTER. Thank you very much, Mr. Hurley.

STATEMENT OF BRIAN HOLMES, M.D.

Senator SPECTER. Our next witness is Dr. Brian Holmes, neurosurgeon, who recently moved from Pennsylvania to join a physician's group based in Hagerstown, Maryland. He has an undergraduate degree from the University of Pennsylvania and medical degree from Pennsylvania State University College of Medicine.

Dr. Holmes, thank you for joining us. We look forward to your testimony.

Dr. HOLMES. Good morning, Mr. Chairman. My physician colleagues and I are grateful for this hearing and the opportunity to testify.

You began to outline my professional training and experience, and I just wanted to reiterate that after 4 years of college, 4 years of medical schools, and then 7 years of postgraduate training in neurological surgery, I accepted the position of assistant professor at the Penn State University College of Medicine, where I re-

mained for 4 years. I then moved on to Scranton, Pennsylvania, where I continued in private practice for 4 years.

I recently moved to Hagerstown, Maryland and joined a group there, and I have a limited practice in Chambersburg, Pennsylvania. I am certified by the American Board of Neurological Surgeons, and I currently hold the office of president of the Pennsylvania Neurosurgical Society.

In October of 2001, I received a letter from my liability insurance carrier stating that my insurance was being terminated effective December 31. When I inquired about that notification, I was told that that company was no longer writing policies for neurosurgeons in Pennsylvania. I found out at that time there was no option for liability insurance outside of the Joint Underwriters Association, a State-mandated organization.

Unfortunately, I could not get a precise quote for my premium at that time, but neurosurgeons in Philadelphia were paying JUA rates in excess of \$200,000. Therefore, I made arrangements to close my practice due to the potential of unaffordable insurance coverage. I canceled operations and appointments that had been scheduled, and made arrangements for the transfer of care for some patients. That transfer of care was difficult, because other neurosurgeons had left the State, and the delay for some patient appointments was up to 6 months.

On December 31, 2001, I was notified that my insurance would not be canceled. This notification came 9 hours before my practice was scheduled to close. I was never able to find a satisfactory explanation as to why this occurred. Nevertheless, I made arrangements to reopen my practice and attempt to minimize the interruption in medical care which fell upon some patients.

As the year 2002 unfolded, I saw other neurosurgeons in the State being assessed with very high premiums, premiums that literally exceeded their incomes. A gifted neurosurgeon specializing in spinal surgery at the Thomas Jefferson University was asked to pay a premium to the Joint Underwriters Association and CAT fund of over \$300,000. He moved to Indiana. Other neurosurgeons retired, or contemplated moving out of the State. I became very outspoken about the liability crisis in an attempt to bring it to the attention of my State legislators and the public.

Although I had a liability insurance policy in effect through the end of 2002, I was not confident that affordable insurance would be available for 2003. Therefore, I made the difficult decision to close my practice and move to Maryland. Unwillingly, I left the region in which I was born and raised, and expected to practice for many years. The professional liability insurance premium for a neurosurgeon in Hagerstown, Maryland, is approximately \$30,000 per year.

I was asked today to speak to give my story, but I believe this is really more a story about patients. I personally perform approximately 300 operations per year. Many are literally life-saving emergency procedures performed in circumstances where delay in treatment may determine the difference between recovery to productive existence versus disability or death.

I evaluate and treat by nonsurgical means maybe 2,000 patients per year. I had intended to practice neurosurgery in Scranton,

Pennsylvania, for another 20 years. My subtraction from that medical community has real consequences for thousands of patients.

The specialty of neurosurgery is numerically small. There are fewer than 3,500 neurosurgeons in the United States. Residency training programs graduate only about 130 neurosurgeons per year nationwide. It is therefore very difficult to recruit neurosurgeons to States where others have left. I had tried to recruit neurosurgeons to Scranton, and was told by potential candidates that other States were preferred due to a more stable liability insurance climate.

The implications for patients are profound. Trauma centers have strict criteria for on-call coverage by board-certified neurosurgeons and are being threatened. Each week now, I evaluate or perform surgery on patients who drive 200 miles from northeastern Pennsylvania to my practice based in Maryland.

I would like to say a few words about neurosurgery and claims of malpractice. Neurosurgeons treat many patients with critical or life-threatening illness such as brain tumors, brain hemorrhage and spinal cord injury. The natural history of many of these disease processes results in some unfavorable outcomes such as disability, chronic pain, or death. That is why neurosurgery is classified as a high risk specialty.

An unfavorable outcome may be due to the natural history of the disease, but patients often hold their physician accountable. The best data that I can derive from my peers in organized neurosurgery is that a neurosurgeon may expect to have a claim filed against him every 1½ years. The result is that most neurosurgeons have some outstanding claims. The majority are decided in favor of the physician. Unfortunately, the process of bringing a claim to closure takes several years. A claims history, which is almost inevitable in my specialty, amplifies the difficulty of obtaining affordable professional liability insurance in some States.

PREPARED STATEMENT

In summary, I would say that as a surgeon and as a physician I am motivated by a sincere concern for patients, and physicians overall are troubled that our ability to promptly deliver high quality medical care to patients is threatened.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF DR. BRIAN HOLMES

I am Brian Holmes. I am a neurosurgeon that recently moved from Pennsylvania to join a physician group based in Hagerstown, Maryland. I had been in practice in Scranton, Pennsylvania for four years.

I will briefly outline my professional training and experience. I received an undergraduate degree from the University of Pennsylvania. I received my medical degree from the Pennsylvania State University College of Medicine in Hershey. I completed a six-year residency training program in neurosurgery at the Dartmouth-Hitchcock Medical Center in New Hampshire and a one year post-graduate fellowship in Cranial Base and Cerebrovascular Surgery at the George Washington University Medical Center. I accepted the position of Assistant Professor at the Penn State University College of Medicine where I remained for four years. I then moved on to Scranton, Pennsylvania where I continued in private practice for four years. I now practice primarily in Hagerstown, Maryland with a limited practice in Chambersburg, Pennsylvania. I am certified by the American Board of Neurological Surgeons and I currently hold the office of President of the Pennsylvania Neurosurgical Society.

In October of 2001, I received a letter from my liability insurance carrier that my insurance was being terminated effective December 31, 2001. When I inquired about the notification, I was told that the company was no longer insuring neurosurgeons in Pennsylvania. I found out that at that time, there was no option for insurance outside of the Joint Underwriters Association, a state mandated organization. Unfortunately, I could not get a precise quote for my premium. Neurosurgeons in Philadelphia at that time were paying JUA rates in excess of \$200,000. Therefore, I made arrangements to close my practice due to the potential of unaffordable insurance coverage. I cancelled operations and appointments that had been scheduled and made arrangements for the transfer of care for some patients. That transfer of care was difficult because other neurosurgeons had left the state and the delay for patient appointments was up to six months.

On December 31, 2001 I was notified that my insurance would not be cancelled. This notification came nine hours before my practice was scheduled to close. I was never able to find a satisfactory explanation as to why this occurred. Nevertheless, I made arrangements to reopen my practice and attempt to minimize the interruption in medical care which fell upon some of my patients.

As the year 2002 unfolded, I saw other neurosurgeons in the state being assessed with very high premiums—premiums that literally exceeded their incomes. A gifted neurosurgeon specializing in spinal surgery at the Thomas Jefferson University was asked to pay a premium to the Joint Underwriters Association and CAT fund of over \$300,000. He moved to Indiana. Other neurosurgeons retired or contemplated moving out of the state. I became very outspoken about the liability crisis in an attempt to bring it to the attention of my legislators and the public.

Although I had a liability insurance policy in effect through the end of 2002, I was not confident that affordable insurance would be available for 2003. Therefore, I made the difficult decision to close my practice and move to Maryland. Unwillingly, I left the region in which I was born and raised and expected to practice for many years.

The professional liability insurance premium for a neurosurgeon in Hagerstown, Maryland is approximately \$30,000 per year.

I was asked to speak today to give "my story." However, I believe that this is really a story about patients.

I perform about three hundred operations per year. Many are literally life-saving emergency procedures performed in circumstances where a delay in treatment may determine the difference between recovery to a productive existence versus disability or death. I evaluate and treat by nonsurgical means about two thousand patients per year. I had intended to practice neurosurgery in Scranton for another twenty years. My subtraction from that medical community has real consequences for thousands of patients.

The specialty of neurosurgery is numerically small. There are fewer than 3,500 neurosurgeons in the United States. Residency training programs graduate only about 130 neurosurgeons per year. It is therefore very difficult to recruit neurosurgeons to states where others have left. I had tried to recruit neurosurgeons to Scranton and was told by many potential candidates that other states were preferred due to a more stable liability insurance climate. The implications for patients are profound. Trauma centers have strict criteria for on-call coverage by Board Certified neurosurgeons and are being threatened. The thousands of patients of the neurosurgeons that are leaving Pennsylvania are experiencing dramatic interruptions and delays in care. Each week, I evaluate or perform surgery on patients who drive almost 200 miles from Northeastern Pennsylvania to my practice based in Maryland.

I would like to say a few words about neurosurgery and claims of malpractice.

Neurosurgeons treat many patients with critical or life-threatening illness such as brain tumors, brain hemorrhage, and spinal cord injury. The natural history of many of these disease processes results in some unfavorable outcomes such as disability, chronic pain, or death. This is why neurosurgery is classified as a "high risk specialty." An unfavorable outcome may be due to the natural history of the disease, but patients often hold their physician accountable. The best data that I can derive from my peers and organized neurosurgery is that a neurosurgeon may expect to have a claim filed against him or her every one and one half years. The result is that most neurosurgeons have some outstanding claims. The majority of claims are decided in favor of the physician. Unfortunately, the process of bringing a claim to closure takes several years. A "claims history," which is almost inevitable in my specialty, amplifies the difficulty of obtaining affordable professional liability insurance in some states.

After almost nine years of practice and seven years of residency and fellowship training in neurosurgery, I am named as a primary defendant in one claim. Two

other claims were filed but dropped before a written complaint was ever generated. I believe that the legal term for this process is “non pros.” I use the term, “frivolous.” Because I was a treating physician in two other cases, I am named on a list of co-defendants. I have never settled a claim or had a jury award decided against me. As a participant in the current discussion I feel that it is important to bring these facts forward.

I would like to close by describing to you what is really second nature to me.

