ARE SKYROCKETING MEDICAL LIABILITY PREMIUMS DRIVING DOCTORS AWAY FROM UNDERSERVED AREAS?

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BEFORE THE

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HOUSE OF REPRESENTATIVES

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Are Skyrocketing Medical Liability Premiums Driving Doctors Away fromUnderserved Areas?

TUESDAY, JUNE 14, 2005

HOUSE OF REPRESENTATIVES
COMMITTEE ON SMALL BUSINESS
Washington, DC

The Committee met, pursuant to call, at 10:07 a.m., in Room 2360, Rayburn House Office Building, Hon. Donald A. Manzullo [Chair of the Committee] Presiding.

Present: Representatives Manzullo, Bartlett, Kelly, Musgrave, Poe, Sodrel, Fortenberry, Westmoreland, Gohmert, Lipinski, Christensen, Bordallo and Moore.

Chairman MANZULLO. Good morning. Welcome to our second hearing on the important subject of medical liability reform. I appreciate everybody who is participating.

We have been blessed with the best system of medicine in the world, but we are having a crisis of access. The problem is not a case of whether a patient has health insurance, though it is the driving force behind the cost of health insurance. Today it could be difficult to find a doctor to treat you.

Headlines are replete with stories of women having to drive several hours because they cannot find a doctor to deliver their baby. It is hard to believe that in the 21st century many women have difficulty finding a doctor to deliver their child.

If you are in a car accident in southern Illinois and need a neurosurgeon, chances are you will be airlifted to another State, which could be a couple of hundred miles away, because there simply are no neurosurgeons left to treat you in that area.

Unfortunately, we live in a time where lawsuits against doctors are rampant, and multimillion dollar court decisions and jury awards have left doctors with medical liability premiums that increase 40 to 50 percent a year. Doctors in certain high-risk fields of medicine can expect to be sued at least once in their career.

Between 2000 and 2003, the number of medical liability claims has jumped 46 percent in Illinois, to more than 35,000 claims. The average indemnity per claim has also risen dramatically. In 1990, the average indemnity was about $310,000. In 2003, it was nearly $600,000, according to the Illinois State Medical Insurance Exchange. As a result, doctors are retiring or leaving the practice of medicine. Emergency rooms have closed. Doctors simply cannot afford to pay premiums that spike every year with no end in sight.

The problem has been exacerbated in the rural areas and inner cities, where doctors are leaving in droves. Millions of rural and

inner city residents are in danger of losing the basic ability to see a doctor when they are ill.

Fortunately, Illinois has just passed medical liability reform that the governor has promised to sign, but there are many other States that do not have caps on non-economic damages. Caps help, but they are not the total solution to it.

I am hopeful the House will soon take up bills such as H.R. 534, the Help, Efficient, Accessible, Low-Cost, Timely Health Care Act of 2005 introduced by Representative Chris Cox.

The President supports reforms in our medical liability law that would improve the ability of patients to collect compensation for economic losses, ensure that recoveries of non-economic damages would not exceed $250,000 and limit punitive damages to $250,000. Congress has to pass legislation to address the problem.

I have practiced law for 22 years before being elected to Congress; and though I did not do any medical liability defense or plaintiff work, what has really disturbed me and what I think has exacerbated a solution on it has been the fact that people will blame the medical crisis upon trial lawyers. I guess that bothers me because they work within the system of laws, and they use the laws that are on the books.

If your kid is involved in a car accident, you are going to want to find the finest trial lawyer in the State. And I think in the past several months at least I have been talking to folks involved in the medical profession, saying you do not accomplish something positive by talking down a profession. Just as medical doctors have studied for years to achieve their expertise, so have people involved in trial litigation; and it just has been counterproductive as far as I am concerned to try to pit the two professions against each other.

Illinois came up with a remarkable solution where, I believe, Governor Blagojevich is an attorney himself, and both houses of the legislature are in Democratic hands. The only way to bring about a result is you just have to show the enormity of the problem, and that is what happened in Illinois where it became almost impossible to find a neurosurgeon in the southern part of the State. Everybody got together and said let us come up with something that we think is workable, with caps of $500,000. Plus, there also is a provision in that bill that says if a study shows that perhaps an insurance company may be gouging, which I do not think is the case, but if that is the case, then there is the opportunity to do is a very in-depth investigation on that.

[Chairman Manzullo's opening statement may be found in the appendix.]

In terms of opening statement, we are waiting for our Ranking minority Member to come and also Dr. Donna Christian Christensen, who is a physician, a member of our panel from the Virgin Islands. I have asked her, if she wants, she can have the opportunity to give an opening statement because she is also a physician; and I begged her to stay on the Small Business Committee because of the talent that she lends.

So let us go with our first panelist. What I would like you to do is, how many here have never testified before Congress? Okay. Two have not. Our goal here today is for you tell us your story. Let us know about the nature of your practice and what has happened to

your medical malpractice premiums and the impact, if any, upon the community. This is the time to tell the story. I am more concerned about your telling the story than the possible solutions that you may want to offer, because those have all been on the table. We have discussed those as a whole.

Dr. Brown, I am going to start with you. Dr. Delorise Brown is an endocrinologist who practices in East Cleveland, Ohio. I have had the opportunity of knowing your brother for several years, and he is the one that alerted me to your situation.

We have what is called a 5-minute rule. When you see the yellow light, that means 4 minutes have expired; and you have about a minute to conclude.

Sit back, relax, take a glass of water. This is your opportunity to tell members of Congress—and there is a lot of press here, also—what your story is.

Dr. Brown, we look forward to your testimony.

STATEMENT OF DELORISE BROWN, M.D., CLEVELAND MEDICAL CENTER

Dr. BROWN. Good morning, Chairman Don Manzullo and members of the Small Business Committee. My name is Delorise Brown.

I am a practicing internal medicine physician with a subspecialty in endocrinology from the great State of Ohio. As a small business owner, I employ six staff members. Together, we support the highly underserved East Cleveland community. I would like to thank you for holding this hearing to discuss the effect of skyrocketing medical liability premiums which are driving physicians who practice in underserved communities across this great Nation out of business.

Mr. Chairman, I have been in private practice for 27 years. My late husband, Alvin Butler, held a Ph.D. In organizational development from Case Western Reserve University; and I made a conscious decision to provide medical service to the underserved. My husband and I decided to focus on our efforts within East Cleveland, Ohio. As of the census of the 2000, 32 percent of the East Cleveland population and 28 percent of families live below the poverty line, earning less than $12,602 per year.

As a physician, I am finding it ever more difficult to maintain sound principles of medicine; and I am forced to practice defensive medicine. The practice of defensive medicine requires me to avoid high-risk patients and procedures, limiting my ability to service the needs of my past and current patient population. In my opinion, defensive medicine is a deviation induced by the threat of medical liability. My malpractice insurance has required me to stop caring for nursing home patients, some of whom I have provided services for over 20 years.

Operating a small business during our current economic climate is very difficult. However, it is exacerbated by the skyrocketing cost of medical malpractice insurance. As I stated, East Cleveland is a poverty stricken community; and the majority of my patients cannot afford traditional health care insurance. Most patients have Medicare and Medicaid or some other managed health care plan which establishes fee schedules that limits the remuneration value for services rendered. As a result, it is becoming increasingly more

difficult to afford purchasing advanced medical equipment that is critical to enhance the level of care for my practice.

Last year, President Bush visited Cleveland and spoke on the topic of electronic medical records, EMR. President Bush stated, and I quote, ″When you multiply the efficiencies to be gained all across the spectrum, whether it be individual doctors or hospitals or networks, that's why some predict you can save 20 percent of the cost of health care as a result of the advent of information technology.″

Last year, the cost of EMR's ranged from 60 to $180,000. The cost of electronic medical records is completely out of reach for me as a physician. I do believe that EMRs provide several levels of benefits and that EMRs would assist in driving down the overall costs associated with running my medical practice, in addition to ensuring accurate recordkeeping of patient information. To date, medical malpractice insurers do not provide any credit or cost reduction to physicians who implement EMR solutions within their medical practice.

Just as I previously stated, medical malpractice insurance companies require physicians to practice defensive medicine, which specifically limits the physician's ability to generate income by setting restrictions upon the physician that potentially assist in limiting medical liability. This concept does not make sense to me, as I have been affected by frivolous lawsuits which have served to move me from a standard market to a nonstandard market. I am presently in negotiations to renew my medical malpractice insurance; and I am uncertain, as are some of my colleagues, as to what market will be available to me this year.

To give you some history, in 2001, my medical malpractice cost me $5,266.79 for an entire year; and I thought that was outrageous then. But then, in 2002, my malpractice was $18,861, with a tail, which covers prior acts, of $15,000, totaling $33,861 for that year; and then I had to pay a $5,000 deductible for each lawsuit. And in 2003 my malpractice was $50,673, with a tail of $19,500, totaling $70,173, with a deductible of $10,000 per lawsuit. And in 2004 my malpractice cost me $73,259, still with a deductible of $10,000 coverage. So, as you can see, from 2001 malpractice costs were lower, at $5,266.79, then skyrocketed to $73,259 within 3 years.

This is I think in part due to several malpractice insurance firms leaving the State of Ohio and in part to the growing epidemic of medical malpractice lawsuits plaguing the medical industry. For the first 22 years of being in practice, I have had three lawsuits. Within the last 5 years, I have had five lawsuits. I am not alone, as this lawsuit trend has affected a great number of my colleagues as well. If this trend continues, we will be forced out of private practice or driven away from serving underserved communities across this great Nation.

Chairman MANZULLO. I kind of have to stop you right there. It is really, really important for witnesses to get into the—tell us what is going on with the premiums, okay, because that is a lot of money.

Dr. BROWN. Yes, it is.

[Dr. Brown's statement may be found in the appendix.]

Chairman MANZULLO. Dr. Fields is the President-elect of the American Academy of Family Physicians. He comes to us from Ashland, Kentucky.

Doctor, we look forward to your testimony. You are going to give us some good background on what is going on in your profession. You are an actual practitioner yourself.

STATEMENT OF LARRY S. FIELDS, M.D., AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. FIELDS. Yes, I am in private practice in rural Kentucky with four partners. I started as a solo practitioner and built the practice up.

I really appreciate the opportunity to be here on behalf of not only my four other partners but the 95,000 of the American Academy of Family Physicians and, much more importantly, probably the 50 million odd—well, they are not all odd—but 50 million patients that allow us the privilege of taking care of their health every day. So I sincerely thank you for this opportunity, and the AAFP would like to commend the Committee for its continued and successful work in alleviating some of the burdens of small businesses in the United States.

As you mentioned, it is a particular honor to be here because one of your members, Dr. Christensen, is one of our members; and she is also the leader of the Congressional Black Caucus Health Brain Trust.

As Dr. Brown said, a large percentage of family doctors work and own small businesses. We have all the same problems that small businesses have. The average revenue of a family physician practice in 2003 was $360,000; and out of that we must pay all the normal things, staff, electricity, rent and medical liability insurance premiums. All of those costs have risen, and most of them predictably over the last several years. However, the liability rates have been increasing. Mine particularly has doubled, and the obstetrics unit at my hospital had to close because people just quit delivering babies because they could not afford the premiums.

So when that happens, when these premiums rise, I have very little choice because we cannot absorb that kind of cost. So I either have to cut services, to cut premiums like obstetrics. I have to reduce the size of my staff, which has the doubly regrettable consequence of further reducing services and providing the human suffering of unemployment. I could borrow money, which is usually the path to bankruptcy for small business. Or I could sell to a larger entity that can afford to pay the high premiums that are currently affecting most of us.

But the people who suffer most from this are our patients. This is really what its all about. They are your constituents, and they no longer have a medical home. They are no longer able to find those familiar faces, the friendly faces that they have come to depend on to humanize medicine and provide a safe haven for them in the complex world of medicine in the 21st century.

I practice in eastern Kentucky, which is a beautiful, rural and underserved area. I was born 25 miles from where I currently practice. Last year, the liability carrier that I had had for 22 years dropped our practice without ever a dime being paid in claims.

They just said we are not going to insure you any more. And that, for about 2 months, posed a real risk that 18,000 human beings would not be able to find those familiar faces that I spoke about. That would have been a real tragedy for the patient.

Like Dr. Brown, my heart aches every day when I see the hardship, the financial hardship that defensive medicine produces on my patients, defensive medicine like it is practiced in the emergency rooms, hospitals and physicians offices, including mine as well as yours.

I have a colleague, Dr. Julie Wood, who is from Missouri. She practiced in her home town as a family physician, providing full-service medical care for 6 years. A year or so ago, she got a notice that her liability premium, even though she had never had a claim, would rise from $19,000 to $71,000. Dr. Wood, who happens to love, as most of us do, mothers and children and the special bond that physicians develop with expectant mothers, felt she had no choice. She had to take a position in Kansas City with a large medical center that could afford to pay her liability premiums.

So what are we supposed to say to people, the people she had to leave behind? Because there is no OB now in a quarter of northern Missouri from St. Joe to Hannibal. These people, some of them, can drive 2 hours to see Julie in Kansas City, but what do we say to the 15-year-old intellectually challenged young girl who rode her bicycle to see Dr. Wood for care so that her baby could be born healthy? What are we supposed to tell them? Do we say because they are poor or not as smart or live in the wrong place that they do not deserve good prenatal care?

I have got another friend, Dr. Neil Brooks, from Connecticut, who practiced in the town where he grew up for 30 years, part of a four-physician group. The town was about 30,000 people. Three years ago, his liability premium went up 600 percent. It rose to $31,000. So at age 51 Dr. Brooks had to leave the practice that he had cared for for four generations of his friends and neighbors.

Chairman MANZULLO. We have sort of run out of time here, Dr. Fields. Hopefully, we can pick up the rest of your testimony in the Q and A session later on.

[Dr. Fields' statement may be found in the appendix.]

Chairman MANZULLO. Dr. Winston Price is the President of the National Medical Association. He hails from Brooklyn, New York.

Dr. Price, we look forward to your testimony.

STATEMENT OF WINSTON PRICE, M.D., NATIONAL MEDICAL ASSOCIATION

Dr. PRICE. Thank you very much, Chairman Manzullo.

Highly distinguished Members of the House, fellow panelists, ladies and gentlemen, as you heard, I am the President of the National Medical Association. This represents the largest member organization for physicians of African decent, and we represent also the many millions of patients and citizens that we serve. We have served as a leading advocate for American health care for over a century; and we thank the Committee for the opportunity to testify this morning and would hasten to inform the audience that with regard to the elimination of health care disparities, particularly for those based on race and ethnicity, our resolve remains as strong as

ever and our efforts will continue unceasingly for what is good for health care for all Americans.

We have already heard some of the alarming statistics, as you elucidated, that define this growing crisis in America with respect to the availability and affordability of medical liability insurance. All Americans are now threatened, whether they live in rural, urban or suburban areas; and all Americans are affected and in real jeopardy of a failed access to health care regardless of race, ethnicity or socioeconomic status. However, it is fair to note that those who already suffer disproportionately from poor health service access and health disparities are even further burdened by the lack of liability insurance in this crisis.

Many of our colleagues in the American Medical Association and in the Obstetrics and Gynecology College share the designation of red States. In both Illinois and New York, Mr. Chairman, where you are from, and New York, where I am sure you love to be, this designation is not symbolic of how people vote, whether they are voting Republican. This designation, rather, betrays the lack of access to health care created by the liability insurance crisis; and there are 18 other States that fall into that same category.

The result of that is that many physicians have had to close their practices; and, as you know, their practices represent to a large degree small business and jobs for many of the community individuals. They have had to go to greener pastures, and many times that means simply going to States that have better situations with respect to the malpractice crisis.

These are troubling statistics, and I would direct your attention southward to Mississippi, one of the poorest States in our country, that has some of the worst health indicators for our Nation, a State whose citizens need even greater access to care than presently exist. But in this State one practitioner after another is being driven out of town, figuratively, by the malpractice issue.

Let me add a personal touch to this particular situation and tell you about Dr. Myers down in Mississippi whose practice in Mississippi had to close at the end of this year as a result of the malpractice crisis. And Dr. Myers is unique. He travels more than 2 hours between his clinics, serving some of the poorest of our Nation, logging more than 50,000 hours per year, because he still makes house calls. But his five clinics had to close because the malpractice insurer decided that he was too much of a risk with the patients who were too sick to be insured. As a result of this, he obviously, as the transcript says, had to file a lawsuit to try and stay in business, but for the last 6 months he has been out of business in all of those five clinics.

For expediency of time, let me share the situation of a colleague who is a surgeon. As you know, among African-Americans the ability to have specialists in all areas of health care, particularly in the surgical specialties, OB-GYN, orthopedics and neurosurgery, this is a luxury. These individuals have seen premium increases as much as 200 or 300 percent, some paying as much as $100,000 a year for their medical malpractice coverage.

Mr. Chairman, it is fair to say that we are at a crisis state within our health care system; and indeed our health care system, with

the liability issue, particularly with those who suffer from health disparities, is itself in critical condition.

