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THE MEDICAL LIABILITY INSURANCE CRISIS: A REVIEW OF THE SITUATION IN PENNSYLVANIA

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND
COMMERCE

HOUSE OF REPRESENTATIVES

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THE MEDICAL LIABILITY INSURANCE CRISIS: A REVIEW OF THE SITUATION IN PENNSYLVANIA

MONDAY, FEBRUARY 10, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Langhorne, PA.

The subcommittee met, pursuant to notice, at 10 a.m., at St. Mary Medical Center, Sister Claire Carty Auditorium, Langhorne-Newton Roads, Langhorne, Pennsylvania, Hon. James C. Greenwood (chairman) presiding.

Members present: Representatives Greenwood, Deutsch, and Schakowsky.

Also present: Representative Gerlach.

Staff present: Anthony M. Cooke, majority counsel; Yong Choe, legislative clerk; and David Nelson, minority professional staff.

Mr. GREENWOOD. Good morning. I am Congressman Jim Greenwood and I want to welcome everyone to St. Mary Medical Center for the field hearing of the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee. On behalf of the committee, I would like to welcome Governor Ed Rendell and thank him for joining us today. I would also like to thank our witnesses and our host, St. Mary Medical Center. And if I may make a personal note, just a few years ago my father was very close to not making it and came to St. Mary and had triple bypass surgery, and after some complications he emerged well enough to 6 months later challenge me to go skydiving with him. So the Greenwood family owes a lot to St. Mary Medical Center. My mother is still a little annoyed that they put him in such good shape that he could go skydiving, but there you go.

Finally, I would also like to welcome our Congressional colleagues. To my left is the ranking member of this subcommittee, Peter Deutsch of Florida, who has traveled to be with us; and to his left is his counsel; and to his left is Ms. Jan Schakowsky, a member of the U.S. House of Representatives from Chicago. And there may be other members of the subcommittee and/or members of the Pennsylvania Delegation who join us later on.

We are here this morning at the front lines of a crisis. Today we will explore, examine, and confront the medical liability insurance crisis here in Pennsylvania. The word "crisis" is often tossed around in Washington, DC, but let me describe for you something that fits this term under anyone's definition. From December 21

until January 3 of this year, for 13 days, the nearby trauma center at Abington Hospital closed its doors because the doctors staffing this critical facility could not obtain the affordable medical liability insurance that they need to practice. For those 13 days, lifesaving protections to the health and the lives of the families in this area ceased to exist. How have we come to this?

The purpose of this hearing is to help this committee and the public learn and understand the events and forces contributing to the growing inability of the people of Pennsylvania to find doctors. What is more, we need to understand why Pennsylvanians can no longer go about their daily lives knowing that if the worst happens, emergency physicians are in place and on call. We in the Philadelphia region have a special obligation and a proud legacy to protect. Since 1751, when the founders of Pennsylvania Hospital, Benjamin Franklin and Dr. Thomas Bond, opened the doors to the Nation's first hospital, we have led in healthcare. Even today, almost one is seven doctors in the United States did some part of their medical training in Philadelphia, home to a host of excellent medical schools and institutions, but today, the signs are ominous. This legacy is threatened. Recently, Methodist Hospital in South Philadelphia, which has served that community for more than 100 years, was forced to close its obstetrics practice. How could this happen? And what hardships have been visited upon the expected mothers who had counted on these service.

This crisis affects more than just patients and doctors. You will hear today from this excellent hospital, St. Mary Medical Center, as well as from Abington Hospital, about the problems growing day by day to find and retain the physicians needed by these facilities to keep open their doors. I am deeply saddened and I am angered that this crisis is having permanent and long-term effects, weakening hospitals, debilitating medical schools, reducing the number of doctors who practice, and destabilizing healthcare institutions, all to the detriment of the people desperately in need of skilled medical treatment. Again I ask, how could this happen? That is the question we seek to answer here today.

Let me tell you what I know so far. Access to healthcare has been diminished and threatened because the individuals and institutions delivering that care cannot find the affordable insurance required to practice medicine. I am sure the companies are raising their rates across the State and turning down doctors looking to find new policies. What is happening to insurers? Insurance companies set their premiums based on their projected risk, the amount they estimate they will have to pay. Yet, they simply cannot make reasonable business decisions of their risk when they don't know with each passing year what juries will award. In the past 3 years, according to a recent Wall Street Journal editorial, juries in Philadelphia have awarded more in medical damages than were awarded in the entire State of California. In the year 2000, Pennsylvania had 19 awards individually exceeding $5 million each. In light of this, can we begin to understand why Pennsylvania insurers facing the unpredictability of Pennsylvania court verdicts continue to increase their rates? Can we then see why Pennsylvania's largest physician insurer this year raised its premiums an average of 54 percent? Does this help us to start to recognize why 72 percent of

Pennsylvania doctors, according to a 2001 survey, deferred the purchase of new equipment or the hiring of new staff because of malpractice costs. And now can we see why since January 2001, more than 900 Pennsylvania physicians have closed their practice, moved out of State, or refused to do high risk procedures.

Earlier, I asked how could this happen. The fact is insurers cannot properly, reasonably, and competitively offer insurance to medical providers within an unpredictable court system prone to jackpot awards. No one here will argue that patients injured by the negligence of a medical provider do not deserve compensation, but we have lost all sense of proportion in the area of non-economic intangible damages. How do we reform the current system in a way which balances the interest of fairly compensating injured patients and the need to ensure all Pennsylvanians have access to quality healthcare? Reasonable caps on the subjective non-economic damages, in my estimation, when teamed with a specific package of other reforms, will bring juries, verdicts, and insurance rates back to earth and keep Pennsylvania doctors where they belong, treating Pennsylvania families.

I have recently introduced legislation in Congress designed to address this problem, however, please know I am, as are all my colleagues here today, and all of us in the U.S. Congress, House, and Senate, wanting to learn. We are here to be persuaded and to be informed. Again, I thank all our witnesses and the members of the public for joining us here on the front lines of this medical crisis. And now I yield to Mr. Deutsch for his opening statement.

Mr. DEUTSCH. Thank you, Mr. Chairman. I have an opening statement that I would like to submit for the record and just make some initial comments. First, I want to thank the chairman for having this hearing. Actually, in this session of Congress, this is our Oversight and Investigations Subcommittee first hearing, and I think it appropriate that we take testimony, especially, in this type of setting, on an issue in terms that would be as important as any other issue that the Congress will face in this session. I also am very happy that the Governor is joining us on the first panel. I have had the good fortune of knowing your Governor in other capacities in his life, and I also see one of the wisest decisions he has made since governing is bring onto his staff Congressman Borski, who I had the pleasure of serving with for 10 years in the Congress.

I would just note as we take testimony, I would agree with the chairman completely that we are here, really, to listen; not to debate. We are here to learn and not to teach today. But I would say that I don't think, at least at this point in terms of, you know, spending fair amounts of time on the issue in the past, that there aren't any easy solutions, and anyone who says there is an easy solution doesn't understand the problem. The chairman mentioned, you know, caps and non-economic damages. I think we will get testimony today that discuss that that is not a panacea that has been presented by many people. The other thing I would note is that, really, one size might not fit all. At this point, we have been, you know—our tort system and malpractice area has been a State endeavor and it is not just a hearing. There is legislation that has been introduced by the chairman of this committee and supported

by the President at this point in time which would nationalize tort reform.

Florida has a crisis as well, but in Florida the legislature has been dealing with it in a different way than has been proposed in Pennsylvania, and it is unclear if our challenges are the same as the challenges in South Dakota, or South Carolina, or Minnesota would be similar or the same. So I am not sure we are ready yet to nationalize this issue, and that is something which I look forward to hearing testimony today. Thank you, Mr. Chairman.

Mr. GREENWOOD. Thank you, Mr. Deutsch. The gentlelady from Chicago is recognized for an opening statement.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. This is my first hearing as a new member of the Energy and Commerce Committee and of your subcommittee, and I feel very privileged to be here today to discuss an issue that is my top priority, which is the quality and accessibility of healthcare, and honored also to be here with Governor Rendell and my former colleague, Bob Borski. Thank you for being here, Governor.

I share the belief that physicians and other healthcare professionals should not be burdened with unreasonable insurance rates, and I would like to work with you, Mr. Chairman, and all the Members of Congress to find solutions to the problem. However, to the extent that a tax on the civil justice system are offered as solutions, I would strongly argue that those solutions stem from a misdiagnosis of the problem. The medical malpractice insurance crisis is not created by the victims. For my opening statement, I wanted to briefly enumerate some of the findings of a public citizen report called Medical Misdiagnosis and asked that the entire report be entered into the record, Mr. Chairman.

One point they made is that there is an epidemic of medical errors and unsafe practices. Between 44,000 and 98,000 Americans die in hospitals each year due to preventable medical errors, just in hospitals. According to the Institute of Medicine, by comparison, the annual death toll is 43,000 from automobile accidents, 42,000 from breast cancer, and 15,000 from AIDS. Second point, there is no growth in the number of new medical malpractice claims. According to the National Association of Insurance Commissioners, the number of new medical malpractice claims declined about 4 percent between 1995 and 2000. Third, the spike in medical liability premiums was caused by the insurance cycle, not by new claims or skyrocketing jury verdicts. Premiums charged to not track losses paid, but instead, rise and fall in concert with the state of the economy. In any case, malpractice insurance costs have risen at half the rate of medical inflation and it is slower paced than health insurance premiums.

Fourth, 5 percent of doctors are responsible for 54 percent of malpractice in the United States. Of these, only 7.6 percent have ever been disciplined by State medical boards. In Pennsylvania, only one doctor has lost his license because of incompetence in 20 days. And fifth, few, if any, malpractice lawsuits are frivolous. Plaintiffs drop ten times more claims than they pursue. Data reported in the study shows that only one in eight medical errors committed in hospitals results in a malpractice claim.

I am concerned, Mr. Chairman, that the sweeping legislation that you introduced this past week would unnecessarily punish people who have truly suffered. I am especially concerned about the effects of the caps on compensatory non-economic damages, and punitive damages on women, children, people of color, and the elderly. Under the bill, a drug company or HMO will almost certainly pay less if they injure a working woman. If they injure a working woman, they will pay less than if they injure a working man since women earn 76 cents on the dollar that men earn. They will pay less if they injure a working African-American woman who earns 69 cents on the dollar, or a Latina who earns 56 cents on the dollar. They will pay less if they injure or kill a senior citizen. And the caps will tell a stay-at-home mom that the loss of her fetus because an HMO refused the proper care is worth no more than $250,000. Or a poor woman who can't have children any longer, that her loss is worth little more than $250,000. I could go on with those examples, but I find the notion of a politician imposing a one-sized fits all remedy and substituting for juries that can listen to each individual case to be very, very disturbing.

I strongly support doctors and other frontline healthcare providers and want to work with them, but this bill goes way beyond them, to nursing homes, to pharmaceutical companies, to medical device manufacturers. Our medical practice insurance system needs to be reformed. We could have an experience rating for doctors just as we do for drivers so that the few bad apples can be weeded out. Doctors who practice medicine in a safe and responsible manner should not have to shoulder the burden for those who don't.

And finally, just a few words about insurance reform. There is no compelling evidence that caps on damages will lower premiums. In California, as we will hear today, it was not MICRA, which imposed caps that lowered medical malpractice rates, but Prop 103 which required rates to be lowered. We need to open up insurance company books to find out why rates fluctuate so widely. We should wait for the results of the GAO studies and the relationships among medical malpractice rates, lawsuits, and insurance industry practices. We should proceed carefully to make sure that victims of medical malpractice are not forced to pay for the mistakes of others. And I applaud, Mr. Chairman, your idea that we all work together, that your legislation is not set in stone, and look forward to working with you to improve it for the sake of all of us. Thank you.

Mr. GREENWOOD. The Chair thanks the gentlelady and now calls forward our first witness, the Honorable Ed Rendell, His Excellency, the Governor of Pennsylvania. Welcome, Governor Rendell.

Governor RENDELL. Good morning, Mr. Chairman and members of the committee, and let me begin——

Mr. GREENWOOD. Before you begin——

Governor RENDELL. Oh, I have to be sworn in. Okay.

Mr. GREENWOOD. I believe, as you and I had a conversation, you understand this is an investigative hearing, and when holding investigative hearings it is the practice of this committee to take testimony under oath. Do you have any objections to giving your testimony under oath?

Governor RENDELL. No, sir.

Mr. GREENWOOD. Seeing that you don't, the Chair then advises you that pursuant to the rules of this committee and the House, you are entitled to be represented by counsel. Do you choose to be represented by counsel?

Governor RENDELL. No, sir.

Mr. GREENWOOD. Okay. In that case, if you would stand, rise, and raise your right hand?

[Witness sworn.]

Mr. GREENWOOD. Okay. You are under oath and we now welcome your opening statement, Governor.

TESTIMONY OF HON. EDWARD G. RENDELL, GOVERNOR, COMMONWEALTH OF PENNSYLVANIA

Governor RENDELL. Let me begin by thanking members of the committee for coming here, and particularly, for coming to St Mary's, because St. Mary's is a good example of a hospital that was on the cutting edge of this crisis. And Mr. Chairman, you are indeed right, it is a crisis in every definition of the word. St. Mary's does a wonderful, wonderful job, but came very close—you mentioned Abington. The President of St. Mary's was just telling me that they came within hours of closing their trauma center early in January, so St. Mary's is a good example of what doctors and hospitals are facing all throughout Pennsylvania. And I do commend the committee for wanting to learn more about this crisis because I don't think it is a simple crisis and I think there are many things that have brought us to where we are today.

Let me first talk about the efforts that Pennsylvania has made. Today's hearing is entitled, A Review of the Situation in Pennsylvania, and early on in the year 2002, the Pennsylvania legislature and then Governor Mark Schwiker tried to take steps to remediate what they saw as a growing crisis. They passed something called Act 13, and although Act 13 did not go nearly as far as advocates of tort reform wanted, it made some positive steps. It did away with and imposed the collateral source rule, it shortened the length of time for people to bring lawsuits, it had some very positive steps in medical safety, and it was passed into law in March. Unfortunately, the crisis had reached such a level in Pennsylvania that Act 13 did, virtually, nothing to change the rate of premium increases that came out in July of that year. But in June of that year, the legislature took a step that had a tremendous impact, and I will explain this a little bit later, for hospitals; less of an impact for doctors but a tremendous impact for hospitals. Although this legislation was not targeted solely to hospitals and doctors, the legislature passed for the first time in Pennsylvania a threshold on joint and several liability. Prior to that, a hospital, for example, if it had 5 percent of the blame, let us say, an attending nurse was in a room and the majority of the blame laid with the doctor. But if the doctor's coverage was capped at a certain level, as all doctors are in Pennsylvania, the hospital, responsible for only 5 percent of the harm, paid the entire verdict to the extent of their coverage, and hospitals carry far more mandated coverage than doctors do. So raising the threshold on joint and several liability to 60 percent, saying nobody could be held liable beyond their share of the harm

unless they had been responsible for 60 percent of the harm was a tremendous positive step for hospitals. That legislation came far too late to have an effect on the July 1 premiums, far too late. The premiums were already set in motion.

In the fall of this year, the legislature passed a fairly important piece of legislation restricting venue in lawsuits, in medical malpractice lawsuits. That was a very, very important step, because as you noted in your remarks, a lot of the problem with the large verdicts occur in Philadelphia, and lawyers were using the remotest possible legal theories to get venue to bring a lawsuit, let us say, a procedure that happened here at St. Mary's, rather than have that tried before a Bucks County jury, they found the remotest elements to bring it back into Philadelphia. The venue statute made it clear that in almost all cases the site of the venue of a malpractice lawsuit has to be where the injury occurred, and that was an important step.

The Supreme Court Rules Committee was not silent during 2002 either. In August 2002, the Supreme Court Rules Committee enacted the equivalent of the Federal Rule 11, and I am sure you are all aware of Federal Rule 11, which allows judges to assess damages against plaintiffs and plaintiff attorneys for bringing frivolous lawsuits. That power had never existed with Pennsylvania trial judges before, but the Supreme Court gave that power to judges in August. Those steps also began to accumulate, and interestingly, a new insurance company was certified by the Insurance Commission in late December. That new insurance company was able to reduce rates because they only handled prospective claims, and on all the prospective claims, the steps that the Pennsylvania legislature had taken kicked in. Now, it wasn't so for outstanding premiums because outstanding premiums went back in time.

And then in January of this year, at my request, Chief Justice Ralph Cappy in the Supreme Court in December ordered the Rules Committee to move swiftly to come up with a rule on certificate of merit. And the rule on certificate of merit was very important. It now requires that a previously certified medical expert must submit an affidavit to every medical malpractice lawsuit that is filed. The insurance defense lawyers estimate, and the Bar Association estimates, that that will reduce almost 25 percent of the number of lawsuits that come into the system. Now, as the Congresswoman said, most of those lawsuits are eventually decided against the plaintiffs, but they run up insurance company costs. The run up the cost because in medical malpractice cases there is so much pretrial discovery so at the time the lawsuits are eventually dismissed, the insurance company may have run up $40,000, $50,000, $80,000, $90,000 of costs just in defending what is a frivolous lawsuit. If, in fact, the Bar Association studies are right, and that will delete 25 percent of the number of lawsuits that are filed, that will also have a great effect on rates here in Pennsylvania.

So all of these steps were in the process of being done or had been done in Pennsylvania during the year 2002. But when I became Governor elect of the State of Pennsylvania, the crisis was by no means abated by these steps because as I said, most of them hadn't even been factored into rate setting. And in fact, in Pennsylvania we went from 17 private insurance companies writing cov-

erage at the beginning of the 1990's to only 2 until that additional company joined us in the year 2002. So it wasn't a question often of how much your coverage was; it was a question of could you obtain coverage by anybody other than JUA. The JUA is the Joint Underwriters Association, set up by act of the legislature, and they are the insurer of the last resort, and they are specifically mandated not to be competitive in their price setting. The legislature didn't want them to compete with existing private companies, but they were the insurer of the last resort, and the premiums that the JUA charged were astronomical, because as the premiums for the private companies went up, the JUA had to stay higher than them.

So the crisis was acute even though the legislature had made some very good steps when I became Governor elect. And on my first day as Governor elect, I appointed a medical malpractice taskforce to look at this problem, to look at short-run solutions and long-run solutions. The taskforce included defense attorneys, it included trial lawyers, plaintiff attorneys. It included practicing doctors, it included hospital administrators, it included the head of the Pennsylvania Medical Society and the Executive Director of the Hospital Association of Pennsylvania. It included representatives of the Chamber of Commerce and the AFL-CIO, who are the most frequent users of healthcare in the Commonwealth of Pennsylvania. It also had the benefit of joining forces with a study that was being done by the Pew Charitable Trust, and I would recommend to this committee that you make contact with Pew. Pew has allocated $3 million to study the medical malpractice crisis across the country, and they have hired some of the best experts to do this work all throughout America, and I am sure that Rebecca Rimel, the Executive Director of Pew, would make their findings, and their research, and what they have come up with available to the committee, and it has been very helpful to our committee as we have gone down the road.

I asked the committee to come back to me by January 20, the day before my inauguration, with recommendations for abating the short-term crisis, and by May 31, with recommendations to try to deal with the long-term problems. Unfortunately, in the weeks that followed, the crisis became more acute. And when Abington Hospital closed its trauma center, State Representative Ellen Bard, who I think is with us today——

Mr. GREENWOOD. Who is with us today.

Governor RENDELL. Representative Bard asked me to come out and meet with doctors and administrators of Abington, and I did, and they convinced me that the crisis was so acute that we couldn't wait until January 20 to make our short-term recommendations. So on December 30, myself and Governor Mark Schwiker, Representative Bard, and Representative Kurt Schroeder from Chester County held a press conference and we announced that I would be asking the legislature to eliminate the premiums, 100 percent of the premiums charged by our catastrophic loan fund, which is now called MCare. In Pennsylvania, for the other representatives, doctors were mandated to carry $500,000 of private insurance, and at one point $750,000 of CAT Fund insurance; Act 13 dropped that to 500. But to put it in context, Pennsylvania doctors are required to carry $1 million of mandated coverage. In California, they are required

to carry $100,000 of mandated coverage, and I will get to that as we get on a little later.

I have asked the legislature to enact legislation that for the four most challenged specialties, and they are obstetrics and gynecology, orthopedic surgeons, neurosurgeons, and general surgeons. For those four specialties, that we relieve them of 100 percent of the necessity to pay premiums into the MCARE fund for the year 2003 only. For all other physicians, to reduce their MCARE payments to 50 percent of what they had been paying for the year 2003. This was a 1-year fix to try to give us time to work out the long-term solutions. I also proposed a way of paying for it to the legislature, surcharging excessive surpluses of health insurance companies that are here in Pennsylvania, that operate here in Pennsylvania. The legislature hasn't taken any action yet, but I have only been Governor for 3 weeks. It hasn't taken any action yet. It has to take action by May 1. The reason they have to take action by May 1, Governor Schwiker, before that press conference, had suspended or pushed back the time period that doctors had to make payments into the MCARE fund for 4 months. He said, for the first 4 months, you don't have to make any payments. He didn't reduce the amount of payments; he just delayed the payment schedule. So on May 1, doctors will have to pay into the MCARE fund. And if the legislature hasn't enacted our short-term solutions, we will see on May 1, and I think the physicians here and the hospital administrators here will tell you, we will see on May 1 the exact same crisis that we averted in Pennsylvania at the last second, the same crisis that has plagued West Virginia and New Jersey, where doctors literally walked off the job.

Because of the action we took, Abington trauma center reopened a couple of days later, St. Mary's trauma center never closed, and two other trauma centers out of the 26 in Pennsylvania that had threatened to close never closed. There was no doctor walkout. And no one on the committee, on my taskforce, believes for 1 second that the short-term remedy did anything but buy us time. It stopped the walkout and bought us time. I asked the committee to come back to me by April 1 with their long-term recommendations so that the legislature would have time to enact them before they recessed for the summer. Our committee is looking at a number of things, and I should mention also, as part of our short-term relief, we advocated the passage of a bill that Representative Schroeder had introduced, giving relief to our trauma centers, where the Commonwealth of Pennsylvania will underwrite the cost of the operation of those trauma centers to the tune of $25 million, roughly, $1 million a center, although, in the formula it doesn't break it out that evenly.

We are looking at a number of things. Caps are one of the things the committee is looking at, although, as you are aware, Congressmen, of the Pennsylvania Limitation and the Pennsylvania Constitution, our constitution has language that has been held would bar caps on non-economic damages. The constitution can be amended. It usually takes 3 to 4 years. There is a process that can speed it up to 2 years. We can't wait for 3 to 4 years, we can't wait for 2 years. So we are looking at a number of things. We are looking at reducing the level of mandated coverage, as Act 13 did, from

$1.25 million to $1 million. We are looking at a more significant reduction in mandated coverage. We are looking at using a long-term bond issue to, basically, get rid of the CAT Fund or the MCARE fund. We are looking at a number of different things to try to bring back insurance companies to Pennsylvania and quoting a reasonable premium for doctors.

Now, let me say that in this effort, I have had discussions with three head of claims departments from three insurance companies that left Pennsylvania, and they have asked not to be identified, but I asked them a number of things about what would cause them to come back to Pennsylvania. The first question I asked is, if we enacted California style caps, that is all we did, we enacted California style caps, would they come back and write insurance in Pennsylvania? The answer was uniformly no. The main problem that these three insurance companies cited, and this might be a surprise to the Congresswoman, was the high number of lawsuits that are filed, particularly, in southeast and northeast Pennsylvania, that those lawsuits, most of them are dismissed or the jury verdict is not guilty, run up the cost of insurance so significantly because of the high number of them. And also, because of the existence of the CAT Fund or what we now call the MCARE fund, because in Pennsylvania, to settle a medical malpractice suit, the lawyer representing the private insurance carrier has to want to settle and the lawyer representing the CAT Fund has to want to settle. The CAT Fund has taken, in an effort to delay premiums and spread out the impact, they have taken what could best be described as a stalling posture. For example, they won't settle. They won't engage in settlement conversation until the eve of trail. Well, that is not very productive, because for an insurance company, most of the costs are incurred prior to the eve of trial, during the pretrial discovery period. What those insurance companies told me, if you could limit the number of lawsuits and if you could get rid of the CAT Fund, they would come back to Pennsylvania and begin writing again. And I think that is very instructive.

I would join with Congressman Deutsch and the Congresswoman from Chicago in saying, very respectfully, Mr. Chairman, that caps are not the sole solution to the problem. There is no magic bullet here. People have been looking for magic bullets everywhere. West Virginia has caps and they have a walkout far in excess of Pennsylvania. And even if you do enact California style caps, the litany that the Congresswoman cited to you is correct. For the first 10 years after California instituted its caps, which everyone here thinks is nirvana, insurance costs continued to rise, and rise substantially. It wasn't until the second ballot referendum which mandated reductions plus the reduction in mandated coverage to $100,000. That was the key, because the mandated coverage drives settlement costs. If you are the plaintiff's lawyer, and you know the mandated coverage is $1,000,000 in Pennsylvania and $100,000 in California, you are going to accept a different settlement offer in each State, and that is really the key. You cited all of those statistics about how incredibly high the dollar number of verdicts in Philadelphia were as opposed to the entire State of California. Well, in most of those jury verdicts they are never paid. They are set aside by the trial judge, they are set aside by the appellate

court, or they are above the mandated coverage. No doctor in Pennsylvania has ever had his personal assets gone against by a lawyer in a medical malpractice suit, which means that even before Act 13, the total amount of payment that a doctor's insurance company and the CAT Fund would give out, even if the verdict was $30 million against that doctor, the total amount of the payment was $1.25 million. Hospitals would get hurt badly because they were a minor participant, and without joint and several liability, they could cover a lot of that verdict up to their cap. But the joint and several liability threshold that the legislature passed, basically, eliminated that. So I am not saying that high verdicts are not a problem, because high verdicts, again, affect settlement, but it is not the problem.

Think for a second, Congressman—I think before you were in the Congress, in the late 1980's and then even in the early 1990's, we had no tort reform in Pennsylvania. None of the things I have delineated this morning existed. We had no caps, we had no joint and several, we had no venue, we had no Act 13, we had no certificate of merit, we had no Rule 11. And what was happening in the 1980's and the 1990's, do you recall, Congressman? The insurance companies were low bidding each other, low-balling each other, to sign up doctors in Pennsylvania. So if tort reform were the reason, that the need for tort reform were the reason that insurance costs have risen so high, there was no tort reform and they were low-balling because they made a miscalculation in their pricing and they thought the cost of paying claims would be less than what they could invest in the market, and to that end, I would like to pass up—and I didn't come with prepared testimony, but I did come with one article.

You quoted, I think, Mr. Chairman, in your remarks, the Wall Street Journal, and I want to pass up to you a June 26, 2002 article in the Wall Street Journal, and I will just quote very briefly from it. The headline is Insurers Missteps Help Provoke Malpractice Crisis. Lawsuits alone didn't cause premiums to skyrocket; early price war was a factor. And this it the Journal, no foe of insurance companies The Journal, on its front page says, but while malpractice litigation has a big effect on premiums, insurers' pricing and accounting practices have paid an equally important role. Following in a cycle that recurs in many parts of the business, a price war that began in the early 1990's led insurers to sell malpractice coverage to obstetricians, gynecologists, at rates that proved inadequate to cover claims.

And then there is a quote from Donald Zuck, the Chief Executor of SCPIE Holdings, a leading malpractice insurer in California. Mr. Zuck said, "I don't like to hear insurance company executives say it is the tort injury law system. It is self-inflicted." And then the Journal goes on to say some doctors are beginning to acknowledge that the conventional focus on jury awards deflects attention from the insurance industry's behavior. The American College of Obstetricians and Gynecologists for the first time is conceding that carriers' business practices have contributed to the current problem. Says Alice Kirkman, a spokesman for that professional group, "We are admitting that it is a much more complex problem than we had previously talked about." Pretty shocking coming from the Wall Street Journal and the American College of Obstetricians and Gyn-

ecologists, but they are right. Not only did the pricing in the 1990's cause this, not only did the bad investments in the late 1990's cause this, but do you know what is shocking—and I forget which one of the Congressmen and women in their opening statements said this, but what is stunning to me, when I came out and met with Abington that night, the Abington Orthopedic Group had never had a claim settled or a jury verdict against them, and their claims were skyrocketing through the roof.

We have an insurance pricing system and it is one of the things that through the Insurance Commission I intend to try to take hold of. We have an insurance pricing system that doesn't give the good doctor the same benefits that the automobile insurance industry gives the good driver. Why should those doctors who have never lost a claim, who have never had a case settled against them, why should their premiums go up? I asked, again, one of the people I talked to in the insurance. He said, well, because by the nature of their practice, they have a lot of claims filed against them. And it is interesting. And you can tell that I am not an advocate for caps, but I think the statistics that opponents of caps quote, about 5 percent of the doctors having 52 percent of the claims, that is a little misleading, because the orthopods, the obstetricians and gynecologists, the neurosurgeons, they do the complex surgery. They are involved in high risk surgery. High risk means we are going to succeed often and do miraculous things, and the doctors in this State I think are the best in America, and they do miraculous things. But by the nature of the complex surgeries they undertake, that lends itself to a lot of claims.

Why does Philadelphia get the most claims? Well (1) because we had lousy venue rules, but (2) the great doctors at CHOP, and at University of Pennsylvania Hospital, and Jefferson, and Hahnemann. These are the great teaching hospitals in America. The great doctor that is there undertakes complex surgery, and those complex surgeries mean there will be claims. And the way our system is structured, the insurance companies pay on those claims even if the verdict is no liability or even if the cases are out of court. So we have to look at the insurance industry, too, and that is a difficult problem. It is a problem for the States at the insurance commissioner level, but I think it is a problem that I would welcome the Congress taking a look at. I think insurance pricing in this area is way out of whack. I think there should be some curb to investing all of the premium money into investments so when the market crashes, we have this crisis. As bad as the medical malpractice problem was in Philadelphia, you didn't hear a peep—you heard some problem, but it didn't escalate the way it did until after the market crashed.

And I just want to say two more things, if I might. A couple of the Congress people talked about the need for medical safety, and Act 13 in Pennsylvania did take some significant steps in the area of medical safety. We have got to do better, but it is a balancing test. We do want to discipline physicians who clearly are guilty of repeated negligence, but we don't ever want to structure a system where physicians are unwilling to take that risk, that risk that can save a life, that risk that can allow a child to walk again, that risk that can maybe reverse serious brain damage. Those are the things

we want. We want the best physicians in America and I do believe we have them here. We want them to continue to feel free to break new ground and do new things, so it is a balance.

And the last thing I would like to say is the doctors often refer to the perfect storm, and they are right when they refer to the perfect storm. The perfect storm can be best summed up as this. All of here on the panel and myself, if we were in the widget business, we manufactured widgets, and the cost of our insurance went up, what would we do? We would, very reluctantly, but we would raise our prices and pass the cost of that increased insurance onto our customers. Physicians, at least in Pennsylvania, are in the perfect storm because they have no ability to do that. Our managed care—and I don't know if this is true in Florida or in Illinois—but our managed care system, except for the poor, our managed care private providers system has broken down to the fact that in almost every region in Pennsylvania, there is one carrier that dominates 65 to 70 percent of the market. That carrier tells physicians what they are going to get paid for a hysterectomy, what they are going to get paid for an appendectomy, what they are going to get paid for delivering a baby, take it or leave it. That is it. And since there is very little competition, there is not much doctors can do. A couple of States have allowed doctors to enter into joint physician negotiation, but that carries some risk because those increased costs are passed onto the consumer, and the consumer is having all sorts of problems dealing with healthcare costs, as you know.

Second, Medicaid and Medicare. The Balanced Budget Act of 1997, in my judgment, and the constant it rendered to the Medicaid and Medicare system, has done more harm than anything else to the healthcare delivery system in America. I know it was well intentioned, I know it was part of trying to get the Federal deficit under control, I know it was part of trying to get better management practices into hospital and medical practices that are fiscal management processed, but it has gone beyond the point of any usefulness. In November, as you will recall, Congressman, I wrote you a letter, as I did to every member of the delegation and to Senator Specter, Senator Santorum, and the leaders in the House and Senate. I wrote a letter asking you in this past session to pass legislation stopping any further phase-out in Medicare and Medicaid costs for doctors, for hospitals, for nursing homes, and the like. I know Congress adjourned without having time to deal with that and we were told by legislative leaders that that would be dealt with in a comprehensive healthcare package that included prescription drugs. I can't emphasize how important that is. I cannot emphasize. Not only should you freeze any further cuts, you should—and I know the Federal Government has terrific budget problems and I am not going to get into a discussion of tax cuts. That wouldn't be very productive, although, it is interesting to note all my fellow Republican Governors who ran on the platform of never raising taxes having to raise taxes, but leave that aside for a moment because that is not directly relevant to us.

But I would really, seriously, urge the Congress, if you are interested in when President Bush came to Scranton to talk about this issue, and he talked about caps, I said, it is okay to talk about caps, but talk about raising the level of Medicaid and Medicare re-

imbursement to our doctors, to our hospitals, and to our nursing homes. Nursing homes lose 10 percent each day for every Medicaid patient they keep, 10 percent. They take that loss. And it is a system that in my judgment is out of whack, and fixing that is as important, and probably more important because it has even broader long-term ramifications than fixing the medical malpractice crisis.

So it is a complex issue. We have to look at insurance costs. We have to continue to look at tort reform. We, certainly, can't turn our back in tort reform. And Pennsylvania has, as I said, taken some terrific steps, and we have to do more. We have to find a way to alleviate this crisis. We should look at medical safety, we should look at insurance costs, we should look at tort reform, and we should look at Medicaid and Medicare reimbursements. If we do all of those things, I believe we can bring this crisis under control. Nobody is assigning blame. There is plenty of blame to go around and assigning blame doesn't do much good in my judgment. But I think this committee's efforts are sincere and I hope you will address all of those issues as you go down the road and do your work. Thank you very much, Mr. Chairman.

[The information referred to follows:]

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Assigning Liability

Insurers' Missteps Helped Provoke Malpractice 'Crisis'

Lawsuits Alone Didn't Cause Premiums to Skyrocket; Earlier Price War a Factor

Delivering Ms. Kline's Baby

By Rachel Zimmerman And Christopher Oster

As medical-malpractice premiums skyrocket in about a dozen states across the country, obstetricians and doctors in other risky specialties, such as neurosurgery, are moving, quitting or retiring. Insurers and many doctors blame the problem on rising jury awards in liability lawsuits.

"The real sickness is people sue at the drop of a hat, judgments are going up and up and up, and the people getting rich out of this are the plaintiffs' attorneys," says David Golden of the National Association of Independent Insurers, a trade group. The American Medical Association says Florida, Nevada, New York, Pennsylvania and eight other states face a "crisis" because "the legal system produces multimillion-dollar jury awards on a regular basis."

But while malpractice litigation has a big effect on premiums, insurers' pricing and accounting practices have played an equally important role. Following a cycle that recurs in many parts of the business, a price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims.

Price Slashing

Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year.

"I don't like to hear insurance-company executives say it's the tort [injury-law] system—it's self-inflicted," says Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California.

What's more, the litigation statistics most insurers trumpet are incomplete. The statistics come from Jury Verdict Research, a Horsham, Pa., information service, which reports that since 1994, jury awards for medical-malpractice cases have jumped 175%, to a median of $1 million in 2000. During that seven-year period, the median award for negligence in childbirth was $2,950,000—the highest for all types of medical-malpractice cases, Jury Verdict Research says. (In any group of figures, half fall above the median, and half fall below.)

Gaps in Database

But Jury Verdict Research says its 2,551-case malpractice database has large gaps. It collects award information unsystematically, and it can't say how many cases it misses. It says it can't calculate the percentage change in the median for childbirth-negligence cases. More important, the database excludes trial victories by doctors and hospitals—verdicts that are worth zero dollars. That's a lot to ignore. Doctors and hospitals win about 62% of the time, Jury Verdict Research says. A separate database on settlements is less comprehensive.

A spokesman for Jury Verdict Research, Gary Bagin, confirms these and other holes in its statistics. He says the numbers nevertheless accurately reflect trends. The company, which sells its data to all comers, has reported jury information this way since 1961. "If we changed now, people looking back historically couldn't compare apples to apples," Mr. Bagin says.

Some doctors are beginning to acknowledge that the conventional focus on jury awards deflects attention from the insurance industry's behavior. The American College of Obstetricians and Gynecologists for the first time is conceding that carriers' business practices have contributed to the current problem, says Alice Kirkman, a spokeswoman for the professional

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Insurers Share Blame for Malpractice Turmoil

Continued From First Page

group. "We are admitting it's a much more complex problem than we have previously talked about," she says.

Scrambling for Doctors

The upshot is beyond dispute: Pregnant women across the country are scrambling for medical attention. Kimberly Mangonotega of Las Vegas is 13 weeks pregnant and hasn't seen an obstetrician. When she learned she was expecting, the 33-year-old mother of two called the doctor who delivered her second child but was told he wasn't taking any new pregnant patients. Dr. Shelby Wilbourn plans to leave Nevada because of soaring medical-malpractice insurance rates there. Ms. Mangonotega says she called 25 obstetricians but couldn't find one who would take her.

Frustrated, she called the office of Nevada Gov. Kenny Guinn. A staff member gave her yet another name. She made an appointment to see that doctor today but says she is skeptical about the quality of care she will receive.

In the Las Vegas area, doctors say some 90 obstetricians have stopped accepting new patients since St. Paul Cos., formerly the country's leading provider of malpractice coverage, quit the business in December. St. Paul had insured more than half of Nevada's 240 obstetricians. Carriers still offering coverage in the state have raised rates by 100% to 400%, physicians say.

Dr. Wilbourn says his annual malpractice premium was due to jump to $108,000 next month, from $33,000. The 41-year-old solo practitioner says the increase would come straight out of his take-home pay of between $150,000 and $200,000 a year. In response, he is moving to Maine this summer.

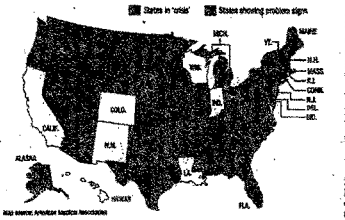


Kimberly Mangonotega

Dr. Wilbourn mourns having "to pick up and leave the patients I cared for and the practice I built up over 12 years." But in Maine, he has found a $200,000-a-year position with an insurance premium of only $9,800 for the first year, although the rate rises significantly after that. Premiums in Maine are relatively low because a dominant doctor-owned insurance cooperative there hasn't pushed to maximize rates, the heavily rural population isn't notably litigious and its court system employs an expert panel to screen out some suits, says Insurance Commissioner Alessandro Iuppa.

Soaring Premiums

Insurance-industry accounting and pricing practices have contributed to sharply rising medical-malpractice rates that are causing doctors in some states to quit or move.



Data source: American Medical Association

Until the 1970s, few doctors faced big-dollar suits. Malpractice coverage was a small specialty. As courts expanded liability rules, malpractice suits became more common. Dozens of doctor-owned insurance cooperatives, or "bedpan mutuals," formed in response. Most stuck to their home states.

St. Paul, a mid-sized national carrier named for its base in Minnesota, saw an opportunity. An insurer of Main Street businesses, St. Paul became the leader in the malpractice field. By 1985, it had a 20% share of the national market. Overall, the company had revenue of $8.9 billion last year, with about 10% of its premium dollars coming from malpractice coverage.

The frequency and size of doctors' malpractice claims rose steadily in the early 1980s, industry officials say. St. Paul and its competitors raised rates sharply during the 1980s.

Expecting malpractice awards to continue rising rapidly, St. Paul increased its reserves. But the company miscalculated, says Kevin Rehnberg, a senior vice president. Claim frequency and size leveled off in the late 1980s, as more than 30 states enacted curbs on malpractice awards, Mr. Rehnberg says. The combination of this so-called tort reform and the industry's rate increases turned malpractice insurance into a very lucrative specialty.

A standard industry accounting device used by St. Paul and, on a smaller scale, by its rivals, made the field look even more attractive. Realizing that it had set aside too much money for malpractice claims, St. Paul "released" $1.1 billion in reserves between 1982 and 1997. The money flowed through its income statement and boosted its bottom line.

St. Paul stated clearly in its annual reports that excess reserves had enlarged its net income. But that part of the message didn't get through to some insurers—especially bedpan mutuals—dazzled by St. Paul's bottom line, according to industry officials.

In the 1990s, some bedpan mutuals began competing for business beyond their original territories. New Jersey's Medical Inter-Insurance Exchange, California's Southern California Physicians Insurance Exchange (now known as Scpie Holdings), and Pennsylvania Hospital Insurance Co., or Phico, fanned out across the country. Some publicly traded insurers also jumped into the business.

With St. Paul seeming to offer a model for big, quick profits, "no one wanted to sit still in their own backyard," says Scpie's Mr. Zuk. "The boards of directors said, 'We've got to grow.'" Scpie expanded into Connecticut, Florida and Texas, among other states, starting in 1997.

As they entered new areas, smaller carriers often tried to attract customers by undercutting St. Paul. The price slashing became contagious, and premiums fell in many states. The mutuals "went in and aggravated the situation by saying, 'Look at all the money St. Paul is making,'" says Tom Gose, President of MAG Mutual Insurance Co., which operates mainly in Georgia. "They came in late to the dance and undercut everyone."

The newer competitors soon discovered, however, that "the so-called profitability of the '90s was the result of those years in the mid-80s when the actuaries were predicting the terrible trends," says Donald J. Fager, president of Medical Liability Mutual Insurance Co., a bedpan mutual started in 1975 in New York. Except for two mergers in the past two years, its company mostly has held to its original single-state focus.

The competition intensified, even though some insurers "knew rates were inadequate from 1995 to 2000" to cover malpractice claims, says Bob Sanders, an actuary with Milliman USA, a Seattle consultancy serving insurance companies.

Alleged Fraud

In at least one case, aggressive pricing allegedly crossed the line into fraud. Pennsylvania regulators last year filed a civil suit in state court in Harrisburg against certain executives and board members of Phico. The state alleges the defendants misled the company's board on the adequacy of Phico's premium rates and funds set aside to pay claims. On the way to becoming the nation's seventh-largest malpractice insurer, the company had suffered mounting losses on policies for medical offices and nursing homes as far away as Miami.

Pennsylvania regulators took over Phico last August. The company filed for bankruptcy-court protection from its creditors in December. A trial date hasn't been set for the state fraud suit. Phico executives and directors have denied wrongdoing.

In the late 1990s, the size of payouts for malpractice awards increased, carriers say. By 2000, many companies were losing money on malpractice coverage. Industywide, carriers paid out $1.36 in claims and expenses for every premium dollar they collected, says Mr. Golden, the trade-group official.

The losses were exacerbated by carriers' declining investment returns. Some insurers had come to expect that big gains in the 1990s from their bond and stock portfolios would continue, industry officials say. When the bull market stalled in 2000, investment gains that had patched over inadequate premium rates disappeared.

Some bedpan mutuals went home. Scpie stopped writing coverage in any state other than California. "We lost money, and we retreated," says the company's Mr. Zuk.

New Jersey's Medical Inter-Insurance Exchange, now known as MIIX, had expanded into 24 states by the time it had a loss of $154 million in the fourth quarter of 2001. The company says it is now refusing

to renew policies for 7,000 physicians outside of New Jersey. It plans to reformulate as a new company operating only in that state.

St. Paul's malpractice business sank into the red. Last December, newly hired Chief Executive Jay Fishman, a former Citigroup Inc. executive, announced the company would drop the coverage line. St. Paul reported a $680 million loss on the business for 2001.

As carriers retrench, competition has slumped and prices in some states have shot up. Lauren Kline, 6½ months pregnant, changed obstetricians when her long-time Philadelphia doctor moved out of state because of rate increases. Now, her new doctor, Robert Friedman, may have to give up delivering babies at his suburban Philadelphia practice. His insurance expires at the end of the month, and he says he is having difficulty finding a carrier that will sell him a policy at any price.

Last year, Dr. Friedman says he paid $50,000 for coverage. If he gets a policy for next year, it will cost $80,000, he predicts, based on his broker's estimate. "I can't pass a single bit of that off to my patients," because managed-care companies don't allow it, he says.

Dr. Friedman says is considering dropping the obstetrics part of his practice. Generally, delivering babies is seen as posing greater risks than most gynecological treatment. As a result, insurers offer less-expensive policies to doctors who don't do deliveries.

Mr. Golden of the insurers' association argues that whatever role industry practices may play, the current turmoil stems from lawsuits. The association says that from 1995 through 2000, total industry payouts to cover losses and legal expenses jumped 52%, to $6.9 billion. "That says there are more really huge verdicts," Mr. Golden says. Even in the majority of cases in which doctors and hospitals win—the zero-dollar verdicts—there are still legal expenses that insurers have to pick up, he adds.

Industry critics point to different sets of statistics. Bob Hunter, director for insurance at Consumer Federation of America, an advocacy group in Washington, prefers numbers generated by A.M. Best Co. The insurance-rating agency estimates that once all malpractice claims from 1991 through 2000 are resolved—which will take until about 2018—the average payout per claim will have risen 67%, to $42,473. That projection includes legal expenses and suits in which doctors or hospitals prevail.



Shelby Wilbourn

While the statistical debate rages, pregnant women adjust to new limits and inconveniences. Kelly Biesecker, 25, spent many extra hours on the highway this spring, driving from her home in Villanova, Pa., to Delran, N.J., so she could continue to use her obstetrician. Dr. Richard Krauss says he moved the obstetrics part of his practice from Philadelphia because malpractice rates had skyrocketed in Pennsylvania. Ms. Biesecker, who gave birth to a healthy boy on June 5, says Dr. Krauss was the doctor she trusted to guard her health and the health of her baby. "You stick with that guy no matter what the distance."

Dr. Krauss, 53, left Philadelphia last year only after his malpractice premium rose to $54,000, from $38,000, and then was cancelled by a carrier getting out of the business, he says. After getting quotes of about $80,000 on a new policy, he moved. New Jersey hasn't been a panacea, however. His policy there expires July 1, and the carrier refuses to renew it. The doctor says he hopes to go to work for a hospital that will pay for his coverage.

Mr. GREENWOOD. Thank you, Governor. We appreciate it. As a matter of housekeeping, without objection, the Wall Street Journal article of June 24 submitted by the Governor will be entered into the record. The Chair recognizes himself for 10 minutes to question the Governor.

Governor Rendell, you have stated repeatedly that caps are not the only answer, and we all agree with that. And first, let me be clear about what I am talking about and what my legislation does with caps. It places, as I think you know, no cap whatsoever on economic damages. So any individual harmed in Pennsylvania by medical error, or anywhere else in the country, under that legislation would be able to recover 100 percent healthcare costs, doctors, hospitals, drugs, rehab. They would be able to recover 100 percent of lost wages for a lifetime if it is a newborn, for instance; any services that they cannot provide for themselves, if they need someone to mow their lawn, or go shopping for them, or walk their dog, 24-hour nursing, they are all reimbursable. Punitive damages in those relatively rare cases where punitive damages apply are payable under the legislation up to twice the economic damages. So the cap only refers to and only applies to the non-economic damages, the so called pain and suffering. And our legislation sets that at $250,000 as a floor. We set it at that number because the Californians do not want us to trump their existing $250,000 cap, but we allow State legislatures and Governors to raise that cap on non-economic damages to wherever they choose, so it has been referred to as draconian but it is only as draconian as the States choose it to be. So I wanted to make that clear.

Now, you said in your testimony that you believe caps are not the panacea. If you only do caps, you don't solve the problem. Agreed. And that is why the legislation that I have introduced does many things, including some of the items that you referred to, but it does the cap. The question is not whether caps are a sufficient response. The question is whether they are necessary. Let me just continue here, because I would argue that while they are not sufficient, they are certainly necessary. You referred to some discussions that you had with medical liability carriers, and I happened to be at the Pennsylvania Society when you spoke and talked about your discussion with the head of Princeton Insurance Company, who said—and I think you paraphrased it today—if you just do caps, we are not coming back.

Here is what he said in the letter to us, February 7, 2003. President of Princeton Insurance Company, William McDonough, wrote that his company has always supported our efforts to establish caps on non-economic damages as part of a package of tort reforms and adds, "Princeton believes these initiatives will serve to bring stability to the medical malpractice market, ensuring the malpractice coverage our physicians need is available and affordable, especially, in the New Jersey and Pennsylvania regions."

Now, does this conflict with your understanding of their position, because this is critical. They want caps.

Governor RENDELL. Well, they want caps, but they wouldn't come back to Pennsylvania if that is all we did.

Mr. GREENWOOD. That is agreed, and that is why none of us——

Governor RENDELL. But if I were in the insurance——

Mr. GREENWOOD. Let me just finish, Governor. None of us propose to do caps and caps alone. All of us propose to take a series of steps. And as I listen to the things, the items under consideration by your taskforce, caps was one of them, and you admitted that you are not a fan of caps. You admitted, or you noted, that the Constitution doesn't allow the legislature to set that cap, which is precisely why I have gone the Federal route to go ahead and do that. You have talked about reducing coverage. Well, you can reduce coverage, but I think that there are many who would argue in favor of the legitimately harmed patient that you don't want to reduce coverage to the point where patients can't—legitimately injured patients can't achieve legitimate coverage or verdicts.

Governor RENDELL. California has reduced coverage to $100,000, and I would argue that that would reach the standard you just said.

Mr. GREENWOOD. Okay. And that does begin to get to the liability issue, because you talked to a bond issue, you have talked about going after a one-time tax on the insurance company surpluses. What those things do is just put more money into the pot. It becomes taxpayers' money and premium payers' money, but I guess what I want to get from you is a clear understanding of do you think that critical to resolving this crisis is to limit in someway the exposure, the liability of the insurance companies, so that when they are confronted with these claims, these cases, that they can decide whether they can afford to go to court and risk a trial or whether they have to settle because their exposure is so unlimited, as it is now in Pennsylvania, that they can't take the risk?

Governor RENDELL. I think if you had to choose between caps, let us say at 250, and reducing the mandated coverage, I think most defense lawyers would tell you reducing the mandated coverage is far superior. For us to have a $1 million coverage, in California you have $100,000, makes no sense. I agree with you, $100,000 is probably too low, but I think mandated coverage, the level of mandated coverage, is probably more important than caps in my judgment. Again, the caps aren't paid; the $30 million you read about is never paid by a doctor, never paid by the insurance company. It just affects the settlement discussions. But reducing the mandated coverage, I think would have a better effect on reducing the coverage. But I am not arguing with you. Would caps have an impact overall in reducing premiums? Absolutely. The question is, and it is a question for all of you, and it is a question for my taskforce, and myself, and the Pennsylvania Legislature, at what cost?

And I know what you said is correct, and I know you are genuine in your desire to see a victim totally taken care of, but let us take a young person, a young person who at the age of 5 or 6 goes in for a procedure, and let us posit for a moment that that young person because of clear-cut negligence comes out of that procedure as a quadriplegic. We are going to take care of that young person's medical needs and the attendant needs for the rest of their life. Well, that young person is likely to live another 70 years, and capping the damages for non-economics to that young person, trying to in some way compensate that young person for the loss of everything and for the emotional distress of knowing that they have lost every basic activity that a normal human being can do at $250,000

for 70 years, that is probably, if you factored in inflation, that is probably about $2,000 a year for that young person.

Mr. GREENWOOD. What is the point of having a cap that is higher than the coverage? If you are going to limit the coverage, and you just said we should limit the coverage.

Governor RENDELL. Right.

Mr. GREENWOOD. Okay. And you said that these big awards aren't actually paid because there is a limit on the coverage. Now, if you limit the coverage, as you have suggested, and now you want to have juries award verdicts that exceed that coverage, what have you accomplished?

Governor RENDELL. Well, it depends if there is hospital liability, et cetera, et cetera. I mean, the bottom line——

Mr. GREENWOOD. You also said that you want to have hospitals only bear their fair share of the burden.

Governor RENDELL. Right.

Mr. GREENWOOD. And you don't want a deep pocket system.

Governor RENDELL. Well, we have done that in Pennsylvania, as I said, and most—I think we were one of the last large States to have a threshold on joint and several. You know, there comes a point where, I agree with you, if you mandate coverage too low—and I don't want to mandate coverage anywhere close to $100,000.

Mr. GREENWOOD. What is a good number?

Governor RENDELL. I don't know. I am waiting for the committee to recommend that.

Mr. GREENWOOD. But you would have the power in the State of Pennsylvania to match the cap with coverage. So if you think $100,000 is too low, and here we are talking about in my bill unlimited economics. I don't want a coverage limit on economic damages. I want that person who is a quadriplegic who might need round-the-care nursing coverage, around the clock, and a lifetime of lost wages, I want that person to get $10 million if he or she needs it because they need it, and they were legitimately harmed and they need that. The question is that when a quadriplegic is lying in the bed getting nursing care, and having his services covered for him, and his wages covered, and all of that, then is there a point to having that jury award an extra $5 million or $10 million for non-economic damages, much of which ends up in the pocket of the attorney, or do you want to put some limits on this?

Governor RENDELL. The only way it ends up in the pocket of the attorney, if a check is cut. The verdict doesn't determine what an attorney gets. It is only when the check is cut. That is another misconception that people throw around. A $30 million verdict means the attorney gets $10 million. Well, that $30 million verdict, assuming now that we have got joint and several for the hospital, could be a $1 million payment and the attorney gets $333,000. If there is hospital liability, it would be higher.

Mr. GREENWOOD. But then, of course, the physician—you said that physicians don't necessarily wind up spending their personal assets, but if you——

Governor RENDELL. No physician has ever been sued in Pennsylvania.

Mr. GREENWOOD. Well, my guess is that part of that is because they have coverage, that they buy coverage sufficient to protect

their personal assets. But if you are recommending a system in which the physician is only required to have a cap on their coverage, and yet, you don't want to cap their exposure, the insurance company's exposure, which is really what you are talking about, the insurance company's exposure, then the hospital and the doctors are stuck with unlimited exposure out of their other assets because they have got a cap on their coverage, no cap on their liability.

Governor RENDELL. Right. But again, let me repeat, at least for physicians, no physician has ever been sued for collection of a verdict above and beyond mandated coverage.

Mr. GREENWOOD. Well, my guess is that is because they have covered themselves. Has my time expired? My time has expired. Then I will yield 10 minutes to the gentleman from Florida.

Mr. DEUTSCH. Thank you, Mr. Chairman. Can we bring up number 5? That is number 6. All right. You can leave it. I have a question on number 6; that is fine. Okay. That is not very helpful. All right. I don't know if you can make it out, but, you know, in Florida we are proud of being No. 1 in a lot of things. This is not something we are proud of being No. 1 in. This is a survey from the Medical Liability Monitor of the cost of malpractice premiums by State, with Florida, as it shows, is the highest State. Pennsylvania, as bad as things are, again, it is somewhat dated data, 2001, but Pennsylvania is less than one-third of Florida in terms of rates. And as you can see by the chart as well, it ties into the conversation that we have been having. Non-economic damage caps have been instituted by the State in Florida, and you know—I mean, Governor, I don't know if you want to respond to it—it lists a number of States. In fact, the top 2, or 4 of the top 5 States, in terms of premiums have some type of non-economic damages.

Governor RENDELL. You mean, caps?

Mr. DEUTSCH. Caps on non-economic——

Governor RENDELL. Yes, although, the advocates for the other side would say they are not California style caps. But I agree. I mean, I don't believe that caps is as a significant factor as mandating coverage, as joint and several, as eliminating frivolous lawsuits, as curbing the number of lawsuits. I think there are so many factors that kick in and are far more influential than caps.

Mr. DEUTSCH. You mentioned, and again, I am not familiar with most of the specifics of Pennsylvania or tort law, but you mentioned several times this $1 million mandatory coverage. Could you explain that a little bit, how that works? Is that by State statute?

Governor RENDELL. It is by State statute. We were mandated, actually, before Act 13 at the beginning of 2002, we were mandated, a doctor was mandated to cover $500,000 of coverage from a private insurance company and pay in a premium that amounted to a $750,000 coverage in the CAT Fund. Act 13 reduced the $750,000 to $500,000.

Mr. DEUTSCH. So every physician that practices in the State of Pennsylvania has that level of coverage?

Governor RENDELL. It depends on the level—well, I am not sure of that. To be honest, Congressman, I am not sure of that.

Mr. DEUTSCH. Okay. I mean, the million dollar number, though, that you were talking about—because again, the Florida experience

is much different. In fact, actually, I asked the staff to check. You mentioned California, and again, this is, you know, sort of how statistics are tough to grab a hold of everything. I am not aware that in Florida there is any requirement of a minimum requirement.

Governor RENDELL. Many States have no mandated coverage.

Mr. DEUTSCH. Right. And so, you know, that is not to say, you know, that would be evidence if we look at high rates in Florida but, in fact, again, it is interesting. My understanding is, particularly in certain subspecialties, and this is, you know, just kind of talking through things. It is not a solution that I would recommend, but in a sense, in Florida two things have occurred. One is a huge number of physicians, particularly, in very high premium areas, have gotten bare and have really dealt with asset protection as a response in terms of not having coverage. The other thing that has happened in Florida is because of sovereign immunity issues in certain subspecialties, physicians have entered into contracts with hospitals that have protection of sovereign immunity to, basically, continue their practices under the umbrella of sovereign immunity. Could you just talk a little bit about——

Governor RENDELL. In terms of going bare, I would suggest that as a short-term remedy, to me, that we allow physicians to just go without coverage for a 6-month or 1-year period while we are trying to sort all this out. The problem is, and I don't know if—I am sure you have got hospital personnel here. The hospital personnel object vociferously to allowing—and I think most Pennsylvania hospitals would not allow a physician with no coverage to practice in their hospitals, and that would cause at least in Pennsylvania a breakdown of the whole medical system.

Mr. DEUTSCH. What about the issue of—again, I am not familiar with Pennsylvania and how it works with sovereign immunity issues. St. Mary's, I assume, is a not for profit hospital. Is it benefited by sovereign immunity?

Governor RENDELL. No, and we have no State run hospitals. We have a couple of mental institutions, but no State run medical facilities in Pennsylvania.

Mr. DEUTSCH. So there is no community hospice, there is nothing——

Governor RENDELL. Nothing that has sovereign immunity.

Mr. DEUTSCH. And so not for profit's do not avail themselves of that type of immunity?

Governor RENDELL. Well, they can't under Pennsylvania law.

Mr. DEUTSCH. Is that something that has been looked at in terms of——

Governor RENDELL. Well, again, I mean, you are back to what Congressman Greenwood says. You don't want to create a system where there can be no recovery at all, because the most important thing is that medical costs and lost wages, but particularly, medical costs, are covered. If you have sovereign immunity, I assume sovereign immunity imposes some sort of cap in Florida?

Mr. DEUTSCH. Well, actually, it ends up being an interesting procedure that those cases go directly to the legislature in terms of a, basically, arbitration process through the legislative process.

Governor RENDELL. And we had sovereign immunity in the city of Philadelphia when I was mayor. Sovereign immunity limited in

some instances what our total liability was; in some instances we had no liability at all. And that can obviously work and have some negative consequences as well.

Mr. DEUTSCH. Can we bring up chart number 6? Okay. This chart, as you can see, it tells us that most of Pennsylvania does not have the medical malpractice problems as Philadelphia County and the counties that surround it. Even as close as Lancaster, medical malpractice premiums are only about 60 percent of Bucks and Montgomery. And when we look at the breakout of types of practice, obviously, the highest ratios and State charges, in fact, you know, in the area, I guess, for family practitioners, some of them pay as little as $5,000 per year. OB-GYN's in Philadelphia pay about $90,000 a year. This is something that you talked a little bit about in your testimony, but is it, you know, your sense that the problem is really local and limited to relatively few physicians?

Governor RENDELL. No. I don't know that is affecting—the problem is intense in the southeast, but also extremely intense in Lackawanna, and I don't know Luzerne, but particularly, Lackawanna, Luzerne, Monroe. Those doctors were about to walk off before we did our short-term remedy, and even across the State. Do you see little Fulton County down in the southern part of the State? I was campaigning, I was the first Democrat. Actually, I was the first candidate for Governor to come to Fulton County in 40 years, and I came this summer. And there aren't a lot of Democrats in Fulton County so the people who came to my press conference, I got to know personally. And one of them—I was on a first name basis with all of them. One of them was the county's only physician, only physician who lives in Fulton County. He had a general practice and he told me that he had no problem with his premiums because he didn't do the complicated work. When someone in Fulton needed orthopedic surgery, a doctor from a hospital in Chambersburg, which is Franklin County and Green, would come over and perform that surgery in the General Hospital in Fulton.

I saw him—that was in July. I saw him about 7 months later at my inaugural ball. I just, you know, was greeting people at the inaugural ball, and he came up to me and said, do you remember me, I am the doctor from Fulton. I said, yes. He said, my medical malpractice has increased two-and-a-half times since I talked to you, and that is in little Fulton, which you have in the purple, which is the least consequential of all. And if you were to ask doctors in—and maybe some of the physicians and maybe the hospital administrators can talk about this. If you were to ask doctors in Pittsburgh, which is Allegheny County, southwest Pennsylvania, Erie, they would tell you that their medical malpractice premiums have increased a large percentage.

But because of the work that is done, and it goes back to that original point I made about the 5 percent, most of the high risk surgery that goes on in Pennsylvania goes on in those dark blue counties in the southeast, a little bit of it in Allegheny County and a little bit of it in Lackawanna County, and then that is the problem. If you were to look at the percentage of the physicians in the four challenged specialties where I eliminated 100 percent of their MCARE payments, a high percentage, a very high percentage, would be in those purple counties. So it is a little bit of the type

and practice. That physician from Fulton County was, basically, your old fashioned GP, and your old fashioned GP hadn't gotten hit yet, but has started to get hit. Now, his medical malpractice premium that has increased two-and-a-half times, any OB-GYN in Philadelphia or the Philadelphia suburbs would give their right arm to have his premium, but it is all relative because remember, it is the premium compared to the amount of gross revenue that comes into the doctor's practice. And the gross revenue in the practice is far greater in those purple, and yellow, and red counties than it is in most other parts of the State. Allegheny County is the one anomaly in that chart.

Mr. GREENWOOD. The time of the gentleman from Florida has expired. The chairman welcomes the gentleman, the new Member of Congress from Chester and Lancaster Counties, and Montgomery County, and Bucks County, Congressman Gerlach, and you are recognized for 10 minutes for questions.

Mr. GERLACH. Thank you. Good morning, Governor.

Governor RENDELL. Good morning.

Mr. GERLACH. First of all, let me commend you on the handle you have on this issue. You seem to have gotten started very quickly in your term with understanding what is going on all across Pennsylvania. And anecdotally, one of those blue counties up there that was not indicated as being a high or a great area of concern is Clarion County. My sister happens to work for an orthopedic surgery group in Clarion County, a very rural, small county in Pennsylvania that, relatively, their rates have been going up very, very rapidly. And again, based upon what the reimbursement rates are for Medicare and Medicaid, as well as third party payer, that has been a very high cost that they have been absorbing in the past few years, and it is at a very difficult level for them as well.

Governor RENDELL. Absolutely. And can I interject, Mr. Chairman, one of the things that, as you know, Medicare and Medicaid reimburse differently, urban and rural. So a physician in Philadelphia will get a higher rate of reimbursement for operation A than that physician in Clarion County.

Mr. GERLACH. Absolutely.

Mr. GREENWOOD. Right. Because of the high tax rates in Philadelphia, they have higher overhead.

Mr. GERLACH. When I was in the legislature, and you covered a number of things that were done in the past year to deal with this issue, and a lot of good things were done, no question about it. One of the things I was involved in, specifically, was the frivolous lawsuit issue, and we had a bill, Senate Bill 406, that would have amended our Dragonetti section of the Pennsylvania Judicial Code to strengthen those provisions, to identify or allow an opportunity for a victim of a frivolous lawsuit to collect attorney's fees and costs against the plaintiff that brought a case that did not have any real basis in law or in fact. And rather than that legislation ultimately getting all the way through the legislature and to the Governor's office was the fact that that also is an issue involving rural support in Pennsylvania, and so that is the constitutional end of the purview of the Pennsylvania Supreme Court. And they, in turn, if you are aware, did amend Pennsylvania Rules of Civil Procedure

1023.1 to, in essence, give us a Federal 11 here at the Pennsylvania State court level.

Additionally, just recently, you know, they amended the Rules of Civil Procedure again to provide for a certificate of merit that will identify, hopefully, and weed out frivolous litigation at the outset if there is not clear grounds for that suit to begin. And you would think based upon those two rule changes that those are a sufficient way to address your point that one of the reasons there is a high cost of doing business as an insurance company in Pennsylvania, to write medical malpractice insurance, is the number of lawsuits that are being filed. Are those two changes to the Rules of Civil Procedure sufficient enough in your opinion, or do you need to go further either by either a procedural rule change through the court, or statutorily, through legislation, to again address the issue of the number of lawsuits that are filed in Pennsylvania that in turn then impact the cost of insurance?

Governor RENDELL. Well, first, let me commend you for trying to take your legislative action to deal with this problem, because like I said, the insurance companies identified this as the No. 1 problem. The answer to your question is I don't know, and we have asked our committee to look at that. There may be a need for some form of arbitration system for lower level claims to continue to weed out those discovery costs and those trial costs, et cetera. But I think those two steps, the American Bar Association and some other group estimated 25 percent of the medical malpractice lawsuits in any State would get knocked out by those two provisions. And that is a significant number.

Mr. GERLACH. There was also, you mentioned, arbitration back in 1996 the legislature passed, I think it was Act 35, that had a number of forms in it, including a mediation process to mediate medical malpractice cases before they get to a writ of summons being filed, or a complaint being filed, and the civil litigation process starting. That was suspended, that and other provisions were suspended by the court back in 1996, and had they been in place over the past 6 or 7 years, there might have been a different story in the medical malpractice situation in Pennsylvania. Do you, as Governor, intend, if you have not already, to go back to the court and have them reconsider that suspension, because again, it is only a suspension. It was not deemed to be constitutionally invalid at this point, as I understand it. It has just been suspended by the court through their King's bench power. Would you look at going back to the court and requesting a review by the court of whether that mediation process ought to be reauthorized by the court and allowed to be brought into place in Pennsylvania to allow a process to mediate or arbitrate these cases before you get into the civil justice system?

Governor RENDELL. Absolutely. That is one of the things the taskforce is looking at. Of course, Congressman Greenwood understands, but for the other Congressman, we have a particular clerk in Pennsylvania where a lot of the Supreme Court controls procedural forms, the legislature controls substantive reforms. And of course, the difference between substantive and procedure is what the Supreme Court says it is. In 1996, the legislature passed a fairly comprehensive set of reforms. The Supreme Court voided all of

them and said they were all procedural, but then didn't take any action on its own to refer to its own rules committee. I will say there is real hope on the horizon because the new Chief Justice, Ralph Cappy, is very responsive. In December, I asked him to expedite the process in looking at the certificate of merit, and they came out with a rule just about a week ago on certificate of merit, as you know. So we are looking at all of the 1996 work of the legislature, which I thought was also good work, and by the way, agreed upon by both sides. As was, interestingly, the certificate of merit rule had the support of the vast majority of trial lawyers in Pennsylvania, because the substantial trial lawyers would never bring a lawsuit without having a certified medical expert's opinion in hand. So the legislature in 1996 crafted out a good area of agreement, and unfortunately, it was voided. We are looking at recommending all of those. Our recommendations will not just be to the legislature, but they will be to the Supreme Court Rules Committee as well.

Mr. GERLACH. Okay. Good. Well, thank you very much.

Mr. GREENWOOD. The Chair thanks the gentleman and recognizes for 10 minutes the gentlelady from Chicago.

Ms. SCHAKOWSKY. Thank you so much, Governor, for all of your testimony. I am wondering if I could go back to chart number 5. Well, the point I wanted to make out of chart number 5 is that at the bottom half, you see, the darkest line is the average, and then below that are those that paid less than average. And what you find in there is that below the line there are 14 States that have no caps, and above the line there are 12 States that have no caps. In other words, there are more States that have caps above the line as a percentage than below the line, and I wanted to just point out a State that may be somewhat comparable to Pennsylvania, Minnesota, which does have large cities and has no caps at all, and has insurance premiums that are much lower, that are third or fourth from the bottom, and just comment that there is this disconnect between the notion that if there were caps, that somehow those premiums would be lower, which I think, really, just reinforces what you were saying.

But I wanted to show you chart number 1 to show in terms of verdicts, and this may reinforce also with what Congressman Gerlach was saying. In terms of payouts here in Pennsylvania, you find that they have, actually, dramatically, been reduced when it comes to verdicts over the years, and are at a low level. So if what these insurers are telling you, that it is the number of lawsuits, then it would seem to me that the critical reason perhaps, or a more critical factor anyway, would be the certificate of merit solution to deal with a number of lawsuits.