I am motivated as a physician by my deep respect for patients. I have studied and worked intensively through over a decade of formal medical and neurosurgical training. I spend countless hours reading and participating in continuing medical education to maintain and improve my skills as a neurosurgeon. I spend many hours of personal time contemplating patients and nuances of their care. Physicians labor to make patients’ lives longer and better because we care deeply about them. We are troubled that our ability to promptly deliver high-quality medical care to patients is threatened.

I am grateful to you for giving me the opportunity to participate in this discussion today.

Thank you.

Senator SPECTER. Thank you very much, Dr. Holmes.

STATEMENT OF LINDA MCDUGAL, WOODVILLE, WI

Senator SPECTER. We now turn to Ms. Linda McDougal, a U.S. Navy veteran, an accountant, married, family in Woodville, WI, three sons, and Ms. McDougal had a medical procedure that she will testify about.

Thank you for joining us, Ms. McDougal. The floor is yours.

Ms. MCDUGAL. Thank you, Chairman Specter. I greatly appreciate the opportunity you have given me.

I am a victim of medical malpractice. I am 46 years old. I live with my husband and three sons in Woodville, a small community in Wisconsin. My husband and I are both veterans. This is my story.

About 9 months ago, in preparation for an annual physical, I went to the hospital for a routine mammogram. I was called back for additional testing and had a needle biopsy. Within a day, I was told that I had breast cancer. We made the difficult, life-changing decision to undergo what we believed was the safest long-term treatment, a double mastectomy, the total removal of both of my breasts.

Forty-eight hours after surgery, the surgeon walked into my room and said, I have bad news for you. You do not have cancer. I never had cancer. My breasts were needlessly removed. The pathologist switched my biopsy slides and paperwork with someone else’s. Unbelievably, I was given another woman’s results.

How could the doctors have made this awful mistake? The hospital called my case an isolated incident. Since then, other cases within the same pathology lab in the same hospital have been found. On February 4, the Minnesota Department of Health made an unannounced visit to the hospital and found that my case had not even been documented and reported, a violation of State statutes. I think that doctors do a bad job of governing themselves.

It has been very difficult for me to deal with this. My scars are not only physical, but emotional. After my breasts were removed, I developed raging infections, requiring emergency surgery. Because of my ongoing infections, I am still unable to have reconstructive surgery. I do not know whether I will ever be able to have anything that ever resembles breasts again.

After I came forward publicly with my story, I was told that one of the pathologists had a 10-year exemplary performance record, and that she would not be reprimanded or punished in any way until a second incident occurred. Should someone else have to suffer or even die before any kind of disciplinary action is taken?

Well, there are no easy answers. Apparently now the insurance industry is telling Congress it knows exactly how to fix what it believes to be the problem caused by malpractice, by limiting the rights of people like me, who have suffered permanent life-altering injuries. Why, even doctors have collectively refused to serve clients in order to gain leverage with the legislature.

Arbitrarily limiting victims' compensation is wrong. Malpractice victims that may never be able to work again and may need help for the rest of their lives should be fairly compensated for their suffering. Without fair compensation, a terrible financial burden is placed on their families.

Those who would limit compensation for life-altering injuries say that malpractice victims still would be compensated for not being able to work, meaning they would be compensated for economic loss. Well, I did not have any significant economic loss. My lost wages were approximately \$8,000, and my medical expenses to date are \$48,000. My disfigurement from medical negligence is almost entirely noneconomic.

As you discuss and debate this issue, I urge you to remember that no two people, no two injuries, and no two personal situations are identical. It is unfair to suggest that all victims should be limited to this one-size-fits-all arbitrary cap that benefits the insurance industry at the expense of patients.

I am a veteran, and I see that patriotism requires an honest recognition of our rights as defined in the Constitution, a foundation that our forefathers fought for, and what I thought we today continue to defend. Victims have a right to have their cases decided by a jury that listens to the facts of a specific case and makes a determination of what is fair compensation based on the facts of that case.

I could never have predicted or imagined in my worst nightmare that I would end up having both of my breasts needlessly removed because of a medical error. No one plans on being a victim of medical malpractice, but it happened, and now proposals are being discussed that would further hurt people like me, all for the sake of helping the insurance industry. It would place negligent or incompetent physicians outside the reach of judicial accountability.

I am not asking for sympathy. What happened to me may happen to you or someone you love, and when it does, maybe you will understand why I am telling my story. The rights of every injured patient in America are at stake, limiting victims' compensation in malpractice cases who have been hurt, who have suffered life-altering injuries like loss of limbs, blindness, brain damage, or even affected with the loss of a child or spouse.

Instead of taking compensation away from people who have been hurt and putting it in the pockets of the insurance industry, we should look for ways to improve the quality of health care service in our country to prevent medical errors like the one that cost me my breasts, part of my sexuality and part of who I am as a woman.

PREPARED STATEMENT

Medical malpractice kills as many as 98,000 Americans each year, and it permanently injures hundreds of thousands of others. We must make hospitals, doctors, HMOs, drug companies, and health insurers more accountable to patients. A good start would be to discipline health care providers who repeatedly commit malpractice. We should make their track records available to the general public. Limiting victims' compensation will not make health care safer or more affordable. All it will do is add to the burden of people whose lives have already been shattered. We should say no to this legislation.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF LINDA MCDUGAL

First, I want to thank Chairman Specter and Senator Harkin. I greatly appreciate the opportunity you have given me. My name is Linda McDougal and I am a victim of medical malpractice.

I am 46 years old. I live with my husband and sons in Woodville, a small community in northwestern Wisconsin. My husband and I are both veterans of the United States Navy. This is my story.

About 8 months ago, in preparation for my annual physical, I went to the hospital for a routine mammogram. I was called back for additional testing and had a needle biopsy. Within a day I was told that I had breast cancer.

My world was shattered. My husband and I discussed the treatment options and decided on the one that would give me the best chance of survival, and maximize my time alive with my family. We made the difficult, life-changing decision to undergo what we believed was the safest, long-term treatment—a double mastectomy.

Forty-Eight hours after my surgery, the surgeon walked in my room and said, "I have bad news for you. You don't have cancer."

I never had cancer. My breasts were needlessly removed. The pathologist switched my biopsy slides and paper work with someone else's. Unbelievably, I was given another woman's results.

I was in shock. My husband was with me in the room and we were reduced to tears. Today, I am still in shock. To some extent, it was easier to hear from the doctor that I supposedly had cancer, than to hear after both my breasts were taken from me the fact that I never had cancer. How could the doctors have made this awful mistake?

The medical profession betrayed the trust I had in them.

It's been very difficult for me to deal with this. My scars are not only physical, but emotional. After my breasts were removed, I developed raging infections requiring emergency surgery. Because of my ongoing infections, I am still unable to have reconstructive surgery. I don't know whether I will ever be able to have anything that will ever resemble breasts.

After I came forward publicly with my story, I was told that one of the pathologists involved had a ten-year exemplary performance record, and that she would not be reprimanded or punished in any way until a second "incident" occurred. Should someone else have to suffer or even die before any kind of disciplinary action is taken?

While there are no easy answers, apparently now the insurance industry is telling Congress it knows exactly how to fix what it believes to be the "problem" caused by malpractice by limiting the rights of people, like me, who have suffered permanent, life-altering injuries.

Arbitrarily limiting victims' compensation is wrong. Malpractice victims may never be able to work again and may need help for the rest of their lives should be fairly compensated for their suffering. Without fair compensation, a terrible financial burden is imposed on their families.

Those who would limit compensation for life-altering injuries say that malpractice victims still would be compensated for not being able to work. Meaning, they would be compensated for their economic loss. Well, I didn't have any significant economic loss. My lost wages were approximately \$8,000, and my hospital expenses of approximately \$48,000 were paid for by my health insurer. My disfigurement from medical negligence is almost entirely non-economic.

As you discuss and debate this issue, I urge you to remember that no two people, no two injuries, no two personal situations are identical. It is unfair to suggest that all victims should be limited to the same one-size-fits-all, arbitrary cap that benefits the insurance industry at the expense of patients. Victims deserve to have their cases decided by a jury that listens to the facts of a specific case and makes a determination of what is fair compensation based on the facts of that case.

Recently, I heard a politician on the news argue in favor of limiting patients' compensation. He said insurance companies need the predictability of knowing, in advance, the maximum amount they might have to pay to injured patients. He said lack of predictability makes it hard for insurance companies to run their businesses profitably. We'd all like to be able to count on the predictability that this politician wants for insurers. But life doesn't work that way. My case is a perfect example.

I could never have predicted or imagined in my worst nightmare that I would end up having both my breasts removed needlessly because of a medical error. No one plans on being a victim of medical malpractice. But it happened, and now, proposals are being discussed that would further hurt people like me . . . all for the sake of helping the insurance industry.

I'm not asking for sympathy. What happened to me may happen to you or someone you love. When it does, maybe you will understand why I am sharing my story. The rights of every injured patient in America are at stake. Limiting victims' compensation in malpractice cases puts the interests of the insurance industry ahead of patients who have been hurt, who have suffered life-altering injuries like loss of limbs, blindness, brain damage, infertility, sexual dysfunction, or loss of a child, spouse, or parent.

Instead of taking compensation away from people who have been hurt and putting it in the pockets of the insurance industry, we should look for ways to improve the quality of health care services in our country to reduce preventable medical errors like the one that cost me my breasts; part of my sexuality; part of who I am as a woman.

Medical malpractice kills as many as 98,000 Americans each year and it permanently injures hundreds of thousands of others. We must make hospitals, doctors, HMOs, drug companies and health insurers more accountable to patients. A good start would be to discipline health care providers who repeatedly commit malpractice. We should make the track records of individual health care providers available to the general public, instead of protecting bad doctors at the expense of unknowing patients.

Limiting victims' compensation will not make health care safer or more affordable. All it do is add to the burden of people whose lives have already been shattered by medical errors. Every patient should say no to any legislation that does not put patients first. I urge you to do the same.

Thank you for your time and consideration.

Senator SPECTER. Thank you very much, Ms. McDougal, for sharing your situation with us.

STATEMENT OF LEANNE DYESS, VICKSBURG, MS

Senator SPECTER. Our next and final witness is Leanne Dyess from Vicksburg, MS, a wife, mother of two, teacher for 20 years. Her husband was involved in a car accident last year and sustained a massive head injury, and because of medical liability costs no neurosurgeon was immediately available to treat her husband.

Thank you for joining us, Mrs. Dyess, and we look forward to your testimony.