So I ask you, Mr. Chairman, your Committee is tasked with trying to make sure that small business is able to be successful. The practitioners in this country who serve all of you in this room, we are all in jeopardy of lack of health care service. Your mothers, your wives, your daughters and your granddaughters deserve access to quality health care. Those individuals who are traumatized on the roads of our highways deserve to have access to the excellent trauma surgery that is available in our health care system.

Thank you, Mr. Chairman.

Chairman MANZULLO. Thank you, Dr. Price.

In summarizing your testimony, you left out the fact that Dr. Myers had never had a medical malpractice lawsuit filed against him.

Dr. PRICE. That is correct. Thank you.

Chairman MANZULLO. It is extremely important.

[Dr. Price's statement may be found in the appendix.]

Chairman MANZULLO. Our next witness is Dr. Elena Rios, President and CEO of the National Hispanic Medical Association. We look forward to your testimony.

STATEMENT OF ELENA RIOS, M.D., NATIONAL HISPANIC MEDICAL ASSOCIATION

Dr. RIOS. Thank you, Chairman Manzullo, members of the Committee and guests. It is an honor to be here today.

I represent the National Hispanic Medical Association, established in 1994 as a non-profit organization representing Hispanic licensed physicians in the United States. The mission of the organization is to improve the health of Hispanics and others underserved. I applaud your commitment to understand the effect of medical malpractice litigation on the access to health care, particularly to minority patients subjected to disparities in health.

Our health system is the best in the world, but in order to be proud of that system we need to develop new strategies to improve the quality of health care delivery.

Chairman MANZULLO. Doctor, could I have you get right to the gut of your testimony? You know what I am looking for.

Dr. RIOS. Sure. I will focus on three points.

The Hispanic physician, unique to the medical delivery system, needs to be protected from the malpractice crisis. Hispanic patients suffer from increased disparities in health and require increased access to care; and there is a need for increased research on Hispanics and health disparities, no matter what crisis we talk about.

In terms of Hispanic physicians, let me just say that the unequal treatment report from the Institute of Medicine brought up the fundamental principal that minority physicians are critical to the increased patient health outcomes and thus a primary focus for reducing disparities in health care delivery.

The literature demonstrates many examples of studies on the outcomes of minority health professionals serving a major need in the United States, namely that they provide health and mental health care services for minority patients of their own ethnicity and for those on Medicaid and uninsured.

According to the AMA, approximately three-fourths of all practice-based physicians work in or own small practices. Among practice-based physicians, roughly 33 percent are in solo practice; 26 percent are in practices with between two and four physicians; 16 percent are in practices with five to nine physicians.

As for Hispanic doctors, we only number about 5 percent, or 36,000, of the total United States physicians in the country. Of these, 3,600, or 10 percent, are full-time faculty of medical schools, according to the AAMC; and less than half of those make up full-time physician administrators, either public or private sector. So, thus, there is only about 23,000 Hispanic doctors in this country in private practice. We estimate that at least one-third of those are foreign doctors who are about to retire, which is about 7,500.

Due to the limited results of national, namely Federal, recruitment programs of minority students to medical schools over the past 3 decades, these physicians will not be replaced at the same rate that they leave practice. Currently, only about 5 percent of 65,000 medical students in this country are Hispanic, which is about 3,000 plus.

I think the most important point here is that the growing Hispanic population, 43 million now, 14 to 15 percent of the country, and by 2050 one out of every four Americans, will be of Hispanic background. We cannot afford to lose any of our Hispanic doctors.

NHMA believes it is vital to the health of America with a growing minority population that we urge you, as leaders in Congress, to create opportunities to increase the number of Hispanic physicians to protect those in practice; and indeed we also strongly feel that we need to develop a more culturally competent physician workforce through education programs for medical students and residents and licensing requirements for CME for non-minority physicians.

But, like all doctors, Hispanic doctors are being turnedaway from their practices. I would like to just tell you three personal stories from our members.

One, Dr. Luis Aguilar, an internist from Tucson, Arizona. He says, subspecialists are leaving. They are limiting their practice. They are retiring early. They have had to assume a defensive strategy, limit accepting challenging patients, see more patients to help defray increased costs, order more tests, not chancing any clinical judgment. Our compliance committee in the local hospital has employed more rigorous guidelines more from a defensive posture then from good medicine, and access to services is thus affected. There is now an extraordinary length of time to see any specialist or to schedule a test, for example, an MRI or a mammogram.

Dr. Miguel Cintron is an obstetrician from Harlingen, Texas. He says, I practice OB-GYN. I am also Chief of Staff at the Valley Baptist Medical Center in Harlingen, Texas. As you know, the Rio Grande Valley is an area with a very high malpractice suit rate and, as a result, high malpractice premiums. The Rio Grande Valley is predominantly Hispanic. Mine is a story in my role as Chief of Staff.

About 4 years ago, due to high malpractice premiums, we lost two general surgeons from practice in our area. One was an experienced surgeon with over 30 years of practice. Another one was a

young surgeon who by himself performed more operations than all the other surgeons together.

Ours is a designated Trauma 3 Level Medical Center which is a ″safety net″ for the whole Rio Grande Valley in the field of trauma. After the loss of these two surgeons from practice, it has been impossible to recruit general surgeons to our facility. Many surgical patients have to be sent elsewhere, away from their families, to get their procedures, including cancer patients.

Fortunately, the cardiovascular surgeons have voluntarily stepped up to the plate and have been performing general surgery cases to hold the fort, but this cannot be a permanent solution.

We have also established the Regional Academic Health Center, trying to train and retain physicians in a medically underserved area, but, again, this is not enough. The malpractice issue is a deterrent for this to happen, since the same issues the surgeons have are all held by other specialties. Hence, the medical malpractice problem has overflowed to being a health care access problem.

The third doctor, Dr. Neredia Correa, is an obstetrician from the Bronx, New York. She says, the issue of malpractice insurance has reached critical proportions. In the past few months, I have been setting up a private practice in women's health, which is my specialty. The premiums have risen from $59,000 a year for part time to as high as $110,000 for full time.

Chairman MANZULLO. We have got a red light flashing in front of you, so we are going to have to cut you off at the pass. Is that okay with you?

Dr. RIOS. That is fine.

Let me end with a concluding statement that I think these high costs have really transferred to a lack of access for many, many Hispanic patients around the country, and I think it is critical that something be done to reform medical malpractice.

Chairman MANZULLO. Thank you.

[Dr. Rios' statement may be found in the appendix.]

Chairman MANZULLO. Our next witness is Wilbur Colom. We look forward to your testimony. We could call you doctor also with your juris doctorate.

STATEMENT OF WILBUR COLOM, THE COLOM LAW FIRM

Mr. COLOM. Yes, sir. Thank you, Mr. Chairman.

I graduated from Antioch School of Law which was designed to champion the low-income and minority people. I have served on its board. I have been an adjunct professor. I established my own law firm in 1977. And we have eight lawyers in three offices and approximately 40 professionals. In your terms, I am a small business as well.

By way of full disclosure, I would like to state that I am a Republican; and I am proud to be co-chair of the ATLA, Association of Trial Lawyers of America, Republican Trial Lawyers Caucus. My Republican credentials go back to being on Thad Cochran's first Campaign Committee for United States Senate, to serving on Ronald Reagan's Transition Team, to being on the Mississippi Republican Executive Committee through much of the 1980s and in 1987 being the unsuccessful Republican nominee for State treasurer. In 2004, I was a George W. Bush delegate to the Republican National

Convention. I am a long-time supporter of many Republican candidates. I have continued to support our President, although we disagree on issues involving medical malpractice.

I started my legal career working in a rural legal services program operated primarily for poor farmers for east Mississippi and west Alabama. The scarcity of physicians back in the 1970s in rural Mississippi is something that I have witnessed firsthand for almost 3 decades.

I do not know how to entice physicians to practice in rural and poor communities, but the one thing that I do know is that this problem has been around for over 30 years and medical malpractice claims and caps have nothing to do with it. Limiting the rights of the underserved, the poor, the abused is not going to improve the situation.

I agree wholeheartedly that doctors have a medical premium crisis, but it is not caused by lawsuits. In fact, there is no so-called liability crisis. I pointed out in my more extensive testimony that in the counties in which I live in rural Mississippi in the four county area there has been not a single judgment against a physician in 15 years; and in the county just south of me with an overwhelming black population, considered one of the most favorable venues use for plaintiffs in the country, no physician has ever lost a case. Physicians who serve in rural areas are generally revered.

What I was going to testify was confirmed by the physicians. I think they should come and support our position on this issue. Dr. Fields testified that his company or firm was dropped without a claim ever being filed against them. Another physician he described had no claim filed against her. Dr. Myers in my home State of Mississippi again, high premiums, dropped from coverage, no lawsuit filed against him.

The problem is not lawsuits. The problem is of things within the insurance industry. Frankly, the insurance company pointing at lawsuits as a cause of high premiums is much like a quarterback faking a pitch. Its only purpose is misdirection. The only question for us is whether or not we are going to fall for it.

Caps have the constant effect of excusing carelessness and ignoring accountability for physician performance and making good physicians pay for the misconduct of poor physicians.

With that, I will stop.

Chairman MANZULLO. Thank you very much for this excellent testimony.

[Mr. Colom's statement may be found in the appendix.]

Chairman MANZULLO. Let me move right to Dr. Fields.

Mr. Colom mentioned the fact that the insurance company came in with the high premium. Was there another insurance company available?

Dr. FIELDS. It was not immediately available. Our hospital stepped in and allowed us to temporarily obtain coverage through the hospital.

Chairman MANZULLO. Okay. Anybody else on the—I can understand where we are going here, but we have been challenged by I think some very well-documented statements by Mr. Column. Dr. Fields and then Dr. Price.

Dr. FIELDS. Well, those statements, I am afraid, fall into the category of myth and—

Chairman MANZULLO. Not all of them, but get particular on them. You mean on caps or what?

Dr. FIELDS. Caps work. They are one of the few reforms that have been shown to work. I happen to be Chair of our Strike Force on Medical Liability; and we are actually producing a document about this particular problem, what works, what does not work and what is a myth. The insurance companies' investment strategies is a myth. The bad doctor problem is a myth. It is the threat of lawsuit that produces defensive medicine, and it is the lawsuits themselves that produce the high premiums because insurance companies in many States or most have to set aside money when a suit is filed.

Chairman MANZULLO. Let me get on to something else here.

I am sorry. Dr. Price, you had an answer for that.

Dr. PRICE. I just want to mention with respect to the caps, certainly, and I would agree with Dr. Fields that one of the things that we have seen with respect to the malpractice crisis is that the justification by the insurance companies has always been that the claims are what is driving up the cost and I think one of the key issues in terms of oversight over the insurance companies say-so that there is some accountability issues for the premiums they put in place. We have a number of physicians who are not able to put in place the very things that our President of the United States says will help to reduce the accidents in health care and help to make better physicians and that is moving towards the use of technology. But physicians who are spending as much as 100 and $150,000 on malpractice insurance when it is not supported by claims or suits that are valid, certainly does not give them the armamentarium to go ahead and purchase the electronic clinical management systems that are going to improve health care. There is something wrong about that system.

Chairman MANZULLO. Dr. Brown.

Dr. BROWN. Yes. I am in private practice, I am a solo practitioner, and, as I mentioned before, that at least in Ohio the availability of the insurers has been a problem. The insurance company that I was using left the State of Ohio so that left fewer companies to cover, and whether or not they adjusted their price accordingly I have no idea, but I think that has to be a factor of the availability of insurers. People have gotten out of this business for one reason or another, and I think that has contributed to the cost, and certainly capping the amount for non-economic damages has made a difference. There are statistics out here to prove that that is the case.

Chairman MANZULLO. Mr. Lipinski, we have a broken clock, so I will keep time. So when we get to 4 minutes I will lightly tap and we will try to work it on that basis.

Mr. LIPINSKI. I thought you might call me doctor, too.

Chairman MANZULLO. You have an earned doctorate, that is right.

Mr. LIPINSKI. Actually, I prefer not to be called doctor. I am the kind of doctor that, as they say, cannot do you any good, unlike the doctors we have here in front of us today.

As the chairman mentioned, Illinois just recently passed a medical malpractice law which was somewhat of a surprise given that it is a Democratic State legislature, both houses, and a Democratic governor, but it is definitely something that is an important issue, and there is no question about that, the problem with losing doctors.

The questions that I have really revolve around what exactly—what else can be done. In Illinois, the caps were set at $500,000 for doctors, a million for hospitals, for maximum non-economic damages. But they also made changes requiring insurance companies to reveal more about how they set rates, also making it a little bit more difficult to bring lawsuits in regard to affidavit of merit for a case so that—to try to prevent frivolous lawsuits. And other things, such as even Dr. Fields says, it is not a problem of bad doctors, but things that were put in this law included posting—maybe I should wait for this.

I guess we are safe here for now. I just wanted to start with Dr. Brown because I know Dr. Brown mentioned in her testimony that there were other recommendations to reform medical malpractice insurance. And I was wondering, there definitely is a problem. We have between 44,000 and—I think the number is between 44,000-98,000 deaths occur each year in hospitals, according to the National Academy of Science, and that is just in hospitals. There are certainly problems there. What else can we do besides and what should we do? What would work? What would help with this problem of losing doctors besides the caps on malpractice rewards?

Dr. BROWN. Well, I think that you touched on one of the things that at least happened to me personally, is that somehow, regardless of what the gentleman said, somehow we have to be able to stop frivolous lawsuits. How do you make sure that the lawsuit is a proper one so that I do not end up having to pay a lawyer to defend me?

For instance, I had a patient who had a goiter on a routine examine. Did a TSH. It was completely normal. Put her on suppressive therapy. I got sued because she claims she developed Graves Disease. If you put a patient on Synthroid or any thyroid preparation and it stopped, it does not cause a disease. So somebody should have been privy to that information. This has been dismissed, and it has been dismissed three times. So that is an example of how do you stop those kinds of things from occurring.

Mr. LIPINSKI. Do you think these kind of things could be stopped?

Dr. BROWN. There has to be some kind of advent of looking at or being held responsible for bringing a lawsuit against a physician that will lead to more and more costs, adding to the costs of malpractice. Because I have had three different lawsuits where this has happened, where on one case I did not even take care of the patient for a month and a half prior to her death and just because my name is on the chart I am sued. Twenty-eight people got sued on one patient. Those kind of things I think somehow—

Then, on top of that, I think the insurer has to be held responsible, too. If a lawsuit comes out of something because the insurer did not allow the doctor to do what was appropriate, then I think

the insurer should be liable for those damages. I will give you a perfect example.

I have a patient right now who is past the age of 50, needs a screening colonoscopy. The insurance company refuses. What if she develops colon cancer? Who is going to get sued? I am. I should not be held responsible because I have asked them not only on one occasion but on several occasions, and the patient has asked her insurance company, why are not you covering this? Well, their excuse is your stool for occult blood is negative. What if it is a right-sided colon cancer, it can be negative and she could still have cancer.

Chairman MANZULLO. Mrs. Kelly.

Mrs. KELLY. I thank you.

Dr. Price, I am really interested in what your recommendations are for us. I want to point out to this Committee that in 2001 six of the top eight medical malpractice awards came from New York courts. Now I represent New York. I represent a district in New York. In 2003, it was four of the top six. New York is considered a red-alert State by the American College of Obstetricians and Gynecologists because 67 percent of the OB-GYNs have been forced to restrict their practice, retire or relocate to another State. According to the Long Island Business Journal, 45 percent of OB-GYN residents who graduated from New York medical schools left the State. We have 55 percent of the orthopedic surgeons Nationwide who do not any longer do some kind of certain high-risk procedures, like 39 percent of them do not perform back surgery, spine surgery any more.

These numbers are outrageous. Because we used to have in the United States of America the best medical care in the world. This system clearly has some problems.

You have pointed out in a couple of things here. You suggest that Congress in the next step respect States' rights by allowing States that have already enacted damage caps to keep the caps in place and have the flexibility to change them. I applaud that. I hope that members of this Committee hear that.

Mrs. KELLY. I also see here that you have said that you think we should reexamine the processes by which malpractice insurance premiums are set by insurance commissioners at the State level. Do you think, and there is my question to you, do you think at the Federal level, we could get in there, pass a bill to effect that and get it right enough that we can help protect doctors like you, especially the doctors who are serving our underserved patients?

Dr. PRICE. You bring up interesting points. I think one of the fundamental problems is, in addition, not looking specifically at the individual lawsuits and the nature by which they come about, but I think we have to look at the health care system as a whole and ask ourselves whether we want to put energy, effort and resources into training individuals in a profession to provide critical care to individuals and then create a system over on top of that where we can put them out of business.

If you think about it, medicine is the only profession in this United States where, in 1 minute, you can lose more money than you can make in a lifetime. And so I ask you whether the oversight in terms of how the premiums are set, irrespective of whether

there was overt or covert damage, is that the system that we really want in place?