Governor RENDELL. Well, we won't know the effect of the certificate of merit or the Rule 11 that Congressman Gerlach talked about, because, again, they were too late to factor into the January 1 premiums. But we believe they will factor into the July 1 premiums that are coming out. You know, again, I have seen this chart and this statistic, and these are the ones that go to trial, and there is no question, juries, I think, have been sensitized about all of the publicity about the crisis and are less—I think a lot of juries in Philadelphia said, well, we will let the insurance company pay.

That was their sort of belief, you know, this poor little girl. In fact, there was a quote in the paper, I think on Sunday, saying, well, we didn't think there was any negligence, but the poor little girl was so nice that we wanted her to get something. I think because of the growing knowledge of the crisis this year, I think juries are a little bit more in tune to that. But the key factor here which would make this chart, and I have asked the trial lawyers to come up with it, is the amount of large settlements as well. If that amount had also gone down as dramatically, then you could see there was real progress being made.

Ms. SCHAKOWSKY. Let me just point out that Minnesota does have a certificate of merit, so that may be one of the factors that will lower the premiums. I wanted to also argue that what you refer to as tax cuts, and I know none of us want to go into that, but it, in fact, may be more relevant, in fact, than caps, because you in your campaign endorsed a 10 to 15 percent enhancement in Medicaid for high risk specialties, some of which, a good deal of which, would come from the Federal Government.

Ms. SCHAKOWSKY. I wondered if you want to——

Governor RENDELL. Well, I was going to have Pennsylvania actually chair some of that, enter into a joint agreement. Again, I go back to what Congressman Greenwood said, and it was the right thing. There is no one answer to this, but clearly, increasing Medicaid and Medicare reimbursements is a crucial step to this. It is a crucial step to this, and again, it is something that we have to do for a whole boatload of reasons, not just the medical malpractice crisis. But we have to alleviate the pressure on the doctors and hospitals from both ways, the rising premium cost and the fixed reimbursement cost. If we can do that, I think we can bring this situation under control. There are a lot of different answers to this, but that is clearly one of them.

Ms. SCHAKOWSKY. Well, I know that Governors across the country, including our new Governor, Governor Blagojevich in Illinois, are certainly facing huge budget deficits largely driven by healthcare costs. I am wondering if you have gotten any response from the Bush administration or the Republican Congress.

Governor RENDELL. No. I have gotten some good indications from some of our Senators and Congressmen here that they intend to work on that this year, as I told you, as part of the comprehensive prescription drug crisis. But you know, if I could put in a plug, in general, before the economic stimulus program was released, all the news media had it that the President was going to include direct relief for the States to the tune of $40 or $50 billion. That disappeared from the President's economic stimulus program on the day it was announced. We were told it would be covered in the budget message. It does not appear to be in the budget message as well. And that direct aid to the states would be one way of alleviating this crisis. And I made the comment about my Republican colleagues having to raise taxes, you know. The States will have by the end of this year $75 billion in accumulated deficits by the end of this fiscal year. Last year the States raised almost $9 billion in taxes, and in my judgment, we are just tax shifting. We are not really reducing taxes; we are tax shifting. But again, that may be another issue.

Ms. SCHAKOWSKY. Well, I mean, I think that certainly relates to the notion of how much money, absolutely. Let me ask you this. You referred pretty knowledgeably to the notion of the responsibility of the insurance industry itself, which was low-balling some of its premiums. How can we address the issue of the insurance cycle itself, which often is unrelated I think to the issue of the payouts. And what are you doing in Pennsylvania to address this?

Governor RENDELL. Well, I am asking our taskforce to look at that, and that is a complicated issue, because you wouldn't want ever to have a system where the premiums were set at a level that covered the claims and allowed the insurance company to make a profit, because that would jack premiums way up. The insurance companies are allowed to and can keep premiums down because they do have the ability to invest that money, but there should be some oversight and some restrictions on the level of investments and some restrictions on the speculative nature of that investment, and I think that is crucial. If you made the investment more diversified and a percentage of that investment in relatively safe investments, you would have less of a spike. I think you can control that by having some monitor on the type of investments, you know. The insurance companies, like so many other people, invested too heavily in dotcoms, and the rest, as they say, is history. And maybe there is a way to have a monitoring on the type of investments they can make and the type of safe reserves they have to have, things that are in bonds, or in T-bills, or things like that. And again, it is a fine line, because that is going to drive up premiums a little bit, but it would keep from having these terrible spikes.

Ms. SCHAKOWSKY. Let me ask you, also, what Pennsylvania is doing to weed out bad doctors. I mean, we know that in addition to a malpractice insurance crisis, there is also a malpractice crisis, that we have a large number of people who die from preventable causes—well, worse than that, from negligence of——

Governor RENDELL. We aren't doing enough and that is something we are studying as well. Act 13 was the first act that tried to do something about patient safety. It didn't go nearly far enough and I think that is acknowledged by a lot of people, and we are trying to make sure that there is reporting, we are trying to make sure that the public is aware, and we are trying to make sure that there is some disciplinary procedure in place. Not that the discipline and review process for lawyers is necessarily a good one, but every year in Pennsylvania, my guess is somewhere between 10 and 20 lawyers lose their license to practice law, and that has a deterrent effect.

Ms. SCHAKOWSKY. Thank you very much.

Mr. GREENWOOD. The Chair thanks the gentlelady. Governor, a couple of questions. My father, a year ago, when we had snow like this, and shoveling snow at age 80, threw out three vertebrae in his back, and his doctors told him he was doing to have to sit in a chair for the rest of his life and do pain management. I found him a great surgeon, Dr. Simeon from your great city of Philadelphia, operated on my father, and in days, he was recuperated and he could go skydiving again today. Now, Dr. Simeon tells me in a letter that his medical malpractice insurance rates are over $600,000 a year, I think $660,000 a year, and he has to do 400 sur-

geries a year just to pay his malpractice rates. His partners left and went to Indiana and pays practically nothing for the same coverage. Now, that is not because in Indiana doctors don't make mistakes, or that they have worse doctors. They don't have worse doctors in Pennsylvania than they do in Indiana. Do they?

Governor RENDELL. No. I think we have the best doctors in the country.

Mr. GREENWOOD. So our doctors aren't accident prone or particularly negligent, so that is not what is causing the difference. Okay. The insurance companies in Indiana invest in the same stock market as insurance companies in Pennsylvania. I don't think you are here to tell us that investors in Pennsylvania are dumber than investors in Indiana.

Governor RENDELL. No.

Mr. GREENWOOD. Okay. But the cost of the premium is extraordinarily by a factor of 300 fold smaller in Indiana. Now, there are certain things you can do. You can put more money into the system here, and you have proposed taxing the insurance premiums, the surpluses. The problem you have with that is when we saw the map there, all those counties, all those legislators from the light blue counties, are not fond, and you have heard this, of passing legislation to transfer money from the premiums paid by their constituents, because they see the problem as being—I will let you answer, Governor. Let me finish here. So that may not happen. I am for raising the Medicare payments to physicians, but at some point, putting more money into this crisis is putting gasoline on the fire.

Now, the other thing you can do is limit what goes out. Put all the money in the pot and you have to limit what goes out, and that is where you get the caps, or coverage limits, or something to limit what goes out. Or the third thing you can argue is that what is really the problem is the insurance companies. You can say that, actually, there is enough premium money coming in to pay for reasonable exposure. It is just that the insurance companies are the culprits. They are either price gauging or they are doing something wrong. But I look at PMSLIC, which is the Pennsylvania Medical Society Liability Insurance Company, the biggest physician owned insurance company in Pennsylvania. They are not there for profit, they don't invest wildly, they invest in treasury bills and AAA corporate equities. They raised their premiums on their doctors that they are serving 54 percent last year. Now, they will tell you, and they are going to testify a little while later. They will tell you it has nothing—the investment piece of this was about 4 to 5 percent of that 54 percent, and the rest is the liability exposure environment.

So my question to you, sir, is if a physician owned insurance company can't figure out how to provide affordable premiums to its own members, then how does insurance reform, without putting some limitation to the exposure, solve the problem?

Governor RENDELL. Well, first of all, no one is saying that you can do one and not the other, and no one should be saying that. Look at what the Pennsylvania legislature, Congressman Gerlach said it, that he is proud of what they did last year, and he should be. And I said in my remarks at the press conference on December 30, that the Governor and the legislature deserve credit. Act 13

was a substantial step, joint and several was a substantial step, the venue legislation was a substantial step, certificate of merit, Rule 11, the Dragonetti proposal which got transferred and Rule 11, those were substantial steps. So no one is saying we shouldn't do tort reform, but I think there should be further tort reform, and again, I am willing to consider caps if the committee recommends them.

Mr. GREENWOOD. I am glad to hear that.

Governor RENDELL. But you cited that PMSLIC went up 54 percent last year. Do you know what the California rates went up last year? Thirty-four percent. So it is not like the States—I mean, again, it is everything. Of course, we should do tort reform, but you can't let the insurance companies off the hook anymore than you can let——

Mr. GREENWOOD. Well, no one is suggesting that we let them off the hook, but if you look at the California situation, Governor, since 1975, the increase in premiums there has been 167 percent while the rest of the Nation faced 505 percent. And the reason, the big difference between Pennsylvania, where Dr. Simeon's partner left, and Indiana, where he wound up, is that they have a cap on non-economic damages. And if you look at the nationwide map, the most direct correlating factor between premiums, relating to premiums, is whether or not they have some limitation whatsoever, be it $250,000, be it $350,000, be it $550,000 on non-economic damages.

Governor RENDELL. Except California, again, let me repeat, the first 10 years after California imposed its caps, they went up 100-and-some percent——

Mr. GREENWOOD. Well, as you testified, yourself, Governor, that has a lot to do with the tail. You said that when you do prospective reform, you get immediate results, but you can't get immediate results when you are bringing in the whole tail.

Governor RENDELL. I understand. But it was only after they passed another proposition mandating the rates for them, plus the coverage dropped in California that you got the real thing. And look at this chart, and I know this chart is dated, and for us it certainly is dated. We are much higher up in this chart and I want to concede that, but look at this chart. Florida, Michigan, Texas, West Virginia, 4 out of the 5 States that have the biggest premiums of all have caps. How do you explain that? And the answer is—do caps help? Of course, caps would help. Every legislative body has to weigh whether caps help enough to justify the potential harm that they do. Every legislative body has to look at everything. All my plea is here today is consider the legislation, consider caps, but please don't totally ignore the insurance industry, don't totally ignore the medical safety issue, don't totally ignore the caps that the Federal Government has placed on Medicaid and Medicare. If we are going to solve this, let us not look for villains, let us not look for bogeymen. Let us try to look for the right result for all of our citizens. Nobody out there—and you said it in your remarks, and I know you well enough to believe this—you don't want to take away the individual's right to sue. You don't want to take away the individual's right for fair compensation. Nobody wants to create a system where doctors don't have to worry about how they practice

and whether they do shoddy things or not shoddy things. Nobody wants to do that. Conversely, nobody wants to put so much pressure on doctors that they become risk diverse. Risk is what allowed your father to walk again. Risk is what allows our medical community to do wonderful things. We have to find an answer that includes looking at all these different solutions, and we are looking at all these different solutions, but we shouldn't hold out caps as—and I am not saying that you do, but there are too many people out there, including some of the doctors—and I love our doctors. I think they do great work. They are looking for a silver bullet, they are looking for the magic cure. If I were them, I would probably be looking for the silver bullet and the magic cure as well. Those of us who have the responsibility of looking at the broad picture should not try to feed into the fact that there is a magic cure. There isn't a magic cure. We have to work hard to make progress on all these fronts, and if we hold out anything as a magic cure, we are missing the point and we are disillusioning people. And again, you are absolutely right about the statistics you quote, but in Pennsylvania, so much of that increase has been from the early 1990's until today, in the last 10 years. And so much of it came from a time—I mean, you close your eyes and go back 10 years ago in Pennsylvania, and there were 17 companies out there competing to sign up doctors, and they were low-balling each other, and we had no tort reform; not only no caps, but we had none of the tort reform that then Senator Gerlach and his colleagues enacted. So it is not that easy and that is all I am saying. And I don't envy you your task, and I don't envy me my task. All we know is—and you may not like the suggestion of what I am going to say—is Highmark, which has the biggest excess surplus by any rendering, well over $1 billion in excess surplus. Most of that surplus that Highmark has is because they purchased Pennsylvania Blue Shield. Most of the customers of Pennsylvania Blue Shield who contributed to that surplus come from those purple counties in the southeast. So Highmark should not try to make this a regional battle because the reason they have that surplus is they got it on the backs of southeastern customers. So again, enough said about that. I know you are trying, but all I am saying is look at everything. Let us look at everything, let us try to find some long-term relief here, and that is all I am saying, and I thank you for your efforts.

Mr. GREENWOOD. We thank you, Governor, and when—I will leave you with this. As the chairman, I get to have the last word.

Governor RENDELL. Sure.

Mr. GREENWOOD. When I come to Harrisburg, you get the last word. When you said that we need to consider everything, and you say that legislatures, as you said, need to consider caps, you and I are in 100 percent agreement. We need to consider this is a complicated problem and we need to confront it from all of its facets. I think the difference is I don't think caps are sufficient; I think they are necessary. You might have not got yourself to believe they are necessary yet, but I am going to make your job easier by putting the caps on at the Federal level, and you can do the rest here in Pennsylvania. Thank you, sir.

All right. We are now going to call forward the witnesses on our second panel and ask them to come forward and be seated. The

first of them is Julia W. Johansson, Dr. Johansson from Doylestown; Mr. Gregory Wozniak, President and Chief Executive Officer of St. Mary Medical Center; Dr. David J. Eskin, Chief of Staff, Abington Memorial Hospital; Dr. Edward H. Dench, Jr., President of Pennsylvania Medical Society; Dr. Donald J. Palmisano, Member of the AMA Board of Trustees, the American Medical Association; Ms. Leanne Dyess from Vicksburg, Mississippi; and Ms. Heather Lewinski. I am not going to ask if there is a doctor in the house because there obviously is, but is Dr. Palmisano in the house? He is probably chasing Governor Rendell down the hall on the way to his car.

Okay. We welcome all of the witnesses on this panel. We thank you so very much for being here and for helping us to get to the bottom of this problem. I think all of you have been made aware that this is an investigative hearing, and when this committee holds investigative hearings, it is our custom to take testimony under oath. Do any of you object to giving your testimony under oath this morning? Okay. Seeing no such objection, I would then advise you that pursuant to the rules of this committee and the House of Representatives, that you are entitled to be represented by counsel. Do any of you choose to be represented by counsel this morning? All right. Seeing no such interest, then I would ask you all to rise and raise your right hand, and I will swear you in.

[Witnesses sworn.]

Mr. GREENWOOD. Okay. Answering in the affirmative, you are all under oath, and we will now recognize each of you for 5 minutes for your opening statement. We are going to ask you to—most of you have not testified before Congress. You will see these little boxes on the table. The green light means take your time, the yellow light means speed it up, and the red means shut up. And then we will give you plenty of time to respond to questions. And I guess we will start with Dr. Julia Johansson.

TESTIMONY OF JULIA W. JOHANSSON; GREGORY T. WOZNIAK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ST. MARY MEDICAL CENTER; DAVID J. ESKIN, CHIEF OF STAFF, ABINGTON MEMORIAL HOSPITAL; EDWARD H. DENCH, JR., PRESIDENT, PENNSYLVANIA MEDICAL SOCIETY; DONALD J. PALMISANO, MEMBER, AMA BOARD OF TRUSTEES; LEANNE DYESS; AND HEATHER LEWINSKI

Ms. JOHANSSON. Ladies and gentlemen, thank you for the opportunity to speak to you today. My name is Julia Johansson. I am a physician specializing in obstetrics and gynecology at Abington Memorial Hospital. I am also a life long resident of Pennsylvania. I am here today to discuss my reasons for leaving my home, how my leaving will affect my family, my patients, and the group in which I practice.

I feel it is important to tell you something about me so that you may understand what a difficult decision leaving has been for me. I was born at Holy Redeemer Hospital. The only time I was ever outside the State was to attend college in Boston to pursue my undergraduate degree. After graduation I returned home to the house I grew up in, married the boy who lived a mile away, and attended and graduated Temple University School of Medicine. While at

Temple, I rotated through Abington Memorial Hospital and so enjoyed the experience that it was one of the only two residency programs to which I applied. Thankfully, I was chosen for the residency program there.

While at Abington, I came to know the members of my group very well. As a matter of fact, members of my group delivered each of my children. When my partners offered me a position with the group, I was ecstatic. It was truly my dream job. My family was thrilled that I landed a position so close to home since my family still lives in the house I grew up in, as well as my in-laws live in Bucks County. I was looking forward to spending the next 30 years of my life practicing at Abington. All that changed last year. While I knew that southeastern Pennsylvania was a fairly litigious are when I first started, only a scant 6 years later the situation has gone from bad to worse and then intolerable. As a matter of fact, I cannot think of an OB-GYN that I know that has not had a lawsuit filed against them. Most times these physicians talk in term of the number of lawsuits they have outstanding rather than if they have pending litigation.

Some within the legal community will have you believe it is only the bad doctors who get sued. I am here to tell you that some of the best, most respected doctors I know have lawsuits filed against them. I am not saying there are not legitimate lawsuits; there are. But it seems to me when so many OB-GYN's are being sued, they cannot all be malpractice. There is a difference between a bad outcome and malpractice, and in the ridiculous situation we find ourselves in, a lawsuit does not even require a bad outcome in order to be filed.

Malpractice lawyers will have you believe that they file these suits to weed out bad doctors. At the rate things are progressing in Pennsylvania, all doctors will be weeded out. It seems to me we are creating a dust bowl within the medical community with physicians fleeing the State, decimated by the scourges of legal abuse, the ever decreasing reimbursements, and the soaring medical malpractice insurance premiums.

About a year ago, my husband noticed I had become crankier, and I am generally an upbeat person. We had long discussions on the looming malpractice crisis and how things only seem to change for the worse. I am working longer hours, seeing more patients, in part, to cover the increase in malpractice, and have had my earnings decreased over the past year. And still, the workload increases as more doctors leave the area and entire groups disband or discontinue the practice of obstetrics. I started to notice that I could not take the time to get to know my patients on a more personal level as I had been doing in the past. This personal approach had helped me to tailor their treatments to their lifestyles, beliefs, and culture.

In my practice we have gotten so busy that people sometimes have to wait as long as 3 months for their regular exams. Those patients with problems can get inserted into an already overbooked schedule. Today, for example, I have reduced the number of patients I will see in order to speak to you. Of the 50 patients I was scheduled to see today, about 30 of them rescheduled. They will be

reinserted into my already full schedule over the course of the next week and I will see the remaining ones later today.

So there I was 5 years into my practice and my dream job seemed to be slipping away. I was working more, making less, practicing defensive medicine, and not having the opportunity to spend as much time as I would like to have with my patients, my family, or friends. My husband suggested that maybe we need to relocate for our own piece of mind. I can only begin to understand how devastating it is to be a victim of true malpractice, but I don't think people understand how truly devastating it is to be named in a lawsuit. I cannot tell you how many times I have heard people say, I am not really suing the doctor; I am suing the insurance company. I believe that people should be fairly compensated for legitimate malpractice, but the damages have gotten out of hand, especially, in Philadelphia. If a lawsuit gets to trial, it is like the plaintiff has won the lottery. Even if the doctor is not at fault, juries have awarded large sums of money because they do feel sorry for the plaintiff.

As a result, an increasing number of physicians and insurance companies have elected to settle these cases, even if there is no fault on the part of the physician. It is these attitudes that have cemented my decision to leave. Although my leaving the are will not have far reaching effects or cause some catastrophe, it has affected all those around me. The members of my practice have told me it will be a great loss to them when I leave. We are actively trying to recruit a replacement but thus far have been unsuccessful. It is nearly impossible to find somebody who wants to start practicing in Pennsylvania given the hostile environment that awaits them. I don't think they will find a suitable replacement before I leave. I feel sorry for my patients. They have come to know and trust me, and given the intimate nature of OB-GYN, this is not insignificant. They will now be forced to find another doctor with which to build a trusting relationship. They will face longer wait times as well.

If something is not done to change our current situation, in the not too distant future it will not only become impossible to recruit new physicians to practice in Pennsylvania, it will begin to affect training programs as future doctors will not choose to train in a State where they will not practice. And in the distant future it looks even darker as the dust bowl spreads and our best and brightest choose not to pursue careers in medicine at all.

In short, I am leaving Pennsylvania to practice medicine in what I hope will be a less hostile environment. I hope to be able to make a comfortable living while practicing effective, rather than defensive, medicine in a place where I can get to know my patients well and not live with the constant threat of a lawsuit. I understand there is no utopia but I want to enjoy the practice of medicine again as much as I had before. If you do not act to establish medical review boards to decide if cases have merit and meaningful tort reform to place caps on damages, the dust will spread and cover the entire country. Thank you for your consideration.

[The prepared statement of Julia W. Johansson follows:]

PREPARED STATEMENT OF JULIA W. JOHANSSON

Ladies and gentlemen, thank you for the opportunity to speak to you today.

My name is Julia Johansson and I am a physician specializing in OB-GYN at Abington Memorial Hospital. I am also a life long resident of Pennsylvania. I am here today to discuss my reasons for leaving my home, how my leaving will affect my family, my patients and the group in which I practice.

I feel it is important to tell you something about me, so that you may understand what a difficult decision leaving has been for me. I was born at Holy Redeemer Hospital in Meadowbrook, Pennsylvania. The only time I have lived outside the state was to attend College in Boston to pursue my undergraduate degree. After graduation I returned home to the house I grew up in. I married a boy who lived 1 mile away and I attended and graduated from Temple University School of Medicine. While at Temple I rotated through Abington Memorial Hospital and so enjoyed the experience that it was one of only two residency programs to which I applied. Thankfully I was chosen for the residency program in OB-GYN. While at Abington I came to know the members of the group to which I now belong very well. As a matter of fact, members of my group delivered each of my children. When my partners offered me a position with the group I was ecstatic. It was truly my dream job. My family was thrilled that I had landed a position so close to home since my family still lives in the house I grew up in and my in-laws still live in Bucks County as well. I looked forward to spending the next 30 years of my life practicing at Abington.

That all changed last year. While I knew that Southeastern Pennsylvania was a fairly litigious area when I first started practicing, only a scant 6 years later the situation has gone from bad to worse and then to intolerable. As a matter of fact, I cannot think of an OB-GYN that I know who has not had a lawsuit filed against them. Most times, these physicians talk in terms of the number of lawsuits they have outstanding rather then if they have pending litigation.

Some within the legal community will have you believe it is only the "bad'" doctors who get sued. I am here to tell you that some of the best, most respected Doctors I know have lawsuits filed against them. I am not saying that there are not legitimate lawsuits, there are, but it seems to me that when so many OB-GYNs are being sued they cannot all be malpractice. There is a difference between a bad outcome and malpractice and in the ridiculous situation we find ourselves in a lawsuit does not even require a bad outcome in order to be filed. Malpractice attorneys will have you believe that they file these suits to weed out the bad doctors. At the rate things are progressing in Pennsylvania all doctors will be weeded out. It seems to me that trial attorneys are creating a dust bowl within the medical community with physicians fleeing the states decimated by the scourges of legal abuse, the ever decreasing reimbursements and soaring medical malpractice insurance premiums.

About a year ago my husband noticed I had become crankier and, believe it or not, I tend to be a pretty upbeat person. We have had long discussions on the looming malpractice crisis here and how it only seems to change for the worse. I am working longer hours, seeing more patients in part to cover the increase in malpractice insurance and have had my earnings decreased over the past year. And still the workload increases as more doctors leave the area and entire groups disband or discontinue the practice of Obstetrics. My 2 year old always asks, "Where are you Mommy?" and invariably my answer is, "Work". Even my 12 year old, who has a very active life of her own, has become annoyed at the amount of time I am spending at work. I started to notice that I could not take the time to get to know my patients on a more personal level, as I had been able to do in the past. This personal approach helps me to tailor their treatments to their lifestyles, beliefs and culture. In my practice we have gotten so busy that people sometimes have to wait as long as 3 months for their regular exams. Those patients with problems can get inserted into an already overbooked schedule. Today, for example, I have reduced the number of patients I will see in order to speak to you. Of the 50 patients I was scheduled to see, about 30 have been rescheduled. They will be inserted in my already full schedule over the course of the next week.

So there I was, 5 years into my practice and my dream job seemed to be slipping away. I was working more, making less, practicing defensive medicine and not having the opportunity to spend as much time as I would have liked with my patients, my family or my friends. My husband suggested that maybe we needed to relocate for our own peace of mind.

I do not think people understand how truly devastating it is to be named in a lawsuit. I cannot tell you how many times I have heard people say, "I'm not really suing the doctor, I'm suing the insurance company." I agree that people should be fairly compensated for legitimate malpractice but the non-economic damages have

gotten out of hand, especially in Philadelphia. If a lawsuit gets to trial it is like the plaintiff has won the lottery. Even if the doctor is not at fault, juries award large sums of money because they feel sorry for the plaintiff and they hope that if their turn comes the jury will be equally generous. It bears repeating, that bad outcomes are not necessarily the result of medical malpractice. As a result, an increasing number of physicians and insurance companies have elected to settle cases even though there may be no fault on the part of the physician. It is these attitudes that have cemented my decision to leave the area.

Although my leaving the area will not have a far-reaching affect or cause some catastrophe, it has affected all those around me. My parents, to whom I have always been close, tell me that they feel as if their "children", meaning my husband and our children and I are being ripped away from them. While my mother cannot bring herself to speak with me about our move, she has written to you directly to express her feelings and, I am sure, the feelings of thousands of members of other families across the Commonwealth as their sons and daughters, fathers and mothers, and grand daughters and grand sons say good bye.

The members of my practice have told me that it will be a great loss to them when I leave. We are actively trying to recruit a replacement but we have been unsuccessful thus far. It is nearly impossible to find someone who wants to start practicing in Pennsylvania given the hostile environment that awaits him or her. I do not think they will find a suitable replacement before I leave, which will place an even larger burden on the remaining members of my group. I also feel sorry for my patients. They have come to know and trust me. Given the intimate nature of OB-GYN this is not insignificant. Now they will be forced to find another doctor with which to build a trusting relationship. They will likely face longer wait times to be seen as well.

If something is not done to change our current situation, in the not too distant future it will not only become impossible to recruit new physicians to practice in Pennsylvania, it will begin to affect training programs as future doctors will not choose to train in a state where they will not practice. And the distant future looks even darker as the dust bowl spreads and our best and brightest choose not to pursue careers in medicine at all.

In short I am leaving Pennsylvania to practice medicine in a less hostile environment. I hope to be able to make a comfortable living while practicing effective rather than defensive medicine in a place where I can get to know my patients well and not live with the constant threat of a lawsuit. I understand that there is no utopia but I want to enjoy the practice of medicine again as much as I had before. If you do not act to establish medical review boards to decide if cases have merit, and meaningful tort reform to place caps on non-economic damages the dust will spread and cover the entire country.

Thank you for your consideration.

Mr. GREENWOOD. Thank you, Dr. Johansson. I feel badly you rush through your practice, and then you come here and I make you rush through your testimony, but we are trying to stay within the limits.

Mr. Wozniak, thank you, again, for hosting this.

TESTIMONY OF GREGORY T. WOZNIAK

Mr. WOZNIAK. You are welcome. Good morning. I am Greg Wozniak, I am the President of St. Mary Medical Center. The medical liability crisis has threatened people's access to healthcare. This is not a new issue, but rather, an old one, which like so many, does not seem to get addressed until a crisis point is reached. I can assure you that crisis point has been reached. In Bucks County and all across this Nation States are struggling, physicians are struggling to provide care.

The debate about medical liability is complex and there are no easy answers. Today I am going to focus on the negative impact the medical liability crisis is having on people and their access to care. First and foremost, access to care is directly depending upon doctors. Without doctors, people cannot receive care. And without doctors, hospitals cannot provide the services to their community. Like

so many communities across the country, Bucks County residents are growing older. In fact, Pennsylvania is the second oldest State by the age of its population following only Florida. What does the aging of our society have to do with the medical liability crisis? Everything. Research shows that people over the age of 45 are two to three times more likely to use healthcare services than people under age 45. And this need again doubles when they reach age 65.

Over the last 3 years, the number of people our doctors have cared for at St. Mary has increased by narrowly 60 percent. We expect that number of people needing care to continue to grow, so much so, we are expanding our 287 inpatient beds to nearly 400 over the next 3 years. Our No. 1 concern is not the nursing shortage, but is the shortage of physicians, are we going to have them to care for the people in our community.

In the last 18 months, 20 physicians on our medical staff have left and more than 50 in Bucks County due directly to the cost and availability of medical liability insurance. We cannot recruit new physicians to replace those who have left, let alone recruit physicians to meet the growing need. Our community has only seen an increase in the number for families as well, and access to care has been a longstanding issue for this population, and I am afraid that once again they are being forgotten as the medical liability crisis is negatively impacting their access to care. On a month-to-month basis, we have evaluated whether St. Mary has enough physicians to continue many of our services. This is particularly true for our trauma center and our Mother Bachmann Maternity Center.

The St. Mary Trauma Center is one of only 26 designated trauma centers in Pennsylvania and is the only one in Bucks County, a county of 600,000 people, providing 24-hour, 7 days per week continuous trauma care requires multiple physician specialties. Unfortunately, each of these physicians have experienced significant challenges in affording medical liability insurance. For example, in our county, we only have two practicing neurosurgeons, only two. Both surgeons have been faced with skyrocketing liability insurance costs which have doubled over the last 2 years. One is now paying in excess of $280,000 per year when he was just paying 2 years ago $100,000.

Over the last 2 years, the trauma centers repeatedly have been faced with possible closure due to doctors' inability to obtain liability insurance. If we close the trauma center, the services would not be available for the over 1,400 people a year we care for in the trauma center. Just as we were speaking today, at ten until eight, a 17 year old involved in an automobile accident is in our OR as we talk today. If we did not have that trauma surgeon, a neurosurgeon, he would not be receiving the care he so justly deservers. Our trauma is not the only service affected by the medical liability crisis.

In 1991, St. Mary conducted a community health needs assessment and identified the need for prenatal care and maternity care for poor families. Since 1991, our Mother Bachmann Maternity Center has provided care to more than 1,600 mothers. In fact, last year we delivered 197 babies. During the past 2 years, we have lost 3 of the 4 obstetricians who provide care. The sole remaining obste-

trician has had difficulty obtaining medical liability insurance and we have been unable to recruit additional OB-GYN physicians.

Who will be impacted most by this potential closure? Poor and underserved people, but yet, they are the ones who need improved access to care most. To put a face on these people, let me share with you a real life person who was cared for at the Mother Bachmann Center. A woman in her 30's who has experienced the first pregnancy came to the Mother Bachmann Maternity Center. She had fled an abusive relationship and was living in her car. She was 4 months pregnant and uninsured. She asked for help for herself and unborn child. We provided that care for her. Who will be available if we don't have that one physician remaining?

Finally, hospitals and physicians across the country are committed to continually improving the quality of care and patient safety. That is unquestioned. Unfortunately, the rising cost of medical liability insurance is draining our resources which can be used for these very improvements. Over the last 2 years, our medical liability insurance at St. Mary had more than doubled. This increase in cost could have been better utilized to employ 40 more nurses, to purchase a state-of-the-art radiation cancer treatment unit to care for our cancer patients, which is the third leading cause of illness in Bucks County. Or to build 20 new inpatient rooms to accommodate the growth of care in our community.

Members of the committee, thank you for your time and consideration. This is a very complex issue, one which we need to solve this year before it becomes worse. If you have any questions, I will be more than happy to answer them for you.

[The prepared statement of Gregory T. Wozniak follows:]

PREPARED STATEMENT OF GREGORY T. WOZNIAK, PRESIDENT AND CEO, ST. MARY MEDICAL CENTER

Members of the Committee, I am Greg Wozniak, President and CEO of St. Mary Medical Center. On behalf of the entire St. Mary Medical Center family—470 physicians, 2000 employees, 400 volunteers, patients, and community, I would like to welcome you today.

The debate about medical liability is complex and there are no easy answers. The answers entail the delicate balance between:

- ensuring access to healthcare—our ability to provide health care services is directly dependent upon the availability of physicians;
- the health care industry's absolute commitment to continually improving the quality of care and patient safety;
- controlling the rising cost of health care service; at a time when physicians are being forced to practice "defensive medicine;"
- and a patient having appropriate remedies if they are injured because of negligence.

I recognize that there are many opinions about the best way to solve the medical liability crisis and I am not here today to advocate one solution over another. Rather, I want to highlight the impact that the medical liability crisis is having on the ability of patients to access health care services.

St. Mary was founded in 1973 by the Sisters of St. Francis of Philadelphia. Our mission is to improve the health and wellness of our community with a particular emphasis on providing access to care for the poor and under-served. St. Mary has grown from a small, community hospital to a 287-bed full service medical center offering a wide array of patient care programs to a population of more than 400,000 in Lower Bucks County, Pennsylvania. These services include a comprehensive heart center, a primary stroke center, the county's only accredited trauma center, and Mother Bachmann Maternity Center, which provides obstetrical services to poor and under-served patients. Together, our medical staff, employees, and volunteers care for nearly 18,000 inpatients, more than 120,000 outpatients, and nearly 38,000 emergency room patients each year.

Like so many other communities across the country, the community we serve is growing older. Bucks County has the third oldest population in the Commonwealth of Pennsylvania, and Pennsylvania has the second oldest population—following only Florida. Within St. Mary's community, aging baby boomers, that is, those 45 to 64, and those over age 65 are the largest and fastest growing segments of our population. What does this mean for health care providers? Research shows that people over age 45 are two to three times more likely to use health care services than people under age 45, and that this need again doubles when they reach age 65. Unfortunately, our community has also seen an increase in the number of poor and uninsured families.

The result of these demographic shifts is an increase in the need for health care services. Over the last three years St. Mary has seen the number of people we care for increase by nearly 60%. Yet at a time when the need for health care services in our community is at its greatest and growing, our ability to attract new physicians or retain physicians already in the community is declining.

Over the last several years, many highly qualified physicians have left our community. And the cost and availability of medical liability insurance is one of the primary reasons physicians leave a practice. Our analysis shows that more than 50 Bucks County physicians left their practices last year. Some have relocated, some sought early retirement, and others changed their clinical practice in order to afford medical liability insurance. Orthopedists, OB/GYNs, and surgeons have been impacted the most.

Moreover, St. Mary, as well as other area hospitals and existing physician practices have experienced tremendous difficulty recruiting new physicians to fill the gaps caused by departing physicians and increased patient need. Although this is a significant and growing concern for St. Mary across all of our specialties and services, it is particularly true for our trauma program and the Mother Bachmann Maternity Center.

The St. Mary Trauma Center is one of only 26 designated trauma centers in the Commonwealth of Pennsylvania and the only one in Bucks County. Without the St. Mary Trauma Center, we would need to transfer patients to trauma centers in neighboring Philadelphia or Montgomery County by either ambulance or helicopter. In caring for the trauma patient, timeliness of treatment is a critical element. The outcomes for the trauma patient improve significantly if the patient is treated within the "golden hour"—the first 60 minute—immediately following an injury. Transferring trauma patients decreases the timeliness of care and reduces the chances for a complete recovery.

Providing a high level of quality trauma care requires multiple physician specialties—specifically dedicated trauma surgeons, anesthesiologists, neurosurgeons and orthopedic surgeons and nurses—available 24-hours-a-day, seven-days-a-week. St. Mary has only two neurosurgeons on staff, the only two neurosurgeons practicing in Lower Bucks County. Both physicians have had significant challenges obtaining affordable medical liability insurance. If one of these physicians decides that he or she can no longer obtain or afford medical liability insurance, we will be forced to close the Trauma Center.

Over the last two years, as every medical liability renewal period approached, we faced the very real threat that we will have to close our trauma program because we won't have the necessary physicians to provide around-the-clock trauma care. During the last medical liability insurance renewal period, St. Mary was not sure it could keep its trauma unit open on January 1, 2003 because our orthopedic surgeons and neurosurgeons could not afford medical liability insurance. We made the decision to keep it open at 2 p.m. on December 31, 2002. The only reason we were able to keep it open was through the commitment and dedication of our physicians to their patients and the promise made by Governor Rendell of a short-term initiative to contain the cost of medical liability insurance. But this was only a stop gap measure—still being considered by our Pennsylvania General Assembly.

Both of our neurosurgeons have seen their insurance premiums more than double over the last two years. One is paying in excess of $280,000/year to maintain the ability to care for people. The only reason he is still practicing today is Governor Rendell's proposed short term solution which would provide a one year premium reduction of approximately $50,000. If a permanent solution is not enacted this year, it is not a matter of *if*, but *when* the trauma center will be forced to close.

Each year we provide care to approximately 1,400 trauma patients. Several days after our decision to keep the trauma unit open, an ambulance delivered a young woman to our emergency room. She had been involved in a very serious automobile accident. The trauma team immediately evaluated her condition. She was stabilized and taken for a CT scan of her head, spine, chest, and abdomen. The Trauma team quickly learned that she had a lacerated spleen, three lacerations on her colon, and

a major abdominal wall tear. Within 30 minutes—well within the "golden hour"—she was in surgery to repair the injuries caused by the accident. Thankfully, the surgery was successful and she was discharged a week later. The injuries that this young woman suffered were life threatening. As with all trauma patients, time was critical. The additional 30 to 40 minutes that it would have taken to transport this patient to a neighboring trauma center could have resulted in very serious consequences. If the St. Mary Trauma Center had closed at the end of 2002, the dedicated trauma team that cared for this patient would not have been available.

Our trauma center is not the only service affected by the current medical liability crisis. In 1991, St. Mary conducted a health needs assessment focused on the needs of the poor in our community. The assessment identified the need for pre-natal and maternity care for low-income families in Lower Bucks County. In response to this need, St. Mary Medical Center established the Mother Bachmann Maternity Center in Bensalem, Pennsylvania. Since 1991, more than 1,600 mothers received pre-natal care and maternity services from the staff of the Mother Bachmann Maternity Center.

Mother Bachmann is the only program of its kind in Lower Bucks County that accepts pregnant women regardless of their ability to pay. Certified nurse midwives with appropriate OB/GYN back-up provide high quality care services. However, the current medical liability crisis has had a significant impact on this program and the program's long-term survival is threatened. As members of this panel know, OB/GYN physicians have been particularly hard hit by the medical liability crisis. During the past two years, we have lost 3 of the 4 OB/GYN physicians who provided physician coverage to the Mother Bachmann Maternity Center. Should the sole remaining obstetrical physician providing coverage continue to experience significant problems in obtaining affordable medical liability insurance, it will jeopardize the ability of the Mother Bachman Maternity Center to continue to provide care to under-served women and children in Lower Bucks County. Without physicians, the Mother Bachmann Maternity Center will be forced to close.

Last year, the Center delivered 197 babies, and in 2003 we expect to deliver 240 babies. However, numbers tell only a small part of the Mother Bachmann Maternity Center story.

Recently, a 35-year-old woman experiencing her first pregnancy came to the Mother Bachmann Maternity Center. She had fled an abusive relationship and was living in her car. She was four months pregnant and uninsured. She asked for help for herself and her unborn child. We provided her with pre-natal care, testing, vitamins, and social work services. She underwent postpartum depression screening for increased risk factors that too often accompany homelessness and domestic violence. We were able to offer her counseling at the Maternity Center.

This is only one of hundreds of success stories. We expect that there will be many more success stories—but only if we have the physicians, and in today's environment, many physicians are not able to provide care, because they don't have access to affordable medical liability coverage.

Although much of the national debate has focused on the cost and availability of medical liability insurance for physicians, the crisis has also had a significant impact on hospitals. Over the past two years, St. Mary's liability insurance costs have more than doubled. In the year 2000 we paid $2,133,000. In 2002 our insurance costs increased to $4,630,411. This increase is the equivalent to approximately 40 nurses who could be providing care to our aging population; or a state of the art radiation oncology unit to treat cancer patients. These increased premiums directly impact our ability to develop new programs and expand to meet the growing health care needs of our community.

Although our insurance costs continue to rise, we are very proud of our long-standing, proactive approach to ensuring patient safety and continuing improvement of the care and service that we provide.

St. Mary has established a full-time Patient Safety Officer and a Patient Safety Committee that involves hospital staff, physicians, and members of the community in patient safety initiatives. These resources are dedicated to continuously examining our systems and processes of care in order to improve patient safety and the quality of care that we provide. We established a dedicated patient safety hotline allowing staff members and physicians to report safety concerns and issues to the Patient Safety Officer.

St. Mary has also embarked on a number of initiatives to address medication safety. Our new system links numerous databases, helping us find known drug allergies and drug-to-drug interactions before they happen. We established pharmacy rounds for all intensive care patients to ensure appropriate medication protocols are being followed. We established a bar code system that ensures that the patient gets the correct drug, dose, timing and mode of administration. St. Mary has also incor-

porated patient safety information into our Patient Handbook, explaining to patients their role, responsibilities, and rights.

This is just a small sample of the numerous safety and quality initiatives underway at St. Mary. I am very proud of the time, energy, and effort that St. Mary physicians and clinical staff expend every day to improve the quality of care that we provide to our patients.

Members of the committee, on behalf of the St. Mary family, and in particular our current and future patients, I want to thank you for your time and consideration. This is a complex problem, but a problem we need to solve this year—before it is too late! Without physicians St. Mary Medical Center cannot deliver services to our community.

Thank you. I will be happy to answer any questions or provide additional information that you may need.

Mr. GREENWOOD. Thank you, Mr. Wozniak. Dr. Eskin.

TESTIMONY OF DAVID J. ESKIN

Mr. ESKIN. Mr. Chairman and committee members, good morning, and thank you for the opportunity of presenting this crucial material to you. I am Dr. David Eskin. I have practiced cardiology at Abington Memorial Hospital in Montgomery County, Pennsylvania for the past 29 years, and for the past 17 years have served as Chief of Staff, or the chief medical officer for that institution. Today I would like to review with you some of the painful circumstances leading to the closure of our trauma center for 13 days in late December 2002, extending into January of this year.

Abington Memorial Hospital is an independent, not for profit, tertiary care, teaching hospital that has served our community for 89 years. We are the only accredited trauma center in Montgomery County which serves a population of greater than 750,000 people, and we are the third largest admitting hospital in the Philadelphia area. Only Thomas Jefferson University Hospital and the Hospital of the University of Pennsylvania admit more patients. Our emergency trauma center treated more than 65,000 patients last year. We are the largest obstetrical hospital in eastern Pennsylvania, having delivered more than 4,500 babies last year, and we are the largest employer in Abington Township with more than 4,600 employees. This makes us the third largest employer in Montgomery County behind only Merck and the U.S. Government.

For the past 4 years, it has become progressively more difficult for our hospital and for our physicians to obtain affordable malpractice insurance. In fact, Abington Memorial Hospital has seen its medical liability insurance premiums increase over the past 4 years from $6 million in the year 2000, to $8 million in the 2001, to $19 million in 2002, and now to an astounding $23 million per year. During this same period, our physicians in the high risk specialties of orthopedic surgery, neurosurgery, general and trauma surgery, and obstetrics have seen marked increases in their annual premiums as well.

In Pennsylvania, one cannot legally practice medicine without malpractice insurance; it is the law. The physicians who provide vital trauma services at Abington have all been in private practice. They have each paid their own malpractice premiums. In the last several years several large malpractice insurers in Pennsylvania have gone bankrupt and a number of other companies have ceased writing insurance in our State. In a number of cases, outstanding physicians of the caliber that you and I would choose to care for

our own families, and in many cases with no—repeat, no adverse legal awards against them—were unable to obtain commercial insurance. If they were quoted premiums, they were so high as to be unaffordable. If a physician is unable to obtain a commercial quote in Pennsylvania, one turns to the Joint Underwriting Association, but historically, their quoted premiums are often one-and-a-half to three times the comparable commercial rate. And in some instances, the JUA has quoted rates that were in excess of $250,000; that is, per physician per year.

Despite an offer by our hospital to offset a portion of the premium, our orthopedists felt they could not afford the quoted rates. Also, by late December, our neurosurgeons had not received a commercial quote. It became clear that without these necessary trauma specialists, we could not meet the staffing requirements required by the Pennsylvania Trauma Systems Foundation. We ceased operations as a designated trauma center on December 21. The decision was painful. We have tried for years to improve the services we provide to our community and the closure of our trauma center was a calamitous step backwards. The following 13 days were truly the most trying of my professional career. We feared, and truly feared, that we would not be able to provide critically needed services for a victim of trauma.

Had it not been for the intervention of then Governor-elect Rendell, as he explained to you this morning, I suspect our trauma center would have remained closed for much longer than 13 days. The creation of the taskforce in conjunction with his pledge to create short and long-term solutions to this intractable problem were enough to bring our doctors back to work. But to date, we have, if you will, an IOU that will require legislative support at the State level and possibly a State constitutional amendment which could take as long as 3 to 4 years to obtain. We endure a crisis that a growing number of States across this Nation have, and that is the inability to obtain affordable malpractice insurance. Changes are clearly necessary and one that demands immediate consideration is the placement of a ceiling on non-economic damages.

What are the consequences of the circumstances that I have described? Our community members suffer by the loss of potential—of vital healthcare service, care for the victims of trauma. During this period that we closed, ambulances were diverted to other hospitals from Abington, and patients who arrived on their own were in some cases transferred elsewhere. We now spend $17 million more a year on malpractice than we did just 4 years ago. How many new nurses could be hired with $17 million or a portion of that money? Our employees openly express fear for the security of their jobs as do the staffs of our many private practice physicians.

More than 15 members of our medical staff have chosen to retire earlier than planned, have altered their scope of practice, or have chosen to practice elsewhere for reasons directly related to the cost of their insurance. This includes the loss of our previous chief of neurosurgery, who is now practicing in North Carolina. Another one of our limited number of neurosurgeons has moved to Ohio. Three obstetricians have moved to New England, and a fourth who has testified before you today will be moving to Utah. Although we often emphasize those practicing high risk surgical specialties,

please be aware that this crisis clearly affects primary care physicians as well. Data obtained from the Pennsylvania Medical Society indicate that more than 500 physicians have chosen to leave Pennsylvania for reasons directly related to this crisis, and that is a conservative estimate. In addition, approximately 100 have chosen to retire early.

This does not include those who have altered the scope of their practices. For example, to practice gynecology and no longer deliver babies, or to limit their practices to non-operative orthopedics in their office. These circumstances create a significant access to care problem for our patients. And possibly of even great consequence than the loss of a number of physicians is the growing difficulty in recruiting young, well-trained physicians to practice in this Commonwealth. We have five medical schools in the Philadelphia area with many wonderful residency training program. Yet, in the high risk surgical areas, most trainees choose to leave our State. All of us suffer the consequences when we cannot recruit an adequate number of well trained physicians and surgeons.

Last, it is emotionally devastating to practice in constant fear of being used. All of us, as Dr. Johansson said earlier, practice defensive medicine; in fact, more so than ever before, and this clearly drives up the cost of healthcare. Also, the time required to document every risk and potential hazard at the time of every office visit—and clearly, I am not referring to informed consent prior to major procedural intervention—clearly, it detracts from time spent with our patients, and that is wrong. We hear so often that suits without merit are usually dismissed. Please realize that the time and dollars spent defending even a frivolous lawsuit are significant, and the emotional burden of being named in a suit is very real.

Patient safety must be foremost. Mistakes are made and patients should be compensated for injuries caused by proven negligence. However, bad outcomes often do not reflect bad care. There must be some meaningful balance to all of this so that our patients can continue to receive the excellent medical care that they have, in fact, come to expect.

Members of this committee, in conclusion, throughout our country there are warning signs of a system which is collapsing. Physicians in Nevada, West Virginia, and Florida have for periods of time within the past year stopped practice. Just last week, physicians in New Jersey demonstrated in their State capitol. To preserve access to care, I respectfully urge you to take appropriate action. Meaningful national tort reform is necessary, critical, and appropriate form the perspective of patients as well as physicians and hospitals. It is not appropriate—and I repeat, it is not appropriate—for individual States to compete for medical talent based on the cost of medical liability insurance. There has to be a level playing field and I urge you to correct this problem now. Thank you very much.

[The prepared statement of David J. Eskin follows:]

PREPARED STATEMENT OF DAVID J. ESKIN, CHIEF OF STAFF, ABINGTON MEMORIAL HOSPITAL

Good morning and thank you for the opportunity of presenting this crucial material to you. I am Dr. David Eskin. I have practiced cardiology at Abington Memorial Hospital in Montgomery County, Pennsylvania for the past 29 years and for the

past 17 years have served as chief-of-staff (chief medical officer) for that institution. Today I would like to review with you some of the painful circumstances leading to the closure of our trauma center for 13 days in late December and early January.

Abington Memorial Hospital is an independent, not for profit, community teaching, tertiary care hospital that has served our community for 89 years. We are the only accredited trauma center in Montgomery County and the third largest admitting hospital in the Philadelphia area behind only Thomas Jefferson University Hospital and the Hospital of the University of Pennsylvania. Our emergency trauma center treated more than 65,000 patients last year. We are also the largest obstetrical hospital in eastern PA having delivered more than 4500 babies last year. We are the largest employer in Abington Township with more than 4600 employees. This makes us the third largest employer in Montgomery County.

For the past 4 years it has become progressively more difficult for our hospital and our physicians to obtain affordable malpractice insurance. In fact, Abington Memorial Hospital has seen its medical liability insurance premiums increase over the past four years from $6 million in the year 2000 to $8 million in 2001, to $19 million in 2002 and now to an astounding *$23 million dollars this year.* During the same period our physicians in the "high risk" specialties of orthopedic surgery, neurosurgery, general and trauma surgery and obstetrics have seen corresponding increases in their annual premiums.

In Pennsylvania, one cannot legally practice medicine without malpractice insurance. The physicians who provide vital trauma services at Abington are all in **private practice! They each pay their own malpractice premiums.** In the last several years several large malpractice insurers in PA have gone bankrupt and a number of other companies have ceased writing insurance in our State. In a number of cases, outstanding physicians—of the caliber that you and I would choose to care for our own families—and in many cases with NO adverse legal awards against them—were unable to obtain commercial insurance. If they were quoted premiums, they were so high as to be unaffordable. If a physician is unable to obtain a commercial quote in PA, one turns to the Joint Underwriting Association but historically their quoted premiums are often 1.5-3 times a comparable commercial rate. In some instances the JUA quoted rates that were in excess of $250,000—per physician per year!

Despite an offer by our Hospital to offset a portion of the premium, our orthopedists felt they could not afford the quoted rates. Also, by late December, our neurosurgeons had not received a commercial quote. It became clear that without these necessary trauma specialists we could not meet the staffing requirements of the Pennsylvania Trauma Systems Foundation and therefore notified the State and the Foundation of our plans to suspend our trauma designation. We ceased operations as a designated trauma center on December 21st. This decision was painful. We have tried for years to improve the service we provide to our community and the closure of our trauma center was a calamitous step backwards. The following thirteen days were the most trying of my professional career. We feared that we would not be able to provide critically needed services for a trauma victim.

Had it not been for the intervention of then Governor-elect Rendell, I suspect our trauma center would have remained closed for much longer than thirteen days. The creation of Gov. Rendell's Task Force, in conjunction with his pledge to create short and long term solutions to this intractable problem were enough to bring our doctors back to work. But to date, we have "if you will—an I.O.U. that will require legislative support and possibly a State constitutional amendment. The latter could take as long as 3-4 years to obtain. We endure a crisis that is shared by physicians and hospitals in a growing number of states across this nation: the inability to obtain affordable malpractice insurance. Changes are clearly necessary and one that demands immediate attention is the placement of a ceiling on *non-economic* damages.

What are the consequences of the circumstances described above?

- Our community members suffer by the loss and potential future loss of a vital health care service: care for the victims of trauma. During this period ambulances were diverted to other hospitals from Abington and patients who arrived on their own were, in some cases, transferred elsewhere.
- Abington Memorial Hospital now spends $17 million *more* on malpractice insurance premiums than it did four years ago. How many new nurses could be hired with $17 million dollars?
- Our employees openly express fear for the security of their jobs as do the staffs of our many private practice physicians. It is an emotionally trying time for those providing health care in Pennsylvania and many other states.
- *Fifteen* members of our medical staff have chosen to retire earlier than planned or have chosen to practice elsewhere for reasons directly related to the cost of their insurance. This includes the loss of our previous chief of neurosurgery who

is now practicing in NC. Another neurosurgeon has moved to Ohio. Two obstetricians have moved to New England and a third, who will be testifying before you later today, will be moving to Utah. Although we often emphasize those practicing high-risk surgical specialties, the crisis clearly affects primary care physicians as well. Data obtained from the Pennsylvania Medical Society indicates that more than 500 physicians have chosen to leave Pennsylvania for reasons directly related to this crisis. In addition approximately 100 have chosen to retire early. This does not include those who have altered their scope of practice and chosen to practice gynecology only and no longer deliver babies or those choosing to practice, for example, non-operative orthopedics. These circumstances create a significant *access to care problem for our patients.*

- Possibly of even greater consequence than the loss of a number of physicians, is the growing difficulty in recruiting young, well-trained physicians to practice in PA. We have FIVE medical schools in the Philadelphia area with many residency training programs. Yet in the high-risk surgical areas most trainees choose to leave our state. All of us suffer the consequences when we cannot recruit an adequate number of well-trained physicians and surgeons.

Lastly, it is emotionally devastating to practice in constant fear of being sued. All of us, I believe, practice defensive medicine—in fact, more so than ever before. This clearly drives up the cost of health care. Also the time required to document every risk and potential hazard at the time of every office visit (I am not referring to "informed consent" prior to major procedural intervention) clearly detracts from time spent with patients. This is wrong. Also, we hear so often, that suits without merit are usually dismissed. Please realize that the time and dollars spent defending even a frivolous lawsuit are quite significant. Also, the emotional burden of being named in a suit is very real!

Patient safety must be foremost. Mistakes are made and patients should be compensated for injuries caused by proven negligence. However, bad outcomes often do not reflect bad care. There must be some meaningful balance to all of this so that our patients can continue to receive the excellent medical care that they have come to expect.

Members of the Committee, throughout our country there are warning signs of a collapsing system. Physicians in Nevada, and West Virginia have, for periods of time within the past year, stopped practice. Just last week physicians in New Jersey demonstrated in their State Capitol. To preserve access to care, I respectfully urge you to take appropriate action. *Meaningful NATIONAL tort reform is necessary, critical and appropriate* from the perspective of patients, physicians and hospitals. It is not appropriate for individual states to compete for medical talent based on the cost of medical liability insurance. There really *MUST* be a level playing field. I urge you to correct this problem now.

THANK YOU VERY MUCH! I will be glad to try to answer any questions that you may have.

Mr. GREENWOOD. Thank you, Dr. Eskin. Dr. Dench.

TESTIMONY OF EDWARD H. DENCH, JR.

Mr. DENCH. Chairman Greenwood, thank you for conducting this important hearing and allowing the Pennsylvania Medical Society to describe how lawsuit abuse is negatively affecting patient care in Pennsylvania.

I am Ed Dench, the President of the Pennsylvania Medical Society, and a practicing anesthesiologist from State College. The Pennsylvania medical Society represents 20,000 physicians and medical students, along with the millions of patients our physicians care for. In addition, we listen closely to the thoughts and concerns of our 1,400 member patient advisory board. There are countless anecdotal stories about doctors retiring early, giving up high risk procedures, or moving out of Pennsylvania as a result of the liability insurance crisis. Scranton lost a neurosurgeon who moved to Hagerstown, Maryland because liability insurance rates are lower there. Some of his patients make the 3-hour drive to continue care with him. Erie lost a prominent pain management physician. His patients are now likely to drive to Pittsburgh or Cleveland for spe-

cific treatment that may no longer be offered in his community. In Philadelphia a young cardiologist is packing up and moving to Delaware. One of his elderly patients said she will follow him into treatment. Her daughter told us, "Naturally, my mom wants to follow his practice. It is real difficult to make dramatic change when a person has made so much of a difference in her life." I could go on with real life stories, but for the sake of time, I will stop with these three examples.

For those who prefer statistics instead of anecdotal stories, the Pennsylvania Medical Society used State provided data from March 2002 to conduct a survey of high risk specialists during the summer of 2002. The survey found that 17 percent of obstetrician-gynecologists, and 18 percent of neurosurgeons had changed to non-operative status, to part-time surgery, decided to move the majority of their practice out of the State, left Pennsylvania, or retired early. A survey of the Pennsylvania Orthopedic Society found similar results for orthopedic surgeons.

You should also know that the liability insurance crisis has been linked to defensive medicine, which drives up the cost of healthcare. Studies from the Pennsylvania Medical Society in 2001 showed that 89 percent of physicians are practicing defensive medicine to avoid frivolous lawsuits. The American Association of Health Plans has linked defensive medicine to increases in health insurance costs. In addition, a 2001 study by the Pennsylvania Medical Society found that 72 percent of doctors have had to defer the purchase of updated equipment or hiring of much needed staff because of the skyrocketing liability insurance costs. Therefore, without a doubt, there is direct evidence that the liability insurance crisis is negatively impacting patients.

The Pennsylvania Medical Society believes that it would be helpful to look at California as a model to correct the problems. California MICRA law has kept rates in California lower than States without similar laws. For the sake of comparison, the independent Medical Liability Monitor based in Chicago reported in an October 2002 rate trend study that an obstetrician-gynecologist in Los Angeles, their highest market, could be expected to pay $65,389 for $1 million worth of coverage through NORCAL. The same doctor in Philadelphia would first pay $64,314 for the first $500,000 of coverage through PMSLIC, which is also owned by NORCAL, and then another $35,731 for the next $500,000 worth of coverage through the MCARE fund. Thus, to pay for the required $1 million worth of liability insurance coverage in Pennsylvania, a doctor would pay about $35,000 more in Philadelphia than in Los Angeles. Ultimately, the rest of the country needs to learn what the Californians learned in the 1970's, that they can get these runaway costs under control by limiting attorneys' contingency fees so that the injured get more of the award, and by placing reasonable limits on non-economic awards after a person has been fully compensated for all financial losses. We must do this now to preserve our world renowned healthcare system.

Representative Greenwood, each and every day that passes without Congress acting on this serious crisis puts patients at risk. They risk losing their doctors, they risk losing trauma centers, they risk losing ambulance units. Healthcare is hanging by a thread as

the patient-doctor relationship is threatened by lawsuit abuse. The time is to clean up lawsuit abuse and protect all patients, and that time is now.

[The prepared statement of Edward H. Dench, Jr. follows:]

PREPARED STATEMENT OF EDWARD H. DENCH, JR., PRESIDENT, PENNSYLVANIA MEDICAL SOCIETY

Chairman Greenwood and members of the United States House Energy and Commerce Committee. Thank you for conducting this important hearing and allowing the Pennsylvania Medical Society to describe how lawsuit abuse is negatively impacting patient care in Pennsylvania.

I am Edward H. Dench, Jr., President of the Pennsylvania Medical Society and a practicing anesthesiologist from State College. The Pennsylvania Medical Society represents more than 20,000 physician members and the millions of patients our members care for. In addition, we pay close attention to the concerns and thoughts of our 1,400-member patient advisory board. This board consists of a demographic cross-section of patients from throughout the commonwealth.

Let me start by reinforcing what you already know: There is a serious liability insurance crisis that is driving a wedge between patients and their doctors. This crisis in our commonwealth, which the Pennsylvania Medical Society has termed a "Code Blue Emergency," can be traced to 1996 when medical liability insurance rates started climbing. In 1996, there was a 100 percent emergency surcharge by the state's Medical CAT Fund. Then, from 1997 until September 11, 2001, rates for major private insurance carriers in Pennsylvania rose between 80.7 and 147.8 percent. Well before problems with the stock market and the terrorist attacks, there were signs of a brewing crisis. Then in 2002,the increase in filed rates ranged from 40 to 50.3 percent. For 2003, similar rate increases were filed.

Any businessperson knows that when expenses increase and revenue remains stagnant, drastic changes must be made to survive.

A 2001 study by the Pennsylvania Medical Society indicated that 72 percent of doctors had deferred the purchase of new equipment or the hiring of new staff due to skyrocketing medical liability insurance costs.

Of course, there are countless anecdotal stories about doctors retiring early, giving up high-risk procedures, or moving out of the state as a result of the liability insurance crisis. For those interested in statistics, the Pennsylvania Medical Society used state-provided data from March 2002 to conduct a survey of high-risk specialists during the summer of 2002. The survey found that 17 percent of obstetricians/gynecologists and 18 percent of neurosurgeons had changed to non-operative status, changed to part-time surgery, decided to move the majority of their practice out of state, left Pennsylvania, or retired early. A survey by the Pennsylvania Orthopaedic Society found similar results for orthopedic surgeons.

I should also mention that the liability insurance crisis has been linked to defensive medicine, which drives up the cost of health care. Studies from the Pennsylvania Medical Society in 2001 showed that 89 percent of physicians are practicing defensive medicine to avoid frivolous lawsuits. The American Association of Health Plans has linked defensive medicine to increases in health insurance.

So, without a doubt, there is direct evidence that the liability insurance crisis is negatively impacting patients.

We all agree that this crisis is very complex. You've heard the arguments during the past several years as to what caused the crisis. One area that must be addressed is lawsuit abuse reform.

Just recently, Governor Ed Rendell claimed that the new certificate of merit would weed out 25 percent of bad lawsuits. That seems like proof of a high level of lawsuit abuse in Pennsylvania. But, when you consider that seven out of 10 malpractice claims are dropped, dismissed, withdrawn, or found in favor of the defendant, there's proof that more work needs to be done. When 70 percent of all claims result in no payment to the plaintiff, it's clear that the system urgently needs to be fixed.

The Pennsylvania Medical Society is currently compiling a list of meritless claims, and early in our efforts, we have collected hundreds of examples, such as the one in which a female patient sued her doctor claiming she couldn't get pregnant due to a treatment he recommended for her. The suit was later dropped when she got pregnant. Another good example is the one in which a female patient branded herself with a hot iron after having a cast removed from her arm. She then tried to blame her doctor for the burn mark. Luckily, the patient's husband turned her in. Interestingly, a lawyer filed each of these frivolous cases. These ridiculous cases

must be stopped in their tracks before thousands of dollars are wasted along with many hours of lost time that could be better spent in patient care.

In addition to the 70 percent of meritless claims, more than 28 percent of medical liability claims are settled, and we suspect there are a significant percentage of claims settled due to "legal blackmail." One recent example happened at Holy Spirit Hospital in Camp Hill. An inmate at the Camp Hill Prison committed suicide after taking himself off psychotropic medicines, which were prescribed through the hospital. Holy Spirit Hospital was sued and ended up settling for about $20,000 to get rid of the case, simply because it would be less expensive to do so. If they had fought the case to a jury verdict, they would have not only wasted their time, but also wasted more money. According to the Physician Insurers Association of America, in 2000 the median cost for a defendant to win a case in front of a jury was $66,767. Likely, it's higher today.

Only one explanation can be given for these types of lawsuits—personal gain. Personal injury lawyers often take up to 40 percent of awards as part of their fees. Sadly, they have no incentive to clean up lawsuit abuse.

Ultimately, the Pennsylvania Medical Society believes that it would be helpful to look at California as a model to correct the problems in our state. California's MICRA law, that has gained so much national attention, has kept rates in California lower than states without similar laws.

For the sake of comparison, the independent Medical Liability Monitor based in Chicago reported in their October 2002 rate trends study that an obstetrician/gynecologist in Los Angeles could have expected to pay $65,389 for $1 million worth of coverage through NORCAL. It appears from the report that Los Angeles is the most expensive market in California for liability insurance.

That same doctor in Philadelphia would first pay $64,314 for the first $500,000 of coverage through PMSLIC, which is owned by NORCAL, then another $35,731 for the next $500,000 worth of coverage through the Mcare Fund. In other words, for $1 million worth of liability insurance coverage, a doctor would pay about $35,000 less in Los Angeles than in Philadelphia.

Furthermore, if you look at the percentage of change, as reported in the 2002 Medical Liability Monitor study, obstetricians/gynecologists in California saw their rates change between a minus three (-3) to plus fourteen (+14) percent. In Pennsylvania for the same period, rates for an obstetrician/gynecologist increased about 40 percent.

Since there is no restriction on economic loss and lost wages, and cost of living in Los Angeles is greater than Philadelphia, this lower premium is even more significant.

Clearly, MICRA is doing its job.

The two parts of the California MICRA law that are not in place in Pennsylvania include limiting attorney contingency fees on a sliding scale and placing a reasonable limit on non-economic awards after a person has been fully compensated for financial losses.

That's what Pennsylvania is missing, and that's what we still desperately need.

Ultimately, Pennsylvania and the rest of the country needs to learn what Californians learned in the 1970s—limiting attorney contingency fees on a sliding scale and placing reasonable limits on non-economic awards after a person has been fully compensated for financial losses are necessary to keep trauma centers open, hospital units functioning, ambulance crews operating, and simply to preserve our world-renowned health care system.

MICRA does not limit economic recovery. It does not deprive injured individuals of full economic compensation. Instead, it provides fair compensation in a timely manner with lower legal expenses. In a nutshell, MICRA proved that providing fair and equitable compensation for those negligently injured can stabilize the insurance marketplace and maintain access to quality health care.

We believe that the most significant changes that can be enacted from the federal level are limiting attorney contingency fees on a sliding scale and placing reasonable limits on non-economic awards after a person has been fully compensated for financial losses.

Thank you.

Mr. GREENWOOD. Thank you, Dr. Dench. Dr. Palmisano.

TESTIMONY OF DONALD J. PALMISANO

Mr. PALMISANO. Good morning. Thank you, Mr. Chairman, for inviting the American Medical Association to participate in today's field hearing. I am President-elect of the American Medical Asso-

ciation and a surgeon in New Orleans. The remarks presented today and the written statement submitted is on behalf of the AMA, a professional organization whose policy is determined by vote of the House of Delegates comprised of all 50 State medical associations and over 100 specialty societies.

There is something terribly wrong when thousands of physicians across the country are forced to take time away from their patients to petition a government that has failed them and their patients. There is something terribly wrong when patients have to bypass the nearest hospital because the specialist who used to care for them have stopped practicing, eliminated certain procedures, or moved out of State because of the liability mess. There is something terribly wrong when dedicated professionals who have trained for years want to give up the work of a lifetime and retire. There is something terribly wrong when medical students make decisions about residency training based upon a State's legal climate.

Pennsylvania is a State in crisis. Last month, President Bush came to Pennsylvania to speak about the medical liability crisis and to proclaim the need for elected officials to pass effective liability reforms. Pennsylvania is not alone. At least 11 other States face the same crisis as Pennsylvania. In many others a crisis is looming. Reports confirm that the cause of the liability crisis is the unrestrained escalation of jury awards. A nonpartisan taskforce in Florida found that, "The centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus, eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages." This limit on non-economic damages has worked in California and it can work nationwide. The National Association of Insurance Commissioners, NAIC, studied 24 years of premiums in California. They found that premiums across the Nation increased three times faster than premiums in California. Opponents claim that soaring medical liability insurance premiums are the result of declining investments in the insurance industry and that liability reforms do not stabilize the insurance market. These claims are misleading, based on Florida analysis, and contrary to the facts.

In its 2002 edition, A.M. Best reports that medical liability insurers have approximately 80 percent of their investments in the bond market and investment yields have been stable and positive since 1997. Other credible stories, including Brown Brothers Harriman's recent study, conclude that, "Investments did not precipitate the current crisis." Opponents' flawed arguments are a disservice to patients who are losing access to healthcare and an affront to physicians and other healthcare professionals. These professionals dedicate their lives to healing and caring for the sick and working to find ways to improve the quality of care. America's medical liability crisis is too serious and the consequences of inaction too great for the public and Congress to use anything but the facts to make decisions about reform.

In conclusion, enacting meaningful medical liability reforms is essential to resolve the current crisis and preserve access to medical services. We must bring common sense back to our courtrooms

so patients have access to their physicians whether in emergency rooms, delivery rooms, or operating rooms. Thank you very much.

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

PREPARED STATEMENT OF DONALD J. PALMISANO, MEMBER, AMERICAN MEDICAL ASSOCIATION

On behalf of the physician members of the American Medical Association (AMA), I appreciate the opportunity to testify before you today regarding an issue that is seriously threatening the availability of and access to quality health care for patients. I would especially like to express our thanks to Representative Jim Greenwood (R-PA) for his continued leadership on this issue. Introduction of H.R. 4600 in the 107th Congress and H.R. 5 in the current session have provided a much needed focus for action at the national level.

Mr. Chair, you know there is something terribly wrong when thousands of physicians in the state to our east (New Jersey) feel compelled to leave their patients, to leave the work they love doing, and stand in the rain in Trenton just to get noticed. There is something terribly wrong when patients have to by-pass the nearest hospital because the specialists who used to care for them have stopped practicing, eliminated certain procedures, or moved out of state because of the liability mess. There is something terribly wrong when dedicated professionals, who have trained for years, want to give up the work of a lifetime and retire. There is something terribly wrong when medical students make decisions about residency training based upon the legal climate in various states.