Ms. DYESS. Thank you, Chairman Specter. It is an honor for me to sit here before you this morning to open up the life of my family in an attempt to demonstrate how medical liability costs are hurting people across America. While others may talk in terms of economics and policy today, I want to speak to you from the heart.

I want to share with you the life my two children and I are forced to live because of the crisis in health care that I believe can be fixed. This crisis is not about insurance, or doctors, or hospitals, or even personal injury lawyers. It is a crisis about individuals like

you and I, and their access to what I believe is otherwise the greatest health care in the world.

Our story began on July 5, when my husband, Tony, was returning from work in Gulfport, MS. We had started a new business. Tony was working hard, as I was. We were doing our best to build a life for our children, and their futures were filled with promise. Everything looked bright.

Then in an instant everything changed. Tony was involved in a single car accident. They suspect he fell asleep, though we will never know. What we do know is that after removing him from the car, they rushed him to Garden Park Hospital in Gulfport. He had head injuries and required immediate attention. Shortly thereafter, I received a telephone call I pray no other wife will ever have to receive. I was informed of the accident and told the injuries were serious, but I cannot describe to you the panic that gave way to hopelessness when they told me, we do not have the specialist necessary to take care of him. We will have to airlift him to another hospital.

I could not understand this. Gulfport is one of the fastest-growing, most prosperous regions in Mississippi. Garden Park is a good hospital. Where were the specialists that could have taken care of my husband?

Almost 6 hours passed before Tony was airlifted to University Medical Center, 6 hours for the damage to his brain to continue before they had a specialist capable of putting a shunt into the back of his head to relieve the pressure on the brain, 6 unforgettable hours that changed our life. Today, Tony is permanently brain-damaged. He is mentally incompetent, unable to care for himself, unable to provide for his children, unable to live the vibrant, active, and loving life he was living just moments before the accident.

I could share with you the panic of a woman suddenly forced into the role of both mother and father to her teenage children, of a woman whose life is suddenly caught in limbo, unable to move forward or backward. I could tell you about a woman who now had to worry about the constant care of her husband, who had to make concessions she never thought she would have to make in order to pay for his care and therapy, but to describe this would be to take us away from the most important point and value of what I have learned.

Mr. Chairman, I have learned that there was no specialist on staff that night in Gulfport because a rising medical liability cost had forced physicians in that community to abandon their practices. In that area, in that time, there was only one doctor who had the expertise to care for Tony, and he was forced to cover multiple hospitals, stretching him thin and unable to care for everyone. Another doctor had quit his practice just days before Tony was admitted because his insurance company terminated all of the medical liability policies nationwide. That doctor could not obtain affordable coverage. He could not practice. And that hot night in July, my husband and our family drew the short straw.

I have also learned that Mississippi is not unique to this crisis. It rages all across America, in Nevada, where young expectant mothers cannot find OB-GYNs, in Florida, where children cannot find pediatric neurosurgeons, and it rages in Pennsylvania, where

the elderly, who have come to depend on their orthopedic surgeons, are being told that those trusted doctors are moving to States where practicing medicine is affordable and less risky.

The real danger of this crisis is not readily seen. It is like termites in the structure of a home. They get into the woodwork, but you cannot see the damage. The walls of the house remain beautiful. You do not know what is going on just beneath the surface, at least not for a season, and then one day you go to hang a picture or a shelf and the whole wall comes down.

Before July 5 I was, like most Americans, completely unaware that just below the surface of our Nation's health care delivery system serious damage was being done through excessive and frivolous litigation, litigation that was forcing liability costs beyond the ability of doctors to pay. I heard about some of these frivolous cases and, of course, the awards that climbed into the hundreds of millions of dollars and, like most Americans, I shook my head. Someone has hit the lottery. But I never asked, at what cost? Who has to pay for those incredible awards?

It is a tragedy when a medical mistake results in a serious injury, but when that injury, often an accident or an oversight by an otherwise skilled physician, is compounded by a lottery-like award and that award, along with others, make it too expensive to practice medicine, there is a cost, and believe me, it is a terrible cost.

Like most Americans, I did not know the cost. I did not know the damage. You see, Mr. Chairman, it is not until it is your spouse that you need a specialist, or you are the expectant mother who needs the OB-GYN, or it is your child who needs a pediatric neurosurgeon that you realize the damage beneath the surface. From my perspective sitting here today, this problem far exceeds any other challenge facing America's health care today, even the challenge of the uninsured.

My family had insurance when Tony was injured. We had good insurance. What we did not have was a doctor, and now no money can relieve our pain and suffering, but knowing that others may not have to go through this, and what we have gone through, goes a long way in helping us heal.

PREPARED STATEMENT

Mr. Chairman, I know of your efforts to see America through this crisis, and I know it is important to you and important to the President. I know the priority Congress is placing on doing something, and doing something now. Today, I pledge to you my complete support. It is my prayer that no woman or anyone anywhere else will ever have to go through what I have gone through, and what I continue to go through every day with my two children and a husband I dearly love.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF LEANNE DYESS

Chairman Specter, Ranking Member Harkin, distinguished members of the Senate Appropriations Committee: It's an honor for me to sit before you this afternoon—to open up my life, and the life of my family, in an attempt to demonstrate how medical liability costs are hurting people all across America. While others may talk in terms of economics and policy today, I want to speak from the heart.

I want to share with you the life my two children and I are now forced to live because of a crisis in health care that I believe can be fixed. And when I leave and the lights turn off and the television cameras go away, I want you—and all America—to know one thing, and that is that this crisis is not about insurance. It's not about doctors, or hospitals, or even personal injury lawyers. It's a crisis about individuals and their access to what I believe is, otherwise, the greatest health care in the world.

Our story began on July 5 of last year, when my husband Tony was returning from work in Gulfport, Mississippi. We had started a new business. Tony was working hard, as was I. We were doing our best to build a life for our children, and their futures were filled with promise. Everything looked bright. Then, in an instant, it changed. Tony was involved in a single car accident. They suspect he may have fallen asleep, though we'll never know.

What we do know is that after removing him from the car, they rushed Tony to Garden Park hospital in Gulfport. He had head injuries and required immediate attention. Shortly thereafter, I received the telephone call that I pray no other wife will ever have to receive. I was informed of the accident and told that the injuries were serious. But I cannot describe to you the panic that gave way to hopelessness when they somberly said, "We don't have the specialist necessary to take care of him. We need to airlift him to another hospital."

I couldn't understand this. Gulfport is one of the fastest growing and most prosperous regions of Mississippi. Garden Park is a good hospital. Where, I wondered, was the specialist—the specialist who could have taken care of my husband?

Almost six hours passed before Tony was airlifted to the University Medical Center—six hours for the damage to his brain to continue before they had a specialist capable of putting a drain into his head to relieve the pressure on his brain—six unforgettable hours that changed our life.

Today Tony is permanently brain damaged. He is mentally incompetent, unable to care for himself—unable to provide for his children—unable to live the vibrant, active and loving life he was living only moments before his accident.

I could share with you the panic of a woman suddenly forced into the role of both mother and father to her teenage children—of a woman whose life is suddenly caught in limbo, unable to move forward or backward. I could tell you about a woman who now had to worry about the constant care of her husband, who had to make concessions she thought she'd never have to make to be able to pay for his therapy and care. But to describe this would be to take us away from the most important point and the value of what I learned.

Chairman Specter, I learned that there was no specialist on staff that night in Gulfport because rising medical liability costs had forced physicians in that community to abandon their practices. In that area, at that time, there was only one doctor who had the expertise to care for Tony and he was forced to cover multiple hospitals—stretched thin and unable to care for everyone. Another doctor quit his practice just days before Tony was admitted because his insurance company terminated all of the medical liability policies nationwide. That doctor could not obtain affordable coverage. He could not practice. And on that hot night in July, my husband and our family drew the short straw.

I have also learned that Mississippi is not unique, that this crisis rages in states all across America. It rages in Nevada, where young expectant mothers cannot find ob/gyns. It rages in Florida, where children cannot find pediatric neurosurgeons. And it rages in Pennsylvania, where the elderly who have come to depend on their orthopedic surgeons are being told that those trusted doctors are moving to states where practicing medicine is affordable and less risky.

The real danger of this crisis is that it is not readily seen. It's insidious, like termites in the structure of a home. They get into the woodwork, but you cannot see the damage. The walls of the house remain beautiful. You don't know what's going on just beneath the surface. At least not for a season. Then, one day you go to hang a picture or shelf and the whole wall comes down; everything is destroyed. Before July 5, I was like most Americans, completely unaware that just below the surface of our nation's health care delivery system, serious damage was being done by excessive and frivolous litigation—litigation that was forcing liability costs beyond the ability of doctors to pay. I had heard about some of the frivolous cases and, of course, the awards that climbed into the hundreds of millions of dollars. And like most Americans I shook my head and said, "Someone hit the lottery."

But I never asked, "At what cost?" I never asked, "Who has to pay for those incredible awards?" It is a tragedy when a medical mistake results in serious injury. But when that injury—often an accident or oversight by an otherwise skilled physician—is compounded by a lottery-like award, and that award along with others

make it too expensive to practice medicine, there is a cost. And believe me, it's a terrible cost to pay.

Like most Americans, I did not know the cost. I did not know the damage. You see, Mr. Chairman, it's not until your spouse needs a specialist, or you're the expectant mother who needs an ob/gyn, or it's your child who needs a pediatric neurosurgeon, that you realize the damage beneath the surface.

From my perspective, sitting here today, this problem far exceeds any other challenge facing America's health care—even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we didn't have was a doctor. And now, no amount of money can relieve our pain and suffering. But knowing that others may not have to go through what we've gone through could go a long way toward helping us heal.

Chairman SPECTER, I know of your efforts to see America through this crisis. I know this is important to you, and that it's important to the President. I know of the priority Congress is placing upon doing something . . . and doing it now. Today, I pledge to you my complete support. It is my prayer that no woman—or anyone else—anywhere will ever have to go through what I've gone through, and what I continue to go through every day with my two beautiful children and a husband I dearly love.

Senator SPECTER. Thank you very much, Mrs. Dyess. The situation that you characterize is obviously a very tragic one. I note that in the last year Mississippi did enact legislation capping non-economic damages, and limiting the issue on venue, but of course that reform came much too late in your husband's case.