One of the other things you can take as an example of how the Federal Government can be creative—and I am not suggesting that the Federal Government should have the full oversight over how the individual States embark on their controls over this issue—but when we decided that the immunization program was an effective public health strategy and when we recognized there are a lot of apparent pushback into damage caused by some of the vaccine, we had the wherewithal to say, we are not going to dismiss the fact that injured individuals are entitled to some compensation, but we are going to create a pool of money so physicians don't have to think about whether or not to give an immunization based on the risk of lawsuit. They knew that a fund was available. Imagine the creativity of this United States, the best health care system in the world, to say to obstetricians, go out and practice your profession, provide the expert care that you can and recognize that bad outcome is not the equivalent of malpractice, but yet those injured infants and those parents and families who are suffering are entitled to some compensation. Well, we have shown we can pool our resources. We have got enough money in the Federal Government to allow for some compensation, but we should not, we cannot afford to put physicians out of practice.

Now, you know, the money trail follows the money, and it is no surprise that in New York where real estate costs and the cost of living is high that attorneys will create a system where they can step it up one notch. And so as we see we are at the top of the ladder in terms of malpractice payouts in New York, that is not going to get better unless we change the system. I applaud you for helping us with some of those changes.

Mrs. KELLY. I thank you, Dr. Price.

I want to point out, between 1998 and 2002, 70 percent of New York's neurosurgeons were sued as well as 60 percent of the OB-GYN, 60 percent of our orthopedic surgeons and 60 percent of our surgeons. We cannot keep going at this pace. I applaud you for that idea. I think perhaps we can model that over the same kind of thing as some other insurance pools work and perhaps that can help us, but certainly, we do have a medical crisis in this Nation when we have percentages that high of doctors being sued and we find out that many of these suits are specious suits.

And I thank you all for appearing here today and I appreciate your ideas

Chairman MANZULLO. Let me get in Dr. Christensen's questions before we break. We have to go vote, and then we will be coming back. I am sure we can pick that up after the break.

Dr. Christensen.

Mrs. CHRISTENSEN. Thank you again for holding the hearing on the malpractice issue. I am a little under the weather, but I will try to perk up for this, because I am so pleased to see not only a representative from my academy of family practice but my President of the National Medical Association and Dr. Rios, with whom I work very closely and have done so for years on issues of minority health, up here.

I am sure there is—while there might be disagreements over the causes and remedies for this issue, I am sure we will all agree that the medical system, our system of health care, is in a crisis in general. And again, as I did last time for the record, I just want to say that while medical malpractice is a major part of the problem, it is not the only problem. And I hope that while maybe not in this committee, we can in the Congress address some of the other issues that are creating a crisis and may lead us to a catastrophe, such as the 45 million uninsured, the assault we are experiencing on Medicaid, the fact that we are ignoring a crisis that is closer to us in Medicare, the high cost of medicine, the cuts in the programs that protect the public health and the high cost of medicine to name a few as well as some of the inequities that minority physicians are facing in some of those underserved areas as well, such as this disparate reimbursement rates in certain communities for the same services.

But I guess one of my questions I would start out with would be with medical liability, is the premium increases the only reason that doctors are leaving underserved areas today?

Dr. PRICE. Not at all. One of the issues is related to the ability to have a successful small business. And you alluded to the fact of the differential reimbursement. As you know, in many of the minority communities—and understand that the liability issue is not a race issue. It is not a black-white issue, but occurring across all of America. And one of the examples that I had is an obstetrician-gynecologist who is practicing in Nevada taking care of the Caucasian population. He is one of our members and in fact one of my classmates, and he is frustrated.

But the key issue with respect to why people are leaving is they just cannot maintain an effective small business. I have kids come up to me when I do mentoring, and they ask me what profession to go into, and jokingly, sometimes I say, if you want to be successful and have a good business, don't go into medicine. And if you think about it, that is becoming so much of a realism that you cannot employ your community, pay them a competitive salary, keep pace with the demands of HIPAA regulations and trying to pay for electronic medical records and the security and risk of practicing in a poor community. So it is a business issue that is at stake.

Mrs. CHRISTENSEN. Reimbursement and the practice as well for which there is no subsidy.

Dr. Fields, in your experience, even though we are talking about underserved areas and some of them may be rural areas, are there increased lawsuits and high payments in some of these rural areas that can account for the increase in the premiums that we are seeing?

Dr. FIELDS. Yes, there is an increased—actually, the amount of awards. And while the specter of medical liability is an equal opportunity employer, it hits everybody, it doesn't hit everybody equally because, if you are black, if you are Hispanic, if you live in eastern Kentucky or Macon, Missouri, or Vernon, Connecticut, it robs you of the ability to obtain all that this country can offer in the way of help. And one of the things I wanted to do here today is come here with a promise from the American Academy, a promise to support you in this committee in all of your efforts and pro-

vide whatever resources we can and to make a promise that if we can free the physicians in America to do what they are trained to do, which is the right thing for each patient each and every time, we will deliver to you the most cost-effective, highest-quality, most accessible health care system in the world.

Chairman MANZULLO. We will take that.

And one thing we cannot change is the clock. We are going to recess for 15 or 20 minutes. We have one vote. And no votes until 4:30. You won't be here that long, but we will have plenty of time for questions when we get back.

[Recess.]

Chairman MANZULLO. While we are waiting for Mr. Westmoreland, Dr. Price, you had attempted—you had raised your finger and wanted to make a point two questions ago. Do you remember what that was about?

Dr. PRICE. Thank you, Mr. Chairman. I just wanted to tell you how personal this was. I was at a meeting the other day, and my own personal physician came up to me and said he had a problem with malpractice and—thinking he just wanted to relate some strange frivolous suit—he—unfortunately, his payment for his malpractice insurance premium to the same company that insured him for the last 15 years arrived 2 weeks late. And when he attempted to reinstate his insurance by simply sending the premium again with a note, they told him that they were not going to reinstate his insurance. He was paying a premium of about $9,000 per year. And what they offered him as an alternative was to take a risk pool insurance policy for $40,000 a year. Not only can he not pay that, but it is not conducive to a good small business.

Chairman MANZULLO. Let me hold you right there.

Mr. Colom, that is a good introduction.

Mr. COLOM. I want to point out anecdotal information is plentiful. But when you look at the real data, the medical liability monitor with insurance companies' premiums in capped States are actually 9.8 percent higher than States without caps.

Chairman MANZULLO. Is that true for California also and Wisconsin?

Mr. COLOM. California premiums are higher.

Chairman MANZULLO. We have people moving from Illinois to Wisconsin. But Wisconsin has not only capped but an indemnity fund, which is a backup for those real tough cases. But go ahead.

Mr. COLOM. We support those sort of remedies to help doctors reduce their premiums, but the total malpractice claims have only gone up 1.7 percent from 1991 and 2003 when it adjusted for inflation. And the same number of physicians have risen 31 percent. So—and I point out, you talk about anecdote, my insurance—I am a lawyer—has tripled. Our property liability has tripled.

Chairman MANZULLO. When I practiced law the last year, I think my liability insurance was about $600 a year. That was in 1992, and I had to buy a tail for 22 years and that was $5,000. I mean it is negligible to compare.

Mr. COLOM. It would cost you $40,000 now for that same insurance.

Chairman MANZULLO. Oh, come on. What do lawyers pay now for liability insurance?

Mr. COLOM. Very few lawyers pay less than $20,000. If you were going to carry a half million dollars to a million dollar limit, you are going to pay anywhere in the area of $15,000 to $20,000. Large firms pay $100,000 to $150,000.

Chairman MANZULLO. Dr. Price, go ahead.

Dr. PRICE. I appreciate Mr. Colom's comments, but you cannot contrast that to medicine. I mean, how many physicians can put up a sign inviting patients to come in for an appendectomy when they are at a state of crisis and say, my fee is a million dollars, and I am only going to take 30 percent of that. There is so much regulation over what physicians can get reimbursement for to cover those increases. Our solution, when we get the increases, is to go out of business. And that is unfair to the public.

Mr. COLOM. The point I am trying to make is the increase in premiums have nothing to do with the lawsuits. If we had the insurance companies here at this table, and they won't show up—

Chairman MANZULLO. Wait a minute. We had a hearing here about 6 weeks ago in March, and we had insurance companies, including the man who started the captive in Pennsylvania. And the issue there is, in some States, there is only one company that will offer insurance. And he had started that, and this is not-for-profit. There are no shareholders in it. The only stakeholders are the physicians that write the checks to be part of the captive and he said when somebody talks to us about unreasonable premiums, he says we only charge what we absolutely must charge. And then there are so many insurance companies going out of business. I mean—Dr. Brown, you got hit, you went from $5,000 in 2002 to what is it, $103,000?

Dr. BROWN. I didn't have the tail off this last year.

Chairman MANZULLO. You were changing insurance companies and had to pay a tail each time?

Dr. BROWN. The insurance company would no longer insure me from before. It has to do with the number of insurers in the market, at least in Ohio. A lot of companies left Ohio.

Chairman MANZULLO. How many are left?

Dr. BROWN. Only three or four at maximum right now. There is a new one that I am negotiating with right now, but I am going to be paying about $68,000. I have to pay about $28,000 for the malpractice that didn't reduce, and I have to pay a $38,000 one-time fee because the insurance company is not underwritten by anyone who is new. So, we, the physicians, are really putting up the money for this.

Chairman MANZULLO. Are there any endocrinologists in East Cleveland?

Dr. BROWN. Other than myself, there is a practicing endocrinologist that practices at the hospital, but he is not in the community itself.

Chairman MANZULLO. What would happen if you left that area?

Dr. BROWN. There would be a lot of diabetics that don't have a specialist that can help to fine-tune their care. So prevention would be a problem in terms of complications. Diabetes is a chronic disease with a major impact on the costs of medical care. From that standpoint, it will be devastating. As far as—that is the major dis-

ease process that I am treating in that area, and then, of course, it is on the rise in the country.

Chairman MANZULLO. Congressman Sodrel.

Mr. SODREL. Forgive me if I am asking a question that is covered someplace in the testimony. I was kind of in and out. But my question is, what percentage of your costs of practice is medical liability insurance? In real life, I was in the trucking business and bus business, and you look at labor costs being 33 percent of what your total expenditures are or fuel costs being 15 percent.

Dr. BROWN. Talking about 38 percent; 38, 40 percent. And when you are limited on what you can make—the problem is I am in a community where there are patients who don't have the insurance that pay a higher amount. So we are limited with Medicare and/or Medicaid or a company that totally limits the amount that you are going to make, then you have to see more patients or you have to cut staff. Just as he said before, there are too many variables that you have to try to adjust just to stay in business. And if you want to do anything, like EMRs that cost $60,000 to $180,000 to try to lower your costs, at least you can reduce the number of people working for you using such a system, but can you afford to buy it?

Mr. SODREL. I have a brother who is a doctor in Florida. And he is a doctor for V.A. Just because of this problem. He couldn't be in private practice; said he couldn't afford to be in private practice. And a lot of doctors in Florida are sending more to the insurance companies than they are taking home to their families.

Dr. BROWN. In situations where you are in private practice, you are the burden. Everything falls on you. You don't have anybody who can come over here and say, can I borrow $10,000 to take care of this? I have to pay it out of my pocket. And my staff isn't going to work for free.

Dr. PRICE. And many practices are running at about 45 to 55 percent in overhead costs. And part of the problem we are seeing every day in terms of the vendors that we have to do business with, sending us very apologetic notes saying that due to increased costs, they have to increase their fees, whether it is vaccines, paper or software or even the biological waste that we have to contract with to remove from our office, 5, 6, 7 percent. We have no recourse.

And when we see that from a malpractice insurance because of the major jumps in costs, many physicians have no choice. I have seen physicians when I worked with managed care crying and begging me as a medical director of a national organization asking me if there was some way that I could lend them money, front them money from the insurance company just so they could pay their staff and keep their doors opened. And these are physicians, highly trained physicians literally crying. That is unfair to this Nation.

Mr. SODREL. As you pointed out earlier, if you want the best and the brightest to pursue a career in medicine, it has to be worthwhile because of all the years you spend in medical school and the money you spend for education and then find yourself in the position you are in today. Thank you.

Chairman MANZULLO. Dr. Christensen.

Mrs. CHRISTENSEN. Thanks, Mr. Chairman.

Looking through some of the testimony and some of the measures in reform that both family physicians and other physician organizations are supporting, almost all of them include limits on payments for noneconomic damages, reducing awards by amount of compensation from collateral sources. But in reviews of States where there has been a significant increase in insurance premiums, as I look at the awards that have been paid out, there hasn't been a commensurate increase in the awards. So if awards have remained relatively stable and insurance premiums are still increasing, why are we supporting the limits on payments for noneconomic damages that don't seem to be related to the cost of insurance premiums as far as I can see?

Do you want to start, Dr. Brown.

Dr. BROWN. At least in Ohio, I can't really agree with that. We just had a young man that was awarded $13 million because he was injured during birth and ended up with a neurologic damage because of, if I remember correctly, forceps or something like that. And there was no way that this person was going to make $13 million in their lifetime. So I think—

Mrs. CHRISTENSEN. What I am saying is, I think Texas is one of the States that they looked at, but when independent organizations looked at this and they looked at the awards, the amount of awards over a period of time, there really hasn't been a significant increase.

Dr. BROWN. I don't think it is fair to use Texas. At least in Ohio, people have left Ohio and gone to Texas because it is cheaper for malpractice. I know several gastroenterologists who practiced at Hillcrest Hospital at Mayfield Village who left and went there. So there are some differences between States. I don't think you can make a statement like that across the board.

Mrs. CHRISTENSEN. I am actually referring to some studies that were done.

Dr. PRICE. I agree with you, and I have seen those studies, and I think where you are going is saying that if the actual payouts are not the basis for the premium, why set a cap? I think what it does is it shifts the framework by which insurance companies try to justify the increases. And certainly, if there are major payouts with no caps, it serves as fodder for those companies to justify to the physicians, who are not knowledgeable about those studies, that they have to increase the premiums because of that. And you realize that many of these companies are not not-for-profit companies. They are for-profit. If you go into some of the buildings that these companies have and look at their portfolios and annual statements, they are making money. And there is only one source that is putting money into their profit margin.

So I think what the caps do is it starts to reduce this litigious society. And I use this as an anecdote: If you are an unemployed individual, and we have several in this State, there is one way that you can do better than the lottery in terms of percentages of getting paid, and that is, you go into a hospital or you go into a physician's office and you hope that the medical errors occur. And you simply find an attorney who will work on a contingency fee and will say there is no cost to you at all.

Chairman MANZULLO. Can I interrupt on that? I don't know if that is the case. I mean, somebody goes in the hospital because he is unemployed and first of all, if he doesn't have insurance, the hospital is going to make it a very short stay, right?

Dr. PRICE. Can't do that.

Chairman MANZULLO. And people are going in just in hopes that their—I think the figure three-tenths of 1 percent of all medical liability lawsuits filed actually go to trial, is that right, Mr. Colom?

Mr. COLOM. Pretty close.

Dr. PRICE. They don't go to trial, but they settle. Many physicians suffer because they have policies that don't give them the option to challenge the lawsuit, but many other physicians are advised by their attorneys thinking that they are getting good advice and told to settle and only comes back to bite them later on when they find out the terms of settlement.

Mr. COLOM. Virtually every State requires, in order for you to succeed in a medical malpractice suit, that you have at least one physician who is in that profession, that area of specialty to testify. You can't get past the Daubert standards, any other standard, you are down on summary judgment unless you have another physician in that same specialty prepared to testify that the conduct was negligent. In most States now, unlike any other lawsuit, before you can file lawsuits in most States now, you have to have a certificate or you must have made a good faith inquiry to determine whether or not under the rules for lawyers, Rule 11 for sanctions, that you have expert testimony, that you have a good claim. And that is only true for physicians.

And I can tell you, I am sympathetic with your situation. I think you guys are the best physicians in America, that we need you a heck of a lot more than we need the ones doing cosmetic surgery in the suburbs of Los Angeles, and you are paying too much in premiums. And I think we need to get it down, but we really need to find out what will really get it down, not the misdirection of the insurance companies trying to deflect the real reason. The real reason has nothing to do with lawsuits and has nothing to do with claims against you doctors, but with other things.

Dr. PRICE. I would agree. If we are going to revisit the McCarran-Ferguson Act, which is what really needs to be looked at in terms of how insurance companies are regulated, how the process is conducted, I think we would get into some of the meat of what is going on with respect to those premiums.

Dr. BROWN. I must be off somewhere else. In Ohio, it is different. I don't understand. I got sued for a bug allegedly in a person's ear; showed up in the emergency room 4 hours later. And I was told to settle for $250, and it came back to bite me in the butt. That is not fair. And I got sued because some gentleman was left in the hallway. How in the world if the lawyers were regulated, how can I get a lawsuit? I was out of town. I had to fly back for this frivolous suit, I call it, because what do I have to do with somebody being left in the hallway, but they had the ability to sue me anyway. It was nothing about malpractice. So they are able to bring a lawsuit against me in Ohio. It was dismissed, but the point is I still had to get a lawyer to defend myself. I am out of town. I have to fly back just for this, and it didn't even make sense. Lawyers,

at least in Ohio, have a different kind of way of doing things than what you are saying.