As you have recognized, the time for action is past due. Physicians across the country are making decisions now and more and more patients are wondering, will their doctor be there. We must act now to fix our broken medical liability system.

OVERVIEW

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

The crisis facing our nation's medical liability system has not waned—in fact, it is getting worse. Escalating jury awards and the high cost of defending against lawsuits, even frivolous ones, have caused medical liability insurance premiums to reach unprecedented levels. As a result, a growing number of physicians can no longer find or afford liability insurance.

Virtually every day for the past year there has been at least one major media story on the plight of American patients and physicians as the liability crisis reaches across the country. Access to health care is now seriously threatened in states such as Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. And, a crisis is looming in more than 30 other states. Emergency departments are losing staff and scaling back certain services such as trauma units. Many obstetrician/gynecologists and family physicians have stopped delivering babies, and some advanced and high-risk procedures (such as neurosurgery) are being postponed because physicians can no longer afford or even find the liability insurance they need to practice.

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

THE LITIGATION SYSTEM IS CAUSING THE CRISIS

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

According to 2001 Jury Verdict Research data, in just a one year period (between 1999 and 2000), the median jury award increased 43 percent. Further, median jury

awards for medical liability claims grew at 7 times the rate of inflation, while settlement payouts grew at nearly 3 times the rate of inflation. Even more telling, however, is that the proportion of jury awards topping $1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top $1 million, and the average jury award has increased to about $3.5 million.

In a July 2002 report prepared by the U.S. Department of Health and Human Services (HHS), the federal government concluded that the excesses of the litigation system are threatening patients' access to health care. HHS reports that insurance premiums are largely determined by the litigation system. The report states that the litigation system is inherently costly, unpredictable, and slow to resolve claims. The cost just to defend a claim averages over $24,000. The fact that about 70 percent of claims end with no payment to the patient indicates the degree to which substantial economic resources are being diverted from patient care to fruitless legal wrangling.

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

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

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

The update further highlighted that liability insurance rates are escalating faster in states that have not established reasonable limits on unquantifiable and arbitrary non-economic damages. HHS reported that:

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

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

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

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

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

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

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

Public Citizen and other trial lawyer supported groups claim that soaring medical liability insurance premiums are the result of declining investments in the insurance industry, and that liability reforms do not stabilize the insurance market. Beyond the reports discussed above, several authoritative and credible studies reveal Public Citizen's claims to be misleading, based on flawed analysis, and contrary to the facts.

The report on which Public Citizen bases most of its speculations, produced under the direction of J. Robert Hunter for the advocacy group Americans for Insurance Reform (AIR), is flawed in a number of ways. The AIR/Hunter study purports to prove that there is no current explosion in medical liability insurance payouts, and that the explosion in medical liability insurance premiums is due to the insurance underwriting cycle. While medical liability insurance premiums, medical liability award payouts, and tort law factors differ across states, the premium and payout data presented in AIR's report are at the national level. One cannot use national data to draw valid conclusions about how state-specific changes in premiums may be related to state-specific changes in payouts. Conclusions about what has or has not caused recent premium escalation without accounting for the state-level factors listed above are unsupportable.

Last month, Brown Brothers Harriman & Co. (BBH) released a report ("Did Investments Affect Medical Malpractice Premiums?") that analyzed the impact of insurers' asset allocation and investment income on the premiums they charge. BBH concluded that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of the U.S. economy, or interest rates, on the other hand. In addition, on February 4, 2003, BBH released an addendum to this study that analyzed National Association of Insurance Commissioners (NAIC) data to determine whether investment gains by medical liability insurance companies declined in the recent bear market. BBH asked the question: "Did medical malpractice companies raise premiums because they had come to expect a certain percentage gain that was not achieved due to market conditions?" BBH determined that the decline in equities (which are a small percentage of insurance company investments) was more than offset by the capital gains by bonds (which make up a substantial part of insurance company investments) due to a decline in interest rates. BBH concluded that "investments did not precipitate the current crisis."

BBH's findings are corroborated by other recent reports. On September 25, 2002, HHS released an update on the medical liability crisis addressing claims by trial lawyers that the crisis is caused by the management practices of the insurance industry. HHS concluded that such claims are not supported by facts, stating "Comparisons of states with and without meaningful medical liability reforms provide clear evidence that the broken medical litigation system is responsible." A summary of medical liability insurer annual statement data in AM Best's Aggregates & Averages, Property-Casualty, 2002 edition shows that the investment yields of medical malpractice insurers have been stable and positive since 1997. AM Best reports that medical liability insurers have approximately 80% of their investments in the bond market. Recent NAIC data show that physicians' medical liability insurance premiums between 1976-2000 have risen 167% in California (which established effective liability reforms in 1975) compared to 505% in the rest of the United States.

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

ACCESS TO CARE IS AT RISK

The most troubling aspect of the current medical liability litigation system is its impact on patients. Unbridled lawsuits have turned some regions in our country—and in several cases entire states—into risky areas to be sick, because it is so risky to practice medicine. Due to large jury awards and the burgeoning costs of defending against lawsuits (including frivolous claims), medical liability insurance premiums are skyrocketing. As insurance becomes unaffordable or unavailable, physicians are being forced to leave their practices, stop performing high-risk procedures, or drop vital services—all of which seriously impede patient access to care.

Four states—Pennsylvania, Florida, West Virginia, and New Jersey—illustrate the crisis many states are experiencing and the problems many other states will face if effective tort reforms are not enacted.

PENNSYLVANIA

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

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

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

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

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

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

FLORIDA

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

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

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

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

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

More than 50 Bradenton patients had to postpone elective surgeries and more than 100 office visits were canceled because two physicians were unable to obtain liability insurance. The insurer may leave the state altogether. (*Bradenton Herald,* Jan. 24, 2003).

After recently receiving notice of a premium spike coming in July 2002, Vladimir Grnja, MD, decided that he would "go bare" and drop all medical liability insurance coverage. Rates for the Hollywood, FL radiologist were to rise to $112,000 from $35,000 a year (a 220% increase), mainly because of litigation over mammograms. "No doctor wants to go bare," said Dennis Agliano, MD, chairman of the Florida

Medical Association's special task force on the Florida medical liability crisis. But with significant premium hikes in Florida for specialties like OB/GYN, neurosurgery, thoracic surgery, radiology and even primary care, "some doctors have no choice," he says. Some neurosurgeons in South Florida, are paying a $200,000 premium for coverage of $250,000 per occurrence, making insurance practically meaningless. The Florida Medical Association reports that more than 1,000 doctors in Florida have no medical liability insurance. Doctors in West Virginia and Ohio are also reportedly going bare. (*Modern Physician,* April 1, 2002).

WEST VIRGINIA

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

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

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

NEW JERSEY

A multi-physician practice in Teaneck, NJ was forced to layoff employees and reduce the number of deliveries it performed because of professional liability insurance premium increases of more than 120 percent. "All of my colleagues are experiencing the same pressures," said George Ajjan, MD (*Bergen Record,* May 22, 2002).

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

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

OTHER STATES

Liability costs for **Texas** physicians skyrocketed as much as 300 percent in some regions and for some specialties. As a result, there is only one neurosurgeon serving 600,000 people in the McAllen area. In the past two years, four South Texas patients with head injuries died before they could be flown out of the area for medical attention. As reported in a July 10, 2002, article in *The Courier*, a community family practice clinic in Conroe (just north of Houston) was recently forced to turn away half of its normal patient load because its liability insurance provider would not provide coverage while "highly lawsuit-risky obstetrics training was conducted."

In **Nevada** more than 30 private-practice OB/GYNs have left the state in 2002 and another 20 are poised to leave in 2003. About half of the OB/GYNs in the state are actively interviewing for positions out of state. "Right now it's almost impossible to recruit an obstetrician in Las Vegas," said University Medical Center obstetrician, Warren Volker, MD. (*Las Vegas Sun,* Sept. 27, 2002). Long-time obstetrician, Frieda Fleischer, MD, gave up obstetrics because her premiums rose from $30,000 annually to $80,000. "So far, I've had about 40 pregnant patients to refer elsewhere and it's been tough." Fleischer's office manager, Dawna Gunning adds, "What do you do when you have patients coming to your door crying and saying they cannot find a doctor and you've called every colleague?" (*Las Vegas Review Journal,* Jan. 10, 2003). The story of a woman who had to wait six months to have suspicious lumps removed from her uterus and ovaries because she couldn't get an appointment for the surgery illustrates that pregnant women are not the only patients affected by the exodus of Las Vegas obstetricians in recent months. (See, *Las Vegas Review Journal,* Nov. 5, 2002).

Obstetricians in **Mississippi** worry about what is going to happen to their patients who face longer trips to the hospital while already in labor. Women who used to walk or make a short drive for both prenatal visits and delivery now face a 45-minute drive. Of the seven doctors in Kosciusko that were practicing obstetrician/gynecologists last year, three will still be delivering babies by January. Right now, pregnant women who are considered high-risk, such as someone with diabetes, can't be treated at the Kosciusko Medical Clinic because it is too risky for physicians. (*The Clarion-Ledger,* Aug. 26, 2002.). Neurologist Terry Smith, MD said he has applied with 14 companies, and Medical Assurance is his last hope to find coverage before his current policy expires on Aug. 4. His premium will go from $55,000 a year to potentially $150,000 with a $132,000 tail to his old insurer. "I'm looking at writing a check for $300,000," said Smith, who does brain surgery at three hospitals in Jackson and Harrison counties. (*Associated Press,* July 11, 2002).

Rural families in John Day, Hermiston, and Roseburg counties, **Oregon** have either lost obstetric care or have seen services drastically reduced. (*The Business Journal of Portland,* Jan. 10, 2003). Only by dropping obstetrics were two Hermiston physicians able to afford their liability insurance premiums. "It's something you don't like to tell patients," said Doug Flaiz, MD. (*The Oregonian,* Oct. 29, 2002). "No one with $100,000 in debt from medical school wants to start a practice in a place where they could find themselves completely broke and having to pick up and go somewhere else to start all over again," said Rosemari Davis, CEO of Willamette Valley Medical Center, who has seen three of her center's family practitioners stop delivering babies. (*The News Register,* Jan. 28, 2003).

A 10-physician OB/GYN group in Columbia, **South Carolina** had to take out a $400,000 loan this year to continue to provide OB services *and* pay malpractice premiums. In rural Oconee County, just four doctors deliver babies now, down from 11 physicians one year ago. A family practice group in Seneca was forced to drop OB coverage for four of their six physicians because of skyrocketing premiums. There are currently a total of four physicians in Seneca treating pregnant women. A solo practitioner practicing geriatrics in Charleston has had to quit treating patients in nursing homes because of high premiums.

THE PRACTICAL SOLUTION

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as devastating or worse to patients and their families than injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation.

This compensation should include, first and foremost, full payment of all out of pocket "economic" losses. The AMA also believes that patients should receive reasonable compensation for intangible "non-economic" losses such as pain and suffering and, where appropriate, the right to pursue punitive damages.

Unfortunately, our medical liability litigation system is neither fair nor cost effective in making a patient whole. Transformed by high-stakes financial incentives, it has become an increasingly irrational "lottery" driven by open-ended non-economic damage awards. A 2002 study by Tillinghast-Towers Perrin shows that our tort system, in general, is an extremely inefficient mechanism for compensating claimants—returning less than 45 cents on the dollar to claimants and only 20 cents of tort cost dollars to compensate for actual economic losses. This study also reveals that the cost of our tort system is significantly higher than other countries and almost twice the average.

To ensure that all patients who have been injured through negligence are fairly compensated, the AMA believes that Congress must pass fair and reasonable reforms to our medical liability litigation system that have proven effective. Toward this end, **we strongly urge Congress to pass H.R. 5, the "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003,"** a *bipartisan* bill that would bring balance to our medical liability litigation system. We applaud Representative Greenwood (R-PA) and the other 65 Republican and Democrat original cosponsors of the HEALTH Act for championing this bill in the 108th Congress.

The major provisions of the HEALTH Act would benefit patients by:

- Awarding injured patients *unlimited* economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);
- Awarding injured patients non-economic damages up to $250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in this bill;

- Awarding injured patients punitive damages up to two times economic damages or $250,000, whichever is *greater;*
- Establishing a "fair share" rule that allocates damage awards fairly and in proportion to a party's degree of fault; and
- Establishing a sliding-scale for attorneys' contingent fees, therefore maximizing the recovery for patients.

These reforms are not part of some untested theory'they work. The major provisions of the HEALTH Act are based on the successful California law known as MICRA (Medical Injury Compensation Reform Act of 1975). MICRA reforms have been proven to stabilize the medical liability insurance market in California—increasing patient access to care and saving more than $1 billion per year in liability premiums—and have reduced the time it takes to settle a claim by 33 percent. MICRA is also saving California from the current medical liability insurance crisis brewing in many states that do not have similar reforms. In fact, according to MLM, as discussed above, the gap between medical liability insurance rates in California and those in the largest states that do not limit non-economic awards is substantial and growing.

MICRA-type reforms are effective, especially at controlling non-economic damages. Several economic studies substantiate this point. One study looked at several types of reforms and concluded that capping non-economic damages reduced premiums for general surgeons by 13% in the year following enactment of MICRA, and by 34% over the long term. Similar results were shown for premiums paid by general practitioners and OB/GYNs. It was also shown that caps on non-economic damages decrease claims severity (Zuckerman et al. 1990).

Another study published in the *Journal of Health Politics, Policy and Law* concluded that caps on non-economic damages reduced insurer payouts by 31%. Caps on total damages reduced payouts by 38% (Sloan, et al. 1989). Another study concluded that states adopting direct reforms experienced reductions in hospital expenditures of 5% to 9% within three to five years. If these figures are extrapolated to all medical spending, a $50 billion reduction in national health spending could be achieved through such reforms (Kessler and McClellan, *Quarterly Journal of Economics*, 1997).

Further, as discussed above, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress) asserts caps on non-economic damages have been extremely effective in reducing the severity of claims and medical liability premiums. Conversely, a 1996 American Academy of Actuaries study shows that medical liability costs rose sharply in Ohio after the Ohio Supreme Court overturned a liability reform law in the 1990s that set limits on non-economic damages. (Ohio recently enacted a new liability reform law.)

Furthermore, three-quarters of Americans understand the detrimental effect that excess litigation has on our health care system. A 2002 survey conducted by Wirthlin Worldwide shows that the vast majority of Americans agree we need common sense medical liability reform. Among the findings:Q02

- 71 percent of Americans agree that a main reason health care costs are rising is because of medical liability lawsuits.
- 78 percent say they are concerned about access to care being affected because doctors are leaving their practices due to rising liability costs.
- 73 percent support reasonable limits on awards for "pain and suffering" in medical liability lawsuits.
- More than 76 percent favor a law limiting the percentage of contingent fees paid by the patient.

These findings are consistent with the results of a Gallup poll released on February 5, 2003, show that 72% of those polled favor a limit on the amount patients can be awarded for pain and suffering.

CONCLUSION

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an erosion in access to care because their physicians can no longer find or afford liability insurance. The reasonable reforms of the HEALTH Act have brought stability in those states that have enacted similar reforms.

By enacting meaningful medical liability reforms, Congress has the opportunity to increase access to medical services, eliminate much of the need for medical treatment motivated primarily as a precaution against lawsuits, improve the patient-physician relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emo-

tional, of health care liability litigation. The modest proposals in the HEALTH Act answer these issues head on and would strengthen our health care system.

The AMA appreciates the opportunity to testify on the adverse effect that our current medical liability litigation system imposes on patient access to health care and urges Congress to pass the HEALTH Act.

Mr. GREENWOOD. Thank you, Dr. Palmisano. Our next witness is Leanne Dyess. Am I pronouncing that right?

Ms. DYESS. Leanne.

Mr. GREENWOOD. Say it again?

Ms. DYESS. Leanne.

Mr. GREENWOOD. Leanne Dyess from Vicksburg, Mississippi. We welcome you and you are recognized for your testimony.

TESTIMONY OF LEANNE DYESS

Ms. DYESS. Thank you. Congressman Greenwood, distinguished ladies and gentlemen, it is an honor for me to be here this morning to share with you the devastating consequences of the crisis surrounding medical liability costs. Others today have talked in terms of economics and policy. I want to speak to you from the heart. I want to share with you the life my two children and I are now forced to live because of rising liability costs that many doctors in many parts of the country cannot afford.

I am a teacher. For 20 years I have taught the brightest young minds in Mississippi. I know the value of a good story to make an important lesson memorable, but never did I think that my life and the life of my children would become that story for this important issue. The story began on July 5 of last year when my husband, Tony, was returning from work in Gulf Port, Mississippi. We had just started a new business and Tony was working hard. We were doing our best to build a life for our children. Everything looked great, and then, suddenly, everything changed. Tony was involved in a car accident. They suspect he fell asleep, though, we will never know.

What we do know is that after removing him from the car, they rushed Tony to Garden Park Hospital. He had head injuries and required immediate attention. Shortly thereafter, I received a phone call that I pray no other wife should ever have to receive. I was informed of the accident and told that the injuries were serious, but I cannot describe to you the panic that gave way to hopelessness when they told me the specialist that Tony needed was not there to take care of him, we will have to airlift him to another hospital.

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

Almost 6 hours passed before Tony was airlifted to the University Medical Center, 6 hours for the damage to his brain to continue before they had a specialist capable of putting a shunt into his brain to drain the fluids, six unforgettable hours that changed our life.

Today, Tony is permanently brain damaged. He is mentally incompetent, unable to care for himself, unable to provide for our children, unable to live the vibrant, active, and loving life he was living just moments before the accident. I could share with you the

panic of a woman suddenly forced into the role of both mother and father to her teenage children, of a woman whose life is suddenly caught in limbo. I could tell you about a woman who had to worry about the constant care of her husband, who had to make concessions she never thought she would have to make to be able to pay for his therapy and his care. But to describe this would be to take us away from the important point and the value of what I have learned, and that is that there was no specialist on staff that night in Gulf Port because rising medical liability costs had forced physicians in that community to abandon their practice. In that area at that time, there was only one doctor who had the expertise to care for Tony, and he was forced to cover multiple hospitals, stretching him thin and unable to care for everyone. Another doctor had recently quit his practice because of medical practice liability costs. And on that hot night in July, my husband drew the short straw.

I have also learned that Mississippi is not unique to this crisis. It rages all across America. It rages in Nevada, where young expectant mothers cannot find OB-GYN's. it rages in Florida, where children in the extremities cannot find pediatric neurologists. It rages here in Pennsylvania, where the elderly who have come to depend on their orthopedic surgeons are being told that those trusted doctors are moving to States where medical liability costs are less and practicing medicine is affordable and less risky.

The crisis, Mr. Chairman, is like termites in the structure of a home. They get into the woodwork but you can't see the damage they are doing. The walls of the house remain beautiful. You don't know what is going on just beneath the surface, at least not for a season. Then 1 day you go to hang a picture and the whole wall comes down, everything is destroyed. Before July 5, I was like most Americans, completely unaware that just below the surface of our Nation's healthcare delivery system, serious damage was being done by excessive, frivolous litigation, litigation that was forcing liability costs beyond the ability of doctors to pay. I had heard about some of the frivolous cases and, of course, the awards that climbed into the hundreds of millions of dollars, and like most Americans, I just shook my head and said someone hit the lottery. I didn't know the damage it was doing to the system. Just think about it—it is not until your spouse needs a specialist, it is not until you are the expectant mother who needs an OB-GYN, or your child who needs a pediatric neurosurgeon, that you realize that the termites work beneath the surface.

From my perspective, sitting here today, this problem far exceeds any other challenge facing America's healthcare, even the challenge of the uninsured. The uninsured can go to the emergency room and find care; hospitals won't turn them away. But if doctors aren't able to practice, if they are unable to provide the expertise they are trained years to provide, then there is nothing anyone can do. My family had insurance when Tony was injured; we had good insurance. What we didn't have was a doctor.

Mr. Greenwood, I know of your efforts to see American through this crisis. I know of your legislation and of its importance to the President. I know of the priority you, and Congress, and many in the Senate are placing upon doing something and doing something now. Today I pledge to you my complete support. It is my prayer

that no woman or anyone else anywhere will ever have to go through what I have gone through and what I continue to go through every day with my two children and a husband I dearly love. Thank you.

[The prepared statement of Leanne Dyess follows:]

PREPARED STATEMENT OF LEANNE DYESS

Congressman Greenwood, Governor Rendell, distinguished guests, ladies and gentlemen, it's an honor for me to be here this afternoon—to share with you the devastating consequences of the crisis surrounding medical liability costs. Others today will talk in terms of economics and policy. I want to speak from the heart. I want to share with you the life my two children and I are now forced to live because of rising liability costs that many doctors in the many parts of the country cannot afford.

I am a teacher. For twenty years, I have taught some of the brightest young minds in Mississippi. I know the value of a story to make an important lesson memorable; but never did I think that my life—and the life of my children—would become the cautionary tale on this important issue.

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

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

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

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

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

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

Congressman Greenwood, I learned that there was no specialist on staff that night in Gulf Port because rising medical liability costs had forced physicians in that community to abandon their practices. In that area, at that time, there was only one doctor who had the expertise to care for Tony and he was forced to cover multiple hospitals—stretched thin and unable to care for everyone. Another doctor had recently quit his practice. And on that hot night in July, my husband drew the short straw.

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

The crisis, Mr. Chairman, is insidious, like termites in the structure of a home. They get into the woodwork, but you cannot see the damage. The walls of the house remain beautiful. You don't know what's going on just beneath the surface. At least not for a season. Then, one day you go to hang a shelf and the whole wall comes

down; everything is destroyed. Before July 5th, I was like most Americans, completely unaware that just below the surface of our nation's health care delivery system, serious damage was being done by excessive and frivolous litigation—litigation that was forcing liability costs beyond the ability of doctors to pay. I had heard about some of the frivolous cases and, of course, the awards that climbed into the hundreds of millions of dollars. And like most Americans I shook my head and said, "Someone hit the lottery."

I did not know the damage it was doing to the system. You see, Congressman Greenwood, it's not until your spouse needs a specialist, or you're the expectant mother who needs an ob/gyn, or it's your child who needs a pediatric neurosurgeon, that you realize there are termites at work beneath the surface.

From my perspective, sitting here today, this problem far exceeds any other challenge facing America's health care—even the challenge of the uninsured. The uninsured can go to the emergency room and find care. Hospitals will not turn them away. But if doctors are unable to practice—if they're unable to provide the expertise they've trained years to provide—then there's nothing anyone can do. My family had insurance when Tony was injured. We had good insurance. What we didn't have was a doctor.

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

Mr. GREENWOOD. Thank you, Ms. Dyess. I am going to go just out of order to make a comment. About 20 years ago, right up the road from where this hospital is located, a woman, a constituent of mine—I was in the State legislature—was in a very bad accident, and we didn't have a trauma center in Bucks County and she was flown to the nearest one. She didn't make it because she didn't get there in that golden hour, and as a result of that, I went back to Harrisburg and wrote legislation to create the trauma centers, and it has been a remarkable success, but it is unbelievably frustrating to me now to see trauma centers close down because of the lack of physicians.

Our next witness has been waiting patiently, and she is Heather Lewinski. And Heather, I don't have your address. Where are you from?

Ms. LEWINSKI. Buffalo, New York.

Mr. GREENWOOD. Okay. Well, we thank you very much for being with us and you are recognized for your testimony.

TESTIMONY OF HEATHER LEWINSKI

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

When I was 8 years old, a doctor performed a surgery on my face that never should have been done.

Mr. GREENWOOD. Take your time, sweetheart.

Ms. LEWINSKI. He told my parents that he had tried this surgery successfully on many other patients with my condition, but my parents and I later found out that that was not true. This doctor had

never done the surgery before, and in fact, we were told that no doctor in the whole United States had ever recommended this surgery for a condition like mine. I feel like the doctor was using me as a guinea pig.

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

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

After every surgery I had, I would be forced to stay in the hospital for a while. Then when I go home, where I would be in bed or on the sofa for weeks and weeks and my mouth would be wired shut. My face would be swollen, my entire head would be wrapped in bandages. Sometimes the pain was so bad it would feel like my whole face was going to explode. It was like someone had a hammer and kept hitting me and hitting me.

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

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

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

From third grade through eighth grade, I missed so much school from all of the surgeries that I had trouble keeping up. In third grade, I missed from March until the end of the year. In fourth grade, I missed from Thanksgiving break to the rest of the school year. In fifth, sixth, seventh, and eighth grades, I missed anywhere from 3 months to 5 months of school each year. I had to have tutors and be home schooled all this time. I remember that even

though I had always been a good student, they had to label me as special ed because I missed so much time from school. I hated that label.

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

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

I really like people but I have only one close friend, my girlfriend, Angela, who I grew up with. It is so hard for me to meet new people and make friends because they just stare. Even a few other kids who are supposedly my friends at school will not walk with me in the halls, and it seems like they are always 2 or 3 steps behind me. I quit riding the bus from school a long time ago because it was torture. My mom has to take me to school and pick me up. Sometimes I wish so hard that there was some magic and I could just make myself invisible to other people but still be able to enjoy them.

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

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

I have never really been involved in school activities because I just do not have that many friends. The one activity that I have that I really love is training and showing dogs. I have been doing that for a few years. Other people hire me to train and show their dog and I also train and show my own dogs. I usually compete in

dog shows on the weekends in New York and some other States. I have been really lucky and have been able to win several awards competing against adults at these shows. I think one of the reasons that I like dog training so much is that animals can't stare or laugh.

I will be graduating from high school in a few months and I have already been accepted to college. Because of my fears of meeting new people, I chose a college that is close to my house so that I do not have to stay in a dorm with other kids. My biggest wish is that some day I will find a boy who will look and see me for what is on the inside of my heart and in my mind and not my appearance. I would love to get married and have a family some day, but if I am honest with myself, I do not know if that will ever happen so I have made other plans. I will finish college and become a kindergarten teacher. I have always loved baby-sitting kids and being around them. Little children do not stare so much and they just accept you for what is inside. I will teach school and live in the country with lots of dogs and I will be self-sufficient.

I know that the President is trying to make good decisions, but if he could see everything that I have gone through the last 10 years and everything that I am going to go through for the rest of my life, I think he would realize that he is wrong about this law and that every patient is entitled to be judged as an individual based on what they have gone through. I think that most doctors try to do the best they can for people, but sometimes they do things that should not be done, and when that happens, I think they should be responsible for all of the harm they cause and not just part of it.

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

Mr. GREENWOOD. Thank you, Heather. I have a daughter just your age, and let me tell you, it is a courageous thing for you to come here and help us understand this issue. I want you to know that kids are awful, but the adults in this room can see exactly who you are and what is in your heart and it looks pretty good.

Ms. LEWINSKI. Thank you.

Mr. GREENWOOD. Can you tell me, Heather, what was the cause of your need for surgery? Was it a congenital birth defect or was it an injury or disease?

Ms. LEWINSKI. It was caused by trauma. When I was 3 years old I fell down the stairs.

Mr. GREENWOOD. You fell down the stairs when you were 3 years old. Was the doctor ever subjected, do you know, to criminal charges for his——

Ms. LEWINSKI. No.

Mr. GREENWOOD. Okay. And there was a lawsuit. Is that settled now?

Ms. LEWINSKI. Yes.

Mr. GREENWOOD. Do you know what the settlement was or are you able to share that?

Ms. LEWINSKI. No, I don't know.

Mr. GREENWOOD. You don't know what the settlement was. Okay. All right. Well, thank you again for being here with us.

Let me address a question to Dr. Dench. Some parties might dispute that there is a loss of doctors in the Commonwealth of Pennsylvania. In fact, that has been the subject of some speculation. The parties point to particularities of Pennsylvania's licensure, MCARE fund, participation, and the like to make their case. Why is there any confusion at this point and how can we know the truth about the impact situation here in Pennsylvania on doctors leaving the State as Dr. Johansson has said she is about to?

Mr. DENCH. We have done some studies in looking at even anecdotal studies where we look at when physicians have left. The auxiliary or alliance has accumulated the names of doctors that are leaving, and we have come up with as many as 900 that are leaving, but by no means is that complete. What we really know, of course, is that throughout the State the patients are telling us that they can't find their doctor, their lines are getting longer, they are having a very difficult time finding physicians. In fact, many of the physicians who have sought to get care, to get a new partner, cannot find anyone to come to Pennsylvania. If you talk to the headhunters, or the people who go out seeking to find physicians, they don't even bring them here. They don't even show us those people, and the reason they don't is because the reimbursement is lower, the malpractice crisis has led to the reputation in this State as a problem, and as a result, physicians don't want to practice here.

One of the reasons—what you were asking, one of the reasons why it is so difficult is because it takes 2 years before the licenses come back up and physicians tend not to drop the license. Hopefully, a lot of those physicians that have left the State will be able to come back when you fix it at the national level. They love this State, they love the patients here, and they would like to be here, but they have left, but they don't give up the license because it takes so long to acquire a license in this State.

Mr. GREENWOOD. Dr. Dench—actually, I want to pose this question to Dr. Dench and also to Dr. Eskin. You heard the Governor say that he has a short-term proposal, and that the short-term proposal is, essentially, to throw money at the problem, to put a one-time tax, if you will, on the premium surpluses of health insurers and use that to subsidize the medical liability premiums. I think that is a good answer in the short run, and I have said for a long time that in the short run, there is nothing that we can do except throw money at it until we change the liability situation. But I am worried because when I attended the Governor's inaugural, I ran into one of the lobbyists for one of the big Blue's, and I asked him, how much do you expect the Governor's proposal is going to cost you when it is finished, and he said zero. And I said, why is that? And he said, because it isn't going to pass because we have the votes to block it. So my question—and the reason I am addressing this to Dr. Dench, as head of the Pennsylvania Medical Society, but also, to Dr. Eskin, who has testified that, essentially, it has an IOU. You have got that trauma center in Abington held open by baling wire until, and in hopes, that the legislature will pass the Governor's proposal and put some money to subsidize the premiums and get us to long-run solutions. So the question is for both

of you, how confident are you, based on what you know, that this is going to happen, that it is going to get through the legislature even in the short run?

Mr. DENCH. I am very concerned about it. In fact, I wanted to send a letter to all the physicians warning of the possibility so that they can notify their representatives of the problem. If we don't get short-term relief, there are a lot of physicians who have been banking—I mean, literally, banking on this relief. Because even with the relief, either the high risk specialist or even the rest of the physicians, their premium is going up this year. Even with 100 percent relief, they are still seeing an increase. And many of them have no way of paying for it. So they are going to come around in May and owe that bill for the year and have no way to pay it. And they are going to be in a position where they don't know what to do, and you see the desperation in their voices.

Mr. GREENWOOD. And what are your lobbyists in Harrisburg telling you about how confident they are that the Pennsylvania House and Senate is going to pass these short-term financial reforms, or subsidies, I should say, given the fact that I am already hearing that State legislators from outside of our Philadelphia metropolitan region are not in a hurry to put up votes in this State House and State Senate to, essentially, transfer money from premium payments of their constituents in central, northern, western Pennsylvania to subsidize what is a problem that is particularly acute here in the southeast?

Mr. DENCH. I have heard the same thing you have heard. I have heard that it isn't going to pass and that is why I am so concerned about the situation. The Rendell taskforce which I sit on did not recommend a specific way of getting the money. We, in fact, had a whole list of proposals of where we should get it. This was the choice of the Governor where we should get those funds. We only can hope and lobby that the short-term funds be found, because if not, I think there will be a catastrophe in this State.

Mr. GREENWOOD. You are on the taskforce. What has the discussion been like with regard to support for caps imposed by the Federal Government, let alone getting around to amending the Pennsylvania constitution to do it?

Mr. DENCH. Well, clearly, all of the physicians and all the defense lawyers feel there should be a cap. Whether or not that taskforce was loaded ahead of time with enough——

Mr. GREENWOOD. What is your estimate of that?

Mr. DENCH. My estimate is that, actually, we will come out in favor of caps, but in any case, there will be a minority report if not. Our evidence clearly shows that caps is one of the most important things that can be done to limit the exposure. I think even the Governor admitted that it was the outlandish awards in Philadelphia that caused the problem, not the frequency, but the outlandish awards. Obviously, the caps would control that. We have many, many examples of awards that are well out of reasonableness that are just leading to care not being made available and access for our patients.

Mr. GREENWOOD. Dr. Eskin, how long can you hold out and keep the trauma center open while you are waiting for these reforms?

Mr. ESKIN. It is definitely an ongoing concern. While we certainly appreciate the Governor's efforts for both short and long-term solutions, taking the best case scenario that we have now, it is a short-term 1-year fix. The majority of our high risk specialist premiums come due in July or January. And while we probably, hopefully, maybe will be able to come through the summer, I fear that this coming November and December, we will be back in the same circumstance that we have been, actually, for the last 3 years, in terms of trying to hold together a vital service. I remain worried, as I said in my testimony. I believe it really is an IOU, but I don't hear a long-term solution at this point. And other States, because of differences in the degree of liability reform that they have enacted, are recruiting away some of our best talent. Thank you.

Mr. GREENWOOD. Dr. Johansson, you said in your testimony that there is a difference between a bad outcome and malpractice. What do you mean by that distinction?

Ms. JOHANSSON. Well, I mean, surgery, there is always inherent risks when doing surgery, and sometimes thing—there are complications that, I mean, even such a simple complication as a minor infection which is treatable with antibiotics, it is not the doctor's negligence, necessarily, that caused this patient to need a course of antibiotics; it is, you know, a bad outcome. There are high risk pregnancies that no matter how much we try and how hard we work to get a successful delivery out of that patient, things happen that we cannot—we don't have control over thing, unfortunately, but a lot of times I feel that people assume we are supposed to have control over everything that happens, and some things are just beyond our control. So a bad outcome does not necessarily mean that anybody did anything negligent. I guess that is what I mean by that.

Mr. GREENWOOD. Okay. My time has expired. I just want to make one more comment to our brave Heather Lewinski here. I want you to understand that the legislation that I am proposing, in a situation like yours, would make sure that your doctor, the doctor that did this procedure on you, would be responsible to pay all of your successive hospitalizations and surgeries, all of your medical bills, and on top of that would make you eligible for at least $250,000 for your pain and suffering. And if the State in which you live chose for that to be $500,000, or $750,000, or $250,000, that they could do that and you, certainly, would deserve as much as that as reasonable and practical.

The Chair recognizes the gentleman from Florida for 10 minutes.

Mr. DEUTSCH. Thank you, Mr. Chairman. Dr. Dench, I guess, you know, I really have been learning today and, you know, just in terms of different States and different issues. And I have expressed, you know, somewhat very briefly, the experience in Florida, which you very well might be more familiar with than I am, since doctors, particularly, heads of medical associations, speak to each other and communicate. As I have said, though, in Florida, as bad as the situation is, there are sort of these two safety valve things that physicians have available to them. One is going bare and one is, basically, setting up practice through community hospitals. I guess what I am hearing today is in Pennsylvania, there is no type of safety valve. I mean, it basically is you pay the pre-

mium, or you leave the State, or you stop practicing, and that is really the options in Pennsylvania.

Mr. DENCH. That is correct, but it should be stated that I know of no hospital in the country that would let you practice without a $1 million coverage. That is generalized and some higher.

Mr. DEUTSCH. I will tell you for a fact that there are many physicians in Florida that have no coverage, period, do not have $1 million in coverage.

Mr. DENCH. So they have hospitals that don't require it?

Mr. DEUTSCH. Absolutely.

Mr. DENCH. Unfortunately, in this State that is not the case; they, of course, require it. But without a doubt, the Medical Society does believe that you shouldn't tie licensure to malpractice coverage.

Mr. DEUTSCH. Right. And I guess the reason I say that, in some ways it makes it more acute, what you are describing, that, basically—I mean, from a physician perspective—and I, again, completely understand. These are real people and I think Dr. Johansson spoke very eloquently as well, who have devoted their lives, you know, to a very noble—as noble as any career—with no expectation when they entered this that this would be the result, that they would be facing 10, or 20, or 30 years into their career. And so I guess—I mean, that is really the point. And I guess the numbers that we are talking about in terms of premium increases, and I really have a sense of it because I have talked to doctors in different communities about this, that you are really talking about someone whose net income could be $150,000 or $200,000 in a particular specialty, getting a $100,000 increase in malpractice insurance. Is that the type of situation you have seen? And that might be an extreme case but those cases do exist.

Mr. DENCH. Yes. They not only exist, but we are put in that problem that government always does. The Secretary of the Commonwealth sent a letter right at Christmas saying to us, we know you can't get insurance, but you have to practice medicine because you can't abandon those patients, but you can't practice if you don't have malpractice insurance. And that was sent to all the physicians in this State right at the end of the year.

Mr. DEUTSCH. I mean, is it a fair assessment, I mean, just some of the dramatic—I mean, in terms of eating into someone's net, just the premium increase, potentially, could be that large a percentage of what their income has been in the previous year?

Mr. DENCH. Absolutely. The doctors in Scranton whose insurance companies left and were forced into the Joint Underwriters Association insurance were facing increases that were equal to their net income.

Mr. DEUTSCH. One of the things you mentioned, and this is something I am always curious about when physicians talk about medical malpractice issues; you mentioned unnecessary procedures. My understanding is you are an anesthesiologist. Can you talk about any unnecessary—this is in terms of the interview you had with our staff on Saturday—at least what they are telling me is that you talked of one of the reasons the current tort system is a problem is unnecessary procedures or tests.

Mr. DENCH. Oh, I see. I don't know about procedures, but certainly, what happens when they are faced with frivolous lawsuits, is they will order all kinds of tests to cover themselves For example, as I was growing up, I had eight sprained ankles at one time or another. I don't think there is anyone today that had a sprained ankle and wouldn't get an X-ray for it because they would be afraid of being sued because there might have been a small fracture that you would have had to wait 2 weeks before you diagnosed. And those are the kinds of tests that, clearly, are out there.

Mr. DEUTSCH. All right. Let me just ask you this just to sort of dialog a little bit about that. But isn't it the case, though, that if there weren't cases where the X-ray, initially, on the sprained ankle, shows a fracture which if you didn't do the X-ray, doing it 2 weeks later becomes, you know, medically problematic. That is the only reason why at some point in time someone could say do the X-ray initially?

Mr. DENCH. Well, that is not what they do. They do the X-rays automatically now, but clearly, the fracture, the small fracture that is there, would undergo maybe an extra week or two before they were casted and that would be the major consequences of not doing it. But no one would—you could be sued with no loss. You could be sued for that extra pain and suffering, et cetera, et cetera, and the net cost to society is tremendous if you have to X-ray every single person whose ankle is sprained. But that is just the beginning of the thing. There are all kinds of extra lab tests, all kinds of extra procedures in the sense that, I guess if I was referring to procedures, you don't believe, for example, that the person has a gastric ulcer. You have every reason to believe that they are doing fine and you would do a wait and see and give some antacids. Well, you could be sued tremendously if they turn around and it just so happens one out of a million is a cancer, and they then try to proceed to claim that that cancer could have been cured if you had done the scooping that first week. So you are always looking at a cost benefit in any procedure done, and now the physicians are asked to be able to do these things right away even though their good medical judgment says that they don't need to be done right away.

Mr. DEUTSCH. Let me, actually, jump around a bit. Dr. Johansson, I served 10 years in the State legislature before I got to Congress. And in Florida, while I was in the legislature, I would see the chairman of the insurance committee at the time. We actually adopted what was called the bad baby bill. I mean, we basically had no fault for babies. Has the legislature here looked at that at all as an option?

Ms. JOHANSSON. As far as I know, there has been nothing discussed about that. And being an obstetrician, I mean, obviously, it is very emotional when something happens to a baby whether it was the fault of the doctor or beyond our control, and no, nothing has been looked at this.

Mr. DEUTSCH. And my understanding is that your practice is changing from a practice affiliated with the hospital to a private practice. Is that accurate?

Ms. JOHANSSON. Well, our practice was a private practice, hospital practice, but again will become a private practice, and part of the problem with going back to it is obtaining affordable insurance.

We couldn't even get a quote, you know, a reasonable quote at this point in Pennsylvania.

Mr. DEUTSCH. So you might stay as a hospital practice or have they——

Ms. JOHANSSON. Actually, now that is not any longer my concern for the group because I am leaving, and that is a decision they are going to have to make, unfortunately.

Mr. DEUTSCH. But my understanding is in a private practice the rates are double what they would be, or 50 percent higher, or——

Ms. JOHANSSON. Actually, our rates when I started, even though we are hospital and group, our rates were about $36,000 my first year. They are hovering just under $90,000, even though we are hospital and group. And I mean, that is——

Mr. DEUTSCH. Per person?

Ms. JOHANSSON. Right, per physician per year.

Mr. DEUTSCH. First of all, Mr. Wozniak, thank you for having us and I appreciate—I know how much work it takes to really create one of these hearings. I would like to, I guess, just ask you a couple of questions regarding hospitals and your concern in terms of both malpractice, but also safety net issues as they affect it. My understanding is that from the American Hospital Association, the number that the American Hospital Association uses, 40 million Americans are basically served by hospitals as a safety net, uninsured Americans. And obviously, by statute, you are required to treat people regardless of their health insurance. How has that affected your operation as a hospital at this point in time?

Mr. WOZNIAK. Well, I think being a Catholic faith based hospital that St. Mary is, we take care of all people, no matter the ability to pay. So first and foremost, that is our ministry. In fact, we go to great extremes to go out and find those people that are often left behind. And as I referenced before, the Mother Bachmann Center. How does that affect us? Well, I really believe for all of you in Congress, you really need to think through those poor people. You and I can find healthcare, we can travel, and we can find that healthcare. But most of the indigent and the poor are really restricted to their local area, and when they need that healthcare, they don't know where to turn. Our Mother Bachmann Center, we go out and we try to enhance the care for that poor and indigent group because that is what our mission calls us to do. As we do that, we try to treat the whole individual. And as I mentioned in my testimony, we have the Mother Bachmann Center. It has cared for over 1,600 women over the last 11 years, and I could tell you many of those women would not have access to healthcare because they wouldn't know how to find it and they would fall through the cracks. So that becomes a challenge. At the same time, to provide care for you and I, literally, I use an analogy. It is like the old Ed Sullivan show. Do you remember that? And the gentleman that was up there spinning plates all the time, and he would run from one plate to the next—and as a hospital administrator, we literally look at making sure our services are available. And without doctors we can't provide those services. We are literally behind the scenes, we are spinning those plates, daily. In all my career the last 15 years, the most difficult have been these past three because people don't realize. I think the lady to my right talked about termites

eating away at the healthcare system; they are very active and this is very fragile at this point in time. And those plates that we keep spinning are going to fall. You saw it with Abington. We are concerned with the Mother Bachmann Center. The question that Congressman Greenwood asked earlier of Dench, how long can we hold this trauma center together? Our physicians have this IOU, and that IOU in their mind comes due April 30. We don't have a year, we don't have 6 months. We have April 30, and we have to move today. If we don't, like that gentleman this morning that came into our trauma center at 7:50 and went to the OR, that neurosurgeon won't be there, and that is not right.

Mr. DEUTSCH. Thank you.

Mr. GERLACH. Congressman Greenwood has asked that I assume the Chair for a few minutes while he is out, and so I am going to do that by using that time to ask some questions, and by that point maybe he will be back in and we can continue with his leadership on the panel here. But I have a couple of questions I want to raise. The first one, perhaps to Dr. Eskin, and maybe you, Mr. Wozniak, dealing with the trauma center issue. In Chester County, I served on the Brandywine Hospital Board of Trustees for a number of years, and Brandywine had a trauma center. Last year, in part because of the sale of the hospital to Community Health Services, a for profit entity out of Tennessee, but also because of the increasing costs of providing that 24-hour 7-day-a-week coverage that is required from a staffing perspective and a medical care perspective, to obtain and continue your trauma center certification, the partnership between the hospital and the University of Pennsylvania, which was providing the staffing and the service to the trauma center, that came to an end. And now Chester County does not have a trauma center and it is a county approaching 500,000 people, and the closest trauma center now would be to come to Abington, or go down to Christiana, Delaware, or over to Lancaster for that care. In following up on the comments by Ms. Dyess, I think—is that how you pronounce your last name?

Ms. DYESS. Yes.

Mr. GERLACH. That scares a lot of people in Chester County not having that kind of trauma center service available to folks in the area. So what is the ripple affect if something happens with Abington then and you are not able to continue to provide trauma center coverage? What does that do to this region in terms of the availability of those needed services? And what do you think the impact is, generally, on the community when trauma center services are not available within a certain geographical area?

Mr. ESKIN. I will start if that is okay. It is frightening from the perspective of one who lives in that community. We are, as I mentioned, the only accredited trauma center in Montgomery County, which is a very large county. And if we were to close, that means that ambulances would obviously bypass us with trauma patients. Patients would have to be either ambulanced or helicoptered to another institution further away. And as Congressman Greenwood said before, that first hour or that first period of time, you define as critical in terms of proven outcomes for victims of trauma. So as one who lives in this community and whose patients live in our community, it really is frightening.

Also, I would like to add that it is becoming extremely difficult to recruit the appropriate specialists to do what we need our trauma center to do. A specific example, a year ago we had seven neurosurgeons. Now we are down to five and we almost lost two of them in the last 2 months to another State. One of the neurosurgeons who left to practice in Ohio, married, in his 40's, wife, four children, believe me, he didn't want to move. For 3½ years this very capable individual attempted to recruit someone to join him of high caliber, and it was just—and I met a number of the people that came through from institutions whose name you would know, and a very good offer at a very good hospital. They chose to go elsewhere, they chose not to practice in our State. But to answer your question, specifically, it is a major concern to us in terms of what we can provide to our community.

Mr. GERLACH. And it is one thing where through Life Flight or Sky Care, the helicopter service, you are able to make up that distance problem pretty effectively through the speed of that service. On days like this, inclement weather, when the helicopters can't get up into the sky, then that ambulance route to the next trauma center becomes very problematic in terms of traffic issues and everything else, and then decreases the amount of the service and the quality of the service able to be provided depending on the time that the patient gets there.

And that really leads in—you are kind of leading me into the next question I had about objective data that is now tracking what is happening to recent graduates of our medical schools, either in this region—and maybe you would know, Dr. Dench, being the President of the Medical Society of Pennsylvania—or more nationally, Dr. Palmisano, maybe you have a sense of this. What is happening to the migration of good young physicians into areas where there is not a problem, real or perceived, with medical malpractice insurance rates versus migration in areas where there is, again, real or perceived crisis in medical malpractice rates. What is the short-term and long-term impact on the quality of care that a region can expect based on its ability to recruit and retain those physicians?

Mr. DENCH. Let me just say that when we questioned and emailed our residents, almost none of them were considering staying in Pennsylvania. And if they did, it was only because of family reasons. I am concerned in the near future that we are going to also have the difficulty in filing our residency programs. This State trains some of the finest physicians all over the country, a very high percentage of physicians relative to the population here are trained here because we have seven MD schools and two DO schools in this State. We see total indication that no one wants to say. The numbers don't show it again in the medical licensing because, of course, they got a license while they were a resident, and they keep the license, but they are not staying, they are not practicing here. They are leaving the State.

Mr. PALMISANO. We also find on a national level, for instance, I had the privilege to visit on behalf of the American Medical Association to Wheeling, West Virginia, and I met with the family practice residents there. In talking with them, none of them indicated they were going to stay in the State because of the medical liability

situation. In Wheeling, for instance, one of the emergency room physicians came up to me and said let me tell you what it is like here. If a 9 year old boy is knocked unconscious in a football game, even if he is unconscious for a minute or 2, and he is brought to me, I have to air-evac him because I don't have a neurosurgeon that does trauma anymore in the community. So even if the child looks okay now, the child could bleed later on and we need to intervene at that point. So he said I air-evac the child to either Pittsburgh, Pennsylvania or Columbus, Ohio, and 30 percent of the time the air ambulance can't fly because of fog or other adverse weather conditions. So in talking with the medical students, they are very much concerned. They hear about this, and they want to know what is happening in the States, and they are very concerned about the 12 States that have been designated as crisis States, and it will affect their location in practice, yes.

Mr. GERLACH. Do you at the national level or at the State level have data that maybe comes from the medical schools themselves as to where a percentage of their graduates went within the first year, within the second year, whatever it is, to demonstrate quantifiably that migration, let us say here in Pennsylvania, of graduates from medical schools, or perhaps being able to do that at the national level by taking data from all of the Nation's medical schools to track where those graduates are going regionally? Is there a way to do that if it doesn't exist now?

Mr. PALMISANO. Well, we certainly want to know that information, just like we want to know the numbers of physicians who are limiting their practice, retiring early, or moving to another State. So we ask all of the States to give us that information as they gather it. And the American Medical Association is trying to put together an information retrieval system so we can present to legislators the facts for their consideration, and that very issue is an excellent one to pursue.

Mr. GERLACH. Because just as important as it is to know how many of your experienced physicians in all the important specialties are leaving a particular area after 10, 15, 25 years of practice, it is also important for the future of a region to know how many young physicians are coming in and putting down roots, and are going to want to be in that community for their working lives. So if there is some way to gather that information and get that to the committee, that would certainly be of great use.

I wondered from Dr. Dench if he heard the testimony earlier, particularly, the exchange with Governor Rendell about putting some limitation on the mandated coverage in Pennsylvania. There was a lowering of that under Act 13 from $1.2 million down to $1 million. Do you have a sense of what would be the impact if that were lowered all the more in Pennsylvania, down to $500,000 or something like that, what the impact would be on practicing medicine, and more particularly, medical malpractice rates in the State?

Mr. DENCH. Well, clearly, as you saw in my testimony, it would cost us less. But I doubt very highly that many doctors can afford to have less than $1 million coverage. Presently, the hospitals all require that you have $1 million coverage independent really of whatever the other law is. We are at $1 million. Only one other State requires as much as Pennsylvania does. There is no question

that we require more, but in reality, most physicians, for example in California, have $1 million coverage. So having said that, I don't believe that is the answer because as it was pointed out in that testimony, you want to be able to cover a person who is injured. And there needs to be a coverage, and it seems unusual, to say the least, to think that you should lower the cap to $500,000 on economic loss and all losses whatsoever, and then be concerned about not lowering the non-economic cost to $250,000. What you are saying is that someone who has no economic loss should be able to take that cap when someone with economic losses is, essentially, capped at the same number, and that doesn't make sense to me.

Mr. GERLACH. And then on the issue, finally, of the premium relief that is being talked about for physicians through the use of insurance premiums, surpluses by insurance carriers, you seem to be pretty pessimistic of the ability to get that kind of proposal passed through the legislature. One of the things that was raised last year at some point, and I am just curious about the taskforce's discussions on this issue of whether or not given about $400 million that the Commonwealth is getting every year now through the national tobacco settlement agreement, whether there ought to be a discussion in the legislature and with Governor Rendell about reprioritizing the use of those dollars from what was initially passed, I guess about 1½ or 2 years ago, with the initial tobacco settlement legislation. It seems to be there was great consensus in the legislature that all of that money ought to be used for healthcare and health related issues, and it seems to me there can't be any higher priority than making sure that we retain good quality physicians and hospitals in Pennsylvania to provide that healthcare. Is there any discussions on the taskforce of using any of the tobacco settlement dollars that come in on an annual basis and tie that to premium relief for physicians?

Mr. DENCH. That was on the list. As I said, there was a whole list of items that we thought were possible places that you could get the money, and one of them was there. We had thought on the taskforce that that is a political decision, where to get the money, and that we just said that we need this money in the short run. In fact, we opposed from the Medical Society saying that for 3 years. We think this problem may take 3 years to solve, because that is how long it will take caps. But we did not want it put on the back burner because we solved the financial crisis for 3 years by throwing gasoline on the fire. We believe we have to solve the problem, and the problem can only be solved when we get meaningful caps, contingency fees, and several other of the proposals we have out there. We have a considerable amount of them with Act 13, but the biggie is caps and contingency fee limitations.

Mr. GERLACH. Thank you very much. I appreciate it. Congresswoman Schakowsky, do you have questions?

Ms. SCHAKOWSKY. Thank you very much. I appreciate very much all of this panel, and I want to direct myself to Dr. Palmisano. You know, for the last couple of years, doctors and patients have really been on the same side advocating in Washington for a patient's bill of rights. We have been trying to put power back into the hands of healthcare professionals to make decisions about patient care, and we have yet to be successful. And I hope that we can continue

to do that because I think when we talk about the quality of the ability of doctors to operate and for the benefit of their patient, that we do need to look at power that has been taken from them by HMO's and others.

And also, we have talked about the responsibility of HMO's, the accountability when things go wrong because often they tell you that you can't practice the kind of medicine that you would like to do. And that is really where we should be, patients and doctors on the same team. And I agree. I think it was Dr. Dench that testified that the liability crisis is "driving a wedge between patients and their doctors". We agree on the problem, that there are particularly some high risk specialties that are paying very high rates and that insurance rates are a problem. And I was as moved by your testimony, Ms. Dyess, as I was by Heather's, where you come to different conclusions. But what I don't understand is why, as healers, the profession focuses almost entirely on victims rather than on the insurance companies that are imposing the high rates.

You talked about—I think it was you, Dr. Palmisano, that talked about caps opponents being an affront to both doctors and patients, and I think the focus on caps in many ways is an affront. The insurers themselves tell us that rates won't go down with caps. "Insurers never promised that tort reform would achieve specific savings from the American Insurance Association." "We wouldn't tell you or anyone that the reason the passed tort reform would be to reduce insurance rates," Sherman Joyce, President of the American Tort Reform Association. So it is unclear to me from the evidence, just the evidence. Given the States you said, you refer to a patient in Florida. Florida has caps. They have the caps that we are talking about in Mr. Greenwood's bill, so where is the evidence?

And so what I am asking is would the AMA, would the doctors support requirements that in legislation that capped victims? And I wanted to—let me say something before I finish that question to Heather, because I just want to congratulate you. Through all that you have gone through, I know that you graduated from high school on time. Is that right?

Ms. LEWINSKI. Yes.

Ms. SCHAKOWSKY. I mean, that is really remarkable, and I want to thank you so much for the courage that it came here—I asked you, I thought, well, maybe you have done this before. This is your first time testifying before a hearing. You did a great job and I congratulate you for your courage not just today but over the many years. So I want to thank you and tell you how much I really appreciate it. But these bills do not require that rates go down. Given States that have caps on awards and on settlements, that have caps on non-economic damages, the rates haven't gone down in every case. So why are you so focused on that as the solution to the problem? Why is this your No. 1 answer?

Mr. PALMISANO. Yes, ma'am. Thank you very much for those questions. Is it okay if I go down the list? The first thing, we believe we are acting on behalf of patients and physicians, the issues on the patient's bill of rights. And as you know, the American Medical Association continues to advocate a fair contract for patients, physicians, and insurance companies. And on the AMA website, we have a model managed care contract. It is in its at least second edi-

tion now, and we believe it is fair to insurance companies, physicians, and patients.

Ms. SCHAKOWSKY. I would rather not focus on that.

Mr. PALMISANO. Okay. I will go down the list. And we also have just published our market concentration study which shows that these insurance companies have too much market power and they can control the rates paid to physicians. So we are continuing to aggressively move on that particular front. We believe that when you look at caps, that you have to go down a little deeper and say what kind of caps. For instance, Missouri has a cap but it is a cap, it started off around $300,000 or $350,000, and its index up and now it is over $500,000. It is a cap per claimant and a cap per physician. That is very similar——

Ms. SCHAKOWSKY. So you wouldn't support a $500,000 cap?

Mr. PALMISANO. Well, what we have said is we know that the $250,000 non-economic cap, a fixed cap in California per incident, is one that has worked over a quarter of a century.

Ms. SCHAKOWSKY. Well, we are going to hear testimony that disputes that entirely, that after the caps were initiated, that rates continued to go up until there was actually rate regulations, so we will hear that.

Mr. PALMISANO. Well, yes, but that is Proposition 103 in California, and when we looked into that, we tried to look into all of the issues that are brought up, because we want the legislators to have the facts. We found that Proposition 103, actually, the court didn't allow the rate rollback. What they did allow was that if someone wants to raise the rates more than 15 percent, then they would have to have a public hearing, and we have not found any instances where the medical liability rates actually were reduced as a result of Proposition 103. We also know that the other States, Wisconsin, Colorado, and Louisiana, Indiana, New Mexico, they don't have a Proposition 103. We believe that every insurance commissioner has the duty to make sure that the rates are justified based on frequency, severity, and actuarial review. So when people say will you support—and I think that is the main thrust of your question, unless I am mistaken, will you support a measure that forces them to reduce the rates. What we are saying is the free marketplace ought to allow companies to come in. Right now, we see them all running out. We see no one rushing in. What we found in Nevada when I had the privilege to testify for AMA, right after our level one trauma center, was a joint meeting of the House and the Senate. After I gave my testimony, they introduced an individual who was brought in to start an insurance company just for Nevada, and they had their own actuary, and my question—I said, may I ask a question, and they said sure. My question was, well, what will the rates be for the obstetricians now that you have studied the frequency and the severity, and they said around $90,000, as I recall the answer. Well, that was about the price that the insurance company that was leaving, or the one they were complaining, around $90,000 to $100,000, and we know that the physicians there who were obstetricians could leave with their same record and move to California and their rates drop down——

Ms. SCHAKOWSKY. You know, I am going to ask that we put up Exhibit 4, that actually refers to California, if we could put it up

there. Where we see that after MICRA was instituted, that the rates went up, that they went up rather high. From the beginning of the chart up to the green line is under MICRA, and we can go State by State and look at those. I don't understand why you wouldn't say then if your main answer to why rates will be reduced if we impose caps, why don't we say you have to then?

Mr. PALMISANO. Well, you know, you have to look at the whole picture when you compare, and Chairman Greenwood made the point about the rates going over a quarter of a century. The rates went up around 167 percent in California, compared to the rest of the Nation, the average was 505 percent. In one of the earlier slides, where they talked about average rates, we need to compare apples to apples. We need to compare Los Angeles to Miami to Philadelphia, and we need to look at the specialty mix. We need to look—all we know is that physicians are closing their practice, retiring earlier, or limiting their practice, and we find patients at risk of not having access to care in that critical moment when they are in need so——

Ms. SCHAKOWSKY. If I could just—on Pennsylvania, if we could have number 12 of our exhibits? This, Dr. Eskin, is—you told us this, reasons for doctors leaving the State, and the yellow being medical malpractice, and the green, new professional and personal opportunity. So then we wanted to know in the yellow, medical malpractice, where did they go. So if we could look at chart number 13, and what we find is that the majority moved within Pennsylvania or to States with no caps. I mean, you know, the overwhelming majority did. Some moved to States that had a much higher cap than is proposed in the chairman's legislation. The orange are people who simply retired. You may argue they wanted to retire, you know, because of this. I don't know. But clearly, most people stayed here in Pennsylvania and probably had a lot of reasons for leaving the practice that they do. Again, this focus on not only the rates, I understand that. I agree with you on that, but as this one solution that you don't even want to make as mandatory.

Mr. PALMISANO. Well, Tillinghast just did a study for the Medical Society in New Jersey at the request of the Medical Society to evaluate two bills that were proposed in their legislature as to whether or not it would have any effect, and they concluded that the bills would not, but they did state in that, and that was a public announcement, there was a press conference involved with it, that the $250,000 cap would lower rates. And as you increased the fixed cap, when you get to $500,000, then it has no further effect. So I think there have been enough studies, and that is the challenge that all of you as legislators have, to listen to all of these facts, and to come out with something that works. All we are saying is that the States with the fixed caps are the ones that are the stable States, the six States are stable, and what we hope is that when the final decision is made, either at the State level or at the Federal level, we will have doctors around to take care of patients. It is——

Ms. SCHAKOWSKY. Well, let me just end this by saying after all is said and done, we have to balance that with people like Heather, and say that if the awards and settlements aren't a significant enough part of the reason that rates are high, which I would con-

tend that that is the case, why would we go after people who, especially, people who are ineligible for high economic awards—that is going to be women, and children, and the elderly, and persons, low income people that have low wage earning jobs. Why would we choose to go after victims not only of malpractice but of prescription drug manufacturers, of nursing homes, of medical device companies, all of which are included in this legislation. You are lumped with all of those. Do you think you should be lumped with those?

Mr. PALMISANO. Well, what we are advocating for is a way to keep the physicians in practice, and we believe that the Bill H.R. 5 is a way to keep physicians in practice. Representative Greenwood, Chairman Greenwood, is going to be the expert on what should be done in Congress to make sure we can get it through the Senate at the national level. And so what we are saying is you do have to balance everything. You have to balance to make sure that physicians are available to treat patients. And we know that the models in the six States, the California model is the one that AMA has embraced since 1989, is a model that works. But it is a difficult task that you have and we want to make sure, and that is why we want to help. We want to get as much information to you so that you can properly evaluate all of this. But the important thing is to come up with a mechanism that keeps physicians in practice.

Ms. SCHAKOWSKY. And finally, let me just say that Democrats, and myself included, and let me just—those of us who oppose caps want to address this problem. We want to be partners with doctors. We want to be advocates for patients, and for victims, and for doctors to stay in practice. I just don't think this notion of caps is the way to go. Thank you.

Mr. GREENWOOD. The Chair thanks the gentlelady. I do want to correct the record in one regard. The gentlelady from Chicago said that Florida has caps. In fact, Florida doesn't have caps and, in fact, their Governor's taskforce, the Governor's taskforce recommendation is that the legislature should in medical malpractice cases cap non-economic damages at $250,000 per incident. So the Governor's taskforce on medical malpractice doesn't think that it has that cap. I did let the——

Mr. DEUTSCH. Mr. Chairman, if I can note—I mean, the only time caps do not apply in Florida is with a doctor who rejects arbitration. There are caps in Florida.

Mr. GREENWOOD. All right. Well, we will need to sort that out because, obviously, we have different sources. I did want to let the gentlelady from Chicago have an extra 3 or 4 minutes. I just did want to ask Dr. Eskin if he wanted to comment about the reasons for doctors leaving Abington Hospital and make sure that you feel that information was accurate.

Mr. ESKIN. I will be very brief. The number of physicians represented by that entire pie diagram was 15. For example, the big orange wedge was one person who, in fact, retired much earlier than he had hoped to retire. Of the 15 physicians that were in that pie chart, in fact, 3 remained in Pennsylvania; the other 12 left. And the point that we have been trying to make is just that our physicians are leaving, it is more difficult to recruit physicians to replace and enhance the skills which we have lost. We really have a problem and we really ask for your help in helping to solve that

problem. We know that it is a complex problem, not a single issue problem, and we are asking for help in bringing this to a proper solution. Thank you.

Mr. GREENWOOD. We appreciate that. And of course, the legislation that I proposed is not just about caps. It touches on a whole host of remedies which we don't need to enumerate right now. I want to thank each of the witnesses, particularly, you, Heather, who have traveled from New York; and you, Ms. Dyess, who traveled from Mississippi, and not only did you travel, but your stories are very personal and very poignant, and it took a lot of courage for both of you to be here. Thank you all. This panel is excused, and we will call up the next panel.

Our third and final panel consists of Mr. Lawrence Smarr, President of Physicians Insurers Association of America; Mr. James Hurley, Chairperson of the Medical Malpractice Subcommittee of the American Academy of Actuaries; Mr. Scott Diener, President and Chief Operating Officer of PMSLIC; Mr. Alan G. Rosenbloom, President and Chief Executive Officer of the Pennsylvania Health Care Association and Center for Assisted Living Management; Thomas J. Nasca, Dr. Thomas J. Nasca is the Dean of Jefferson Medical School; Dr. Harvey Rosenfield, President of the Foundation for Consumer and Taxpayer Rights; Ms. Diane Menio——

Ms. MENIO. Menio.

Mr. GREENWOOD. Menio?

Ms. MENIO. Yes, sir.

Mr. GREENWOOD. [continuing] Executive Director of the Center for Advocacy for the Rights and Interests of the Elderly; Mr. John Reed of Selinsgrove, Pennsylvania; Dr. Neil Vidmar, Professor of Law at Duke Law School; and Mr. James Mundy of Philadelphia.

We welcome all of you. We thank you for the patience you have evidenced so far and the patience you will be required to evidence for the next hour or so. We have all but—Okay. I think if you were here earlier today, you know that—you have heard me say twice now that this is an investigative hearing, and it is the custom of this committee to take testimony in investigative hearings under oath. And so I would ask if any of you have objections to giving your testimony under oath this afternoon? Seeing no such objection, I would advise you that pursuant to the rules of this committee and the House of Representatives, that you are entitled to be represented by counsel, and ask if any of you wish to be represented by counsel today for your testimony? Seeing no such request, I would ask if you would rise and raise your right hand, and I will give you the oath.

[Witnesses sworn.]

Mr. GREENWOOD. Okay. You are under oath. Now, we are going to ask that the three of our witnesses who are about to be identified for me, Ms. Menio, Mr. Rosenbloom, and Mr. Doyg. Are you going to testify, Mr. Doyg?

Mr. DOYG. I think Ms. Menio is going to read a statement. I am available for any questions that you might have.

Mr. GREENWOOD. Okay. Well, if you need to, you may advise her with regard to her testimony, but if you need to speak yourself, then we will have to swear you in.

Mr. DOYG. Certainly.

Mr. GREENWOOD. But we are going to ask that Ms. Menio and Mr. Rosenbloom give their opening statements first. Then we are going to ask questions of them, and that is because Ms. Schakowsky needs to get a plane and wants to make sure that she participates in this part of the discussion, and then we will take statements from the rest of the witnesses. And so we will start with Mr. Rosenbloom, President and Chief Executive Officer of the Pennsylvania Health Care Association.

TESTIMONY OF ALAN G. ROSENBLOOM, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PENNSYLVANIA HEALTH CARE ASSOCIATION AND CENTER FOR ASSISTED LIVING MANAGEMENT; DIANE A. MENIO, EXECUTIVE DIRECTOR, CENTER FOR ADVOCACY FOR THE RIGHTS AND INTERESTS OF THE ELDERLY; LAWRENCE E. SMARR, PRESIDENT, PHYSICIANS INSURERS ASSOCIATION OF AMERICA; JAMES HURLEY, CHAIRPERSON, MEDICAL MALPRACTICE SUBCOMMITTEE, AMERICAN ACADEMY OF ACTUARIES; SCOTT DIENER, PRESIDENT AND CHIEF OPERATING OFFICER, PMSLIC; THOMAS J. NASCA, DEAN OF JEFFERSON MEDICAL SCHOOL; HARVEY ROSENFIELD, PRESIDENT, FOUNDATION FOR CONSUMER AND TAXPAYER RIGHTS; JOHN H. REED; NEIL VIDMAR, PROFESSOR OF LAW, DUKE LAW SCHOOL; AND JAMES MUNDY

Mr. ROSENBLOOM. Thank you, Chairman Greenwood, and also to the members of the subcommittee, thank you for the opportunity to appear here today. My name is Alan Rosenbloom and I serve as President and Chief Executive Officer of the Pennsylvania Health Care Association and its sister organization, the Center for the Assisted Living Management. The association represents about 325 long-term care providers and senior service providers across the Commonwealth of Pennsylvania.

We, especially, appreciate the opportunity to discuss the effects of the medical liability insurance crisis on nursing homes and other long-term care providers. For too long, State and Federal officials have not seen long-term care as part of an integrated healthcare delivery system. The challenges facing long-term providers, however, mirror and in some areas are more acute than those facing physicians and hospitals. Given that Pennsylvania is the second oldest State in the Nation as defined by the percentage of our population age 65 or older, and given that the fastest growing age group in the Commonwealth is the 85 and older cohort, it is both necessary and appropriate that our Federal and State officials appreciate that key legislative and policy changes must encompass long-term care providers if they and we hope to craft a workable healthcare system for today's seniors and for tomorrow's aging baby boom.

Put simply, liability insurance for long-term care providers in Pennsylvania increasingly is unavailable and unaffordable, and now poses a growing threat to access to care. In 1999, seven carriers offered professional liability insurance to long-term care providers in this State. By 2001, that number had shrunk to four, which dropped to three in 2002. For all practical purposes, today, two or fewer carriers now appear willing to write new long-term care business in Pennsylvania.

Not surprisingly, insurance and related costs have skyrocketed. Since Pennsylvania requires nursing facilities to maintain insurance and to participate in the CAT and MCare Funds, about which other witnesses have testified, much of my commentary will focus on them. I would like you to note, however, that the basic trends identified affect the entire continuum of long-term care and senior services, from nursing homes and assisted living providers, to integrated retirement communities, to home care providers and community based providers.

In 2001, rates for primary coverage for nursing homes increased by as much as 87 percent. In each year since, primary premiums have increased by as much as 500 percent for both nursing homes and assisted living residences. In addition, the CAT Fund surcharges and MCare Fund assessments have skyrocketed as well. In 2002, for example, CAT Fund surcharges for nursing homes increased by as much as 121 percent. MCare surcharges for 2003 increased at least 43 percent for most nursing homes across the Commonwealth. I offer a few specific examples. Belle Haven is a single site facility, family owned facility, providing nursing home and personal care home services. It has 59 beds, it is located in Quakertown, Pennsylvania. In its 40-year history, Belle Haven has had no loss experience whatsoever, no claims, no judgments, no settlements, no awards. From 2001 to 2002, its primary premium increased 336 percent. From 2002 to 2003, it increased another 74 percent. During that last year, its MCare Fund assessment also increased by 97 percent.