Dr. McCombs, you started off with a comment about what is going on in Pennsylvania by way of changes in legislation, referring to what Governor Rendell has said in your testimony. There have been a number of changes on joint and several liability and on venues so that cases cannot all be brought in Philadelphia County. They have to be brought in the county where the incident occurred.

The issue of the caps is a very critical one, and the suggestion has been made, as I had mentioned earlier, of a certain category of cases like the one that Mrs. McDougal testified to about the double mastectomy. There is a concern about large verdicts in cases which do not warrant that, and I would be interested in your view as to having caps imposed at the national level.

Of course, Pennsylvania has a constitutional amendment prohibiting caps, which is the reason Pennsylvania cannot handle it as Mississippi handled it, by imposing caps on the State level, but what would you think if a precedent was followed like the one in Michigan, where damages are limited very sharply, except in a category of three matters, where there is death, serious impairment of bodily function, or permanent serious disfigurement, like Mrs. McDougal's case? What would your thinking on that be?

Dr. MCCOMBS. Mr. Chairman, first of all, let me congratulate your subcommittee on assembling such a powerful, moving, and representative collection of witnesses today.

Senator SPECTER. We tried to make it balanced so that every point of view would be heard. We face a very difficult legislative question here, and we are really trying to not only dig into the facts and find and analyze the complexities at many levels, but see really what we have to do to try to improve the situation.

Dr. MCCOMBS. We are very grateful for that.

Senator, I am not a lawyer, I am not an insurance expert, I am a surgeon. My colleagues and I support very strongly the provisions that are included in the Greenwood legislation, H.R. 5, which does include caps, as I understand it. There is a lot of controversy as

to just how that should be applied, and whether or not some provision for catastrophic, I think was the term, or—I cannot remember exactly, but exceptions to that.

The surgical community in Pennsylvania feels very strongly that the provisions that have already passed the legislature in Pennsylvania will help, although it will take a considerable amount of time for the effects of these to be seen, and ultimately we feel that caps will provide the balance that is going to be necessary to level the playing field, as I referred to earlier.

Senator SPECTER. Mr. Hurley, from the insurance point of view, I would be interested in your views as to the impact on limiting claims which are frivolous, where you would require a certification in advance and could hold the lawyers personally accountable if the suit had no basis, in the context that I referred to earlier, where the hearing last month said that while 70 percent of the cases were won, the insurance companies had tremendous costs. How far do you think the limitations on frivolous suits would go in providing some realistic relief to insurance costs?

Mr. HURLEY. Mr. Specter, I think that the changes that you are discussing, or the proposed changes that you are discussing to find some way—for example, certificates of merit and those types of things, we probably have some examples of those in various States. The individual States have put some provisions in place from time to time that may be similar. Maybe we can get some guidance from that.

But I think the insurance, the loss costs and the defense costs that insurance companies are dealing with would be obviously reduced by the fact that, if there was a provision in place that would stop claims from being filed and stop the expenditures that companies make, so that would be a savings that companies would reflect in their losses, and if losses go down, premiums go down, so there would be some savings if you could actually implement a provision that you would be assured would eliminate claims on which companies are spending moneys right now, yes.

Senator SPECTER. Mr. Angoff, as an insurance regulator, you testified that even though the number of cases and the payments went down, the insurance premiums went up, and you described the anomalous result. Do you know why that was, or have a view on it?

Mr. ANGOFF. Yes, I do, and this data is just from obviously Missouri. We only collect Missouri data. I do not know what the data is from other States, but in Missouri, claims went down, but because there was such a change in investment income, and because the cost of reinsurance went up so much, the overall costs of the insurers went up.

In malpractice insurance particularly, investment income is very, very important, because in malpractice insurance, unlike, let us say, homeowners insurance, insurers hold onto their premium income for a long time, 6 years in malpractice insurance, less than a year in homeowners, so investment income is very, very important.

So during the nineties, when the stock market was great, when interest rates were higher, the insurers made a lot on their investment income, they could cut rates. Today, when they are making

nothing on their investment income, it is exactly the opposite situation, so they have got to raise rates even if their payments decrease. If their payments decrease a little, but their investment income decreases a lot, they have got to raise their rates.

Senator SPECTER. Mr. Hurley, from an actuarial point of view, as you have analyzed what goes on with the insurance rates, to what extent is Mr. Angoff right, or is he totally wrong that the shifts in the investment markets have accounted for at least some, or if you can quantify, to what extent is the insurance company problem on raising rates?

Mr. HURLEY. I think, Mr. Specter, that Mr. Angoff is right to some point. Medical malpractice companies generally invest in bonds, fixed income instruments. They are not allowed to make up for past mistakes in investments. The ratemaking process, as mentioned in my testimony, is a forward-looking process.

When we evaluate what rates to charge, or when companies evaluate what rates to charge, they consider the time value of money, as was described, how long they are going to hold that money until such time as they make payments. They estimate what a reasonable rate of return is that they can make prospectively, and they will set rates accordingly.

When interest rates go down, as they have, that will put upward pressure on those rates in the absence of any other changes, so what Mr. Angoff has said to some degree is correct, but we cannot make up for past mistakes in investments, and the ratemaking process is a forward-looking process, but when interest rates go down, insurance rates will go up, because rates are made in contemplation of what investment income is going to be made prospectively.

Senator SPECTER. From a legislative point of view, we are trying to assess how to cure the problem, and we are trying to apportion how much of it is due to a variety of factors. It would be very difficult for the Federal Government to get involved in insurance regulation. I think that is the last thing you want to have come out of Washington, is more regulation and picking up another line.

This is sort of like the joint liability problem. Pennsylvania has eliminated joint and several liability, Dr. McCombs, so that it cannot all go to the deep pocket any more. It is a matter of proportional error, and now we are trying to find out what proportion of responsibility there is. Any ideas as to how we might deal, Mr. Hurley, with the insurance industry to deal with at least the portion of the problem attributed there?

Mr. HURLEY. Mr. Specter, I am not sure I understand what you are saying the problem is, as far as the insurance industry—

Senator SPECTER. Well, part of the difficulty as Mr. Angoff described it, and you agree, comes because of insurance investments. If we are going to create a new system, if we are going to legislate at the Federal level, how can we deal with that aspect of the problem, or can we deal with it?

Mr. HURLEY. I would like to clarify what I hear you interpreting, your interpretation of my prior answer. I did not imply that there is a problem in that reaction of the insurance industry to changes in interest rates.

The insurance industry is subject to regulation when it makes rates. They are reviewed at the State level in most jurisdictions, and those regulations require that the industry, when it sets rates, reflect investment income, so it must consider the time value of money when it sets rates, even in some States where the formula by which they do that is mandated, so they do consider that. When interest rates go down, then the rates must go up just to respond to that.

I am not sure whether I think there is a problem that needs intervention from the Federal level as far as the insurance industry is concerned. I am not suggesting that would happen or be necessary as far as interest income is concerned, so I do not know that I agree with the premise.

Senator SPECTER. Okay. Mr. Angoff, do you have any suggestion as to what might be done at the Federal level on the problem you identified?

Mr. ANGOFF. Yes, and I agree, Mr. Chairman, insurance is State-regulated. In general the Federal Government does not have much to do with it, but I do think that if Congress either repealed or narrowed the McCarran-Ferguson antitrust exemption, that could have an effect.

Senator SPECTER. How?

Mr. ANGOFF. Okay, particularly in view of—McCarran-Ferguson says, insurers are not subject to the antitrust laws except for boycott, coercion, and intimidation. What that means is, insurers are permitted to engage in anticompetitive activities, including agreeing on price, as long as it does not rise to the level of a boycott, of a total collective refusal to deal.

Now, when investment income is high, the antitrust exemption is irrelevant. Insurers compete like crazy to cut price, so the antitrust exemption is irrelevant, but when investment income is low and insurers need to raise their prices, the antitrust exemption allows them to raise their prices without fear.

Does that mean that they sit down in a smoke-filled room and agree on price? Not necessarily, but it does allow them to raise their prices collectively without the fear that companies in other industries have, so I think that that is one thing that Congress could do, and even if Congress did not want to go as far as repealing the exemption, I think it is very important for Congress to at least carve out a real boycott exception.

The Scalia opinion in the Hartford Fire case, which was the Supreme Court case growing out of the last insurance crisis, very, very narrowly interprets the boycott exception so there is almost now a blanket exemption from the antitrust laws for insurers, so I do think that there is something in the area of narrowing the McCarran-Ferguson antitrust exemption that would be productive for Congress to pursue.

Senator SPECTER. Dr. Holmes, this is a legal issue. It may be outside of your purview, but I would like to get your thinking on it. If we were to put caps on at the Federal level that would exclude this category of cases which has been excluded under somewhat analogous State law to exclude death, serious impairment of bodily function, or permanent serious disfigurement, how would you respond to that?

Dr. HOLMES. I would respond by saying that that definition may be so broad that the exception may become the rule, and I think that there may be cases where so-called egregious cases could fall outside of that standard cap, but I think the definition would have to be very narrow and very clearly defined.

Senator SPECTER. Well, what would you say to Mrs. McDougal's case? She has a classical case where there are no real economic damages, that the economic damages are a very small part of what is involved here, so if you say noneconomic to a double mastectomy, would you agree that that kind of a case ought to be outside of the cap?

Dr. HOLMES. Well, I would like to say to Mrs. McDougal thank you for coming, and I found your story very powerful.

Senator SPECTER. Dr. Holmes, I do not want to press you to answer that if you do not want to.

Dr. HOLMES. Oh, I am just trying to be kind.

I think we are just looking at a system with limited resources. If that were not the case, I would be happy to see a great deal of compensation to a patient such as Mrs. McDougal, but I am troubled by the fact, for example, in Pennsylvania we have 30,000 physicians, and these premiums are spread among those 30,000 physicians in order to pay out these awards, and it just reaches the point where those 30,000 premiums cannot cover a certain dollar amount.

The answer to your question is, within reason I think it is possible for certain cases to be deemed outside of that cap, but again, clearly defined.

Senator SPECTER. Ms. Dyess, you had a personal experience and tragedy here. The Mississippi law was changed, much too late to affect your situation. Do you think there ought to be exceptions to the \$250,000 or \$350,000 cap on noneconomic damages?

Ms. DYESS. In my particular case, what was passed in Mississippi would not have made us any difference, because I am not suing anybody. I do not have anybody to sue.

Senator SPECTER. Well, there might have been a doctor available had things been different in Mississippi.