Dr. PRICE. There are expert witnesses. But not being derogatory to our profession, you can find a physician, a professional to say whatever you want to spin it enough that it will get by and become a trial. Many physicians suffer needlessly as a result of litigation that is charged to the physician. And again, bad outcome is not malpractice. And number two, physicians, who, because of the structure of HMOs and oversight we put in place, if a patient is on our panel, you are deemed to be responsible for that patient 24/7 irrespective of where you are. And to drag that physician into a court of law, even to the point of an attorney's office to have an examination before a trial, that physician is placed at risk because they are not earning income and not conducting their business during the 3, 4, 5 days they are involved in this trial. We have to change the system. And granted, it may not be related to the claims that are paid, but it is related to premium notices that come to physicians. And we have got to change it. There is a way to do it.

Dr. FIELDS. One of the reasons, if I might, that premiums in a State don't track with awards in a State is most of these liability insurance companies are doing multi-State business. And physicians in one State are subsidizing physicians in other States. And Indiana is a perfect example of that. They have had liability reform for many years. Their premiums stayed down. Their major carrier was sold, and now they are subsidizing three other States. So their premiums are rising, but it doesn't have anything to do with Indiana, but it has to do with what is going on in the other States. And currently, we have a system where any lawyer who can find a client and an expert, which they advertise for heavily in very blatant forms, can drag a physician through the court system for 5 years. Every year that physician is paying higher and higher premiums. And then, at the end of the day, most of the money doesn't go to the alleged victim, if anything is awarded at all. But it is a system that promotes a lottery mentality. It is the lawyers. It is the amounts that the damages are paid. The AMA is clear on that.

Chairman MANZULLO. Mrs. Christensen, can I ask a few questions?

Mr. Colom, I know you have a response to that answer.

Mr. COLOM. I think the AMA is sincere in its desire to control outrageous premiums, and we really support what you are trying to do. And we just keep asking, why not go to the real source? You know, one thing I am going to concede to you, doctor, at the end, this system is a system that creates a lot of inconvenience. I got sued recently. I had a news letter from my law firm, and we sued a guy who was the head of the Environmental Protection Agency, chairman in Mississippi. My guy who writes the newsletter referred to him as a fox in a hen house. He sued me. And we were in litigation for 3 years. I won it on summary judgment. Inconvenient, but it is the nature of our system. And I think that is true.

But there is a lot of inconvenience in a system such as ours that is so democratic. Doctors complain to us all the time, they have to come to court personally in personal injury cases, and they have to sit and wait. And juries complain they have to sit and wait. I am

sympathetic. We can work on things like that to make the system better, but this is a system that has existed for 500 years. And just like this is the best medical system in the world, without a doubt, this is the best legal system.

Dr. BROWN. Doesn't mean it should have to exist for 500 more.

Dr. FIELDS. I would contest the word inconvenient when somebody is questioning your professional judgment and alleging that you participated in the death of someone. I take affront to the term inconvenience.

Mr. COLOM. I know you people take it—everybody who is sued feels really bad, but she won the lawsuit.

Dr. FIELDS. That is not the point.

Dr. PRICE. If we at the Federal level or at the State level have regulatory oversight, and we know how much is being paid out on premiums, and we know how many physicians are practicing, and we know how many patients we are serving, why are we having so much difficulty deciding, with all of the MBAs and actuaries we have at our disposal, and determining what is a reasonable premium by specialty of physicians? Why are we not able to tell a physician whose company goes out of business that we have a Federal or State emergency fund to keep you in practice so that you can take care of America's ill until there is some solution found to put an insurance company back in your State?

Chairman MANZULLO. The problem is, according to Mr. Colom, we don't have a crisis. The statement on page two is, "I agree wholeheartedly that doctors have a malpractice premium crisis, but it is not caused by lawsuits. In fact, there is no so-called liability crisis." Is there any area of agreement here?

Mrs. CHRISTENSEN. He agrees there is a crisis. The issue is, what is the best way to resolve it? Not a quick fix, not something that makes some people feel good, not a political fix, but a fix that gets to the bottom of the issue. And I think, you know, just to single out caps as the primary way to address it is not looking at some very, very important other causes of the problem, and the insurance companies are part of it. Doctors take a history. They examine their patient. And then they use their training to kind of figure out, okay, this is the problem. This is what I found. This is how we are going to treat it. And that is what we have to do with the problem, not just assume that caps are going to be the right way to approach this. We need to look at what are the real causes and address all of them.

And to me, also caps may be unfair—noneconomic damages may be unfair to certificate segments of our community because—particularly minorities. And my understanding is that also they don't even get the payments on their capped damages.

Mr. COLOM. Mr. Chairman, I would say one of the big issues I would observe, and I represent a few physicians, is that reimbursement has gone down. It is more difficult to run a small business as a physician now, removing the issue of liability. It is managed care reimbursements. Rural hospitals are closing, even the ones that are run by States that have sovereign immunity and have capped their total damages so they can only, in Mississippi, where a local county hospital is limited to $500,000 economic and non-

economic damage, still struggles because of the reimbursement of Medicare and Medicaid. And think of that situation.

Perfect example, someone has their liability capped at $500,000 economic and noneconomic damages, and they are still having trouble. The clinics run by the State, whether they are the doctors or employees of the State, again subject to these absolute caps, are having trouble surviving. That is absolutely—the data will not support the claim that the liability is the issue, particularly—

Chairman MANZULLO. Dr. Fields, you mentioned in your testimony that an OB unit closed in a rural area in Kentucky. Was that you or your testimony?

Dr. FIELDS. My hospital.

Chairman MANZULLO. Would you tell us what caused the closing?

Dr. FIELDS. Liability premiums for obstetrics in Kentucky went up. I am not sure of the percent, but it was 300, 400 percent in like a year. Every obstetrician that delivered babies in our hospital stopped delivering babies to lower their premiums.

Chairman MANZULLO. Let me stop you right there. Have there been claims against the hospital that precipitated that?

Dr. FIELDS. No.

Chairman MANZULLO. How many insurers were there—were available?

Dr. FIELDS. Three.

Chairman MANZULLO. Mr. Colom, what do you do in that case?

Mr. COLOM. It is not a liability problem.

Chairman MANZULLO. You mean liability on the part of the doctors?

Mr. COLOM. Right. They have no claims, which is true. Again, I keep searching for—you can come up with the anecdotes—if you look at, across the spectrum—

Chairman MANZULLO. What do you do in that case? And we had the hearing in April where a man who had set up a captive, one State only, period, so they don't use community experiences as it were, bring in other States for what they charge for the premium. And the captive was the only one in the State, and all they charged was the absolute minimum. What do you do in a case like that where the doctors still have a difficult time trying to afford the insurance and the captive, which is comprised of doctors themselves, are setting their own rates, and they say even with us doing that, it has been difficult to keep down the rates? Wouldn't litigation be causing that insurance to go up?

Mr. COLOM. There is no evidence to suggest that. And I think it is important to keep in mind, there is no—

Chairman MANZULLO. The evidence they gave is, it is not just the payment but the cost of litigation.

Dr. PRICE. What State are you talking about?

Chairman MANZULLO. In Pennsylvania. And of course, they don't have exactly a rosy time going on up there. There is a hidden side on this, and Mr. Colom, you are the only one that can answer that. Have you had a clear case—you do malpractice litigation. Do you plaintiff or defendant?

Mr. COLOM. Just plaintiff.

Chairman MANZULLO. Have you ever had a case where it is very clear—someone cut off the wrong leg, that is probably a very, very

clear case of medical malpractice where the community of doctors themselves would say, this is not a judgment thing, this is just medical malpractice and the attorney for the insurance company stroked the case to build a file, no one talks about that, do they?

Mr. COLOM. Very common.

Chairman MANZULLO. I did litigation myself and was not involved in medical liability, because it was a one-man firm. You didn't have the resources to do that. But does anybody talk about the cost of defense attorneys in a case—not an open intersection case, someone blowing a stop sign, and somebody sitting down to figure out the amount of damages, not the liability where the defense firm will build the file just to charge a fee? Why doesn't anybody talk about that?

Mr. COLOM. I tell you the reason people are not talking about it, is because of instructions from the insurance company. One of the great things the insurance companies has going for them, the longer the litigation lasts, the more desperate the client becomes, because they still have to make that house payment or whatever other payment they have to make. And you know, my number—

Chairman MANZULLO. Lawyers can't make loans to clients, that is called maintenance, which violates the code of ethics.

Mr. COLOM. In Mississippi, we are limited to $1,500 or you could lose your license. That is all you can advance a client. And the most common thing—I mean, I had a perfect case, I knew was worth at least a million dollars. The client walked in to me and asked me to settle the case for $300,000, and I pleaded with the person not to, held on for three months, and she got $900,000. The insurance companies know they can string the case out. When the car gets repossessed, the person will take nominal value. The smaller claim, the less likely they are to pay it because they know they can string the case out.

But I think there is an important principle as well, and I am going to stop at this point. We have to keep in mind that, Doctor, if you cap noneconomic damages at $250,000, if one of these doctors who works in a rural area is injured, he will be worth about one-tenth of the plastic surgeon in Los Angeles. We can't value people, their service, solely on income. And I think it is unfair to say arbitrarily that you are scarred across the face and you are a child, you are worth $250,000. If you are a housewife and you are killed by someone's negligence and you are 60 and you have no earning power, or some guy who is cutting faces for people in Hollywood who serve value other than to make people beautiful is worth $10 million. And that is the problem with caps. What juries can do is they can hone the remedy to the particular plaintiff who is there. You say, okay, there are bad examples, and there are bad examples. But if you follow those bad examples, the appellate system controls it. Outrageous verdicts, the judge reduces it. There is a thing in the law called a remitter; the judge says, bang, this is going down. On appeal, it gets reversed. You see the headlines, but the headlines are not the end of the story on these outrageous cases.

Dr. FIELDS. There is a saying, if you say something loud enough and long enough, that you might convince some people to believe it. But most of that stuff is simply not true. If we cap noneconomic

damages, we are going to affect your contingency fee. That is the thing that the trial attorneys are scared to death of, that somebody will go over that. Nobody is saying conduct or limit medical expenses, that sort of thing. Nobody is advocating that sort of thing. And you know, the trial attorneys also do the bait and switch, and they try to blame everybody else other than the trial attorneys. But it is pretty clear in Texas, where they passed liability reform and their rates went down 17 percent immediately, that some things do work to control the cost of liability insurance. And a lot of things don't work. And what doesn't work, primarily, is a lot of the insurance stuff that the attorneys always try to trot out to deflect attention from the root of the problem.

Mrs. CHRISTENSEN. I would like to ask Attorney Colom, what about limiting the contingency fees? I tend to agree with you on the cap issue. But limiting contingency fees is perhaps, you know, another approach.

Mr. COLOM. It is something I think that should be discussed. It depends on the particular circumstances of a case.

Mrs. CHRISTENSEN. I am more inclined to limiting contingency fees, finding ways to limit the frivolous suits because there are ways we can do that, maybe looking at the alternative to in court litigation. What would you think about that, Dr. Fields?

Dr. FIELDS. Absolutely.

Mrs. CHRISTENSEN. And how effective do you think that would be?

Dr. FIELDS. Absolutely. If we could find a system that did not involve attorneys, that involved like, you know, health court judges, that sort of thing, I believe we probably would be on the right track or maybe a no-fault system. And we are looking into those possibilities. But I am the AAFP's commissioner to the AMA's commission for health care disparities, and Dr. Rios serves with me on that commission. And I can tell you now that this problem of health disparities can be solved, but it will never be solved as long as physicians in America are hamstrung by a system that forces them to do things that they know they don't have to do simply to try to avoid getting entangled in the legal system.

If somebody is egregiously injured, they deserve compensation, no question about. But why does it take a trial to do that? It should be a no-brainer. But those aren't the people who get lawsuits filed. Those aren't, in general, the people who get the money. It really isn't. And so you really do have to try to look at the system in an overall manner to determine what actually is effective and continuing to trot this out. And we should try to look at alternative systems, but we have to do something about the current problem in order to get to that system.

Chairman MANZULLO. Maryland just adopted a law about 3 months ago that puts the 2 percent tax on—is it on HMOs or a sales tax—2 percent tax on HMOs, and I assume that is passed onto the consumer. I need Mr. Colom's attention here. He is huddling. Let me re-ask the question. Maryland just passed a law about 3 months ago that places a 2 percent user fee on HMOs, and I presume that is passed along to the consumer, but to create a fund. And did Maryland also adopt caps on it? Million dollar caps. Pretty high caps. And so the people and the governor vetoed it, and

it was passed over his veto. And the theory there is the people who use the medical services, by paying 2 percent more—of course, that goes down to the insurance companies or maybe the 2 percent gets passed along to their deductible—create their own fund for problems caused within the industry itself. I am open to almost anything that is fair. What do you guys think about that?

Dr. PRICE. Well, you know—

Chairman MANZULLO. You can tell that is Midwest. Sorry about that.

Dr. PRICE. I think if you parallel what we have seen in the difficulties the airline industry has entailed over the last 4 years, legislation was very quick to find solutions and create security surcharges and 9/11 fees and all sorts of mechanisms to add additional revenue. But nowhere within the crisis within health care, if we did not place caps on liability payouts, was there an effort to say to physicians, because of the increased costs, even if you wanted to go the route to say it was related to claims, to say that we are going to allow you to have an additional surcharge on your fees that you charge based on the liability or malpractice risk to your profession, because I think if—and I would agree with our esteemed Dr. Christensen, if you did not put a cap on pain and suffering, noneconomic damages, but you allowed physicians to continue to conduct a business, which said cost of business, overhead, additional charges to take care of those expenses, that we would still be in a deeper crisis because the consumer is the one who would have to bear those charges. I don't know if this 2 percent is the total answer.

Chairman MANZULLO. Dr. Bartlett, Ph.D. In physical science.

Mr. BARTLETT. I am sorry I couldn't be here for all of the questions and answers, but I am glad I had a chance to get back before the hearing adjourned. I read the title of our hearing this morning, is skyrocketing medical liability premiums driving doctors away from underserved areas? And I thought that was a little bit like the question, does the sun come up in the east? Of course, it does. I just wanted to note, Mr. Chairman, we keep talking about our health care system. We don't really have a health care system in this country. We have a really good sick care system. Ordinarily, our folk don't get involved in the system until they are sick, and it would be nice if we are able to evolve that to a health care system.

Mr. Chairman, I have a very simple two-word bill that I think would solve a lot of these problems, and I just wanted to get the reaction of our panelists. My bill is short, and it is two words, loser pays. That is all the bill needs to say. That is what they do in England. And they have an amazingly small number of suits compared to us. What is wrong with that bill, Mr. Chairman, loser pays?

Dr. BROWN. Fine by me. We suggested that earlier that if someone files a lawsuit and they lose the lawsuit, why don't they pay for it?

Mr. BARTLETT. They do it in England.

Dr. BROWN. Because some suits I think are truly frivolous. And without any investigation by the lawyers, they should be held responsible for their actions.

Dr. FIELDS. The lawyers will say because it takes peoples' rights away—

Mr. BARTLETT. How does that take rights away?

Dr. FIELDS. Ask the lawyer, but that is what he is going to say. But that system is fine by me.

Mr. BARTLETT. If it is a legitimate suit, the lawyer will take it, and he will win, and the other guy will pay. If it is a frivolous lawsuit, he won't take it, and we won't clog up the courts and insurance premiums won't be going up.

Mr. BARTLETT. It has been working for a long time in England. Why would it not work here.

Dr. FIELDS. It would.

Dr. PRICE. Again, I think we are missing a fundamental issue. If you took all of the payouts, reasonable payouts for what is deemed to be malpractice, it is not in concert with the premiums that physicians pay. And again, I contend that even if you went State by State based on risk to the consumers in that particular State, physicians can afford to pay premiums to cover the risks to those patients based on what we know is likely to happen to a population of people over a period of time.

Mr. BARTLETT. Then why are the rates going up? Are the insurance companies simply gouging?

Dr. PRICE. I do not want to use the term gouging but somebody is pocketing a lot of money that is not being paid out to consumers based on risk.

Mr. BARTLETT. Mr. Chairman, maybe we need to have a hearing and have the insurance companies here.

Chairman MANZULLO. We did.

Mr. BARTLETT. What did they tell us?

Chairman MANZULLO. We had somebody who had a captive, that was owned by the physicians themselves, and the only issue there was the amount of money that had to go into the reserve and that they charged just enough to meet the expenses or the overhead of it.

Dr. PRICE. I think that is the exception. Let us be real.

Chairman MANZULLO. You are blaming the insurance companies.

Dr. PRICE. I am saying most of the insurance companies that are getting away with exorbitant increases in premiums are doing very well profitably. I do not care if they are able to tweak their books and show that they are at an economic loss.