Gwynedd Square is a freestanding nursing facility with 181 beds located in Lansdale. It has had no claims in 15 years. From 2000 to 2001, its premium for $10 million in coverage, which represented both primary and excess coverage above the CAT Fund layer, increased 112 percent. From 2001 to 2002, the cost of the policy grew so great that the facility cut its coverage in half merely to maintain its existing premium level. There are other examples in the written testimony, which in the interest of time, I will not present at the moment.

What is ironic about this is that the loss experience among long-term care providers in Pennsylvania does not justify such precipitous increases in insurance costs. In 2000, for example, the average non-zero claim against a nursing home in this State, that is one that actually resulted in the payment of money, was $61,000, well below the national average of $246,00 and well below the current CAT Fund attachment point of $.5 million. From the inception of the CAT Fund in 1976 until July 2001, the CAT Fund in this State paid only $2.6 million in nursing facility claims, yet, collected more than $41 million in surcharges from nursing homes. In other words, nursing homes paid in more than 15 times what the CAT Fund paid out on their behalf. What is driving our insurance rates in Pennsylvania is not our loss experience here; it is loss experience in other States, is general market conditions affecting the insurance industry, and it is generalized concern about the out of control malpractice environment for physicians and hospitals in Pennsylvania. This reality underscores the need for reform that encompasses the entire healthcare delivery system, including long-

term care providers, as well as the need for both Federal and State reforms if we are to stabilize the insurance marketplace.

While we applaud the various tort reforms adopted by the Pennsylvania General Assembly in the past 18 months, we reluctantly agree with the Governor, that much remains to be done. While we are heartened that the Rendell administration has urgently focused on the liability crisis, we are dismayed that it has approached to date ignores the long-term care component of the Commonwealth's healthcare delivery system. Despite the Governor's recognition this morning that a key factor in this whole problem is the rising insurance shrinking reimbursement vice, as the Governor eloquently noted, about 70 percent of long-term care in this State is paid for by the combination of Federal and State government, so this vice is uniquely one that the Federal Government can solve.

We do appreciate, Congressman Greenwood, H.R. 5, which you introduced last week, and which extends relief to the entire healthcare delivery system, whether healthcare services are provided in hospitals, physicians' offices, long-term care settings, or home and community based care settings. Absent prompt and meaningful reform, however, it is certain that frail, vulnerable seniors in Pennsylvania will face access to care difficulties. In fact, we have already begun to see such problems manifest. In late December 2002, Temple University Hospital announced the closure of the Temple Continuing Care Center in North Philadelphia. In addition to this 538-bed facility, Temple closed two other nursing homes that year, the 180-bed Elmira Jeffries Nursing Home and the 140-bed Northwood Nursing and Convalescent Center. According to press reports, liability insurance costs were cited as a significant contributing factor in all three of those closures.

As a result, some of Philadelphia's most frail and vulnerable citizens were relocated from facility to facility and some of the Temple's Continuing Care Center's 450 residents were transferred as far away as Hazelton, Pennsylvania. The added stress of such a long move undoubtedly exacerbated the transfer trauma nursing home residents typically suffer during any relocation. Given the demographics of the North Philadelphia area in which the Temple Continuing Care Center was located, it seems unlikely that many family members of residents will have easy access to cars, and it is certain that travel from North Philadelphia to Hazelton without a car is difficult at best and impossible at worse. Consequently, closures of this kind may well cut residents off from family and friends forever.

A more prevalent and insidious threat to quality care underscores just how crucial it is that we address this problem systemically. Due to growing liability costs, fewer physicians are available or willing to serve as medical directors or attending physicians in nursing homes. Physicians who do undertake these roles face increasing difficulties in finding specialists for referrals of nursing home residents. Unless we take action to stem the rising tide of liability, closures and relocations will become all too routine for the more than 135,000 frail, elderly Pennsylvanians who rely on nursing homes and assisted living residences to support their needs. Unless we take action, our seniors increasingly will not have the access to primary care physicians and specialists they need. Unless

we take action, the more than 700 nursing facilities and 1,800 personal care homes in Pennsylvania will face increasingly serious financial difficulties, threatening the $2.2 billion they pay in salaries to 165,000 employees in Pennsylvania and the $30 million they pay in local property taxes each year. Indeed, since the government is the primary payer of long-term care and senior services in this country, through the Medicaid program, and to a lesser extent, through the Medicare program, ultimately, the cost of increasing liability costs for the long-term care segment of the healthcare delivery system are disproportionately born by government as those costs are passed along through the system.

It is noteworthy that in States that have not pursued liability reforms that recognize the entire spectrum of the healthcare system we have seen situations where Medicare—Medicaid, pardon me—is now paying as much as 30 percent of every single dollar, 30 cents of every dollar that is supposed to care for seniors in long-term care settings is going to pay insurance costs, it is going to pay settlements and judgments. I, respectfully, submit that that is not an appropriate use for the public fisc when money is designed to provide quality care and services to older citizens and other vulnerable populations with special needs.

In conclusion, the professional liability situation for long-term care providers in Pennsylvania is bleak. We are on a course that will deprive frail and vulnerable seniors access to quality care and services, prevent providers from devoting optimal resources to patient care, and compel government to devote a growing percentage of scare Medicaid dollars to liability rather than patients. We must alter that course quickly and effectively for the good of the Commonwealth and the good of the Nation. Thank you.

[The prepared statement of Alan G. Rosenbloom follows:]

PREPARED STATEMENT OF ALAN G. ROSENBLOOM, PRESIDENT AND CEO, PENNSYLVANIA HEALTH CARE ASSOCIATION AND CENTER FOR ASSISTED LIVING MANAGEMENT

Chairman Greenwood and members of the subcommittee, thank you for the opportunity to testify today. My name is Alan Rosenbloom and I serve as President and Chief Executive Officer of the Pennsylvania Health Care Association and its sister organization, the Center for Assisted Living Management. The association represents 325 long term care and senior service providers across the Commonwealth of Pennsylvania. Our members include publicly traded companies, closely held companies, non-profit facilities and county facilities, and their services run the gamut from integrated retirement communities and multi-level care campuses, to free-standing nursing homes and assisted living/personal care homes to ancillary care and home care enterprises.

We especially appreciate the opportunity to discuss the effects of the medical liability insurance crisis on nursing homes and other long term care providers in Pennsylvania. For too long, state and federal officials have not seen long term care providers as part of the health care delivery system. The challenges facing long term care providers, however, mirror and, in some areas are more acute than, than those facing physicians and hospitals. Given that Pennsylvania is the second-oldest state in the nation, as defined by the percentage of our population age 65 or older, and given that the fastest-growing age group in the Commonwealth is the 85+ cohort, it is both necessary and appropriate that our federal and state officials appreciate that key legislative and policy changes must consider long term care providers if they hope to craft a workable health care system for today's seniors and tomorrow's aging Baby Boom.

Put simply, liability insurance for long term care providers in Pennsylvania increasingly is unavailable and unaffordable, and now poses a major threat to access to care. In 1999, seven carriers offered professional liability insurance to long term care providers in the state. By 2001, the number had shrunk to four, which dropped

to three in 2002. For all practical purposes, two or fewer carriers now appear willing to write new long term care business here.

Not surprisingly, insurance and related costs have skyrocketed. In this context, it should be understood that nursing homes in Pennsylvania must maintain primary insurance coverage and participate in the CAT Fund/MCare Fund [1] as a condition of licensure, while personal care homes/assisted living residences and other long term care providers are not required by licensure to do so. As a result, I will address the situation confronting nursing homes separately, unless otherwise noted. The subcommittee should appreciate, however, that the basic trends identified affect the entire continuum of long term care and senior services.

In 2001, rates for primary coverage increased by as much as 87%. In each year since, primary premiums have increased by as much as 500% for both nursing homes and assisted living residences. In addition, the CAT Fund surcharges and MCare Fund assessments imposed on nursing homes have skyrocketed as well. In 2002, for example, CAT Fund surcharges for nursing homes increased by as much as 121% for nursing homes throughout Pennsylvania. MCare surcharges for 2003 increased at least 43% for most nursing homes. I offer a few specific examples to illustrate these trends:

- **Belle Haven.** Belle Haven is a single site, family owned nursing home and personal care home with 59 nursing beds located in Quakertown, Pennsylvania. In its 40 year history, Belle Haven has had no loss experience whatsoever. From 2001 to 2002, Belle Haven's primary premium increased 336% and grew another 74% from 2002 to 2003. From 2002 to 2003, the facility's Mcare Fund surcharge increased 97%.
- **Gwynedd Square.** Gwynedd Square is a freestanding nursing facility with 181 beds located in Lansdale, Pennsylvania. Gwynedd Square has had no claims in 15 years. From 2000 to 2001, its premium for $10 million in coverage (both primary and excess above the CAT Fund layer) increased 112%. From 2001 to 2002, the cost of the policy grew so great that the facility cut its coverage in half to maintain a level premium.
- **Wilmac Corporation.** Wilmac Corporation, based in York, Pennsylvania, operates five nursing facilities and a retirement community at various sites in the Commonwealth. Despite no claims during the prior reporting period, Wilmac's premium increased 479% from 2001 to 2002, yet its deductible rose from zero to $50,000 per incident.
- **George M. Leader Family Corporation.** The George M. Leader Family Corporation, based in Hershey, Pennsylvania, operates assisted living residences and nursing homes across the Commonwealth. In 2000, it purchased $25 million of coverage. In 2001, despite modest claims experience, no insurer would offer more than $5 million in coverage, yet the premium for ⅕th the coverage increased 31%, representing an effective 150% increase.

Ironically, loss experience among long term care providers in Pennsylvania does not justify such precipitous increases in insurance costs. In 2000, for example, the average non-zero claim against nursing homes was $61,000, well below the national average of $246,000 and the $500,000 threshold for CAT Fund attachment. Indeed, from its inception in 1976 until July 2001, the CAT Fund paid only $2,670,000 in nursing facility claims, yet collected $41,449,325 in surcharges from nursing homes. Nursing homes paid surcharges of more than 15 times the amount that the CAT Fund paid on their behalf.

Clearly, factors *other than* Pennsylvania-specific loss experience are causing precipitous increases in professional liability insurance costs. Nursing home loss experience in other states, general market conditions affecting the insurance industry and generalized concern that the "out-of-control" malpractice environment for physicians and hospitals in Pennsylvania are the true drivers of our costs. This reality underscores the need for reform that encompasses the *entire* health care delivery system, including long term care providers, as well as the need for both federal and state reforms, if we are to stabilize the insurance marketplace.

While we applaud the various tort reform initiatives adopted by the Pennsylvania General Assembly in the past 18 months, we reluctantly must conclude that those initiatives have not been sufficient. While we are heartened by the Rendell Adminis-

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[1] As the Subcommittee presumably is aware, from 1976 until 2002, Pennsylvania maintained a Catastrophe Loss Fund, or CAT Fund, which afforded an initial layer of excess coverage to physicians, hospitals, nursing homes and a few other provider types. The CAT Fund was administered by the state but funded by surcharges on providers. In 2002, Pennsylvania replaced the CAT Fund with the Mcare Fund, as part of a broader plan to eliminate this intermediate government-administered insurance layer altogether. During the transition, however, the MCare Fund continues to assess providers in a manner substantially similar to the CAT Fund.

tration's urgent focus on the malpractice crisis, we are dismayed that its approach to date ignores the long term care component of the Commonwealth's health care delivery system. We do appreciate, however, that H.R. 5, which Congressman Greenwood introduced last week, extends to the entire health care delivery system, whether health care services are provided in hospitals, physicians offices, long term care settings or home-and-community-based care settings.

Absent prompt and meaningful reform, it is certain that frail, vulnerable seniors in Pennsylvania will face access to care difficulties. In fact, we already have begun to see such difficulties manifest. In late December of 2002, Temple University Health System announced the closure of the Temple Continuing Care Center located in North Philadelphia. In addition to this 538-bed facility, Temple closed two other nursing homes in 2002, the 180-bed Elmira Jeffries Nursing Home and the 148-bed Northwood Nursing and Convalescent Center. According to press reports, liability insurance costs were cited as a significant contributing factor in all three closures.

As a result of these closures, some of Philadelphia's most frail and vulnerable citizens were relocated from facility to facility, with some of the Temple Continuing Care Center's 450 residents transferred as far away as Hazleton, Pennsylvania. The added stress of such a long move undoubtedly exacerbated the "transfer trauma" nursing homes residents typically suffer during any relocation process. Given the demographics of the North Philadelphia area in which the Temple Continuing Care Center was located, it seems unlikely that many family members of residents will have easy access to cars and it is certain that travel from North Philadelphia to Hazleton without a car is difficult at best and impossible at worst. Consequently, closures of this kind may well cut residents off from family and friends forever.

A more prevalent and insidious threat to quality care underscores just how crucial it is that we address the malpractice liability crisis systemically. Due to growing liability costs, fewer physicians are available or willing to serve as medical directors or attending physicians in nursing homes. Physicians who do undertake these roles, moreover, face increasing difficulties in finding specialists for referrals of nursing home residents.

Unless we take action to stem the rising liability tide, closures and relocations will become all too routine for the more than 135,000 frail, elderly Pennsylvanians who rely on nursing homes and personal care homes to support their housing, social and health care needs. Unless we take action, our seniors increasingly will not have access to the primary care physicians and specialists they need. Unless we take action, the roughly 700 nursing facilities and 1800 personal care homes in Pennsylvania will face serious financial difficulties, threatening the $2.2 billion they pay in salaries to 165,000 employees and the $30 million they pay in local property taxes each year.

Unless we take action, taxpayers will bear the brunt of escalating liability costs. In the Commonwealth, the Medical Assistance (Medicaid) program pays for roughly 70% of nursing home days. Since liability costs are apportioned to the Medical Assistance program and since the state and federal governments fund Medicaid jointly, the taxpayers ultimately will bear the burden of these costs.

It is noteworthy that the Commonwealth already has acknowledged this problem, at least with respect to county nursing homes. Our state and county governments have capitalized a captive insurance company to offer more affordable liability insurance to the Commonwealth's 40 or so county-owned nursing homes. While somewhat beyond the scope of today's hearing, this fact both reflects the severity of the problem and counsels in favor of affording similar relief to non-governmental long term care providers.

It also is noteworthy that, in states that have not pursued liability reforms encompassing the entire health care delivery system, the result has been catastrophic not only with respect to claims and access, but also with respect to Medicaid costs. In at least one such state, fully 30% of every Medicaid dollar paid to nursing homes and assisted living residences funds insurance, lawyers, settlements or awards rather than patient care and services.

Frankly, the professional liability situation for long term care providers in Pennsylvania is bleak. We are on a course that will deprive frail and vulnerable seniors access to quality care and services, prevent providers from devoting optimal resources to patient care and compel government to devote a growing percentage of scarce Medicaid dollars to liability rather than patients. We must alter that course quickly and effectively for the good of the Commonwealth and the nation.

Thank you for the opportunity to appear to day. I am happy to entertain questions.

Mr. GREENWOOD. Thank you, Mr. Rosenbloom. Ms. Menio. Help me pronounce that.

Ms. MENIO. Menio.
Mr. GREENWOOD. Menio. Okay.

TESTIMONY OF DIANE A. MENIO

Ms. MENIO. Thank you, Mr. Chairman, for inviting me. My name is Diane Menio and I represent CARIE, which stands for the Center for Advocacy for the Rights and Interests of the Elderly. Are you hearing me? I am sorry. CARIE stands for the Center for Advocacy for the Rights and Interest of the Elderly. We have been advocating for older adults for over 25 years. Notably, one of the programs we have is a long-term care ombudsman, in which we go into nursing homes and personal care homes to help resolve complaints that they have. We cover more than 7,500 residents in 140 nursing homes in Philadelphia, and we also have other programs. We try to be part of the solution as well.

We have an elder abuse prevention training program which has been replicated nationwide, in which we go out and try to train staff in detecting and preventing abuse and neglect. I also should tell you that Mr. Marty Berger sends his regards and he is the President of the Pennsylvania Alliance for Retired Americans. It is a 250,000 member group of older adults who are mostly retired Union members, steelworkers, mineworkers, and so on, and he concurs with what I am going to be saying.

Medical liability presents a dynamic issue for advocates concerned about older adults. The issue embraces two major areas of interest, access and quality, and as Mr. Rosenbloom very eloquently talked about the stress on the system and residents, we are concerned about those issues as well. As medical malpractice is splashed through the headlines, the problem of rising premiums and the impact on physicians, hospitals, nursing facilities, personal care homes, and other providers, presents a compelling problem that needs a legislative solution. No one wants to see a caring physician forced out of his or her practice or a quality nursing facility close its doors. It is also troubling when quality nursing home or personal care home providers must be higher insurance premiums when those financial resources could be expended on caring for residents.

While residents receive quality care at most long-term care facilities, there are serious problems with quality care at numerous nursing facilities and personal care homes. Since there are about 55,200 residents in approximately 785 nursing facilities and 1,800 personal care homes, serving about almost 80,000 residents in Pennsylvania, there is much at stake. Advocates have been fighting for years at the State and Federal level for reforms needed to improve the crisis and care provided. Pennsylvania, like the rest of the Nation, has a real crisis regarding the quality of care provided at long-term care facilities. There are numerous studies and research documents documenting the extensive problems that exist. In Pennsylvania, the Pennsylvania Health Law project recently released a white paper that examined data from the Pennsylvania Department of Public Welfare. And using the Department's own records, it shows how homes have been allowed to operate sometimes for years, even when they are jeopardizing the health and safety of residents.

Pennsylvania Auditor General Bob Casey also highlighted serious problems with the oversight of nursing facilities and personal care homes. All of these things can be found online. A quote from his report, "Health permitted five nursing homes with a total of 549 Federal and State deficiencies to continue operating with no sanctions." So we are seeing problems in these places and they are not—the oversight that is in place, it doesn't seem to be working.

Insurance carriers should consider the enforcement actions, licensing history, and claims history when determining premiums. Certainly, the examples that Mr. Rosenbloom presented are of places that haven't had this history, that don't have the risk, and we would like to see them not jeopardizing resident care because of those benefits. We have talked a lot about public citizen, and you know what the statistics show. I just wanted to talk about—I have a couple of case examples in my testimony, but yesterday, in the Philadelphia Enquirer, on the front page, you might have seen a story about a very awful—I don't know how to say it, but it was a horrible situation of resident abuse not too far away from here in Yardley, in which a resident was stomped to death. And in that case, according to the article, there were 29 incidents, and this comes from the Grand Jury, 29 incidents of abuse or of unexplained injury is the way it is described in 8 months before this man died. And of those 29 incidents, all but four were during the shift of the person who is accused of having committed this harm on this individual. In addition, there were reports of her having taken drugs from residents, and in fact, when one of the staff who saw her do that reported it to the administrator, she was fired.

And so I talk about that case because this is not very dissimilar to other cases that we see. I met Congresswoman Schakowsky last year at a press conference for staffing in nursing homes, and we know that there are very severe problems with staffing. I don't know why this person's egregious actions were overlooked, but they were, nevertheless, and I do know there is a severe staffing shortage. I also noted the average wage for personal care home workers in the State of Pennsylvania is about $6.50 per hour. I am not a high paid person. I work for a non-profit organization, but I can't remember the last time I worked for $6.90 an hour. I know that I could not take care of my family on that wage. And so we have serious, serious problems in this industry that are multifaceted.

The debate as to how to solve the problem with rising malpractice premiums has led to this idea of proposing caps. While conflicting information exists as to whether the caps will reduce the malpractice premiums, and we certainly heard a lot about that, we are very concerned about that. This gentleman who was stomped to death, if you think about him, a gentleman who has Alzheimer's disease, and I don't know how many of us have had people with Alzheimer's disease in their family, but I have had one and I know how difficult it is for families to make decisions, and to make a decision to place their loved one in a long-term care facility is very painful in and of itself. But then to find out that those you have trusted, those you have paid a fair amount to take care of your loved one have actually brutally abused that person is very difficult. And I speak today for those who have very few economic damages but really have non-economic damages, that pain and suf-

fering. And families who have people in long-term care facilities have pain and suffering as do those residents. That man worked many, many, many years not to be stomped to death.

I know my time is up, but as we—the solutions, you know, again, I think more needs to be done to distinguish between good and poor performing providers. There is no better way to decrease liability than to quickly bring poor performing providers into compliance, or as a last resort, after other remedies have been exhausted, force them out of business. I don't propose we close those facilities, because as Mr. Rosenbloom said, we are in very critical need of long-term care in Pennsylvania. Those providers that have established risk reduction program addressing such resident care concerns as nutrition and preventing bedsores should be rewarded with lower premiums. Ensuring residents receive good care would eliminate the need for malpractice suits. Legislators should prohibit non-disclosure agreements so that consumers, providers, and insurers are aware of the claims against facilities and the amounts paid. We are hoping this is a deterrent.

Finally, it is important for you to consider other factors facing providers that make it difficult to operate a facility, including Medicare cuts and inadequate Medicaid reimbursement. Due to the lack of insurance competition in Pennsylvania for patient insurance, physicians receive one of the lowest reimbursement rates. These fiscal realities make it difficult for providers and physicians to cover the cost associated with increasing premiums.

In conclusion, there are thousands of vulnerable nursing home and personal care home residents throughout the Commonwealth who deserve better standards of care and better enforcement of these standards. There should be no further delays in implementing policies that will work to improve the standard of care and ensure the health and well being of residents. The time for change is long overdue. We hope that solutions sought to resolve the malpractice problem will not inadvertently be at the expense of frail older victims. Thank you, again, for the opportunity to testify and for seeking public input into this very important problem.

[The prepared statement of Diane A. Menio follows:]

PREPARED STATEMENT OF DAVID MENIO, CENTER FOR ADVOCACY FOR THE RIGHTS AND INTERESTS OF THE ELDERLY

Thank you for convening today's hearing about medical liability in Pennsylvania and for the opportunity to present testimony.

My name is Diane Menio and I represent CARIE, the Center for Advocacy for the Rights and Interests of the Elderly. Founded in 1977, CARIE is a non-profit organization dedicated to improving the quality of life for frail older adults. CARIE's focus of concern spans the long-term care continuum of needs from those who are homebound to those who are institutionalized. Older adults who experience physical or psychological impairment frequently have difficulty advocating for themselves and are often a silent group. CARIE works to protect their rights and promote awareness of their special needs and concerns. CARIE serves as the long-term care ombudsman providing complaint handling and general advocacy services for about 7,500 residents of approximately 140 nursing homes and personal care facilities located in various Philadelphia neighborhoods. CARIE also provides a model training program that has worked to reduce the incidence of resident abuse and neglect. We are also pleased to be initiating a Long Term Care Ethics Network for providers in Pennsylvania that is helping them address challenging situations at their facilities. It is through this experience that we offer the following comments.

INTRODUCTION

Medical liability presents a dynamic issue for advocates concerned about older adults. The issue embraces two major areas of interest: access and quality. As "medical malpractice" is splashed throughout the headlines, the problems of rising premiums and the impact on physicians, hospitals, nursing facilities, personal care homes and other providers, presents a compelling problem that needs a legislative solution. No one wants to see a caring physician forced out of his or her practice or a quality nursing facility close its doors. It is also troubling when quality nursing home or personal care home providers must pay higher insurance premiums when those financial resources could be expended on caring for residents. While residents receive quality care at many long term care facilities, there are serious problems with quality care at numerous nursing facilities and personal care homes. Since there are about 55,200 residents in approximately 785 nursing facilities and about 1,800 licensed personal care homes caring for approximately 79,800 residents throughout Pennsylvania, there is much at stake. Advocates have been fighting for years at the state and federal level for reforms needed to improve the "crisis in care" provided.

CRISIS IN CARE

Pennsylvania, like the rest of the nation, has a real crisis regarding the quality of care provided at long term care facilities. There are numerous studies and research documenting the extensive problems that exist. In Pennsylvania, the Pennsylvania Health Law Project recently released a white paper that examined data from the Pennsylvania Department of Welfare (DPW). (The white paper can be found at www.phlp.org.) *A Report on Pennsylvania's Personal Care Homes and Assisted Living Residences: A Call for Reform That has Gone Unheard for Over 20 Years* provides evidence using DPW's own records to show that DPW permits personal care homes to operate, sometimes for years, even when they are jeopardizing the health and safety of residents.

Pennsylvania Auditor General Bob Casey also highlighted serious problems with the oversight of nursing facilities and personal care homes. (These audits can be found online at www.auditorgen.state.pa.us/senior/.) An audit found DPW "seriously deficient" in its oversight of personal care homes. A follow-up audit of the Department of Health oversight of nursing facilities found that while there were improvements in the Department's response time to investigating complaints, there were still serious problems with sanctioning poor performing providers. "Health permitted five nursing homes with a total of 549 federal and state deficiencies to continue operating with no sanctions."

Insurance carriers should consider the enforcement actions, licensing history, and claims history when determining premiums. Providers that have a good record in terms of the care being provided should not have to subsidize the costs of providers that are found to repeatedly provide substandard care. Poor performing providers should be forced to pay more and improve the care they provide or get of the business. These actions would not only work to help consumers but also decrease the costs associated with malpractice.

Public Citizen recently released a report, "Medical Misdiagnosis in Pennsylvania: Challenging the Medical Malpractice Claims of the Doctors' Lobby." (The report can be found at www.publicitizen.org.) According to the report, "repeat offender physicians are responsible for the bulk of medical malpractice costs." "Only 4.7% of Pennsylvania's doctors (1,838), each of whom has paid three or more malpractice claims, are responsible for 51.4% of all payments." Public Citizen documents that only a very small percentage of doctors in Pennsylvania with multiple malpractice payments are disciplined. Good doctors should not be forced to pay for their colleagues' errors. Targeting policies that minimize "repeat offenders" and improve oversight would not only help consumers from becoming victims of poor practices but would also help contain malpractice costs.

CASE EXAMPLES

CARIE has visited many facilities that are understaffed, dirty, bug infested, and where residents are being neglected. The indignities that many residents endure reflect the fears and anxieties that prospective residents and families have about turning to a nursing home for care. The U.S. Attorney's Office for the Eastern District of Pennsylvania lists some very compelling case examples and these lawsuits have had a dramatic impact on care provided. The cases can be found at www.usaoedpa.com/Invest/nursing.htm. One case example describes a 60-year-old man with dementia who could walk with a walker when he was admitted to the facility and

participated in activities. He had no bedsores. Two years later, he could no longer walk. He lost a substantial amount of weight and continued to lose weight even after a feeding tube was inserted. Three years after his admission, he had 15 bedsores. The pain associated with the bedsores and his contracting limbs went unattended. His autopsy showed that several of his bedsores could have easily been prevented with "simple nursing intervention."

$250,000 CAP ON NON-ECONOMIC DAMAGES

The debate as to how to solve the problem with rising malpractice premiums has led some legislators to propose caps of $250,000 for non-economic damages. While conflicting information exists as to whether this cap will help reduce malpractice premiums, we want to testify that this proposal will ultimately prevent residents of long tem care facilities from obtaining justice from egregious acts against them. Limits on non-economic damages discriminate against older adults. Since residents do not have damages for lost wages, the non-economic damages are the only damages nursing home residents can be awarded. Since California instituted its $250,000 cap, virtually no malpractice lawsuits have been litigated on behalf of a nursing home resident. While it's clear that residents lost rights in California, data shows that the cap has done little to decrease malpractice premiums.

Federal estate recovery policies are another factor to consider. The federal government requires states to have estate recovery regulations in place for older adults who receive Medicaid services as a condition for participation. If they have resources, older Medicaid beneficiaries are required to pay the state back for any Medicaid expenditures paid on their behalf. As you know, there are many nursing home residents who rely upon Medicaid to help pay for their care. Obviously, nursing home residents cannot even begin to repay this debt, unless there is a property that is sold. However, should a resident receive a settlement, they may ultimately receive little or any compensation for their pain and loss to their quality of life as the money would go to pay their debt.

Ageism is pervasive in our society and rears its ugly head in many ways. For example, as we described the substandard level of care that many nursing facility residents receive becomes at times "acceptable" or "unavoidable" because they are old. Very little value is placed upon nursing facility residents. The last time nursing home residents in Pennsylvania saw a meager increase in their income was when the federal government increased their personal needs allowance from $25 to $30 per month in 1988.

Civil lawsuits can help to improve care. We have witnessed that when a lawsuit is filed, regulators who may have been unresponsive, heighten their attention to that facility and often take action to bring the facility into compliance. Lawsuits and even the threat of a lawsuit can serve as a deterrent and improve care. Particularly since most cases in nursing homes relate to a systemic problem that negatively impacted the individual filing the suit, any improvement tends to impact other residents in the facility. Oftentimes as part of the settlement of civil lawsuits, facilities are required to establish policies or implement a follow-up plan to be sure problems are corrected. Residents and their families demand that something be done to prevent another human being from suffering as they have.

SOLUTIONS

As we described, more needs to be done to distinguish between good and poor performing providers. There is no better way to decrease liability than to quickly bring poor performing providers into compliance, or as a last resort after other remedies have been exhausted, force them out of business. Those providers that have established risk reduction programs, addressing such resident care concerns, as nutrition and preventing bedsores, should be rewarded with lower premiums. Ensuring residents receive good care would eliminate the need for malpractice suits.

Legislators should prohibit non-disclosure agreements so that consumers, providers and insurers are aware of the claims against facilities and the amounts paid.

Finally, it is important for you to consider other factors facing providers that make it difficult to operate a facility including Medicare cuts and inadequate Medicaid reimbursement. Due to the lack of insurance competition in Pennsylvania for patient insurance, physicians receive one of the lowest reimbursement rates from insurance companies. These fiscal realities make it difficult for providers and physicians to cover the costs associated with increasing malpractice premiums.

CONCLUSION

In conclusion, there are thousands of vulnerable nursing home and personal care home residents throughout the Commonwealth who deserve better standards of care

and better enforcement of these standards. There should be no further delays in implementing policies that will work to improve the standard of care and ensure the health and well being of residents. The time for change is long overdue. CARIE hopes that the solutions sought to resolve the malpractice problem will not inadvertently be at the expense of frail older victims.

Thank you again for the opportunity to testify and for seeking public input.

Mr. GREENWOOD. Thank you for your testimony, and in respect for Ms. Schakowsky's need to get to the airport, we are going to allow her to question first, so you are recognized for 10 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I appreciate this and all the other courtesies that you have allowed me today, going a little over before, et cetera. I appreciate it.

I was looking at and listening carefully to your testimony, Mr. Rosenbloom, and if there is a—I know something about this industry. I was Director of the Illinois State Council of Senior Citizens before I went into public office, and if there were any industry crying out for experience rating; that is, not penalizing the good institutions for the bad, I would think it would be the nursing home industry. You know, you have to know, that there are bad actors in your business. There are some places that you would not want your parents to go, and you know where they are, and you know that they have inadequate care. And then when you tell me in your testimony that the CAT Fund paid only $2,670,000 in nursing facilities claims, yet, collected $41.4 million in surcharges from nursing homes, it boggles my mind then in almost a non sequitur why you would turn to those who have been compensated $2 million as opposed to those who have collected $41 million. That is, the rates don't make sense, and therefore, the solution should not be to go after those who have not been compensated very much.

When you talk about Medicare and Medicaid, I am with you, and Ms. Menio, as well, that the underfunding of healthcare professionals and the quality of care in nursing homes, I am on it, I am with you 100 percent. But why you would—I would hope—and let me just ask you this. doesn't experience rating, when you have such a variety of quality within your industry, I would think it would be your goal to figure out solutions that weed out bad actors rather than institutionalizing a system that actually helps them exist, which I could think a limitation on payouts would.

Mr. ROSENBLOOM. Well, first of all, I appreciate that question, and I appreciate the information base from which it arises. My initial observation is that with respect to bad actors, my position is that bad actors should be eliminated from the system as promptly as possible. I believe that our regulatory system, State and Federal, gives government currently the opportunity to do that. Whether they choose to exercise it or not is a different question.

Second, with respect to the question of why not go after the insurance companies or at least put those into the mix, I circle back a little bit to the dialog between Congressman Greenwood and Governor Rendell this morning. In my judgment, there are a mix of issues that need to be addressed to crack not only the medical liability insurance problems, but also, the long-term solutions to providing long-term care and senior services for us, for our parents—those of us that are in the baby boom are dealing with this right now, and for ourselves as we age, and it is a complex mix of issues.

I agree that, in my view, damage caps, whether it is $250,000 or something else, are a necessary but not sufficient component of the solution. And the reason I draw that conclusion is that in my own investigations of what is driving the liability insurance crisis for long-term care providers in this State and elsewhere, I have been informed by insurance companies, by representatives of insurance companies, that in order to stabilize rates—and no one is suggesting that rates are going to go down. We have heard a fair amount of dialog about that today. I am not suggesting it. I don't think that caps will reduce rates, necessarily. I think they might be one of the important factors in stabilizing them. What I am told is here is what we need to stabilize the insurance market. We need predictability and regularity. That is true with respect to the number of claims, that is true with the average cost for each claim, not just how much is ultimately paid out in judgments and awards, but also how much each claim costs to get from filing to ultimate disposition, whether it is dismissal, settlement, judgment, or award.

And so from my perspective, that is an important component. I believe, frankly, Congresswoman, that if we are going to solve this problem, we are going to solve it in part by everybody, you know, experiencing a little bit of pain, if you will. And I agree with much of the comment that we have heard today, that on the quality side of the ledger, there has to be more done—excuse me, I have a little cold—more done there, as well as more done on the insurance side, as well as more done on the civil justice system side.

Ms. SCHAKOWSKY. Okay. I have to tell you, I actually find it rather shocking, knowing what I know about the industry from personal experience and from GAO reports that were done in my Government Reform Subcommittee that I was on before that you would be advocating for some of these bad actors to actually pay lower rates. It is just shocking to me. It would seem to me that some of those nursing homes that are responsible for some of the abuses that we know happen every single day in nursing homes, that you would seek a solution that would actually lower their rates.

Mr. ROSENBLOOM. Congresswoman, I, respectfully, disagree. I think my solution that I am proposing is to create and actually to use the regulatory tools that exist so that those bad actors simply are not providing care and services, so that they don't exist. But a part of my solution is also to say that if we are going to appropriately balance between compensating injured parties for legitimate injuries that they have incurred because of negligence on the one hand, and otherwise stabilize the healthcare delivery system and use public resources as effectively as possible, that the balance has to be struck somewhat differently from where it is right now.

Ms. SCHAKOWSKY. Could I, in the minute before my taxi comes, I wondered if I could ask Ms. Menio—I, actually, just would like you to that on behalf of the people who then would be limited to $250,000.

Ms. MENIO. Yes. I just, you know, I did already talk about some of these things. And certainly, you made some very good points, why should we subsidize bad actors. And one of the areas I am concerned about is nursing homes closing and personal care homes closing. They are a resource, and having people that live in our

community have to go miles and miles away is a severe problem. We need to be——

Ms. SCHAKOWSKY. The regulatory system—is the regulatory system working?

Ms. MENIO. No, in some cases it is not. And you know, the reports that I have referenced in my testimony will show you reports on Pennsylvania. There are GAO reports about, you know, and a CMS report that is available on the Nation. But on Pennsylvania, and also a GAO report on Pennsylvania that was done last year. You will find that the regulatory system doesn't always work. And we know that firsthand because we are in there reviewing complaints, sitting at exit conferences where the regulators talk about what the issues are. And some of the places that I talked about were places that have been—we had a personal care home in Philadelphia that was on a cease and desist order for more than 5 years. During those 5 years, we were in that facility dealing with residents, severe resident neglect. They stole their money, you know, and they don't have much money. These are not people that—these are poor people we are talking about, and that was allowed to happen by the regulatory system that exists.

I also have to say that we have Federal law that regulates nursing homes. We do not have Federal law that regulates personal care or assisted living. And in the State, we have personal care home regulations which regulates facilities that call themselves assisted living as well. They are quite minimal. So there aren't strong regulations in place to regulate what in some places are called adult care homes, or personal care homes, or assisted living in Pennsylvania.

Ms. SCHAKOWSKY. Let me just ask this final question. Could you explain to the committee the relationship between substantial civil judgments and criminal prosecutions of nursing home abuses in southeastern Pennsylvania?

Ms. MENIO. Well, you know, my experience has been in working with the Eastern District Office of the U.S. Attorney's Office, which a number of years ago did some groundbreaking prosecution based on the False Claims Act, because we have providers who are taking Medicaid and Medicare moneys to provide care, and then lo and behold, they are not providing care. Nutrition is a good example. Nutrition is something that is included in the Medicaid reimbursement rate. If they are not providing adequate nutrition, they are not fulfilling their responsibility as a Medicaid provider. And so the judgments that have—or the settlements that have taken place here in Philadelphia and the Eastern District, which includes southeastern Pennsylvania, have actually—we have seen great advances, because what the settlements include is not just money, but include having solutions put in place, having people come in, experts come in and monitor medication administration, monitor nutrition, and so there is actually solutions being put in place.

Ms. SCHAKOWSKY. Not just for that individual but——

Ms. MENIO. No. To change the system, to raise the bar so to speak, so that is what we see the civil suits can sometimes do, and on the Federal level civil suits have accomplished that, and I can tell you some of the facilities that we dreaded going into, that we

were in many, many times 10 years ago are better today because of those settlements.

Ms. SCHAKOWSKY. Thank you. And thank you, Mr. Chairman.

Mr. GREENWOOD. I thank the gentlelady from Illinois for coming and recognize that she has a plane to catch so you may slink off whenever you choose.

And now we will return to Mr. Smarr and ask for your testimony, sir.

TESTIMONY OF LAWRENCE E. SMARR

Mr. SMARR. Chairman Greenwood, Representative Deutsch, and members of the subcommittee, I am Larry Smarr, President of the Physician Insurers Association of America. The PIAA is an association comprised of professional liability insurance companies owned and/or operated by physicians, dentists, and other healthcare providers. The 43 PIAA insurance company members, such as the Pennsylvania Medical Society Liability Insurance Company, can also be characterized as healthcare professionals caring for the professional liability risks of their colleagues, doctors insuring doctors and hospitals insuring hospitals. We believe that the physician owned/operated insurance company members of the PIAA insure over 60 percent of America's doctors.

Let me get right to the issue. Over the past 3 years, medical liability insurers have seen their financial performance deteriorate substantially due to the rapidly rising cost of medical liability claims. According to A.M. Best, the leading insurance industry rating agency, the medical liability insurance industry incurred $1.53 in losses and expenses for every $1 of premium incurred. The primary driver of the deterioration in the medical malpractice insurance industry performance has been paid claim severity or the average cost of a paid claim.

Exhibit A, and I believe you have these charts before you, shows the average dollar amounts paid in indemnity to plaintiffs on behalf of individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9 percent over the past 10 years. That is compared to 2.6 percent increase in the consumer price index. The data from this exhibit comes from the PIAA data sharing project, a medical cause of loss data base created in 1985 for the purpose of identifying common trends among malpractice claims which are used for patient safety purposes. To date, over 180,000 claims and suits have been reported to this data base. One very troubling aspect is proportion of claims filed which are ultimately determined to be without merit; 61 percent of all claims closed in 2001 were dropped or dismissed by the court. An additional 5.7 percent were won by the doctor at trial. Only 33 percent of all claims closed were found to be meritorious, and most of these being paid through settlement. Of all claims closed, more than two-thirds had no indemnity payment to the plaintiff. And when the claim was closed at trial at verdict, the defendant prevailed an astonishing 80 percent of the time.

As shown in Exhibit B, the mean settlement amount on behalf of an individual defendant was just over $299,000. Most medical malpractice cases have multiple defendants, and thus, these values

are below those which may be reported on a case basis. The mean verdict amount last year was almost $497,000 per defendant.

Exhibit C shows the mean expense payment for claims by category of disposition. As can be seen, the cost of taking a claim for each doctor named in a case all the way through trial is fast approaching $100,000.

Exhibit D shows the distribution of claims payments at various payment thresholds. It can be readily seen that the number of larger payments are growing as a percentage of the total number of payments. This is especially true for payments at or exceeding $1 million, which comprised almost 8 percent of all claims paid on behalf of individual practitioners in 2001 as shown on Exhibit E. This percentage has doubled in the past 4 years.

Unfortunately, I am going to spend the rest of my time debunking a major myth being propagated by those who oppose effective Federal healthcare liability reform. Contrary to the unfounded allegations of those who oppose effective reforms, medical malpractice insurers are primarily invested in high grade bond and have not lost large sums in the stock market as we have heard here today. Brown Brothers Harriman, a leading investment and asset management firm, in a recent investment research report states that over the last 5 years, the amount medical malpractice companies have invested in equities has remained fairly constant. In 2001, the equity allocation was 9 percent. As Exhibit F shows, the medical liability insurance companies invest significantly less in equities than did all property-casualty insurers. Brown Brothers states that the equity investments of medical liability companies had returned similar to the market as a whole. This indicates that they maintain a versified equity investment strategy. Since medical malpractice companies did not have an unusual amount invested in equities, and what they did was invest it in a reasonable market-like fashion, we conclude that the decline in equity valuations is not the cause of rising medical malpractice premiums.

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

The PIAA firmly believes that the adoption and effect of Federal healthcare liability reforms similar to the California MICRA reforms enacted in 1975, will have a demonstrable effect on professional liability costs. The keystone of the MICRA reforms is a $250,000 cap on non-economic damages. These reforms are similar to the revisions of H.R. 5, the Health Act. The same bill was passed by the House last year as H.R. 4600 and was scored by the CBO as providing over $14 billion in savings to the Federal Government and an additional $7 billion to the States, because tort reform works. Using annual data published by the National Association of Insurance Commissioners, Exhibit H documents the savings California practitioners and healthcare consumers have enjoyed since the enactment of MICRA over 25 years ago. As Chairman Greenwood has already pointed out, the total malpractice premiums re-

ported to the NAIC since 1976 have grown by 167 percent, while premiums for the rest of the Nation have grown by 505 percent. These savings are truly demonstrated in the rates charged to California doctors as shown on Exhibit I. Successful experience in California and other States, such as Colorado, makes it clear that MICRA style tort reforms do work without lowering healthcare quality or limiting access to care.

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

The PIAA strongly urges members of the House of Representatives to pass H.R. 5, the Health Act, thereby assuring fair compensation for patients injured in the healthcare system and also assuring Pennsylvania's citizens and people across the Nation that they will be able to receive necessary healthcare services. Thank you.

[The prepared statement of Lawrence D. Smarr follows:]

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

INTRODUCTION

Chairman Greenwood, Representative Deutsch and members of the Sub-Committee, I am Lawrence E. Smarr, President of the Physician Insurers Association of America (PIAA). Thank you for allowing me the opportunity to appear before you today and speak regarding the medical liability crisis as it affects patients and health care providers in Pennsylvania and across the nation.

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

DOCTORS INSURING DOCTORS

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

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

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

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

My goal here today is to discuss what the PIAA sees as the underlying causes of the current medical liability crisis in Pennsylvania and other crisis states across the nation. I want to stress that I believe that this situation should be characterized as a medical liability crisis, and not a medical liability insurance crisis. The PIAA companies covering the majority of the market are in sound financial condition. The crisis we face today is a crisis of affordability and availability of insurance for health care providers, and more importantly, the resulting growing crisis of access to the health care system for patients across the country.

INSURANCE INDUSTRY UNDERWRITING PERFORMANCE

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

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

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

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

For calendar year 2001, the combined ratio (including dividends paid) was 141, meaning that total losses and dividends paid were 41% more than the premiums collected. Even when considering investment income, net income for the year was a negative ten percent. This follows a meager 4 percent net income in 2000. This

average experience is indicative of the problems being experienced by insurers in general, and demonstrates the carriers' needs to raise rates to counter increasing losses. All of the basic components of the combined ratio calculation (loss and loss adjustment expense, underwriting expense) have risen as a percentage of premium for all years shown. The only declining component has been dividends paid to policyholders.

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

THE ROLE OF INVESTMENT INCOME

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

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

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

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

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

The Brown Brothers report further states:

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

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

THE INSURANCE CYCLE

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

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

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

INSURER SOLVENCY

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

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

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

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

THE CAUSE OF THE CRISIS

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

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

The primary driver of the deterioration in the medical liability insurance industry performance has been paid claim severity, or the average cost of a paid claim.

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

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

One very troubling aspect of medical malpractice claims is the proportion of those filed which are ultimately determined to be without merit. Exhibit 12 shows the distribution of claims closed in 2001 as reported to the PIAA Data Sharing Project. Sixty-one percent of all claims filed against individual practitioners were dropped or dismissed by the court. An additional 5.7% were won by the doctor at trial. Only 33.2% of all claims closed were found to be meritorious, with most of these being paid through settlement. Of all claims closed, more than two-thirds had no indem-

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

nity payment to the plaintiff. When the claim was concluded at verdict, the defendant prevailed an astonishing 80% of the time. This data clearly shows that those attorneys trying these cases are woefully deficient in recognizing meritorious actions to be pursued to conclusion.

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

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

Exhibit 16 shows the mean expense payment for claims by category of disposition. As can be seen, the cost of taking a claim for each doctor named in a case all the way through trial is fast approaching $100,000.

Exhibit 15 shows the distribution of claims payments at various payment thresholds. It can be readily seen that the number of larger payments are growing as a percentage of the total number of payments.

This is especially true for payments at or exceeding $1 million, which comprised almost eight percent of all claims paid on behalf of individual practitioners in 2001 (Exhibit 16). This percentage has doubled in the past four years, and clearly demonstrates why insurers are facing dramatic increases in the amounts they have to pay for reinsurance. While medical liability insurers are reinsured by many of the same companies having high losses from the World Trade Center disaster, their medical liability experience was rapidly deteriorating prior to September 11, 2001.

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

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

THE ANSWER

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

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

The keystone of the MICRA reforms is the $250,000 cap on non-economic damages (pain and suffering) on a per-incident basis. Under MICRA, injured patients receive full compensation for all quantifiable damages, such as lost income, medical expenses, long-term care, etc. In addition, injured patients can get as much as one-quarter million dollars for pain and suffering. Advising juries of economic damages that have already been paid by other sources serves to reduce double payment for

damages. An important component of MICRA is a reasonable limitation on plaintiff attorney contingency fees, which currently can be 40% or more of the total amount of the award. Under MICRA, a trial lawyer must be satisfied with only a $220,000 contingency fee for a $1 million award.

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

The U.S. House of Representatives adopted legislation containing tort reforms similar to MICRA, including a $250,000 cap on non-economic damages, for the seventh time in September of last year. HR 4600, known as the HEALTH Act, was introduced and adopted on a bi-partisan basis. We are very pleased that Chairman Greenwood and his many co-sponsors have reintroduced this legislation as HR 5 in the 108th Congress. The Congressional Budget Office (CBO) conducted an extensive review of the provisions of HR 4600, and reported to Congress that if the reforms were enacted, "... premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

The CBO found that HR 4600 reforms, the same reforms found in HR 5, would result in savings of $14.1 billion to the federal government through Medicare and other health care programs for the period 2004-2012. An additional $7 billion of savings would be enjoyed by the states through their health care programs. The CBO's analysis did not consider the effects federal tort reform would have on reducing the incidence of defensive medicine, but did acknowledge that savings were likely to result.

The US Department of Health and Human Services published a report on July 24, 2002, which evaluated the effects of tort reforms in those states that have enacted them. As stated in Exhibit 23, HHS found that practitioners in states with effective caps on non-economic damages were currently experiencing premium increases in the 12-15% range, as compared to average 44% increases in other states.

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

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

PROP 103 HAD NO EFFECT ON CALIFORNIA MEDICAL LIABILITY PREMIUMS

In an effort to derail desperately need tort reforms as described above, the Association of Trial Lawyers of America and related individuals and groups have stated that the beneficial effects of MICRA as shown on Exhibit 24 are due to Proposition 103, a ballot initiative passed in 1989 aimed primarily at controlling auto insurance costs. The ballot initiative passed by a 51% majority vote, with voters in only 7 of California's 58 counties approving the measure. The major changes made by Prop 103 include:Q02

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

[3] Ironically, the Proposition 103 Enforcement Project headed by Harvey Rosenfeld, a self-proclaimed consumer advocate who led the fight for the adoption of Prop 103, has received almost

Medical liability insurers were not the intended target of Prop 103, but were covered by the resulting regulations. However, Prop 103 did not have any substantive effect on medical liability insurance rates. Prop 103 did have the effect of freezing most insurance rates in California until as late as 1994.[4] This all came at a time when medical liability insurers across the nation were seeing their rates level off or even decline. One major California medical liability insurer, the NORCAL Mutual Insurance Company, actually had two rate decrease filings (-2%, -12%) which had been made with the department of insurance in 1990 and 1991 held up until the conclusion of legal challenges and exemption issues were resolved. NORCAL reached a consent agreement with the California Department of Insurance in November of 1991, at which time its rate decreases were granted. NORCAL was specifically permitted to declare a one-time 20% return of premium for policyholders insured between November 8, 1988 and November 8, 1989 as a dividend and was not required to reduce its rates as a result of Prop 103. As NORCAL had already paid dividends exceeding 20% during the period in question, no monies were returned to policyholders as a result of Prop 103. The experience of other California physician-owned companies was similar to that of NORCAL. Even if California medical liability insurers had been required to reduce rates by 20%, this in no way could explain the wide gap in experience shown on Exhibit 21.

CONCLUSION

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

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

The PIAA strongly urges members of the House of Representatives to pass HR 5, the HEALTH Act, thereby stopping the exodus from Pennsylvania and similar states of health care professionals and institutions which can no longer afford to fund an inequitable and inefficient tort system which benefits neither injured plaintiffs or the health care community.

$1.5 million in intervenor fees through 1997. In total, "consumer organizations" and individuals have received over $7.1 million in intervenor fees and administrative costs through 1997. Source: Personal Insurance Federation of America, www.pifc.org/insurance/prop103.html.

[4] Background on Insurance Reform—A Detailed Analysis of California Proposition 103, www.consumerwatchdog.org/insurance/fs/fs000159.php3.

EXHIBIT 1

FINANCIAL RATIOS TO NET PREMIUMS EARNED

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

Source: Tillinghast Survey of PIAA Companies NAIC Filings

EXHIBIT 2

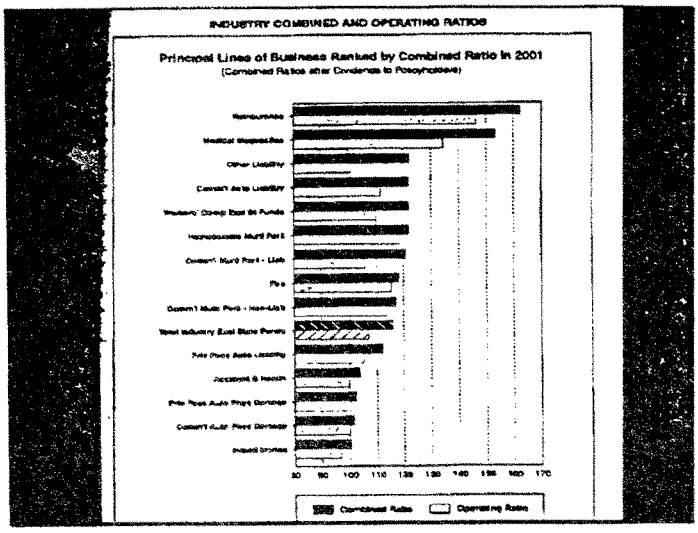


EXHIBIT 3

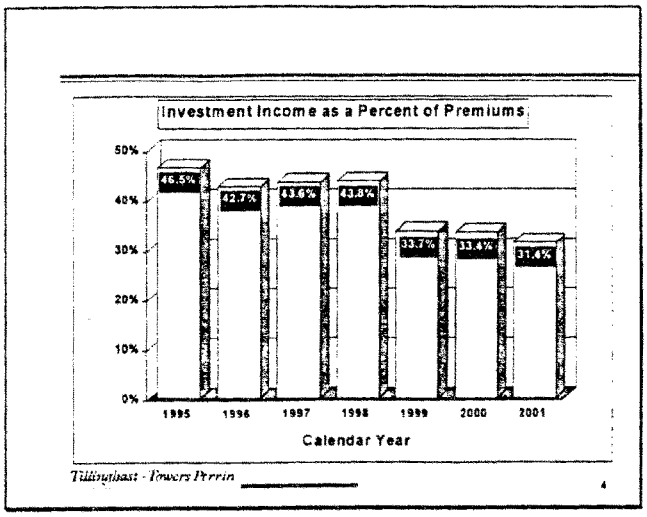


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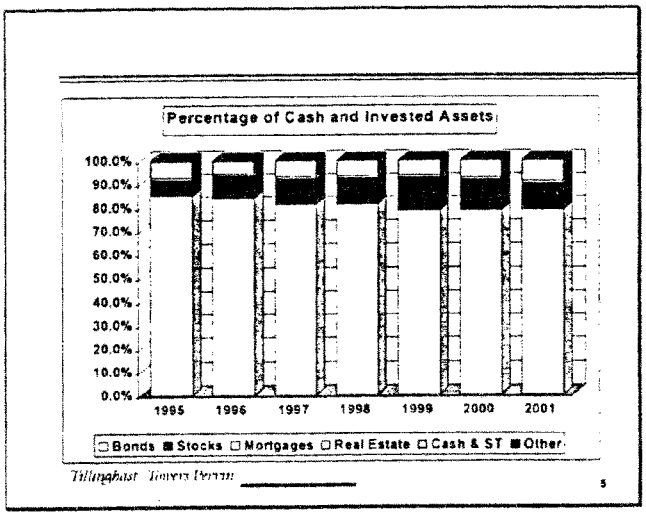


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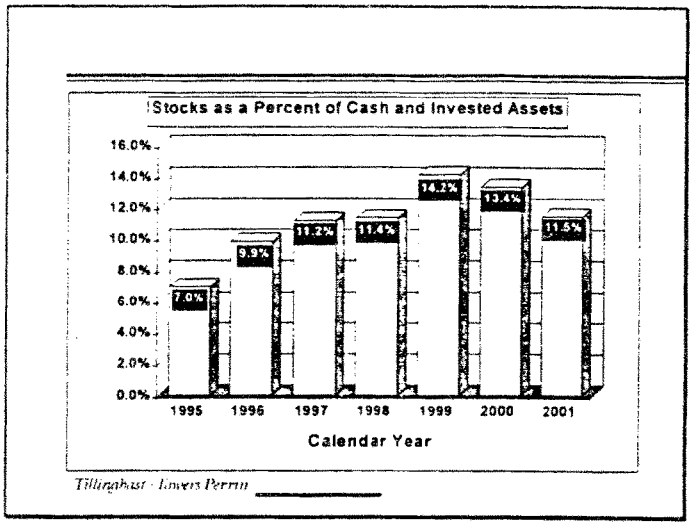
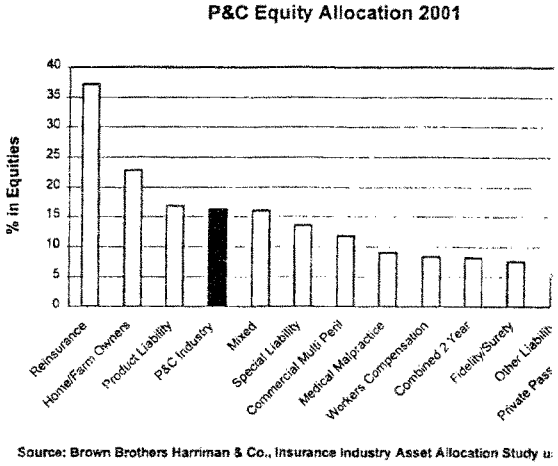
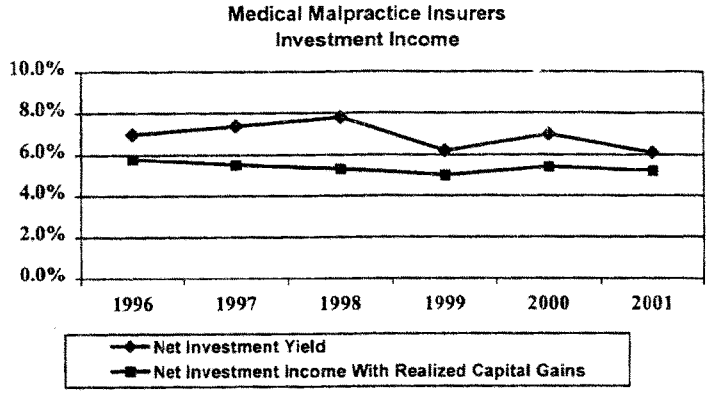


EXHIBIT 6



Source: Brown Brothers Harriman & Co., Insurance Industry Asset Allocation Study u

EXHIBIT 7



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

EXHIBIT 8

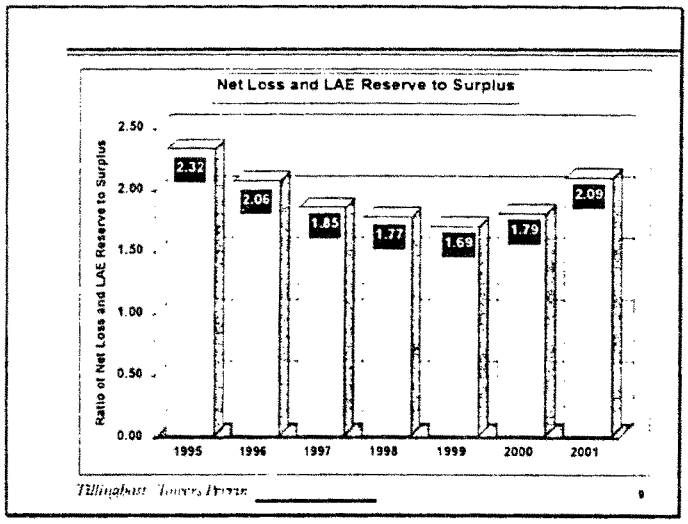


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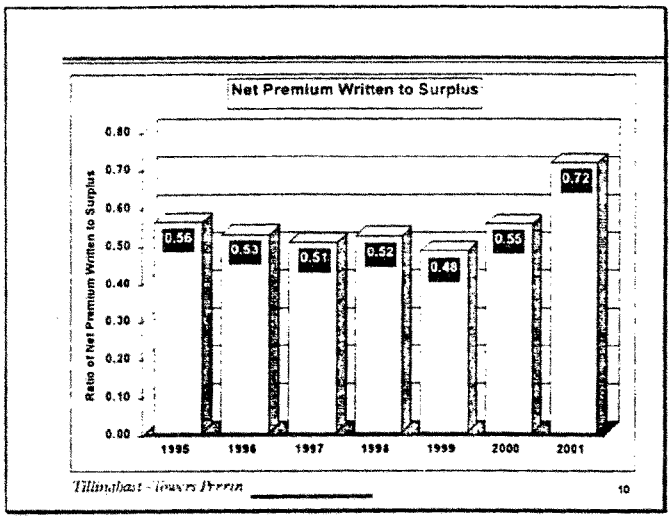


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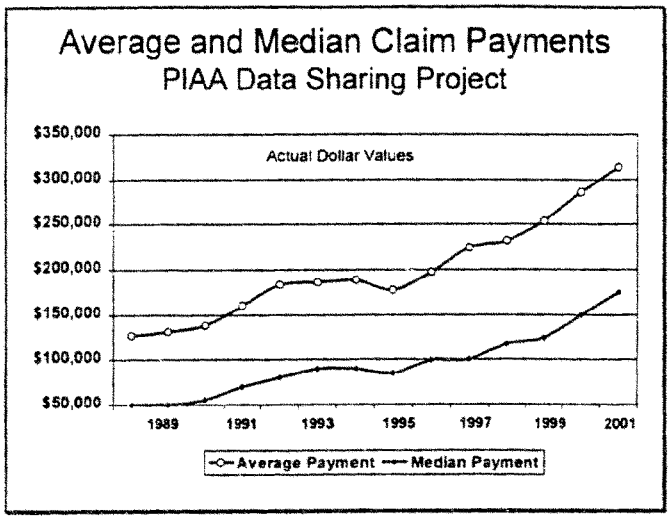


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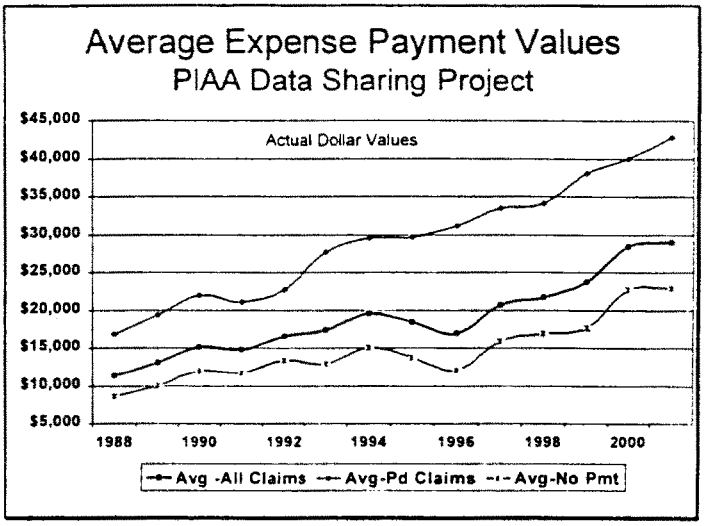


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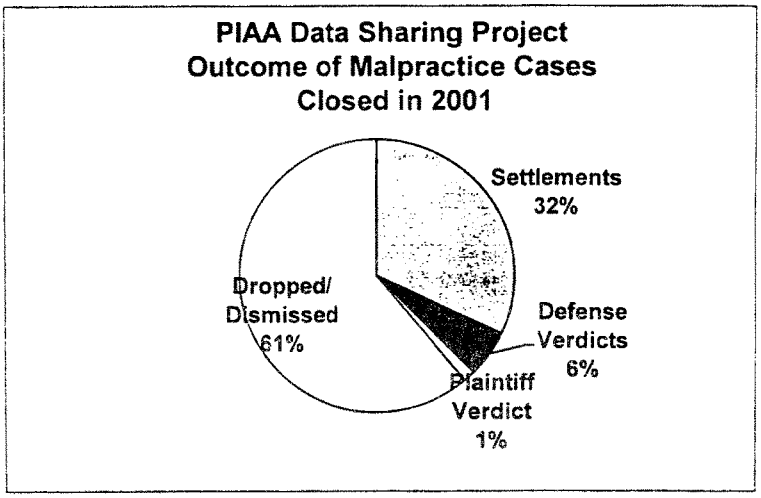


EXHIBIT 13

PAYMENT VALUES – 2001

As of 09/04/02

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

EXHIBIT 14

PAYMENT VALUES – 2001

As of 09/04/02

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

EXHIBIT 15

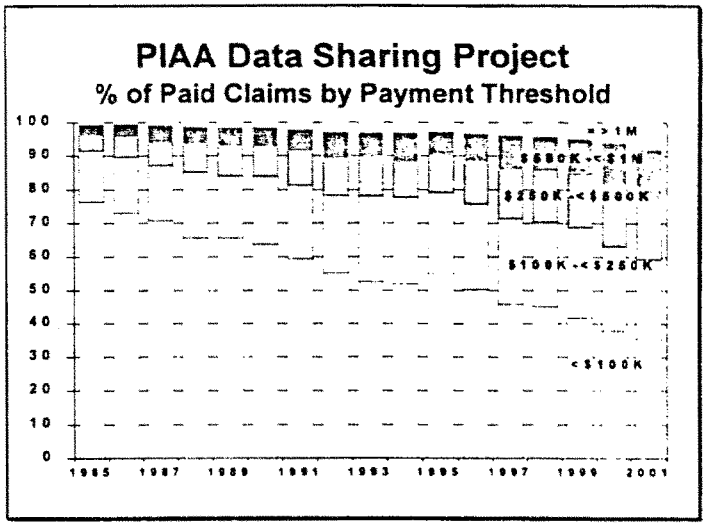


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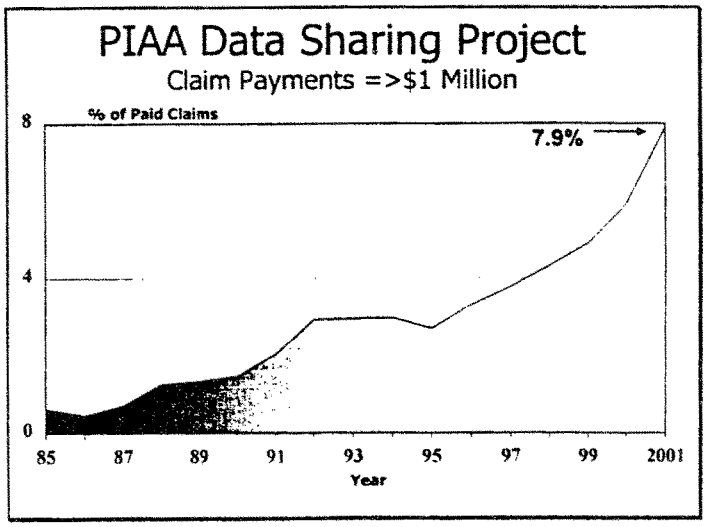


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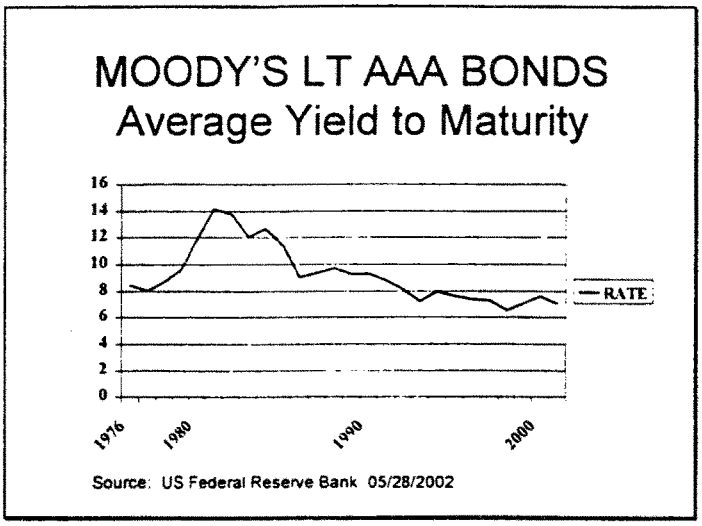


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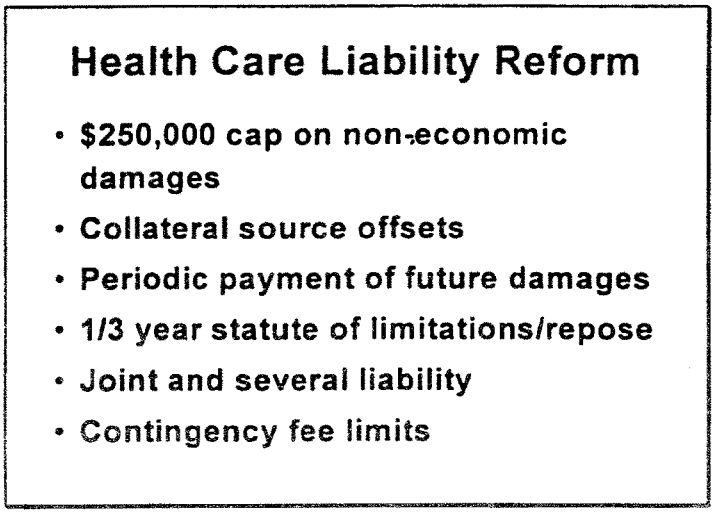


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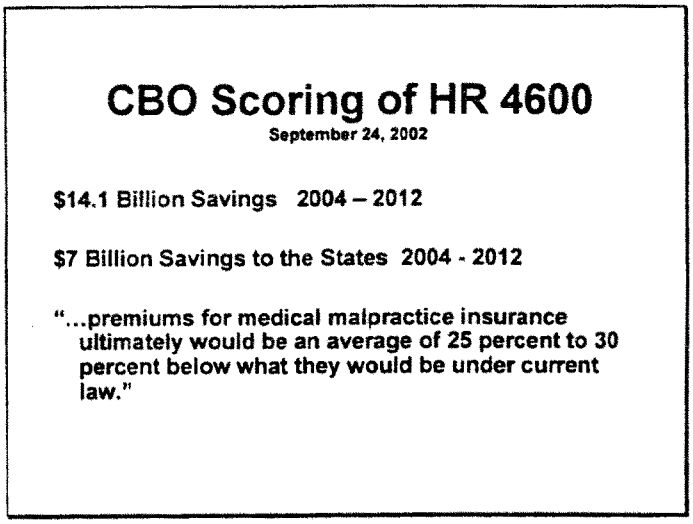


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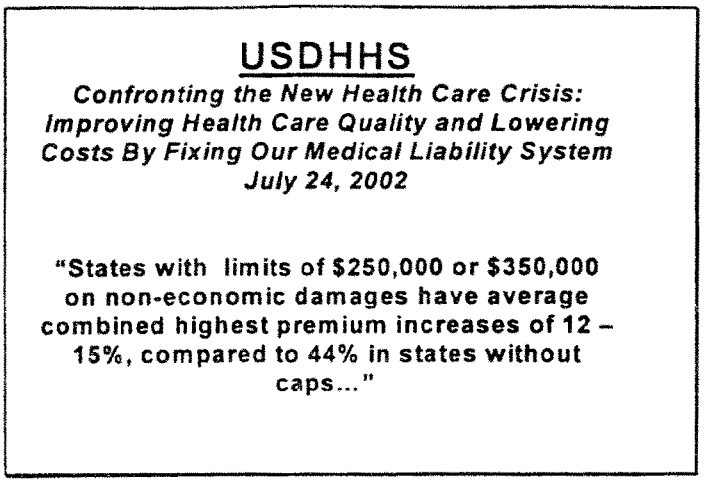


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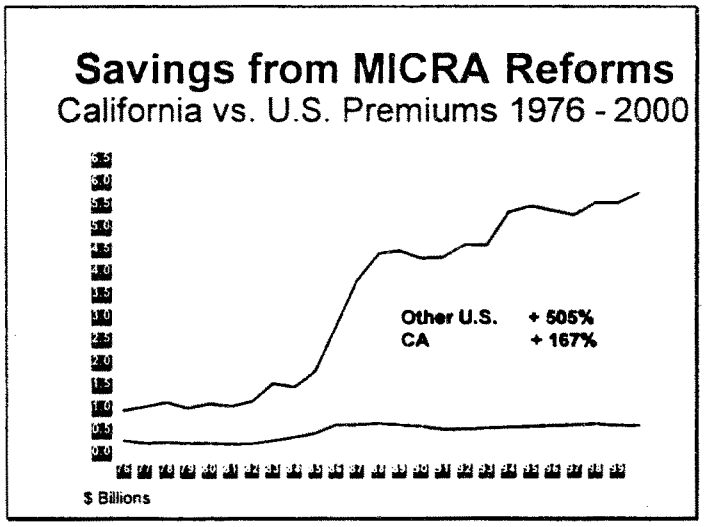


EXHIBIT 22

2002 Rates- $1mil/3mil Coverage

(as reported by Medical Liability Monitor)

	LA[1]	Denver[2]	Chicago[3]	Phila[4]	Miami[5]
IM	11,164	9,845	26,404	18,429	56,153
GS	36,740	34,644	68,080	82,157	174,268
OB/ Gyn	54,563	30,905	102,640	100,045	201,376

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

Mr. GREENWOOD. Thank you, Mr. Smarr. Mr. Hurley.