Ms. DYESS. Say that last part again.

Senator SPECTER. Doctors might not have moved away, a neurosurgeon might have been available at the hospital where your husband was taken. That is the contention here, that if the system had been structured differently, doctors would not have moved away, as Dr. Holmes moved from Scranton to Hagerstown. He did not move too far from Pennsylvania. He can come back. He is pretty close to the border.

Ms. DYESS. Well, what we have to do is to work together. In your case, if something happened to you, I would want a doctor to be there. If Ms. McDougal needs further care for her injuries, I want there to be a doctor there. I want there to be medical assistance there for all of us, whatever it takes. Instead of taking care of a few, let us do what we can to take care of everybody.

Senator SPECTER. Well, that is certainly the goal. I agree with you on that, Ms. Dyess.

Dr. Berwick, you talked about a fair and reasonable compensation system, as you have testified. Do you have any suggestion as to what that would be?

Dr. BERWICK. I know its properties. At the moment, most injured patients never get compensated at all, and quite a proportion of the patients that do get compensated were not injured by negligence in a technical way, we have a maldistribution problem, not to mention the transactional costs of the system which bleed a tremendous amount of the money that changes hands away from the hands of the people like Mrs. McDougal who ought to get the money.

Fair and reasonable to me means that most of the money that changes hands goes to injured parties and that it is reliable, that a patient who is injured in the United States knows that they will be compensated. That is what fair would mean. Today, by that standard it is quite unfair.

Senator SPECTER. Dr. Berwick, this subcommittee has taken the lead, as you probably know, on increasing NIH funding from \$12 billion to \$27 billion, and when you talk about research, could we task NIH to do something here?

Dr. BERWICK. Absolutely, yes.

Senator SPECTER. I would be interested in your suggestions, if you would provide them in writing. In the Institute of Medicine you are right in the heart of that approach. If you would give us an idea, we intend to press for additional funds.

Dr. BERWICK. Mr. Chairman, may I make a comment in addition to the written answer to your question? The investment in research we are making in biotechnology, knowing what drug to give or what operation to do, is extraordinary. It is world-leading. We are way underinvested in understanding how to design systems to provide excellent system research that would make no more cases like Mrs. McDougal's occur. It is a scientific challenge with which we are not grappling. How can you make the pathology sequence 100 percent reliable? What is the design of that system? We know some of its properties, but we have not designed that system as a country.

Senator SPECTER. Well, if you give us some ideas on systems research, I would be really interested to know.

Dr. BERWICK. Thank you for the invitation.

Senator SPECTER. Because we have some sway, with all the money we are putting up there, if we have some good ideas.

Ms. McDougal, what is your thinking on all of these efforts? In light of what you hear with Ms. Dyess, Dr. Holmes moved away, all of the difficulties, do you think that if we excluded these egregious cases or catastrophic cases, death, double mastectomy, or serious impairment of bodily function, that there ought to be caps on other matters?

I am asking you for your feel of it, although this is not your area of expertise, obviously, but you have been very close to the system, and I would be interested in your thinking.

Ms. McDUGAL. I believe in the Constitution and my right to trial with a jury by my peers. I believe they need to hear the individual facts of a case and make a decision. We trust them to make decisions about death sentences or murder convictions, but yet we do not trust them to determine what a specific case is worth.

I know there are great costs associated with taking a case like mine, and I would have no recourse without an attorney. I do not think there is accountability for doctors. There are several components to it, but I do not believe to assign a cap—basically it takes away my rights that are awarded by the Constitution, that has been in effect over 215 years.

Senator SPECTER. Well, thank you very much, ladies and gentlemen. We are wrestling with the problem with lots of hearings, lots of studies. A lot of Senators are working on it. This is one of the most intensely studied questions that we have in Washington today, and I think the testimony which has been given here is very, very helpful, so thank you.

PREPARED STATEMENTS RECEIVED

We have received prepared statements from Senator Thad Cochran, the American Bar Association, the Alliance of Specialty Medicine, and the American College of Legal Medicine that will be placed in the hearing record.

[The statements follow:]

PREPARED STATEMENT OF SENATOR THAD COCHRAN

Mr. Chairman, thank you for holding this hearing on an issue that has seriously affected my state of Mississippi. Deputy Secretary Allen, thank you for joining us today to discuss this important issue. I also appreciated your visit to Mississippi last fall. I know you saw first hand some of the health care challenges we are facing. Your testimony today on behalf of the Department of Health and Human Services and the millions of Medicare and Medicaid beneficiaries you serve will be important for us to hear.

The issues of medical liability, affordability and access to health care, and insurance coverage are serious challenges in my state and across the country. We have had numerous examples in Mississippi of physicians who have retired, left the state, or simply could not practice for some period of time due to an inability to attain liability insurance.

Just last month, in my state over 530 physicians and 53 hospitals lost their malpractice coverage, and many could not find any replacement coverage. In Oxford, no internal medicine physician could find replacement coverage for weeks. They are now practicing again, but only with temporary coverage.

Another situation that I know the Deputy Secretary is familiar with is in Natchez, where a group of physicians have moved across the river to Louisiana. On the Mississippi Gulf Coast, a group of physicians walked out because of the increases in their liability premiums. My state faces some of the most dramatic health challenges in our nation and cannot afford a decrease in access to physicians and hospitals.

We realize the risk faced by insurers is spread across all states, and it affects physicians everywhere. If one state is in crisis, it has the potential to negatively affect many others. It is for these reasons that this issue has received national attention and requires serious consideration by the Congress.

LETTER FROM THE AMERICAN BAR ASSOCIATION

WASHINGTON, DC, *March 14, 2003.*

Re March 13, 2003, hearing on Medical Liability Insurance

Hon. ARLEN SPECTER,
*Chairman, Subcommittee on Labor, Health and Human Services, and Education,
Committee on Appropriations, U.S. Senate, Washington, DC.*

DEAR SENATOR SPECTER: On behalf of the American Bar Association ("ABA"), I would like to thank you for the opportunity to submit the ABA's views regarding medical professional liability, and we request that this letter be included in the record of the Subcommittee's March 13, 2003, hearing entitled, "Causes of the Medical Liability Insurance Crisis."

Insurance premiums in a number of areas are up significantly. A threshold question is “why?” The U.S. insurance market is intensely competitive, which has caused both dramatic increases and dramatic decreases in insurance rates over time. For example, competition caused insurance rates to be comparatively lower in the United States from 1979 through 1983 than in other countries. When increases occurred in the United States between 1984 and 1986, they appeared more dramatic because they occurred against the background of the prior artificially low rates.¹ That same cycle seems to be operating today.² The General Accounting Office is currently examining the reasons for—and the role insurance companies have played in—rate increases.

For over 200 years, the authority to promulgate medical liability laws has rested with the states. This system, which allows each state autonomy to regulate the resolution of medical liability actions within its borders, is a hallmark of our American justice system. Because of the role they have played, the states are the repositories of experience and expertise in these matters. Legislation such as S. 607 would preempt portions of the state medical and product liability laws, and, therefore, the ABA opposes enactment of S. 607.

In addition to the policy reasons why this long- and effectively-functioning liability system should not be altered by the U.S. Congress, it should be noted that the constitutionality of the amendment will surely be challenged based on constitutional separation-of-powers grounds. The Supreme Court, in the recent decisions of *Pegram et al. v. Herdrich*, 120 S.Ct. 2143 (2000), and *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2002), continued to recognize that it is appropriate for the states to handle health accountability matters because health care is an area traditionally left to the states to regulate.

Currently, states have the opportunity to enact and amend their tort laws, and the system functions well. Congress should not substitute its judgement for the systems which have thoughtfully evolved in each state over time. To do so would limit the ability of a patient who has been injured by medical malpractice to receive the compensation he or she deserves. This is especially problematic since such a patient already is in a very difficult position.

When a car is hit by another car that has run a red light, it is relatively easy to know what caused the accident. But when, by way of example, a surgery patient wakes up to an unexpected bad outcome, he or she cannot possibly comprehend the cause. Those in the position to know what caused the bad outcome are the medical professionals. Because patients lack the necessary information, they often must file a claim to determine what happened. If it is without merit, it is in the patient’s own interest to drop the claim, and thus many claims are dropped once the patient finds out the facts. And contrary to what some believe, juries do not favor plaintiffs over doctors in medical malpractice cases. Duke University School of Law Professor Neil Vidmar’s extensive study of juries found that:

“[o]n balance, there is no empirical support for the propositions that juries are biased against doctors or that they are prone to ignore legal and medical standards in order to decide in favor of plaintiffs with severe injuries. This evidence in fact indicates that there is reasonable concordance between jury verdicts and doctors’ ratings of negligence. On balance, juries may have a slight bias in favor of doctors.”

See *Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets, and Outrageous Damage Awards*, University of Michigan Press at page 182 (1995).

In addition, he concludes at page 259 of his book that research “does not support the widely made claims that jury damage awards are based on the depth of the defendants’ pockets, sympathies for plaintiffs, caprice, or excessive generosity.” A survey of studies in the area by University of Missouri-Columbia Law Professor, Philip Peters, Jr. published in March 2002 likewise found that:

“[t]here is simply no evidence that juries are prejudiced against physician defendants or that their verdicts are distorted by their sympathy for injured plaintiffs. Instead, the existing evidence strongly indicates that jurors begin their task harboring sympathy for the defendant physician and skepticism about the plaintiff.”

¹See Werner Pfennigstorf & Donald G. Gifford, *A Comparative Study of Liability Law and Compensation Schemes in Ten Countries and the United States*, 159 (Donald G. Gifford & William M. Richman, eds., commissioned by the Insurance Research Council) (1991).

²See Edward Wasserman, “Blaming the Victim: Why are Liability Insurance Rates Soaring Again?”, *Miami Herald*, December 30, 2002; Zimmerman, Rachel and Oster, Christopher, “Insurers’ Price Wars Contributed to Doctors Facing Soaring Costs,” *Wall Street Journal*, June 24, 2002.

See Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 Iowa L. Rev. 934 (2002).

The ABA also opposes caps on pain and suffering awards. Those affected by caps on damages are the patients who have been most severely injured by the negligence of others. No one has stated that their pain and suffering injuries are not real or severe. These patients should not be told that, due to an arbitrary limit, they will be deprived of the compensation they need to carry on.

Thank you for the opportunity to present our views on this issue.

Sincerely,

ROBERT D. EVANS.