Chairman MANZULLO. Why not perform a captive in the State itself?

Dr. Fields, do you have an answer to that?

Dr. FIELD. Yes. We have actually looked into that, and that is not really the way it is; that insurance companies are not setting their premiums based on their investment strategies or how well they have done or whatever. Captives certainly can, and we have looked into captives, too, and captives can be effective in large groups, and they may have to be statewide, but that is an option.

Dr. PRICE. But the start-up fee is too exorbitant for most groups to even begin to entertain them.

Dr. FIELD. That is true. And when a suit is filed in many States, the insurance company is required to put more money into reserves even before the suit is litigated.

Mr. BARTLETT. Mr. Chairman, the clock is running down. I just have one more suggestion. I have talked to a lot of people about it, even lawyers, and they tell me, yeah, that is legal, and it would probably work. When you go to the doctor for your health care, the doctor says, Suzie, you have got a problem. There are two paths we can tread to treat your problem. The first path is a no-fault insurance. You would not have come to me if you did not trust me. You would be in front of another doctor if you did not trust me. So I believe you trust me. And I am going to do the best I can for you. If I should screw up or something is going to happen, you are going to be compensated for it, but you cannot sue me. There is going to be an awards board. If you choose to walk that path, then it will cost you $400 for the procedure.

If you want to use Joe down the street to sue me if I screw up, then it will cost you $800 for the procedure and the other $400 you will have to pay out of your pocket. Suzie, which path would you like to tread to get your health care? I will bet you 99.99 percent of the time the patient is going to say, Doc, I trust you or I would not be here. Let us go the no-fault insurance path. Why would this not get rid of most of the suits?

Dr. BROWN. Let me ask you a question before they answer that. Will that hold up in court?

Mr. BARTLETT. If we pass a law I assume it would hold up in court.

Dr. BROWN. As I understand it, under the current law—

Mr. BARTLETT. Why would it not hold up? It does for workers comp. That is exactly the way we resolve worker comp things. What is different?

Dr. PRICE. The risk pool that was set up for immunization works the same way. There have been no successful lawsuits, and no one brings a lawsuit for damage from immunization.

Mr. BARTLETT. So why do we not do that? The insurance industry for health care would almost go away because we would hardly need them. There would not be more than one patient in a thousand that says, gee, doc, I am here because I think you are a quack and you are going to injure me and I want to have the chance to sue you. It is not going to happen; is it?

Dr. FIELDS. It is a very rare day I go to the office intending to harm somebody. That kind of system, if you could get it by the judiciary after it left Congress, on the constitutional grounds—

Chairman MANZULLO. It works in these other areas, does it not?

Dr. RIOS. Yes.

Mr. BARTLETT. So why would it not work here?

Dr. FIELDS. I do not see any reason it would not.

Chairman MANZULLO. Ask the guys in Illinois what has happened to the workers compensation premiums. That has gone through the roof.

Mr. BARTLETT. Yes, but it is not $100,000. I was a builder, and we had workers comp, and we had to pay for it.

Chairman MANZULLO. Yes, but, Roscoe, that has been how many years ago?

Mr. BARTLETT. If there were injuries, it goes up. And those things are based on your history. If you have an injury, it goes up. If you do not have injuries, by and by, it goes down.

Chairman MANZULLO. Let me ask you, I am sorry. It is your time.

Mr. BARTLETT. It is your time because the clock ran down.

Chairman MANZULLO. This has been fascinating, this sort of an open mike type of hearing which is what I really enjoy because I like when you guys ask questions and challenge each other to what is going on.

On this question of loser pays, when I practiced law, I did a lot of business litigation contracts and stuff like that. Roscoe,what happens when you have two people who have a bona fide dispute against each other? Each has acted in good faith. Each is relying on a theory of law that may or may not prevail, but they cannot agree before court as to whether or not there should be a settlement. Do you think that the party that loses should have to jeopardize the sale of his house because his theory did not prevail in court, for example?

Mr. BARTLETT. I think that if you have the law loser pays, that almost none of those would ever go to trial because each party in it contests.

Chairman MANZULLO. It will be a deterrent to litigate.

Mr. BARTLETT. But a screwy judge or a whacky jury may decide for the other guy, and so you would not want to risk that in court so you will settle out of court. I think the legitimate cases would be solved out of court, and the frivolous cases would never be filed.

Mr. COLOM. I know one thing I am pretty sure of, and if you studied the English system, I think you will find out it is true, is that very few poor people would ever be able to file lawsuits because they could not pay and they could not go into the system. It becomes a system then—

Mr. BARTLETT. Sir, if you had a poor person come to you, and they had a really good case, would you not take that case if you were going to make some money on it? The only time you would not take that case is if it was a frivolous case, and you thought you were going to lose, and you would have to pay. Now there is no chance you would have to pay because there is no loser pays, so you take the case. And every once in a while, even though it is a frivolous case, you are going to win in court, and it does not cost you much to go to court anyhow so why not.

Mr. COLOM. The cases that I have that are slam dunks, the insurance carriers settle them. The cases that are frivolous, the judge dismisses them. The ones that go to trial are the ones that can go either way, and that is the dilemma you face.

Chairman MANZULLO. Those are the big ones.

Mr. COLOM. Those are the big ones, and they can go either way. That is always a question, when the case is so clear that the judge can dispose of it, it does not go to trial. Are you saying that if a person does not have the capacity to pay if they lose, they cannot file?

Mr. BARTLETT. It is not the person making that decision, it will be the lawyer making that decision.

Mr. COLOM. So that means a poor person can only pursue a claim if they have a lawyer who is willing to risk his wealth for them?

Mr. BARTLETT. There is another way of saying that which makes more sense. The lawyer is only going to take—

Chairman MANZULLO. I need this lawyer's card here.

Dr. PRICE. One of the things I have not heard a solution is to how we continue to allow physicians who are taking care of the sickest of the sick and the poorest of the poor in practice while we wrangle through some of the issues that we talked about. Obviously, there is no magic bullet in terms of how we will solve this problem. This has been debated for a number of years. But the reality is that, among those 45 million Americans who are uninsured and probably more who have inadequate insurance, there are many rural and metropolitan areas where there are physicians dying and crying to work, to stay in business to take care of those populations. And we do not have a mechanism either at the Federal level or at the State level for many of those individuals to ensure they have health care. That is a solution I think we need to come to grips with in the short order.

I am hoping that there will be some resolve within the Small Business Administration Committee to create that mechanism for those individuals.

Chairman MANZULLO. Let me as Chairman have the last question here even though I have heard some great closing arguments from non-attorneys. That is, Mr. Colom, in your testimony, in chief, you said you grew up in rural Mississippi, and you have seen the scarcity of doctors for the past 3 decades. And I guess my question here is, across the board, is there more a scarcity now than there were 10, 20, 30 years ago, or is this just a phenomenon that started a couple of decades ago and continues? Why don't you take a crack at that?

Dr. Fields, what would be a good response on that.

Mr. COLOM. My first job was a legal service attorney, and I are worked for the group called the Federation of Southern Cooperatives. And we only represented poor farmers in rural west Alabama and east Mississippi. Most of those rural counties have more physicians now than they did then for two reasons primarily. One, the incentives, giving medical students aid and in return they would go work in under served areas. And secondly, we have many foreign physicians who would get a visa in return for agreeing to come to the United States to serve an underserved area. That is what has had the most impact during my career.

I have represented a few physicians, in fact, one who came from the Caribbean, who came here solely for that reason.

We are making some improvements. What the physicians really need is help because they are really underpaid in rural areas. They cannot get reimbursed adequately. And they are forced to live a lifestyle not commensurate with their education because of that. And many of them leave to go to more urban areas because of the lifestyle and the income. That is the struggle at least in rural areas.

Dr. RIOS. I just want to say that I think it has gotten worse, and it has also gotten worse because of geographic distribution. The underserved areas are really, really hurting, and I do not think there has been much incentive outside of the Federal community health centers to be able to get doctors into underserved areas. And the doctors that have been in the Hispanic neighborhoods all over the country have been there for generations as solo small practice doc-

tors, and they have had to take a cut in everything. But I think they have stayed there because they have such a demand. There is such a demand, and I do not think people have really studied the small private practice doctors in low-income neighborhoods to understand how to keep them going.

And for Hispanic doctors, again, I mentioned this, the doctors from foreign countries that have come here are all retiring, and they were never replaced. The Federal Government started pushing out the four pathways and all of those programs, the visa programs to be able to help bring in doctors to some of these areas, and our minority recruitment has never escalated to the point where we would have parity for our populations. This goes for all minority doctors.

And I also think the biggest problem with our doctors is they are not telling the younger students to go into medicine because of all the frustrations, because doctors are working part time and trying to get into other businesses, or some doctors are on disability. There are all kind of issues going on.

And I am from California, and I know, in California, there has been a lot of problems with doctors leaving the State also, not just for malpractice but lots of reimbursement problems. And I think that, for minority communities, we definitely have a crisis, and we need to figure out a way to have special targeted reimbursements for doctors.

Chairman MANZULLO. Reimbursement is not going up. The government is broke. I do not care how you look at the pie, we passed the Prescription Drug Bill last year. There were 13 parts to that bill. One of them dealt with drugs, and one of them supposedly addressed the issue of parity, that the rural hospitals would get as much as urban hospitals and also get reimbursement for the docs.

The question here, Dr. Fields, if you want to tackle this, I am trying to find out if there is any agreement here at all. We could probably agree on the time of day. Dr. Fields, Attorney Colom says that his experience in the last 20 and 30 years as a resident, someone who knows the area intimately is that he sees no increase in the number of doctors leaving rural areas. Do you agree with that?

Dr. FIELDS. The number leaving rural areas right now is not great, unless they leave the State for a variety of reasons. However, the real point is what is going to happen in the future.

We actually have a map that we trot out a lot which shows underserved areas, and they are red. And the rest of the area is white. If you take out the family physicians, the whole map almost in the United States turns red. And those primary care physicians are the ones who are operating on the smallest margins. So things like we are talking about today, if they continue, will almost have to affect that in an extremely negative way because we know what will happen to these areas if those doctors actually do leave.

Chairman MANZULLO. Dr. Jones, one of your predecessors testified a couple of years ago; he had that chart. That was the hearing when the head of HCFA came here, and he said he was not going to sit at the same table as a bunch of lobbyists. So the smart alec left, and then I issued a subpoena for him. I was going to throw him in jail for a year. He was governing HFCA. Fortunately, he is gone.

Dr. FIELDS. How did Warren react to that?

Chairman MANZULLO. To call Dr. Jones a lobbyist, one of the most preeminent African-American physicians in the country and the incoming president of the American Academy of Family Physicians, it was incredible.

Dr. Brown, I think you have the last word.

Dr. BROWN. Okay. Well, I will say this.

Chairman MANZULLO. Unless Dr. Christensen had something she wanted to add?

Go ahead.

Dr. BROWN. Being in private practice, a solo physician, responsible for my own business, as I said, it is going to be very difficult to stay in private practice. I know friends of mine or colleagues of mine who are going to work for a managed care organization rather than stay in private practice because they are not making any money and they cannot afford to continue to practice. What I found is that, in order to pay my malpractice, I have to borrow from things that I should have in reserve for my future. And being in private practice does not allow me the ability to draw up on somebody else's retirement. So what am I going to live on in the future?

It is an uncertain sort of an answer for me. So it is really going to drive me. If I continue along these lines, I will not be able to practice. It is as simple as that. The numbers do not support it.

Chairman MANZULLO. Well, this has been a high-spirited hearing, especially after the votes when we have the ability, with the open mike and fewer Members, to allow more interaction. I want to thank each of you for what I think is just tremendous testimony. If anything, it shows that a lot of work has to be done to try to convince enough people that there is a problem.

And, Mr. Colom, you were four to one here. I appreciate you holding your ground, and I appreciate the physicians that have to actually be the brunt of the crisis as we see what is going on. I know one thing for sure, that is my wife's OB-GYN left the practice in medicine in Rockford, Illinois, when his premium went from $30,000 a year to $210,000 a year within 3 years. And there is no way possible that he could have afforded to pay that. No claims. He went into the ministry. I guess if you cannot take care of somebody's body, take care of their soul. Maybe you will get some kind of a stipend to do that. But then the OB-GYN who delivered our three children moved from Michigan back to Rockford, Illinois. So he is there to help pick up the slack on that.

We had a hearing in Congressman Kirk's district about 3 years ago. Four women, OB-GYNs, practicing together, and their insurance premium for the last year was $430,000. The office manager made more than three of the four partners did. They made about $75,000 a year. The witness told us that, at this rate, she was going to leave being an OB-GYN and go back to work as a pharmacist, which was her prior profession, for about 120-some thousand dollars a year. You can now find her at the Walgreen's, filling the prescriptions of her fellow physicians.

I do not care how you dice this, this is a crisis. There is a crisis going on, and I do not know what the solution is at this point. It may be a combination of all things. In fact, at the last hearing, someone said, well, the doctors have got to police their own and get

rid of those bad actors that are really committing acts of malpractice. And there was a colloquy going on, and someone said, yes, that happened in our State, but the doctor that we took away his license and he went out and he hired a trial lawyer to represent him to sue the medical licensing board. And I said, well, that is interesting.

Dr. Christensen, do you have one last note.

Mrs. CHRISTENSEN. I just want to say, Mr. Chairman and colleagues, we have been talking about this issue up here for at least 4 years with some intensity and yet have done nothing. It is a crisis. Whether it is going to be resolved by tort reform or something with some kind of insurance reform or some combination of both, something needs to be done. And I would hope that, despite the fact that we do not have the jurisdiction over the issue in this committee, that we can help to find some common ground. There are some things that we ought to be able to agree on. The physicians today need some kind of relief, and I heard you say that we are not going to be able to increase physicians' salaries. But we have seen the rising costs of health care and the decreasing physician reimbursement, and that cannot go on unaddressed either. So I am hoping that we can look at some of the issues where there can be some common ground, some immediate kind of relief provided to the physicians and work with our colleagues who have jurisdiction to do something about it.

Chairman MANZULLO. Thank you. On this note, this hearing is adjourned.

[Whereupon, at 12:34 p.m., the committee was adjourned.]

Are Skyrocketing Medical Liability Premiums Driving Doctors Away from Underserved Areas?
2360 Rayburn House Office Building
June 14, 2005
10:00 am

Opening Statement
Chairman Donald A. Manzullo

Good Morning and welcome to our second hearing on the important subject of medical liability reform. I appreciate everyone who is participating in this hearing.

The United States has been blessed with the best system of medicine in the world. But we are having a crisis of access. This problem is not a case of whether a patient has health insurance, although it is driving force behind the cost of health insurance.

Today, you may not be able to find a doctor to treat you.

The headlines are replete with stories of women having to drive several hours because they cannot find a doctor to deliver their baby. It is hard to believe that in the 21st century, many women have difficulty finding a doctor to deliver their child.

If you are in a car accident in southern Illinois and need a neurosurgeon, you will be airlifted to another state because there are no neurosurgeons left to treat you.

Unfortunately, we live in a time where lawsuits against doctors are rampant. Multi-million dollar court decisions and jury awards have left doctors with medical liability premiums that increase 40 to 50 percent per year. Doctors in certain high-risk fields of medicine can expect to be sued at least once in their career.

Between 2000 and 2003, the number of medical liability claims has jumped 46 percent in Illinois to more than 3,500 claims. The average indemnity per claim also has risen dramatically. In 1990, the average indemnity was about $310,000. In 2003, it was nearly $600,000, according to the Illinois State Medical Insurance Exchange.

As a result, doctors are retiring or leaving the practice of medicine. Emergency rooms have closed. Doctors simply cannot afford to pay premiums that spike every year with no end in sight.

The problem has been exacerbated in our rural areas and inner cities, where doctors are leaving in droves. Millions of our rural and inner-city residents are in danger of losing the basic ability to see a doctor when they are ill.

Fortunately, Illinois has just passed a medical liability reform bill that the Governor has promised to sign. But there are many other states without that do not have caps on non-economic damages.

I am hopeful that the House will soon take up a bill such as HR 534, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2005, introduced by Representative Chris Cox.

The President support reforms in our medical liability law that would: improve the ability of patients to collect compensation for their economic losses; ensure that recoveries of non-economic damages would not exceed $250,000; and limit punitive damages to $250,000.

It is clear that the Congress must pass legislation to address this problem.

I look forward to the testimony of all the witnesses here this morning and I turn to my colleague, the Ranking Member for her Opening Statement.

June 14, 2005
Small Business Committee hearing on:
Are Skyrocketing Medical Liability Premiums Driving Doctors Away from Underserved Areas?
Opening Statement of Congressman Lynn Westmoreland

Thank you Mr. Chairman for holding this hearing and I appreciate the willingness of all the witnesses to testify today.

When we had a similar hearing on medical liability back in February, we looked at the big picture.

Today, we will focus on the effect medical malpractice litigation has on access to health care, particularly in underserved areas.

Since about 80% of my district is rural I'm ready to see what we find out today and let's see if we can't get the ball rolling on some fixes!