TESTIMONY OF JAMES HURLEY

Mr. HURLEY. Good afternoon, Chairman Greenwood, Ranking Member Deutsch, and members of the subcommittee. Thank you for inviting me to testify today on behalf of the American Academy of Actuaries. It is an honor to be here in a facility where so much good is accomplished.

The Academy is the public policy and professionalism organization for actuaries practicing in all specialties within the United States. The Academy is nonpartisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy also developed and upholds actuarial standards of conduct, qualification, and practice. For those not familiar with actuaries, actuaries collect and evaluate loss and exposure data to advise about rates to be charged for prospective coverage and reserve liabilities be carried related to the coverage already provided.

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

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

Two indicators of financial results are the combined ratio and the operating ratio. We can obtain these indicators for reporting companies from A.M. Best Company, a company that offers comprehensive data to insurance professionals and tracks these results. The combined ratio is an indication of how the company is doing in its insurance underwriting. For all companies reporting to A.M. Best, the medical malpractice combined ratio of 130 percent and 134 percent for 1999 and 2000, respectively, deteriorated, as Mr. Smarr noted, to 153 percent for 2001. For underwriting, as Mr. Smarr noted, this represents a loss of 53 cents on each dollar of premium written in 2001. Preliminary projections for 2002 are for a combined ration just under 140 percent.

A measure of the overall profitability of insurers is given by the operating ratio. The A.M. Best operating ratio adjusts the combined ratio for other expense and income items, primarily, investment income, but with the exception of Federal income tax. The op-

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

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

My written statement summarizes the two key drivers of financial results and their effects on operating results and surplus for some 30 companies specializing in this coverage. These companies represent about one-third of the companies reporting to Best. The results for these companies reflect similar deterioration. In Chart C on page 6 of my testimony, it shows the total after tax operating income for these companies. The favorable operating income of the earlier years in the 20 percent neighborhood declines to a slight profit in 2000 and to a 10 percent loss in 2001. Regarding the consequential impact on surplus, Chart D on page 7 of my testimony demonstrates the change in surplus from year to year for these same companies. Surplus increased through 1999 by 5 percent, to as much as 20 percent at the beginning of the period, but at a decreasing rate over the timeframe.

Importantly, however, surplus declined in 2000, and more significantly, in 2001. This is important because surplus represents the capital base for these insurers. Its decline reduces capacity to write new or renewing business prospectively and lessens their ability to absorb any adverse development on business written in prior years. And this includes their opportunity to write business that is becoming available due to companies no longer writing the coverage.

Companies continuing to write medical malpractice coverage must interpret the current experience and determine what rates to charge for prospective coverage. The term ratemaking is used to describe this process. In ratemaking, the company must estimate the cost of the prospective coverage, set a price for it, and assume the risk that the cost may differ, perhaps substantially, from those estimates. The ratemaking process is forward looking and normally does not reflect loadings for past pricing inadequacy or past investment losses. In short, ratemaking reflects future costs and expectations.

The ratemaking process starts with historical experience for the specific coverage, usually, within a State, and is intended to determine rates for that coverage and that jurisdiction for a given time period. To appropriately adjust a loss experience, a company must incorporate consideration of expenses, the time value of money, and an appropriate provision for risk and profit associated with the insurance transaction.

Some liens of business are more predictable than others. Medical malpractice is generally viewed as being more difficult to predict than most other lines. This is because the relatively low number of claims, high and variable size of claim paths, and the long delay between occurrence, report, and disposition of a claim. Hence, rate setting is more uncertain for medical malpractice coverage. My written testimony provides a bit more detailed discussion of this process, however, three additional observations: (1) It should be noted that rates are generally subject to regulatory oversight in most jurisdictions; (2) Likely, or in similar fashion, investment portfolios of insurance companies are also regulated by the insurance code; and (3) Because rates are generally reduced to reflect investment income on the insurance transaction based on prospective bond yields when interest rates yields decrease, rates need to increase.

In conclusion, I appreciate this opportunity to provide an actuarial perspective on these important issues. As the person who chairs the Medical Malpractice Subcommittee at the Academy, let me say that we are encouraged by the interest the chairman and others have shown in working toward long-term solutions in this area, and I would be glad to answer any questions you have or provide any additional information that would be helpful to the committee. Thank you.

[The prepared statement of James Hurley follows:]

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

The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

INTRODUCTION

The American Academy of Actuaries appreciates the opportunity to provide comments on issues related to the availability and pricing of medical malpractice insurance. The Academy hopes these comments will be helpful as the subcommittee considers related proposals.

This testimony provides some facts about medical malpractice financial results updated through 2001, contributing factors, and some common misconceptions about the results. Additionally, we provide ratemaking information.

Then and Now

During the 1990s, the medical malpractice insurance line of business experienced favorable operating results primarily due to favorable development of prior coverage years and healthy investment returns. Insurers offering this line of coverage in the 1990s competed aggressively. Healthcare providers shared in the benefit of improved loss experience and higher levels of investment income through stable or even decreasing premium charges. Specialty companies have had a substantial market share for this line of business because it has been considered a high-risk type of insurance, which requires specialists to underwrite policies and administer claims.

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

From a financial standpoint, medical malpractice insurance results deteriorated significantly during the last three years ending in 2001. One measure of financial results is the combined ratio—the ratio of all incurred losses and expenses to premium. For all companies reporting to A.M. Best (an organization offering comprehensive data to insurance professionals), the combined ratio of 130 percent and 134 percent in 1999 and 2000, respectively, deteriorated to 153 percent in 2001. Results for 2002 are not yet available, however, preliminary A.M. Best projections for 2002 are for a combined ratio slightly under 140 percent. This means insurers are expected to pay out $1.40 in losses and expenses for every dollar of premium they collect.

A measure of the overall profitability of insurers is the operating ratio. The A.M. Best operating ratio adjusts the combined ratio for other expense and income items, primarily investment income, with the exception of federal income tax. The operating ratio for 1999 and 2000 was approximately 106 percent, indicating a net loss of six cents on every dollar of premium. This deteriorated to 134 percent in 2001, indicating a loss of 34 cents on every dollar of premium. Considering the lower investment income return likely to be achieved by insurers in 2002, the 2002 operating ratio will probably not improve as much as the combined ratio. At these levels, 2001 and 2002 results are the worst they have been in 15 years or more, approximating levels of the 1980s. State insurance laws regulate the type of allowable investments for insurers and these laws have fairly low limits on the amount of equity investments permitted.

Today, the loss environment has deteriorated, the benefits of favorable reserve development appear to be gone, and the expected future investment income has declined. As a result, rates for both insurers and reinsurers need to increase to properly align with current loss and investment income levels. Companies failing to do this jeopardize their surplus base and financial health. Counter to what some may perceive, the investment results I have mentioned are based on a portfolio that is dominated by bonds with equity investments representing a minority of the portfolio.

SOME FACTS

The following discussion is based on results of 30 companies (the Group), primarily physician-owned and/or operated medical liability insurers. Notably, these results exclude St. Paul and other commercial insurers, as well as MLMIC, the latter primarily a writer insuring New York state physicians. These results represent more than one-third of the exposure reported to A.M. Best. Information is shown for the last seven years ending 2001 because 2002 results have not been reported.

Results for these companies reflect a four percent after-tax operating profit in 2000. However, the results deteriorate to a 10 percent operating loss for 2001.

The following is a discussion and charts summarizing the two key drivers of financial results and their effects on operating results and surplus:

Driver #1—Higher combined ratio (defined here as all incurred loss and expenses to premium earned). The combined ratio deteriorated by ten points in 2000 and a further 14 points in 2001. The ratios were 124 percent and 138 percent in 2000 and 2001, respectively. The preceding five years reflect a rather stable 110-115 percent range. The driver of the poorer experience in 2000 and 2001 is the deterioration in the loss and loss adjustment expense ratio, because the underwriting expense ratio has remained relatively constant. The earlier years reflect the benefit of significant reserve reductions from prior coverage years.

Driver #2—Decreased investment income (shown here as pre-tax investment income divided by premium earned). As shown in Chart A, these insurers generally spend more money on loss and expense than they collect in premium. This is possible because investment income can offset a modest underwriting loss.

In Chart B, pre-tax investment income is divided by earned premium to estimate the amount by which the underwriting combined ratio can be offset by investment income. This percentage has declined from the mid-40s in the early years, to the mid-30s in 1999, and in 2001, to 31 percent. This "offset" will continue to decline in the future. Most insurance company invested assets are in bonds, which are affected by the current lower yield environment. Overall yields going forward will be less than they were in the past.

Effect #1—Net operating income falls (shown in Chart C as a percentage of premium). Net operating income represents the net impact of the combined ratio and investment income ratio, adjusted for other income statement items (primarily policyholder dividends, miscellaneous other income, and federal income tax). The strong operating returns of the early years have been followed by the slight 2000 profit and 10 percent loss for 2001 described earlier.

Effect #2—Chart D shows the percentage change in surplus from one year to the next. Surplus represents the capital base for these insurers, and its decline in 2000 and 2001 reduces their capacity to write new or renewing business prospectively, and lessens their ability to absorb adverse loss developments on business written in prior years.

CONTRIBUTING FACTORS

There are several factors contributing to the financial results described in Chart D. It is probably best to note the factors contributing to the favorable results of the early and mid-1990s and then discuss the changes in these factors today.

Factor #1: Throughout the 1990s, premium rates for the insurance industry as a whole were relatively flat or down in several states. Rates decreased toward the middle and end of the period in comparison to rates at the beginning of the decade. Note that the final price charged is a function of several different items, including the filed rate and premium discounts.

Factor #2: Loss-cost trends (the annual change in the frequency and severity of claims) during this time period were relatively low. Long-term indications suggest a low single-digit change, three percent to five percent, varying from state to state. Rates established at the beginning of the period contemplated higher trends. Companies responded to this emerging data in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others found they needed to increase rates modestly and tried to refine pricing models to improve the equity of their program costs. Many insurers employed combinations of these, with resulting increases in some programs and decreases in others, depending on specific facts and circumstances. However, in general, there was a decline in the adequacy of premiums during this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower in some jurisdictions.

Factor #3: Ultimate losses for accident years in the late 1980s and early 1990s ultimately were lower than originally projected. Evidence of this emerged gradually over a period of years as claims settled. When loss reserves for prior years are reduced, it contributes income to the current calendar years, improving financial results (i.e., the combined and operating ratios). That was the pattern during the middle to late 1990s, as shown in Chart E. What is evident from that chart is that favorable reserve development was not a significant factor in 2001 for these companies. In contrast, the total medical malpractice line of business increased reserves in 2000 and even more significantly in 2001.

Factor #4: During the 1990s, there was a real spread between returns on fixed-income investments and economic inflation. In addition, returns on the Group's modest equity investments contributed to produce significant investment gains, improving overall financial results. These gains increased the investment income ratio (see earlier graph) and improved the operating ratio.

Factor #5: Given the financial results of the early-to-mid-1990s, some companies considered expansion into new markets (although they may have had limited information to develop rates), became more competitive in existing markets, and offered more aggressive premium discounts. In most jurisdictions, "discounts" against the manual premium became common, reducing the actual premiums paid by health care providers. As a consequence, market prices decreased.

Factor #6: Loss-cost trends, particularly claim severity, began to increase toward the latter part of the 1990s. The number of large claims increased, but even analyses designed to eliminate the distorting effects of very large claims began to show a significant increase. This, coupled with the cumulative effect of the low loss-cost trend and rate activity in the earlier part of the decade, produced rate indications that were increasing rapidly in many states.

Factor #7: In 2001, there was little favorable loss reserve development or "good news" from prior coverage years, although results varied on a company-by-company basis. By comparison, total industry medical malpractice results reflected adverse or unfavorable loss development (defined as approximately 20 percent of premium) in 2001. The increase in loss/cost trends calls into question, however, whether current reserve levels will ultimately be adequate to pay all future losses.

Factor #8: Rates of return on bonds declined and equity values fell. This affected investment earnings on newly invested assets and the expected future investment earnings that are used to offset prospective premiums A one percent drop in interest rates can be translated into a rate increase of two to four percent. A two and one-half percent drop in interest rates, which has occurred since 2000, can translate into a rate increase of between five and ten percent.

Factor #9: Reinsurers' experience deteriorated as their results were affected by the increased claim severity and pricing changes in the early-to-mid-1990s. Many medical malpractice insurers are not large enough to take on the risks inherent in this line of insurance on their own. They require someone else (reinsurers) to share the risk. There would be less medical malpractice insurer capacity without reinsurers. Because reinsurers generally cover the higher layers of exposure, their results were disproportionately affected by claim severity increases. This, coupled with the broadly tightened reinsurance market after the events of Sept. 11, 2001, caused reinsurers to substantially increase rates and tighten terms of reinsurance for medical malpractice.

THE RATEMAKING PROCESS

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

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

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

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

The following facts explain the ratemaking process:

1. Historical loss experience is collected in coverage year detail for the last several years. This usually will include paid and outstanding losses and counts. The data is reviewed for reasonableness and consistency, and estimates of the ultimate value of the coverage-year loss are developed using actuarial techniques.
2. Ultimate losses are adjusted to the prospective level (i.e., the period for which rates are being made). This involves an appropriate adjustment for changes in average costs and claim frequencies (called trend). Adjustments also would be made for any changes in circumstances that may affect costs (e.g., if a coverage provision has been altered).
3. Adjusted ultimate losses are compared to premium (or doctor counts) to determine a loss ratio (or loss cost per doctor) for the prospective period.
4. Expenses associated with the business must be included. These are underwriting and general expenses (review of application, policy issuance, accounting, agent commission, premium tax, etc.) Other items to consider are the profit and contingency provision, reinsurance impact, and federal income tax.

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

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

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

FREQUENT MISCONCEPTIONS

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

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

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

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

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

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

Financial results for medical liability insurers have deteriorated. Some portion of these adverse results might be attributed to inadequate knowledge about rates in newly entered markets and to being too competitive in offering premium discounts on existing business. However, decisions related to these actions were based on expectations that recent loss and investment markets would follow the same relatively stable patterns reflected in the mid-1990s. As noted earlier, these results also reflect favorable reserve development from prior coverage years or, in other words, "good news on old business." Unfortunately, the environment unexpectedly changed on several fronts—loss/cost levels increased, in several states significantly; the favorable reserve development ceased; investment yields declined; and reinsurance costs jumped. Today's rate increases reflect a reconciliation of rates to current loss and reinsurance cost levels, given available interest yields. The "current problem" reflects current data.

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

This is a false observation. Companies are reporting losses primarily because claim experience is worse than anticipated when prices were set. Further, it would seem illogical that companies would have reported profitable results during most of the 1990s and, at the end of the decade, decide to report unsupported losses in an effort to justify higher rates. Several companies have suffered serious adverse con-

sequences given these financial results, including liquidation or near liquidation. Phico, MIIX, Frontier and, most recently, the Reciprocal of America, are all companies forced out of the business and in run-off due to underwriting losses. Further, the St. Paul Cos., formerly the largest writer of medical malpractice insurance, are now in the process of withdrawing from the medical liability insurance market. One reason for this decision is an expressed belief that the losses are too unpredictable to continue to write the business.

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

Mr. GREENWOOD. We thank you, Mr. Hurley, very much. Scott Diener or Diener?

Mr. DIENER. Diener.

Mr. GREENWOOD. Mr. Diener.

TESTIMONY OF SCOTT DIENER

Mr. DIENER. Chairman Greenwood, Ranking Member Deutsch, members and staff of the committee, thank you for this opportunity——

Mr. GREENWOOD. You may want to pull that microphone right in front of you, if you would, please.

Mr. DIENER. Our views on the need for Federal medical liability reform—is that better? My name is Scott Diener, and I am President and CEO of PMSLIC, a physician owned and physician managed medical professional liability insurance company. PMSLIC was formed by the Pennsylvania Medical Society and began to issue policies in 1978 when the Argonaut Insurance Company ceased writing. We have been providing medical professional liability insurance to Pennsylvania physicians for 26 years. We insure approximately 7,000 physicians in Pennsylvania. We are no longer a subsidiary of the Medical Society. We operate independently as a member of the NORCAL Group of insurance companies. Our only business mission is to be a long-term stable provider of medical liability insurance in Pennsylvania. We have stayed true to that mission by using cost based pricing strategies that have routinely resulted in our rates being the highest in the Pennsylvania market.

Even with this cost based strategy, the unpredictable nature of both the number of lawsuits filed against physicians, frequency, and the amount needed to pay injured patients, severity, make it very difficult to determine an adequate premium. Please allow me to briefly provide some statistical background. In 2002, we received 1,800 new claims and lawsuits and had 4,300 open at year-end; 85 percent of our claims and lawsuits are closed without any payment to patients or their lawyers. Our average defense costs are $8,000 on cases closed without payment to patients or their lawyers.

Conceptually, the job of rate setting is relatively simple. We first analyze historical data to establish a trend line. We use that trend line to estimate the ultimate cost of the claims and suits that will be made against our insured physicians during the next year. We then estimate the amount of investment income that we will earn between the time we collect the premium and the time we pay the claims. This we used to subsidize the rate we would otherwise have to charge. We then add in taxes, expenses, divide by the number of insureds, and send out the bills.

The actual ratemaking process is, naturally, more complicated. On average, our claims are generally resolved a little over 3 years

after they are filed, about 6 years after the incident occurs. During that time, the costs of medical care go up, new theories of liability are developed, investment yields fluctuate, and juries willingness to award money changes. Even using the best experts as we do, these factors make rate setting very difficult, more of an art than a science.

In our view, a solution to the medical availability crisis must include four elements: real medical liability reform, improvements in patient safety, increased reimbursements to physicians, and improved insurance regulation. PMSLIC supports real, proven, time tested reforms such as MICRA. I have been in the medical liability insurance business for over 20 years. I have worked in Arizona and California, coming to Pennsylvania a year ago. I can tell you that MICRA works to produce a more stable and predictable insurance market, and is fair to the medically injured, and improves access to healthcare.

Injured parties in California are fully compensated for their medical bills, lost wages, and all economic damages. This is as it should be. However, here in Pennsylvania and other states without caps on non-economic damages, there is always the potential in a case that the jury will be persuaded to award millions of dollars in non-economic damages. This introduces tremendous uncertainty into our process. By capping these non-economic damages at $250,000, a large part of the lottery system we have in Pennsylvania is removed.

PMSLIC also supports the limits on plaintiff attorney contingency fees in MICRA. This, naturally, makes more money available to the injured plaintiff. PMSLIC supports efforts to improve patient safety. We have a long history of offering our insureds risk management programs with the goal of improving patient safety. In 1999, for example, in response to an increase in the number of lawsuits alleging diagnostic errors, we produced a risk management course entitled, The Diagnostic Dilemma, which approximately 4,000 physicians requested. Those physicians who completed it successfully earned a 5 percent premium reduction. The Pennsylvania Legislature has taken aggressive steps to address patient safety in the MCare legislation. We look forward to the results of those efforts.

PMSLIC supports increases in physician reimbursements. Physicians need to be able to make a reasonable income so that they can pay their costs of doing business and continue to provide excellent healthcare to our citizens. PMSLIC supports insurance reforms that ensure companies are charging adequate rates for medical liability insurance. PIC, PIE, and PHICO are insolvent. In Pennsylvania, as in many states, there is a guaranty fund that pays the claimants of these insolvent carriers. The money for these payments comes from assessments on the companies still writing coverage. From 1997 through 2002, PMSLIC paid $5 million in guaranty fund assessments, thus, those physicians insured by properly run carriers, who many times have paid higher premiums all along, are now also paying for the claims of the insolvent carriers.

We are committed to ensuring physicians in the Commonwealth of Pennsylvania at adequate rates that are based on our loss experience. We believe that if we are to restore stability and predict-

ability to our medical liability market, all interested parties must be willing to seek and accept the comprehensive solution.

In conclusion, we encourage you to enact Federal medical liability reform to improve access to healthcare by bringing stability and predictability to the medical liability market, like that in California, to the rest of the United States. Mr. Chairman, thank you, again, for the opportunity to present our views. I will be happy to answer any questions.

[The prepared statement of Scott Diener follows:]

PREPARED STATEMENT OF SCOTT DIENER, PRESIDENT AND COO, PENNSYLVANIA MEDICAL SOCIETY LIABILTY INSURANCE COMPANY

Chairman Greenwood, Ranking Member Deutsch, members and staff of the committee, thank you for this opportunity to present our views on the need for Federal medical liability reform.

My name is Scott Diener and I am President and COO of PMSLIC, a physician owned and physician managed medical professional liability insurance company.

PMSLIC was formed by the Pennsylvania Medical Society and began to issue policies in 1978 when the Argonaut insurance company ceased writing.

We have been providing medical professional liability insurance to Pennsylvania physicians for 26 years. We insure approximately 7,000 physicians in Pennsylvania.

We are no longer a subsidiary of the Medical Society. We operate independently as a member of the NORCAL Group of insurance companies.

Our only business mission is to be a long term and stable provider of medical liability insurance in Pennsylvania.

PMSLIC has stayed true to that mission by using cost based strategies that have routinely resulted in PMSLIC's rates being the highest in the Pennsylvania market.

Even with this cost based strategy, the unpredictable nature of both the number of lawsuits filed against physicians (frequency) and the amount needed to pay injured plaintiffs (severity) make it very difficult to determine an adequate premium.

Please allow me to briefly provide some statistical background:

- In 2002 we received 1,800 new claims and lawsuits and had 4,300 open at year end.
- 85% of our claims are closed with no payment to patients or their lawyers.
- Our average defense costs are $8,000 on cases closed without payment to patients or their lawyers.

Conceptually, the job of rate setting is relatively simple.

We first analyze historical data to establish a trend line. We use that trend line to estimate the ultimate cost of the claims and suits that will be made against our insured physicians during the next year.

Next we estimate the amount of investment income that we will earn between the time we collect the premium and the time we pay the claims. This we use to subsidize the rate we would otherwise have to charge. We then add in taxes and other expenses, divide by the number of insureds and send out the bills.

The actual rate making process is naturally more complicated.

On average, our claims are generally resolved a little over three years after they're filed, about six years after the incident. During that time the costs of medical care go up, new theories of liability are developed, investment yields fluctuate and juries' willingness to award money changes.

Even using the best experts as PMSLIC does, these factors make rate setting very difficult—more of an art than a science.

In our view, a solution to the medical availability crisis must include four elements: real medical liability reform, improvements in patient safety, increased reimbursements to physicians and improved insurance regulation.

PMSLIC supports real, proven, time-tested reforms such as MICRA (the Medical Injury Compensation Reform Act) in California.

I have been in the medical liability insurance business for over twenty years. I have worked in Arizona and California, coming to Pennsylvania just over a year ago. I can tell you that MICRA works to produce a more stable and predictable insurance market and is fair to the medically injured and improves access to health care.

Injured parties in California are fully compensated for their medical bills, lost wages and all "economic damages." This is as it should be.

However, here in Pennsylvania and other states without caps on non-economic damages, there is always the potential in a case that the jury will be persuaded to award millions of dollars in non-economic damages.

This introduces tremendous uncertainty into the process. By capping non-economic damages at $250,000 a large part of the "lottery" system we have in Pennsylvania is removed.

PMSLIC also supports the limits on plaintiff attorney contingency fees in MICRA. This makes more money available to the injured plaintiff.

PMSLIC supports efforts to improve patient safety.

PMSLIC has a long history of offering our insureds risk management programs with the goal of improving patient safety. In 1999, for example, in response to an increase in the number of lawsuits alleging diagnostic errors, we produced a risk management course entitled *The Diagnostic Dilemma,* which approximately 4,000 physicians completed.

Those physicians who completed it successfully earned a 5% premium reduction.

The Pennsylvania Legislature took aggressive steps last year to address patient safety in the MCARE legislation. We look forward to the results of those efforts.

PMSLIC supports increases in physician reimbursements.

Physicians need to be able to make a reasonable income so that they can pay their costs of doing business and continue to provide excellent health care to our citizens.

Currently they are being squeezed between increasing costs and reduced revenue. This needs to be addressed.

PMSLIC supports insurance reforms that ensure companies are charging adequate rates for medical liability insurance.

PIC, PIE and PHICO are insolvent.

In Pennsylvania, as in many states, there is a guaranty fund that pays the claimants of these insolvent carriers. The money for these payments comes from assessments on the companies still writing coverage.

From 1997 through 2002 PMSLIC paid $5 million in guaranty fund assessments.

Thus, those physicians insured by properly run carriers, who many times have paid higher premiums all along, are now also paying for the claims of the insolvent carriers!

PMSLIC is committed to insuring physicians in the Commonwealth of Pennsylvania at adequate rates that are based on our loss experience.

PMSLIC has been working for meaningful medical liability reform for over twenty years.

We believe that if we are to restore stability and predictability to our medical liability market, ALL interested parties must be willing to seek and accept a comprehensive solution.

In conclusion, we encourage you to enact federal medical liability reform to improve access to health care by bringing stability and predictability to the medical liability market, like that in California, to the rest of the United States.

Mr. Chairman, thank you, again, for the opportunity to present our views this afternoon. I would be happy to answer your questions.

Mr. GREENWOOD. Thank you, sir. Dr. Nasca.

TESTIMONY OF THOMAS J. NASCA

Mr. NASCA. Chairman Greenwood, members of the subcommittee, thank you for the opportunity to address you today on this important issue. By way of introduction, my name is Thomas J. Nasca, MD. I am a Board certified nephrologist, I am the Senior Vice President of Thomas Jefferson University, the Dean of the Medical College, and the President of Jefferson University Physicians, the practice plan of Jefferson's 469 full-time physician faculty. My curriculum vitae is attached to my testimony.

I would like to address the impact of medical liability insurance issues on medical schools, their faculty, students, and residents, specifically, using Jefferson as an example. Let me start with a story. I was approached by a young physician who was completing his training at Jefferson last June. I have known him for almost 10 years. He is from Coal Country in Pennsylvania and he was a high school quarterback. He was a local hero but decided to pursue

his dream of becoming a doctor rather than play football in college. He came to Jefferson, graduated in 1993, he completed his medicine training, and just completed 4 years of additional cardiology training. He had a budding career in academic medicine. He was offered a position on the faculty, which he reluctantly declined. He entered the private practice of cardiology less than two miles away, just across the river in New Jersey. His reasoning was that he was afraid that the medical liability crisis in Pennsylvania could never be solved and that he had to be sure that he could support his family and pay back his student loans. He clearly indicated that this was a pragmatic decision, as he had always dreamed of being a teacher of doctors.

Now, give me a few moments to emphasize four points developed in greater detail in my written testimony. First, medical schools and their related academic medical centers have unique tripartite missions. These missions are public goods and are carried out in an environment with significant governmental and accrediting agency oversight. They are threefold: the mission of education, the mission of discovery and scholarship, and the mission of clinical care. Medical schools are much more than hospitals. They are not only the germinal centers for the miracle cures and clinical innovations which have enhanced the lifespan and quality of life of all Americans. They are also educational gems, the desired destination of potential physicians and researchers around the world. They are a unique subset of our American healthcare delivery system.

Second, the education and research missions of medical schools are based on the fundamental ability of the clinical enterprise to support the physician cohort of the faculty and to subsidize unfunded components of their educational and research enterprise.

Third, academic physicians and their institutions care for all patients who come to their doors regardless of their ability to pay. Patients with severe or unusual illnesses seek out experts at academic medical centers. These patients require more time, more effort, and more oversight. Differential reimbursement for these services is not routinely provided by governmental or third party payers and is often systematically inadequate to cover the cost of provision of care. Academic physicians have traditionally accepted lower salaries in order to participate in this wonderful tripartite mission. Indeed, medical schools have utilized this altruistic dimension of the academic physician to subsidize the education of medical students, residents, and clinical fellows.

Fourth, the unprecedented escalation in medical liability insurance premiums for the 469 clinical faculty at Jefferson will result in an increase of over $30 million over the 3-year period from 2001 through 2004. Jefferson's physicians—this is not the hospital, this is just the physicians—will spend approximately $50 million in these 3 years for the opportunity to care for the citizens of this region, to teach medical students, and to conduct research.

The impact of these cost increases at Jefferson have been significant. The net result of such phenomena is predictable. Faculty morale is suffering. There is less and less time available to conduct research and to teach and there is less and less time to care for each individual patient. This phenomena is by no means confined to Jefferson. The impact, if continued, is clear. While the country

is looking to the academic medical community to solve the problems of our population, such as cancer, heart disease, neuro-degenerative diseases, while providing protection from bioterrorism and emerging diseases, the academic medical community may be disintegrating.

Medical schools and their academic medical centers are clearly in jeopardy and the message is reaching those who are choosing medicine as a career. Applications are down from a high of over $45,000 in 1996 to less than $32,000 in the year 2002. Further, the attitudes of graduating students and residents are very concerning. The Association of American Medical College graduation questionnaire and the graduate medical education tracking system questionnaires indicate significant medical student and graduating resident dissatisfaction with the practice environment in Pennsylvania. Of programs completing the graduate medical education tracking survey over the last 2 years, no graduating neurosurgeons—that is zero graduating neurosurgeons, orthopedic surgeons, or radiologists entered private practice in Pennsylvania last year. The number of young obstetricians decreased by nearly 40 percent entering practice in Pennsylvania. Further, the number of anesthesiologists decreased by over 80 percent. Young graduates are voting with their feet.

Another closing story, a young surgeon at Jefferson developed a new technology that would permit the safe operation of a previously lethal heart condition. He worked on this machine day and night for over 5 years, testing it in animals, working with engineers from a computer manufacturer, and discussing each nuance with a host of other medical specialists. His salary was paid by Jefferson from funds generated by others. He finally tested his machine on a patient and it worked. That test occurred 50 years ago this spring at Jefferson. The physician was John Gibbon and the machine he tested was the first cardiac bypass machine ever successfully used in a human. Dr. Gibbon revolutionized the care of patients with heart disease and has saved millions upon million of lives because of his invention. He was a clinical scientist, a translator of results from the laboratory to the bedside. He was doing something that no one thought feasible. Were he trying to accomplish a like feat in today's environment, I fear that I, as dean, might not have the dollars to support his work.

The physician who educates the next generation of physicians is performing a societal good greater than the actual provision of individual patient care. She is making it possible for thousands of other patients to receive healthcare from those she is training. The physician scientist who creates a new treatment not only treats the patient on whom the treatment is proven efficacious, he gives that treatment to others to treat others. We cannot as a Nation learn the physician teachers or the physician scientists. We cannot permit the medical liability insurance costs to consume tens of millions of dollars a year at Jefferson or any other institution while similar costs are half as much nearly two miles away. These are dollars required to constructively build the future of healthcare, its practitioners, and its innovations, all with the goal of improving the care of our citizens.

I believe that States such as Pennsylvania, because of unique circumstances, may be incapable of fixing this problem. Short-term fixes fail to solve the fundamental structural issues and merely divert resources from other needs. I wish you well as you tackle and hopefully solve for all of us this pressing national issue that threatens the fabric of our medical schools and their related academic medical centers. Thank you.

[The prepared statement of Thomas J. Nasca follows:]

PREPARED STATEMENT OF THOMAS J. NASCA, BOARD CERTIFIED NEPHROLOGIST, SENIOR VICE PRESIDENT OF THOMAS JEFFERSON UNIVERSITY, DEAN OF JEFFERSON MEDICAL COLLEGE

Chairman Greenwood, Members of the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, of the United States of America House of Representatives:

Thank you for the opportunity to address you today on the important issue at hand. By way of introduction, my name is Thomas J. Nasca, M.D. I am a Board Certified Nephrologist, and am the Senior Vice President of Thomas Jefferson University, the Dean of Jefferson Medical College, the 8th oldest medical school in the United States, and the President of Jefferson University Physicians, the "practice plan" of the nearly 500 full time clinical faculty of Jefferson Medical College. My curriculum vitae is attached to my written testimony.

I will not present views concerning the causes of the medical liability insurance crisis in this and a number of other states. You have many experts providing testimony clarifying prevailing, often conflicting views on this very difficult issue.

Rather, I would like to present to you the impact, both currently measurable, and anecdotally not yet measurable (but felt "on the ground") in at least one major medical school and academic medical center which has served the citizens of this country for nearly 200 years. To do so, I will take the liberty of briefly explaining the missions of the academic medical center, the basics of its funding streams, and the impact of rapid escalation of costs, in this case medical liability insurance costs, on these core missions.

MISSIONS OF MEDICAL SCHOOLS AND ACADEMIC MEDICAL CENTERS

The missions of the 125 allopathic medical schools and their related academic medical centers are public goods. These missions are carried out in an environment with significant governmental and accrediting agency oversight. They are threefold:

1. **The Mission of Education:** education of the next generation of caregivers, including physicians and nurses.
2. **The Mission of Discovery and Scholarship:** the search for basic and clinically relevant discoveries which lead to prevention of disease, enhancement of survival, or amelioration of suffering of persons. This mission also includes the dissemination of this information to all practitioners to enhance care across the nation and the world.
3. **The Mission of Clinical Care:** the provision of state-of-the-art care, often research based, which will lead to the patient centered care of the individual, provide the opportunity for education of the next generation of caregivers, and the development and dissemination of knowledge beyond the individual patient.

These institution are not only the germinal center for the miracle cures and clinical innovations which have enhanced the life span and quality of life of all Americans. They are also educational gems, the desired destination of potential physicians and researchers across the world. I89Funding Streams to Support the Missions

1. Funding the Educational Mission

Medical student education is partially supported through tuition dollars of medical students. Educational efforts of the faculty in the pre-clinical years for medical students are supported largely through these dollars.

In the clinical setting and in the conference room, trainees are supervised in the care of patients. This model of progressive responsibility under direct faculty supervision ultimately yields (after 4 years of medical school, and up to 10 years of graduate medical education) a practitioner who is competent to practice medicine independent of direct supervision. There are limited dollars from tuition to support medical student education. (Tuition supports less than 40% of the total costs of provision of medical student education at Jefferson Medical College). The majority of clinical education is supported through willingness of the physician to perform this impor-

tant task without institutional compensation. This is done at a cost of time of the physician faculty.

Thus, medical student education in the clinical phase is provided through the volunteer efforts of clinicians who are faculty members of the school, whether they are "full time" or "volunteer" clinical faculty. In essence, the time spent teaching is being subsidized by the clinical income of the physicians' practice.

Medicare (and in some states Medicaid) recognizes faculty expenses incurred in the education of residents and fellows, but this is not the case for most other insurance providers. Thus, teaching efforts by the faculty on behalf of residents and fellows in the clinical setting are partially supported by Medicare Direct Graduate Medical Education (DGME) funding. These dollars come to the faculty from the hospital, in Jefferson's case, Thomas Jefferson University Hospital (TJUH).

2. Funding the Research Mission

In general terms, direct research awards pay for the actual costs of conducting research. Indirect cost recovery is provided by federal sponsors and some other sponsors to support the institutional infrastructure costs incurred in creation of the research environment. Since all direct and indirect costs of the research enterprise are not reimbursed, shortfalls must be provided by the institution.

Of important note in these discussions is the unique role of the "Translational Scientist-Clinician." These are the specialized physician scientists who search for cures for illness found in his or her patients. These physician-scientists are the translators of discoveries made in the laboratory into relevant clinical treatments, procedures, or cures. They are usually highly sub-specialized clinicians who care for a group of patients with a particular disease, while also conducting laboratory-based research. Thus, they practice medicine "part time," usually between 15-50% of their effort. Their research time is usually funded through National Institutes of Health awards, or other sources of research funding. Their clinical time must be supported through their clinical practice. Since their practice is part time, high fixed costs, such as medical liability insurance premiums, make the economic dimensions of clinical practice increasingly difficult, or impossible.

Shortfalls in research faculty, facility and other related costs are born by the institution. Sources of funding for these shortfalls are:

a. Institutional Endowments
b. Philanthropy
c. Surplus clinical revenue from the practice plan (the "dean's tax")

3. Funding the Clinical Mission

Clinical care is supported through the clinical revenue generated in the care of patients. Institutional support is provided during start-up of new faculty, but the clinical enterprise is expected to be largely self-supporting. Academic physicians and their institutions care for all patients who come to their doors, regardless of their ability to pay. Furthermore, patients with severe or unusual illnesses seek out experts at academic medical centers. These patients require more time, more effort, and oversight. Reimbursement for these services is not routinely recognized by third party payors, and is often systematically inadequate to cover the costs of provision of care. Academic physicians have traditionally accepted lower salaries in order to participate in the tripartite mission of the medical school and academic medical center. Indeed, medical schools have utilized this altruistic dimension of the academic physician to subsidize the education of medical students, residents, and clinical fellows over the past 100 years, in the post-Flexnerian era of medical education.

THE IMPACT OF THE CURRENT CRISIS ON JEFFERSON MEDICAL COLLEGE

The tenuous balance between clinical service, education, and the funding of research at Jefferson is in jeopardy of disruption due to the recent, unprecedented increases in cost for medical liability insurance.

The impact of such dramatic increases, in excess of 100%, are significant on the financial health of the organization. With approximately $145,000,000 in total revenue and expenses in the practice plan (Jefferson University Physicians), malpractice costs in the current fiscal year account for 12.8% of all expenses. Furthermore, the increase in medical liability insurance costs has not abated since it doubled in 2001-2002. The continued annual increase in premiums has forced increases in clinical service provision to merely "keep pace" with the unprecedented costs of insurance. Further, it should be noted that Jefferson University Physicians has had a lower than expected claims history over the past 15 years than expected (by specialty) according to actuarial analysis. It is also important to understand that these figures do not include medical liability insurance costs for the University Hospital

(TJUH), where resident physician liability costs hare borne. They are merely the cost of insuring the 469 full time clinicians of the faculty.

It is instructive to review specialty specific data. Below in Table 1. is listed the per physician medical liability insurance annual premiums for Jefferson physicians for 1996-97 to the present. As can be seen in this data, the striking increase has not only been seen in specialized surgical disciplines such as Obstetrics and Gynecology, but also in the primary care discipline of General Internal Medicine. The impact on actual salaries of physicians in these disciplines is predictable, and seen in Table 2.

Table 1. Specialty Specific Medical Liability Insurance Premiums, son University Physicians

Specialty	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004 Proj.
OB/GYN	48,400	48,000	51,300	60,948	106,600	122,000	137,188
General Surgery ...	41,600	40,300	43,390	48,500	82,600	91,946	100,164
Internal Medicine	9,780	9,702	10,714	12,000	22,185	24,981	29,650

Table 2. Median Specialty Specific Compensation, Jefferson University Physicians

Specialty	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003.
OB/GYN	100,000	103,796	114,478	119,544	112,435	110,000
General Surgery	196,500	191,350	197,386	172,703	193,734	212,715
Internal Medicine	180,983	167,770	157,500	158,713	169,869	147,102

The result of these increases in medical liability insurance costs at Jefferson has been threefold.

1. The clinical faculty are providing more clinical services, and spending more time seeing patients.
2. The clinical faculty are seeing compensation decrease in constant dollars, and in many instances decrease in total dollars. This is despite the fact that salaries at Jefferson are, in general, lower than competitive salary scales at our regional competitors, and when viewed in comparison to other Northeastern University Medical Schools (AAMC Salary Survey).
3. The time for teaching, conducting clinical research, and for each patient encounter is decreasing.

The net result of such phenomena is predictable. Faculty morale is suffering, and individual faculty members are questioning the utility of spending as much time in direct clinical practice as the physicians in private practice, with less and less time able to be dedicated to research and education. This phenomena is not confined to Jefferson. In a soon to be published study conducted by the Group on Practice Affairs of the Association of American Medical Colleges, faculty morale brought about by these and related phenomena is dropping significantly. (Lynne Davis Boyle, AAMC, unpublished data).

The impact on faculty, if continued, is clear. Dissatisfaction with the academic practice of medicine will lead to loss of faculty from medical schools, and the inability to recruit the best and brightest young faculty to fill their shoes. Deterioration of the educational and translational research efforts will have long-ten-n disastrous effects on the public. As the country is looking to the academic medical community to solve problems such as cancer, heart disease, while providing protection from bioterrorism and emerging diseases, the academic medical community will be disintegrating.

Much has been written concerning the fragility of the American Health Care system. After over a decade of absent capital reimbursement, “cost minus” adjustments in hospital reimbursement, managed care “discounting” of physician reimbursement; recent reductions in Medicare reimbursement for physician services, and dramatic escalations of medical liability insurance premiums for hospitals and doctors, the health care system is in a precarious state. An important subset of this health care system is the Medical School-Academic Medical Center. These 125 medical school based delivery systems are a national resource. They clearly are jeopardized, and the message is reaching those who are choosing medicine as a career. In addition to those students who have chosen not to pursue medicine as a career (applications are down from a high of >45,000 in 1996 to <32,000 in 2002, source, AMCAS, AAMC), the attitudes of graduating students and residents are instructive. Attached in the Appendix to this testimony are two documents obtained from the Association

of American Medical Colleges (AAMC). The first is a comparison of the results of the graduation questionnaire administered to all medical students (>95% response rate). In analysis of this question, responses of students indicating an intent to ultimately practice in the state of Pennsylvania are compared to all other students completing the questionnaire. Of note are two important phenomena. First, there was little difference between students interested in practicing in Pennsylvania and the rest of the country in 2001. Additionally, there were 525 students intending to practice in Pennsylvania.

Second, in 2002, there is a clear trend seen in the students interested in ultimately practicing in Pennsylvania, with 92.1% of students agreeing or strongly agreeing (with 60.0% strongly agreeing) with this statement, in comparison to a stable 84.6% (40.1% strongly agreeing) in students interested in practicing in other states. Finally, a trend may be developing. There were only 445 students indicating intention to practice in Pennsylvania. This is a reduction of 80, or 15% over the prior year.

Table 3. Opinion of Graduating Medical Students (2001 and 2002) on Medical Liability: Students Planning to Practice in Pennsylvania vs. All Graduating Students

Question: Based on your experiences, indicate whether you agree or disagree with the following statement: ''Physicians' legal liabilities and the high cost of malpractice insurance are major problems.''

Year	Category of Graduating Medical Student	Strongly Agree %	Agree %	No Opinion %	Disagree %	Strongly Disagree %	Count %
2001	Plan to Practice in Pennsylvania	39.8	46.9	10.3	2.9	0.2	525
2001	All Graduating Students	34.4	48.10	12.8	4.6	0.1	14,139
2002	Plan to Practice in Pennsylvania	60.0	31.2	5.6	3.1	0.0	445
2002	All Graduating Students	40.1	44.2	11.7	3.8	0.2	14,162

Source: 2001 and 2002 Medical School Graduation Questionnaire, Association of American Medical Colleges. Lynne Davis Boyle, personal communications.

Medical students are years away from a practice site choice. Residents and fellows make that choice at the end of their training. GME Track (AAMC) is a survey intended to follow these and other trends. Results from the recent GME Track survey provide more concerning information which, if it is a trend, would demonstrated significant concerns for the future flow of young physicians to Pennsylvania.

Pennsylvania-Trained Residents in ''High-Risk'' Specialties: Immediate Career Plans Upon Completion of Training Programs, 2000-2002*

Source: AAMC GME Track, 2000-2002

Specialty	Of Those Choosing Private Practice: % Remaining in Pennsylvania 2000	Of Those Choosing Private Practice: % Remaining in Pennsylvania 2001	Of Those Choosing Private Practice: % Remaining in Pennsylvania 2002	% Change 2000-2002
Neurosurgery	25%	0%	0%	100% decline
OB/GYN	44%	42%	28%	36% decline
Anesthesiology	56%	25%	10%	82% decline
Orthopedic Surgery	50%	50%	0%	100% decline
Radiology (Diagnostic)	0%	40%	0%	0%
Internal Medicine	46%	45%	41%	11% decline

Summary:

While the table reflects data compiled via a relatively new survey (responses are not high, but are increasing over time), preliminary data show a trend of residents leaving the state upon completion of their training program.

Although there is no specific evidence of a relationship between residents' choices and the liability issue, there is also no evidence that would rule it out.

***Notes on Data:**

''GME Track'' surveys residency program directors annually. The survey includes a request for program directors to identify the immediate career plans of residents who have completed their training.

Data reflects only those residents who have completed their training, plan to enter private practice, and whose program directors responded to the survey.

''High-Risk'' reflects specialties commonly identified by the physician community and the press, as well as specialties that have helped lead recent physician strikes''.

As can be seen from this early data, the Pennsylvania practice environment is viewed negatively by young physicians entering residencies (graduation questionnaire) and leaving residency and entering private practice (GME Track data).

These data, coupled with the emerging national data on faculty morale, the local information I have provided to you raise issues which must be addressed. The

emerging realization that Medical Schools and Academic Medical Centers are nearing their limit of survivability of the external economic factors that are buffeting all of health care should be of concern to all.

The physician who educates the next generation of physicians is performing a societal good greater than the actual provision of patient care. She is making it possible for thousands of other patients to receive health care from those she is training. The physician-scientist who creates a new treatment not only treats the patient on whom the treatment is proven efficacious, he gives that treatment to others, to treat others.

Two anecdotes may help underscore these points.

I was approached by a young physicians who was completing his training at Jefferson last June. I have known him for almost 10 years. He was from coal country in Pennsylvania, and was a high school quarterback. He was a local hero, but decided to pursue his dream of becoming a doctor rather than play football in college. He came to Jefferson, graduating in 1993. He completed his hitemal Medicine residency at Jefferson, and just complete 4 years of Cardiology training. He had a budding career in academic medicine, having already written two research papers, and showing tremendous teaching talent as well. He was offered a position on the faculty, but reluctantly declined. He entered the private practice of Cardiology less than 2 miles away, across the river in New Jersey. His reasoning was that he was afraid that the medical liability crisis in Pennsylvania could never be solved, and that he had to be sure that he could support his family, and pay back his student loans. He clearly indicated that this was a pragmatic decision, as he always had dreamed of being a teacher of doctors. (Physician's name withheld).

A young surgeon at Jefferson developed a new machine that would permit the safe operation of a previously lethal heart problem. He worked on this machine day and night for over 5 years, testing it in animals, working with engineers from a computer manufacturer, and discussing each nuance with a host of other medical specialists. His salary was paid by the institution, from funds generated by others. He finally tested his machine on a patient, and it worked. That test occurred 50 years ago this Spring, at Jefferson. The physician was John Gibbon, M.D., and the machine he tested was the first cardiac by-pass machine ever successfully used in a human. Dr. Gibbon revolutionized the care of patients with heart disease, and has saved millions upon millions of lives because of his invention. He was a Clinician Scientist, a translator of results from the laboratory to the bedside. He was doing something that no one thought feasible. Were he trying to accomplish a like feat in today's environment, there might be inadequate institutional money to support his clinical research.

We cannot, as a nation, loose the physician teachers, or the physician scientists. We cannot permit the medical liability insurance costs to consume tens of millions of dollars per year at Jefferson, or any other institution. These are dollars required to constructively build the future of health care, its practitioners, and its innovations, with a goal of improving the care of our citizens. I believe that states such as Pennsylvania, because of unique circumstances, may be incapable of fixing this problem. Short term fixes fail to solve the fundamental structural issues, and merely divert resources from other needs. I wish you well as you tackle, and hopefully solve for all of us, this pressing national issue that threatens the fabric of our academic medical centers.

Mr. GREENWOOD. Thank you, Dr. Nasca. Mr. Rosenfield.

TESTIMONY OF HARVEY ROSENFIELD

Mr. ROSENFIELD. Thank you, Mr. Chairman, members. My name is Harvey Rosenfield. There is, indeed, a law in California that has lowered malpractice insurance premiums for doctors and other medical providers. It is not MICRA. I am the author of that law. I was the sponsor of the measure before the voters in 1988 and ran the campaign that defended the measure against an $80 million campaign by the insurance industry, including medical malpractice insurers. That law is known as Proposition 103.

Prior to Proposition 103, let us go back to 1976 when MICRA was passed. We had an insurance crisis in California. Once MICRA was passed, between 1976 and 1988, 12 years, medical malpractice insurance premiums for doctors rose 190 percent. During the crit-

ical years, between 1985 and 1988, and as the chairman will know, those are the years of the last insurance crisis in our Nation, years during which the insurance companies were inflating their losses, their projections of future losses, in order to show poor financial results, in order to justify rate increases; losses, the projections of which never came to pass. During that crisis, medical malpractice insurance premiums in California rose 47 percent.

In 1988, the voters of California were confronted with this dilemma. The voters had previously enacted insurance industry sponsored tort reform; not just MICRA, other tort reforms in the mid 1980's, and rates had not gone down. So they put Proposition 103 on the ballot and it was approved by the electorate. It took effect in May 1989 and it mandated across the board rate rollbacks. I want to be very clear about this, Mr. Chairman, because the insurance industry and the AMA have told people around the country that Proposition 103 did not apply to medical malpractice carriers. They have also—and Mr. Smarr's testimony states that rollbacks were not paid under Proposition 103. These assertions are incorrect. Proposition 103 applied to all forms of property-casualty insurance. It required a 20 percent rollback and stringent regulation of the industry thereafter. Of the $1.2 billion in rate refund checks issued by insurance companies between 1989 and 1995 under Proposition 103, $135 million went to doctors. If the committee would like to see them, I have got the actual settlement agreements here. These were not, as the testimony suggests, dividends. They were rate rollbacks. Here are the actual legal documents. I would be glad to make them available to the committee.

Mr. GREENWOOD. Mr. Rosenfield, is that a copy that we can incorporate into our record?

Mr. ROSENFIELD. It is my only copy, but if you want to take it, could you make me a copy?

Mr. GREENWOOD. If it is your only copy, it is going to be difficult for us to incorporate it into the record unless we take it.

Mr. ROSENFIELD. Could I Fed-Ex it to you tomorrow?

Mr. GREENWOOD. We will work that out.

Mr. ROSENFIELD. Okay. Thank you.

Mr. GREENWOOD. Why don't you make it available to our staff and we will see if we can find a copier.

Mr. ROSENFIELD. Okay. Thank you, Mr. Chairman. Now, after Proposition 103 passed, the major insurance carriers that sold medical malpractice coverage, as is noted in my testimony, dropped premiums 20 percent. They paid the 20 percent rollbacks and they dropped their premiums, and that is why between 1988 and the year 2000, California premiums for medical malpractice insurance coverage dropped 2 percent over that period of time.

My testimony goes into much more detail in this, Mr. Chairman, but I want to move to a different area. I want to talk about MICRA, because MICRA has become the model, as it were, for your bill, for the President's proposal, and I wrote a book about it 10 years ago: Silent Violence, Silent Death, the Hidden Epidemic of Medical Malpractice. Mr. Chairman, if you could be in my shoes as a consumer advocate and take the phone calls day after day, month after month, and year after year, from people in California who cannot even get a lawyer to bring a legitimate lawsuit. Why? The

one thing that has not been mentioned today is that MICRA not only caps non-economic damages, but it caps attorneys' fees. And as we all know, unless you are a very wealthy person and can afford to pay a lawyer $400 an hour, like insurance companies do, most victims of medical malpractice have to find a contingency fee lawyer, and they will not take most medical malpractice cases in California. It is simply not profitable. As a result, I have what I call death bed voicemails where people call and say, Harvey, can you please find my next of kin, a lawyer to represent them, because I am dying and I couldn't find one.

The tragic thing here is that the medical profession, whose principle is do no harm, is the lead advocate for reforms which in California have done harm. And this terrible conflict of interest comes on top of a decade of fighting with HMO's and profit driven medical care. Our organization—I am the President of the Foundation for Taxpayer and Consumer Rights. It is a nonprofit, nonpartisan organization. We have led the battle in California successfully to force HMO's to focus on quality healthcare, not just the bottom line. And doctors have been the victims of that battle, yet, today, they side with the insurers against the victims of medical malpractice.

I want to close my testimony by suggesting that this committee follow the principle that should be applicable to the medical profession. First, do no harm. Come to California, Mr. Chairman. Come to California and let us provide some not only public input on MICRA, but let us have a real debate. It is the debate the insurance company and the AMA do not want to have about the alternative, which is rate regulation, which is really what lowered premiums in California.

And finally, if you will come to California, here is one of the things you would find. I found it on the California Medical Association's website, buried. It is a 2001 report. This is before the current "crisis". This is a study done by the CMA of its physicians and it is titled, And Then There Were None, the Coming Physician Supply Problem. This is in California, the nirvana of where MICRA exists. I am quoting now, "43 percent of surveyed physicians plan to leave medical practice in the next 3 years; 75 percent of physicians have become less satisfied with medical practice; more than one-quarter of physicians would no longer choose medicine as a career; 58 percent of physicians have experienced difficulty attracting other physicians to join their practice." These findings foretell a dark and startling picture concerning physician supply in California. They predict a future with many fewer physicians. A majority say they will express this dramatically in the next 3 years by quitting practice. Physician flight from California is dramatic.

There is much to be learned in this debate. A few minutes ago one of the panelists here said everybody has to experience a little pain. As an advocate working in the legislature and in Congress, I know that there is a tendency for people to say let us just spread the pain, let everybody force something to give—force everybody to give something. I leave you with this one thought. Why should Heather Lewinski experience even 1 second more pain? Thank you, Mr. Chairman, members of the committee.

[The prepared statement of Harvey Rosenfield follows:]



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Testimony of Harvey Rosenfield
The Foundation for Taxpayer and Consumer Rights[1]
Before the House Energy and Commerce Committee
Subcommittee on Oversight and Investigations
February 10, 2003
Langhorne, Pennsylvania

Insurance Regulation vs. Tort Reform

Mr. Chairman and Members of the Committee:

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

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

In 1988, California voters, facing skyrocketing insurance premiums and angry at the failure of tort reform to deliver its promised savings, went to the ballot box and passed the nation's most stringent reform of the insurance industry's rates and practices.

Proposition 103:

- **Mandated immediate rate relief** to offset excessive rate increases by establishing a baseline for measuring appropriate rates. Prop. 103 required a roll back of at least 20% for all property and casualty insurance companies, *including* medical malpractice insurers.
- **Froze rates for one year**. Ultimately, because of the delay caused by insurance company legal challenges to Proposition 103, rates remained frozen for four years pursuant to decisions by the state's insurance commissioner.

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

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

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

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

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

Attached as Appendix A is a copy of the text and a detailed description of Proposition 103 and its provisions.

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

Proposition 103 worked. Insurance companies refunded over $1.2 billion to policyholders, including doctors. In the closely studied area of auto insurance, California was the only state in the nation in which auto insurance premiums actually dropped between 1989 and 1998 (4%), while rising 25% on average throughout the rest of the nation, according to a 2001 study by the Consumer Federation of America.[2] The report concluded that the prior approval provision of

[2] California auto insurers also prospered during the same period. A calculation of annual return on net worth from 1990 to 1999 reveals that these insurers received a 16.0 percent return compared to only 10.9 percent received by auto insurers nationally. "Why Not The Best? The Most Effective Auto Insurance Regulation In The Nation," by Robert Hunter, Director of Insurance, Consumer Federation of America. June 2001

Proposition 103 blocked over $23 billion in rate increases for auto insurance alone through 2000.

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

I. Impact of MICRA on Medical Malpractice Insurance Premiums

MICRA was enacted in 1975. However, premiums continued to rise. By 1988, twelve years after the passage of MICRA, California medical malpractice premiums had reached an all-time high – 190% higher than 1976, when MICRA was enacted.

During the mid 1980s, California malpractice premiums increased by more than 20% annually. Insurance companies argue that premiums continued to increase after MICRA's passage because of court challenges to the law: the California Supreme Court upheld the damage cap in 1985. Despite that ruling, however, malpractice premiums in California increased more dramatically in 1986 than any year since the passage of MICRA. Between 1985, when the cap was upheld, and 1988, malpractice premiums soared 47%, to the highest levels in California history.

Figure 1. Premium Increases During the Last Insurance Crisis

Year	California Premiums Earned	Percentage Change
1983	$287,256,000	36.37%
1984	$374,661,000	30.43%
1985	$449,727,000	20.04%
1986	$629,448,000	39.96%
1987	$633,903,000	0.71%
1988	$663,155,000	4.61%

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

II. Impact of Proposition 103 on Malpractice Insurance Premiums

A. Premiums Drop by 20% After Proposition 103

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

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

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

Figure 2. Premiums dropped after Prop. 103

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

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

After adjusting for inflation, the premium drop is actually 30.7%.

B. Insurance Reform Requires Medical Malpractice Insurers to Refund Millions to Doctors.

Lobbyists for the insurance industry have told lawmakers in some states that Proposition 103's rollback did not apply to medical malpractice insurers. Their statements are false. Medical malpractice insurers were among the first insurance companies in California to comply with Proposition 103's mandatory rate rollback. Three of the state's largest malpractice insurers – Norcal Mutual, SCPIE and The Doctors Company – refunded $69.1 million to doctors by 1992. By 1995, insurers providing medical malpractice coverage issued more than $135 million in refunds to policyholders.

According to a California Department of Insurance news release of February 18, 1992:

> The Doctors' Company follows two other medical malpractice insurance groups and the Automobile Club of Southern California in agreeing to voluntarily comply with the

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

News releases and articles about the malpractice rollbacks are attached as Appendix B

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

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

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

C. Insurance Reform Imposed Moratorium on Rate Increases in California

According to Proposition 103, all insurance rates were to be frozen for one year at the rolled-back rate level. After the passage of the initiative, a moratorium was declared on all rate increases by medical malpractice insurance companies, as well as other insurers, pending resolution of the insurers' legal challenges and the promulgation of regulations governing the rollback process.

The initiative itself, including the rollback requirement, was upheld by a unanimous California Supreme Court in May, 1989. The insurance commissioner at the time imposed a freeze while developing rollback regulations. Litigation delays blocked the regulations, and when California's first elected insurance commissioner took office, he announced rollback regulations and ordered a rate freeze pending payment of the rollbacks by each insurer.

Largely because of lawsuits brought by the insurers against the rollback regulations, the rate freeze remained in effect for many insurers for four years.

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

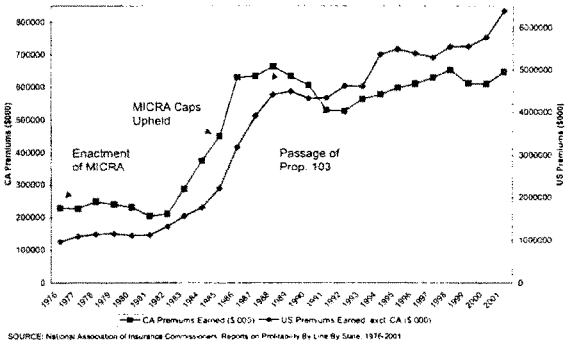
Upon payment of the rate rollback refunds, insurers were then subject to Proposition 103's "prior approval" regulatory system, which requires medical malpractice insurers to justify rate increases or decreases to the Department of Insurance, and the commissioner may, at any time, invalidate an insurers'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

III. Comparing MICRA v. Proposition 103

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

California doctors' premiums generally tracked premiums countrywide between 1976 and 1988, following the recognized boom-bust "insurance cycle" that has coincided with each insurance "crisis" in this country, including the present one.[3]

Figure 4. Medical Malpractice Aggregate Premiums CA v. US (1976-2001)



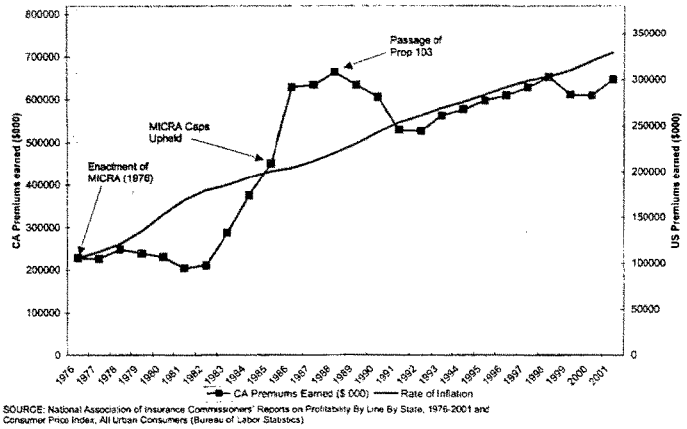
SOURCE: National Association of Insurance Commissioners, Reports on Premiums by Line By State, 1976-2001

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

But malpractice premiums fell sharply in California immediately after passage of Proposition 103. Moreover, they continued to drop in ensuing years, bucking the national trends, and then stabilized while national rates continued to fluctuate.

In the twelve years after the enactment of MICRA, California doctors' premiums rose much faster, overall, than the national rate of inflation. After California voters enacted insurance reform Proposition 103 in 1988, medical malpractice rates first fell dramatically and then generally followed the rate of inflation or declined still.

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



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

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

Figure 6. Annual Change in California Medical Malpractice Premiums

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

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

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

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

Legislation enacted in Florida in the spring of 1986 at the behest of a coalition of insurance companies, medical lobbies and corporations contained dramatic restrictions on victims' rights. But it also required insurers to reduce their insurance rates concomitantly, unless they could demonstrate to state insurance regulators that the limitations on consumers' rights would not reduce their costs. Six months after the law was enacted, two of the nation's largest insurance companies told the Florida Insurance Department that limiting compensation to injury victims would not reduce insurance rates. St. Paul Fire and Marine Insurance Company, then the nation's largest medical malpractice insurer, and Aetna Casualty & Surety Co., provided an extensive "actuarial analysis" of five specific limitations on victim's rights that the insurance industry had promised would reduce premiums. Overall, the Aetna report concluded that one provision of the law would reduce rates by a maximum of 4/10 of 1 percent, while all the other tort restrictions would have "no impact" on rates.[4] In fact, Aetna asked for a 17 percent rate *increase* based on its analysis of the impact of the law. The St. Paul

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

study concluded that the restrictions "will produce little or no savings to the tort system as it pertains to medical malpractice." [5] St. Paul stated:

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

In April, 1987, the insurance industry's rate-making agency, the Insurance Services Office (ISO), released the results of a study intended to respond to repeated demands from policymakers and legislators across the country that the industry provide empirical data to support its claims that changes in the tort law system would alleviate the nation's insurance crisis. The study examined the responses of 1262 insurance adjusters from nine property-casualty insurance companies and two independent adjusting firms located in 24 states. The adjusters were asked to determine the impact of actual restrictions in the tort laws of 15 of the states on six hypothetical injury cases. In addition, they were asked to judge the impact of similar proposals which did not become law in the remaining nine states. Much to the chagrin of the insurance industry, the study failed to support years of insurance industry propaganda. Instead, it disclaimed any impact upon rates. One insurance industry official was quoted as saying, "Some state legislators are going to be shaking their heads after hearing us tell them for months how important tort reform is, and now we come out with a study that says the legislation they passed was meaningless." [6]

The Florida filings and excerpts from the ISO study are attached as Appendix C.

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

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[5] Addendum of St. Paul Fire and Marine Insurance Company," undated 1986 filing before the Office of the Insurance Commissioner of Florida.
[6] Robert Finlayson, "Insurers Fear Reform Foes to Capitalize on ISO Study," *Business Insurance*, May 18, 1987, p. 2.

1980 and 1986."[7] The GAO study concluded:

> While it is not possible to assess the extent to which the act [MICRA] has had an impact on the state's malpractice situation, our analysis of key indicators indicated that the problem is continuing to worsen in California. [8]

According to the GAO, four states (Arkansas, Florida, New York and North Carolina) reported that the restrictions had had "little effect" on insurance premiums. [9]

So-called "tort reform" does not lower insurance premiums.[10]

B. Malpractice Caps Resulted in Less for Injured Patients, More for Insurance Companies and Insurance Defense Lawyers

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

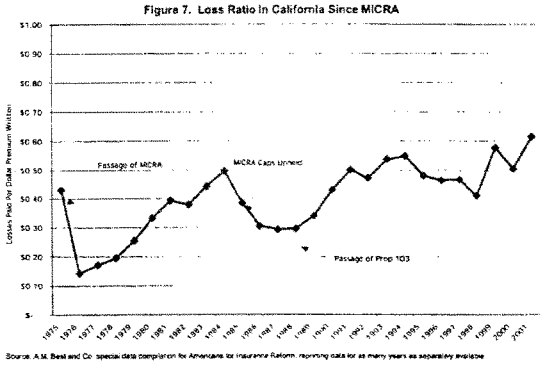
In fact, between the enactment of MICRA in 1975 and the 1988 passage of Proposition 103, which disallowed excessive rates (and thereby forced loss ratios towards more appropriate levels), California insurers never paid out in claims more than half of premiums written. Between 1976 and 1988, the average percentage of each premium dollar paid out in the form of compensation to malpractice victims - expressed as a "loss ratio" - was 31.4%. The balance - sixty-eight cents of every premium dollar - paid for other insurer costs, primarily profits, insurance company lawyers and overhead. That is, more than sixty-eight cents of every

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

premium dollar paid by doctors was used for purposes other than compensating victims. Insurers had promised doctors lower premiums, but instead of reducing premiums commensurate with the lower claims payouts associated with malpractice caps, insurers simply captured higher profits in California.

Figure 7. Loss Ratio in California Since MICRA

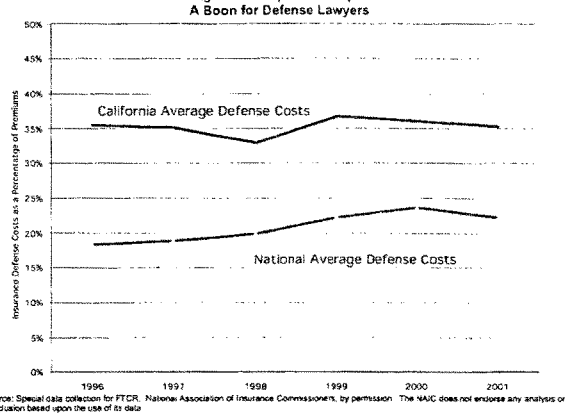


Source: A.M. Best and Co. special data compilation for Americans for Insurance Reform, reporting data for as many years as separately available

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

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

Figure 8. Malpractice Caps: A Boon for Defense Lawyers



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

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

Figure 9. Malpractice Defense Expenditures (1992-1995)

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

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

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

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

What explains this behavior? Because the rigid caps make it more difficult for victims to obtain representation and prosecute a case, and because such caps limit companies' exposure, insurers have an incentive to withhold claims payment as a negotiating tactic, which will force plaintiffs and their attorneys to spend inordinate resources to recover losses, thereby discouraging cases and forcing lower recoveries.

Although, under the strictures of MICRA, insurers will continue to pay limited claim settlements in California, sustained and increasingly rigorous regulation will continue to improve insurers' loss ratio over time. Under Proposition 103, our organization has challenged a recent rate increase proposed by the state's second largest medical malpractice insurer. Using the consumer intervention aspect of the law, we are investigating the company's loss ratio and the company's defense costs. Due to our regulatory challenge, that company's policyholders have been shielded from 15% rate hikes.