PREPARED STATEMENT OF THE ALLIANCE OF SPECIALTY MEDICINE

CAUSES OF THE MEDICAL LIABILITY INSURANCE CRISIS

Chairman Specter, and Members of the Subcommittee, the Alliance of Specialty Medicine, a coalition of 13 medical organizations representing over 160,000 specialty care physicians in the United States, thanks you for holding this hearing and appreciates the opportunity to comment on the causes of the medical liability insurance system and the impact that our current medical litigation system is having on patient access to medical care, which necessitates the immediate need to enact federal medical liability reform legislation. While our nation is facing myriad problems with various other elements of our health care system, none is as pressing and immediate as the current medical liability crisis.

And it is a crisis. The media now report on a daily basis that the situation has become so critical that many physicians are forced to limit services, move to other states where the medical liability system is more stable, or retire altogether. Much of the "face" of this crisis has centered around the great difficulties that pregnant women are having in finding obstetricians to deliver their babies, but the simple truth is that this is a problem that potentially affects all of our citizens: the mother whose little boy has fallen off of the jungle gym and needs an orthopaedic surgeon to fix his broken arm; the teenager who has been in a serious car accident and needs a neurosurgeon to treat his severe head injury; the woman who needs a pathologist to evaluate her Pap smear to screen for cervical cancer; the elderly man who has a poor heart and needs a cardiologist or cardio-thoracic surgeon to unblock a clogged artery or replace a failing valve; the woman who has a family history of breast cancer and needs a radiologist to perform a mammography to make sure she is cancer free; the business man who needs a gastroenterologist to treat his ulcer; the man who needs a urologist to screen for prostate cancer; and the list goes on and on.

CAUSE OF THE CRISIS: THE CURRENT MEDICAL LITIGATION SYSTEM IS OUT OF CONTROL

The root cause of this problem is quite simple: the unrestrained escalation of jury awards and settlements, in even a small number of medical liability cases, is driving up doctors' liability insurance premiums and is forcing some insurance companies out of business altogether. This problem is making it difficult, and sometimes impossible, for doctors to obtain affordable liability insurance so they can remain in practice. Adding to this is the fact that doctors distrust and fear the medical litigation system, causing them to alter the way they deliver medical care to their patients, and in some cases this fear is causing doctors to cease practicing altogether. There is a wide body of evidence to substantiate these conclusions:

Medical Liability Awards are On the Rise

Medical liability awards have been growing steadily, and according to Jury Verdict Research data, from 1994 to 2000 the median jury award rose by 176 percent. The number of mega-verdicts is also on the rise, with the proportion of million dollar plus awards increasing dramatically over this same time period. In 1996, 34 percent of all jury awards exceeded \$1 million. Four years later, the number of million dollar awards increased to 52 percent, and the average jury award in 2000 was nearly \$3.5 million.

Medical Liability Insurance Premiums are Skyrocketing

It is clear that the increasing number of multi-million dollar jury awards is driving up the costs of medical liability insurance and insurance companies are now paying out approximately \$1.40 for every premium dollar collected. Obviously, this is not sustainable, and this trend is therefore forcing insurance companies, which must set their rates based on anticipated future losses, to steeply increase doctors'

medical liability premiums to ensure adequate reserves to pay future judgments. As a result, over the past several years, physicians across the country have faced double, and sometimes triple, digit rate increases. Alliance members, including high-risk specialists like neurosurgeons, orthopaedic surgeons and emergency physicians, have been disproportionately affected by these premium increases. For example:

- According to a national survey of neurosurgeons, between 2000 and 2002 the national average premium increase was 63 percent, from \$44,493 to \$72,682. In some states, neurosurgeons are now paying medical liability insurance premiums in excess of \$300,000 per year.
- Utah orthopaedic surgeons have seen medical liability rate increases of 60 percent since last year and in Texas they are rising by more than 50 percent. In Pennsylvania, a survey conducted in June 2002 revealed rate increases as high as 59 percent. In other areas of the country, orthopaedic surgeons are finding that their premiums have risen by over 100 percent, even if they have never had a claim filed against them.
- Over the past several years, over 95 percent of emergency medicine physicians have experienced medical liability premium increases, with approximately 69 percent facing increases between 60 to 500 percent. This is attributed to the fact that emergency medicine physicians are almost always named in any litigation that arises from a patient encounter that begins in the emergency department. Since most hospital admissions now come through the emergency department, these doctors are experiencing steep premium rises even though the lawsuits against them may have no merit and result in either dismissal or a defendant's verdict.
- Even those specialists who are not in high-risk categories are affected by this upward trend in premium costs. For example, 80 percent of recently surveyed dermatologists reported that their premiums increased last year and those dermatologists who were insured by a state plan were paying nearly double what their colleagues were paying in the private market.

Medical Liability Insurance is Unavailable

Not only are medical liability insurance premiums rising at astronomical rates, but many doctors are also finding it increasingly difficult to obtain medical liability insurance at any price. Citing the increases in liability losses, several companies, including, St. Paul, MIXX, PHICO, Frontier Insurance Group and Doctors Insurance Reciprocal, have recently stopped selling medical liability insurance or have gone out of business, leaving thousands of doctors scrambling to find replacement coverage. Of the companies that have remained in the market, many are no longer renewing insurance coverage for existing policyholders and/or they are not issuing new insurance policies to new customers. This is particularly true in states that have no effective medical liability reform laws in place, where, for instance, in Mississippi fifteen insurers have left the market in the past five years. Alliance members have witnessed the impact of this problem first hand. For example:

- In 2002, nearly 40 percent of orthopaedic surgeons in Pennsylvania were not able to renew their medical liability coverage with the same carrier and 31 percent did not find new coverage. Close to 50 percent of Pennsylvania orthopaedic surgeons have reported that their liability policies will not be renewed for 2003.
- In 2002, 15 percent of dermatologists experienced difficulties securing their liability insurance. In some cases, dermatologists in solo practice who have never even been sued were forced to turn to the state for coverage because the remaining insurers in their area made a blanket decision to no longer insure solo practice physicians, regardless of specialty.
- Today in Mississippi, the only way a neurosurgeon can even be considered for coverage is if he or she joins an existing group that already is covered by the state medical society's insurance company. The other two companies providing insurance coverage in Mississippi will not issue new policies for neurosurgeons at all. In addition, neurosurgeons in Florida have been unable to obtain medical liability insurance at any cost, forcing them to "go bare" or self-insure.
- Recently one internationally-recognized pathologist, who has never had a claim filed against him, was turned down by three insurers and a fourth offered him a policy that was simply too expensive.
- Three of four insurance carriers with the largest market share in Missouri have stopped writing policies in that state. This means that physicians can often obtain a quote from only one company. For example, one group of 12 cardiologists could get only one quote with an 80 percent increase for 2003.

Medical Litigation System Breeds Fear in Doctors

Given the litigious nature of our society, every physician faces the reality that he or she may at some time be named in a medical liability lawsuit, whether meritorious or not, and the current medical litigation system breeds fear in all doctors. This fear of litigation, particularly among high-risk specialists, is a contributing factor in doctors' decisions to change the way in which they are practicing medicine. Data from a 2002 Harris Interactive study conducted for the Common Good, a bipartisan legal reform organization, validates this point. According to the data, nearly all physicians feel that unnecessary care is provided because of fear about litigation. To protect themselves in the event that they might be sued:

- 91 percent of doctors are ordering more tests than are medically needed;
- 85 percent of doctors refer patients to specialists more often than is necessary; and
- 73 percent of doctors suggest that patients have invasive procedures to confirm medical diagnoses

The report aptly concludes: "From the increased ordering of tests, medications, referrals, and procedures to increased paperwork and reluctance to offer off-duty medical assistance, the impact of the fear of litigation is far-reaching and profound."

RESULT OF THE CRISIS: PATIENT ACCESS TO MEDICAL CARE IS IN JEOPARDY

There are many casualties of the current medical liability crisis—but those affected the most are patients. Because the medical litigation system is broken, across the nation patients are finding it harder and harder to get access to the care they need, when they need it. As medical liability insurance becomes unaffordable or unavailable, more and more doctors, especially specialists, are no longer performing high-risk procedures, or they are being forced to move their practices to states with stable medical liability systems, or they are simply retiring from medical practice—all of which seriously impede patient access to care. Once gone, these doctors are hard to replace, and those states currently facing a medical liability crisis are having a difficult time recruiting new physicians to their communities adding to the shortage of doctors in many parts of the country. The combination of these factors is also now severely straining our nation's already stressed emergency medical system, as patients who have no access to doctors inevitably end up on the emergency department's doorsteps, further exacerbating the hospital emergency department overcrowding problem. A growing list of examples demonstrates just how serious this crisis is becoming:

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

According to a nationwide survey conducted last year, 43 percent of neurosurgeons reported that they are no longer performing high-risk surgery such as treating brain aneurysms, removing brain and spinal tumors, or complex spinal surgery. In addition, many neurosurgeons are no longer serving on-call to hospital emergency departments or operating on children.

A recent survey found that 55 percent of orthopaedic surgeons nationwide have reduced the type of operational procedures they perform, with 39 percent avoiding performing spine surgery and 48 percent altering their practice in other ways, including eliminating emergency room call or trauma call.

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

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

In the case of neurosurgery, in 2001 alone, 327 board certified neurosurgeons retired, representing an alarming 10 percent of the neurosurgical workforce in the United States. Recently, the only neurosurgeon practicing at Cottonwood Hospital in Salt Lake City, Utah quit practicing following a steep insurance premium increase.

Recent press accounts are replete with stories about the closure of trauma centers in Pennsylvania, West Virginia, Nevada, Mississippi, Missouri and Florida because of a shortage of orthopaedic surgeons, neurosurgeons and other specialists available to provide emergency medical care. Chicago's trauma centers are also now vulnerable to closing or downgrading their status.

- In the last 18 months, nearly 700 mammography facilities have closed nationwide. The continued and steady closing of mammography facilities throughout the country has led to increased waiting times for women seeking both screening mammograms and diagnostic mammograms. The longer waiting times are

now on the brink of affecting clinical outcomes for those women who must wait for a possible diagnosis of breast cancer.