Since the hearing in February, I've heard over and over again from small businesses that say the skyrocketing cost of health care insurance is the biggest impediment to their business.

And I think we were able to prove in the last hearing that the ever-escalating cost of medical malpractice was the culprit of the high cost of health care in this country.

I know there was a Health and Human Services report released a few weeks ago that showed a growing trend of doctors moving to states with damage caps and how doctors in rural areas are affected.

This past February, Georgia passed meaningful medical malpractice reform that caps noneconomic damage awards at $350,000 and establishes a system to encourage out of court settlement.

The law also gives additional protections for doctors serving in an emergency room, when they often have to make decisions without a full knowledge of the patient's health history.

This reform will go into effect in July and I am optimistic about what it can do for doctors and patients alike – hopefully our doctors won't have to worry about frivolous lawsuits and our patients can have access to affordable health care.

I look forward to hearing what everyone has to say today.

STATEMENT
of the
Honorable Nydia M. Velázquez, Ranking Member
House Committee on Small Business
Hearing on "Are Skyrocketing Medical Liability Premiums
Driving Doctors Away from Underserved Areas?"
June 14, 2005

Thank you Mr. Chairman. As we have discussed time and again, our country is facing a health care crisis – so much so, that 44 million Americans cannot even afford health care. To make matters worse, the health insurance premium costs have consistently risen by double digits – adding up to an increase of 60 percent over the past five years.

For small business owners who bear the brunt of the health care crisis, these rising costs make it all the more difficult to access affordable health care. Nearly 6 out of every 10 uninsured Americans are in families headed by self-employed workers, or small business employees.

As we already discussed at length several months ago, and considered twice in the 108th Congress – an element contributing to increased costs are these high medical malpractice premiums. Today, we will take yet another look at the medical liability crisis, and how this situation contributes to the difficulty in offering health care coverage in underserved areas.

Providing adequate medical care, particularly in these low-income and rural communities, has been a longstanding challenge. Studies tell us that uninsured individuals are less likely to seek adequate medical care and are less likely to have the means to pay for the care they receive. High premiums only exacerbate the problem.

Likewise, medical practices in low income communities generally face challenges in supporting high medical liability premiums than practices in other more prosperous regions. But based on the facts before us today, it is impossible to automatically conclude that medical shortages in underserved areas result from some liability crises.

First, as we will hear in the testimony, there is significant doubt whether there is a liability crisis or a health insurance pricing and reform crisis. A series of comprehensive new studies have shown that health insurance claims and payouts have not significantly increased when you adjust for inflation and population growth over the last decade. Additionally, the problems low income communities face in retaining quality medical services have plagued these areas for decades.

I believe we need to dig deeper to find the real cause of the problem.

In this day and age, it is unfair to ask Americans to choose between quality health care and justice – and that is exactly what is happening. This situation presents us with a dilemma – and we have not gotten to the point where we can find meaningful solutions to this very real problem millions of Americans face today. So, is this a liability crisis or an insurance premium crisis?

Mr. Chairman, the committee was certainly on the right track several months back when we agreed the insurance companies would speak at the next hearing to get to the bottom of the issue – because without them, the record is incomplete. But from what I can tell, there are no insurance companies here today. So here we are again, listening to stories of staggering malpractice insurance rates with no means to get to the heart of the matter and find out what is really driving those increases, and ultimately, hurting our small businesses.

It is my hope that today's hearing will help us to unmask the real reasons for the high insurance premiums that drive up medical costs and make it impossible for small businesses and the less privileged to afford health insurance for their employees. The sooner we identify the problems, the closer we are to developing the right strategies for addressing these very real issues. Thank you.

Chairman Don Manzullo, Ranking Member Nydia Velazquez, and Members of the Small Business Committee, my name is Delorise Brown, MD. I am a practicing internal medicine physician with a subspecialty in endocrinology from the great state of Ohio. As a small business owner, I employ six staff members. Together we support the highly underserved East Cleveland community. I would like to thank you for holding this hearing to discuss the effect of skyrocketing medical liability premiums, which are driving physicians who serve underserved communities, across our great nation, out of business.

Mr. Chairman, I have been in private practice for 27 years. My late husband, Alvin Butler, who held a PHD in organizational development from Case Western Reserve, and I made a conscious decision to provide medical service to the underserved. My husband and I decided to focus our efforts within East Cleveland, OH. As of the census of 2000, 32% of the East Cleveland population and 28% of families live below the poverty line, earning less then $12,602 per year.

As a physician, I am finding it ever more difficult to maintain the sound principles of medicine, rather forced to practice defensive medicine. The practice of defensive medicine requires me to avoid "high risk" patients and procedures, limiting my ability to service the needs of my past and current patient population. In my opinion, defensive medicine is a deviation; induced by the threat of medical liability. My medical malpractice insurance has required me to stop caring for nursing home patients, some of whom I have provided services to for over 20 years. Operating a Small Business during our current economic climate is difficult. However, it is exacerbated by the skyrocketing cost of medical malpractice insurance.

As I stated, East Cleveland is a poverty stricken community, and the majority my patients cannot afford traditional health care insurance. Most patients have Medicare and or Medicaid, or some other Managed Healthcare Organizations, which establishes fee schedules, that limits the remuneration value for services rendered. As a result, it is becoming increasingly more difficult to afford purchasing advanced medical equipment that is critical to enhance the level of care to my patients.

Last year, President Bush visited Cleveland and spoke on the topic of electronic medical records (EMR). President Bush stated, "when you multiply the efficiencies to be gained, all across the spectrum, whether it be individual doctors or hospitals or networks, that's' why some predict that you can save 20% of the cost of health care as a result of the advent of information technology". Last year, the cost of electronic medical records ranged from $60,000 to $180,000. The cost of electronic medical records is completely out of reach for me as a physician. I do believe that EMR's provide several levels of benefits and that EMR's would assist in driving down the overall costs associated with running my medical practice, in addition to ensuring accurate records keeping of patient information. To date, medical malpractice insurers do not provide any credit or cost reduction to physicians who implement EMR solutions within their medical practice.

Just as previously stated, medical malpractice insurance companies require physicians to practice defensive medicine, which specifically limits the physicians ability to generate income, by setting restrictions upon the physician that potentially assist in limiting medical liability. This concept does not make sense to me, as I have been affected by frivolous lawsuits, which have served to move me from a standard market to a non-standard market. I am presently in negotiations to renew my medical malpractice insurance and I am uncertain, as are some of my colleagues, as to what market will be available to me this year.

To give you some history, in 2001, medical malpractice cost me $5,266.79 for an entire year, and I thought that was outrageous then. In 2002, malpractice was $18,861 with a tail, which is prior act coverage, of $15,000 totaling $33,861 for the year with a deductible of $5,000 per lawsuit. In 2003, malpractice was $50,673 with a tail of $19,500, totaling $70,173 with a deductible $10,000 per lawsuit and in 2004; malpractice was $73,259 plus a tail of $30,000 totaling $103,259 with a deductible of $10,000 per lawsuit. As I mentioned, this year I am in negotiations for malpractice coverage, and as you can see 2001 malpractice insurance costs were lower at 5,266.79 then skyrocketed to over $103,259 within three years. This is due in part to several malpractice insurance firms leaving the state of Ohio and in part to the growing epidemic of medical malpractice lawsuits plaguing the medical industry. For the first 22 years of being in practice, I have had three lawsuits. Within the past five years, I have had five lawsuits. I am not alone, as this lawsuit trend has affected a great number of my colleagues as well. If this trend continues, we will be forced out of private practice or driven away from serving underserved communities across this great nation.

I would like to make four recommendations:

1. Attorneys who bring lawsuit against a physician or medical entity, who lose their lawsuit, that judgment require the attorney of record to reimburse the physician or medical entity for all losses and damages that were incurred due to their failed lawsuit or frivolous action.

2. Should an Insurer refuse to allow coverage for medical treatment or testing deemed medically necessary by the physician and a lawsuit be ensued by the patient/insured, then the insurer should be solely liable for any malpractice liability claims that ensue from failure to obtain medical treatment or testing.

3. Medical malpractice insurers be mandated to offer reduced rates of coverage to physicians who implement predetermined strategies that are proven to reduce malpractice liability without impeding the physician's ability to provide medical services to underserved patients.

4. Cap payments for non-economic damages in malpractice cases.

In closing, I wish to again thank you for this opportunity to express my concerns and articulate a few recommendations in support of the HEALTH Act in bill H.R. 534.

STATEMENT OF LARRY S. FIELDS, MD
ASHLAND, KENTUCKY

PRESIDENT-ELECT
AMERICAN ACADEMY OF FAMILY PHYSICIANS

TO

THE COMMITTEE ON SMALL BUSINESS
U.S. HOUSE OF REPRESENTATAIVES
WASHINGTON, DC

TUESDAY, JUNE 14, 2005

AT

THE HEARING ENTITLED
"ARE SKYROCKTING MEDICAL LIABILITY PREMIUMS
DRIVING DOCTORS AWAY FROM UNDERSERVED AREAS?"

Chairman Manzullo and Representative Velazquez,

For the 95,000 members of the American Academy of Family Physicians and, more importantly, for the 50 million of your constituents who give us the privilege of taking care of their health every day, I sincerely and, humbly, thank you for your invitation to participate in this hearing.

A few years ago, you invited our then-President, my friend, Dr.Warren Jones of Mississippi, to testify on Medicare payment policies.
He remembers that exciting, thoughtful experience as the highlight of his service as leader of our academy.

Like Warren, I am truly honored by your request to testify this morning.

On behalf of the AAFP, I commend you for your persistent and successful efforts to ease the burdens of small businesses in this country.

I am particularly honored to be here before this committee
as it includes one of our academy's outstanding members,
Rep. Donna Christensen, who is serving as the leader of the Congressional Black Caucus Health Brain Trust.

Family physicians are serving proudly and with distinction in all branches of our military. We Practice in all 50 states, here in the District of Columbia, Puerto Rico, Guam ,and, as Rep. Christensen can attest, in the Virgin Islands.

As family physician's, nearly half of Dr. Christensen's and my patients are Medicare beneficiaries, on Medicaid, or have no insurance at all.

A large percentage of family physicians work in small and medium sized practices of four physicians or fewer.

Our practices are typical small businesses that operate with very tight financial margins.

The average gross revenue for family medicine practices in 2003 was $360,000.

From this total, family physicians pay staff salaries, rent, utilities, medical equipment costs and medical liability insurance premiums.

Most of these costs have risen rather steadily and predictably with the single, significant exception of medical liability premiums.

When they increase at the rate we have seen for the last several years my practice has no way to absorb them.

So, among my alternatives are:

- Cutting premium costs by eliminating specific services;
- Reducing staff, thus creating the equally regrettable consequences of human suffering because of unemployment and the further reduction of services;
- Borrowing to cover current costs -usually the path to bankruptcy for a small business; or
- Selling the business to a larger organization that can absorb the sudden spikes in premiums.

Those who suffer the most are our patients.

They are <u>your</u> constituents, who no longer have a medical home, who can no longer find the friendly, familiar faces that humanize medicine and provide a safe haven in the complex world of 21st. century medicine, or who can't find the obstetric services they need.

I practice in Eastern Kentucky, close to where I was born, a beautiful, rural, underserved area.

Last year, the liability carrier we had for 22 years, without a dime ever being paid in claims, dropped our practice and, for a couple of months, there was the very real possibility that 18,000 human beings would not find that friendly face I spoke of earlier.

My heart aches every day when I see the financial hardship created for my patients by the forced defensive medicine practiced by emergency physicians, sub-specialists, and by me.

Much like me, my colleague Dr. Julie Wood in Missouri was raised in a rural area to which she returned to practice family medicine.

Julie did a full scope of practice including OB. 50% of her patients were Medicaid and that program covered 80% of her OB patients.

Six years after starting practice, her liability carrier informed Julie her premium would raise from $19,000 to $71,000 .

Because she loves mothers and children and the special relationship that forms between physician and expectant mother, she had no alternative.

She left practice in her hometown and took a position with a large academic health center in Kansas City where the hospital pays her insurance.

There is now no OB in a corridor of northern Missouri stretching from Hannibal to St. Jo.

Some people can drive the 2 hours to see Julie,
but what do we tell the people who can't afford to do that?

What do we tell the 15 year old, intellectually challenged, pregnant girl who rode her bicycle to Dr. Wood's office because her only other way to get there would have been to walk?

Do we say that because they are poor, or not as smart, or live in the wrong place they do not deserve prenatal care or must risk having their baby born in a car or ambulance on a lonely highway in the middle of the night?

My friend, Dr. Neil Brooks is a family physician in Connecticut, where he was born and raised.

He was part of a 4-physician group in his hometown of 30,000.

Three years ago his liability premium had skyrocketed 600% to $31,000, and, at age 59, Dr. Brooks was forced to retire from his practice through which he had served four generations of his friends and neighbors, 50% of whom were by then MEDICARE beneficiaries.

Neil was followed into retirement by the best surgeon in town and by two ob/gyns, all of who had to leave practice before they drowned in red ink produced by liability premiums.

I am the AAFP's Commissioner to the AMA's Commission to end health care disparities.

I assure you that American Medicine can end this problem.

But, I have to tell you now that such disparities will never end unless physicians in this country are freed to do the right thing for our patients, each and every one each and every time.

Free of a system that allows any lawyer who can chase down a victim and dig up an expert to drag a physician through the courts for 5 years, all the while demanding that the physician pay ever higher liability premiums, and at the end of the day pays next to nothing to the alleged victim.

The specter of medical liability is an equal opportunity employer. It affects everyone, but it does not affect everyone equally.

If you are black, if you are Hispanic, if you are poor, if you are weak or innocent,
If you live in Eastern Kentucky, or Macon, Missouri, or Vernon Vermont it robs you of the full opportunity that this country can offer.

What I am really saying is there is opportunity here.

American medicine can be the highest quality, most cost efficient, most accessible, health care system in the world not just for a segment of our people, but for everyone in this country.

Please, for the good of those innocents, continue to try and find ways to free American Medicine to be what I know in my heart it can be.

I promise you the full support and assistance of America's Family Doctors in your work.

And, I promise you a health care system the likes of which the world has never seen.

Thank you, Chairman Manzullo and Rep. Velazquez. I am happy to be here and to be able to answer any questions you may have.

American Academy of Family Physician

Professional Medical Liability

Academy Goals and Methods

As one of its highest priorities, the Academy will continue to work on the professional medical liability problem through it's Strike Force on Medical Liability which will have specific recommendations this summer.

No responsible party in the medical profession denies the existence of malpractice and the right of a fair recovery to the negligently injured patient.

The goals of the AAFP in this area are:

a. To be an advocate for the patient and help them obtain relief from costs related to professional medical liability insurance and to support solutions that more equitably and quickly compensate those truly injured in the course of medical care.

b. To be an advocate for family physicians regarding any mechanism for: (1) affordable premiums; (2) differential premiums for beginning and part time physicians; and (3) equitable premium differentials for family physicians who provide obstetrical and surgical services based on sound actuarial evidence and standards of care.
c. To encourage and support in depth study and implementation of non-legislative solutions to the professional liability problem.
d. To encourage and support state and national legislative solutions to aid physicians providing medical care (including obstetrics) in underserved areas. Such relief could be in the form of tax relief, partial reimbursement of professional liability insurance premium and/or loan forgiveness.
e. To support chapters by serving as a resource center to provide information of evolving solutions in other areas.
(1976) (2004)

The American Academy of Family Physicians supports the following federal liability reforms:

1. Limit on payments for "non economic damages,"
2. Reducing awards by the amount of compensation from collateral sources,

3. Allowing periodic payment of future damages at a defined award limit,
4. Limiting attorneys' contingency fees,
5. Replacing joint and several liability with proportionate liability among the defendants in a case,
6. Reduce statute of limitations for commencing professional liability actions to one to three years after injury, with an absolute limit of six years for minors.
7. Incentives for states to establish Alternative Dispute Resolution Systems, and
8. An expert affidavit that must be provided by a specialist who possesses knowledge and expertise and practices in the same medical specialty as the defendant.

Other methods that the Academy believes will be helpful in stabilizing unacceptably high liability premiums and aid in abating the medical liability problem are:

1. Secure state legislation requiring joint underwriting associations (JUAs), consisting of all casualty insurance carriers in the state, to provide professional liability coverage on a collective basis.
2. Redefine, by legislation, medical negligence and liability, including specific designations concerning implied warranty and informed consent.
3. Legislate limits on awards including, but not limited to, limits on awards for total damages, non-economic damages, damages for dependent care, and wrongful death benefits. Punitive damages should be eliminated.
4. Mandate catastrophic insurance coverage.
5. Make information concerning collateral sources of income, and the tax status of awards, admissible in evidence.
6. Increase disciplinary authority of state boards of medical examiners.
7. Require 60 days advance notice of intention to sue.
8. Affirm a physician's right to recover from plaintiff reasonable legal costs and attorney's fees in successful defense of professional liability suits.
9. Eliminate the ad damnum clause in the filing of lawsuits.
10. Require that accompanying the filing of a claim is an affidavit from a physician stating the physician's opinion that the claim has merit.
11. Require that expert witnesses meet specific requirements (see Academy's policy regarding expert witnesses).
12. Required that insurance companies provide information regarding economic versus non-economic damages and settled versus verdict cases to state and national regulators.
    (1975) (2004)

National Medical Association

STATEMENT
BY
Winston Price, MD, FAAP
President, National Medical Association
Before
COMMITTEE ON SMALL BUSINESS
House of Representatives
109th Congress of the United States
14 June 2005

Chairman Manzullo, Ranking Member Velasquez, distinguished members of the US House of Representatives, fellow panelists, ladies and gentlemen: I am Dr Winston Price, President of the National Medical Association (NMA).