IV. MICRA: Benefits to the Public – Or to Physicians?

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

But what of the American Medical Association and its counterparts in states across the nation, whose member doctors can be found in recent weeks angrily on strike, refusing to see patients and threatening to "leave the state" unless MICRA legislation is enacted?

The physicians promoting MICRA complain that they cannot afford the increasing cost of malpractice coverage. This is hard to fathom, since, according to *Medical Economics* magazine, medical malpractice insurance premiums account for between 1.2% of a doctor's gross receipts and 5.5% of receipts, depending upon the specialty. General surgeons, for example, have a relatively high average malpractice premium of $21,641 annually, but that is only a small fraction of a surgeon's $497,633 average collections for 2001. That same surgeon has, on average, a net income of more than $257,000 per year, *after* accounting for expenses, such as

rent, staff salaries and medical malpractice insurance. In other words, that doctor will make more in a year than many brutally injured patients will have access to for a lifetime of suffering under the proposed non-economic caps. [11]

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

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

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

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

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

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

Trinity counties.
- Primary care, neurology, orthopedic surgery and neurosurgery lead in specialty shortages.
- 2/3 of physicians are not advising their children to practice medicine. (p.ii)

The CMA says:

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

The CMA study is a decisive refutation of the rosy picture painted by the AMA – and the CMA – of California under MICRA. Indeed, far from heaven on earth for physicians, California is apparently one of the less lucrative states in which to practice medicine in the nation. *Medical Economics* reports that doctors in the West, the many of whom are in California earn the lowest annual salary in almost every specialty and overall, with an average of $212,810.[12]

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

Contrary to the claims made by proponents of MICRA, restricting malpractice payouts would do nothing to benefit the economy. MICRA has been portrayed by physicians and, most

[12] "More Hours, More Patients, No Raise?" Medical Economics, November 22, 2002

recently, President Bush, as a way to lower health care costs for the nation. This is incorrect. Medical malpractice premiums are 0.55% of the national health care expenditures, an all time low.[13] Malpractice payments to victims by insurers averaged $3 billion per year between 1991 and 1999 - roughly 0.3% of national health care expenditures, according to industry data. By contrast, the total cost of malpractice deaths and injuries to the national economy has been estimated at ten times the amount of payouts.[14]

Trading on their credibility – already diminished in recent years as profit-driven HMO medicine has wreaked havoc upon patients - the physicians promoting MICRA insist that it has provided other benefits to Californians, and thus deserves to be considered as a model for legislation in other states and for legislation which would federalize the malpractice tort system by imposing MICRA nationally. However, there is no independent evidence that MICRA has been of value to anyone other than the insurance companies – and perhaps the fraction of physicians, estimated at 5%, who commit 54% of the malpractice in the U.S.[15]

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

V. MICRA: The Impact on Patients

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

MICRA main provisions:

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

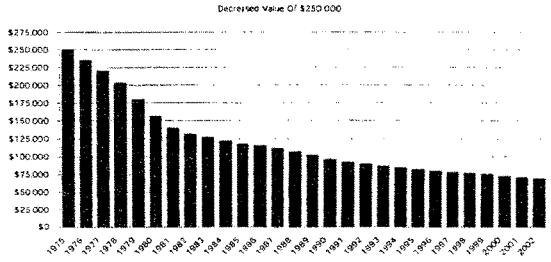
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[13] Letter to President Bush, Consumer Federation of America, July 30, 2002.
[14] Kohn, Corrigan, Donaldson, Eds., *To Err is Human, Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).
[15] "Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors' Lobby," Congress Watch, January 2003, p. 21

• Eliminate the "collateral source rule" that forces those found liable for malpractice to pay all the expenses incurred by the victim.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

Periodic payments reduce the already limited compensation received by victims, as the value of the verdict diminishes over time due to inflation. No adjustment is ever made in

the payments to reflect the inflation rate or changes in the costs for medical care -- which have risen sharply and well above the inflation rate for many years.

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

Closed-door settlements that result from the periodic payment provision let dangerous doctors off cheap and shield their name from public record. In California, the periodic payment provision results in the settling of cases through closed door agreements - even after a verdict for the victim. Because periodic payments reduce the value of awards over time due to inflationary factors, plaintiffs are encouraged to enter a settlement for a greatly reduced amount. Not only insurers of convicted doctors pay significantly lowered penalties for wrong-doing in California, but the state Medical Board - as a result of a lawsuit by the California Medical Association - reports no information about negligent doctors who have settled cases to the public, denying consumers vital information to deter future incidents of medical malpractice.

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

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

Only the most seriously injured victims with clear-cut cases to prove can ever find legal representation. In states with caps on attorney contingency fees for medical malpractice cases (and particularly in states such as California where a victim's pain and suffering compensation is also capped), victims of medical malpractice simply cannot find legal representation. It is not cost effective for attorneys to take the vast majority of cases. Says the President of Safe Medicine For Consumers, a California-based medical malpractice survivors group, "The vast

majority of individuals who contact us are women, parents of children or senior citizens. 90% of these individuals are unable to pursue meritorious medical malpractice cases because they can not find legal representation on a contingency basis and their savings have been wiped out."

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

Undermining the contingency fee mechanism contributes to a deteriorating quality of health care and passes costs onto taxpayers. Left without legal representation in California, victims go uncompensated, and dangerous doctors go undeterred. Taxpayers pay the cost of low-income victims' medical care and basic needs through public assistance programs if the physicians responsible for the injuries are not held accountable.

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

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

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

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

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

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

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

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

VI. CONCLUSION

Malpractice litigation is not responsible for the present "crisis." In fact, the real crisis today is not the price of malpractice insurance, but the epidemic of medical mistakes. The solution is not limiting the rights of victims of malpractice to have their day in court. The way to lower and stabilize medical malpractice premiums is to adopt insurance reforms. And the best way to reduce malpractice claims is to reduce the amount of medical malpractice in our country. Appendix D contains a series of proposals to address the insurance and malpractice crises facing the nation today.

Testimony of Harvey Rosenfield
February 10, 2003

Appendix A

Complete Text and Explanation of Proposition 103

I. Complete Text Of Proposition 103 As Approved By The California Electors, November 8, 1988

Insurance Rate Reduction and Reform Act

Section 1. Findings and Declaration.

The People of California find and declare as follows:

Enormous increases in the cost of insurance have made it both unaffordable and unavailable to millions of Californians.

The existing laws inadequately protect consumers and allow insurance companies to charge excessive, unjustified and arbitrary rates.

Therefore, the People of California declare that insurance reform is necessary. First, property-casualty insurance rates shall be immediately rolled back to what they were on November 8, 1987, and reduced no less than an additional 20%. Second, automobile insurance rates shall be determined primarily by a driver's safety record and mileage driven. Third, insurance rates shall be maintained at fair levels by requiring insurers to justify all future increases. Finally, the state Insurance Commissioner shall be elected. Insurance companies shall pay a fee to cover the costs of administering these new laws so that this reform will cost taxpayers nothing.

Section 2: Purpose.

The purpose of this chapter is to protect consumers from arbitrary insurance rates and practices, to encourage a competitive insurance marketplace, to provide for an accountable Insurance Commissioner, and to ensure that insurance is fair, available, and affordable for all Californians.

Section 3: Reduction and Control of Insurance Rates.

Article 10, commencing with Section 1861.01 is added to Chapter 9 of Part 2 of Division 1 of the Insurance Code to read:

Insurance Rate Rollback
1861.01.(a) For any coverage for a policy for automobile and any other form of insurance subject to this chapter issued or renewed on or after November 8, 1988, every insurer shall reduce its charges to levels which are at least 20% less than the charges for the same coverage which were in effect on November 8, 1987.

(b) Between November 8, 1988, and November 8, 1989, rates and premiums reduced pursuant to subdivision (a) may be only increased if the commissioner finds, after a hearing, that an insurer is substantially threatened with insolvency.

(c) Commencing November 8, 1989, insurance rates subject to this chapter must be approved by the commissioner prior to their use.

(d) For those who apply for an automobile insurance policy for the first time on or after November 8, 1988, the rate shall be 20% less than the rate which was in effect on November 8, 1987, for similarly situated risks.

(e) Any separate affiliate of an insurer, established on or after November 8, 1987, shall be subject to the provisions of this section and shall reduce its charges to levels which are at least 20% less than the insurer's charges in effect on that date.

Automobile Rates & Good Driver Discount Plan
1861.02. (a) Rates and premiums for an automobile insurance policy, as described in subdivision (a) of Section 660, shall be determined by application of the following factors in decreasing order of importance: (1) The insured's driving safety record.
(2) The number of miles he or she drives annually.
(3) The number of years of driving experience the insured has had.
(4) Such other factors as the commissioner may adopt by regulation that have a substantial relationship to the risk of loss. The regulations shall set forth the respective weight to be given each factor in determining automobile rates and premiums. Notwithstanding any other provision of law, the use of any criterion without such approval shall constitute unfair discrimination.

(b) (1) Every person who (A) has been licensed to drive a motor vehicle for the previous three years and (B) has had, during that period, not more than one conviction for a moving violation which has not eventually been dismissed shall be qualified to purchase a Good Driver Discount policy from the insurer of his or her choice. An insurer shall not refuse to offer and sell a Good Driver Discount policy to any person who meets the standards of this subdivision. (2) The rate charged for a Good Driver Discount policy shall comply with subdivision (a) and shall be at least 20% below the rate the insured would otherwise have been charged for the same coverage. Rates for Good Driver Discount policies shall be approved pursuant to this article.

(c) The absence of prior automobile insurance coverage, in and of itself, shall not be a criterion for determining eligibility for a Good Driver Discount policy, or generally for automobile rates, premiums, or insurability.

(d) This section shall become operative on November 8, 1989. The commissioner shall adopt regulations implementing this section and insurers may submit applications pursuant to this article which comply with such regulations prior to that date, provided that no such application shall be approved prior to that date.

Prohibition on Unfair Insurance Practices
1861.03 (a) The business of insurance shall be subject to the laws of California applicable to any other business, including, but not limited to, the Unruh Civil Rights Act (Civil Code Sections 51 through 53), and the antitrust and unfair business practices laws (Parts 2 and 3, commencing with section 16600 of Division 7, of the Business and Professions Code).

(b) Nothing in this section shall be construed to prohibit (1) any agreement to collect, compile and disseminate historical data on paid claims or reserves for reported claims, provided such data is contemporaneously transmitted to the commissioner, or (2) participation in any joint arrangement established by statute or the commissioner to assure availability of insurance.

(c) Notwithstanding any other provision of law, a notice of cancellation or non-renewal of a policy for automobile insurance shall be effective only if it is based on one or more of the following reasons: (1) non-payment of premium; (2) fraud or material misrepresentation affecting the policy or insured; (3) a substantial increase in the hazard insured against.

Full Disclosure of Insurance Information
1861.04. (a) Upon request, and for a reasonable fee to cover costs, the commissioner shall provide consumers with a comparison of the rate in effect for each personal line of insurance for every insurer.

Approval of Insurance Rates
1861.05. (a) No rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter. In considering whether a rate is excessive, inadequate or unfairly discriminatory, no consideration shall be given to the degree of competition and the commissioner shall consider whether the rate mathematically reflects the insurance company's investment income.

(b) Every insurer which desires to change any rate shall file a complete rate application with the commissioner. A complete rate application shall include all data referred to in Sections 1857.7, 1857.9, 1857.15, and 1864 and such other information as the commissioner may require. The applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this article.

(c) The commissioner shall notify the public of any application by an insurer for a rate change. The application shall be deemed approved sixty days after public notice unless (1) a consumer or his or her representative requests a hearing within forty-five days of public notice and the commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision, or (2) the commissioner on his or her own motion determines to hold a hearing, or (3) the proposed rate adjustment exceeds 7% of the then applicable rate for personal lines or 15% for commercial lines, in which case the commissioner must hold a hearing upon a timely request.

1861.06. Public notice required by this article shall be made through distribution to the news media and to any member of the public who requests placement on a mailing list for that purpose.

1861.07. All information provided to the commissioner pursuant to this article shall be available for public inspection, and the provisions of Section 6254(d) of the Government Code and Section 1857.9 of the Insurance Code shall not apply thereto.

1861.08. Hearings shall be conducted pursuant to Sections 11500 through 11528 of the Government Code, except that: (a) hearings shall be conducted by administrative law judges for purposes of Sections 11512 and 11517, chosen under Section 11502 or appointed by the commissioner; (b) hearings are commenced by a filing of a Notice in lieu of Sections 11503 and 11504; (c) the commissioner shall adopt, amend or reject a decision only under Section 11517 (c) and (e) and solely on the basis of the record; (d) Section 11513.5 shall apply to the commissioner; (e) discovery shall be liberally construed and disputes determined by the administrative law judge.

1861.09. Judicial review shall be in accordance with Section 1858.6. For purposes of judicial review, a decision to hold a hearing is not a final order or decision; however, a decision not to hold a hearing is final.

Consumer Participation
1861.10. (a) Any person may initiate or intervene in any proceeding permitted or established pursuant to this chapter, challenge any action of the commissioner under this article, and enforce any provision of this article.

(b) The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that (1) the person represents the interests of consumers, and, (2) that he or she has made a substantial contribution to the adoption of any order, regulation or decision by the commissioner or a court. Where such advocacy occurs in response to a rate application, the award shall be paid by the applicant.

(c) (1) The commissioner shall require every insurer to enclose notices in every policy or renewal premium bill informing policyholders of the opportunity to join an independent, non- profit corporation which shall advocate the interests of insurance consumers in any forum. This organization shall be established by an interim board of public members designated by the commissioner and operated by individuals who are democratically elected from its membership. The corporation shall proportionately reimburse insurers for any additional costs incurred by insertion of the enclosure, except no postage shall be charged for any enclosure weighing less than 1/3 of an ounce. (2) The commissioner shall by regulation determine the content of the enclosures and other procedures necessary for implementation of this provision. The legislature shall make no appropriation for this subdivision.

Emergency Authority
1861.11. In the event that the commissioner finds that (a) insurers have substantially withdrawn from any insurance market covered by this article, including insurance described by Section 660, and (b) a market assistance plan would not be sufficient to make insurance available, the commissioner shall establish a joint underwriting authority in the manner set forth by Section 11891, without the prior creation of a market assistance plan.

Group Insurance Plans
1861.12. Any insurer may issue any insurance coverage on a group plan, without restriction as to the purpose of the group, occupation or type of group. Group insurance

rates shall not be considered to be unfairly discriminatory, if they are averaged broadly among persons insured under the group plan.

Application
1861.13. This article shall apply to all insurance on risks or on operations in this state, except those listed in Section 1851.

Enforcement & Penalties
1861.14. Violations of this article shall be subject to the penalties set forth in Section 1859.1. In addition to the other penalties provided in this chapter, the commissioner may suspend or revoke, in whole or in part, the certificate of authority of any insurer which fails to comply with the provisions of this article.

Section 4. Elected Commissioner

Section 12900 is added to the Insurance Code to read:

(a) The commissioner shall be elected by the People in the same time, place and manner and for the same term as the Governor.

Section 5. Insurance Company Filing Fees
Section 12979 is added to the Insurance Code to read:

Notwithstanding the provisions of Section 12978, the commissioner shall establish a schedule of filing fees to be paid by insurers to cover any administrative or operational costs arising from the provisions of Article 10 (commencing with Section 1861.01) of Chapter 9 of Part 2 of Division 1.

Section 6. Transitional Adjustment of Gross Premiums Tax

Section 12202.1 is added to the Revenue & Taxation Code to read:

Notwithstanding the rate specified by Section 12202, the gross premiums tax rate paid by insurers for any premiums collected between November 8, 1988 and January 1, 1991 shall be adjusted by the Board of Equalization in January of each year so that the gross premium tax revenues collected for each prior calendar year shall be sufficient to compensate for changes in such revenues, if any, including changes in anticipated revenues, arising from this act. In calculating the necessary adjustment, the Board of Equalization shall consider the growth in premiums in the most recent three year period, and the impact of general economic factors including, but not limited to, the inflation and interest rates.

Section 7. Repeal of Existing Law

Sections 1643, 1850, 1850.1, 1850.2, 1850.3, 1852, 1853, 1853.6, 1853.7, 1857.5, 12900, Article 3 (commencing with Section 1854) of Chapter 9 of Part 2 of Division 1, and Article 5 (commencing with Section 750) of Chapter 1 of Part 2 of Division 1, of the Insurance Code are repealed.

Section 8. Technical Matters

(a) This act shall be liberally construed and applied in order to fully promote its underlying purposes.

(b) The provisions of this act shall not be amended by the Legislature except to further its purposes by a statute passed in each house by roll call vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate.

(c) If any provision of this act or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

-End-

II. History and Explanation of Provisions of Proposition 103

California is the single biggest market for insurance in the nation. Not surprisingly, California has been a fertile environment for efforts to reform the insurance system. In 1988, two distinct approaches to insurance reform were presented to California voters.

The 1988 initiative battle. During 1985 and 1986, the cost of liability coverage for businesses, municipal governments, non-profits, and ultimately, motorists, rose rapidly. The insurance industry also reduced the availability of coverage; the resulting shortages further boosted prices. Previous "tort reforms," enacted by the voters in 1986 at the behest of insurers and the business community, had failed to lower premiums. During 1987, California consumer advocacy groups sponsored legislation which would have instituted limited regulation of property-casualty insurance premiums, including auto insurance, and repeal of the industry's exemption from state antitrust laws. Opposition from insurers blocked the measures' passage, and the advocates drafted a ballot proposition entitled, "The Insurance Rate Reduction and Reform Act of 1988," which they placed before California voters on November 8, 1988.

Concerned that it could not defeat Proposition 103, elements of the insurance industry responded by placing three separate "tort reform" measures on the ballot to compete with 103.[1] Proposition 104 called for the establishment of a no-fault auto insurance system. This was the insurers' main concern. Proposition 101 limited payments for pain and suffering in excess of economic damages unless a specific threshold was met. Proposition 106, also sponsored by insurers, imposed limits on the size of contingency

[1] To defeat insurance industry reform, insurers employed a "Trojan Horse" strategy unique to California's initiative process. Included within Proposition 104's text were provisions conflicting with each provision of Proposition 103. Article II, § 10(b) of the California Constitution provides that in the event that two measures with conflicting provisions are approved by the voters, the provisions of the initiative that obtained the great number of voters prevail. With polls indicating overwhelming public support for Proposition 103, the insurance industry's political consultants recognized that the measure would be difficult to defeat. Instead, the insurers hoped to invalidate 103 by getting more votes for Proposition 104, a strategy that was revealed to voters by the official state ballot pamphlet.

fees a plaintiff could pay to an attorney in any tort case. At the same time, the California Trial Lawyers Association and some consumer advocacy groups sponsored Proposition 100, a less comprehensive version of Proposition 103.

To pass Proposition 104 and defeat Proposition 103, insurers spent over $80 million.[2] Most of these funds were expended on electronic and print advertising. The central issue in the campaign was which proposal would lower insurance premiums for motorists.[3] Thus, the two insurance reform alternatives came head to head in a highly visible, albeit financially lopsided, public debate in the nation's largest state. On Election Day, Proposition 104 was defeated by a three-to-one margin. Proposition 103 was approved by 51% of the voters. Propositions 100, 101 and 106 were also defeated.

Immediately after the passage of Proposition 103, most insurers in the state ceased selling new policies to exert pressure upon the California Supreme Court to rule favorably on the industry's request for an immediate stay of the ballot measure. The state Attorney General subsequently found the boycott to be a violation of the antitrust laws made applicable by the measure, although he declined to prosecute.[4] And despite repeated threats that many insurers would leave the state if Proposition 103 became law (see Jay Angoff, *Quit California? Don't Bet on It*, Los Angeles Times Opinion-Editorial, December 1, 1988, at B7) no major auto insurance company closed its California operations after the passage of Proposition 103. Indeed, one analysis concluded that more insurance companies had applied to do business in California since the passage of Proposition 103 (85) than withdrew (3) or had requested permission to withdraw as of July, 1990 (25). The three companies that withdrew were: Allegiance Life, Teachers Insurance and Travelers (which withdrew from eight other states simultaneously).[5]

The passage of Proposition 103 represented a dramatic turning point in the insurance debate throughout the nation. Driven by the California initiative, insurance industry reform occupied the focus of policymakers throughout the United States in the years after 103's passage.

The insurance industry's initial response was stunned, then angry, denial.[6] Determined to discourage the similar efforts underway in other states, various insurers filed nearly

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[2] Kenneth Reich, *Insurance Fight Cost Initiative Backers a Total of $83.9 Million*, Los Angeles Times, February 7, 1989, at 3. The consumer advocates sponsoring Proposition 103, led by Ralph Nader, spent $2.9 million raised through modest donations from direct mail solicitations to the public. Susan Seager, *Insurance Initiative War Hits Record $63.5 Million*, L.A. Herald-Examiner, October 29, 1988. We spent $2.9 million in support of 103, raised from modest contributions from the public.

[3] *See e.g.*, Ramon G. McLeod, *Voters Angry About Rates for Auto Insurance*, San Francisco Chronicle, June 10, 1988. Consumer advocate Ralph Nader's support for Proposition 103 had a powerful impact upon many voters who found the presence of five insurance related initiatives on the ballot confusing. Arthur Lupia, *Shortcuts Versus Encyclopedias: Information and Voting Behavior in California Insurance Reform Elections*, 88 American Political Science Review No. 1 (March 1994).

[4] E. Scott Reckard, *Insurers' Pullout Blamed on Conspiracy*, The Orange County Register, January 3, 1991 at A3. E. Scott Reckard, *Insurers' Pullout Blamed on Conspiracy*, The Orange County Register, January 3, 1991 at A3.

[5] L.P. Baldocchi, *The Post-103 Competitive Climate in California*, Underwriter's Report, July 26, 1990.

[6] A typical remark by an industry official portrayed Proposition 103 as "an example of mob rule." *Don't Shoot the Messenger*, Best's Review, January 1990, at 95-96. *See also* Mark Magnier, *California Rate Rollback Incenses Auto*

one hundred legal challenges to Proposition 103; none succeeded.[7] Meanwhile, Proposition 103's passage inspired similar efforts in nearly every state legislature in the nation.[8] Despite the industry's efforts to blunt further Proposition 103-style reforms, nineteen states enacted insurance industry reforms.[9]

Provisions of Proposition 103. Prior to 1988, California was one of the few states in the nation that did not require insurance companies to obtain regulatory approval of rate changes.[10] Moreover, California law shielded the industry from both competition[11] and regulation.[12] Thus, neither the free market nor government supervision was permitted to moderate the impact on the economy of the insurance cycle. Proposition 103, sought to impose regulation and create a more competitive and fair marketplace for insurance in California. The following components comprise the Proposition 103 model of insurance industry reform.

A. Short Term Relief: The Insurance Rate Freeze and Rollback

In order to protect consumers during the transition to the new system established by the Proposition, and to offset the rate increases during the year prior to the election, the initiative froze automobile and other property-casualty insurance rates and premiums at 80% of November 8, 1987 levels for one year.[13] The 20% rollback avoided "locking in" the excessive rates of the preceding years, during which time insurance rates rose well in excess of the inflation rate. During the period of the rate freeze and rollback (November 8, 1988 through November 8, 1989), insurers were prohibited from raising rates or premiums. However, the initiative was drafted to allow an insurer to obtain increases from the Insurance Commissioner, if the freeze and/or the rate rollback "substantially threatened" the company's solvency.[14]

Insurers, Journal of Commerce, November 10, 1988, at 1A. Richard B. Schmitt and Sonja Steptoe, *California's Voters Shake Up Insurers*, Wall Street Journal, November 10, 1988.

[7] Susan Seager, *Insurers' New Policy: Sue to Stop Prop. 103*, Los Angeles Herald Examiner, November 10, 1988; Kenneth Reich and Philip Hager, *Nine Suits Challenge Auto Rate Rollbacks*, Los Angeles Times, November 10, 1988, at 1. As a federal court, addressing a legal challenge by insurers against regulations implementing Proposition 103, later noted: "Insurers doing business in California certainly have a right to challenge any unconstitutional aspects of the rate making process which have been forced on them by the initiative. But the multiple and overlapping assertions of these challenges in state court, before the commissioner, and in this court causes this court to question those tactics. Numerous insurers are involved in these multiple challenges, some represented by the same law firms. Some challenges are filed in state court and some are filed in federal. The challenges are at the same time identical, separate and overlapping. Some of that appears to be coordinated and calculated...." *Fireman's Fund Ins. Co. v. Garamendi* (N.D. 1992) 790 F. Supp. at 964.

[8] *See* NICO, *A Consumer Triumph: Proposition 103 Revisited* (1992). Richard W. Stevenson, *As California Tells Insurers What To Do, the Nation Listens*, New York Times, May 14, 1989.

[9] National Insurance Consumers Organization, *A Consumer Triumph: Proposition 103 Revisited* 35-36 (1992).

[10] Michigan, Illinois and Ohio, like California, were so-called "open competition" states. Jeffrey A. Eisanach, *The Role of Effective Pricing in Auto Insurance*, U.S. Federal Trade Commission, Bureau of Economics, November 1985.

[11] *See, e.g.*, former C.I.C. § 1643 (prohibiting sale of insurance by banks), repealed by Proposition 103, § 7.

[12] McBride-Grunsky Insurance Regulatory Act, C.I.C. §§ 1850-1860.3 (1947), provisions of which were repealed by Proposition 103, § 7.

[13] CIC § 1861.01.

[14] CIC § 1861.01(b).

The rollback provision of 103 became the focal point of the insurance industry's legal challenge to the initiative, filed two days after the election.[15] In May, 1989, the California Supreme Court unanimously upheld the rollback but ruled that the "substantially threatened with insolvency" standard might be interpreted by the Insurance Commissioner in a manner that would deny insurers their constitutional right to obtain an adequate return on their property.[16] The Court substituted a "fair rate of return" constitutional standard, leaving it to the Commissioner to determine on a company-by-company basis, through the individual rollback exemption hearings contemplated by CIC § 1861.01(b), whether the rate rollback would deprive an insurer of a fair rate of return. Virtually all of the insurance companies operating in California filed requests for a rollback exemption hearing, claiming that they would be deprived of a fair rate of return if forced to comply.

The fair return standard is well-established in constitutional jurisprudence, as is the corollary principle that not every enterprise is entitled to earn a rate of return -- only those which operate reasonably and efficiently.[17] It was not until after the state's first elected insurance commissioner took office in 1990 that normative standards for analyzing insurer profitability and efficiency were promulgated as regulations. These regulations contained a rollback formula, the application of which determines whether an insurer should be ordered to issue premium rebates, with interest.[18] Specifically, the "rollback" formula:

- Caps the rate of return.

- Establishes ceilings for executive salaries, and sets an overall limit on expenses equal to the industry average, rewarding insurers which operate more efficiently with a higher rate of return. Expenses in excess of that amount cannot be included in the rate base.

- Prohibits insurers from engaging in bookkeeping practices that inflate their claims losses, and limits the amount insurers can set aside as surplus and reserves.

- Forbids insurers from passing through to consumers the costs of the industry's lobbying, political contributions, institutional advertising, the unsuccessful defense of discrimination cases, bad faith damage awards and fines or penalties.

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[15] On November 10, 1988, the California Supreme court granted the requests of numerous insurance companies and trade associations to stay the initiative in its entirety. On December 7, 1988, the court vacated the stay except as to the provisions (1) requiring a rate reduction to 20 percent below 1987 rates and (2) requiring insurers to enclose in their bills an insert notifying insureds of the opportunity to join a nonprofit corporation to advocate their interests pursuant to CIC § 1861.10(c) (*see* discussion *infra*). *Calfarm v. Deukmejian*, 48 Cal. 3d 805, 814 (1989).

[16] "The risk that the rate set by the statute is confiscatory as to some insurers from its inception is high enough to require an adequate method for obtaining individualized relief." *Calfarm* at 820.

[17] *See, e.g., Aetna Insurance Co. v. Hyde* 275 U.S. 440, 446-47 (1928); *Troy Hills Village v. Township Council*, 68 N.J. 604 (1975).

[18] Findings and Determinations of the Insurance Commissioner, State of California, *In the Matter of Determination of Exposure Basis, Reserve-Strengthening, Executive Compensation and Efficiency Standards for 1989 Rate Calculations*, File No. RCD-1 (August 14, 1991); Findings and Determinations of the Insurance Commissioner, State of California, *In the Matter of Determination of Rate of Return, Leverage Factors and Projected Yield for 1989 Rate Calculations*, File No. RCD-2 (August 14, 1991).

Insurers challenged the formula as confiscatory. However, in August 1994, the California Supreme Court unanimously upheld the regulations as constitutional.[19]

Between 1989 and 1997, insurance companies operating in California issued over $1.18 billion in premium refunds to more than seven million policyholders.[20] Among those companies that have complied with the rollback are nine of the ten largest auto insurance companies operating in California. They represent 61.4% of the marketplace.[21]

B. Regulation

Proposition 103 changed California's insurance laws from a so-called "open competition" to a "prior approval" regulatory system.[22] Insurance companies are required to submit an application for desired rate changes to the Department of Insurance. To justify the request, the application must comply with disclosure requirements and financial standards promulgated by regulations.[23] Properly administered, the prior approval system disengages the insurers' traditional "cost-plus" approach, ending their ability to unilaterally pass through to policyholders all claims costs, accompanied by overhead and profits. It substitutes a rate structure that encourages both insurers and consumers to engage in loss prevention.[24] Insurers are rewarded for research and innovative programs that lead to reduced losses and claims. Consumers, in turn, are rewarded with lower premiums for their individual loss prevention efforts, such as installation of anti-theft or anti-fraud devices and maintenance of a safe driving record.

Between 1989 and 1994, most insurance rates in California remained frozen pending conclusion of the legal challenges and final compliance by insurance companies with the rollback requirement. However, a new insurance commissioner, Republican Chuck Quackenbush, took office in January 1995. Mr. Quackenbush, an avowed opponent of

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[19] *Twentieth Century Insurance Co. v. Garamendi*, 8 Cal.4th 216 (1994). The U.S. Supreme Court refused the insurance industry's final appeal. *Century-National Ins. Co. v. Quackenbush*, 513 U.S. 1153 (February 21, 1995) (*cert. denied*); *State Farm Mutual Automobile Insurance Co. v. Quackenbush*, 513 U.S. 1153 (February 21, 1995) (*cert. denied*).

[20] Calif. Department of Insurance, "Garamendi Orders 28 Insurance Companies to Pay $1.2 Billion in Proposition 103 Rollbacks," News Release, November 22, 1994; Calif. Department of Insurance, "Proposition 103 Rollback Settlement Status Report," Rate Specialist Bureau, June 13, 1996; Calif. Department Insurance; "Stipulation and Consent Orders of December 23, 1994," Calif. Department Insurance, various stipulation and consent Orders (1995-1997).

[21] The companies, in order of their 1996 market share, are: Farmers Insurance, Calif. State Automobile Association, Allstate Insurance Group, the Auto Club of Southern California, 20th Century Insurance Co., Mercury General Group, United States Automobile Association, Safeco Insurance Cos., California Casualty.

[22] A 1986 study by the U.S. General Accounting Office concluded that insurance rates were higher in states without such prior approval systems. U.S. General Accounting Office, *Auto Insurance: State Regulation Affects Cost and Availability*, August 1986.

[23] CIC § 1861.05.

[24] Under an effective regulatory regime, efficiency is rewarded with higher profits; inefficiency with a lower rate of return. The normative standards by which insurer profits, expenses, surplus, reserves, accounting practices and other behavior are to be measured are based upon the regulations developed for the rollback exemption hearings.

Proposition 103,[25] lifted the rate freeze and refused to implement or enforce many of 103's statutory requirements, including the "prior approval" process, despite excessive premium levels in the state. Mr. Quackenbush was forced to resign under threat of impeachment in 2000, after it was revealed he had permitted insurance companies to evade $3 billion in proposed fines for violation of claims-handling rules in exchange for donations to a slush fund he controlled.

C. Competition

At its best, the insurance marketplace operates imperfectly. There can never be a truly "free," i.e., perfectly competitive, market for auto insurance because (1) consumers are compelled by law to purchase insurance; (2) there are many variations on the product, making comparison shopping difficult; and (3) the underwriting process is often subjective and by definition excludes certain willing purchasers. Indeed, a recent news release issued by Progressive Insurance Company illustrates how imperfect the auto insurance market is: the company determined that auto insurance rates for identical drivers varied by a nationwide average of $481, and urged consumers to "shop around."[26]

Regulation and competition are not mutually exclusive, however. To encourage a more functional marketplace, Proposition 103 repealed a variety of statutory barriers to competition common in other jurisdictions.

• **Antitrust Exemption.** The insurance industry won an exemption from California's antitrust laws in 1947;[27] similar exemptions remain on the books of virtually every other state and in federal law as well.[28] As a result, insurer-controlled "rating bureaus" freely distributed proposed pricing data, including projected losses, expenses, profits and overhead charges, to all insurers who wished to obtain the information -- allowing tacit price collusion. Proposition 103 repealed the insurance industry's exemption from the antitrust laws and prohibited the operation of "rating" and "advisory" organizations set up by the industry to circulate pricing and policy information to insurance companies.[29]

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[25] Quackenbush, then a member of the California Assembly, urged voters to defeat Proposition 103 in a campaign mailer attributed to "Republican Leadership for Insurance Reform," but mailed to voters by Californians Against Unfair Rate Increases, a group sponsored by independent agents and insurers. Mailer on file with author.

[26] The Progressive news release is attached.

[27] McBride-Grunsky Insurance Regulatory Act, Insurance Code sections 1850-1860.3 (1947) repealed by Proposition 103, § 7.

[28] McCarran-Ferguson Act, 15 U.S.C. sections 1101 *et. seq.* (1988).

[29] C.I.C. § 1861.03. However, 103 permits insurers to exchange certain historical data, as opposed to projections, about claims. This enables insurers -- particularly new or small carriers -- to obtain information that will assist them in developing their own projections and prices. All such information must also be provided to the Insurance Commissioner and to the public. C.I.C. § 1861.03(b). The initiative further permits insurers to continue to participate in special joint pooling arrangements -- as long as they are established by the Insurance Commissioner or by law -- to make insurance more available to certain kinds of customers, such as day care centers, automobile drivers, etc. *Id.*

• **Commission Discounting.** Commissions and related selling expenditures amount to between 15 and 30 percent of each year's premiums, according to a federal study.[30] Under California's so-called "anti-rebate law," similar to statutes in effect in most other states, insurance agents and brokers were prohibited by law from reducing their own commissions in order to offer consumers a lower price.[31] The anti-rebate law rewarded the inefficiency of some agents because it shielded them from competition by agents who are willing to work harder to satisfy their customers. A study by the U.S. Department of Justice estimated savings of 6-7% annually for insurance consumers merely by eliminating "anti-rebate" laws.[32] Proposition 103 repealed the state anti-rebate law. To date, however, few California agents have reduced their commissions, largely because insurance companies and trade associations representing agents have actively discouraged such competition.

• **Bank Sales of Insurance.** 103 repealed the statutory prohibition on the sale of insurance by financial institutions.[33] By 1992, an estimated 133 banks had obtained permission to enter the insurance business, including several of the state's largest banks.[34] Suits by insurance agents to block this provision of Proposition 103 were unsuccessful.[35]

• **Expanded Group Insurance.** Proposition 103 empowered consumers to more easily negotiate group insurance purchases.[36] As a result, consumers are empowered to join together to negotiate the kind of policies and coverage they want, using their bargaining power in the insurance marketplace just as large corporations do when purchasing commercial insurance policies.

• **Consumer Comparison Shopping Service.** It is a basic tenet of economics that consumers must be well informed if the marketplace is to operate correctly. A 1987 study documented the often-insurmountable obstacles consumers confront when shopping for insurance.[37] Proposition 103 requires the California Commissioner to provide consumers with a current rate comparison survey for automobile, homeowner and other lines of insurance.[38] Consumers are to be charged a modest fee to cover the

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[30] Staff of Federal Trade Commission, Report on Life Insurance Cost Disclosure, at 86-87 (1979).

[31] *See* C.I.C. § 750.1, repealed by Proposition 103, § 7.

[32] U.S. Justice Department, *The Pricing and Marketing of Insurance: A Report of the U.S. Justice Department to the Task Group on Antitrust Immunities* 302 (January, 1977).

[33] *See* C.I.C. § 1643, repealed by Proposition 103 § 7. California's antitrust and consumer protection laws, applicable to the business of insurance pursuant to C.I.C. § 1861.03, ensure that financial institutions do not attempt to coercively tie the sale of insurance to other financial products or services they provide -- a frequent argument against permitting competition from banks.

[34] NICO, *A Consumer Triumph: Proposition 103 Revisited* (1992) at ii.

[35] *See e.g., Sanford v. Garamendi*, 233 Cal. App. 3d 1609 (August 28, 1991).

[36] C.I.C. § 1861.12.

[37] California Public Interest Research Group, *Pick a Price, Any Price, A Report on Inconsistent Price Quoting of Automobile Insurance* (June 1987).

[38] C.I.C. § 1861.04(a).

costs of this system. The California Department of Insurance has not yet implemented this provision of 103.[39]

D. Fairness

Insurance is, by definition, a discriminatory enterprise. In order to allocate risk, insurance companies group individual consumers into a larger pool composed of similar risks. To a degree often poorly understood by the insurers themselves, the business of insurance depends on the consumer's trust in the fairness of the industry's classification system.

• **Emphasis on Driving Safety Record.** Proposition 103 prohibits the use of "territorial rating," under which insurance companies determine an individual's automobile insurance premium by calculating claims payments made within the motorist's zip code. Instead, auto insurance premiums must be based primarily upon three rating factors: a motorist's driving safety record, the number of miles he or she drives each year, and the motorist's years of driving experience, weighting those factors in that order. [40] Making the driver's own safety record the principal determinant of premiums gives motorists a strong incentive to drive safely.

The measure further requires insurers to grant a 20% Good Driver Discount to all qualifying consumers -- individuals with a virtually clean driving record (one moving violation is permitted) for the preceding three years.[41] This provides a further incentive for careful driving.

Judicial review of a legal challenge brought by insurers against implementation of this provision of the proposition blocked its implementation for more than three years. Insurers contended that rates must be "cost-based" under 103 and that the voters could not lawfully alter insurance classifications to substitute the "mandatory" factors for other factors which the industry argued could be shown to hold more predictive power (i.e., territory). On November 27, 1990, a California Court of Appeal dismissed the challenge without deciding the merits.[42] In December 1994, the Department of

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[39] Several private firms have entered the California marketplace to provide similar information, though with limited scope and at a significant cost. *Progressive Offers California Auto Rate Comparisons*, Underwriters Report, Nov. 27, 1997, at 12; *Consumers Access to Multiple Competitive Rates Grows Through Insweb Deal With Consumers Car Club*, Auto Insurance Report, December 1, 1997, at 8. The Internet has eased comparison shopping significantly.

[40] C.I.C. § 1861.02 (a). The commissioner can approve additional rating factors -- but only pursuant to a formal rulemaking process, and only if they "have a substantial relationship to the risk of loss" (C.I.C. §1861.02 (a) (4)). Such additional factors must be shown by statistical analysis to hold predictive power once the first three "mandatory" factors are applied to determine the majority of the premium. Additional factors approved by the commissioner will have relatively little impact on premiums, as the initiative requires that all optional factors combined cannot collectively outweigh the three mandatory factors in determining a motorist's premium. C.I.C. § 1861.02 (a)

[41] C.I.C. § 1861.02(b).

[42] *Allstate Ins. Co. v. Gillespie*, As Modified on Denial of Rehearing and Decertifying Opinion, February 2, 1992, reported at 1992 Cal. App. Lexis 194; 92 Cal. Daily Op. Service 675; 92 Daily Journal DAR 1035. (Filed January 22, 1992). Previously published at 225 Cal. App. 3d 798 (1990)

Insurance published a study that rebutted the industry's subsequent contention that territorial rating was consistent with the provisions of Proposition 103. [43]

In 1997, Commissioner Chuck Quackenbush promulgated new regulations which allowed insurance companies to continue to base premiums on a motorist's zip code, in violation of the law.[44] However, an independent review of the rating plans filed by three major insurance companies determined that they were not in compliance with the requirements of the law.[45] FTCR and other citizen groups filed lawsuits to compel the Insurance Commissioner to properly enforce the statute. The San Francisco Superior Court ruled that the regulations violated Proposition 103. Both insurers and Quackenbush appealed, however, and 2001, the California Court of Appeal reversed and upheld the regulations. [46] The California Supreme Court refused to review the Court of Appeal decision.

• **Redlining.** The failure of insurers to service particular communities, principally in urban areas, has been amply documented.[47] Proposition 103's emphasis on driving record and individual driving habits establishes a more equitable system for determining premiums which requires insurers to diminish the importance of geography. However, mandating the use of new rating factors does not address the practical reality that the availability of insurance agents and brokers is extremely circumscribed in some communities.[48] To ensure that qualified drivers can obtain insurance regardless of where they live, the measure specifies that any good driver, as defined in the initiative, has the right to purchase an auto insurance policy from the

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[43] Calif. Department of Insurance, Office of Policy Research, *Impact Analysis of Weighting Auto Rating Factors to Comply With Proposition 103*, December 1994. The study found that, contrary to the industry's predictions, eliminating territory as the primary determinant of premiums would not result in substantial premium increases for good drivers. *Id.* at 4.

[44] Title 10, Chapter 5, Subchapter 4.7, Article 7. C.C.R. § 2632.1 *et. seq.*

[45] Virtually all insurance companies in the state were found to be misinterpreting the regulations in order to continue to base premiums on territory, in violation of Proposition 103. Kenneth Reich, *Loophole Seen Gutting New Car Insurance Plan*, Los Angeles Times, October 4, 1997, at A1. An industry trade journal noted that Insurance Commissioner Quackenbush had improperly approved the rating plans: "[T]he commissioner has been misleading the public and the media by proclaiming that under his new rules territory is no longer the dominant factor in setting auto insurance rates." *California Class Plan Ruling Should Be in Quackenbush's Hands; What Will He Do?* Auto Insurance Report, November 17, 1997 at 1, 3.

[46] *Proposition 103 Enforcement Project v. Quackenbush*, Alameda Superior Ct. Case No. 796082-2 (filed March 25, 1998); *Spanish Speaking Citizens Foundation, Inc., et. al., v. . Quackenbush*, Alameda Superior Ct. Case No. 796071-6 (filed March 25, 1998); *Spanish Speaking Citizens Foundation v. Low* (2001) 85 Cal.App.4th 1179.

[47] *See, e.g.*: *Broken Promises: The Thirty-third Insurance Commissioner's Record on Redlining and Minorities*, California Council of Urban Leagues, Latino Issues Forum, Mexican American Political Association, San Francisco Black Chamber of Commerce, Public Advocates on Behalf of Fifteen Low-income, Minority and Consumer Groups, 1990. Hearing before the Committee on Banking, Finance and Urban Affairs, Subcommittee on Consumer Credit & Insurance, U.S. House of Representatives, 103rd Congress 1st Session, February 24, 1993. (Testimony of the Honorable John Garamendi, Insurance Commissioner, State of California). National Association of Insurance Commissioners, *Urban Insurance Problems and Solutions: Interim Report*, Insurance Availability and Affordability (EX3) Task Force, December 6, 1994.

[48] Khalid Al-Faris, *Selling and Servicing Levels of Private Passenger Auto Liability in Urban Cities*, Calif. Department of Insurance, Statistical Analysis Bureau, April 1993.

insurer of his or her choice.[49] The absence of prior insurance coverage cannot disqualify an otherwise good driver.[50]

• Arbitrary Cancellations and Non-Renewals. A frequent complaint among automobile insurance policyholders is that insurance companies may cancel or non-renew policies without justification – sometimes merely for the act of filing a claim. Proposition 103 prohibits such arbitrary actions unless based on three specific reasons: non-payment of premium, fraud, or the policyholder presents a substantial increase in the hazard insured against.[51]

E. Public Accountability

"Capture" of the regulators by the regulated industry is common in state-based insurance systems,[52] and highly corrupting of public faith. The public accountability of those administering insurance industry reform is critical to its success. Proposition 103 contained three mechanisms to ensure such accountability.

• Consumer Intervention. It is a basic tenet of democratic government that each party to a proceeding has the right to be fully represented. The adversarial process enhances openness, constructive change, and consumer acceptance.

Proposition 103 provides several avenues for consumer representation in insurance matters. First, it authorizes individual consumers to go before the Department of Insurance or the courts should insurance companies fail to comply with their responsibilities under the proposition. If the Department of Insurance fails to enforce the law or respond effectively to a consumer's complaint, consumers will not be "locked out" of the courts with no remedy, as often occurs in states with lax regulators.

Second, Proposition 103 encourages non-profit consumer advocacy groups to intervene in the regulatory process to protect the interests of the public. Citizen groups which make a "substantial contribution" to a rate hearing or other matter before the Department of Insurance, or to an insurance matter which goes before a court, are entitled to receive reasonable advocacy fees and reimbursement of expenses for such costs as expert witnesses.[53] Assessments collected from insurers are used to fund this

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[49] C.I.C. § 1861.02(b)(3).

[50] *Id.*

[51] C.I.C. § 1861.03(c). The California Supreme Court has ruled that this provision does not prevent an insurance company from terminating its policyholders as part of a plan to cease doing business in the state. *Travelers Indemnity Company v. Gillespie*, 50 Cal. 3d 82 (1990). Indeed, Proposition 103 contained a specific provision intended to protect California policyholders against a boycott or market withdrawal by insurance companies. Under C.I.C. § 1861.11, the insurance commissioner is empowered to establish a "joint underwriting authority" in which all insurance companies selling any form of insurance in California must participate to provide coverage in the event of a shortage in any specific line of insurance

[52] *See Sorry We Could Not Be of More Help": How the Calif. Department of Insurance Regulates a Trillion Dollar Industry*, A report to Consumers Union by Dan Noyes, Center for Investigative Reporting, May 1996, at 39. Walter L. Updegrave, *How the Insurance Industry Collects an Extra $65 Billion a Year From You By Stacking The Deck*, Money Magazine, August 1996, at 50.

[53] C.I.C. § 1861.1(b) was loosely modeled upon a similar consumer representation system in effect at the California Public Utilities Commission. *See* California Public Utilities Code (CPUC) § 1801 *et seq.*

program.[54] Funded citizen intervention programs protect against unnecessary or duplicative proceedings, while providing consumers with the professional, skilled representation that insurance companies are able to obtain – at policyholder expense. [55]

• **Elected Insurance Commissioner.** In the majority of states, the Insurance Commissioner is a political appointee with no direct accountability to the public. Often, the appointee is a former insurance industry executive, and the appointment a form of political patronage. It is no surprise then that state regulatory insurance agencies have frequently been criticized for poor enforcement and a pro-industry bias.[56] In California, for example, independent reports repeatedly criticized the appointed insurance commissioner for inaction during the 1985-1987 insurance crisis, for failure to respond to consumer complaints and for incompetent enforcement of the Insurance Code.[57]

Proposition 103 required that the Insurance Commissioner be elected, commencing in November 1990.[58] Currently, twelve states elect their insurance commissioner.[59] The theoretical advantages of an elected commissioner are consequential, particularly to the implementation of insurance industry reforms. An elected commissioner is accountable to the public, rather than to other elected officials, whose own accountability to the public on specific issues may be less direct. Since only the voters may pass judgment on the commissioner's performance, the commissioner has the independence -- and incentive -- necessary to act in the public interest. Because voters will evaluate the insurance commissioner by the fairness of the rates and practices of insurers, a commissioner who fails to satisfy the public should find it difficult to win re-election.

As a practical matter, however, the ability of insurance companies – a powerful constituency within the political economy – to elect sympathetic candidates has been

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[54] C.I.C. § 12979, enacted by § 5 of Proposition 103.

[55] An additional device to guarantee effective consumer representation was struck from the measure by the California Supreme Court. *See* CIC § 1861.10(c). Insurance consumers were to be given the opportunity to establish and join a democratically-created and controlled advocacy organization. A staff of advocates, funded by voluntary contributions and grants, would represent consumers on insurance matters before the Insurance Commissioner, the courts, and the state legislature. In order to enable the advocacy organization to obtain the support of consumers, insurers were to be required to enclose special notices within their premium bills, informing their customers of the opportunity to participate in the program. (Insurers would be reimbursed by the organization for any additional expenses caused by insertion of the notice). However, the California Supreme Court excised this provision of Proposition 103, ruling that § 1861.10(c) violated Article II, § 12 of the California Constitution, which prohibits an initiative from "naming or identifying" a private corporation. *Calfarm, supra* at 832. A subsequent effort in the California legislature to create such an advocacy group was blocked by insurance industry lobbyists.

[56] National Association of Ins. Commissioners, *1995 Insurance Department Resources Report*, at 2, Table 1 (1996). *See High Turnover in Regulators Ranks, PIA/CIIG Study*, Insurance Journal, May 14, 1990 at 12, which reported that 37% of Insurance Commissioners were employed in the insurance industry before taking office.

[57] Dan Noyes, *"Sorry we could not be of more help": How the California Department of Insurance Regulates a Trillion Dollar Industry* (A report to Consumers Union by Dan Noyes, Center for Investigative Reporting) May 1996, at 39; Auditor General of California, *The Department of Insurance Needs to Further Improve and Increase Its Regulatory Efforts* (June 1987); Robert Shireman, *Bark But No Bite: Toothless Regulation by the Department of Insurance Has Left California Consumers Unprotected*, Consumers Union, July 1987.

[58] C.I.C. § 12900, enacted by Proposition 103, §4.

[59] National Association of Insurance Commissioners, *1995 Insurance Department Resources Report* at 2, Table 1 (1996).

demonstrated in several instances,[60] including the second election of insurance commissioner in California in 1994.

Critics argue that election of the commissioner "politicizes" the office and may attract officials who view the position as a "stepping-stone" to higher office. That is certainly correct, to the same extent that every other office filled by popular vote is subject to the same politicization. And while a commissioner's desire to be re-elected or to proceed to higher office would seem to work to the advantage of voters in their role as policyholders, to the degree that insurance companies are more concerned about electing a supportive candidate than is the general public, the more likely it will be that insurers will successfully dominate the electoral process.

▪ **Statutory Remedies.** Prior to Proposition 103, California's consumer protection, civil rights and other statutes were inapplicable to the insurance industry by express statutory exemption.[61] The initiative repealed the exemption, making available to the consumers a host of state law remedies for improper conduct. [62]

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[60] L.H. Otis, *Delaware Funding for Regulator Questioned*, National Underwriter, Nov. 11, 1996, at 1; Susan Briggs, *U.S. Drops Indictment of Mississippi Commissioner*, Best Week, August 29, 1994, at 3.

[61] *See e.g.*, McBride - Grunsky Act, Cal. Ins. Code §§ 1850 to 1863.3, portions repealed by Proposition 103, § 7.

[62] C.I.C. § 1861.03(a).

California Department of Insurance
John Garamendi, Commissioner
News Release

FOR IMMEDIATE RELEASE:
October 9, 1991

CONTACT:
Bill Schulz/Elena Stern
213/736-2381

FIRST INSURANCE COMPANY TO VOLUNTARILY COMPLY WITH PROPOSITION 103

NORCAL Mutual Agrees to 20 Percent Policyholder Refund Totalling $19.9 Million

In the first action of its kind, NORCAL Mutual Insurance Company has agreed to voluntarily comply with the rollback provisions of Proposition 103 enacted by California voters nearly three years ago, and will return to policyholders a 20 percent rebate totalling $19.9 million, announced Insurance Commissioner John Garamendi.

"NORCAL Mutual has wisely decided to fulfill the letter and spirit of Proposition 103, place the interests of its policyholders first, and put their rollback liability behind them," said Garamendi. "While NORCAL Mutual is a unique company with a specialized niche market, I hope their decision will serve as an example to other insurers that Proposition 103 can be fully, fairly and quickly implemented."

According to a stipulation between NORCAL Mutual and the Department of Insurance, the company will pay a refund of $15,316,000 and an additional estimated $4,558,972 in interest. The rebate is based on the company's 1989 total premiums of $76,581,000, plus interest calculated at 10 percent since May 8, 1989 (the date the California Supreme Court upheld the legality of Proposition 103).

Refunds will be paid to policyholders of the company between November 8, 1988 and November 8, 1989. Current policyholders will receive four quarterly installment credits applied to their 1992 premium. If no longer insured by the company, policyholders will receive the entire refund by March 31, 1992.

The San Francisco-based mutual insurance company provides medical malpractice coverage to physicians and, as a mutual company, is owned by the doctors it insures. NORCAL Mutual has 9,000 policyholders in California.

August 15, Garamendi announced that Californians are owed a total of $2.5 billion in Proposition 103 rebates. On Monday, October 7, Governor Wilson over-ruled his administration's prior rejection of Garamendi's new emergency regulations that trigger the rollbacks mandated by Proposition 103.

The Department of Insurance is now in the final stages of determining the rollback amounts each insurance company will be required to rebate their policyholders.

On October 16, Garamendi will announce the first of numerous individual company rollback amounts to be rebated to California policyholders.

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California Department of Insurance
John Garamendi, Commissioner
News Release

FOR IMMEDIATE RELEASE:
October 18, 1991

CONTACT:
Bill Schulz/Elena Stern
213/736-2381

MORE REBATES TO COME AS SECOND INSURER VOLUNTARILY AGREES TO COMPLY WITH PROPOSITION 103

Physicians Exchange To Refund Over $30 Million To Policyholders

A second insurance company has agreed to pay their policyholders the rebates approved by voters almost three years ago, announced Insurance Commissioner John Garamendi today.

The Southern California Physicians Insurance Exchange (SCPIE) follows NORCAL Mutual in agreeing to voluntarily comply with the rollback provisions of Proposition 103. The agreement calls for the return of over $30 million to approximately 14,000 policyholders.

"While some insurance companies have already threatened to waste yet more time and money fighting us in court, others are taking the high road to put the Proposition 103 rebates behind them and get on with the business of insurance," said Garamendi. "SCPIE and NORCAL have formally acknowledged their policyholders' rights to receive these rebates, and I hope that other insurance companies will see the wisdom of their approach."

According to the stipulation between SCPIE and the Department of Insurance, the company will refund the rollback amount of $24,706,146, plus the current accrued interest of $6,024,238 (through October 15). An initial $20 million of the total will be paid to former policyholders and credited to current policyholders through the end of 1992. The full balance, including any additional interest that continues to accrue on the rollback amount, will be paid or credited to policyholders by the end of 1993.

The Southern California Physicians Insurance Exchange, based in Beverly Hills, provides medical malpractice insurance to 13,800 physicians. The exchange is owned by the doctors it insures.

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On August 15, Garamendi announced that Californians are owed a total of $2.5 billion in Proposition 103 rebates. On Monday, October 7, Governor Wilson overruled his administration's prior rejection of Garamendi's new emergency regulations that trigger the rollbacks mandated by Proposition 103. On October 16, Garamendi announced the first wave of individual company rollback amounts to be rebated to California policyholders. Fourteen insurance companies were ordered to pay their policyholders a total of $1.5 billion. Garamendi has encouraged policyholders to contact their insurance companies to demand payment of the rebates they deserve.

# # #

California Department of Insurance
John Garamendi, Commissioner
News Release

FOR IMMEDIATE RELEASE:
February 18, 1992

CONTACT:
Elena Stern 213 / 736-2389

GARAMENDI ANNOUNCES PROP 103 REBATE OF ALMOST $20 MILLION

The Doctors' Company To Write Checks, Give Credit to 9,500 Policyholders

A fourth insurance company has agreed to pay its policyholders the Proposition 103 rebates approved by voters over three years ago, Insurance Commissioner John Garamendi announced today.

The Doctors' Company follows two other medical malpractice insurance groups and the Automobile Club of Southern California in agreeing to voluntarily comply with the rollback provisions of Proposition 103. The agreement calls for the return of $18.5 million to the company's 9,500 California physician members, a 19.24% rebate.

"I am pleased that The Doctors' Company has decided to fulfill the letter and the spirit of Proposition 103 by giving its policyholders the rebates they deserve," said Garamendi. "I hope their decision will serve as an example to other insurers that Proposition 103 can be fully, fairly, and quickly implemented."

According to the stipulation between the Doctors' Company and the Department of Insurance, the company will pay a refund of $14,333,178 and an additional $4,186,056 in accrued interest, for a total rollback obligation of $18.5 million. The insurer will offer credit to current members on their next four quarterly statements beginning April 1, 1992, and will send refund checks to all 1989 policyholders who are no longer with the company by April 8, 1992. Interest will continue to be charged until the entire rollback refund has been paid or the last quarterly credit applied.

The company joins two other medical malpractice insurers, Norcal Mutual and the Southern California Physicians Insurance Exchange (SCPIE) that have already agreed to pay Proposition 103 rebates to their policyholders. Norcal Mutual agreed to pay 9,000 policyholders $19.9 million, while SCPIE's agreement calls for $30.7 million to be paid to its 13,800 members. The Automobile Club of Southern California agreed in October to refund its 515,000 policyholders over $104 million.

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NEWS

JOHN GARAMENDI
Insurance Commissioner

FOR IMMEDIATE RELEASE:
JULY 1, 1994 (#74)

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ST. PAUL COMPANIES PAY $10 MILLION PROP. 103 REBATE

Seven insurer affiliates of the St. Paul Companies will pay their policyholders $10 million in Proposition 103 rebates under an agreement announced today by Insurance Commissioner John Garamendi.

"While I remain confident that the California Supreme Court will shortly give me the green light to gain the remaining rebates for consumers, this agreement demonstrates the willingness of some insurance companies to do right by their policyholders," said Garamendi. "This rebate is fair, sizeable and consistent with the regulations I created and by which all companies should abide."

The rebate is 10% of the companies' $100 million in written premium for the 1989 rollback year, and will result in an average check of $270 for the 37,000 policyholders covered under the agreement.

The companies write commercial liability, medical malpractice, surety coverage and other commercial lines, but no private passenger automobile or homeowners insurance. The companies covered by the agreement are Seaboard Surety Company, St. Paul Fire & Marine Insurance Company, St. Paul Guardian Insurance Company, St. Paul Mercury Insurance Company, Ramsey Insurance Company, Athena Insurance Company and Economy Fire and Casualty Company.

To date, 33 insurance groups or companies have issued rebate checks and credited dividends totalling $780 million to 6.8 million Californians. This represents approximately 34% of policyholders due rebates.

On June 8th, The state Supreme Court heard oral argument in the pivotal case to determine the fate of Garamendi's Proposition 103 rebate regulations. At stake is an estimated more than $1 billion in outstanding rebates due policyholders. The court is expected to rule in the case, 20th Century v. Garamendi, by early September.

# # #

Los Angeles, CA
(Los Angeles Co.)
Central News Wave
(Cir. W. 18,500)

FEB 26 1992

Insurance Firm Agrees to Pay Prop. 103 Malpractice Rebates

From United Press International

A medical malpractice insurance company has agreed to pay $18.5 million in Proposition 103 rebates, becoming the fourth such insurer to do so.

The Doctors' Co. agreed Feb. 18 to a 19.24 percent rebate to its 9,500 California physician members under the provisions of Proposition 103, which was passed in November 1988 and required insurers to rollback rates by 20 percent for the next year.

"I am pleased that The Doctors' Co. has decided to fulfill the letter and the spirit of Proposition 103 by giving its policyholders the rebates they deserve," said State Insurance Commissioner John Garamendi. "I hope their decision will serve as an example to other insurers that Proposition 103 can be fully, fairly and quickly implemented."

The Doctors' Co. will pay a refund of $14.3 million and $4.2 million in interest by offering credit to current members on their next four quarterly statements beginning April 1. It will send refund checks to all 1989 policyholders who are no longer with the company by April 8.

Two other medical malpractice insurers, Norcal Mutual and the Southern California Physicians Insurance Exchange agreed last year to pay Proposition 103 rebates of $19.9 million and $30.7 million, respectively. The Automobile Club of Southern California agreed in October to refund more than $104 million.

Insurers have bitterly opposed Proposition 103, passed by a 53-47 margin in November 1988 following several years of rapidly escalating premiums. The insurers have claimed the measure's requirement of a 20 percent roll back in premiums during November 1988-November 1989 year was unfair.

The state Supreme Court upheld the constitutonality of Proposition 103 in May 1989, but ruled that the rebates must not be "confiscatory" and that insurers should be allowed a "fair rate of return."

The implementation of the measure has been bogged down ever since, with much of the blame falling on former insurance commissioner Roxani Gillespie for stalling. She set a "rate of return" in late 1990 of between 11 percent and 19 percent, but Garamendi threw out those rules early last year after becoming the state's first elected insurance commissioner.

Garamendi promised in August that consumers would soon get $2.5 billion in rebates under his emergency regulations that set the rate of return at 10 percent. About half of the rebates would come in auto insurance, with consumers receiving more than $100 per car.

Those plans have twice been blocked by the state Office of Administrative Law, but Gov. Pete Wilson has agreed twice to stop the delay. Garamendi has assigned specific rebate amounts to more than a dozen of the state's biggest insurers, who have — except for the Auto Club —responded by demanding administrative hearings.

Commercial Insurance Division
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123

August 8, 1986

FCC-86-2172

FORMS AND CONTRACTS

Honorable Bill Gunter
INSURANCE COMMISSIONER
Florida Department of Insurance
Tallahassee, FL 32301

ATTN: Mr. Charlie Gray, Chief
Bureau of Policy and Contract Review

Dear Mr. Gray:

RATE REVISION
CONTRACTORS LIABILITY POLICY PROGRAM
THE AETNA CASUALTY AND SURETY COMPANY
THE STANDARD FIRE INSURANCE COMPANY
THE AUTOMOBILE INSURANCE COMPANY OF HARTFORD, CONNECTICUT

In accordance with your Insurance Laws, our Companies file a revised liability rate level which results in an overall selected premium increase of 17.2% with an annual premium effect of $622,250.

Our Companies' decision to revise rates results only after a thorough and comprehensive analysis. We evaluated our experience, market conditions, tort reform, and other relevant factors as they affect the establishment of adequate rate levels. The enclosed exhibits prepared by actuarial unit are submitted in support of our rate filing decision, and demonstrate that the resultant rates are neither excessive, inadequate, nor unfairly discriminatory.

We propose to implement this filing with respect to all policies written on or after January 1, 1987. So as to not delay the filing of our rate level decision, revised rate pages will be forwarded under separate cover when available.

A stamped, self-addressed envelope is enclosed for your convenience in responding.

Sincerely,

Thomas L. Rudd

Thomas L. Rudd, Superintendent
Insurance Department Affairs - Commercial Lines

BODILY INJURY CLAIM COST IMPACT OF FLORIDA TORT LAW CHANGE

Summary

The following table summarizes the expected impact of the new Florida law on bodily injury claims costs (including Allocated Loss Adjustment Expenses). The impacts shown were developed from data gathered via a special claim study conducted by the AEtna. The claim study and the analysis are detailed in the succeeding sections of this memorandum.

Impact of Tort Law Changes

Impact of Tort Law Changes

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

All Other General Liability includes the bodily injury liability portion of package policies, SMP Section II, and monoline General Liability policies. The analysis as shown is based solely on AEtna data and, therefore, is applicable only to AEtna's book of business.

Claim Study

The attached special claim analysis form, designed to gather data on the impact of the tort reforms, was completed by experienced Branch Office claim personnel. Claims eligible for analysis were selected according to the following criteria:

1. Commercial Casualty claims (excluding National Accounts business) for policy years 1981 through 1985
   a. reported prior to January 1, 1986
   b. open as of May, 1986
   c. closed during the last six months

2. All claims in category (1) with indemnity payments or reserves over $25,000 were analyzed (total of 55 claims).

3. Fifty closed claims with indemnity of less that $25,000 were randomly selected.

The completed forms were reviewed for internal consistency prior to coding and analysis.

Collateral Source Analysis

Exhibits I and II detail the analysis of the revision in the collateral source rules. Exhibit I is for claims over $25,000 indemnity. Exhibit II is for claims under $25,000 indemnity.

Exhibit I shows that since the right of subrogation exists for many collateral sources available to the plaintiff, the economic losses incurred are not expected to be substantially reduced due to the law change. Furthermore, current AEtna claim settlement practices recognize, in part, the existence of collateral sources as part of the negotiating process used in arriving at a mutually satisfactory damage value with the plaintiff.

Exhibit II shows that for claims under $25,000, no additional savings are expected due to the change in Florida law.

Joint and Several Analysis

Exhibit III details the analysis of joint and several additional payments made by AEtna. Total joint and several payments were 4.5% of indemnity payments over $25,000. A review of each claim generating additional payments due to joint and several liability indicated no reduction in those payment due to the interaction of economic damages sustained by the plaintiff, the percentage of liability assigned to AEtna's insured, and the policy limits purchased.

Analysis of Limitation of Noneconomic Damages to $450,000

Nine claims had the potential for coming under the new limitation for noneconomic losses. The nine cases were identified on the basis of full liability value--not our insured's share of the liability. Data in the above format allowed for a review of whether total claim value could be reduced and whether such a reduction would impact on AEtna's incurred claim cost.

The review of the actual data submitted on these cases indicated no reduction of cost. This result is due to the impact of degree of disability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff; all seemed to reduce the expected noneconomic component of damages to less than $450,000.

Analysis of Punitive Damages

Only two cases were found where punitive damages had an impact on the claim settlement value. The total impact was estimated at less than $15,000 or less than 0.1% of total indemnity payments. Consequently, it appears that there will be no impact on AEtna's claim values due to changes in the allocation of the punitive damages awarded.

Analysis of Installment Payment of Future Economic Damages Over $250,000

Ten claims had the potential for coming under this section of the law. The review of individual cases indicated no net savings to AEtna for the following reasons:

1. interaction of policy limits, past economic losses, and future economic losses
2. settlement value of the case
3. apparent implicit recognition of the periodic nature of future damages

Overall Summary

The expected net reduction in claim costs is based on an analysis of AEtna claims. As such, the analysis is applicable only to AEtna's book of business.

Due to the level of detail of the historical claim data, informed claim judgement was required in some instances to ascertain some of the detail required for the analysis. The judgement, if any, was exercised by experienced claim adjustors and is implicit in the analysis.

The analysis shown represents the best estimate of future cost reductions if the law as currently structured remains in effect. However, the sunset provision of the law takes effect in four years. Furthermore, the law applies only to cases filed under the law, and the Florida statute of limitations is four years. Consequently, it is possible that any plaintiff who might be severely impacted by the provisions of the law would delay filing until after the law expires. If this situation arises, then the expected reductions will be lower than those indicated in this memorandum.

EXHIBIT I

FLORIDA

COLLATERAL SOURCES - CLAIMS OVER $25,000

	Products	All Other
Economic Paid	$ 206,000	$ 1,854,000
Future Economic	466,000	2,567,000
General	624,000	11,960,000
Total Indemnity	1,296,000	16,380,000
Claims with Collateral Sources	628,000	4,187,000
Claims with Collateral Sources and with Liens	255,000	1,987,000
Claims with Collateral Sources and without Liens	378,000	2,200,000
% of Claims with Collateral Sources Available	28.8%	13.4%
Estimated Reimbursement Rate	50%	50%
Economic as % of Total Indicated	51.9%	27.0%
% of Indicated which could be Reduced	7.5%	1.8%
Claims with Collateral Sources without Liens - subject to:		
Statutory Liens	378,000	1,132,000
Contractual Liens	0	100,000
Not Subject to Liens	0	949,000
% Not Subject to Liens	0%	43.1%
Claims with Collateral Sources not Subject to Liens where Collateral Sources had an Impact on Settlement	N/A	556,000
Estimated Impact	N/A	28,000
Estimated Impact - % of Total Award	N/A	5%
Net Reduction to Collateral Source Savings Due to Right of Subrogation	7.5%	1.0%*
Previously Recognized Collateral Sources	N/A	0.2%
Net Impact of Collateral Source Changes	0	0.8%

*(1.0 - .431) x 1.8%

EXHIBIT I
(cont.)