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

Every state that is experiencing a medical liability crisis reports that doctors are leaving in droves in search of another location in which to practice where the medical litigation climate is more favorable. The list of states experiencing the exodus of doctors continues to grow, and as with other elements of this crisis, specialists are most likely to “hit the road” in search of a safe haven state. For instance:

- Pennsylvania has been especially hard hit, and some counties no longer have any practicing orthopaedic surgeons. For example, Bedford County’s only orthopaedic surgeon left the state in October 2001, and Pike and Monroe Counties are down from nine to five orthopaedic surgeons. Huntingdon County has just one orthopaedic surgeon remaining to take trauma call at two hospitals. The situation is the same in West Virginia, and a number of orthopaedic surgeons either have left the state or are scaling back their practices. At the end of 2002, five orthopaedic surgeons in Parkersburg moved their practice to Ohio.
- Neurosurgery’s survey data show that nearly 19 percent of practicing neurosurgeons either plan to, or are considering, moving their practice to another state where the medical liability costs are relatively stable. Mississippi, for instance, has lost 35 percent of its neurosurgeons in the past two years, and the flight of neurosurgeons from Pennsylvania and West Virginia mirrors the Mississippi experience.

The State of America’s Health Now and in the Future is at Risk

The combination of all the above factors is clearly placing the health of our nation’s citizens at considerable risk. Because of the medical liability crisis, more and more people are finding it difficult to get the specialized medical attention they need, when they need it. This is causing a national health care emergency. Thus:

- When patients can’t find a specialist close to home, they must sometimes travel great distances, often going out of state, to get their medical care.
- When fewer specialists are available, hospital emergency departments and trauma centers must shut their doors, and patients with emergency medical conditions lose critical life-saving time searching for an available emergency room.
- When specialists stop performing high-risk medical services, patients are often referred to academic medical centers, and these medical facilities are already overburdened and are ill equipped to handle the increase in patient volume.
- When specialists retire at an early age, the looming shortage of doctors is accelerated, which, if left unchecked will place additional burdens on the health care system as the population ages and requires more medical care from an increasingly shrinking pool of practicing doctors.
- When the practice of medicine becomes so uninviting, fewer and fewer of our nation’s best and brightest will want to become doctors, thus jeopardizing our country’s status as one of the finest health care systems in the world.

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

Those who oppose federal legislation to address this crisis cite various reasons to support their contention that this is not a national problem that merits a federal solution. In particular, they note that the regulation of insurance and health care are generally state issues, and therefore principles of Federalism preclude federal legislation to address this problem. They are, however, wrong. The undisputed truth is that this problem now touches nearly every American and a federal solution is therefore a national imperative. As the following demonstrate:

Nearly All States are Facing a Medical Liability Crisis

The AMA has identified 12 states that are in a medical liability crisis for all physicians. These include: Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia. However, for many high-risk specialties, like neurosurgery and orthopaedic surgery, the situation is even more widespread than the AMA reports. A 2002 national survey of neurosurgeons identified 25 states that are in a severe medical liability crisis, with an additional 12 states in potential crisis. In addition to those identified by the AMA, the crisis states for neurosurgery include: Alabama, Arkansas, District of Columbia, Illinois, Kentucky, Missouri, New Hampshire, North Carolina, South Carolina, Rhode Island, Tennessee, Utah and Virginia.

Every American Pays for the Costs of the Current Medical Litigation System

According to the U.S. Department of Health and Human Services (HHS), in its report entitled, “Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System,” the current medical litigation system imposes enormous direct and indirect costs on the health care system. These costs are passed on to all Americans in the form of increased health insurance premiums, higher out-of-pocket medical expenses and higher taxes. The report estimates that enacting federal medical liability legislation could save between \$60–108 billion in health care costs each year. These savings would in turn lower the cost of health insurance and make health care more affordable and available to many more Americans.

Federal Medical Liability Reform Will Save the Federal Government Money

Each year, the Federal Government pays for the increased costs associated with the current medical litigation system through various health care programs, including Medicare, Medicaid, Community Health Centers and other health care programs for veterans and members of the armed forces. The Department of Health and Human Services estimates that the direct cost of medical liability insurance coverage and the indirect cost of defensive medicine, increases the Federal Government’s costs of these health programs by \$28.6 to \$47.5 billion each year. In the above referenced report, HHS estimates that if reasonable limits were placed on non-economic damages, it would reduce Federal Government spending by \$25.3 to \$44.3 billion per year. The Congressional Budget Office (CBO), in its cost estimate of H.R. 4600, the HEALTH Act of 2002, confirms that passage of federal medical liability reform legislation that includes a cap on non-economic damages will increase federal tax revenues, and at the same time reduce the costs of federal health care programs.

States Face Significant Barriers to Implementing Medical Liability Reforms

Many states face barriers—some legal and some political—to enacting effective medical liability reform laws. Some states, including Texas, Florida, Ohio and Pennsylvania, have enacted medical liability reform laws, only to have their state Supreme Courts strike them down as unconstitutional. New laws passed by Mississippi and Nevada face certain court challenge, and it will be years before it is determined whether these laws pass state constitutional muster. Finally, in some other states, the issue has become a political one, effectively killing any chances for passage. As a consequence, despite the increasing medical liability crisis in many of these states, they are effectively powerless to act to effectively solve the problem.

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

Fortunately, Congress does not need to start from scratch and identify and implement a solution that is untested. Faced with a similar crisis in the early 1970’s, the state of California, with bipartisan support, enacted the Medical Injury Compensation Reform Act or MICRA. The key elements of MICRA include:

- Providing full compensation for all economic damages, including medical bills, lost wages, future earnings, custodial care and rehabilitation;
- Placing a fair and reasonable limit of \$250,000 on non-economic damages, such as pain and suffering;
- Establishing a reasonable statute of limitations for filing a lawsuit;
- Allowing for periodic payments of damages rather than lump sum awards; and
- Ensuring that the bulk of any award goes to the plaintiffs, not attorneys

The clear and simple truth is that MICRA works. For nearly three decades, this law has ensured that legitimately injured patients get unfettered access to the courts and receive full compensation for their injuries, while at the same time providing stability to the medical liability insurance market to ensure that doctors can remain available to care for their patients.

Consider the following points about the effectiveness of MICRA:

MICRA Fully Compensates Injured Patients

First and foremost, under MICRA, patients receive full compensation for legitimate injuries resulting from medical negligence. Detractors of federal reform legislation are attempting to obfuscate the facts by scaring the public and policymakers into believing that injured patients will only receive a maximum of \$250,000 to compensate them for their injuries. This is simply not the case. Patients receive full compensation for all of their quantifiable needs, with up to an additional \$250,000 for non-economic damages, such as pain and suffering. To demonstrate this fact, the Californians Allied for Patient Protection recently compiled a sample of total awards

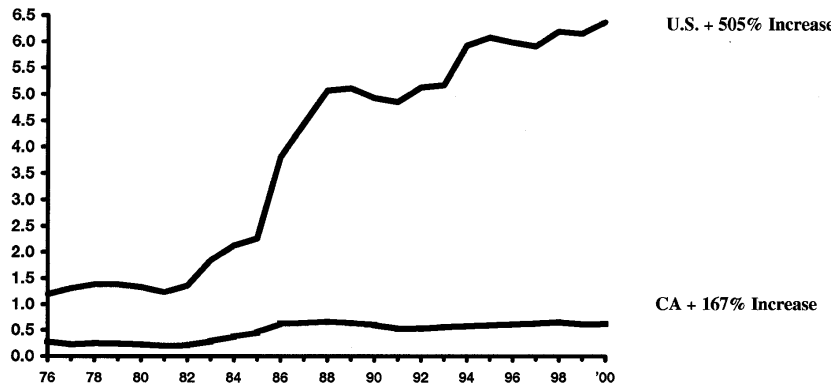
(including both economic and non-economic damages) provided to injured patients. For example:

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

MICRA Significantly Minimizes Premium Increases

Opponents of reform cite statistics that over the past several years, premiums for doctors in California have also been rising; thus proving that MICRA does not have any impact in holding down the costs of medical liability insurance. While it is true that premiums are on the rise in nearly all states, including California, the rate of increase of premiums for California doctors is significantly lower than in other states, and over time, MICRA has, in fact, stabilized medical liability insurance premiums as compared to the rate of increase in the rest of the country. As the following chart demonstrates, from 1976 to 2000, premiums for physicians in California have risen only 167 percent as compared to an increase of 505 percent for the entire United States.

Premium Growth: California vs. U. S. Premiums 1976-2000



Source: NAIC Profitability Study, 2000

Data collected from high-risk medical specialties from 2000 to 2002 also validate these trends. For example, according to a nationwide survey of neurosurgeons, the national average premium increase for California neurosurgeons was 39 percent as compared to 63 percent for neurosurgeons in the entire country. In addition, the same survey clearly demonstrated that the rate of increase for an individual neurosurgeon in Los Angeles, California, as compared to other neurosurgeons who practice medicine in crisis states where there are no reforms in place, is significantly lower. The average rate of increase for the neurosurgeons in these non-reform states was 143 percent as compared to just 8 percent in Los Angeles, CA.

State/City	2000	2002	Percentage Increase
Los Angeles, CA	\$48,000	\$52,000	8
West Palm, FL	58,000	210,000	262
Cleveland, OH	75,675	167,941	122
Oaklawn, IL	110,000	282,720	157
Philadelphia, PA	90,000	190,000	111

State/City	2000	2002	Percentage Increase
New York, NY	154,890	251,126	62

Source.—American Association of Neurological Surgeons/Congress of Neurological Surgeons Nationwide Survey April 2002.

The Alliance does acknowledge that despite the successful reforms contained in MICRA, the average medical liability claim in California has outpaced the rate of inflation. This is in large part due to the fact that economic damages are not limited under MICRA and have grown as a component of medical liability claims. Notwithstanding this, however, the undisputed fact remains that MICRA prevents runaway juries from awarding outrageous awards for subjective, arbitrary and often unquantifiable non-economic damages, which allows insurance companies to adequately predict future lawsuit awards, bring stability to the health care delivery system.

Federal Government Validates that MICRA Works

U.S. Government experts agree that MICRA does in fact hold down the costs of medical liability insurance, and over the years there have been a number of studies that have identified MICRA's \$250,000 cap on non-economic damages as a critical element in stabilizing premium costs. For example, dating back to September 1993, the former U.S. Office of Technology Assessment (OTA), in a report entitled, "Impact of Legal Reforms on Medical Malpractice Costs," concluded that caps on damages were consistently found to be an effective mechanism for lowering medical liability insurance premiums. Most recently, the previously referenced HHS report, "Confronting the New Health Care Crisis" and the CBO cost estimate report of the HEALTH Act, came to the same conclusion.