The NMA is the nation's largest membership organization for physicians of African descent, representing the vital interests of over 25,000 physicians, and the patients they serve. As most of you know, the NMA has been a leading advocate for parity in American healthcare for over a century. We thank the Committee for the opportunity to testify this morning. We would hasten to inform this audience that with regard to the elimination of healthcare disparities, particularly those based on race and ethnicity, our resolve remains strong as ever, and our efforts untiring.

We have already heard some of the alarming statistics that define this growing crisis in the availability of medical liability insurance in American medicine. All Americans are threatened, whether they live in rural, urban or suburban areas. The Chairman's home state – Illinois, as well as the Ranking Member's home state - New York, have been designated by the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) as **red states**. This designation is not symbolic of voting Republican in a Presidential Election! But rather it is recognition of the fact that the *Land of Lincoln* and the *Empire State,* as well as 18 other states in the union, are in the throes of a medical liability crisis.

Both states have a significant minority population, and in both states minority physicians in private practice are either limiting the scope of their practices, closing up shop altogether, or moving to 'greener pastures'. (In this instance, by greener pastures we mean a state where a physician can afford malpractice insurance and keep the doors open at the same time.) We must also add that there are at least 20 other states approaching 'crisis' status, and the picture is getting bleaker.

These troubling statistics need a human face however, so we would direct the attention of this Committee southward, to another 'red' state - Mississippi.

Rev. Ronald V. Myers Sr., MD, practiced medicine in the Mississippi Delta for close to 2 decades, averaging about 50,000 miles a year on his truck, because **he still made house calls!** This dedicated physician, jazz musician, and ordained Baptist minister, made national news this past winter, when he was forced to close 5 – yes, five clinics, in January of this year. Why, you ask?

Well, Dr Myers' malpractice policy was cancelled in January because he refused to give his insurance carrier *carte blanche* access to his patients' records. He asked his patients' consent, but some of them were understandably nervous about the privacy issue, so they said no. After the carrier decided he would no longer be their customer, Dr Myers decided to take legal action. He is striving to ensure that the case is tried in the county where his main clinic was located, rather than have the trial moved to a county where the insurance carrier perceives it might receive a more favorable verdict.

Dr Myers has since tried obtaining coverage from a risk management pool, but the price quote from them totaled almost **$200,000** for the 5 clinics, as opposed to the $6,000 total he paid prior to cancellation of his policies.

It is notable that Dr. Myers has never had a malpractice lawsuit filed against him, and his approximately 3,000 (mostly African-American) patients now do not have assured access to medical care, but are left to fend for themselves. When we spoke to Dr Myers by phone last week, he asked us to convey his personal regret that "the poorest, neediest, most vulnerable people in America are left without adequate medical care because of this medical liability crisis". This would be bad enough if it only involved one isolated case, but Dr Myers insisted that we speak with **another African American physician**, Dr. Frank McCune, who serves the underserved and who was also covered by the very same insurance carrier as Dr. Myers.

We spoke with Dr. McCune by phone as well, from his home in Jackson, Mississippi. Dr. McCune's situation, as he described it, was a case of contract violation and misrepresentation. He had bought a malpractice policy to cover him in a primary care practice, and the policy was supposed to cover him throughout the state of Mississippi. After the policy was 'signed, sealed and delivered', the carrier apparently had a change of heart, and decided they would only cover him at one hospital though he has practice privileges at numerous hospitals. Dr. McCune has taken legal action as well, and his case goes to trial next month. He asked us to convey to you that malpractice insurance carriers "have so much power in the marketplace that the doctors feel as though they are under siege".

Dr. Joseph Harris, who lives in Reno, Nevada, is just as troubled by this medical liability insurance crisis. Northwestern Nevada, where he works, and northeastern California, which is right across the border, are rural areas. The obstetricians in that section of the United States are struggling to find coverage as well, and many are moving away or closing up shop. Dr. Harris' main concern is that this problem crosses geographic as well as racial lines, and certain specialties such as OB/GYNs are especially vulnerable. Also an NMA member, Dr. Harris wanted us to convey his urgent plea that if this problem is not addressed expeditiously, every American is in jeopardy and will face, as so many

now are doing, the requirement of driving 100 miles or more in order to obtain quality healthcare and critical services such as obstetrics and gynecology.

The NMA has spoken out about the medical liability crisis in the past, and our opinion is clear. With each passing year, we are becoming more convinced that it is time to revisit the McCarron-Ferguson Act. Not all State Insurance Commissioners are created alike, so we think the time has come for a more substantive national dialogue about their role and influence.

Over the years, the NMA has deliberated the key macro issues that make medical liability reform in particular, and tort reform in general, such a divisive subject. A few of the following terms and concepts have been the object of debate and discussion for quite some time, therefore we feel they should be raised within the context of this hearing and our continuing discussion. They include:

- collateral source rule
- contingency fees
- periodic payments
- provision of qualified expert witnesses
- clarification of informed consent.

Addressing each of these terms and concepts will be indispensable in any discussion, adoption and implementation of effective, long-term legislative solutions to the medical liability insurance crisis at the federal level. Mr. Chairman and Members of the Committee, as you prepare recommendations to the Congress regarding 'next steps', we urge you to consider legislation that would achieve the following:

- limit unquantifiable non-economic damages, such as pain and suffering, to reasonable levels (consider a possible cap of $250,000.00),
- respect states' rights by allowing states that have already enacted damages caps, to keep those caps in place and have the flexibility to change them;
- allocate damages fairly, in proportion to a party's degree of fault and considering other payments already made,
- limit the number of years a plaintiff has to file a health care liability action to ensure that claims are brought before evidence is destroyed, while witnesses are available and memories are fresh, and
- re-examine the processes by which malpractice insurance premiums are set by insurance commissions at the state level.

Ladies and gentlemen, there is no silver bullet. There is no magic wand we can wave to make these problems go away. Every one of us in this room is in danger however, of being in a possibly fatal collision on a federal highway somewhere and there is no trauma surgeon available for over a hundred miles to minister to our need, thanks to this medical liability insurance crisis. Any woman in a red state, and any of the women in this very room of child-bearing age, should be worried if they go into labor in a 'red' state, because it could mean having to deliver their baby without the benefit of an obstetrician or a midwife, because the closest one available is three hours away!

Each of the foregoing situations clearly demonstrates the unacceptability of the state affairs we now confront in the availability of medical liability insurance. We simply cannot continue to allow this state of affairs to exist. We implore this Committee to move forward, consider effective solutions, and then advocate for their adoption among your colleagues in the Congress.

Mr. Chairman, and Members of the Committee, thank you all for your attention. We look forward to the discussion to follow, and we commit to working with you to fashion and adopt effective solutions,

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Testimony

To the

Committee on Small Business
U.S. House of Representatives

"Are Skyrocketing Medical Liability Premiums Driving Doctors Away from Underserved Areas?"

Elena Rios, M.D., M.S.P.H.
President & CEO
National Hispanic Medical Association

June 14, 2005

1411 K St. NW, Suite 1100
Washington, DC 20005
(202) 628-5895
Fax (202) 628-5898
nhma@nhmamd.org
www.nhmamd.org

Chairman Donald Mansullo, members of the committee, and guests, it is an honor to be here today. Established in 1994 in Washington, DC, the National Hispanic Medical Association (NHMA) is a non-profit organization representing Hispanic licensed physicians in the United States. The mission of the organization is to improve the health of Hispanics and other underserved. I am the President and CEO of NHMA and will discuss medical malpractice and its impact in our Hispanic communities. I applaud your commitment to understand the effect medical malpractice litigation has on access to health care, particularly to minority patients subject to disparities in health.

Our health system is the best in the world; but in order to be proud of that system, we need to develop new strategies to improve the quality of health care delivery. One of those key strategies is to find a solution to the growing national crisis of medical liability insurance due to increased premiums. According to estimates by the U.S. Department of Health and Human Services, medical liability adds $70 to $126 billion to the cost of health care each year.[1] These costs mean higher health insurance premiums and higher medical costs for all Americans, especially for the growing number of Hispanics who live in underserved areas and in the states where medical liability is a focus of this Committee's work.

I will focus on 3 major points regarding medical liability and its impact on Hispanics: 1. Hispanic physicians are unique to the medical delivery system and need to be protected from the malpractice crisis; 2. Hispanic patients suffer from increased disparities in health and require increased access to care; and 3. There is a need to increase research on Hispanics and Disparities in Health.

Hispanic Physicians are Unique and Need to be Protected

The 2002 IOM Report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" addressed the fundamental principle that minority physicians are critical to the increased patient satisfaction and health outcomes of the minority patient and, thus, a primary focus for reducing disparities in health care delivery.

The literature demonstrates many examples of studies on the outcomes of minority health professionals serving a major need in the U.S., namely that they provide health and mental health care services for minority patients of their own ethnicity and for those on Medicaid or uninsured.

Keith (1985, New England Journal of Medicine) found that minority medical graduates practiced in federally designated health-manpower shortage areas almost twice as often as non-minority graduates. He also found that minority physicians tended to serve members of their own racial or ethnic population group more than members of other groups.

Moy and Bartman (1987 National Medical Expenditure Survey) that minority patients were more than four times more likely to receive care from non-white physicians

[1] Testimony from the American Medical Association to the Small Business Committee, Feb. 2005.

than were white patients not of Hispanic origin. Low-income, uninsured, and Medicaid patients were also more likely to receive care from non-white physicians.

Kamaromy et. al. (1993, NEJM) reported that Black physicians practiced in areas where the percent of Black residents was nearly five times higher than in communities where non-Black physicians practiced. Similarly, Hispanic physicians practiced in areas where the percent of Hispanic residents was twice as high as in areas where non-Hispanic physicians practiced. Hispanic physicians cared for three times as many Hispanics and for more uninsured patients as did other physicians.

According to the American Medical Association, approximately three-fourths of practice-based physicians work in or own small practices. Among practice-based physicians, roughly 33 percent are in solo-practice, 26 percent are in practices with between 2 and 4 physicians, and 16 percent are in practices with 5-9 physicians. [2] As for Hispanic physicians, we number about 36,000 or 5 percent of the total number of U.S. physicians. Of these, 3,600 or ten percent are full-time faculty of medical schools, according to the Association of American Medical Colleges [3] and less than half of those make-up full-time physician administrators of the public and private sectors in the country. Thus, roughly 23,000 Hispanic physicians are in private practice. We estimate at least one-third or 7,500 of those are foreign medical graduates, many of whom are about to retire.

Due to the limited results of the national, mainly Federal, recruitment programs of minority students to medical schools over the past three decades, these physicians will not be replaced at the same rate that they leave practice. Currently, only about 5 percent of medical school matriculants are Hispanic - out of 65,000 that is about 3,250 new Hispanic medical students per year. Graduates number about the same.

According to the U.S. Census, the Hispanics are now 43 million or 15 percent of the U.S. population. By 2050, one out of four Americans will be of Hispanic background. The NHMA believes that it is vital to the health of America, with a growing minority population, that we urge Congress and leaders in health care to create opportunity to increase the number of Hispanic physicians and to protect those in practice. Additionally, we strongly feel that we need to develop a more culturally competent physician workforce through education programs for medical students and residents and licensing requirements for CME for non- minority physicians.

Any major crisis affecting physicians, in this case, the medical liability insurance skyrocketing increase in premiums for physicians, has a compounded impact on Hispanic physicians because we are so unique and face tremendous demand and expectations from our communities. Hispanic patients revere their Hispanic physicians and by word of mouth and other marketing, Hispanic physicians have long waiting lists of patients demanding their services.

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[2] Department of Economic and Statistical Research, American Medical Association. The Practice Arrangements of Patient Care Physicians (2001).

[3] Association of American Medical Colleges Facts and Figures XII, 2003.

It has been widely reported that an increasing number of America's doctors are being driven out of business because they cannot afford their malpractice insurance premiums. The result is that doctors are retiring earlier than they would otherwise have, scaling down their practices (OB/GYN physicians decide to only practice only the obstetrics part of their business), or relocating to states where they can afford their liability coverage. Hispanic physicians, obviously are affected, and have seen the rise of premiums and the resulting cost-shifting to their patients, streamlining of staff and budgets; the rise of administrative burden and peer review and utilization and the resulting decrease physician time with patient care; the fear of practice in high-risk specialties and closing of practices; the rise in defensive medicine and evidenced-based medicine; the escalating costs of a dysfunctional medical liability system.

PERSONAL STORIES FROM THE FIELD

Dr. Luis Aguilar, Internist from Tucson, Arizona
Subspecialists are leaving, limiting their practice or retiring. They've had to assume a defensive strategy--limit accepting challenging patients, see more patients to help defray increased costs, order more tests, not chancing clinical judgment. Our compliance committee has employed more rigorous guidelines, more from a defensive posture than from good medicine, and access to services is thus affected. There is now an extraordinary length of time to see a specialist or to schedule a test, for example, an MRI, Mammograms.

Dr. Miguel A. Cintron, Obstetrician from Harlingen, Texas
My name is Miguel Cintron and I practice OB-GYN. I'm also Chief of Staff at Valley Baptist Medical Center in Harlingen, TX. As you know, the Rio Grande Valley is an area with a very high malpractice suit rate and as a result, high malpractice premiums. The Rio Grande Valley is predominantly Hispanic by a wide margin. Mine is a story in my role as Chief of Staff. About four years ago, due to high malpractice premiums we lost two general surgeons from practice at in our area. One was an experienced Surgeon with over 30 years of practice and another one was a young surgeon who by himself, performed more operations than all the other surgeons together! Our's is a designated Trauma 3 Level Medical Center which is a "safety net" for the whole Rio Grande Valley in the field of Trauma as well as other specialties. After the loss of these two surgeons from practice in the area, it has been impossible to recruit General Surgeons to our facility. Many surgical patients have to be sent elsewhere, away from their families, to get their procedures, including cancer patients.

Fortunately, the Cardiovascular Surgeons have voluntarily stepped up to the plate and have been performing general surgery cases to "hold the fort" but this cannot be a permanent solution. We have established the Regional Academic Health Center, affiliated to the University of Texas Health Science Center in San Antonio mainly for the purpose of training and retaining Physicians to this medically underserved area. But this is not enough. We must make the area attractive for our graduates to stay. The malpractice issue is a deterrent for this to happen since the same issues as the Surgeons have area held by all the other specialists. Hence, the medical malpractice problem has overflowed to being

a heath care ACCESS problem. What we have in our country is a finger pointing circus in which the physicians, the insurance companies and the lawyers each say it's the other two parties fault. None of the parties deny there is a problem just the cause of the problem is what is being debated. Unfortunately, the real victims are the patients. As has been the history of our country, this problem must be addressed by our legislative bodies for a just resolution. Our citizens deserve it!

Dr. Nereida Correa, Obstetrician from Bronx, New York

The issue of malpractice insurance has reached critical proportions. In the past few months I have been setting up a private practice in women's health which is my specialty. The premiums for malpractice insurance for full range Obstetrics and Gynecology would be about $59,000 per year part-time or as high as $110,000 for a full-time practice. I am faced with the decision to limit my practice to office gynecology despite the needs of my patients and of my community which is predominantly Hispanic. We all know that beyond the issue of premiums that have put physicians out of business in many areas there is the ever growing fear of frivolous law suits. The legal system and the current practice of awarding settlements and large awards to patients who irregardless of their own personal issues and liabilities expect a perfect obstetrical outcome has devastated some of the best in the profession. No physician enters the medical field with the intent of giving poor care and to be criminalized for a poor outcome in a birth which has no evidence of causality is unfair. In many cases, as data on cerebral palsy has shown, the poor outcomes of a birth are not the result of negligence or poor care but of anoxic events that occur at anytime during the pregnancy. Yet most would vehemently blame the physician or midwife despite their best efforts. The problem has led many physicians out of the obstetrical arena and has essentially made it impossible to be back-up physician for the many midwives who can provide competent and excellent care to women desiring a natural labor experience. By pushing these skilled and caring practitioners out of the field we are allowing the health of all women to be qualitatively impoverished. Soon there will be no one left who can practice obstetrics, and those who want may not be able to afford the luxury of giving full range care to women and their babies. As a Hispanic woman and a physician I am appalled that this situation is allowed to continue. We need the ability to define our practices by the needs of our patients and communities and this is not happening. This is not a story, but it is a strong opinion in favor of tort reform and no-fault medical malpractice insurance.