Net Impact of Collateral Source Offset on Claims Over $25,000 Adjusted to Total Loss Costs, including Allocated Loss Adjustment Expense

$25,000 and over Claims Dollars as a % of Total Claims Dollars (est.)	75%
Estimated Allocated Expense as % Total Loss x ALAE	33%
Net Impact of Total Loss and ALAE: 0.8% x .75 x (1 − .33) =	0.4%

EXHIBIT II

FLORIDA

COLLATERAL SOURCES - CLAIMS UNDER $25,000
WITH COLLATERAL SOURCES

	Products	All Other
Total Indemnity Paid - Claims with Collateral Sources	$ 36,500	$149,215
Indemnity Paid on Claims with Liens	5,000	16,300
Indemnity Paid on Claims without Liens but with Right of Subrogation		
Statutory	13,500	33,750
Contractual	0	67,200
Indemnity Paid on Claims not Subject to Subrogation where Collateral Sources Influenced Settlement	18,000	29,965
Net Indemnity Payments where Some Offset Could be Made	0	2,000
Total Indemnity for Claims Less Than $25,000	170,648	816,506
% of Total Indemnity Available for Additional Offset	0	0.2%
Estimated Additional Offset for Claims Under $25,000 Adjusted to Total Loss Costs Including Allocated Loss Adjustment Expense (cf Exhibit I) (0.2% x .25 x (1 - .33)) =	0	0.0%

EXHIBIT III

FLORIDA

JOINT & SEVERAL PAYMENTS
CLAIMS OVER $25,000

	Products	All Other
Total Indemnity Payments	$1,296,000	$16,380,000
Additional Payments Due to Joint & Several	232,000	568,000
Reduction in Potential Savings Due to File Review	232,000 *	568,000 **
Net Savings	0	0

*1 Claim - death case - expected economic losses high enough to cover additional payment

**2 Claims - 1 death case - estimated settlement value may be close to economic value; therefore, additional payment of $193,000 would still be required (policy limits paid out at that time)

1 permanent total case - estimated settlements probably will cover custodial care (i.e., economic loss); therefore, no savings due to law change.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM

In 1986, Florida passed a number of changes to the tort system. We have reviewed the tort changes and their potential effect on our medical professional liability experience. Our review is based on a study of over 300 Florida closed claims. The total effect of the bill based on this evaluation was very small.

Evaluation:

Of the 313 closed claims that were studied, only four claims would have been effected by the law for a total effect of about 1% savings. (Exhibit A) Furthermore, all of these savings would have been eliminated if the courts had assigned only 10% more of the blame on our insureds than our claim department had estimated. It's highly likely that there would have been no savings on these claims had the bill been in effect. (Exhibit B)

Our study covered all of our Florida physicians, surgeons and hospital claims that closed in 1983 and 1984. Economic loss was determined based on the plaintiff's medical loss, weekly wage, and time lost from work. These losses were reduced for the time value of money.

We added the noneconomic loss cap to the total economic losses. The cap is $450,000 times the portion of negligence assigned to our insured. We compared this maximum award under the new law to the amount that the St. Paul actually paid on behalf of our insured.

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

Comments on other provisions of the bill:

a. Collateral source offset

The medical malpractice provisions prior to this act provided for subrogation against collateral providers. The effect of this subrogation would be similar to the effect of the collateral source rule. Therefore, the net effect of eliminating the subrogation and allowing collateral sources is negligible.

b. Itemization of Damages

Damages were itemized in our evaluation of this tort reform and no savings were shown. They are probably already implicitly itemized by either juries or our claim department when settling claims. We expect no savings from this provision.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM
(Continued)

c. Frivolous Suit Protection

This provision can either work for or against us depending on who wins the case. No savings are expected from it.

d. Additur/Remittitur

This provision can also work for or against us. No savings are expected.

e. Punitive Damages

The legislation reduces the monetary incentive for punitive damage cases, but not total award amounts. Since these cases often have a retaliatory incentive, no savings are expected.

f. Timing of Effects

The tort changes made in Florida apply to losses occurring on or after July 1, 1986. On a claims-made policy, they will effect only the portion of our expected losses with accident date after July 1, 1986. This will impact the equivalent of our first year losses.

g. Conclusion

The tort law changes effective July 1, 1986 in Florida will, hopefully, have a positive impact on loss costs for occurrences after that date. However, to forecast the effect is highly speculative. Our evaluation of prior losses showed little or no savings under key provisions of the law and our analysis of other provisions show no expected savings. Our best estimate is no effect from the tort changes.

It can be hoped that the adoption of these tort changes will have an intangible effect on society, and further work to mitigate future loss trends. However, the trends in medical malpractice have been very high. The effect of the reform needs to be very strong to stem such trends.

Medical Professional Liability
State of Florida

Exhibit A

FLORIDA STATE TORT REFORM EVALUATION

EFFECT OF NONECONOMIC DAMAGES CAP, APPORTIONMENT OF LIABILITY, AND MANDATORY STRUCTURED SETTLEMENTS

FLORIDA PHYSICIANS' AND SURGEONS' DATA

LOSS SEVERITY	1984 INCURRED LOSS & LAE	PROJECTED PERCENTAGE SAVINGS	PROJECTED LOSS DOLLAR SAVINGS
EMOTIONAL	$759,962	0.0%	$0
TEMPORARY	$5,867,384	0.0%	$0
PERMANENT PARTIAL	$12,424,121	0.0%	$0
PERMANENT TOTAL	$8,347,000	0.0%	$0
DEATH	$9,337,688	4.5%	$420,196
TOTAL	$36,736,155	1.1%	$420,196

COUNTRYWIDE PHYSICIANS' AND SURGEONS' DATA

LOSS SEVERITY	1985 INCURRED LOSS & LAE	PROJECTED PERCENTAGE SAVINGS	PROJECTED LOSS DOLLAR SAVINGS
EMOTIONAL	$8,217,941	0.0%	$0
TEMPORARY	$81,439,529	0.0%	$0
PERMANENT PARTIAL	$110,004,377	0.0%	$0
PERMANENT TOTAL	$80,695,313	0.0%	$0
DEATH	$99,481,842	4.5%	$4,476,683
TOTAL	$379,899,002	1.2%	$4,476,683

Medical Professional Liability
State of Florida

Exhibit B

FLORIDA CLOSED CLAIM STUDY

CLAIMS PRODUCING SAVINGS UNDER JULY 1,1986 LEGISLATION

LOSS SEVERITY	ECONOMIC LOSS	INSURED NEGLIGENCE	INDEMNITY PAYMENT	NONECONOMIC CAP	PROJECTED SAVINGS
TEMPORARY	$0	0%	$66	$0	$66
TEMPORARY	$0	0%	$194	$0	$194
DEATH	$10,000	3%	$38,975	$11,250	$17,725
DEATH	$5,000	25%	$350,000	$112,500	$232,500

CLAIMS PRODUCING SAVINGS UNDER JULY 1,1986 LEGISLATION
ASSUMING 10% GRLATER LIABILITY ASSIGNED TO INSURED

LOSS SEVERITY	ECONOMIC LOSS	INSURED NEGLIGENCE	INDEMNITY PAYMENT	NONECONOMIC CAP	PROJECTED SAVINGS
TEMPORARY	$0	10%	$66	$45,000	$0
TEMPORARY	$0	10%	$194	$45,000	$0
DEATH	$10,000	13%	$38,975	$56,250	$0
DEATH	$5,000	35%	$350,000	$450,000*	$0

* INSURED LIABILITY EXCEEDS CLAIMANT LIABILITY

Claim Evaluation Project
National Overview
Conducted by
Hamilton, Rabinovitz & Alschuler, Inc.
Commissioned by
Insurance Services Office, Inc.

A. Modifications of the Rule of Joint and Several Liability

Chart II on the following page summarizes the changes in the indemnity value of each of the four multi-defendant "core" claim situations[1] that resulted when each of the 12 generic modifications of this rule enacted during 1986 were tested. The Chart groups the 12 into seven rough subcategories. Please note, both here and in all other subsections below, that *the diversity of the measures enacted makes all attempts at subcategorization necessarily imprecise.* Many important differences must be glossed over in the Charts in order to develop any subcategories at all.

Moreover, no set of standardized claim situations can test all of the differences between changes in the same rule of law that have been enacted in different States. Thus, the fact that two changes may have identical effects in the standardized situations tested by no means necessarily implies that they would have similar effects in other situations, where the difference between the two changes might come into play. Finally, many enacted changes contain exclusions (e.g., of toxic substance cases) that do not come into play in the claim situations tested, and therefore are not mentioned here.[2] For all of these reasons, neither the Charts nor the associated discussion should be taken as a full treatment of all of the fine points of these enactments.

The differences that divide the 12 different modifications enacted are described below. The median expected percentage effect on indemnity value that was predicted by the participants in each enacting State with respect to that State's amendment of the rule is shown for each claim situation tested. Again, Situations I and II (supermarket and stairway fall) are not relevant to this rule because they are both single-defendant cases. Thus, the array of claim situations is reduced to four. There follows a summary of the enacted measures that are grouped within each subcategory and the impacts projected for each.

Subcategory (a): Outright Abolition of the Doctrine

Three States--*Colorado, Utah and Wyoming*--enacted a complete shift to several liability only, under which each defendant found to have any share of liability to the claimant is liable only for the share of total compensatory damages awarded (both economic and non-economic) that is equal to the percentage share of liability assessed to that defendant at trial.

Observations:

1. This change was expected to reduce the indemnity value of the "deep pocket" construction site claim (Situation III) by on the order of two-thirds to three-quarters in each of the three States.

2. In the industrial product liability situation represented by Situation V (punch press accident), the reduction was also considerable, but considerably greater in the other two States than in Utah.

3. Only in Wyoming was the change expected to have any measurable effect in the consumer product liability context (Situation VI -- chair collapse), and in the wrongful death claim (Situation IV -- truck-car accident).

[1] ***The rule of joint and several liability is only relevant, of course, where there are two or more defendants. Thus, it is not involved in the two slip-and-fall claims (Situations I and II), but only in the four where there are multiple liable parties. Thus, only these four claims are shown on the Chart.***

[2] ***However, they were normally communicated to the participants in the materials summarizing the newly enacted law.***

Chart II

Median Expected Changes in Indemnity Value in Four Standardized, Multi-Defendant Claim Situations from Enacted Modifications of the Rule of Joint and Several Liability

State	III (Construction Site Fall)	IV (Fatal Truck-Car Crash)	V (Punch Press Accident)	VI (Chair Failure)
(a) Outright Abolition of the Rule				
Colorado	-73%	0%	-45%	0%
Utah	-82	0	-25	0
Wyoming	-63	-8	-39	-10
(b) Abolition Except Where Plaintiff is Fault-Free				
Washington	-71*	0	0	0
(c) Abolition for Non-Economic Damages Only				
California	-25	0	-18	0
(d) Abolition with Apportionment of Orphan Share(s)				
Connecticut	-13	0	0	0
Michigan	-18*	0	0	0
(e) Abolition for Non-Economic Damages in Larger Cases				
Florida	-23	0	0	0
(f) Abolition or Limitation for Low Fault Defendants				
Alaska	-43	0	0	0
Illinois	-50*	0	0	0
New York	0	0	0	0
(g) Apportionment of Orphan Share Only				
New Hampshire	0	0	0	0

Note: The estimates obtained in these standardized claim contexts cannot be generalized to the full claim portfolio of any insurer or to that of the insurance industry as a whole. Therefore, the results are not directly relevant to issues of insurance pricing or rate regulation.

** "Core" claim altered to introduce 10% claimant fault*

Subcategory (b): Abolition Except Where Plaintiff is Fault-Free

One State, *Washington*, abolished the rule except where the plaintiff is adjudged to be without fault. If all of the "core" claim situations had involved entirely fault-free plaintiffs, as they did in the form in which they were presented to the participants in the great majority of States, no meaningful test of the Washington modification of the rule would have been possible. As noted earlier, therefore, Washington was one of six States in which the facts of the construction site claim (Situation III) were slightly altered to give the claimant 10% contributory negligence, while not reducing the liability of the "deep pocket" defendant which is the "insured party" in the claim. All other claims tested continued to involve claimants who were free of fault.

Observations:

1. With 10% contributory negligence resting with the plaintiff, the impact predicted in Washington in the construction site claim (Situation III) was essentially interchangeable with those in States that fully abolished the rule.

2. However, the Washington modification was expected to have no effect in any of the other multi-defendant claims, all of which involved fault-free plaintiffs, and it would presumably have had no effect in Situation III if that claim had been left in the form in which it was tested in most States.

Subcategory (c): Abolition for Non-Economic Damages Only

One State—*California*—enacted (by an initiative vote of the people) a modification in which each co-defendant is jointly and severally liable for only the economic portion of the damages assessed. With respect to the non-economic portion, each defendant is only severally liable. The participants were instructed to assume that it had been definitively held by the appropriate appellate courts that economic damages include objectively verifiable past or future monetary losses, and that non-economic damages include such forms of harm as pain and suffering, inconvenience, mental suffering, emotional distress, loss of consortium, loss of companionship, injury to reputation or humiliation.[1] Finally, they were instructed to assume, despite some arguable unclarity in the language of the initiative, that all fault is to be apportioned only to the parties involved in the action, and that the rule change applies whether or not any contributory fault is assigned to the plaintiff.[2]

Observations:

1. The California modification was expected to reduce the indemnity value of the construction site claim (Situation III) by about one-quarter, and that of the industrial product liability claim (Situation V – punch press accident) by a bit less than one-fifth.

2. Although the median view was that the modification would have no effect in either of the other multi-defendant situations, this was not a consensus judgment.[3] A substantial minority of the California participants felt that the modification would have some impact in the wrongful death claim (Situation IV – truck-car accident), and about half the respondents believed that there would be some effect in the chair failure claim (Situation VI).

[1] These definitions are drawn from the material supplied to voters with the initiative.

[2] As referred to earlier, and reported in detail in the State-specific Report for California, a variation was also tested in which it was assumed that all of these interpretational issues, plus the constitutionality of the initiative, had not yet been definitively ruled upon by the appropriate appellate court. This variation produced higher estimates of impact on the indemnity value of the construction site claim (Situation III) and lesser impact in the punch press accident claim (Situation IV) than did the variation reported on herein, where all of these questions are assumed to have been settled. See the State-specific Report on California for an interpretation of these results.

[3] As noted above, the study defines a forecast of zero effect shared by 71% or more of the respondents as a consensus judgment of no expected impact, representing the preponderance of expert opinion.

Subcategory (g): Apportionment of Orphan Share Only

One State, *New Hampshire*, while retaining the traditional rule for purposes of entry and payment of judgments to plaintiffs, provided that, for purposes of actions brought by the paying defendant against other defendants for partial reimbursement of the payment made,[1] any uncollectible orphan share is allocated among the defendants that are solvent and not immune from judgment according to their respective degrees of assessed fault.

Observations:

1. The median view in New Hampshire was that this modification would have no impact on the indemnity value of any of the claims tested.

2. However, this was not a consensus judgment in any of the four multi-defendant claims, though it was very nearly so in the chair failure case (Situation VI). Elsewhere:

- In the construction site claim (Situation III) a majority of participants felt that there would be some impact, and their net judgment was that the modification would increase the indemnity value of the claim.
- In the punch press claim (Situation V), just under half the respondents expected some impact, and here again their net judgment was that the modification would raise the indemnity value of the claim.
- In the truck-car accident claim (Situation IV), a minority believed that the modification would have some impact on indemnity value, which their net judgment suggested would be downward.

B. Changes in the Collateral Source Rule

Eight of the 15 enacting States passed laws relaxing, in different ways, the traditional collateral source rule. These changes can roughly be divided into three subcategories, which are described below. The reported expectations of impact on the indemnity value of each State's change in each of the six situations tested (all of which involved some volume of collateral benefits) are summarized in Chart III.

Great care should be taken in interpreting these results in terms of comparison of one State's approach to that of another. First, the incidence of collateral benefits, and of benefits of specific types (e.g., salary continuation), varies from area to area, so that a benefit pattern that may be common in one State may be relatively unusual in another. Second, the standardized claim situations cannot test the effects of all of the distinctions drawn in the various State measures with respect to which collateral benefits are included within the "set off" from any tort award, and which are not. Third, because agreement is often voluntarily reached in claim negotiations to fully or partially set off collateral benefits in the course of achieving settlement—even though these benefits would not be set off by the court if the case went to trial—the base against which the predicted change in indemnity outcome is projected is not necessarily founded on the assumption that a requirement of judicial set off introduces a wholly new factor into the negotiation. For all of these reasons, it bears emphasizing that *the fact that a particular version of relaxation may have generated a particular pattern of State-by-State indemnity effects in these standardized claim situations does not mean that this pattern would necessarily reappear if the facts of the claims were materially changed.*

[1] *This is referred to in the law as an action for contribution.*

Chart III

Median Changes in Indemnity Value in Six Standardized Claim Situations Expected from Enacted Relaxation of the Collateral Source Rule

State	I (Supermarket Slip-and-Fall)	II (Stairway Fall)	III (Construction Site Fall)	IV (Fatal Truck-Car Crash)	V (Punch Press Accident)	VI (Chair Failure)
(a) Relaxation Except for Legal Entitlements						
New York	-20%	-20%	-17%	-1%	0%	-3%
(b) Relaxation with Broader Exclusions from Set Off						
Alaska	-28	-20	0	-6	0	-13
Colorado	-13	-4	0	0	-2	0
Connecticut	-24	-18	-7	-1	0	-8
Florida	-26	-25	0	-1	-5	-7
Minnesota	-30	-22	0	-1	0	-6
(c) Relaxation with Ceilings on Set Off						
Illinois	0	0	0	0	0	0
Michigan	-25	-24	0	0	0	-7

Note: The estimates obtained in these standardized claim contexts cannot be generalized to the full claim portfolio of any insurer or to that of the insurance industry as a whole. Therefore, the results are not directly relevant to issues of insurance pricing or rate regulation.

Subcategory (a): Relaxation Except for Legal Entitlements

One State, *New York*, mandated that the judge reduce any tort verdict for the plaintiff by the total amount of collateral benefits that have been received or are reasonably expected to be received by the plaintiff, saving only those expressed in a lien that represents a legal entitlement. In addition, this "set off" of benefits was to be reduced by the amount of any premiums paid by the plaintiff (not by his/her employer or any other party) during the two years before the action or at any time in the future in order to secure the benefits being set off.[1] The participants were instructed to assume that the benefits set off would at least include any insurance except life insurance, any Social Security payment except ones made under Title XVIII of the Social Security Act (which deals with rehabilitation benefits), and the proceeds of any employee benefit program, including salary continuation during time away from work.

Observations:

1. The median view was that the New York relaxation of the rule would reduce by one-fifth the indemnity value in each of two "core" claims: Situations I (supermarket fall), and II (stairway fall), while having a slightly smaller impact in Situation III (construction site accident).

2. The New York change was expected to have little or no impact in any of the other three situations. However, only about half of the participants shared the median view of no impact in the industrial product liability context (Situation V-punch press accident).

Subcategory (b): Relaxation with Broader Exclusions From Set Off

Five States—*Alaska, Colorado, Connecticut, Florida and Minnesota*—enacted forms of relaxation of the collateral source rule which, although always calling for judicial set off of collateral benefits, exclude from that set off one or more of several different types of benefits. These differ considerably from State to State, as described below.

In *Alaska*, all benefits that involve subrogation rights[2] are excluded from the set off. So is an amount equal to any premiums paid by the plaintiff in order to secure the benefits being set off, as well as any excess of plaintiff's attorney fees above an amount set by the court. Finally, the statute specifically excludes the setting off of (i) benefits not subject to such offset by reason of Federal law; (ii) life insurance proceeds; and (iii) gratuitous payments to the plaintiff from any source (but apparently not including simple salary continuation by the the plaintiff's employer).

In *Colorado*, no benefit for which premiums have been paid by or on behalf of the plaintiff may be set off.

In *Connecticut*, only certain specified benefits may be set off. These include (i) health related insurance benefits, except for life insurance proceeds; and (ii) compensation attributable to the accident which has already been received by the plaintiff (but not Workers' Compensation or no-fault auto compensation). The set off is then reduced by the amount of the premiums paid by or on behalf of the plaintiff to secure the benefits being set off.[3]

[1] *As noted earlier, the New York version of relaxation of the collateral source rule is essentially identical to the one tested in all 24 States. The results of the testing of the nationally-tested changes are reported in Part VII below.*

[2] *The right of subrogation is the right of one person or entity (e.g., an insurer) who has paid a debt to assume the rights of the person or entity (e.g., an insured) to whom it was paid.*

[3] *The set off is further adjusted in the event that any contributory negligence is found in the plaintiff, but this situation never arises in any of the "core" situations as presented in Connecticut.*

In *Florida*, the set off may not include any benefits where subrogation rights exist either by law or by contract.[1] Also excluded are life insurance proceeds, Medicaid payments, the value of medical services provided by the State Department of Health and Rehabilitative Services, and benefits provided through employee benefit programs, including salary continuation by the claimant's employer. The amount of the set off is also reduced by any premiums paid by the plaintiff or his/her immediate family in order to secure the benefits set off.

In *Minnesota*, the set off may not include any benefits from sources that have subrogation rights, or any that may be received by the plaintiff after the date of the verdict. Benefits from private disability plans are also excluded from set off, as are life insurance proceeds. The set off is also reduced in the amount of any premiums paid by or on behalf of the plaintiff to secure the set off benefits during the two years prior to accrual of the action.

Observations:

1. These relaxations of the rule, though quite different in detail, were expected to reduce indemnity value in Situation I (supermarket slip-and-fall) by 24-30% in all these States other than Colorado, where the effect was anticipated to be about half as great. The difference in Colorado presumably reflected the fact that benefits for which premiums have been paid may not be set off there, whereas in the other States, the amount of the set off is simply reduced by the amount of the premiums.

2. The same pattern emerged in Situation II (stairway fall), where the range of effects in the other three States was 18-25%, while the Colorado participants registered only 4%.

3. The respective relaxations of three States—Connecticut, Florida and Minnesota—were expected to have modest effects in the 6-8% range in Situation VI (chair failure), whereas a larger effect was expected in Alaska, and no impact at all was anticipated in Colorado.

4. Little or no effect was expected in Situation IV (truck-car accident), except for a modest effect in Alaska. The median expectation of no impact in Colorado was very nearly a consensus judgment.

5. No effects were anticipated in Situation V (punch press accident) in three of the five States, and only very modest ones in Colorado and Florida. The expectation of no impact was a consensus judgment in Alaska and very nearly one in Minnesota. In Connecticut, however, just over half of the participants shared this view.

6. Except in the case of Connecticut, where participants recorded a modest impact, the median view in these States was that their respective relaxations would have no effect in Situation III (construction site accident). However, this was a consensus judgment only in Alaska. A substantial minority foresaw some impact in Minnesota, and in Colorado and Florida, where some participants thought the new law would increase the indemnity value of this claim, the median view was a minority opinion.

[1] It should be noted that a typographical error in the Glossary of changes tested that was provided to the Florida participants resulted in failure to make clear that benefits involving subrogation rights are excluded from the set off. While irrelevant in the four of the six claims tested where it was specifically stated that no subrogation rights existed, this unclarity could have made a difference in the construction site claim (Situation III) and the punch press claim (Situation V). However, careful examination of the Florida results in those claims indicates that participants systematically acted as though they believed (correctly) that subrogatable benefits cannot be set off under the Florida statute.

7. In each of the four States in this group other than Colorado, the relaxations of the rule that have been enacted were expected to have greater effects on indemnity value in the supermarket slip-and-fall and consumer product liability claims (I and VI) than the New York participants felt would be created by a form of relaxation that appears, on paper, to involve fewer exclusions. However, this result did not appear to reflect the difference in exclusions, but rather the relative effect that the change in the rule would have on the settlement of claims of these types in these disparate jurisdictions. An example of a contrary judgment is provided by the fact that the New York version of relaxation of the rule was expected to have noticeably more effect in the construction site claim (Situation III).

Subcategory (c): Relaxation with Ceilings on Set Off

Two States, *Illinois and Michigan*, enacted statutes that more narrowly circumscribed and placed a ceiling on the collateral benefits that may be set off. Again, the nature of these limitations is quite different in the two cases.

In *Illinois*, the set off can only include past medical charges in excess of $25,000 which have been paid or are payable at the time of the award, and which involve no subrogation rights. The set off is also reduced by the amount of any premiums paid by the plaintiff to secure the benefit being set off during the two years prior to the injury. Finally, the total set off is capped at 50% of the amount of the award prior to set off.

In *Michigan*, the set off cannot include any benefits from sources with a statutorily based lien, or from those with a contractually based lien who have asserted it, or the proceeds of life insurance. In addition, the total amount of the set off cannot exceed the amount of the economic damages awarded to the plaintiff in the case.

Observations:

1. There was a consensus judgment in Illinois that that State's version of relaxation would have no impact on indemnity value in four of the six claims (II, IV, V, and VI), and the median view was that it would have no effect in any of the six. There was very nearly a consensus on no impact in Situation I (supermarket fall), but a sizable minority expected some impact in Situation III (construction site accident).

2. The Michigan relaxation, on the other hand, was expected to reduce indemnity value by about one-quarter in both Situations I (supermarket fall) and II (stairway fall), and have a modest impact in Situation VI (chair failure). The median view was that it would have no effect in the other three claims. However, about half the respondents did expect some impact in the construction site claim (Situation III), and minorities anticipated some change in the truck-car collision and punch press accident contexts (Situations IV and V).

C. Ceilings on Non-Economic Damage Awards

Seven of the 15 enacting States established ceilings on some or all non-economic damages, although the latter term was not always similarly defined from State to State. The types of caps enacted fit into three very rough subcategories, as shown on Chart IV, which reports the results received with respect to this type of change taken alone.

Chart IV

Median Changes in Indemnity Value in Six Standardized Claim Situations Expected from Enacted Ceilings on Non-Economic Damages

State	I (Supermarket Slip-and-Fall)	II (Stairway Fall)	III (Construction Site Fall)	IV (Fatal Truck-Car Crash)	V (Punch Press Accident)	VI (Chair Failure)
(a) Flat Caps						
Colorado	0%	0%	-5%	0%	0%	0%
Florida	0	0	0	0	0	0
Maryland	0	0	0	0	0	0
New Hampshire	0	0	0	0	0	0
(b) Flexible Caps						
Washington	0	0	-19	0	0	0
(c) Partial Caps						
Alaska	0	0	0	0	0	0
Minnesota	0	0	0	0	0	0

Note: The estimates obtained in these standardized claim contexts cannot be generalized to the full claim portfolio of any insurer or to that of the insurance industry as a whole. Therefore, the results are not directly relevant to issues of insurance pricing or rate regulation.

Although the Chart correctly summarizes the median view that the ceilings enacted in 1986 would, by and large, have little or no effect in any of the six claims tested, this should not be taken as a unanimous view, nor should it be understood to mean that no such ceiling would make any difference. As noted below, minorities of participants often did expect the enacted ceilings to have some impact in some of these claims, and a later section of the Report details the quite noticeable impact that was projected to result in some instances from the nationally-tested flat cap of $250,000 on non-economic damages. Had the standardized claims been designed specifically and solely to test the effects of each cap in a situation certain to bring it into play, the estimates of impact would doubtless have been quite different. However, as the Chart implies, claim situations capable of provoking these different estimates would need to be quite singular in nature.

Subcategory (a): Flat Caps

Four States—*Colorado, Florida, Maryland and New Hampshire*—enacted fixed caps on non-economic damages. They differed as described below.

In *Colorado*, the ceiling is set at $250,000 unless the judge is persuaded that there is clear and convincing evidence to justify a higher award. Even in that event, the ceiling is $500,000. Non-economic damages are defined to include pain, suffering, inconvenience, emotional stress, and impairment of the quality of life. They specifically do not include physical impairment or disfigurement.

In *Florida*, the ceiling is set at $450,000. Non-economic damages are defined as non-pecuniary losses, specifically including disfigurement and physical impairment.

In *Maryland*, the ceiling is set at $350,000.

In *New Hampshire*, the ceiling is set at $875,000.

Observations:

1. The median view was that none of these ceilings would have any effect on the indemnity value of any of the six claims in any of the four States, with the exception of a very modest impact by the Colorado cap in the construction site claim (Situation III).

2. There was a consensus judgment of no impact in all States with respect to Situations I (supermarket fall), II (stairway fall), and VI (chair failure).

3. There was a consensus judgment of no effect in New Hampshire in all claims except the construction site claim (Situation III), and a very nearly consensus judgment to the same effect in that claim. There were very nearly consensual judgments to the same effect in Colorado in all claims except the construction site claim (Situation III).

4. There was a consensus judgment of no effect in Florida in Situation IV (truck-car accident). However, a substantial minority in Maryland felt that the lower Maryland cap would have some effect in that claim.

5. Substantial minorities in Florida and Maryland felt that their respective caps would have some effect on the indemnity value of the construction site claim (Situation III).

6. A substantial minority in Florida believed that that State's cap would have some effect in the truck-car collision claim (Situation IV), and about half of the Maryland participants were of this view with respect to the Maryland cap.

Subcategory (b): Flexible Cap

One State, *Washington*, enacted a ceiling which is computed according to a statutorily specified formula. This formula starts with the average annual wage in the State,[1] multiplies it by .43, and then multiplies the resulting product by the number of years in the life expectancy of the plaintiff, which, the statute provides, cannot be taken to be less than 15 years. The non-economic damages to which the cap applies are defined as subjective, non-monetary losses. The single cap computed in a given case not only limits damages paid to the claimant, but also all derivative claims (e.g., for loss of consortium, loss of society and companionship or destruction of the parent-child relationship) that may be filed by persons other than the injured party but which arise from the same injury.

Observations:

1. The median opinion was that the Washington cap would have no impact on indemnity value in any claim except the construction site accident (Situation III), where it would reduce that value by about one-fifth[2]

2. There was a consensus judgment of no impact in Situations II (stairway fall) and VI (chair failure). There were very nearly consensus judgments to the same effect in Situations IV (truck-car collision) and V (punch press accident).

3. A substantial minority expected the ceiling to have some effect on indemnity value in Situation I (supermarket fall), and their net judgment was that the existence of the cap would raise the indemnity paid in that claim.

Subcategory (c): Partial Caps

Two States—*Alaska and Minnesota*—excluded important types of harms or claims from the ceilings that they adopted.

In *Alaska*, the ceiling is $500,000, but it does not apply to product liability actions, nor does it limit claims involving disfigurement or severe physical impairment. Non-economic damages are defined as including pain, suffering, inconvenience, loss of enjoyment of life, physical impairment and disfigurement (sic).

In *Minnesota*, the ceiling is $400,000, but pain and suffering are specifically excluded from application of the cap. The types of harm that are specified as limited by the cap are embarrassment, emotional distress and loss of consortium.

Observations:

1. There was a consensus judgment in Minnesota that that State's cap would have no effect on indemnity value in any claim situation tested.

2. There was a consensus judgment of no effect in Alaska with regard to the stairway fall claim (Situation II), the construction site claim (Situation III), the punch press accident claim (Situation V) and the chair failure claim (Situation VI). There was very nearly a consensus judgment of this kind in the truck-car accident claim (Situation IV).

3. The median view in both States was that neither ceiling would have any impact on the indemnity value of any claim tested.

4. A minority of participants in Alaska felt that the cap would have some impact in the supermarket fall claim (Situation I).

[1] *The participants were given a specific figure—$19,000—to assume for this value.*

[2] *It will be recalled that the claimant plumber in Situation III is 50 years old, so that the life expectancy calculation involved in computing the cap was probably well down toward the statutory minimum multiple of 15 years. To the degree that this was true, it had the effect of drawing the cap down near its statutory minimum.*

D. Changes in Punitive Damage Regimes

Six of the 15 enacting States made changes in their rules governing the awarding of punitive damages. These changes can roughly be divided into four categories, as shown in Chart V, but the reader should be informed that some States made several alterations in their punitive damage regimes at the same time. Where several changes were made, all were included in the package tested in the survey. Thus, in these instances, which will be noted below, the test was of all changes made in the regime, not of any one of them. Also, tests of the effects of changes in the punitive damage rules were made only with respect to "core" situations IV (truck-car accident) and V (punch press accident). Reported here are solely the predicted effects of enacted changes in punitive regime on the indemnity value of these two claims. Tests of the propensity of experts in each State to anticipate a punitive award if either of these claims went to verdict are reported on in a later Part of this Report.

In reviewing these results, it is important to keep in mind that the majority of the participants in most—but not in all—States believed that neither of the claims tested for the effects of changing the rules governing punitive damages involved defendant behavior that would in fact provoke a punitive award in the host State if either claim were brought to verdict. This was particularly true of Situation IV (truck-car accident), but it also held to a lesser degree for Situation V (punch press accident). In most States, therefore, the test of the impact of changes in the punitive damage regime was *not* carried out in the context of a claim in which most experts believed that a plausible punitive claim was involved. Had the facts of the standardized situations been changed to introduce behavior that would have posed this threat more vividly, the results received might well have been quite different.

Subcategory (a): Abolition of Punitive Damages

One State—*New Hampshire*—simply abolished punitive damages except where they may be specifically authorized by statute.[1]

Observation:

There was a consensus judgment that abolition of punitive damages in New Hampshire would have no effect on the indemnity value of either claim situation tested for such effects.

[1]This legislative action represented codification of a ruling to the same effect made in 1985 by the State's highest court. It may be, therefore, that at least some participants regarded this as no change in existing New Hampshire law.

Subcategory (b): Ceilings on Punitive Awards

Three States, *Colorado, Florida and Oklahoma*, enacted such caps, though of quite different kinds, as shown below.

In *Colorado*, the ceiling on punitive damages is ordinarily equal to the amount of compensatory damages awarded in the case. Punitive damages can only be awarded on a finding of willful or wanton conduct, fraud or malice on the part of the defendant. But the statute authorizes the court to triple the amount of the award if it finds that the defendant has repeated or aggravated the conduct, whether against the plaintiff or someone else. Conversely, the court may reduce the punitive award if it is considered excessive, or if the court believes that the deterrent effect has been accomplished, the objectionable conduct has ceased, or the purpose of the award has already been served. Finally, two-thirds of any punitive award is now paid to the plaintiff, but the remainder is paid into the State treasury.

Chart V

Median Changes in Indemnity Value in Two Standardized Claim Situations Expected from Enacted Restrictions on Punitive Damage Awards[1]

State	IV Fatal Truck-Car Crash)	V (Punch Press Accident)
(a) Abolition of Punitive Damages		
New Hampshire	0%	0%
(b) Ceilings on Punitive Awards		
Colorado	0	0
Florida	0	0
Oklahoma	0	0
(c) Restrictions on Filing for Punitive Damages		
Minnesota	0	0
(d) Evidentiary Standard for Proof of Misconduct		
Alaska	0	0

Note: The estimates obtained in these standardized claim contexts cannot be generalized to the full claim portfolio of any insurer or to that of the insurance industry as a whole. Therefore, the results are not directly relevant to issues of insurance pricing or rate regulation.

Tests of the effects of changes in the punitive damages rules were made only with respect to Situations IV and V.

In *Florida*, an award of punitive damages cannot exceed three times the amount of the award of compensatory damages unless the plaintiff can demonstrate to the judge by clear and convincing evidence that a larger award would not be excessive. Further, the judge is authorized to reduce a punitive award deemed to be excessive and to order a new trial of the damages issue if this reduction is not accepted. And, 40% of the punitive award is paid to the claimant, but 60% is paid to the State.

In *Oklahoma*, where the issue whether punitive damages should be awarded is given to the jury, an award of punitive damages usually cannot exceed the amount of compensatory damages awarded in the case. However, where the judge independently determines, before giving the case to the jury, that there is clear and convincing evidence justifying a punitive award, there is no limit on it.

Observations:

1. There was a consensus judgment in Oklahoma that the changes in that State's punitive regime would have no indemnity effect in either Situation IV (truck-car accident) or Situation V (punch press accident).[1]

2. There was a consensus judgment of no impact in Colorado and Florida with respect to the punch press claim (Situation V), and very nearly a consensual judgment to the same effect in both States in the truck-car claim.

3. The median view was that the changes enacted by each of these States would have no effect on indemnity value in any claim tested.

Subcategory (c): Restrictions on Filing for Punitives

One State, *Minnesota*, barred plaintiffs from including a plea for punitive damages in their original complaints. To seek such damages, the plaintiff must make a later pre-trial motion to amend the complaint. The judge must then be persuaded that there is prima facie evidence in support of a punitive claim before the court is permitted to grant the motion to amend.

Observation:

There was a consensus judgment in Minnesota that this change would have no effect on indemnity value in either of the claim situations tested.

Subcategory (d): Hardening of Evidentiary Standards

One State, *Alaska*, changed the standard that must be fulfilled by the supporting evidence in order to win an award of punitive damages. Punitive damages cannot now be awarded unless clear and convincing evidence, rather than just a preponderance of the evidence, establishes that the defendant's behavior makes such an award appropriate.

Observation:

There was a unanimous judgment among Alaska participants that this change would have no effect on indemnity value in any claim situation tested.

[1] ***In Oklahoma the same test was applied in Situations III (construction site accident) and VI (chair failure) as well. A consensus judgment of no effect was received in the latter claim, and the median view was that there would be no impact in either claim. However a minority of participants felt that there would be some impact in the construction site claim.***

E. Contingent Attorney Fee Regulation and Review

Three of the 15 enacting States adopted rules designed to regulate or review the contingent fees commonly charged by plaintiffs' counsel in tort actions.[1] The changes adopted were sufficiently different to be treated separately here. The results received for each of them are shown on Chart VI.

Subcategory (a): Sliding Scale Schedule of Limitations

One State, *Connecticut*, enacted a schedule of maximum percentage shares of awards or settlements that lawyers are permitted to charge in tort actions.[2] The specified maximums are as follows:

--33 1/3% of the first $300,000

--25% of the next $300,000

--20% of the next $300,000

--15% of the next $300,000

--10% of any amount in excess of $1.2 million

Observations:

1. There was a consensus judgment that imposition of this fee schedule would have no impact on indemnity value in Situations I (supermarket fall), II (stairway fall), or VI (chair failure).

2. The median view was that the schedule would have no effect in any claim tested, except for a very modest impact in the construction site claim (Situation III).

3. Substantial minorities of Connecticut respondents also believed that there would be some impact in Situations IV (truck-car accident) and V (punch press accident).

Subcategory (b): Mandatory Filing and Court Review

One State, *New Hampshire*, enacted a requirement that all contingent fee arrangements must be filed with the court at the time of the filing of the plaintiff's pleadings. In cases that result in verdicts, judgments or settlements in excess of $200,000, all such fees are subject to the approval of the court.

Observations:

1. There was a consensus judgment that this requirement would have no effect on indemnity value in the two slip-and-fall claims (Situations I and II), in the truck-car accident (IV), and in the chair failure case (VI). There was a very nearly consensual judgment to the same effect in the construction site claim (III).

2. The median view was that the schedule would have no effect on indemnity value in any claim tested.

3. A substantial minority of New Hampshire respondents felt that the schedule would have some effect in the construction site claim, and their net judgment was that it would increase the indemnity value in that Situation (III).

Subcategory (c): Court Review Upon Request

One State, *Washington*, enacted a statute requiring that, upon petition by a named party in a tort action, the Court must determine the reasonableness of that party's attorney fees, whether contingent or fixed. The statute lists a series of factors that the court is required to take into account in making such a review, such as the time and labor required, the fee customarily charged in the locality for similar services, the amount involved in the case and the results achieved, whether the fee agreement was in writing, and so forth.

[1] In such an arrangement, receipt of any fee by the lawyer is normally contingent upon the recovery of some amount in damages, and the fee is expressed as a percentage share of that recovery.

[2] It should be kept in mind that the existence of fee regulations may not affect only claims in which an attorney has already been engaged by the claimant. A claim professional must also take into account the probability that the claimant will engage a lawyer at some future time before the matter is resolved.

Chart VI

Median Changes in Indemnity Value in Six Standardized Claim Situations Expected from Enacted Contingent Fee Regulation

State	I (Supermarket Slip-and-Fall)	II (Stairway Fall)	III (Construction Site Fall)	IV (Fatal Truck-Car Crash)	V (Punch Press Accident)	VI (Chair Failure)
(a) Schedule of Sliding Scale Limitations						
Connecticut	0%	0%	–3%	0%	0%	0%
(b) Mandatory Filing and Court Review						
New Hampshire	0	0	0	0	0	0
(c) Court Review Upon Request						
Washington	0	0	0	0	0	0

Note: The estimates obtained in these standardized claim contexts cannot be generalized to the full claim portfolio of any insurer or to that of the insurance industry as a whole. Therefore, the results are not directly relevant to issues of insurance pricing or rate regulation.

Observations:

1. There was a consensus judgment that this measure would have no effect on indemnity value in any situation tested other than the supermarket fall (I) and the punch press accident (V). In these claims there was a very nearly consensual judgment of no expected impact.

2. The median view was that the provision would have no effect on indemnity value in any situation tested.

F. Sanctions Against Frivolous Suits and Defenses

Three of the 15 enacting States—*New Hampshire, New York, and Oklahoma*—wrote into law new sanctions against frivolous litigative behavior in bringing or defending against tort actions. Though they differ a bit, as will be described below, they generally fit into a single category, as shown on Chart VII on the following page.

It must be emphasized that *none of the standardized "core" situations arguably provides a true test of the effects of these sanctions* because to perform such a test requires specialized and relatively unusual factual circumstances which would not be of much use in testing any other type of change in law. The standardized claims tested herein were all designed as legitimate in every respect, and no suggestion of questionable litigation tactics was introduced into any one of them because of the distorting effects that information of that kind would necessarily have exerted with regard to claim valuation judgments. In these circumstances, little effect was to be expected from frivolous suit/defense sanctions. Nevertheless, the sanctions of these States were tested in the process, and the results are therefore reported. The three State measures involved are as follows:

IX. General Findings

As the length and complexity of this Report attest, the Project produced a wealth of data, generating an equivalent volume of inferences and arguable explanatory theses. However, when all of the sifting is done, the following three conclusory propositions seem to stand out:

1. While the 1986 legislative year produced more statutory generic change in the law of torts than any previous year in living memory, the changes enacted are likely to have a relatively narrow and specialized impact on indemnities paid in bodily injury claims. In claims of a few types, principally those involving a "deep pocket" defendant with limited assessed liability and those where collateral benefits are available in the form of private insurance other than Workers' Compensation, the study indicates that the impact of the enacted changes can be substantial. However, in the other types of claims tested, the impact generally ranged from marginal to non-existent.

2. The exceptions, exclusions, sunset provisions and unclarities included in many of the statutes enacted make the impact of many changes difficult to predict with confidence, as well as enormously sensitive to very fine changes in the facts (and perceptions of the facts) of the claim. A small margin of claimant negligence, for example, can control a very large difference in the impact of the changes enacted in a number of States. The same scale of leverage can be exerted by the rather obscure fact that the source of a given collateral benefit either does or does not enjoy the right of subrogration with respect to the claimant, and, even more obscure, whether that right is statutorily or contractually based.

3. By contrast, if the States were to enact a package of relatively simply stated and comprehensive changes along the same subject matter lines as the packages that many of them have enacted, the Project demonstrates that quite considerable indemnity cost savings would be realized in virtually all of the States in the sample. These reductions would not necessarily translate into net savings for individual insurers because indemnity not paid by one carrier would often translate into new indemnity obligations for another. Nevertheless, some substantial cost savings to the primary insurer in some of the claim situations tested would seem inevitable under these circumstances.

The outcome of the Project, therefore, represents a dual message. On the one hand, steps were taken by some States in 1986 that the preponderance of insurance claim professionals believe should have some effects in some limited types of claims. On the other hand, even in the small assortment of standardized claim situations tested, this likely impact does not loom large in most instances, though the tests of the nationally-tested package of changes indicate that a more comprehensive effect on these six situations could have been accomplished through changes in the law that have in fact been enacted in some States. Whether this larger scale of impact is desired is a matter for the conscience of every citizen. What the Project makes clear is that it could be achieved, but that it has not yet been accomplished in most States.

Testimony of Harvey Rosenfield
February 10, 2003

Appendix D

How to Address the Insurance and Malpractice Crises Facing the Nation

A. Insurance Reform

The real cause of the cyclical insurance crisis, and the driving force behind the contrived malpractice lawsuit crisis, is the cash flow underwriting practices of the insurance industry. Unless the destabilizing premium surges and mismanagement caused by the "insurance cycle" are stopped, the result will be periodic "crises" in the insurance market, each an opportunity to scapegoat victims' rights in order to cloak massive premium gouging, arbitrary cancellations and reduced coverage. California's Proposition 103 is a model:

• **Limit insurance rates, expenses, loss projections and profits.** One of the reasons that the insurance industry has been able to squeeze its customers in the malpractice insurance market and elsewhere is the lack of serious regulation and oversight of the industry. Most state regulation of insurers is weak to non-existent, reflecting the fact that officials responsible for oversight are typically beholden to the industry through previous or promised employment. Following the lead of California, there must be greater regulation of the industry's prices and underwriting practices. To prevent wild fluctuations in insurance rates and instability that can lead to insolvency, state insurance departments should set upper and lower limits on permissible rates that insurance companies may charge. All rate increases should be subject to the prior approval of an insurance commissioner, who should be accountable directly to the voters by election. Similarly, insurers should be prohibited from arbitrarily canceling or refusing to renew policies. There must be more effective insurance disclosure laws, so that citizens, consumers and policymakers can review lawsuit and claims information to determine the extent of malpractice claims, whether the price of premiums is justified, and what further measures need to be taken to limit malpractice. Finally, state insurance departments need more resources to effectively and independently monitor the industry.

• **Repeal the industry exemption from the antitrust laws.** The insurance industry is not subject to federal regulation and it is exempt from the federal antitrust laws, and even from Federal Trade Commission scrutiny without explicit Congressional approval. Congress should repeal these barriers to competition and oversight.

• **Mandate fair rating practices to reward good doctors.** Currently, insurance companies use narrowly defined subcategories to classify physicians who apply for malpractice liability insurance. Because there are so few physicians in some of the specialties, insurers cannot spread the risk effectively: the result is extremely high premiums for certain specialties, such as obstetricians. These rating systems force a majority of good doctors to subsidize the few bad ones. (It should be noted, however, that physicians collectively bear some responsibility for higher premiums to the extent that they do not discipline negligent physicians within their own ranks.)

Instead, insurance companies should be required by law to spread risk more equitably by placing physicians in a reduced number of underwriting categories. However, in order to differentiate poor doctors from the rest of the pool, insurance companies should charge rates based on a physician's own experience with malpractice claims. This practice, known as "experience rating," is much the same as the practice of rewarding good drivers with a discount on their auto insurance. It would ensure that doctors with histories of negligence or incompetence pay more, and doctors with clean records would be rewarded with lower rates.

B. **Reducing Malpractice**

• **Protect the Doctor-Patient Relationship.** In 1990, the Texas Medical Association invited doctors who had practiced at least 20 years without a malpractice lawsuit to explain how they handle their relationships with their patients. Over 200 doctors responded, and almost all of them focused on improving communication with patients as the key to avoiding lawsuits. In the current era of profit-driven medicine, protecting the doctor-patient relationship – and the ability of doctors to properly treat their patients – is essential.

• **Improve Loss Prevention" Techniques.** Medical science should do more to prevent malpractice through research that is disseminated to physicians and hospitals. So-called "outcomes research" enables health care practitioners to determine what works and what doesn't. There is presently no program in place to make sure all practitioners get this important information."Practice guidelines" could provide physicians with a check-list of standard, proven procedures. However, if physicians need only show they complied with such guidelines in order to escape malpractice liability, the effect will be to lead medical associations to issue minimal guidelines, a "lowest common denominator" approach that harms rather than protects patients.

Hospitals could improve their mechanisms for identifying and monitoring hospital-caused injuries. Aggressive risk management programs such as those instituted by the Harvard University-affiliated hospitals for anesthesia have proven very effective in reducing liability costs and insurance premiums. An integral part of the program was the development and implementation of clinical standards or protocols. Prior to the use of such standards, the average anesthesia-related malpractice claim was approximately $153,000; after such standards were effected, the average claim dropped to roughly $34,000.

• **Require Periodic Check-Ups for Doctors, Nurses and Hospitals.** Periodic refresher courses and continuing education is required of many professionals, including lawyers, accountants and, in some cases, doctors. However, as is true of many other professions, the requirements are weak and accountability is limited. Incompetence that might be merely costly when it involves other professionals becomes a matter of life and death when a medical practitioner makes a mistake. Doctors should be required to obtain periodic re-certification based upon written exams, clinical evaluations and audits of patients' medical care records. The best way to prevent malpractice is to educate physicians before they make a mistake.

• **Toughen Government Monitoring and Discipline of Physicians.** Independent and rigorous oversight of the medical profession, including a crackdown on dangerous doctors, is essential to curb malpractice. Medical boards should be restructured so that local medical societies are not allowed to dominate, and eviscerate, the boards' oversight and disciplinary functions. Boards should be controlled by non-physician majorities accountable only to the public. The medical lobby argues that lay people

don't have the expertise necessary to evaluate the practices of physicians and hospitals, but this is a phony argument. Publicly-controlled medical boards can hire physicians and other technical experts as staff or consultants to review complaints and make recommendations to board members. But consumers, not physicians, should make the final decision.

State medical boards are typically underfunded, with too few investigators and administrative personnel to do the job. Lobbyists for the medical industry usually oppose legislative efforts to strengthen the boards with increased funding and staffing that would ensure timely and thorough investigations of complaints. Adequate resources should be provided to the boards. One hundred percent of physicians' license fees should go to funding the boards; presently, these funds are often diverted by lawmakers to pay for other state programs. In addition, Congress should create a small program of grants-in-aid to state medical boards. These federal grants should be tied to the boards' agreement to meet high standards of performance and independence.

Boards should be given more disciplinary authority, and the disciplinary process should be made more efficient. Presently, bureaucratic procedures slow the resolution of serious cases. Lawyers for physicians can fend off action for months or years, allowing dangerous physicians to remain "on the street." The boards should be given the authority to suspend a physician on an emergency basis pending formal hearings in cases where a doctor poses a potential danger to other patients. In addition, medical board disciplinary actions should not be stalled or delayed by litigation. In serious cases, they should take effect while a physician pursues lengthy appeals through the court system.

All formal disciplinary actions and all formal complaints, regardless of the outcome, should be considered public matters and the records of such cases should be made available promptly and easily (through a toll-free number, for example) to anyone who requests them.

• **Improve national coordination.** The National Practitioner Data Bank (NPDB), taxpayer-funded and operated by the federal government, tracks doctor disciplinary actions, hospital revocation of physicians' privileges and malpractice claims paid by insurers throughout the country and makes the data available to state medical boards and hospitals. Other state and federal agencies should be required to coordinate with the NPDB. For example, the Drug Enforcement Administration should alert pharmacists and the public about which doctors' prescription licenses it has pulled or restricted. Moreover, criminal sanctions should be imposed for misuse of prescription drugs. Finally, consumers should have full access to the information contained in the NPDB.

• **Protect patient and whistle-blower confidentiality.** To encourage patients and witnesses to come forward with evidence of malpractice, the identity of those who complain in good faith to the medical board should be kept confidential. Those who make such complaints should be given immunity from anti-free speech lawsuits brought by physicians to intimidate whistle-blowers and discourage such disclosures.

• **Force insurance companies to cooperate.** Insurance companies should be required to forward all claims and settlement information involving malpractice claims against physicians, hospitals and other medical professionals to state licensing boards.

• **End Conflicts of Interest That Lead to Financial Malpractice.** Physicians should not have a financial interest in hospitals, laboratories, diagnostic facilities and other health care institutions. Research studies have demonstrated that such conflicts of interest lead to unnecessary medical care, raising health care costs and, worse, exposing patients to unnecessary medical risks. Until the profit motive is removed from medical practice, physicians will continue to order unnecessary and expensive medical procedures.

Mr. GREENWOOD. Thank you, Mr. Rosenfield. I think no one would suggest that she should. Mr. Reed.

TESTIMONY OF JOHN H. REED

Mr. REED. Thank you, Mr. Chairman. Members of the committee, thank you for inviting me to appear here. Notwithstanding the passage of significant remedial legislation in Pennsylvania in 2002, the insurance affordability and availability problem being faced by hospitals and physicians today in the commercial marketplace has not been corrected. This problem has confronted healthcare providers across a broad front, including those who don't have a record of prior lawsuits and who practice in regions of the State where juries have consistently proven to be unreceptive to medical malpractice claims. Indeed, the cost of traditional coverage is escalating sharply, even though the aggregate amount of jury verdicts in Pennsylvania in medical malpractice cases has declined in each of the last 2 years, with the amount awarded last year being 65 percent lower than in 2000.

The factors that contribute to the current difficulty are complex and by no means did they develop overnight. The insurance cycle and insufficient regulatory oversight has played a role. Carrier insolvency has created added expense for all insurers in Pennsylvania, triggering an estimated $30 million annual additional cost for the Pennsylvania medical professional liability CAT Fund, now know as the MCare Fund, at the peak of the PIC, PIE, PHICO and Reliance debacle. The current situation has also been distorted by the pace of the medical malpractice insurance privatization process initiated by Act 135, with healthcare providers now having to bear the burden of purchasing increased primary limits from private insurers before that expense can be offset by the winding down of fund obligation which by legislative design were not funded in advance.

Pennsylvania's CAT Fund is one of the Nation's largest medical malpractice insurers. During my 7 years there as Director, the agency reviewed, administered, and defended more than 30,000 reported catastrophic medical malpractice claims. While agency staff worked with defense counsel and medical experts to succeed in closing 85 percent of those claims without payment by the fund, the agency also paid more than $2.2 billion in compensation to catastrophically injured patients and their families. As part of my testimony, I have attached copies of several memoranda that were authored addressing a number of the issues discussed here today while I was serving as Director of the Pennsylvania fund. In particular, I invite your attention to the February 2002 memorandum, outlining several alternative approaches that would immediately reduce the cost of medical malpractice insurance and thereby help avert the overall financial crisis in medicine.

The following, however, are some recommended solutions. First, I recommend self-insurance or risk retention groups as an approach. A risk retention group permits healthcare providers to reach substantial and immediate savings on their malpractice insurance premiums. Other than a governmental mechanism, such as Pennsylvania's fund, RRG's provide the least expense, most flexible, self-insurance vehicle available to the healthcare community.

When designed properly, these programs can serve to reduce losses through peer review by the owners insured and consequently result in savings.

Many hospital systems are now using this approach, and this past year, a number of new insurers for physicians in Pennsylvania have used this model. When operating on a nonprofit basis, such programs have the potential to offer coverage to Pennsylvania healthcare providers at premium levels that are substantially less than what is otherwise available in the marketplace today. However, individual physicians are often reticent to take advantage of this insurance alternative absent some protection in the event of program insolvency. A provision in the Federal enabling legislation, 15 United States Code Section 3902(a)(2) presently precludes risk retention groups from participating in the State guaranty funds. Were Congress to address that problem, I am certain that a significant percentage of the physician community would elect to benefit from the lower cost and long-term assured availability of coverage that the risk retention approach can provide.

I also discussed compressing the rate schedule, and to shorten it—I mean, in Pennsylvania, we have multiple rate territories and we have a breakout of physicians by specialty. At the fund level, premiums ranged on a low from $1,500 last year up to, I think it was $44,000 for a neurosurgeon. As I pointed out in that memo, if the State were to compress its rate schedule into one, premiums for the higher level physicians in the Philadelphia area, obviously, would drop by one-third. If you were to add $1,000 to the insurance level of physicians paying $10,000 or less to the CAT Fund at the present time, you would also achieve another one-third savings. I did some calculations in the process of representing some risk retention groups and other things, and also, again today. The cost of malpractice insurance and using the rates that I have from the actuaries that I have been working with, a governmental model, on average, could insure every physician in this Commonwealth from dollar one up to $1 million for under $17,000, if you did it on an average basis.

I am suggesting that we focus more on risk management and problem providers. Many medical errors are preventable through proper selection, training, and coordination of professional personnel and provider programs. In addition, the economic stresses faced today by the medical profession have sometimes led to business decisions that adversely impact patient care. Notwithstanding, risk management has traditionally not ranked as a top priority and the medical profession has been slow to identify, monitor, and counsel the small subset of providers that are responsible for a major portion of medical malpractice awards. I submitted a chart that shows that 10 percent of Pennsylvania physicians who have practiced since the fund was established back, I believe in 1975, are responsible for 100 percent of the agency's payout, while just 2 percent of the physician population account for 41 percent of the payout.

And yes, while there are physicians in the high risk specialties that obviously are at higher risk, even though they are great physicians, there are also a number of rogue physicians out there who have had multiple paid claims. I have seen them at the fund. We

have had individuals having as many as 17 paid claims by the agency. And one of the frustrations I had as director of that agency is that I had no power over the pricing. I could not give a doctor with a great claims record a lower price and I couldn't charge the guy with a bad claims record any more.

I recommend that we look at fast track arbitration of claims. The adoption of a fast track mediation or arbitration of claims before a qualified medically knowledgeable panel would lower litigation costs and ensure greater consistency and fairness of results. The findings of that panel would be nonbinding and the case could subsequently be presented to a jury, but the arbitration results would be admissible at trial. This approach would reduce the risk of aberrant verdicts while also assuring that healthcare providers across the State would be accountable to a uniform and predictable standard of care.

I am also suggesting that we look at regional juries. As with the suggestions regarding fast track arbitration, this would better assure fairness and uniformity of results given similar fact patterns. I think we need to closely monitor the impact of the reforms already adopted in Pennsylvania. The substantial changes were adopted in 2002 and these will eventually produce the lowering of claim payments. The venue provisions alone will transfer 40 percent of the claims in Philadelphia County when you measure them by fund payout to courts in suburban counties and elsewhere. This, combined with reforms to the collateral source rule, reduce payments for future losses and restrictions on joint and several liability should serve to lower claim payments for all insurers. The impact of these reforms should be monitored to assure that they accomplish their intended purpose of maintaining a fair balance between the interest of the medical profession and the public that they serve.

In short, I think there are a number of things that can be done that will reduce medical malpractice premiums for physicians immediately, and I am not certain that caps will. In fact, I read just a couple of weeks ago that one of the representatives of General Electric was quoted in the Scranton Times as saying that caps won't reduce malpractice premiums. But reforms such as the ones I am suggesting can reduce premiums for doctors immediately without having to lock the door to the courthouse.

A lot has been said today about defense costs. I want to just bring a couple of facts to you. Obviously, defense costs were a factor. I had to hire a lot of lawyers to defend doctors at the CAT Fund. We spent anywhere from $13 to $15 million a year defending claims. It was a relatively small portion of our overall payout. Defense costs are a higher portion, obviously, for the private or the primary carriers. However, looking at the National Association of Insurance Committee data for the various States, I did this about a year ago, and I found out that defense costs in Pennsylvania constitute only about 14 percent of the total insurance dollar. The vast majority of the dollars in Pennsylvania are paid over to victims of claims. The total defense cost, obviously, is about $100 million, which is relatively small compared to the overall payout.

Now, a lot has been made recently about the statistic which I put out in public for the first time several years ago, about the Phila-

delphia awards equaling what goes on in the State of California, and that was true at the time I put it out, and it may still be true today. However, I have also since learned a lot more and there is some misleading in that, in that the insurance premiums in Pennsylvania—excuse me—in California aren't as low as people think they are. In fact, I did a survey a year ago, and in many places in Pennsylvania, you could get insurance for a given professional for less than you could do it for in California. And this is another interesting observation. While the premiums are up there in California and the payouts to the victims are down there, they have a tremendous layer that goes for defense costs. It is totally different than in Pennsylvania.

As I mentioned at the outset, through risk retention groups, doctors can save a great deal of money because they don't have the same cost factors that commercial insurers have and I am certainly not critical of PMSLIC. They are a good company. And MedPro is a good company. Those are the only two insurers left in our State. In fact, our group has recruited a number of physicians simply on the basis that PMSLIC and MedPro aren't taking on new business. But at any rate, with that said, I know that a lot that has been talked about with premiums for various groups are sometimes misleading because they relate to the Joint Underwriting Association. And from my experience, seeing the cost data of the insurance companies, seeing the cost data of the medical CAT Fund, and looking at the things that MedPro and PMSLIC do, I know that doctors, and working with actuaries, can be insured for a lot less than what has been said sometimes before in front of this committee.

Mr. GREENWOOD. Mr. Reed, I have given you 11 minutes and 44 seconds of your 5 minutes so far, so we are going to have to ask that you reserve the rest of your comments for questions.

Mr. REED. I will reserve the rest of my comments.

[The prepared statement of John H. Reed follows:]

Thank you for inviting me to appear before the Committee. Notwithstanding the passage of significant remedial legislation in Pennsylvania in 2002, the insurance affordability and availability problem being faced by hospitals and physicians today in the commercial marketplace has not been corrected. This problem has confronted health care providers across a broad front, including those not having a record of prior lawsuits and who practice in regions of the state where juries have consistently proven to be unreceptive to medical malpractice claims. Indeed, the cost of traditional coverage is escalating sharply even though the aggregate amount of jury verdicts in Pennsylvania medical malpractice cases has declined markedly in each of the last two years, with the amount awarded in 2002 being 65% lower than in 2000.

The factors that contribute to the current difficulty are complex and by no means did they develop overnight. The "insurance cycle" and insufficient regulatory oversight has played a role. Carrier insolvency has created added expense for all insurers in Pennsylvania, triggering an estimated $30 million addtional annual cost for the Fund at the peak of the PIC/PIE/PHICO/and RELIANCE debacle. The current situation has also been distorted by the pace of the medical malpractice insurance privitization process initiated by Act 135, with health care providers now having to bear the burden of purchasing increased primary limits from private insurers before that expense can be offset by the winding down of Fund obligations which, by legislative design, were not prefunded. .

As part of my testimony, I am attaching copies of several memoranda that were authored addressing a number of these issues while I served as Director of Pennsylvania's Medical Professional

Liability Catastrophe Loss Fund (now known as the MCARE Fund). In particular, I invite your attention to the February 2002 memorandum outlining several alternative approaches that would immediately reduce the cost of medical malpractice insurance and thereby help avert the overall financial crisis in medicine. The following are some of my recommended solutions.

Risk Retention Groups

An RRG permits health care providers to reap substantial and immediate savings on their malpractice insurance premiums. Other than a governmental mechanism such as Pennsylvania's Fund, RRGs provide the least expensive, most flexible self-insurance vehicle available to the health care community. When designed properly, these programs can serve to reduce losses through peer review by the owners/insured and consequently result in savings. Many hospital systems are now using this approach and this past year a number of new insurers for physicians have been formed on this model. When operating on a non-profit basis, such programs have the potential to offer coverage to Pennsylvania health care providers at premium levels that are substantially less than what is otherwise available in the marketplace today. However, individual physicians are often reticent to take advantage of this insurance alternative absent some protection in the event of program insolvency. Federal enabling legislation presently does not permit risk retention groups to participate in the guaranty funds that the states have created for commercial insurers. Were Congress to address that problem, I am certain a significant percentage of the physician community would elect to benefit from the lower cost and the long term assured availability of coverage that the risk retention approach can provide.

Compressing the Rate Schedule

Obviously, not all physicians pay the "average" physician surcharge. Their rates vary by specialty and geography in accordance with the JUA schedule. For 2002, Fund charges for physicians ranged from $1,702 for allergists and hematologists in areas such as Lancaster and Harrisburg, to $44,659 for neurosurgeons and orthopedic surgeons in Philadelphia and Delaware counties (the Fund assessment for the last two specialties was cut by 17% for 2002). For 2002 the average physician surcharge was approximately $7,000. The rate range could be compressed if the state either reduced the number of specialty classifications or if the geographic areas were combined into fewer rating territories. For example, if all of Pennsylvania were considered one rating territory, as is presently the case in New Jersey, the surcharge for Philadelphia orthopedists and neurosurgeons would drop by one-third. Similarly, placing a $1,000 increase on the surcharge of those physicians who presently pay under $10,000 (Class 35 and lower) would have a similar impact of reducing the surcharge of all those physicians in the higher classes by approximately one-third. However, because these types of smoothing mechanisms go outside the conventions of traditional insurance, and would probably be opposed by those adversely affected, it is not likely that they would be accepted.

Focus on Risk Management and Problem Providers

Many medical errors are often preventable through proper selection, training, and coordination of professional personnel and provider programs. In addition, the economic

stresses faced today by the medical profession have sometimes lead to business decisions that adversely impact patient care. Notwithstanding, risk management has traditionally not ranked as a top priority and the medical profession has been slow identify, monitor, and counsel the small subset of providers that are responsible for a major portion of medical malpractice awards. The accompanying chart shows that 10% of the Pennsylvania physicians who have practiced since the Fund was established are responsible for 100% of its claim payments, while just 2% of the physician population account for 41% of the total payout.

Fast-track Arbitration of Claims

The adoption of fast-track mediation/arbitration of claims before a qualified, medically knowledgeable panel would lower litigation costs and assure greater consistency and fairness of results. The findings of the panel would be non-binding and the case could subsequently be presented to a jury, but the arbitration results would be admissible at trial. This approach would reduce the risk of aberrant verdicts while also assuring that health care providers across the state would be accountable to a uniform and predictable standard of care.

Regional Juries

As with the suggestions in the preceding paragraph, this would better assure fairness and uniformity of results given similar fact patterns.

Closely Monitor the Impact of the Reforms Already Adopted

Substantial changes in Pennslvania medical malpractice litigation will eventually occur as a result of the reforms adopted in 2002. The venue provisions alone will transfer 40% of the claims in Philadelphia county court (measured by Fund payments) to courts in suburban counties and elsewhere. This, combined with reforms to the collateral source rule, reduced payments for future losses, and restrictions on joint and several liability, should serve to lower claim payments for all insurers. The impact of these reforms should be monitored to assure that they accomplish their intended purpose of maintaining a fair balance between the interests of the medical profession and the public that they serve.

All of the above suggestions will reduce malpractice premiums for health care providers. Most importantly, they can accomplish that result without having to bar the door of the courthouse to those individuals having legitimate claims.

Medical Professional Liability Catastrophe Loss Fund
30 North Third Street, 8th Floor
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Tel: 717-783-3770 x213
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DATE: January 2, 2002

SUBJECT: Pennsylvania Physician Census

TO: Dave LaTorre
Deputy Press Secretary
Governor's Office

FROM: John H. Reed, Esq.
Director

Although the overall population of Pennsylvania has remained relatively unchanged over the last two decades, the number of physicians practicing in the state has increased significantly. In the year 2000, the Medical CAT Fund insured 34,565 physicians, approximately 12% more than in 1990, and only very slightly less than the peak in 1998.

Even when one examines the three medical specialties having the highest malpractice insurance costs – neurosurgery, orthopedics, and obstetrics/gynecology – the number of physicians appears to have remained relatively stable.

⇒ Despite some common misconceptions to the contrary, in 2000 there were more neurosurgeons in eastern Pennsylvania than in 1997. While the number of orthopedic surgeons in eastern Pennsylvania decreased slightly during that time period, the census of those specialists increased in western and central Pennsylvania.

⇒ The number of ob-gyns in central and western Pennsylvania has grown over the four years since 1997, and in 2000, there were more ob-gyns practicing in eastern Pennsylvania than in the preceding year. The are twice as many ob-gyns practicing in eastern Pennsylvania than in central and western Pennsylvania, even though these regions have identical overall populations. The ratio of Pennsylvania physicians to patients is above the national average for this specialty. Please note that the figures we have reported to you do not include general and family practice doctors who have obstetrical privileges.

Although it is not yet possible to report a Pennsylvania physician census for 2001, an evaluation of our surcharge records demonstrates renewals to have been in line with 2000. Indeed, for the first six months of 2001, we obtained surcharge from more doctors than we did during that same period in 2000. As I indicated in our telephone conversation, we cannot accurately predict what physicians will do in the future given their dissatisfaction with rising malpractice premiums. However, if they are inclined to leave Pennsylvania, they will discover that insurance companies are in the process of raising medical malpractice premiums across the country.

DATE: February 28, 2002

SUBJECT: **Suggestions to Effect Immediate Premium Savings For Health Care Providers**

TO: Fund Policy Service Unit and Claims Management Staff

FROM: John H. Reed, Director and Robert W. Waeger, Deputy Director

We recognize that the Fund staff has received numerous inquiries from physicians and hospitals questioning how they may obtain affordable medical malpractice insurance in what, by now, has proven to be an extremely hard market. Despite our best efforts, there is not much we can do for many of them because we are now **down to two major carriers that are still participating in our market** and they have either reached the limit of their capacity or have chosen to be very selective in the risk they will underwrite. The only alternatives – the JUA and a few smaller out of state carriers – have proven to be prohibitively expensive. **Some physicians have been quoted in excess of $360,000 for primary coverage**. Many of you have been closely studying this issue and have suggested a couple of very realistic solutions to the current problems of availability and affordability of medical malpractice insurance. As we did several weeks ago in regard to your "Proposal for Hospital Opt-Out/Elective Self-Administration of Claims," this memorandum will summarize your proposed alternatives and quantify the range of cost savings that could be expected were they to be adopted.