JUSTIFICATION FOR FEDERAL REFORM LEGISLATION: AMERICANS OVERWHELMINGLY SUPPORT A MICRA-STYLE SOLUTION

Americans are becoming acutely aware of the impact that this crisis is having on our nation's health care system, and overwhelmingly favor having Congress pass legislation to reform the current medical liability system and create one that balances the rights of patients to seek and obtain appropriate compensation for injuries caused by medical negligence against the right of all our citizens to have continued access to medical care. Two recent polls clearly demonstrate this support. In January 2003, Gallup conducted a poll on this issue and found the following:

- Americans believe that the medical liability insurance issue is either a major problem (56 percent) or a health care crisis (18 percent);
- 72 percent favor passing a law that would limit the amount that patients can be awarded for their emotional pain and suffering; and
- 57 percent responded that they think patients bring too many lawsuits against doctors

These findings were confirmed most recently by a February 2003 study conducted by Wirthlin Worldwide for the Health Coalition on Liability and Access, which found that:

- 84 percent of Americans are concerned that skyrocketing medical liability costs could limit their access to care;
- 76 percent favor a federal law that guarantees injured patients full payment for lost wages and medical costs and reasonable limits on awards for "pain and suffering" in medical liability cases; and
- 61 percent believe the number of medical liability lawsuits against doctors is higher than justified.

CONCLUSION

We have reached a very important juncture in the evolution of the U.S. health care system. At a time when lifesaving scientific advances are being made in nearly every area of health care, patients across the country are facing a situation in which access to health care is in serious jeopardy. Thus, as the Congress deliberates the many facets of this issue, the Alliance urges you to continue to keep in mind that this issue is not about doctors, lawyers and insurance companies. Rather, it is about patients and their ability to continue to receive timely and consistent access to quality medical care. By reforming the medical litigation system, the crisis will ultimately be abated. Patients are calling for reform. Doctors are calling for reform. President Bush is calling for reform. The House of Representatives is calling for reform. And the Alliance now urges the Senate to heed these calls and, at a minimum, pass MICRA-style medical liability reform legislation so all Americans are able to

find a doctor when they most need one. Ultimately, when the question "Will your doctor be there?" is asked, the answer must be an unqualified yes.

Thank you for considering our comments and recommendations. The Alliance of Specialty Medicine, whose mission is to improve access to quality medical care for all Americans through the unified voice of specialty physicians promoting sound federal policy, stands ready to assist you on this and other important health care policy issues facing our nation.

LETTER FROM THE AMERICAN COLLEGE OF LEGAL MEDICINE

KAMENSKY & RUBINSTEIN,
7250 N. CICERO AVE., SUITE 200,
Lincolnwood, IL, March 17, 2003.

Re Solutions to Medical Liability/Insurance "Crisis"

Hon. ARLEN SPECTER,
*Chairman, Subcommittee on Labor, Health and Human Services, and Education,
Committee on Appropriations, U.S. Senate, Washington, DC.*

DEAR SENATOR SPECTER: On behalf of the American College of Legal Medicine ("ACLM"), I would like to thank you for the opportunity to submit the ACLM's views regarding medical professional liability, and we request that this letter be included in the record of the Subcommittee's March 13, 2003 hearing entitled, "Causes of the Medical Liability Insurance Crisis."

Much occurred late last week regarding medical liability, for example, passage by the House of H.R. 5 on March 13, 2003, hearings conducted by the Senate Appropriations Labor Subcommittee on Health, chaired by you on March 13, 2003, (looking into a compromise proposal on medical liability), and introduction, also on March 13, 2003, of S. 607 by Senator Ensign and others of the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2003, or the HEALTH Act of 2003. The ACLM wishes to add to these developments and, thus, would like to add to the discussions put forth during your committee hearings (see below).

First, the ACLM is in its 43rd year and is unique among medical legal and health care organizations in our country. The majority of its membership (1,200) is composed of individuals who possess both the medical and law degrees. Our membership also consists of physicians, attorneys, healthcare practitioners, those in government and those in academia. Our mission is to educate and train through our meetings, publications and advocacy, such as we are doing here, on issues affecting the country which are at the crossroads of medicine, law and health care.

We understand that items put forth for consideration in the subcommittee hearings on March 13 included the following topics:

"Affidavits of meritoriousness and attorney sanctions for filing frivolous lawsuits; caps on non-economic damages with exceptions for serious cases; legislation to curb medical errors, and legislation to address instability within the insurance industry, including, perhaps, revisiting the McCarran Ferguson Act exemption."

Let us respond.

Affidavits of meritoriousness or attorney sanctions for frivolously filed suits are already part of states' laws governing medical professional liability and civil litigation. Such legislation, if enacted on the federal level, would invade an area of states' rights that has never been an area intended for federal intervention. A reading of United States Supreme Court decisions, highlighted by the Pegram and Rush Prudential cases, clearly and unmistakably show that health care is an area traditional left to the states to regulate. Affidavits of meritoriousness and attorney sanctions for filing frivolous cases surely fall within this area of state regulation.

Federal legislation to curb medical errors is fraught with skepticism as well. We are not saying that there must not be a continued effort to stem the tide of medical errors in our nation's healthcare institutions, such as to prevent, for example, what occurred with that transplant patient at the Duke Medical Center recently, but the emphasis has to be on prevention of systems errors, not on errors committed individually by physicians leading to malpractice lawsuits. We question whether there can ever be any effective legislation on the federal level to stem the tide of systems' errors. This, we feel, is best left to states, their licensing boards and those regulatory entities governing hospitals and healthcare providers, like the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), to regulate. If anything, if the subcommittee you chair wishes to consider and promote legislation in this area at all, perhaps it should be to strengthen the ability of licensing organizations, like the JCAHO, to conduct their affairs without the fear of having their

work-product discovered by attorneys who would use same in cases of professional medical negligence. In other words, we feel that an effective peer review statute on the federal level to protect from discoverability records of entities that can ensure better quality of care and, thus, reduce system errors in our country's healthcare institutions would be in order.

Further, there is, and well there should be, concern regarding the insurance industry. Surely, it serves a purpose in our country; we all need insurance and we are all insured for losses, be they from automobile collisions, for miscues as directors and officers sitting on corporate boards, or, as is quite prominent now, for professionals, like doctors, rendering professional services. But the insurance industry should not make up for losses incurred in financial instruments in which it invests by gouging professionals, notably doctors, for purposes here, in the form of skyrocketing insurance premiums.

There is a hue and cry afoot mandating caps on damages, and that with caps, premiums will become more reasonable. Caps on non-economic damages do not lower malpractice premiums. They really never have. Our research has found so-called crises, such as in which we now find ourselves, have occurred cyclically over the last 40 years, and are driven by the inability of insurers to perform well in the markets in which insurance premiums are invested. Moreover, where caps have been imposed, research and empirical data have shown that premiums have not gone down; premiums still increase, and so have health care costs in considerable measure. Concomitantly, you and some of your colleagues in the Senate may be impressed by California's experience with their MICRA law, originally enacted in 1975. What you haven't been told, we suspect, is that also put in place legislatively by the California assembly in the 1980s was a law to roll back insurance premiums in that state; another state law there was enacted that provided for insurance premium increases only with prior approval of the insurance commissioner. And, yet, even with this legislation, malpractice premiums and health care costs have risen quite a bit.

Further, we feel that to preclude serious injury from a cap raises constitutional problems based in large measure on equal protection standards. For example, is loss of sight in one eye a serious injury? How about a permanent limp? Or what about the death of a newborn—is that a serious enough injury to be precluded from caps? Also, we think ill-advised any federal government attempt to immerse itself in the business of defining what a serious injury will be nationwide for purposes of exempting certain injuries from a cap.

If caps on non-economic damages are not the reason for a spike now in malpractice insurance premiums, then what is the cause? To put the answer another way, the lower the return (due to down markets) on investments by insurers, the higher the cost of malpractice insurance. Ok, if this is what we opine as the cause for the malpractice crisis today, what is the solution?

The solution is twofold. First, the exemption provided by the McCarran-Ferguson Act for the insurance industry should be taken away. This will allow for proper regulation of insurance rates. Second, and a proposal we have yet to see floated legislatively, is the following. We know physicians (nee, any one of us) do not wish to be at the receiving end of a lawsuit. It isn't being the defendant in a lawsuit that has prompted physicians to carry on marches or participate in work stoppages that have given rise to public scrutiny and have been the subject of media attention all over the country; it is physicians inability to pass on in some fashion the cost of malpractice insurance premiums. As we are sure of which you are well aware [certainly at least through your son's expertise as a lawyer representing injured persons], physicians are locked into the reimbursement rates they receive for patient care, either from health plans under which they are under contract in order to be provided a base of patients to care and treat, or through government programs, such as Medicare. Why can't, therefore, there be considered federal legislation that will provide that physicians and health care practitioners be allowed to pass along a certain portion of malpractice insurance rate increases (let's say, if malpractice insurance premiums exceed a certain, defined cap over a designated period), to the government and health care plans? In this way, the government and the current era of health care delivery, i.e., managed care, will take part in ensuring that insuring entities are brought under control and that we avoid the cyclical trends of every decade or so we are seeing now, viz, insuring the nation's doctors and their ability to treat and care for patients unimpaired by astronomical malpractice premiums. Again, nonetheless, we suspect that the McCarran-Ferguson Act and its exemption will have to be revisited to order to consider the proposal we are putting forth here. But this proposal is a worthy alternative to anything suggested so far. Other alternatives in the form of tort reform have been shown to be a failure at lowering malpractice insurance premiums.

To conclude, we feel to continue to blame states' legal justice systems for the ills we now see today involving physicians and medical liability is ill-founded and not based on other than emotion and a "the sky is falling" mentality. It has always been easy to declare lawyers as a class of scapegoat for causing the malady seen once more, but that is created by insuring entities not making their profit margins in the financial markets. Now, though, is finally the time to separate fact from fiction. S. 607 should be voted down in the Senate by you and your colleagues.

Thank you for the opportunity to consider our views on this issue.

Sincerely,

MILES J. ZAREMSKI,
Immediate Past President.

CONCLUSION OF HEARING

Senator SPECTER. Thank you all very much for being here. That concludes our hearing.

[Whereupon, at 11:54 a.m., Thursday, March 13, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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