Hispanics suffer from Disparities in Health and Require Increased Access to Care

The National Hispanic Medical Association is concerned, not only about the impact of medical liability crisis on Hispanic physicians, who are committed to providing quality culturally competent care to our underserved communities, but about the resulting disastrous decrease in access to medical care for Hispanic and other underserved populations. The access issue is especially high for the Federal government programs, since one-third of total health care spending is paid by Medicare and Medicaid.

Hispanic patients are subject to alarming rates of decreased access to health care services in low income neighborhoods; the highest rates of lacking health insurance; less information to make appropriate decisions about their care due to language issues, literacy rates and lower levels of education; less access to Hispanic physicians or culturally competent physicians; and less ability to challenge the system, due to citizenship status, fear of deportation or less familiarity with the system due to less acculturation.

The medical liability crisis puts all patients at risk, especially those who have the least access to care. The loss of physicians due to medical liability is devastating to rural and underserved communities, especially in the case of private physicians who sponsor charity care or a free or sliding fee clinic. The rise in emergency services is another costly setback to Hispanics who already have the lowest rates of a regular source of care, according to the Agency for Healthcare Research and Quality Health Disparities Report.[4]

Hispanics and other minorities receive inferior medical treatment and are being subjected to high rates of preventable medical errors. As a result, increased liability costs are disproportionately affecting minorities with a decreased access to needed health care and a severely limited quality of life.

In 2002, the National Academy of Sciences Institute of Medicine (IOM) published its landmark study, entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* that found disparities, after accounting for access to medical care, are associated with higher mortality among racial and ethnic minorities.

According to the Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services, the length of time between an abnormal screening mammogram and the follow-up diagnostic test to determine whether a woman has breast cancer is more than twice as long for Asian-American, African-American and Hispanic women as it is for white women. Moreover, as discovered by AHRQ, relative to non-Hispanic whites, racial and ethnic minorities are less likely to receive appropriate cancer care, cardiac care, diabetes care, pediatric care and many surgical procedures.

According to the 1999 Institute of Medicine Report, To Err is Human: Building a Safer Health System, the vast majority of patient injuries are due to defects in the medical care delivery system and adverse events that are preventable, with highly technical subspecialties contributing to higher rates of medical errors.[5] According to a 2003 U.S. General Accounting Office report, medical liability premiums have skyrocketed in some states and specialties ...and increased losses on claims are the primary contributor. [6]

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[4] AHRQ, US DHHS. National Disparities in Health Report, 2005.
[5] Institute of Medicine, To Err is Human, 2001.
[6] U.S. General Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates, p.15, 2003.

There has been a national challenge taken up by the U.S. Congress and by the private sector, the Joint Commission on Accreditation of Health Organizations, to build patient safety standards, which will only be able to occur if the system can be redirected from a system of defensive medicine which leads to decreased sharing of information.

The Congressional Black, Hispanic, and Asian Caucuses as well as the Republican and Democratic Leadership have called for minority health disparities legislation to address our minority communities' dilemma – living in America without a right to a quality life.

Need for Research on Hispanics and Health Disparities

If we are truly concerned how the malpractice liability issues affect our communities, we need to support health care research on Hispanic patients. The Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services and the National Institutes of Health Center on Minority Health and Health Disparities should collaborate on data collection and Disparities Research programs to build strategic requirements of grantees as they build minority health research centers. Congress should expand this area of critical research which is a cross –cutting activity that has limited support compared to biomedical research. Without new knowledge with community-based research, we will never advance beyond the disparities that now exist in the health care system. In addition, states and health surveys and health facilities should be mandated to collect data by race and ethnicity and language use and conduct interviews in Spanish.

The NHMA established the National Hispanic Health Foundation, a 501(c) 3 organization, to develop health services research to focus on such issues as disparities in the health system, cultural competence, language services and health professions diversity. The NHHF is affiliated with the Robert F. Wagner Graduate School of Public Service, New York University, the largest graduate health management/public service training program in the U.S. with researchers already engaged in Hispanic research. The Foundation would also be linked to the NYU Medical School, which also has a strong interest in Hispanic health research. The purpose of the Foundation is to develop knowledge about Hispanic health, a "think tank" for Hispanic health in the United States.

In summary, the NHMA recognizes the impact of the medical liability crisis on our Hispanic physicians and the loss of access to health care for our communities. We stand with Congress, ready to develop solutions that can protect our physicians and increase the health status of our patients and create a healthier America, with decreased disparities in health care.

STATEMENT OF WILBUR COLOM
ATTORNEY AT LAW, THE COLOM LAW FIRM

BEFORE THE HOUSE SMALL BUSINESS COMMITTEE

Medical Liability Reform: "Are Skyrocketing Medical Liability Premiums Driving Doctors Away from Underserved Areas?"

June 14, 2005

Thank you, Chairman Manzullo, and Ranking Member Velazquez, for calling this hearing and for inviting me to testify. By way of introduction, my name is Wilbur Colom, and I am the founding, senior partner of the The Colom Law Firm, with offices in Columbus and Jackson, Mississippi and Atlanta, Georgia.

I graduated from Antioch School of Law which was created in 1972 by Edgar S. and Jean Camper Cahn who championed the rights of low-income people and minorities. I served on the school's Board of Governors from 1978-1984. In addition, I was an adjunct professor at Mississippi University for Women in 1980, and the University of Mississippi Law School in 1985 and was a Municipal Court Judge in Columbus from 1985-1987.

I established the firm in 1977 as a sole practitioner, and today the firm has eight lawyers and a staff of almost 40 professionals. In SBA terms, I am a small business owner, and in Mississippi, small businesses are the driving force behind our economy. My firm practices primarily in the areas of personal injury, medical malpractice and mass tort litigation, and the majority of our clients are working-class African Americans.

By way of full disclosure, I should state that I am a Republican, and am proud to be co-chair of the ATLA Republican Trial Lawyers Caucus. My Republican credentials go back to being on Thad Cochran's first campaign Committee for United States Senate, to serving on Ronald Reagan's Presidential Transition Team, to being on the Mississippi Republican Executive Committee through much of the 1980's and in 1987 being the unsuccessful Republican nominee for State Treasurer. In 2004, I was a George W. Bush delegate to the Republican National Convention. I am a long-time supporter of many Republican candidates and have continued to support our President although we disagree on issues involving medical malpractice.

In Mississippi, we recently adopted a $500,000 cap on non-economic damages in medical malpractice cases. This means that there are already many cases which our firm has had to turn down because expert and other expenses make the case economically unfeasible with such a cap. Caps on non-economic damages—which are designed to compensate people for their injuries—hurt people who are not in the workforce, such as children and senior citizens, and those who do not have high lost wages or salary (economic loss). My clients are not working for some big corporation; they are mostly small business employees because Mississippi is made up largely of small business employers. For the

most part, my clients do not earn large salaries, and cannot afford huge medical expenses caused by doctor error.

I started my legal career working in a rural legal services program operated primarily for poor farmers in the Southeast. The scarcity of physicians in rural America is something I have witnessed first hand for almost three decades. I do not know how to entice physicians to practice in rural and poor communities, but the one thing that I do know is that this problem has been around for over 30 years and medical malpractice claims and caps have nothing to do with it.

NEITHER UNDERSERVED COMMUNITIES NOR SMALL BUSINESSES WILL BE HELPED BY LIMITING LEGAL RIGHTS.

Limiting the rights of the underserved will not help America's small businesses thrive and will not help underserved communities get access to quality healthcare.

First, small businesses will suffer as taxpaying entities that are forced to pay for the healthcare of those who cannot afford it. When low wage earners with little or no health insurance are injured by medical negligence, they are forced to go on public assistance and taxpayers bear the brunt of the necessary medical care. Why should all taxpayers, rather than those responsible for the injury, bear the burden of the cost? Further, small businesses as employers have an incentive to make sure their employees are covered, should they be injured by medical negligence.

Second, underserved communities deserve access to quality healthcare and the same legal rights and protections as the rest of the community. Accountability encourages better and safer healthcare, and limiting the ability to hold healthcare providers accountable will hurt the quality of healthcare.

THERE IS NO MEDICAL LIABILITY CRISIS—ONLY A PREMIUM CRISIS

I agree wholeheartedly that doctors have a malpractice premium crisis, but it is *not* caused by lawsuits. In fact, there is no so-called "liability crisis."

Recent evidence from the National Practitioner's Databank supports this fact. The National Practitioner Data Bank is the most comprehensive source of statistics on malpractice payments. All malpractice payments made on behalf of health care providers must be reported to the NPDB. In contrast, the jury verdict reports highlighted by tort reform proponents such as the American Medical Association discuss only judgments, which make up only 4 percent of all payments and only 5 percent of medical malpractice dollars. Judgments also frequently do not reflect the final payment total, and jury verdict reports tend to skew to the higher, more frequently reported verdicts.

Now, consider the following points made by a study published in the May edition of Health Affairs which analyzed data from the National Practitioner Databank and proves that there has not been an "explosion" of medical malpractice lawsuits or claims:

- The growth of medical malpractice payments is far less than previously thought. The average payment amount grew at an annual rate of only 4 percent between 1991 and 2003. Over the most recent four years the annual growth rate slowed to just 1.6 percent. Despite anecdotes of an explosion of multimillion dollar awards, the top ten percent of malpractice payments grew only 2.6 percent annually.

- The frequency of malpractice payments remained stable over the ten years of the study period.

- Settlements, which make up 96 percent of all payments, were 1.7-2.4 times smaller than judgments. The average settlement in 2003 was $257,000.[1]

Not only does the data show a decrease in claims, evidence also shows—contrary to the popular mythology—that doctors are not leaving the practice of medicine. In fact, the number of doctors appears to be increasing. A recent Kaiser Family Foundation study finds that medical malpractice payments have been growing at a slow rate, while the number of practicing doctors has been on the rise.[2] The study supports the conclusions of numerous other studies on malpractice payments, including a new study by researchers at Dartmouth College, which found that slow growing malpractice payments had remained under 0.3% of health care spending for over ten years.[3]

The Kaiser Family Foundation's findings include the following:

- Total malpractice payments increased by only 1.7% annually between 1991 and 2003, when adjusted for medical care inflation.

- At the same time, the number of physicians rose 31%, from 623,378 in 1992 to 814,909 in 2003.

- The stable frequency of malpractice payments, combined with the increase in the number of practicing physicians, produced a 25 % decrease in the average number of claims per physician. By 2003 the average number of claims had dropped to 1.88 for every 100 physicians.[4]

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[1] Amitabh Chandra, Shantanu Nundy, Seth A. Seabury, *The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank*, Health Affairs, May 31, 2005
[2] Peter Budetti and Teresa Waters, *Medical Malpractice Law in the United States*, Kaiser Family Foundation, May 2005
[3] Amitabh Chandra, Shantanu Nundy, Seth A. Seabury, The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank, Health Affairs, May 31, 2005
[4] Peter Budetti and Teresa Waters, *Medical Malpractice Law in the United States*, Kaiser Family Foundation, May 2005

The study's lead author, Peter Budetti, said, "For most doctors, there is a perception of a serious problem. [But] the likelihood of having a claim paid on your behalf over the years has diminished."[5]

These factual trends are confirmed by my nearly 30 years of legal experience. Noxubee County, Mississippi, considered one of the most sympathetic venues for plaintiffs in the state, has never returned a verdict against a physician. In the four county circuit districts where I primarily practice, no physician has lost a jury trial in over 15 years. Physicians in rural areas are generally the most highly regarded people in the community and only the most egregious conduct can motivate a jury to return an adverse verdict.

Finally, data shows that the elderly and low-income patients are less likely than the general population to file a malpractice lawsuit.[6] It's ironic that those who want to insist that premium rates are tied to the number of lawsuits would be especially concerned with premium amounts in underserved areas. That's where individuals are *least likely* to file a lawsuit.

It is clear, Mr. Chairman, that we agree that good doctors are paying too much for their malpractice insurance premiums, but we disagree on the cause and the solution. It is my recommendation that we look to the insurance companies' role in this. The evidence proves that lawsuits are not the case. Lawsuits and lawyers have become easy and convenient political targets to blame.

Frankly, the insurance company pointing at lawsuits as the cause of high premiums is much like a quarterback faking a pitch: Its only purpose is misdirection. The only question for us is whether we are going to fall for it.

"CAPPING" DAMAGES IS NOT THE SOLUTION

Limiting compensation to victims does *not* lower malpractice premiums.

The fact is, limiting or "capping" non-economic damages does not lower doctor's premiums. According to data derived from the Medical Liability Monitor, insurance premiums in states with caps are 9.8% higher than in states without caps on damages.[7] So there appears to be no solid trend one way or another showing that caps affect premiums.

Even the insurance industry admits that caps won't lower premiums. Consider the following statements made by insurance industry insiders admitting that caps won't save costs or lower premiums:

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[5] Los Angeles Times, 6/1

[6] Studdert, David M., Troyen A. Brennan and Eric J. Thomas, *What Have We Learned Since the Harvard Medical Practice Study?* Medical Error: What Do We Know? What Do We DO?, Jossey-Bass, 2002

[7] Data derived from *Medical Liability Monitor,* October 2004

- "[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'" (Victor Schwartz, General Counsel, American Tort Reform Association, Business Insurance, July 19, 1999)
- "Insurers never promised that tort reform would achieve specific premium savings . . ." (March 13, 2002 press release by the American Insurance Association)
- "Tort reform" advocates have long rejected the notion that enactment of caps on damages would lower insurance rates See: http://centerjd.org/air/pr/Quotes.pdf
- "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." (Sherman Joyce, President of the American Tort Reform Association, as quoted in "Study Finds No Link Between Tort Reforms and Insurance Rates," Liability Week, July 19, 1999)

Caps on Damages Disproportionately Affect Underserved Communities.

We can't provide good care to underserved communities by limiting their legal rights. The only people affected by caps are those individuals with the most egregious cases where there is clear negligence. Because these cases are so expensive to bring and the cap so restrictive, victims are often unable to obtain counsel and consequently are left with no compensation for their injuries.

The California cap of $250,000 serves a perfect example of how victims have been affected since this cap was passed in 1975. According to a recent Rand Corporation survey, the "most significant impact of California's 29-year-old medical malpractice caps law falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes."[8]

Before supporting proposals that deprive individuals of their legal rights, first consider the devastating effects that legal limitations have on injured people. For example, my firm recently turned down a case of medical malpractice where a child's face was severely and permanently scarred. Because of the limitations on damages in the state of Mississippi, pursuit of the case was economically impossible. Similarly, we were forced to reject a clear case of misdiagnosis because the victim was a house wife and her restricted "economic value" made pursuit of the case economically impractical. Caps close the courthouse door to those individuals whose lives have little "economic" value.

The cap you are proposing is based on the notion that there is only one way to value a human life, and that is based on your economic status. Consider this, should the life of a doctor who has chosen to practice in an underserved county in Mississippi be worth less than a doctor who is a plastic surgeon practicing in Beverly Hills? Why should the law provide that one life is worth more than another simply because of the salary an individual commands? However, capping non-economic damages does just that.

[8] See. "Rand Study: California patients Killed or Maimed by Malpractice Lose Most Under Damage Caps," Foundation for Taxpayer and Consumer Rights, July 2004

H.R. 534, THE MEDICAL MALPRACTICE BILL, IS NOT THE SOLUTION

H.R. 534, the medical malpractice bill pending in the House of Representatives, does nothing to increase patient safety or provide more affordable prescription drugs or provide a way for working families to get good health insurance. Instead the bill protects drug and insurance companies and makes it extremely difficult for people who have been injured by medical negligence to receive any compensation for their injuries. Still worse, the cap of $250,000 applies not just to doctors but also to cases against drug companies and nursing homes.

Let us not forget Mr. Chairman that patients are suffering from medical errors at an extreme rate. Five years after the Institute of Medicine (IOM) released its seminal report, *To Err is Human*, which concluded up to 98,000 Americans died each year from medical errors, the medical community has made little progress in reducing the risk to patients who use the healthcare system. An article by Lucian Leape, Adjunct Professor of Health Policy at the Harvard School of Public Health, in the *Journal of the American Medical Association* concedes that "the proven measured fruits of the IOM report so far are few."[9]

In my experience, the worst negligence tends to happen to the elderly, children, and the poor—people who are least able to command the highest standard of care and least able to seek justice in a court of law. The best form of medical malpractice reform would be to have less malpractice. That could be achieved by implementing well known and established controls.

Mr. Chairman, I truly commend these doctors who have chosen to serve these communities. And I truly believe these individuals want to give the best care they are able to give. However, limiting the rights of the underserved cannot be the solution you adopt. Let's work together to help people get access to quality healthcare care while preserving their legal rights.

Thank you.

[9] Leape, Lucian L. & Berwick, Donald M., "Five Years after *To Err is Human*: What Have We Learned?" *Journal of the American Medical Association (JAMA)*, 2005.

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