Reduce the Primary Limit to $200,000

If the Legislature were to return the primary limits to their pre-Act 135 level ($200,000), physicians would benefit from a substantial immediate decrease in the primary premium. We would project these **savings at approximately 25%-35% below what they are being asked to pay to their primary carriers today**. While these savings would likely vary by specialty, we would expect that the highest priced surgical specialties, which are now suffering the most, would be in position to reap the greatest savings. The lowering of primary limits will provide the following benefits:

A. It is a given that lowering primary limits will attract new and old carriers to the Pennsylvania market because their exposure has been significantly reduced. [Availability]

B. It would then naturally follow that this would help solve the capacity problem because primary carriers will be able to write many more physicians at $200,000 than they can at $500,000. [Availability]

C. Therefore, primary insurance becomes more affordable in that the primary carrier does not have to purchase reinsurance for any amount between $200,000 and $500,000. [Affordability]

D. An added benefit to returning the Fund to writing over a $200,000 primary would be to foster an environment wherein more health care providers would be able to use alternative risk transfer mechanisms (self-insurance, fronted captives, risk retention groups) to meet their primary insurance need at a lower and more predictable cost than has proven possible in the commercial market. [Affordability and Availability]

Promote the Use of Risk Retention Groups (RRGs)

An RRG permits health care providers to **reap substantial and immediate savings** on their malpractice insurance premiums. As noted above, a lower primary limit would enable more health care providers to avail themselves of an alternative to the commercial insurance market. Other than the Fund mechanism itself, RRGs provide the least expensive, most flexible self-insurance vehicle available to the health care community. When designed properly, these non-profit mechanisms serve to reduce losses through peer review by the owners/insureds and consequently result in savings. Some large hospital systems have successfully used this approach. RRGs are considered mini-insurance companies for policyholders with similar business activities, with each insured being an owner. At present, we are assisting several outside groups who are considering same, including orthopedists and some smaller hospitals that are discovering that even at the current $500,000 primary level, they can **reduce their primary premium by approximately 40% or more** using a fully funded RRG. (One preliminary report indicates that some experienced specialists in high-exposure practices may be able to save 60%-70% off current primary quotes.) Reducing the primary premium to the $200,000 or $300,000 level will lower the RRG capitalization threshold and its premium level, thereby making this alternative available to classes of health care providers that cannot now afford to establish or capitalize an RRG at the $500,000 level.

CAT Fund Providing the Full Coverage from Dollar One

If new legislation permits health care providers the choice of turning to the Fund for coverage from dollar one to the $500,000 primary limit, health care providers would be able to benefit from an immediate annual savings in their total malpractice premium. As with an RRG, the outside and Fund data we have reviewed demonstrates that a **40% savings on the primary portion is a reasonable expectation.** This is true even though we propose that the Fund's primary coverage would be extended on an occurrence basis and fully funded in a separate investment account controlled by the State Treasurer, as opposed to the pay-as-you-go mechanism presently set by statute for the Fund's excess coverage. This alternative can be established quickly and would provide the greatest immediate savings to health care providers, while retaining flexibility for medical professionals to return to commercial coverage once the private market is reestablished.

Lower Expense Ratio

Allowing the Fund to provide malpractice coverage for the entire $1.2 million statutory requirement will result in a price break for health care providers as the Fund is able to provide this coverage at a significantly lower expense ratio than private carriers as documented by the "increased limits factor" charged by primary carriers and the real world experience of the last several years. The Fund is a non-profit entity that collects only enough surcharge on its excess layer to cover claims

payments and its operating budget. The Fund returns almost all the surcharge it collects in the form of claims payments to the injured, paying for most of its operating budget and defense costs through the interest it earns. The creation of a reserve for the assumption of a new primary level responsibility would not detract from this efficiency. In contrast to a private insurance company, the Fund is not burdened with the obligation to return a profit to investors, pay commissions to brokers and sales agents, pay taxes, pay for marketing expenses or support an extensive and expensive corporate structure. If you review the records of the National Association of Insurance Commissioners (NAIC), you will see that historically medical malpractice carriers pay only 60 to 65 cents in claims for every dollar they collected in premiums, as opposed to the nearly 99 cents paid out of every dollar collected by the Fund.

Lower Administrative Costs and Effective Claims Administration

The Fund today is one of the largest and most professional medical malpractice claims handling operations in the United States. **Each year the physicians and claim attorneys employed by the Fund receive, evaluate, and defend more than 4,500 new catastrophic claims.** Through your efforts, the Fund is able to keep pace and succeeds in closing 85% of these claims without Fund payment while protecting the interests of our insured health care providers. It is interesting to note that someone else other than the Fund has usually been in control of the case when large verdicts are returned, although the Fund nevertheless generally receives the blame. **It never gets publicized when you succeed in obtaining an acquittal or settle cases for less than the primary limit,** even after receiving the carrier's tender, or when you close cases for a fraction of the total amount than plaintiffs, defendants, insurers and trial judges were demanding. Were you to accede to the settlement pressures we face every day, this agency's claim payments would soar.

Under the current legislative proposal, all claims, whatever the potential liability - approximately 11,000 new files each year - would be reported to the Fund. It will require your continued efforts to hold our administrative costs per file to our current reasonable level. Catastrophic claims will still need to be reviewed carefully in the manner we do now - looking to protect each of our insured, while at the same time restraining the overall Fund cost, facilitating movement of cases through the judicial system, and where appropriate, paying reasonable compensation to people who have been injured as a result of medical malpractice. Your task is an important one, and far more complex than the administration of other types of claims such as automobile and workers compensation. This is not a task that can be undertaken easily, on a timely basis, or at reasonable cost by an outside vendor.

The average cost in the private sector for the administration of a medical malpractice claim is $3,000, with one carrier in the state charging up to $5,000 for each file in its fronting program. Given the Fund's claim volume, a third party administrator could easily justify charging $13.5 million to $22.5 million per year for the current program. In contrast, the Fund's total cost for handling claims is approximately $2.7 million per year, or about $550 per file. This cost differential becomes even more significant in view of the expanded claim reporting presently being contemplated. **The Fund already meets the qualifications set forth for claims administration in House Bill 1802, Section 713, and is the only entity able to do it without the tremendous increase in operational and indemnity cost that our insured health care providers would face if a third party administrator were used.**

Lost in the misinformation that the Legislature is constantly being bombarded with is the fact that the **aggregate Fund surcharge was reduced by approximately 6% for 2002**. Although 5 years have passed since the limit changes of Act 135 were begun, the Fund still continues to have $1 million of coverage exposed for a substantial majority of its insured in the cases that are being paid at this time. Consequently, we have 5-times as much coverage at risk in those cases than do the primary carriers. That is what is driving our surcharge. In the future the primary carriers will have $500,000 exposed, but they don't now. Notwithstanding that situation, **the surcharge today is one half or less than what the JUA and private carriers are charging for primary coverage.**

In the face of the inflationary pressure experienced nationwide in the medical malpractice arena, you have performed commendably in limiting the growth, holding down the cost of claims, operational expenses, and naturally, the surcharge. **In 2001, this agency reduced its indemnity and defense costs even though it had to handle more claims than the year before. What other major medical malpractice insurer can make that same statement?** In 1997, our average physician surcharge was $6,843. For 2002, that same average physician charge will be $7,158, less than 5% more than in 1997. That is far below the rate of inflation and clearly far below the 200% or more increases that Pennsylvania physicians have experienced at the primary level.

After carefully reviewing the Fund's history for handling claims between $200,000 to $500,000, and after reviewing the records that we have of payments made by primary carriers on cases reported to the Fund, reviewing the reports submitted to us each year by the primary carriers under Section 809, and studying the statistics reported concerning the medical malpractice insurance sector by the NAIC, we are confident of the conclusions stated earlier in this memorandum: namely, if permitted, the Fund would be able to assume responsibility for writing physicians on a fully funded basis at the $500,000 primary level for approximately 40% less than they are being asked to pay in the current market. **The Fund has the basic infrastructure needed for the task.** We already have most of the specialized medical malpractice defense firms on contract, we have an experienced claims team, and we have a policy service unit with the computer capability to quickly convert for direct billing.

The Fund would benefit from a **synergy and economy of scale** were it to be in seamless control from dollar one. While we constantly extend ourselves to work in cooperation with primary carriers, that effort is frequently not reciprocated. As you know, some carriers, who earn money from "the float" on surcharge collections, are late in remitting money to the Fund. Just today, we received a remittance from a carrier that is 3 years late. There is no financial penalty to them for having missed the statutory deadline, but the coverage to their insured could be jeopardized, and their licenses placed in question. Some carriers defend claims with no concern for the Fund. In the past we have testified about meritorious cases that have cost the Fund millions of dollars because the carrier did not report them to the Fund in a timely manner and refused to settle indefensible claims. Today, we are confronting a claim where the Fund may have to pay a couple of million dollars because the carrier did not report and tender the case to the Fund until the very late, with the Fund then learning that a defense to an otherwise defensible claim (at least as to one defendant) is being precluded by the court because the carrier and its counsel failed to file an answer to the complaint on a timely basis, and later further failed to file an appeal on a timely basis. All efforts by the Fund to regulate or penalize such inappropriate conduct have thus far failed. Given sufficient control and responsibility for the claim, you are correct in concluding that you can control costs.

Compressing the Rate Schedule

Obviously, not all physicians pay the "average" physician surcharge. Their rates vary by specialty and geography in accordance with the JUA schedule. For 2002, Fund charges for physicians will range from $1,702 for allergists and hematologists in areas such as Lancaster and Harrisburg, to $44,659 for neurosurgeons and orthopedic surgeons in Philadelphia and Delaware counties (the Fund assessment for the last two specialties was cut by 17% for 2002). Some of you have suggested that the rate range could be compressed if either we reduced the number of specialty classifications or if the geographic areas were combined into fewer rating territories. Both assumptions are correct. For example, if all of Pennsylvania were considered one rating territory, as is presently the case in New Jersey, the surcharge for Philadelphia orthopedists and neurosurgeons would drop by one-third. Similarly, placing a $1,000 increase on the surcharge of those physicians who presently pay under $10,000 (Class 35 and lower) would have a similar impact of reducing the surcharge of all those physicians in the higher classes by approximately one-third. However, because these types of smoothing mechanisms go outside the conventions of traditional insurance, and would probably be opposed by those adversely affected, it is not likely that they would be accepted.

Conclusion

The financial projections stated above are made in the context of the present litigation environment in Pennsylvania. Obviously, if progress is made in reducing the number of medical errors and reducing the cost of claims through one or more legislative enactments, it is reasonable to expect that further savings could be achieved. However, let us caution you that even with the adoption of tort reform, the insurance availability and affordability problems being faced by medical professionals today in the commercial marketplace will not be corrected in the near future.

What now seems to be a looming crisis can be averted. All of the above options that you have suggested will immediately reduce malpractice premiums to health care providers. Most importantly, they can accomplish that result without taking money from taxpayers, without triggering the additional expense of borrowing, without burdening future generations of health care providers, and without having to bar the door of the courthouse to those individuals having legitimate claims.

Medical Professional Liability Catastrophe Loss Fund
30 North Third Street, 8th Floor
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Fax: 717-705-7341

DATE: January 2, 2002

SUBJECT: The History of Tort Reform in the Context of CAT Fund Legislation
Executive Summary

TO: Dave LaTorre
Deputy Press Secretary
Governor's Office

FROM: John H. Reed, Esq.
Director

The Medical Professional Liability Catastrophe Loss Fund began operation on January 13, 1976, by the passage of Act 111 (the Health Care Services Malpractice Act of 1975) because of a lack of availability and affordability of commercial professional liability insurance. This crisis also led to the creation of PHICO by the Hospital Association (HAP) and PMSLIC by the Pennsylvania Medical Society. The legislation was designed to make malpractice insurance coverage available at a reasonable cost, establish a system to provide prompt determination and adjudication of negligence claims, and determine fair and reasonable compensation.

Initially, because carriers were withdrawing from the marketplace a three-pronged approach was fashioned, consisting of 1) the JUA, 2) Arbitration Panels for Health Care, and 3) the Medical Professional Liability Catastrophe Loss Fund. The intent was to stabilize the medical malpractice market while assuring the presence of adequate insurance (because of lack of carriers capacity) and establish an arbitration system for prompt resolution of claims. (Repealed 40 P.S. §§ 1301.301-309; §§ 1301.501-514 and §§ 1301.603-604.)

The Supreme Court of Pennsylvania "gutted" the Arbitration Panel sections of the statute because the Court deemed the arbitration process too slow. See, Heller v. Frankston, 504 Pa. 528, 475 A.2nd 1291 (1984). Heller also ruled against the Act's limitation on attorney fees. Another provision that was also struck down as unconstitutional was related to the reduction of damages that had been paid for by public collateral sources. The Pennsylvania Supreme Court overruled this benefit in Chiesa v. Fetchko, 504 Pa. 503, 475 A.2nd 740 (1984). Both the collateral source rule and an appropriately administered arbitration process would have served to streamline the litigation process, reduce total cost, and assure equitable compensation.

Initially, the primary carriers issued policies for $100,000 (1976 to 1982); $150,000 (1983 to 1984); then $200,000 until 1997 when, under Act 135, the primary carrier's limits increased every 2 years by $100,000 to the current primary limits of $500,000. ($300,000 1997-1998; $400,000 1999-2000; $500,000 2001). Historically, the fund covered the healthcare providers of Pennsylvania with $1,000,000 excess liability protection until Act 135 in 1996 began to progressively lower the Fund's

limits to its current level of $700,000. Most claims that are being resolved today are still at the $1,000,000 Fund coverage level.

The principle feature of Act 135 eliminated some of the gamesmanship being played by the primary carriers in discounting their premiums when the Joint Under-writing Association's schedule of rates was established as the basis for determining the Fund's surcharge. Unfortunately, the Administration's proposal to promote improved medical practices by incorporating underwriting authority for the Fund was thwarted by the objection of the Pennsylvania Medical Society.

Included in Act 135 were substantive provisions affecting claims, procedural provisions affecting pre-trial and trial proceedings, as well as risk management and underwriting provisions. However, immediately after final passage of Act 135, the Pennsylvania Supreme Court, sua sponte, issued a per curiam order (1/17/97), suspending certain procedural sections of the new act. (Relating to punitive damages, complaint and discovery procedures, mediation, advance payment and periodic payments. 40 P.S. §§ 1301.801 et seq.) Due to the essentially non-binding nature of these reforms, the provisions stricken by the court would not have produced substantial savings for the health care community. Other provisions relating to informed consent and mandatory risk management programs remain in place. Unfortunately, the health care industry, to its own detriment thus far, has paid scant attention to the risk management portion of the Act.

The Supreme Court decision having the greatest impact on the cost of medical malpractice claims was the Court's determination in Kaczowski v. Bołuasz, 412 A.2d 561 (Pa. 1980) that future earnings are not to be reduced to present value. This substantially inflates the size of awards and settlements in all cases involving future medical care and the loss of projected earnings.

For your review, I am attaching a copy of a more comprehensive chronology of professional liability reform initiatives in Pennsylvania that was prepared by the law firm of Duane Morris & Heckscher LLP for the Hospital Association of Pennsylvania.

JHR:d
Gov/tortprovs
Attachment

Mr. GREENWOOD. Thank you, sir. Dr. Vidmar.

TESTIMONY OF NEIL VIDMAR

Mr. VIDMAR. Thank you very much for—is that on?

Mr. GREENWOOD. I think it is, yes.

Mr. VIDMAR. I am here as a professor of law, but I am neither a lawyer nor a medical doctor. I have a Ph.D. in Social Psychology.

Mr. GREENWOOD. Now we have the expert here.

Mr. VIDMAR. Well, only somewhat. I want to say that, obviously, we have a serious crisis in many places throughout the United States, and I have given two written submissions to this committee and I simply want to touch on a couple of highlights in those. I have been mapping the litigation system. That is what I do; especially, medical malpractice, and I published a book called Medical Malpractice and the American Jury in 1995. Most recently, I have done some work in Mississippi. And although we are talking about Pennsylvania today, I just want to make a couple of comments about the Mississippi study, and that is part of my written submission.

Mississippi has been picked on as one of the other States where there is a major crisis. The problem is that we so often get a distorted picture of what goes on in the litigation system. And just to give you an example, during the debate in the Mississippi legislature, doctor groups and others were saying that there were 52 awards since 1995 that were over $1 million. And I have heard the American Medical Association make some similar sorts of comments. I actually managed to get those data of those 52 awards. It turns out there were only seven medical malpractice cases over $1 million. The rest were some tort things, some contracts. In fact, the second largest award in Mississippi turned out to be the State of Mississippi as the plaintiff in a contract dispute.

So the point that I am making is that often we see things at a certain surface level that are not so apparent. Over a year ago, the Pennsylvania trial lawyers asked me to look at Pennsylvania, and I managed to get a little bit of data and I thought that I would be able to share that with you. Again, these data are in the report that you have before you. In Pennsylvania, seven out of ten lawsuits that go to trial are won by the doctors. In the year 2000, there were 76 plaintiff verdicts. The average verdict was a little bit over $5.5 million, but the median verdict was $1,200,000. In the year 2001, there 76 plaintiff verdicts and the average was $2,620,000, or a median award of $872,000.

Now, you ask what is the difference between the mean and the median. Well, you can have outlier awards, these large awards that actually increase the median. So I looked at those. And in fact, the Governor this morning talked about 19 cases over $5 million; it turns out I found 22 in these data. But what I also found was that the average recovery in these cases was 22 percent of the actual verdict, and that is very consistent with research that I have done in Florida, and New York, and in California. In other words, jury verdicts are not necessarily the end result. One of the things that I found in Pennsylvania was that in a number of cases there were high-low agreements before the case even got to trial. The lawyers in advance had said, well, it won't be any higher than this and it

won't be any lower than this, and in fact, the whole issue was one of a planned settlement, but all that is reported is that $20 million verdict that appeared in the newspapers when, in fact, that is not what the ultimate outcome was. There are post trial settlements, judges reduce awards. So that is one of the things you have to look at is not what is in the surface in the claims that are being made, but rather, what actually happens in the system.

Second, as many people pointed out, the economic costs when there is medical negligence are very high. In the 1990's, Frank Sloan, an economist, examined bad baby cases and emergency room cases and examined with a team of economists only economic costs, not the pain and suffering costs. In today's awards, the average economic loss for these was $2.1 million, and there was a lot of variation around that. So you can think of someone who has got a high income could lose a lot more, but let us stick with the figure of $2.1 million. I think that caps on pain and suffering isn't going to do a lot in a case like that. So one of the things you have to look at is what are the actual economic costs, and that was probably the most careful study that I know of that has been published showing what the actual costs are when someone is injured through medical negligence.

I would make a little side comment, Congressman Greenwood, about Pennsylvania versus Indiana. Indiana actually has—I think you talked about some physician that was leaving. Indiana has a cap on economic damages. I mean, the total award can only be $750,000. It is being raised, but there are some clear instances of great injustice through that, simply because of the actual economic cost, and it is something that needs to be taken into consideration.

I have two final comments to make. Again, many of these are continued in the paper. There is the comment about frivolous litigation, and I don't deny that there is some frivolous litigation, and I do not know the exact situation here in Pennsylvania, but what I do know is that the figure that says 40 percent of cases that are filed end up receiving no payment as an instance of frivolous litigation is just not correct. When I was doing my work on the medical malpractice in North Carolina, we were fortunate in that we convinced three medical insurers to give us some samples of their files. So I was able to trace—and they kept fairly detailed files of what was going on. In the first place, for a lawyer to begin to sue for a plaintiff, he has to get, he or she has to get the medical records, and doctors often resist this. So they have to file a lawsuit to get the medical records. Once they get the medical records, then they get someone to examine them. And what I learned from the insurers' files was something very interesting. After the filing, the plaintiff says I have got this expert and we think it is medical malpractice, the defendant says, well, I am going to have somebody take a look at the case and we will get it. Well, it turns out they often get a local doctor who says, no, there is no medical malpractice here at all. The next thing is the plaintiff comes in with an expert that says, yes, there really is, and here is the reason why. And we get this in the deposition. All of a sudden, the insurer says—it is the lawyers who are doing this, but this is in the insurer's records—oh, my gosh, maybe this doctor really didn't have a very accurate estimate of what this was. We should go out and get

our own insurer—I mean, get our own doctor outside the State. They go outside the State and they get someone, and then this doctor from the defense side says, yes, I think there was negligence here. And this goes on for a period of time. That is why it takes so long to resolve these kinds of cases, is what we discovered. But ultimately, it may turn out that the plaintiff says after they have gotten a couple of doctors to look at this, the plaintiff says, you know, we thought we had a case, and we don't, and we drop it.

My point about this is—and 40 percent of the cases in North Carolina were dropped in the study that I was doing. But the point is these were not frivolous cases; these, ultimately, were non-meritorious cases, but through the process of discovery, it only turns out that these are complex issues when you get involved in medical malpractice, and then the case is dropped. That doesn't mean it was frivolous, and therefore, I think it is very misleading when you say that these dropped cases end up being frivolous cases.

And finally, I have been studying juries, civil juries, for the better part of two decades now. And in fact, doing some interesting work in Arizona where I have actually been able to videotape the deliberations of 50 civil juries with my colleague, Sherry Diamond. This is a court initiated project. And the data that we found from seeing real juries deliberating and videotaping what they have done, and it is all kept within our research group, is consistently, juries have heard and read about medical malpractice cases, they have heard about the large awards, and juries consistently end up being very conservative in what they do.

And you know, this system wouldn't have lasted if it was as crazy as people say that it is. It is part of our American Constitution and it is part of the practice that we have had. And when you talk to judges who sit side by side with juries and hear the same evidence, and you do studies of them asking are juries crazy, what they say is no, I agree with the juries most of the time, 80 percent of the time. In fact, more recently, they show 80 percent of the time, and when I did disagree with them, it was close enough because of the cases that one would have to say it could have gone either way, and therefore, maybe the jury was right and I was wrong. So there is a whole body of research that suggests that juries are not so crazy as this. They tend to be rather conservative. And so all of those need to be looked at.

Now, that is only part of the problem, but what I am suggesting in my paper, in the testimony, is—and this goes back to what the Governor was saying, is to me, the focus on a single issue like caps on pain and suffering, and trying to lose sight of what the major problem is, and blaming it all on the litigation process—the tort system is very inefficient. It ends up in making bad mistakes, it is very costly, and I would be the first person to jump up and say that to you. But it is the only system we have got, and it is the only system that we have got that allows people to get compensation when they have been injured. I could find alternatives, Workmen's Comp of some form for this, but our system won't allow it, and so we have to stick with what we have. Thank you very much.

[Material submitted by Neil Vidmar is retained in subcommittee files.]

Mr. GREENWOOD. Thank you, Dr. Vidmar. Mr. Mundy.

TESTIMONY OF JAMES F. MUNDY

Mr. MUNDY. It is Jim Mundy, Mr. Chairman. You and I go back to the days when you were in the Pennsylvania Legislature. I have known you for many years, and it is a privilege for me to be here before this committee. And let me just say that I had always heard that Congress works very hard. It is 3:10 in the afternoon, there has been no break, you have been here since 10 this morning, and I think you should be congratulated, all of you, on the kind of zeal you have for this project that would keep you here with no break at all for the better part of a day.

Mr. GREENWOOD. Thank you. And by the way, the day is young.

Mr. MUNDY. And I know that, too, and I know there is more that you will be doing after this is over.

Let me tell you the perspective from which I come to this problem. First of all, I am a claims lawyer. I represent victims, and a good percentage of those victims are medical malpractice victims. I am also a patient. I have some great and wonderful physicians who have taken care of me. I have great friends who are physicians. I have worked on this problem with physicians for almost 20 years. I go back to a day when I was very perhaps naive, or idealistic, or some combination thereof, when the then majority leader of the Pennsylvania Senate, Bob Jubelirer, called us in and said we had to come up with a solution to the 1985 malpractice problem which had succeeded from where the 1974 medical malpractice had left off. And I went out on my own, and I went to nine state-wide organizations, hat in hand, and I asked them to give me money, a minimum of $10,000 each, so we could go out and have a study done to find out what in the heck was going on with the medical malpractice insurance delivery system in Pennsylvania.

It was recommended to us that we hire two professors from California, two Ph.D.'s from California, because they had done a study for the Los Angeles Medical Society and the Los Angeles Medical Society said they had done a great job, and we did. We hired Al Hofflander and Wayne Nye. If Wayne Nye's name registers with you, he was one and the same, a Dallas Cowboys offensive guard for a decade. They came to Pennsylvania and did an in-depth study. They were given all of the CAT Fund data, and the CAT Fund was 10 years old then. They were given all of PMSLIC's data because the Pennsylvania Medical Society was one of those nine organizations along with the Hospital Association of Pennsylvania, the Defense Research Institute, the Philadelphia Bar, the Pennsylvania Bar, and the Allegheny County Bar. Most of them didn't even know who I was. They put up the money, not for me, because they believed in this. And we found then that there were myths, things that we had all believed which was that if medical malpractice rates or any insurance rate is high, there must be too many claims and too much payout.

The reason it is relevant what we did in 1985 is because those same professors, Hofflander and Nye, came back here in 2001 and brought the study up-to-date. And so there is a few things that have been said today, and I like to give you a little bit of perspective from what I have learned about them. First of all, there is nothing more damaging that has been said here today to consumers and patients than the concept of physicians are leaving this

State. The statistics are that in the decade from 1990 to 2000, the number of physicians coming into this State increased at 12 percent. The general population of Pennsylvania increased to 3.4 percent, so there was a fourfold influx of physicians into Pennsylvania greater than the population growth. But in 2000, according to CAT Fund data, we lost 900 physicians, 3.5 percent, and that is a big loss.

What are the causes for that? One, I am sure, is what you hear about, the medical malpractice rates. But there is another. We rank in Pennsylvania—and this was alluded to by the Governor earlier—almost dead last in physician reimbursements across the board, not just Medicare, across the board. We have a monopoly of providers here and our doctors are being hurt by that. Why they are not saying that here, I can't fathom, because that is a fact. I have, part of my practice is representing physicians. Usually, they come to me after they have been sued by somebody because they know I will do my best to help them get through it. But in part of that, just an anecdotal story to give an idea how this affects our doctors, the chairman of the department of gastroenterology at a major hospital called me in and said I need your advice on something. I have high risk patients for colon cancer. I want to give them a colonoscopy once a year, but the reimbursement I get on that costs me more money to use the hospital's facilities to give the colonoscopy than I get in reimbursement. In other words, I lose money every time I do a medical procedure. That is wrong. And his question to me was if I start spreading these patients out, the person who should get it every year, the high risk person every 2 years, and the person who should get it every 2 years to every 4 years, and somebody ends up with colon cancer, will I be liable? And his next question to me when I said, yes, you probably will, because you probably won't testify that it was the provider that made me do it, he said, well, why can't you barracudas do something about that? Why can't you do something about reimbursements? I would like some physicians to come forward and talk about that.

Physicians are victimized in another way rather uniquely in Pennsylvania, and maybe it is because we had an absent market in the 1970's that was filled by a captive insurance company, PMSLIC, when first formed, and it was difficult to compete as a noncompetitive carrier, somebody who is trying to service their members, with a private carrier that would come in and be a very selective carrier. So what we have in Pennsylvania is a rate classification distribution, 13 to 16 rate classifications. What does that mean? There is a neurosurgeon in this audience. There were 250 neurosurgeons in Pennsylvania in 1985, approximately. If you put them in one group and say you are a rate classification, the basic principle of insurance is violated, which is spread the risk. That neurosurgeon may have been missing in Mississippi because of a rate classification that sent his rates through the roof and his partner had to leave. To put it basically, if in 1620 there were 20 ships insured in Plymouth, England, instead of 200, and one went down, there wouldn't be any insurance today. There is a need to come in and what we call collapse the pyramid. We started out with three

classifications, those who don't operate, minor surgery, and major surgery. Now we are at 16.

We have another problem addressed in both studies, the problem of recidivism and an absolute lack of doing anything about this. And it is not just—I know neurosurgeons take great risk and work with brains and spines and do wonderful things, but within the specialties, we have a problem. In 1985, 228 doctors, 1 percent, were responsible for 25 percent of the 10-year payout of the CAT Fund; 10 percent of the neurosurgeons were responsible for 47 percent of the 10-year payout of that specialty; 4 percent of the orthopedic surgeons were responsible for 45 percent of the 10-year payout; one ophthalmologic surgeon, one alone, was responsible for 25 percent of the 10-year payout of the CAT Fund for that specialty. That was in 1985. We had 17 years to do something about that. When Hofflander and Nye came back in, this is what they found: less than 2 percent of all the physicians in Pennsylvania were responsible for 41.5 percent of the 25-year payout, less than 2 percent. That is half the number that left Pennsylvania in the year 2000; 151 doctors, all with four paid claims or more, .27 percent, were responsible for 12 percent of the 25-year payout of the CAT Fund. If something had been done about that, we wouldn't be here.

We have had one physician lose his license in 25 years for incompetence, one. If we cannot get the licensure department to look at that problem as they did not after 1985,m there is another way to do it, and that is to mandate experience rating, make it too expensive for someone who is not capable of performing adequate medicine to practice here.

Is there a crisis in torts? The number of filings in Pennsylvania, according to the organization that keeps track of all filings in all State courts, we are in the middle; 26 States and the District of Columbia file more medical malpractice cases per population than does Pennsylvania. We are in the low middle. The mean verdict, according to the National Practitioners Data bank, which has been around for 10 years, over that 10-year span, nationally, was $209,000 and Pennsylvania was $211,000. In fact, if you take away asbestos claims, Pennsylvania is one of the least litigious States in the whole United States. Only in Maine do they file fewer suits per population than does Pennsylvania.

We have unique problems. We had a unique system in place to answer it. We chose to do it—that was the CAT Fund. We chose to do away with that at a period of time when there is no market. There is no investment market. And in those 30 years that I have been around here and testifying before committees, every time we have a bear market and no interest rates we have a tort reform crisis. They go hand in hand. You first have an insurance availability problem because no one wants to write, and then when you have a seller's market, you have a price problem, too, affordability problem. That is the way it goes, that is the cycle.

The statistics from the CAT Fund in its last 2 years showed we have already probably turned around in that cycle and we are on our way back down. Does that mean you shouldn't look at it? No. We shouldn't be victimized every 13 years or so by these horrible fluctuations in the market that are terrible for our physicians to try to handle. There is no way to plan for it, there is no way to

predict it, but the answer is not tort reform; the answer is insurance reform.

[The prepared statement of James F. Mundy follows:]

INTRODUCTION

There is considerable evidence that in Pennsylvania, high medical malpractice insurance rates are the result of factors other than claims and claims payout. The concepts under consideration by this Committee as embodied in HR 4600, do not address the plethora of factors, other than claims payout, that have caused a premium spirale. It is our hope that this Committee will expand its viewpoint of this problem. Further, it is our belief that these issues, with one exception, can and should be addressed by the Commonwealth of Pennsylvania and not by Federal intervention.

Pennsylvania, has had the benefit of two in-depth studies on medical malpractice within the Commonwealth performed by essentially the same individuals, first in 1985 and again in 2001.[1] The initial study was the result of a cooperative effort of nine statewide organizations, who collectively, along with the Pennsylvania Senate, financed the study. These studies identified problems in the insurance delivery system in Pennsylvania and other factors which were the root cause of the malpractice insurance price spiral which led to the 1985 study, as well as the spiral which preceded 2001. Much of what is set forth in this paper is based upon the findings of Hofflander/Nye.

A. Physicians Need Reimbursement Relief

I think all of us agree that physicians all across the United States have experienced sharp increases in medical malpractice insurance premiums. In Pennsylvania, the effect of these increases have been greatly exacerbated by the fact physicians reimbursements for services rendered to patients is amongst the lowest in the United States. According to Howard Richter, M.D., immediate Past President of the Pennsylvania Medical Society, those reimbursements average 20% below the Medicare schedules. Since physicians fees in Pennsylvania are essentially capped, any increase in the cost of doing business, including increases in malpractice premiums, is vexating.

This is a problem not addressed by HB 4600 and yet Federal legislation will be needed to remedy this inequity. Irrespective of what ultimately happens with respect to medical malpractice insurance, how can we stop the flow of physicians out of Pennsylvania when they can earn as much as 2 to 2 1/2 times more for doing

a procedure in our neighboring state of New Jersey? If Medicare truly represen the gold standard of health care cost containment in the United States, how can such a disparity be tolerable. Only by Federal mandate can this problem be addressed.

B. Malpractice Rates Are Directly Related To Declines In the Investmer Market

Malpractice insurance rates are adversely affected, as are virtually all for of casualty insurance rates, by a poor investment market characterized by a bea stock market and low interest rates. This dependency of casualty insurance up the investment market is well documented. We all are aware of the investment market decline over the past several years. Casualty insurers target a 20% retu on the dollar and when they cannot obtain this return, at least in part, through investments, they must raise premiums. It is also well accepted that casualty insurers tend to contract and consolidate during such periods and are thus reluc to expand their underwriting or enter new territories.

These factors result in an availability of insurance problem and we are fa with an availability problem today in Pennsylvania. When availability is a problem, it follows like night follows day that there will be an affordability problem. We have today a true "seller's market" in medical malpractice here a across the United States.

In addition, insurance availability in Pennsylvania has been adversely impacted by the failure of four major insurers over the past six years. Three o these, Physicians Insurance Company (PIC), Physicians Insurance Exchange (and Pennsylvania Hospital Insurance Company (PHICO) were leading primar insurance carriers at the time of their demise. The fourth insurance company fail, Reliance Insurance Company, was a major provider of excess insurance t Pennsylvania hospitals.

There is an important common denominator to each of these failures; al were allegedly brought about by fraud or mismanagement; each are subject t and criminal charges by the insurance departments of Pennsylvania and in the of PIE, Ohio; and none of the failures have been linked to any adverse claims experience in Pennsylvania. These failures alone wiped out more than 50% c primary insurance market in Pennsylvania[2] Obviously, the result has been a d in terms of medical malpractice insurance availability.

C. Pennsylvania Has Not Experienced A sharp Increase in Either The Filing of Claims or In Paid Claims.

Pennsylvania enacted legislation, The Health Care Malpractice Service in 1975, which fundamentally changed the medical malpractice insurance del system in Pennsylvania. One of the changes was the creation of a non-profit, operated fund, the Medical Professional Liability Catastrophic Loss Fund (C. Fund) to handle all claims above the primary insurance limit of $200,000 thr the mandatory coverage ceiling of $1.2 million. The CAT fund went into op in 1976. Claims covered by the Fund began maturation in 1980. Thus, 1980 obvious year to use as a base from which to track growth.

CAT Fund data demonstrates a composite growth in claims paid of 7.3 the years 1980 through 1996. The medical cost index for this period was 7% Since medical costs are a common primary element of personal injury claim Hofflander/Nye concluded that the rate of growth was not out of sync. Clair payout declined in 1997, but then turned sharply higher in 1998 and 1999. T increases however can be at least partially attributable to the failures of PIC PIE which virtually eliminated more than 25% of primary coverage.[3] CAT I Director, John Reed, has estimated that these failures alone cost the CAT Fu approximately $30 million per year.

The National Practitioner Data Bank provides comparable informatior verdicts in Pennsylvania as compared with the nation as a whole. It has bee existence since 1990. From 1990 to 2000, the national mean average verdic medical malpractice cases was $202,000. In Pennsylvania, the mean averag $211,000. In the year 2000, it was $249,000 nationally and $251,000 for Pennsylvania. Verdicts in Pennsylvania were in sync with those across the

With respect to the filing of medical malpractice claims, twenty-six st and the District of Columbia, had a higher ratio of filing, per capita, than di Pennsylvania. Pennsylvania is in the low middle when compared to the rest country in the filing of medical negligence claims.

If tort payout were really the culprit in the increase in malpractice ins premiums, it would logically follow that those states which have enacted long-standing reforms would not be experiencing a crisis. We note, howeve states such as West Virginia, Maryland and even California all with major t

premiums. It is submitted that this is further evidence that tort reform cannot cure the insurance crisis that has plagued our doctors. The numbers, whether viewed i terms of filings, verdicts or payouts, belie the existence of a crisis.

D. Pennsylvania Has Become a Safe Haven for Incompetent Physicians.

There is compelling evidence that a very few physicians are responsible for very substantial portion of the claims payout in Pennsylvania. In their study of 2001, Hofflander & Nye were able to obtain complete data on claims paid from th CAT Fund. They found that 41.5% of the total 25 year CAT Fund payout was made on behalf of less than 2% of all physicians. They found that 151 physician .027% of the physicians covered, were responsible for 12% of the total 25 year CAT Fund payout. Each of those 151 physicians had four or more paid claims.

These statistics, though startling, are certainly not new. In the 1985 study, Hofflander & Nye uncovered the same pattern of recidivism. As a result of that study, the following examples were revealed:

* 228 physicians - 1% of the covered physicians - were responsible for 25% of the ten year payout (1975-85) of the C/ Fund;
* 10% of the neurosurgeons were responsible for 47% of the ten year payout for that specialty;
* 4% of the orthopaedic surgeons were responsible for 45% of th ten year payout for orthopaedics;
* One optomilogical surgeon, alone, was responsible for 25% of the ten year payout for his specialty.

It was expected that this revelation would bring about some change in licensure and physician discipline procedures. Nevertheless, in the 25 years at issue, only one physician in the Commonwealth of Pennsylvania has had his license taken away for incompetence. Who should pay for the bad actors in the system? The legislation under consideration would levy that cost upon victims. that fair?

E. Pennsylvania Physicians Are Victims of Rate Structure Anomalies:

The basic principle of insurance is "spread the risk". If, at the time that th first casualty insurance company was formed in Plymouth, England, only 20 shi had been insured, instead of 200, there may not have been any insurance compa

When Hofflander & Nye did their study in 1985, they found that there wa tendency to separate doctors into multiple risk categories. This was referred to : "pyramiding". The purpose was to enable a carrier to maintain very competitive rates for the low risk insureds for whom they wished to continue to write insura These include family practitioners, non-interventional dentists, and the like. Higher risk physicians, particularly those who perform surgeries, were separate out into different classifications so that the low risk physicians would be insulat from the claims experience of the higher risk physicians. The problem is that w additional rate classifications, the numbers involved in the higher risk classifications are often insufficient to comport with the principle of "spread the risk". As an example, in 1986, there were approximately 200 neurosurgeons in Pennsylvania. Neurosurgeons deal with backs and spines. Almost any mistak made by a neurosurgeon is going to be a seven figure, and perhaps multiple sev figure, mistake. Obviously, these numbers are too high to provide adequate funding for claims without charging exorbitant rates. In 1985, Hofflander & N estimated that there were as many as thirteen to sixteen rate classifications in th ranks of medical practitioners.

They recommended then, and CAT Fund Director, John Reed, recommer in 2001, that the pyramid be "collapsed". A collapsing of the pyramid to four c five categories could result in very substantial premium savings at the top of th pyramid, and a very minimal increase in premiums at the bottom of the pyrami (lower risk physicians).

CONCLUSION

The physicians in this Commonwealth, and around the country face a se problem with respect to medical malpractice insurance rates. Relief can only b obtained by examining the root causes of the problem and addressing those. It unfair to assume that spiraling rates are caused by he civil justice system

[1]Alfred E. Hofflander is Professor Emeritus of Finance and Insurance at the Graduate School of Management, University of California at Los Angeles; Blaine F. Nye is President and Jane D. Nettesheim is Vice President of Stanford Consulting Group, Inc. of Redwood City, California.

[2]At the time of its failure in 1996, PIC underwrote approximate 20% of the primary insurance market. When PIC went under in 1997, its underwriting accounted for 7.3%. PHICO was Pennsylvania's largest underwriter of medical malpractice insurance with 26% of the primary market.

[3]Pennsylvania has an insurance guaranty fund but it's exposure per claim is limited to $300,000. That number is further reduced (offset) by any insurance payments made to or on behalf of the claimant.

Mr. GREENWOOD. Thank you. Thank you all for your testimony. Without objection, we will enter into the record the document provided by Mr. Rosenfield, which is entitled, The Matter of Rate Rollback and Refund Obligation of NORCAL Mutual Insurance Company. And let me turn to you, Mr. Rosenfield, if I could. The Chair recognizes himself for 10 minutes.

When there is a rate rollback, the money has to come from somewhere. I don't think it is too much of an oversimplification to say that a medical liability insurance company has two sources of revenue. It has premiums coming in and it has return on investments which are usually positive. Its returns on investments are usually a positive number, not a negative number. And then it pays out claims. It made investments in order to get that return, but that is, as I said, a net plus. And it has some profit and administrative costs.

Now, if we look at the physician owned and operated insurance companies, which I believe is 60 percent of the market in the United States, and you look at PMSLIC in Pennsylvania, if the solution is rollback rates, you have to help me understand where that comes from, because PMSLIC isn't paying shareholders profits, it doesn't have—it is not a privately held company pouring big whopping salaries into its administrators, and yet, it is completely competitive with the private sector. So what I have a difficulty trying to understand is there is a lot of interest in blaming the insurance companies, and let me tell you something. If I thought the insurance companies were the culprit here, I would go get them, both guns blazing. You ask me to name somebody who operates a medical liability insurance company, I don't know anybody. I can't name them. If you ask if they have come into my office, I can't tell you that they have. If you ask me if anybody ever contributed to my campaign, I would say I don't think so. So I have no vested interest in going easy on those guys if those guys are the culprit.

But when I look at the PMSLIC's of the world and the other physician operated systems and see that they are sitting here saying it is paid claim severity, I don't know where to squeeze that stone and get blood out of it. So why don't you help me with that?

Mr. ROSENFIELD. Well, first, I do think there is a distinction between the commercial carriers and what we call in California the bedpan mutuals that were set up largely after MICRA passed and the commercial insurers wouldn't come in. But we have found—and what happened with Proposition 103 and the rollback shows that they had—they were holding too much money, and that was the fact of it. There were very specific rollback regulations that were approved and litigated, by the way, for years.

Mr. GREENWOOD. All right. Let me stop you there. Let us talk about here and now. Let us not talk about California many years ago.

Mr. ROSENFIELD. Sure.

Mr. GREENWOOD. I would be very surprised if the physicians who own and operate PMSLIC, and who pay the premiums that PMSLIC sets, are sitting around in this crisis allowing them to withhold too much money. Let us assume that is not the case here.

Mr. ROSENFIELD. Well, let me talk to you about that, let me answer that question. My experience is that most physicians just want to practice medicine and they aren't such great consumers themselves. And that has turned out to be an interesting thing in California, where under Proposition 103, anybody can challenge a rate increase over a certain percentage and obtain a mandatory hearing. No physician has ever done that. Now, rates are starting to go up in California because of the cycle, and in the absence of any physician group challenging a rate increase request—we did about 3 months ago. We challenged NORCAL—that is right, I am sorry, we did not challenge NORCAL. We challenged SCPIE, which is the second largest medical malpractice liability insurer in the State, and we—then wanted a 15 percent rate increase. We had an actuary examine it, preliminarily, to determine that it was excessive, filed the request, filed the demand for hearing, the company withdraws its application. All of a sudden, it doesn't want a rate increase. And then we made a big deal about that nationwide, which is maybe a mistake. And I think what happened was it got all of the people all over the country who understood the political ramifications of them withdrawing their requested rate increase and how that endorsed regulation, and so they went to the commissioner and said how about a little rate increase, can you do it under the table so you don't have to give a hearing, and the commissioner said no.

Mr. GREENWOOD. Well, this is a physician operated——

Mr. ROSENFIELD. Yes.

Mr. GREENWOOD. So explain to me what the motivation is for a physician operated medical liability insurance company to charge excessive rates.

Mr. ROSENFIELD. Well, I can give you two motivations and I can't tell you about this one company, but I can tell you this for sure. There is two options. One is that they are mistakenly projecting claims payments, claims payouts, for this year, for the future years. Or two, they may have goofed on their investments.

Mr. GREENWOOD. So it is incompetence? When you say goofed on their investments, now, PMSLIC invested in treasury bills, and we are going to go to them, and I think they are going to tell you under oath that of their 54 percent rate increase, a very small por-

tion of that is attributable to investment issues. And we have also heard from Mr. Hurley that the investment issue is not about the fall of the stock market in the past, it is about projections of what investments are likely to yield in the future. Isn't that accurate?

Mr. ROSENFIELD. Well, I think that is correct. That is how it is supposed to be. But the reason why we set up a regulatory system in California is to not have to be in this hearing and rely on that kind of discussion. Without being able to have our own actuaries, the public and the Department of Insurance own actuaries go in there and look at the——

Mr. GREENWOOD. So you think that you need to get the government and public advocates in between the doctors and the insurance companies that they own to protect the doctors from their own insurance companies?

Mr. ROSENFIELD. Unequivocally, yes. And I know that for somebody like you with your particular beliefs, the idea of government intervention——

Mr. GREENWOOD. No, I don't—government intervention is cool with me. I am just trying to figure out why we need it to get in between a physician and the insurance company that is his own physician nonprofit insurance company.

Mr. ROSENFIELD. All I can tell you is this. They paid the rollbacks in the early 1990's, without suffering, without going into insolvency. There was legal constitutional protection for them. They had to roll it back.

Mr. GREENWOOD. But you said that is all you can tell me, so that is all you are going to tell me. Let us hear on this question from Mr. Smarr and Mr. Diener, because to me, this is critical, and then I want to go to Mr. Hurley. This is a critical issue. What Mr. Rosenfield said is, essentially, that the problem here is not severity of paid claims, as you gentlemen have testified, but it is really that you need rate regulation. Now, I am trying to understand, if for profit insurance companies were charging rates up here and you guys were out there in the marketplace looking at your exposure to liability and you were way down here in your premiums, then I would say, well, look what the guys who aren't trying to price gouge are doing. But in fact, you can't get a premium—you can't sell a premium policy for less than the private sector can. So I am trying to figure out where the fat is in the process that we are supposed to cut out here if you are owned and operated by physicians and you can't find it. Would you like to comment? We will start with you, Mr. Smarr.

Mr. SMARR. Well, you are exactly correct, Mr. Chairman. There is no fat in the process. In fact, the physician owned carriers lost 10 cents on the premium dollar in 2001, and medical malpractice insurance is a line of insurance. Just like any other, it is a free open market under our free enterprise system. There are a large number of competitors in the market, although, dwindling very rapidly in Pennsylvania due to the very unfavorable situation with losses.

Mr. GREENWOOD. Somebody told me that there are only a couple insurance companies. How many people are selling—how many companies are selling medical malpractice insurance, medical liability insurance in Pennsylvania?

Mr. SMARR. I am aware of three at this time. The major market is PMSLIC and the Medical Protective Company.

Mr. GREENWOOD. What percentage of the market do you have, does PMSLIC have?

Mr. DIENER. It is a difficult market to identify in size, but if you will allow me to use round numbers, probably around 30 percent if you define the market as physicians who buy their own malpractice insurance.

Mr. GREENWOOD. Okay. I am sorry. I interrupted you, Mr. Smarr.

Mr. SMARR. And I think First Professionals Insurance Company is also writing in the State.

Mr. DIENER. It is our understanding that our company and Medical Protective are the only two large companies writing. We understand that a new company has begun business in Philadelphia, and with the State run Joint Underwriting Association, that would make four insurers that we are aware of.

Mr. GREENWOOD. Let me ask a question of you, Mr. Hurley. In your testimony, you say that recently, the cost of medical malpractice insurance has been rising, rate increases have been precipitated, in part, by the first item you list is growing size of claims. The second item you list is more frequent claims. The third item you list is higher defense costs. And the fourth item you list is the decline in expected future bond yields. Now, I guess you must have forgotten to say all of the money that was lost by the insurance companies in the stock market decline, because that is what we are hearing is the real culprit. Why did you not identify that?

Mr. HURLEY. No, sir, I did not forget to include it. It is because it should not be included.

Mr. GREENWOOD. because it is not a factor?

Mr. HURLEY. It is not a factor in determining——

Mr. GREENWOOD. Explain that, because I swear to you my good friend, Peter Deutsch, thinks it is.

Mr. HURLEY. As indicated in the testimony, the ratemaking exercise is a forward looking process.

Mr. GREENWOOD. Is that in all States?

Mr. HURLEY. The ratemaking exercise is forward looking in all States. What happens is companies will collect historical data. They will adjust that historical data to make it an appropriate estimate of what they think their loss experience is going to be for the upcoming period. They will consider the time value of money; that is to say, investment income they think they can make in the future, and they will incorporate their costs and a profit contingency load if that is the appropriate component to incorporate for that particular company, and that will depend. However, that is the process that they go through. It is uniform, or I think it is consistent across State lines. It is subject to State review in many jurisdictions, more thorough in some than in others, but it is reviewed at the State level by insurance regulators. It is documented, the process is documented in actuarial principles of practice, and again, is subject to review at the State level. And it does not encompass, it does include a provision for prior year's losses in the stock market, for example. There is no provision for that.

Mr. GREENWOOD. Okay. I itemized the four causes that you cite, growing size of claims, more frequent claims, higher defense costs, decline in future bond yields. Did you list them in that order—are they in any order? Did you mean to list them in the order of the sort of percentage of the contribution that they make?

Mr. HURLEY. I had not intended them to be in any order in terms of order of magnitude, for example, sir, but I would say that the interest income component, investment income component, is probably less important than the others.

Mr. GREENWOOD. So growing size of claims, and frequency of claims, and the higher defense costs, which are associated with the tort system, are the main drivers, and the decline in expected future bond yields, you are saying, is the smaller of the causes?

Mr. HURLEY. That is correct.

Mr. GREENWOOD. You don't have a dog in this fight. Right? You are not paid by the doctors, or the lawyers, or the hospitals. Are you?

Mr. HURLEY. I am here as the representative of the American Academy of Actuaries. In my work, where I do get paid, I work for insurance companies, I work for regulators, I work for healthcare providers, so I work for the broad spectrum of folks interested in this sort of question. I, actually, do work for PMSLIC, as a matter of fact.

Mr. GREENWOOD. The final question—I am over, but this will be my last series of questions, I think. And I want to address this to you, Mr. Diener. In setting your premiums, you take into account the investment income you expect to make from the premiums that are collected until you make any payments. We have been talking about that. And again there is this allegation or assumption that is made in some corners that what has changed here is the recent—we know what the stock market has done. We have all seen it in our 401K's, and IRA's, and so forth. What do you currently use as your assumed rate of return this year in this poor market, and how have those assumptions changed since the bull market of the 1990's? In other words, what do you expect now as opposed to then?

Mr. DIENER. If you would allow me a brief digression to a point of clarification, I think that SCPIE, the company that the gentleman from California alluded to, is in fact, not a physician owned company. It is, in fact, a publicly traded, publicly held insurance company. I am not certain of that, but that is—we have lowered our investment rate assumption in the 2003 filing, which we filed with the State in October 2002, from that we used in our 2002 filing, which we filed with the State, in October 2001, from about 6 percent to 5 percent.

Mr. GREENWOOD. So that is it. It is a 1 percent difference?

Mr. DIENER. From last year to this, yes, sir, that is correct. I am sorry I am not able to tell you what it was from the 1990's. I would expect the differential is not anything that would astound you. We are 100 percent invested in treasury's and investment grade corporate's.

Mr. GREENWOOD. Okay. The gentleman from Florida is recognized for 10 minutes.

Mr. DEUTSCH. Thank you. Mr. Hurley, again, I think this is really sort of a follow-up on what the chairman was saying, but you know, I think we need to really distinguish between losses versus less investment income in the future. I mean, losses are not the change at all, but less investment. Could you try to follow up a little bit on Mr. Diener's statement. Let us say, 2000, what would have been, you know, your recommendation for a company to use as a rate of return for investment income?

Mr. HURLEY. Well, I can't recollect, specifically, but in general, when we make a determination about—or when an actuary makes a determination about what investment yield to use, it will seek the input of the advisors of the particular circumstance he is dealing with. In the case of a company, you might ask what yields do you expect to get with this money that you are going to collect in the year 2001 in the case of the example you are talking about in the year 2000, and based on that yield, do a calculation to reflect the implied investment credit associated with the assumption of that yield. Those yields have come down, as I think is your inference, over the course of the last couple of years, not unlike what Mr. Diener said. I would say that in most situations, we probably have seen occasions where that yield has come down to less than 5 percent, probably 4 percent. There are some occasions where I have seen 3 percent used.

Mr. DEUTSCH. And in the past, what is the highest percent you ever saw?

Mr. HURLEY. I have seen, historically, as high as 7, 8 percent.

Mr. DEUTSCH. That is the highest you have ever seen?

Mr. HURLEY. I don't want to say that is the highest I have ever seen, but I think I can recollect seeing 7, 8 percent.

Mr. DEUTSCH. Well, I am not going to hold you on it, but I mean, I just, you know——

Mr. HURLEY. Well, this is sworn testimony, so I want to be a little careful.

Mr. DEUTSCH. Right. Okay. I mean, so even in 1999, 2000, 2001—I mean, 8, 9 percent, or even going back to, you know, a point in time when inflation was higher. Let me, I guess, get a sense of let us say you went from 8 percent to 3 percent. What effect would that have on rates? The same year, same deal, use 8 percent, use 3 percent. What would the increase in rates be?

Mr. HURLEY. Maybe 10 percent at the low end and it could be as high as 20 percent at the high end, something along those lines.

Mr. DEUTSCH. Okay. So I mean, just even from the—does anyone want to, again, from this panel, offer a different estimate of that? Okay. I mean, you are the actuary on the panel. Let me—I want to jump around a bit, because really, the testimony hasn't really integrated completely, but I think all of you have said significant things. Mr. Diener, we have had testimony today on a number of occasions saying that, as far as people are aware, there is only one physician who has actually lost their license in Pennsylvania in the last 20 years because of incompetence. I mean, that is my understanding, which is interesting. I mean, comparative in terms of other States. You told the staff that you cut 50 doctors from coverage because the risks were too high. Now, were these bad doctors

or, I mean, why did you choose to eliminate coverage for those 50 doctors?

Mr. DIENER. We non-renewed about 50 physicians at year end 2002 because we felt they represented an exceptional risk to the company.

Mr. DEUTSCH. And I mean, were they bad doctors? I mean, why were these particular doctors problematic for you?

Mr. DIENER. We look at trends. We try and understand frequency and severity and the risk that different physicians present to our company. We do not non-renew or surcharge as a punishment for past losses, but rather, as a projection of future losses. I would be unable to characterize the quality of care those physicians delivered, but I can tell you that after considerable study, we felt their risk profile was exceptional.

Mr. DEUTSCH. And again, I just want to be—you know, I would want to get some comparative sense from other States about this but, you know, one of the things that we really haven't touched on today is, really, the issue of maybe looking at the whole problem of malpractice at least a little bit differently. We have talked about a variety of, you know, legislative issues, but I think one of the things that on a personal basis, I know stuff is going on. I know hospitals are doing risk evaluation things, and you probably give discounts, I would assume, for certain programs that physicians or hospitals sponsor. And one of the things that I guess, you know, I would hope when we finally, if we do come to legislation, that we spend a lot of time on, is, ultimately, trying to reduce malpractice. You know, not just dealing with the premium side, because again, I guess one of the ways I view it is if there were no malpractice, there would be no malpractice crisis. And ultimately, I guess have enough sense in the system. And maybe, you know, we hear these things continuously of, you know, unjust rewards. I want to see the case where, you know, a $1 million claim was awarded by a jury or by a judge where there wasn't malpractice by the standard of, you know, reasonable care in the specialty. And you know, from a societal basis, it is really sort of putting it on its head. And again, I think we have also talked about that the procedures by their nature of risk, either it is going to be a certain percentage that, you know, just the human condition is not perfect, that there are going to be sometimes, you know, the wrong leg is going to be amputated, and it is going to happen, but how do we prevent that from occurring.

And I guess—I mean, I open it up really to Dr. Vidmar, if you can kind of talk maybe a little bit about that because that really addresses the research that you talked about, I mean, in terms of malpractice itself, or is there anyone else here that can really talk about where from a policy side, because ultimately, there is a reasonable chance that there will be Federal legislation. Both the chairman and I are well aware of the politics. The House is going to pass a bill for sure. The House passed a bill in the last Congress and it will be a very protracted debate in the Senate in terms of what the legislation will be, and hopefully, as it goes to the Senate, some of these issues, some of these other concerns, will be addressed. And ultimately, you know, I hope that I want to reduce malpractice premiums as much as my colleague, and I really want

to. I think our goal is exactly the same. I mean, I have discussed it somewhat in anecdotal conversations during this hearing is that not just on a policy basis, but definitely on a policy basis—I mean, I have an incredible amount of respect for physicians at so many—I mean, I have not met a physician in my life who did not get into the profession for the best reasons, and I understand, I have plenty, you know, friends, relatives who are physicians, and understand, you know, the commitment that it takes, and also, some other issues related to it. But I think, you know, we have really gotten to a point where premiums throughout the country, Pennsylvania does seem to be more problematic than most States, where the analogy that I use, if there is a doc out there that the net income is, let us say, $180,000, and that person has a $30,000 increase, and we really are in this world, in the malpractice rate, where they just can't do anything to generate an additional $30,000 more of income. I mean, they are not going to get more reimbursement from their managed care company, they can't do anymore procedures, they can't see anymore patients, and so that person—you know, a lot of people in America have more serious concerns, but for that person it is an unfair situation. And from the policy side, for us, I think the challenge for us is how to deal with that person, specifically, and all the implications in terms of the access to care issues.

But I guess I focus back—I mean, have you looked at that at all in terms of things we can do in terms of reducing malpractice itself?

Mr. VIDMAR. Well, this is not my area of specialization. I probably shouldn't go beyond that, but I can point you to the fact that people have been working on that. In fact, just this week I was talking with a doctor at Duke Medical Center. He and I are going to have a mini-seminar on medical malpractice litigation at the end of this month. He informs me that there are things, but I think you should turn to someone who is more specialized in that area.

Mr. DEUTSCH. Let me ask Mr. Diener. In terms of what types of programs do you have in place, in terms of discounts for physicians who are doing certain things to reduce malpractice?

Mr. DIENER. We offer up to a 15 percent reduction in premiums for physicians who stay claims free. That does not address your question specifically, but it hasn't been talked a lot about today. We do make an effort to differentiate between physicians who have not had claims. Every year, in addition, we offer a risk management course written by either our risk management staff or lawyers and physicians whom we use as consultants, successful completion of which gets an addition 5 percent. We endeavor to make that course responsive to what we are seeing in our loss trends.

Mr. DEUTSCH. And presently, of your clients, how many are actually participating in that risk management?

Mr. DIENER. In any given year, probably about 4,000 of our 7,000 physicians will take advantage of that.

Mr. DEUTSCH. And has your experience been that it is justified based on the claims?

Mr. DIENER. I wish I could say we had data that correlates risk management activity directly to loss experience. We do not. We nonetheless proceed to give those discounts in the assumption, in

the hope, that it must be in the better interest of improving patient care to make physicians more sensitive to those situations that are creating losses.

Mr. DEUTSCH. Let me take one last question to Mr. Smarr. We have spent a lot of time today talking about the $250,000 cap in non-economic damages. In one of the perspectives, I am just curious from your point of view, if that was applied across the Nation in medical malpractice cases, what percentage do you think member companies would reduce the premiums that physicians would pay?

Mr. SMARR. Well, for companies writing in States that do not already have a $250,000 cap, we could expect that rates would decrease significantly. The Congressional Budget Office recently did a scoring analysis of H.R. 4600, and in that analysis, which they found $14 billion in savings to the Federal Government and $7 billion in savings to the States, they also state that if H.R. 4600 were to become law, that rates would be 25 to 30 percent lower than they would be if H.R. 4600 would not be adopted into law. And those estimates are consistent with other actuarial estimates I have seen over the years as to the effect of the California MICRA reforms.

Mr. DEUTSCH. Now, one of the questions, and it would make many of us feel a lot better if, in fact, you know, if this legislation ends up passing, that there would be, really, a requirement that goes along with that. Because I guess, you know, I would want to go through the analysis of that calculation. But you know, if we actually believe that, I mean, would you expect your companies—how aggressively would your companies fight mandating that pass through savings? I mean, are you willing to say that companies would agree to the actuarial savings on that? I mean, the CBO number that comes up with a 25 percent savings?

Mr. SMARR. I think I can tell you that the companies would not agree to automatically reduce their rates. We have seen in States throughout the country that have adopted tort reforms that these tort reforms are automatically challenged on constitutional grounds, and the companies would be reticent to take any significant reduction actions until any such law passed constitutional muster. But what I can tell you is that if H.R. 5 would become law, this would immediately take the pressure off the marketplace. Carriers that are thinking of coming back into the marketplace and new carriers that would come into the marketplace would see some potential sign of relief because there would be the hope in the future that the continuing spiraling cost in severity would be taken care of. I think that because of that you would have more competition in the market, there would be more providers in the market, more doctors would be able to afford insurance. The normal competitive model would force rates down somewhat, but I don't think you would see any large reductions until there is some assurance that this law would not be thrown out.

Mr. DEUTSCH. Thank you.

Mr. GREENWOOD. I am just going to use the prerogative of the Chair to ask a few more questions and then reserve the same to the ranking member. Dr. Nasca, have you noticed a decrease in the number of medical students who want to specialize in the areas

that are seeing the greatest rate problems, obstetrics, orthopedics, neurosurgeons?

Mr. NASCA. You know, interpreting these trends are difficult because it is a multifactorial influence. It is clear that in general surgery there has been over the last 5 years a fairly significant reduction in the number of medical students choosing general surgery. Anecdotally, the number of graduating seniors seeking obstetrics and gynecology seems to be decreasing. There has been a shift in gender as well, with almost all of the young physicians interested in OB-GYN women, and there is some movement of that subgroup more toward some of the other primary care disciplines, internal medicine and family medicine, and so that may cause those numbers to further drop. Neurosurgery is a very small discipline. There are very few trainees nationally. The applicant pool is equally small and highly qualified. Thus far, that applicant pool, to my knowledge, is relatively stable. Orthopedic surgery, because of the desirability of the field and the opportunities for the excitement of the medical advances, continues to have a strong interest, as does ophthalmology, which has seen a resurgence. Anesthesiology, a critical discipline, has seen a beginning of a resurgence, but has tremendously low numbers interested in comparison to a decade ago.

If I might, there was a question posed about decreasing malpractice. I think that the Institute of Medicine report is very instructive in that regard, you know. There are numbers that are thrown around and they are challenged, but if we take it on its face that there is somewhere between 50 and 100,000 lives lost or major injury caused by the healthcare delivery system, one must read that report even further because it points out that most of that is not related to individual malfeasants in conduct of their duties, that it is a fundamental systems issue. I think that—and I did mention, by the way, physician reimbursement in passing. I think we are approaching a time where the systematic underfunding of the healthcare delivery system in this Nation is reaching crisis proportion. The analogy of termites is very applicable. We have had cost minus escalations in Medicare payments, Medicaid payments, across almost 20 years now. We have systematically dismantled the ability of institutions, whether it be physician groups or hospitals, to cost shift and reap surpluses from the commercial side because of managed care, and so we are down to the margin for every payer. If you add to that the fact that the Federal Government did away, and therefore, all other insurers did away with capital reimbursement, you are seeing the systematic underinvestment in systems to support patient care, and so we are not as a Nation in the healthcare delivery side able to take advantage of the information system technology that would minimize or do away with medical errors, prevent overdosing or underdosing medication because it is not possible in a computerized medical system, that would enhance the transmission of information with the patient from provider to provider.

There are very few healthcare delivery systems in the United States now that are operating with the kinds of surpluses necessary to make the tens to multiples of ten million dollar investment in information systems necessary to take advantage of what

is available and has been pointed out would dramatically decrease the number of medical errors in this system. This has to be addressed. We cannot continue to systematically underfund while expanding the responsibilities and the numbers of patients, the numbers of uncompensated patients, as well as the technology mix that our population demands.

Mr. GREENWOOD. Amen to that, but the follow-up question that I would pose is, of course, there are medical errors committed by physicians all across this country. Of course, there are things such as the ones you have just suggested that we could do to try to reduce medical errors using the best in technology, et cetera, but as I look at Pennsylvania, and I look at what we are going through here with regard to premiums, no one has suggested so far that the fundamental cause of that is because Pennsylvania physicians are making higher rates of—committing higher rates of malpractice, that they are making more errors, that our system of preventing those errors are as uniquely lacking as our premiums are extraordinarily high.

Mr. NASCA. I agree with you 100 percent. I was merely responding to the question, what can we do to decrease the front end, because as a physician, and I think as a member of the general public, I would much rather see not worrying about limiting pain and suffering awards to have no one having any pain and suffering. I think all of us are interested in that.

Mr. GREENWOOD. Let me quickly—Mr. Rosenfield, just one factual thing we need to get corrected here. You had said that this company, SCPIE, or whatever, if that is how that is spelled or——

Mr. ROSENFIELD. It is the Southern California Physicians Insurance Exchange, and you know, I apologize. I don't know for sure. It is my impression, but I am a little jetlagged. I will write a letter to the committee.

Mr. GREENWOOD. We need to know because we have had two different statements about whether it is physician owned or not.

Mr. ROSENFIELD. I will get that information for you.

Mr. GREENWOOD. And you representing the Foundation for Consumer and Taxpayer Rights. Can you tell me who funds that, where does your funding come from?

Mr. ROSENFIELD. Seventy-five percent from foundation grants, 25 percent from donations from the public.

Mr. GREENWOOD. Okay. And are any of those foundations, do they tend to be foundations like Pew and so forth?

Mr. ROSENFIELD. Yes.

Mr. GREENWOOD. Are any of those foundations specifically funded primarily by physicians, or trial lawyers, or——

Mr. ROSENFIELD. No.

Mr. GREENWOOD. Can't get you that way?

Mr. ROSENFIELD. No, but we do get—you know, of the 25 percent or so of our individual donors, defense lawyers, trial lawyers, a few insurance company honoraria, so you can get me that way if you want.

Mr. GREENWOOD. We can get you that way. All right. Very well. My last point that I want to make, a question, Mr. Mundy, and this goes—some other people made the comment about we need to have more money in the system. We need to pay doctors more and they

need to get more from their HMO's, they need to get more from Medicare, and so do hospitals. I am working on all of those issues. But again, if what I looked at when I looked across the country were fairly uniform premiums, and Pennsylvania physicians just not earning enough money to pay the same kind of premiums that are affordable in the rest of the States, I would say that is the No. 1 culprit, but I don't think that is what you are suggesting. Is it? I mean, that is a universal problem. It is not the case that we have got reasonably priced premiums but docs here don't make enough money, as much as it is that we have docs in this State like docs in every State, who are underpaid, and in this State, we have got these out of reach premiums that they just can't afford.

Mr. MUNDY. What I am saying is physicians are willing to jump from Pennsylvania to New Jersey, where premiums are just as high but they had earned twice as much money. And that is why the reimbursement disproportion that Pennsylvania physicians have is a big factor in the——

Mr. GREENWOOD. Are premiums just as high in New Jersey as they are in Pennsylvania, Mr. Diener?

Mr. DIENER. I am sorry, Congressman, I don't know what they are in New Jersey.

Mr. GREENWOOD. Does anybody know the answer to that? Are premiums—nobody knows the answer to that. In that case——

Mr. MUNDY. They just went on strike in New Jersey.

Mr. DEUTSCH. I would ask that the record stay open for any written questions from any members of the subcommittee.

Mr. GREENWOOD. Okay. With that, I would like to thank all of our witnesses on this panel, the witnesses on the other panel, and I thank Mr. Deutsch and his staff for your help. I want to thank my splendid staff in Washington and here in the District for all of your work. I thank St. Mary Hospital. This hearing is adjourned.

[Whereupon, at 4 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]



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February 21, 2003

Honorable James Greenwood
Chairman, Energy and Commerce Committee's Subcommittee on Oversight and Investigation
United States House of Representatives
2125 Rayburn House Office Bldg.
Washington, D.C. 20515

Dear Representative Greenwood:

I would like to clarify two issues that arose during the February 10, 2003 hearing of the House Energy and Commerce Committee Subcommittee on Oversight and Investigations, held in Langhorne, Pennsylvania.

1. Minimum coverage for doctors in California. One of the witnesses at the hearing suggested that a possible explanation for the reduction in medical malpractice premiums after the passage of Proposition 103 was that there was a substantial reduction – from $1 million to $100,000 – in the minimum amount of malpractice coverage California physicians must purchase. We have inquired into this issue and have learned that there is not now, nor was there previously, any minimum compulsory malpractice insurance requirement in California. There is no state law requiring that physicians carry medical malpractice insurance at all. The Medical Board of California further confirmed that the board has no coverage requirement as a condition for obtaining a license.

It is our understanding that the vast majority of physicians in the state voluntarily maintain high limits coverage, of at least $1 million. The implication that doctors in California have opted for lower coverage in recent years is unsubstantiated and likely incorrect. Again, the evidence shows that Proposition 103's 20% rollback and stringent regulation of malpractice insurers, not MICRA, was responsible for the 20% reduction in medical malpractice premiums in California after the passage of Proposition 103.

2. Status of SCPIE case. As I noted in my presentation, FTCR has challenged, under Proposition 103's authority, a 15% rate increase requested by SCPIE Corporation, the parent company of California's second largest medical malpractice insurer. Two days ago, our actuaries determined that SCPIE's rate increase request was unjustified and misspoke at the hearing when I stated that SCPIE was currently a physician-owned insurer. SCPIE's predecessor, the Southern California Physicians Insurance Exchange (also known as SCPIE), was a reciprocal insurer rather than a public company. In 1991, that company refunded $30.7 million to policyholders to comply with Proposition 103. In 1997, however, SCPIE converted into a publicly held stock insurer traded on the New York Stock Exchange.

Please include this in the record of the hearing as an attachment to my testimony.

Thank you.

Sincerely,

Harvey Rosenfield